

COUNSELING AND PSYCHOTHERAPY WITH CLIENTS OF
MIDDLE EASTERN DESCENT: A QUALITATIVE INQUIRY

by

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ABSTRACT

Counseling and Psychotherapy with Clients of
Middle Eastern Descent: A Qualitative Inquiry

by

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It is becoming increasingly important for clinical and counseling psychologists to have multicultural competence skills for treating an increasingly diverse client population. The psychology literature related to culturally competent treatment with persons of Middle Eastern descent is currently limited. In this study, qualitative methodology was utilized to explore the mental health attitudes and psychotherapy experiences of clients of Middle Eastern descent. Participants described culturally influenced mental health attitudes. Major themes included the severity of stigma associated with mental illness, the importance of family in responding to mental illness, and the process of grieving in Middle Eastern cultures. Study findings suggest that culture influenced the experience of counseling and psychotherapy for these participants. Cultural identity and family dynamics played an important role in the therapy experiences of study participants. The therapists' ability to understand cultural identity and family dynamics was related to treatment acceptance and efficacy for these clients.

Recommendations for culturally competent therapy with persons of Middle Eastern descent are provided in terms of attitudes, knowledge, and skills.

(164 pages)

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Sara Boghosian

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CHAPTER I

INTRODUCTION

It is typical in postmodern qualitative research to make the life story and opinion of the researcher explicit, especially as they pertain to the topic being studied (Glesne, 2006; Lincoln & Guba, 1985; Morrow, 2007). However, it is typical in psychology research to introduce a topic area based solely upon empirical grounds and logical deduction. The following introduction will attempt to do both.

The Researcher

In the third year of a clinical psychology-training program I entered a classroom and was promptly told that I now had to re-evaluate everything that I knew about doing psychotherapy. This was the first day of a class called “Diversity Issues in Treatment and Assessment” and the professor was quick to point out that most of what we had been learning about conducting psychotherapy was designed by and for White Westerners and did not necessarily generalize to work with minority clients. I remember feeling very overwhelmed. Throughout this semester-long course we learned about different cultural groups and the ways in which culture can affect the psychotherapy process. In this class I received a lot of information about diversity and about the importance of becoming a culturally competent therapist. This class was designed not so much to turn students into culturally competent therapists in a single semester, but to begin our professional journeys in the direction of multicultural counseling competence.

The course itself, based on the multicultural psychology literature, focused exclusively on the four main ethnic minority groups in the United States: Asian

American/Pacific Islander, African American, Latino, and Native American. Although the class was not intended to develop expertise on working with these specific populations, it did introduce us to the vast multicultural psychology literature. I left the class knowing where to look for information and consultation in the future when working with people belonging to one of these four specific minority populations. However, I received no specific information regarding cultural groups outside of these four ethnic groups.

In this class we were also encouraged to explore our own culture and to become aware of the ways in which our culture shaped who we are as therapists. As an American therapist of Middle Eastern (Armenian) descent I found that although I related in many ways to the majority culture of my peers, I was also shaped by some Middle Eastern cultural influences that made me different. I began to wonder how the current psychology literature would have informed a therapist who might have met with my Armenian grandfather who emigrated from the Middle East (Turkey) during the 1920s. I felt as though my family would not have fit neatly into either the majority population's culture or into any of the cultural contexts of the four major minority cultural groups. I also began to wonder how prepared Western psychologists are for working with Middle Eastern clients today. These questions led me to want to understand more about Middle Eastern culture and also about the potential effectiveness or utility of traditional Western mental health psychotherapy for Middle Eastern clients.

The Study

Current theories of psychotherapy have primarily evolved from the clinical and research experiences of White therapists working with upper middle-class White clients (Dana, 2002) in Europe and the United States of America. However, scholars have questioned the applicability of the assumptions and techniques of mainstream Western psychotherapies to people of other cultures (Ridley, 2005; Sayed, 2003; Sue & Sue, 2003). This would not be a concern if psychological distress and mental illness only affected White individuals. However, prevalence rates for mental illness across ethnic groups suggest that this is not the case U.S. Department of Health and Human Services, 1999; DHHS). What is distressing and healing varies across cultural groups (Tsai, Butcher, Munoz, & Vitousek, 2001). It seems important to first understand the mental health attitudes and psychotherapy experiences of minority clients in order to begin to understand how to provide culturally competent services to diverse populations. Sue et al. (1982) suggested that cultural competence involves having the (a) knowledge, (b) attitudes, and (c) skills to work effectively with diverse cultural groups.

The psychotherapy experiences and mental health attitudes of some ethnic minorities are well documented in the psychology literature. There is an abundance of multicultural counseling literature based upon the psychotherapy experiences and mental health attitudes of the four major ethnic minority groups within the United States: Latino, African American, Asian American, and Native American (Atkinson, 2004; Bernal, Trimble, Burlew, & Leong, 2003; Brammer, 2003; Canino & Spurlock, 2000; Carter, 2004; Constantine & Sue, 2006; Cuellar & Paniagua, 2000; Dana, 1998; Diller, 2007;

Hays, 2001; Ho, 1987; Houser, Wilczenski, & Ham, 2006; Lee & Richardson, 1991; Lonner & Malpass, 1994; McFadden, 1999; McGoldrick, Giordano, & Garcia-Preto, 2005; Palmer, 2002; Paniagua, 1994; Patel, 2001; Pedersen, 1999; Pedersen, Draguns, Lonner, & Trimble, 2002; Pedersen & Locke, 1996; Ponterotto & Casas, 1991; Ponterotto, Casas, Suzuki, & Alexander, 2001; Pope-Davis & Coleman, 2001; Robinson, 2004; Smith, 2004; Sue & Sue, 2003; Thomas & Schwarzbaum, 2006; Vace, DeVaney, & Wittmer, 1995).

It is from this ever-growing body of literature that several versions of multicultural competencies for therapists and counselors have evolved (APA, 1993, 2002, 2003; Sue & Sue, 2003). Multicultural competencies are a set of skills and/or guidelines designed to help a therapist or counselor provide culturally competent psychotherapy regardless of the culture of the client. Although, these competencies are meant to be general and can be applied when working with any diverse individual or system in psychotherapy, it is suggested that therapists also have knowledge about the cultural norms of any specific population with whom they work (APA, 1993, 2002, 2003). This means that therapists are expected to look to the relevant literature and/or to consult with experts in order to have specific knowledge about the cultural norms of any minority group that they are working with in psychotherapy.

Although there is a plethora of literature available, the state of the ethnic minority mental health literature is relatively underdeveloped to meet the needs of clinicians looking to adhere to the multicultural competencies due to the immense complexity of the task. In addition, the APA (1999) reports that 91% of psychologists are White, and only 9% of psychologists report that they provide services in a language other than English

(APA, 2010). This means that less than 10% of psychologists represent all other ethnic groups and primary languages in the United States. Meanwhile, many of these White psychologists are treating ethnic minority patients (Schwartz, Domenech-Rodriguez, Santiago-Rivera, Arrendondo, & Field, 2010). This highlights the need not only for recruitment of ethnic minorities into psychology training programs, but the importance of all psychologists having multicultural competence skills. Psychologists in training will likely receive information about working with the major ethnic groups in psychotherapy. However, a clear need for further study exists with groups outside of the large ethnic minority groups, one of which is with persons of Middle Eastern descent.

Persons of Middle Eastern descent have not been researched extensively in the psychology literature. Given the broader social/historical context (September 11th, 2001; recent wars in Middle East) research on this population may be particularly timely. For example, awareness of and discrimination towards Middle Eastern people seems to have increased dramatically in the last decade (Arjouch, 2005; Awad, 2010; Cainkar, 2002; Ibish, 2003). It will be important for the psychotherapy experiences and mental health attitudes of clients of Middle Eastern descent to be explored in depth in order to begin to make recommendations for culturally competent psychotherapy with this population.

The current study seeks to explore from clients' perspectives what therapists and counselors working with this population need to know in order to provide culturally competent psychotherapy. Thus far, existing recommendations in the psychological literature for how to provide culturally competent services to persons of Middle Eastern descent come exclusively from therapists who work with this population. These articles, which will be reviewed in Chapter II, are primarily anecdotal accounts written by Middle

Eastern therapists and are not based upon empirical studies. Gathering information and feedback from persons of Middle Eastern descent who have engaged in psychotherapy could add important support to existing recommendations and possibly add new insights for practitioners and researchers alike.

CHAPTER II

REVIEW OF LITERATURE

This literature review covers four primary areas of inquiry. First, the review presents existing definitions of what constitutes a person of Middle Eastern descent. The review of these definitions is presented to orient the reader toward what groups are encompassed in this broad category, as well as a rationale for focusing on a broad Middle Eastern population rather than specific cultural groups within it (e.g., only Arabs, only Persians, only Muslims). Evidence that persons of Middle Eastern descent are a growing population in the U.S. is also presented. Second, existing scholarly efforts to present guidelines for working with this population are reviewed. Third, the evidence supporting a need for multicultural competence in counseling and therapy is presented. Also, a definition/theory of multicultural counseling competence is presented as a guiding framework for this qualitative inquiry. Finally, a review of the expectations of psychologists working with diverse populations is included.

What Is the Middle East and Who Is Middle Eastern?

There is no universally accepted definition of the term “Middle East” among scholars who study the region and its people. The complexity of geographical boundaries extends to Middle Eastern identity (Gregg, 2005). A thorough review of published definitions is outlined below. Four major dimensions of Middle Eastern identity emerged including: geography, religion, nationality, and ethnicity. Any one person of Middle

Eastern descent may identify by each of these independent domains and most often by a combination of them.

Nationality

Nations that are often included in definitions of the Middle East are Turkey, Syria, Lebanon, Israel, Jordan, Iraq, Iran, Saudi Arabia, Yemen, Oman, United Arab Emirates, Qatar, Bahrian, Kuwait, Egypt, Sudan, and Cyprus (Academic American Encyclopedia, 1997; Bahr & Johnston, 1993; Chernow & Vallisi, 2003; CIA World Factbook, 2006; Heravi, 1973; Mattar, 2004; Mostyn, 1988; The New Encyclopedia Britannica, 2005; The New Dictionary of Cultural Literacy, 2002; The World Book Encyclopedia, 1988. Sometimes the Palestinian Territories, Libya, Azerbaijan, North Africa, Afghanistan, Pakistan, Morocco, and even Greece are included in the definitions from these same sources. However, a quick review of several different dictionaries and encyclopedias created some confusion, because each of them had slightly different lists of countries included in the definition of The Middle East. Table 1 shows the countries included in various definitions of the Middle East.

Nationality in the Middle East is never synonymous with ethnicity or religion although most nations in the Middle East have a strong majority ethnicity and religion. A national identity in the Middle East necessarily includes a political context. The nations of the Middle East subscribe to a vast array of political ideologies (Gregg, 2005). For example, Syria practices a form of socialism, whereas Saudi Arabia and Jordan have monarchies (Monacco, 1985). Turkey is currently attempting to join the European Union

Table 1

Nationalities Included in Definitions of Middle East

Nationalities	Citings	Academic American Encyclopedia (1997)	Britannica Encyclopedia (2006)	Columbia Encyclopedia (2003)	New Dictionary of Cultural Literacy (2002)	CIA World Factbook (2008)	Collier's Encyclopedia (1993)	The World Book Encyclopedia (1988)	Encyclopedia of the Modern Middle East (2004)	Concise Encyclopedia of the Middle East (1973)	The Cambridge Encyclopedia of the Middle East and North Africa (1988)
Iraq	10	X	X	X	X	X	X	X	X	X	X
Iran	10	X	X	X	X	X	X	X	X	X	X
Saudia Arabia	10	X	X	X	X	X	X	X	X	X	X
Yemen	10	X	X	X	X	X	X	X	X	X	X
United Arab Emirates	10	X	X	X	X	X	X	X	X	X	X
Qatar	10	X	X	X	X	X	X	X	X	X	X
Bahrain	10	X	X	X	X	X	X	X	X	X	X
Kuwait	9	X	X	X	X		X	X	X	X	X
Turkey	9	X	X	X	X	X	X	X		X	X
Syria	9	X	X	X	X	X	X	X		X	X

(table continues)

Nationalities	Citings	Academic American Encyclopedia (1997)	Britannica Encyclopedia (2006)	Columbia Encyclopedia (2003)	New Dictionary of Cultural Literacy (2002)	CIA World Factbook (2008)	Collier's Encyclopedia (1993)	The World Book Encyclopedia (1988)	Encyclopedia of the Modern Middle East (2004)	Concise Encyclopedia of the Middle East (1973)	The Cambridge Encyclopedia of the Middle East and North Africa (1988)
Lebanon	9	X	X	X	X	X	X	X		X	X
Israel	9	X	X	X	X	X	X	X		X	X
Jordan	9	X	X	X	X		X	X	X	X	X
Egypt	7	X		X		X	X	X		X	X
Cyprus	6	X	X				X	X	X		X
Sudan	5	X	X	X			X				X
Libya	5	X	X	X			X				X
Afghanistan	4						X	X	X		X
Morocco											
North Africa	4	X					X		X		X
Palestinian Territories	3			X		X					X
Pakistan	3	X		X			X				
Azerbaijan	1	X									
Greece	1	X									

Note. 1. Academic American Encyclopedia (1997); 2. Britannica Encyclopedia (2006); 3. Columbia Encyclopedia (2003); 4. New Dictionary of Cultural Literacy (2002); 5. CIA World Factbook (2007); 6. Collier's Encyclopedia (1993); 7. The World Book Encyclopedia (1988); 8. Encyclopedia of the Modern Middle East (2004); 9. Concise Encyclopedia of the Middle East (1973); 10. The Cambridge Encyclopedia of the Middle East and North Africa (1988).

(Buzan & Diez, 1999), while Iran is a republic guided by an Islamic ideology (Arjomand, 1988).

Ethnicity

The Middle East is populated by various ethnic groups. Ethnic groups tend to dominate particular Middle Eastern nations; however, the overlap is not total. A review of commonly cited encyclopedias produced a short list of ethnic groups found in the Middle East. Arabs, Kurds, Turks, and Jews were always mentioned (Academic American Encyclopedia, 1997; Bahr & Johnston, 1993; Compton's by Britannica Encyclopedia, 2007; Heravi, 1973; Mostyn, 1988; World Book Encyclopedia, 1988) whereas Persians, Armenians, Copts, and Africans were listed in at least four of these resources. Table 2 shows the ethnic groups included in various encyclopedic definitions of the Middle East.

Arabs are the largest ethnic group in the Middle East (Dwairy, 2006). The term "Arab" has come to be synonymous with those who speak Arabic, but originally included the tribes that lived on the Arabian Peninsula (Abuddabbeh, 2005; Abudabbeh & Aseel, 1999). However, in the region there are also Turkic people who speak Turkish and primarily live in Turkey (Katzner, 2002). In the region, there are Persians who speak Farsi and primarily live in Iran (Katzner). Kurds are another ethnic minority in the Middle East, who speak their own language, but do not have their own country (Mattar, 2004). Kurds can be found primarily in Iraq, Iran, and Turkey. Armenians are another ethnic group that is scattered throughout the Middle Eastern region (McGoldrick et al., 2005). Armenians speak their own language (Katzner, 2002) and since the breakup of

Table 2

Ethnic Groups Located in Middle Eastern Region

Ethnicity	Citings	Academic American Encyclopedia (1997)	Collier's Encyclopedia (1993)	World Book Encyclopedia (1988)	Concise Encyclopedia (1988)	Cambridge Encyclopedia of Middle East and North Africa (1988)	Compton's by Britannica Encyclopedia (2007)
Arab	6	X	X	X	X	X	X
Kurd	6	X	X	X	X	X	X
Turk	6	X	X	X	X	X	X
Jews	6	X	X	X	X	X	X
Armenian	5	X		X	X	X	X
African	5	X		X	X	X	X
Persian	4	X			X	X	X
Copts	4			X	X	X	X

the Soviet Union in 1991 have their own country. However, more Armenians live outside of Armenia than in it (Tololyan, 2000). Armenians from Armenia proper differ in many ways from those who come from the Middle East. In the Middle East, Armenians often live in Lebanon, Jordan, and Turkey (Tololyan, 2000).

Geography

The Middle East encompasses a vast range of geography including arid and semi-arid deserts, rich river valleys, mountains, and coastal regions (Peretz, 1994). The people from a given region will differ in ways from people from another region. For example, the cultures of the Persian Gulf states have been heavily impacted by oil money. However, many people who live in the Middle East live below the poverty line (van Eeghan, 1998). The cultures of the Arab Peninsula also differ from cultures that do not live in an arid desert, because the geography itself had a role in shaping these cultures

over time. A participant in an unpublished pilot study (Boghosian, 2007) leading to the current inquiry said:

I'll give you an example. In Jordan you travel half an hour, you can be in Africa, otherwise, tropical, in a half an hour, and a half an hour in the other direction is snow. So how diverse the geography is, is how diverse the people

The confusion surrounding the physical boundaries that demarcate the Middle East is further complicated by the fact that national borders have been drawn somewhat arbitrarily and do not necessarily reflect the ethnicity or geography of the region (Kamrava, 2005). A country may include rival sects or ethnicities or cut a mountain region in half. For example, there is a Kurdish cultural region that is half located in Iraq and half in Turkey. The people of this region call it Kurdistan, but there is no such recognized country. Half of the Kurds in this region are Turkish citizens and half are Iraqi citizens, however, the more salient identity for most of them is their Kurdish ethnicity rather than their Iraqi or Turkish nationality (Yavuz, 1998). A map of the Middle East prepared by the United Nations is included in Appendix A.

Religion

Although, most Middle Easterners are Muslim, there are actually more Muslims outside of the Middle East than in it (Westerlund & Svanberg, 1999). For example, most of the world's Muslims live in Indonesia (Kettani, 2010). The Middle East is also home to several other religious groups including Christians, Jews, and Hindus (Bushra, Khadivi, & Frewat-Nikowitz, 2007). Each of these major religions encompasses a variety of sects that differ in terms of belief and practice. Dwairy (2006) stated that "Muslim and non-Muslim Arabic culture is deeply influenced by the heritage and history of Islam" (p. 15). Although, in the Middle East most Arabs are Muslim, in the U.S. at

least half of the Arab population is Christian (Abu-Baker, 2006). Samhan (2006) reported that 77% of the Arab American population is Christian. However, Abu-Baker stated that, “even Christian Arabs who felt themselves to be a minority in the Middle East feel more Arab than Christian in the United States” (p. 30). This comment highlights the difficulty of separating these four domains for the purposes of research.

Defining Middle Eastern. With such rich cultural diversity, it would be appropriate to ask whether it make sense to use the Middle Eastern label at all. However, the importance of each of these dimensions (geography, religion, nationality, and ethnicity) to the formation of Middle Eastern identity makes it difficult to isolate and study single groups within these dimensions. For example, attempting to studying a religious cultural group like Muslims forces one to either encompass or ignore the ethnic, national, and geographical differences within this group, while studying an ethnic group like Arabs requires encompassing or ignoring the religious, national, and geographical differences within this group. Perhaps, it is at the intersection of these four dimensions that one should begin. It could be argued that any Middle Eastern identity would include all four dimensions. It is by studying those from the entire Middle Eastern region that one can encompass and highlight each of these dimensions.

Although there is no set definition of the term “Middle East,” according to the Middle East Network Information Center (MENIC) at the University of Texas at Austin, there are at least 27 departments of Middle Eastern Studies at prominent U.S. universities. These academic departments primarily define the Middle East region based upon the languages that they study (e.g., Arabic, Farsi, Turkish). Dr. Peter von Sivers, the

associate director of the Middle East Center at the University of Utah, stated in a personal email communication (September 18, 2007):

There is no official definition of the Middle East as a region. For the most part, however, Middle East Centers at American universities are agreed that the region encompasses Sudan, Egypt, Israel, Lebanon, Syria, Turkey, Iran, Iraq, Saudi Arabia, Yemen, Oman, and the Gulf States. Often the region of “North Africa” (Libya, Tunisia, Algeria, Morocco) is added to the Middle East designation, which then becomes “MENA.” Some scholars add Afghanistan in the east and Mauritania in the west to the MENA region, but these are in a minority. Afghanistan is generally considered to be part of “South Asia” and Mauritania of “Africa South of the Sahara.” The ethnic groups of the Middle East (minus Afghanistan and Mauritania) are: Arabs, Turks, Iranians (Persians), Kurds, Armenians, Jews, Berbers (in North Africa), and a few small minorities (e.g., Circassians, Turcomans, etc.).

For a list of U.S. universities with academic departments in Middle Eastern studies see Table 3.

Gregg (2005) in his book *The Middle East: A Cultural Psychology* described the Middle East as a “cultural area.” He has argued that although there are certainly diverse cultures within the Middle East, there are also many shared characteristics as a result of “nomadism, peasant agriculture, and urban commerce in arid and semiarid lands, combined with the widespread adoption of Arab culture and Islam” (p. 4). He defended the study of the region by saying:

Far from portraying a culture as homogeneous and cut off from its neighbors, the culture area concept can help (1) recognize patterns of psychological development that this region shares with neighboring culture areas; (2) identify patterns that differ from those of neighboring areas; and (3) do justice to the great range of variation (male-female, urban-rural, country-to-country, and individual-to-individual) observed within the region. Viewing the region in comparison with its neighbors also helps take an important step away from ethnocentrically seeing it in the light of American middle class values. (p. 5)

Table 3

Middle Eastern Studies Departments at Universities in U.S.

-
- Brandeis University, Near Eastern and Judaic Studies
 - Columbia University, Department of Middle East and Asian Language and Cultures
 - Cornell University, Department of Near Eastern Studies
 - Dartmouth University, Department of Asian and Middle Eastern Languages and Literatures | Asian and Middle Eastern Studies Program
 - Emory University, Middle Eastern Studies
 - Georgetown University, Center for Contemporary Arab Studies
 - Harvard University, Center for Middle Eastern Studies
 - Indiana University, Department of Near Eastern Languages and Cultures
 - Johns Hopkins University, Near Eastern Studies
 - Johns Hopkins University, Nitze School of Advanced International Studies, Middle Eastern Studies Department
 - MIT Electronic Journal of Middle Eastern Studies
 - New York University, Hagop Kevorkian Center for Middle Eastern Studies
 - Ohio State University, Middle East Studies Center
 - Portland State University, Middle East Studies Center
 - Princeton University, Near Eastern Studies
 - University of Arizona, Center for Middle Eastern Studies | Near Eastern Studies
 - University of California, Berkeley, Middle Eastern Studies
 - University of California, Los Angeles, G.E. von Grunebaum Center for Near Eastern Studies | Dept of Near Eastern Languages & Cultures
 - University of Chicago, Center for Middle Eastern Studies | Dept of Near Eastern Languages & Civilizations (NELC) | Middle East Documentation Center (MEDOC) | Oriental Institute
 - University of Florida, Asian and African Languages and Literatures
 - University of Massachusetts, Amherst, Judaic and Near Eastern Studies
 - University of Michigan, Center for Middle Eastern and North African Studies | Dept of Near Eastern Studies
 - University of Texas at Austin, Center for Middle Eastern Studies | Department of Middle Eastern Studies
 - University of Utah, Middle East Center
 - University of Washington, Middle East Studies Center | Dept of Near Eastern Languages & Civilization, Middle East Studies Center
 - Washington University St. Louis, Asian and Near Eastern Languages and Cultures
 - Yale University, Near Eastern Languages and Cultures
-

While arguing for the use of the Middle Eastern label in his research, Gregg (2005) also acknowledged the dangers of doing so. The dangers of grouping together distinct groups into one larger ethnic group using “ethnic gloss” is outlined by Trimble and Dickson (2005). Trimble and Dickson define ethnic gloss as “an overgeneralization or simplistic categorical label of ethnic groups...that neglect the unique differences found among individuals in various cultures or groups.” However, Gregg (2005) suggests that the benefits of researching Middle Eastern people together, rather than as separate cultural groups seem to outweigh the costs of doing so at this time.

Despite the vast diversity across multiple dimensions of identity, some scholars argue that there are important similarities across Middle Eastern subgroups. Bushra and colleagues (2007) highlighted that the people of this region “shared common architectural, agricultural, and intellectual influences under the Arab caliphate for three centuries, and culturally, therefore, they are permeated by Islamic influence, even those whose majority do not speak Arabic” (p. 222). This geographical region has also been subject to the conquering influences of The Ottoman Empire and The Persian Empire. Gregg (2005) argued that “the societies in this region share many characteristics with each other that they do not share with neighboring regions.” Moracco (1985), in defense of studying Middle Eastern people as whole rather than distinct cultural groups, stated that “it seems that the powerful influence of language and religion creates more similarities than differences.” Dwairy (2006) suggests that it is tribalism, Islam, and exposure to the West that have shaped the culture of this region.

Bushra and colleagues (2007) referred to people of Middle Eastern origin as

the descendants of all peoples around the southern and eastern edges of the Mediterranean basin that were invaded and converted to Islam in the original 7th century conquests and that to this day have remained Arab societies to varying degrees. This geographic area includes Turkey, Iran, Iraq, Israel (i.e., its residents of Arab [Christian or Muslim] and Sephardic Jewish origin), the Palestine Territory, Syria, Lebanon, Jordan, Egypt, Libya, Tunisia, Algeria, Morocco, and the countries of the Arabian peninsula (Bahrain, Kuwait, Maldives, Oman, Qatar, Saudi Arabia, United Arab Emirates, and Yemen). (p. 222)

In an unpublished pilot study (Boghossian, 2007), a diverse group of Middle Easterners living in the U.S. were asked about their cultural identity and mental health attitudes. Although these participants reportedly did not prefer to be identified as Middle Easterners and came from very different cultural groups (i.e., Muslim Kurds from Turkey, a Muslim Turk, an Iraqi Kurd who was not practicing Islam, an Arab Afghani who was not practicing Islam, and a Christian Arab from Jordan), the common themes in their individual interviews made their similarities notable. Participants in this study speculated that the influences of Islam, Arab culture, and/or the Ottoman empire were responsible for such similarities. Each of them at some point in the interview also referred to themselves as a Middle Easterner. In fact, many Middle Easterners use the Arabic term “al-Sharq al-Awsat” (Middle East) to refer to themselves (von Sivers, personal communication, September 18, 2007).

Growing Middle Eastern American Population

According to the U.S. Census (2008) the United States of America is becoming increasingly ethnically diverse. For example, by the year 2050 Whites will only consist of 50.1% of the American population (U.S. Census Bureau, 2008) and will likely become

a numerical minority soon after that. The Census has been, in the recent decades, tracking the growth of the four major ethnic minority groups (Latino, American Indian, Asian American, and African American). However, members of other minority groups are likely to garner closer attention from census demographers on future surveys. Persons of Middle Eastern descent are one of those ethnic minority groups.

It is difficult to accurately estimate the number of persons of Middle Eastern descent currently living in the U.S., because no question on the 2000 U.S. Census survey directly assessed this. However, more than 3 million census respondents claimed an ethnic heritage in 2000 that fit common definitions of Middle Easterners (e.g., Arab, Persian, Turkish, and Armenian). Approximately 1.2 million people reported Arab ancestry on the 2000 U.S. census. However, according to the Arab American Institute (AAI), the population of Arab Americans alone is around 3 million (Samhan, 2006). This number represents approximately 1% of the current U.S. population. That means that in 2000, persons of Middle Eastern descent accounted for approximately the same amount of the U.S. population as Native Americans. These census numbers are likely an underestimate of the population of Middle Eastern descent in the U.S. given that the over 3 million that self-reported on the 2000 census were selecting an “other” category and generating an ethnic label. It is likely that many others simply chose one of the pre-existing categories.

Arab Americans alone are one of the fastest growing minority groups in the United States (de la Cruz & Brittingham, 2003). As another example, the Armenian American population increased by 25% between 1990 and 2000 (U.S. Census, 2008). The numbers of Middle Eastern Americans are increasing (de la Cruz & Brittingham, 2003),

while psychological research on Middle Eastern culture is slow to catch up. Overall, persons of Middle Eastern descent have backgrounds common enough to generate a collective identity (i.e., “al-Sharq al-Awsat”) and sociopolitical histories that are difficult to disentangle. The population is growing and increasingly seeking psychological treatment. These combined elements support the study of a Middle Eastern population rather than specific subgroups. The focus of this research on informing mental health interventions further supports the study of a panethnic group given that each subgroup within it is part of a larger context and without knowing one a therapist cannot possibly be culturally competent with another (e.g., providing services to a non-Arab, non-Muslim person from Jordan or Syria). The growing proportion of persons of Middle Eastern descent within the broader U.S. population suggests that the time is ripe for this research.

For the purposes of this study, a person of Middle Eastern descent will be defined as a person of any ethnic or religious group who comes from this defined geographical region: Turkey, Syria, Lebanon, Israel, Jordan, Iraq, Iran, Saudi Arabia, Yemen, Oman, United Arab Emirates, Qatar, Bahrain, Kuwait, Egypt, Sudan, and Cyprus. Persons from the Palestinian territories will also be included in this definition. Although, these territories were not often cited in the review of encyclopedia definitions of the Middle East, they are located within the broader geographical region defined and are only excluded from definitions for political reasons. The Palestinian territories were recognized as an independent state by the United Nations in December 2009 and, therefore, were not often included in definitions before that time.

Also, only those Israeli individuals who immigrated to Israel from other countries in the Middle East or whose families resided in the geographical area now known as

Israel since before the Zionist movement will be included in the studies definition of Middle Easterner. The Zionist movement began in the late 1800s with a goal of establishing a Jewish homeland in the Middle East. The land currently known as Israel was declared a nation-state in 1947. The Jews that migrated to the new homeland came primarily from Europe and more recently from Russia and Ethiopia (Ziv, 2005). Israel is primarily a country of immigrants (Neuman, 1999). These immigrants have more in common culturally with Europeans than with other Middle Easterners, because most came to the area from Europe in the years following World War I (Kimmerling, 1989). Indeed, Israelis are unlikely to claim a Middle Eastern identity and see it as a goal to adopt a uniquely Israeli identity (Ziv, 2005).

The purpose of this research is to contribute information that will help therapists and counselors provide culturally competent psychotherapy to persons of Middle Eastern descent. To that effect, it is important to identify what is already known about working with this population in counseling and psychotherapy. The next section will attempt to consolidate and analyze what it known, thus far, about conducting psychotherapy and counseling with persons of Middle Eastern descent.

Middle Eastern Mental Health Attitudes

Little is known about the mental health attitudes of persons of Middle Eastern descent living in the United States. For the purposes of this study, mental health attitudes are defined as perceived cultural beliefs as well as personally held beliefs about mental health, mental illness, correlates of each, and appropriate responses to mental illness. Indigenous mental health healing practices would also be included in the definition of

mental health attitudes, because they include the mental health healing practices that are acceptable in a given culture.

Unfortunately, there is no empirical research available to identify the number of persons of Middle Eastern descent who are utilizing mental health services in the U.S. Scattered research is available on the mental health attitudes of Middle Eastern subgroups. For example, one study (Carolan, Bagherinia, Juhari, Himelright, & Mouton-Sanders, 2000) found that Muslim Americans are open to seeking help through Western psychotherapy. Another study found that Muslims in the United States are willing to see a therapist who is not Muslim, as long as that therapist has knowledge of and respect for Muslim culture (Kelly & Aridi, 1996). Although, not all Muslims living in the United States descend from the Middle East, these two studies (Carolan et al., 2000; Kelly & Aridi, 1996) provide some evidence that Middle Eastern Muslims may be willing to seek services in general and even receive services from non-Muslim American therapists.

One other study (Yuen & Tinsley, 1981) included some Iranian participants in a study that explored American college students' expectancies about counseling. However, the data for these participants was not reported independently. Therefore, little information can be gained from this study about Iranian attitudes about counseling in the United States. However, the fact that Iranian participants were included in this study does suggest that some Iranian college students were seeking services at a university counseling center and were willing to participate in a study related to psychotherapy experiences. Overall, however, it is unclear how Middle Eastern persons in the United States view psychotherapy and counseling.

Indirect evidence suggests that persons of Middle Eastern descent do utilize the services of therapists and counselors in the United States. For example, there are several articles in the multicultural psychology literature written by or about experts who work with this population (Abudabbeh, 2005; Abudabbeh & Aseel, 1999; Azary, 20006; Bushra et al., 2007; Carolan et al., 2000; Dagirmanjian, 2005; Dwairy, 1998; Erickson & Al-Timimi, 2004; Hall & Livingston, 2006; Jackson, 1997; Jalali, 2005; Kaeni, 2006; Kelly & Aridi, 1996; Khalid, 2006; Nassar-McMillan & Hakim-Larson, 2003; Rehman & Dziegielewski, 2003; Sayed, 2003; Tahmassian, 2003; Vartan, 1997). The 19 available articles were reviewed in order to extract the relevant recommendations. All of the articles focused solely upon specific subgroups within the broader Middle Eastern population (e.g., Arabs, Muslims, Armenians). Although, these articles focused on a variety of Middle Eastern subgroups, many of the recommendations were similar.

Across 19 articles, there was greatest agreement on the recommendation that a therapist understand the specific culture of the client in order to treat them effectively (84%). A majority (63%) also recommended that the therapist assess the acculturation level of the client before proceeding with psychotherapy. One third to a half of these authors also suggested that: the family be present for psychotherapy, the therapist understand the religion of the client, a more directive form of psychotherapy be used, experienced racism should be explored, a more holistic approach is culturally appropriate, somatization should be viewed as a culturally proscribed behavior rather than as pathology, psychoeducation about counseling process should be included at the beginning of psychotherapy, psychotherapists should engage in examination of their own biases and stereotypes, and encourage therapist recognition of the diversity within the

population. Tables 4 and 5 below include complete information on the recommendations included in these articles.

These cultural experts provide insight into their psychotherapy work with clients of Middle Eastern descent. However, they also indirectly provide evidence that persons of Middle Eastern descent living in the United States are not only open to psychotherapy, but are actually engaged in psychotherapy within the United States. The experiences and recommendations of therapists working with this population are very important to the field of multicultural psychology. However, it will be important to add the voice of Middle Eastern clients to this dialogue. In the broader culture, clients often have different insights about the psychotherapy process than therapists themselves (Yalom, 2005). It is by having both client and therapist perspectives included in the dialogue that the field of psychology can best increase efficacy.

Middle Eastern Culture

Dwairy (2006), a Palestinian therapist trained in Western psychotherapy methods who practices in the Middle East, argued that there are qualitative differences between Western and Middle Eastern culture that directly affect the practice of psychotherapy. Some of these differences may include the role of religion in daily life (Gregg, 2005), the importance of history and culture (Abu-Baker, 2006), collectivist culture (Dwairy, 2006) and unique family dynamics (Dwairy, 2006). Jafari (1993) indicated that Muslim Americans, although open to counseling in general, are reluctant to meet with Western counselors because they do not believe that their values will be understood or respected. It is unknown how these cultural values actually affect the mental health attitudes and

Table 4

Recommendations Endorsed by Multiple Articles

Recommendation	N	Publication
Understand culture	16	17, 10, 1, 2, 7, 15, 9, 13, 5, 16, 19, 18, 6, 11, 12, 3
Assess for acculturation status	12	4, 10, 8, 15, 9, 16, 19, 18, 6, 11, 12, 3
Family present	9	10, 8, 2, 7, 15, 9, 5, 6, 11
Understand religion	9	10, 8, 15, 9, 13, 14, 5, 16, 3
Holistic approach	9	10, 1, 7, 15, 9, 14, 11, 12, 3
Examine own biases	8	4, 1, 8, 2, 13, 14, 16, 19
Recognize diversity within population	8	1, 8, 13, 19, 18, 6, 11, 3
Directive psychotherapy	7	1, 8, 2, 7, 15, 11, 12
Explore experienced racism	7	4, 10, 8, 15, 14, 5, 16
Somatization is culturally appropriate	6	4, 8, 7, 14, 11, 3
Educate about counseling process	6	4, 7, 15, 6, 12, 3
Explore reason for immigration	5	15, 19, 6, 12, 3
Expect reticence to speak to nonfamily member	5	1, 8, 15, 6, 11
Speak language	4	17, 10, 14, 12
Community involvement	4	10, 1, 15, 9
Enmeshment is culturally appropriate	4	7, 6, 11, 12
Openness to indigenous healing practices	4	8, 7, 15, 3
Consult with cultural experts	4	8, 2, 9, 14
Same gender therapist	3	10, 16, 11
Individuation not goal	3	8, 7, 12
Explore experienced trauma	2	19, 6
In-home or telephone psychotherapy	2	1, 15
Stress located in heart not head	2	11, 14

Note. 1. Abudabbeh & Aseel, 1999; 2. Abudabbeh, 2005; 3. Azaary, 2006; 4. Bushra et al., 2007; 5. Carolan et al., 2000; 6. Dagirmanjian, 2005; 7. Dwairy, 1998; 8. Erickson & Al-Timimi, 2004; 9. Hall & Livingston, 2006; 10. Jackson, 1997; 11. Jalali, 2005; 12. Kaeni, 2006; 13. Kelly & Aridi, 1996; 14. Khalid, 2006; 15. Nassar & Hakim, 2003; 16. Rehman & Dziegielewski, 2003; 17. Sayed, 2003; 18. Tahmassian, 2003; 19. Vartan, 1997.

Table 5

Recommendations Endorsed in Only One Article

Recommendation	<i>N</i>	Publication
Nondirective psychotherapy	1	9
CBT	1	12
Systems approach	1	12
Narrative psychotherapy	1	18
Gender equity may not be goal	1	5
No group psychotherapy	1	11
Avoid future orientation	1	8
Avoid problem solving	1	8
Solution-focused brief psychotherapy	1	3
Avoid why questions	1	8
Avoid sustained eye contact	1	8
Don't refuse gifts	1	2
Flexible scheduling	1	2
No free services	1	15
Bargaining is culturally appropriate	1	12
No criticism or direct confrontation	1	15
Social rules/hierarchy is culturally appropriate	1	4
Answer personal questions	1	4
Greet as though entering home	1	12
Educate about U.S. culture/laws	1	12
Focus on strengths not weaknesses	1	3
Empower client to find own answers	1	3

Note. 1. Abudabbeh & Aseel, 1999; 2. Abudabbeh, 2005; 3. Azaary, 2006; 4. Bushra et al., 2007; 5. Carolan et al., 2000; 6. Dagirmanjian, 2005; 7. Dwairy, 1998; 8. Erickson & Al-Timimi, 2004; 9. Hall & Livingston, 2006; 10. Jackson, 1997; 11. Jalali, 2005; 12. Kaeni, 2006; 13. Kelly & Aridi, 1996; 14. Khalid, 2006; 15. Nassar & Hakim, 2003; 16. Rehman & Dziegielewski, 2003; 17. Sayed, 2003; 18. Tahmassian, 2003; 19. Vartan, 1997.

experience of counseling and therapy of persons of Middle Eastern descent when they do seek services from Western psychologists. Due to the lack of studies related to Middle Eastern attitudes about counseling in the West it will be important for researchers explore this topic in depth. It will be necessary to capture the views and opinions of a diverse sample of persons of Middle Eastern descent because little is known about within group differences and previous researchers have focused on only one Middle Eastern group at a time. The current state of knowledge presents a challenge for practicing psychologists who are increasingly likely to see persons of Middle Eastern descent in psychotherapy.

The Need for Multicultural Counseling Competence

Despite somewhat limited knowledge about conducting psychotherapy and counseling with this population, therapists and counselors in the United States are treating persons of Middle Eastern descent. Unfortunately, psychology as a field has a history of pathologizing and victimizing minority cultures (Dana, 2002; Guthrie, 2003; Pedersen, 2004) at times intentionally and more often, unintentionally (Ridley, 2005). Ridley suggested that psychologists are taught and later adopt certain models of mental health that inadvertently lead to unintentional racism in counseling and psychotherapy. Bernal and Sharrón-Del_Río (2001) suggest that psychotherapy itself is a White cultural phenomenon and that psychotherapy theories inherently include mainstream cultural values that often clash with minority values. A decade ago, Pedersen (1999) recommended multiculturalism as the fourth wave in psychology, because the previous waves of thinking did not take culture into account and therefore left minority cultures disenfranchised.

Health disparities between majority and minority cultures in the U.S. are well-documented (Schulman et al., 1999; Smedley, Stith, & Nelson, 2003; U.S. DHHS, 1999) and certainly extend to mental health services (Sue, Zane, Nagayama-Hall, & Berger, 2009). The relative absence of minority psychologists (APA, 1999, 2010) adds to this problem, given the increasing diversity of the U.S. population and therefore, persons requiring mental health services.

Guthrie (2003) has suggested that psychologists, as individuals, and psychology as a field have perpetuated the biases and racism found in the larger culture at each point in the field's short history. In 1971, Halleck referred to psychology as "the handmaiden of the status quo" (p. 30). In his book *Reel Bad Arabs: How Hollywood Vilifies a People* Shaheen (2001) explored how the film industry has perpetuated negative myths about Middle Eastern people to the American populace. Given that bias and racism directed at Middle Eastern people is rampant (Erickson & Al-Timimi, 2004; Said, 1997; Shaheen, 2001) in the broader American culture, particularly since the events of September 11, 2001, it will be important for psychologists to actively work against bringing such biases into the psychotherapy room.

Definition of Multicultural Counseling Competence

There is some confusion in the psychology literature regarding the definition of multicultural competence (Ridley, 2005). Sue and colleagues (2009) reviewed the varying definitions of cultural competence in the psychology literature. They found some commonalities across definitions, but also found many differences. A primary critique of

these definitions is that many of them do not lend themselves to empirical (positivist) examination and therefore are difficult to empirically support or refute.

Ridley (2005) explained that some experts champion general competencies that prepare a professional for work with all minority groups, while others support more specific competencies that suggest competency only with one minority group. However, there is agreement that cultural adaptations and multicultural competencies are necessary and positive additions to the field of psychology.

Cross (1989) offered an operational definition of cultural competence, stating that

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations. The word culture is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, or religious group. The word competence is used because it implies having the capacity to function effectively. A culturally competent system of care acknowledges and incorporates-at all levels-the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural difference, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. (pp. iv-v.)

In 1982, Sue and colleagues provided the most commonly utilized definition of multicultural counseling competence. These authors outlined three important areas of cultural competence: knowledge, attitudes, and skills. The three areas were defined by Sue and colleagues (2009, p. 529).

- Cultural awareness and beliefs: The provider is sensitive to her or his personal values and biases and how these may influence perceptions of the client, the client's problem, and the counseling relationship.
- Cultural knowledge: The counselor has knowledge of the client's culture, world-view, and expectations for the counseling relationship.

- Cultural skills: the counselor has the ability to intervene in a manner that is culturally sensitive and relevant.

These subdomains of multicultural competence continue to guide thinking and research in the area of multicultural counseling competence (Ridley & Kleiner, 2003). This generally accepted definition of multicultural competence will guide the current inquiry.

The American Psychological Association has attempted to address the complexity of incorporating multicultural competence into psychological practice by developing specific standards for psychologists who work with minority populations. The next section of this review will focus upon the professional expectations of psychologists who work with ethnic minorities. This section of the review may clarify the need to further explore the needs of persons of Middle Eastern descent in psychotherapy.

Expectations of Psychologists Working with Diverse Populations

The American Psychological Association (APA, 2010) published the most recent Ethical Principles of Psychologists and Code of Conduct. This report was designed to outline a code of conduct for the general practice of all psychologists in research, teaching, assessment, and psychotherapy work. The ethical principles and standards integrate expectations with regards to diversity and individual differences across the code, but nowhere as clearly as in the area of competence. Standard 2.01(a) of the APA ethics code requires that “psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience.” Standard 2.01(b) stated:

Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with age, gender, gender identity, race, ethnicity, culture, national origin, religion, sexual orientation, disability, language, or socioeconomic status is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services.

These standards seem to require that psychologists working with diverse clients have an understanding of information relevant to that population. This suggests that therapists who may work with Middle Eastern clients need to understand the culture of persons of Middle Eastern descent.

In 1993, the APA published the *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations*. These guidelines were meant to provide suggestions to psychologists who work with diverse populations. They suggest that clients “acknowledge that ethnicity and culture impact behavior and take those factors into account when working with various ethnic/racial groups” (APA, 1993, p. 46). These guidelines also suggest that psychologists understand the culture of populations with whom they work and that they seek out training and information about populations with whom they are not familiar.

A decade later, the APA published a much more detailed set of guidelines for psychologists working with diverse populations. These were called the *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003). Guideline 2 states, “Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals” (p. 385). In 2006, the APA Presidential Task Force on Evidence-Based Practice reported that “clinical

expertise requires an awareness of the individual, social, and cultural context of the patient” (p. 277) and discussed the difficulties of translating evidence-based psychological practice to populations that were not included in the research that supported their use. The APA clearly expects that psychologists become knowledgeable about the cultures of the diverse clients with whom they work. Although, persons of Middle Eastern descent are not directly addressed within these documents, the guidelines clearly suggest that therapists working with all diverse populations have knowledge about the applicable cultural differences.

As a result of the APA’s expectations for psychologists working with diverse populations, culturally adapted psychotherapy interventions have gained in popularity in the United States in recent years. Two recent meta-analytic reviews (Griner & Smith, 2006; Smith, Domenech-Rodriguez, & Bernal, 2011) found that culturally adapted mental health interventions were significantly more effective than interventions that were delivered to minorities but did not make adaptations for cultural context. Griner and Smith also found that interventions that were designed for a specific cultural group were four times more effective than those that targeted multiple minority cultures. These findings suggest that interventions that take specific cultural needs into account will affect the most client improvement.

It is clear that not only are psychologists expected to be informed about diverse populations that they may encounter in psychotherapy (knowledge), and that psychologists need to understand their own biases related to cultural minorities (attitudes), but that psychologists who culturally tailor their treatments have the potential to be most effective in producing positive change in their clients (skills).

This makes it clear that therapists working with clients of Middle Eastern descent need to be knowledgeable about the culture of this growing population and that knowledge alone may not be sufficient to produce the best results. The present research therefore seeks to make a contribution towards better understanding the relationship between Middle Eastern culture and psychotherapy in the West. It will be necessary to explore in depth the psychotherapy experiences and mental health attitudes of persons of Middle Eastern descent in order to begin to understand what knowledge, attitudes, and skills will lead to culturally competent treatment of Middle Eastern people in the U.S.

Ridley (2005) stated:

Unless researchers provide useful knowledge about the experiences of minorities in the mental health care system, the system will continue to treat minority clients unfairly. Practice-based research that examines the experiences of minority clients is unquestionably the intervention most likely to gather the knowledge required to alter professional practice and counter the institutional racism of the mental health system. (p. 182)

The primary purpose of this study is to identify, from the perspective of the client, what therapists working with clients of Middle Eastern descent need to know in order to begin to provide culturally competent psychotherapy and counseling to this population.

Therefore, participants will be asked about their experiences in psychotherapy and about their attitudes about mental health and mental health treatment. This study will attempt to add relevant information to all three of the domains of multicultural counseling competence: knowledge, attitudes, and skills (Sue et al., 1982) for professionals who work with Middle Eastern people in counseling and therapy in the U.S.

Research Questions

1. What are the mental health attitudes of persons of Middle Eastern descent?
2. What are the experiences of persons of Middle Eastern descent who receive psychotherapy in the U.S.?
3. How can psychologists begin to provide culturally competent psychotherapy to persons of Middle Eastern descent living in the U.S.?
 - What are the attitudes that lead to cultural competence in counseling and psychotherapy with persons of Middle Eastern descent?
 - What knowledge leads to cultural competence in counseling and therapy with persons of Middle Eastern descent?
4. What are the skills necessary to provide culturally competent psychotherapy to persons of Middle Eastern descent?

Helpful Definitions

This section includes definitions for words that may be used often in the following chapters. The definitions are intended to provide the reader with explanations for how the researcher understands these terms and what is meant when they are used in this manuscript.

- Cultural Identity--The way that a person self identifies along various dimensions. This may include, but is not limited to, religious identification, national identification, and ethnic identification (Pratt, 2005).

- Acculturation--the process of change that individuals (Teske & Nelson, 1974) and/or groups (Redfield, Linton, & Herskovits, 1936) go through as a result of contact with another culture.
- Enmeshment--Describes a lack of boundaries between family members that theoretically (Minuchin, 1974) leads to an individual's inability to individuate from their family of origin. The use of the term enmeshment in this document is used essentially as Minuchin intended it.
- Collectivism--A social pattern consisting of closely linked individuals who see themselves as part of the larger whole rather than as individuals and who place the norms and goals of the collective over their own interests. Members of the collective also emphasize their connectedness (Triandis, 1995).
- Individualism--A social or familial pattern of valuing individual goals and needs over group/collective goals (Triandis, 1995).
- Ethnic Gloss--When broad ethnic labels are used to identify individuals, which limits the understanding of their cultural and individual complexity (Trimble, 1990).

CHAPTER III

METHODS

In order to explore the psychotherapy experiences and mental health attitudes of persons of Middle Eastern descent an exploratory qualitative study from a critical-ideological paradigm (Morrow, 2007) was conducted. This relativistic paradigm “posits multiple, equally valid social realities” (Haverkamp & Young, 2007, p. 266). This paradigm also assumes that research cannot be value free and that a researcher’s values must be articulated explicitly (Morrow, 2007; Haverkamp & Young, 2007; Suzuki, Ahluwalia, Arora, & Mattis, 2007). Therefore, the researcher has included explicit discussions of her own background and values within the discussion and interpretation of the data. Within this critical-ideological paradigm, the purpose of this study is practice oriented (Haverkamp & Young, 2007) meaning that the findings should directly apply to the practice of multicultural counseling and psychotherapy.

Qualitative research may be the most appropriate research methodology when one needs to present a detailed and in-depth view of a particular phenomenon (Morrow, 2007) such as the psychotherapy experience of a particular ethnic group. Therefore, a phenomenological methodology, as outlined by Creswell, Hanson, Plano Clark, and Morales (2007), was utilized in this study. These authors state that “a description of common experiences of persons about a phenomenon results in phenomenology” (p. 259). In this case, the phenomenon studied is the experience of persons of Middle Eastern descent in Western psychotherapy. Morrow (2007) stated that qualitative

research methods are well suited for counseling psychology research and for culturally relevant theory building.

Participants were eligible for the study if they had seen a therapist in the U.S., lived in the U.S. for at least 5 years, and planned to remain in the U.S. for the foreseeable future. Participants were recruited through several Middle Eastern Studies list-serves, Middle Eastern student groups, mosques and other Middle Eastern churches, participant recruitment fliers at Middle Eastern restaurants and delis, and informal networks. Interested participants contacted the researcher after seeing a flier or hearing about the study. Nine of the participants responded as a result of seeing the flier. The remaining four heard about the study from an acquaintance. Six participants currently reside in California, all in different cities. Three participants currently reside in Utah. Two participants currently reside in Virginia. The other two participants live in Georgia and Washington, DC.

During the recruitment, two American-born women of Middle Eastern descent asked to participate in the study. These perspectives will be included in the study, because both women felt strongly about their participation and identified strongly as Middle Easterners. However, their comments will not be analyzed with the rest of the participants. Their perspectives will be discussed separately from the other participants within the findings section.

All participants participated in two semistructured telephone interviews that lasted approximately one hour each. This sample size is considered adequate by qualitative methods experts (Suzuki et al., 2007). Participants each selected a pseudonym before their first interview, so that their names are not associated with them in this manuscript.

The interviews were conducted at least one day apart so that participants could have some time to reflect upon the first interview before engaging in the second. Each participant was asked at the beginning of the second interview if they had anything that they wanted to add or change to their responses on the previous interview. The guiding interview questions for the first and second interviews are included in Appendix B.

Participants were sent transcripts from each of their interviews for member checking (Glesne, 2006) and were invited to comment upon their reactions to reading the transcripts during a follow-up phone call or email if they preferred that method. All of the participants chose to follow up via email or did not respond at all. These reactions and changes were added to the transcriptions of the original interview before data analysis. This data collection method was included as a result of comments from participants in the pilot study (Boghosian, 2007) who indicated that they thought a lot about the interview afterwards and had comments that they wished they could add. Experts on qualitative methodology suggest that sufficient data rather than large samples of participants is most important in studies such as this (Morrow, 2007).

The interviews were not fully structured, so as not to limit the type of information that was received. There is not yet enough research related to this population to allow for fully structured interview questions in studies exploring mental health attitudes and psychotherapy experiences. Therefore, open-ended questions were used. Open-ended questions are typical and recommended in qualitative research (Lincoln & Guba, 1985; Suzuki et al., 2007). Interviews were tape recorded and transcribed verbatim as described by Suzuki and colleagues.

An emergent design (Morrow, 2007) was utilized to analyze the data. In this case the data is the contents of the two interviews with the 13 participants. The researcher conducted the telephone interviews, listened to the recorder of each of the interviews at least once, and then read through each of the transcripts before analyzing the data. The relevant psychological literature and the findings from an unpublished pilot study (Boghosian, 2007) were utilized in the analysis and interpretation of the interview data (Haverkamp & Young, 2007). Thematic analysis as outlined by Glesne (2006) was used to analyze the interview data.

The interviews, member checking, and relevant literature provided for triangulation of data. All three forms of data served to answer the stated research questions. The outlined triangulation methods are typical in qualitative research and are suggested by qualitative methods experts (Glesne, 2006; Denzin & Lincoln, 2005).

Participants in this study were persons of Middle Eastern descent who had seen a therapist or counselor in the U.S. and were willing to speak about their experience. All of the participants volunteered to speak about their experiences in psychotherapy and counseling. The diversity of this small sample illustrates the diversity of cultural identities among Middle Eastern people. Given the complexity of Middle Eastern identities that was discussed above, it seems inappropriate to simply report aggregate statistics to describe these participants. For example, to say that the study includes eight women and five men is useful and yet inadequate. It will be important to describe each participant individually in order to capture the complexity of each person as an individual and as a Middle Easterner. Therefore a short descriptive narrative describing each participant will follow. These narratives were inspired by Marx's (2006) use of similar

narratives in her qualitative work on passive racism in education. Table 6 outlining the gender, nationality of origin, ethnicity, and religious identification follows.

Harout is a young Armenian man from Lebanon. He spent a few years as a young boy traveling in and out of Lebanon with his mother in order to flee religious persecution. When a war was being fought in Lebanon, his father had asked his mother to leave in order to keep his son safe. The two of them lived with family members all over the world during this 3-year period, while his father and sisters remained in Lebanon. Harout reported that he has not been back to Lebanon since age 5. His family reunited in the U.S. They speak a mix of Armenian, Turkish, and Arabic in their home. Harout speaks English with only a faint accent at this time. Harout reportedly struggled with drug and alcohol addiction throughout adolescence and young adulthood. As a result, he has been to see several outpatient therapists and has been to several inpatient substance abuse treatment facilities.

Shay is a young woman whose father is an Arab from Egypt and who has an American mother. She was born in California, but spent most of her youth in Egypt. Her mother converted to Islam and the family spoke both Arabic and English in the home, while Shay was growing up. She noted that Arabic was predominantly used for teaching lessons in the home. She added that there was no Christian influence in her home in spite of her mother having been raised Christian. Shay explained that she was somewhat of an outsider in both cultures: In the U.S. because she was Arab and Muslim and in Egypt because she was American and her father was well educated and wealthy. She attended a local school while growing up in Egypt. Shay speaks with a faint accent and used Arabic terms and Islamic references on several occasions during the interviews. She converted to

Table 6

Demographics of Participants

Participant	Gender	Nationality of origin	Ethnicity	Religion
Harout	Male	Lebanon	Armenian	Christian
Shay	Female	Egypt	Arab	Raised Muslim; converted to Christian
Arsineh	Female	Iran	Armenian	Raised Christian
Beti	Female	Iran	Assyrian	Christian
Nasim	Female	Iran	Persian	Raised Zoroastrian and Muslim
Ezgur	Male	Turkey	Kkurdish	Raised Muslim
Arzu	Female	Turkey	Turkish	Muslim
Eshan	Male	Iran	Persian	Raised Muslim
Nima	Male	Iran	Persian	Muslim
Sophia	Female	Iran	Armenian	Raised Christian
Jon	Male	Iran	Persian	Christian
Marie	Female	Canada; family is from Lebanon	Arab	Christian
Sahar	Female	U.S.; family is from Iran	Persian	Baha'i

a Christian faith during her late adolescence. She has been living in the U.S. since adolescence. In the U.S., Shay has seen one outpatient therapist and went to a long-term residential treatment facility to treat a substance use disorder when she was 16.

Arsineh is a young Armenian woman from Iran. She moved to the U.S. to attend college. She has been in the U.S. for several years and plans to stay for a while in order to get work experience following the attainment of a graduate degree. Her family is Christian and members of the Armenian Orthodox church. She admitted that she is not particularly religious herself. She noted that Armenians pretty much kept to themselves in Iran when she was growing up. Her family speaks only Armenian in the home and in their neighborhood. However, *Arsineh* is also fluent at Farsi/Persian, because that was the primary language spoken at her schools in Iran. *Arsineh* worked with a therapist at a university counseling center to deal with acculturation stress and symptoms of depression for a short time while in graduate school.

Beti is a young Assyrian woman from Iran. She describes her family as Assyrian Christians. They speak Assyrian at home, but she spoke Farsi/Persian at school and in the community while living in Iran. *Beti* considers herself to be Iranian, though not Persian. She admits that it was not easy or comfortable to be a Christian in Iran. She explained that she had to cover her head and hair fully whenever outside of the home and at school. She added that four pastors of her church were killed during her childhood. She added that Assyrians are very careful to preserve their ancient culture in Iran by speaking only Assyrian in the home and making sure that their children only marry Assyrians. *Beti* moved to the U.S. at age 15. Her mother came to the U.S. with *Beti*, because she planned to divorce *Beti*'s father and would have had no parental rights in Iran as a divorced

woman. Beti speaks with a clear non-native accent. She admitted during the interview that speaking in English remains difficult for her. She explained, “I’m thinking in a different language.” Beti has seen two different therapists in the U.S. to deal with what she describes as depression.

Nasim is a young woman from Iran. When asked how she identifies herself, she noted that she tells some people that she is Persian and others that she is Iranian. When asked about this, she noted that “some people don’t know the difference between Iraq and Iran and they judge me.” She explained that her mother is Muslim and her father Zoroastrian. She added that her father converted to Islam in order to marry her mother, but neither is active in their religion. Nasim explained that it is a cultural custom for children to take on the religion of their father. However, the schooling in Iran is more difficult for a person who is Zoroastrian, so she and her siblings would just say that they were Muslim for the purposes of schooling. She noted that she learned a lot about Islam at school, but that her mother did not emphasize religion at home. She added that she was exposed to the Zoroastrian religion at her paternal grandmother’s house. Nasim came to the U.S. at age 13. She began high school here in the U.S. She has seen one therapist at a local university as part of her own training to become a therapist. She then also saw a therapist later to further her self-examination and to deal with issues related to anxiety and/or acculturation stress.

Ezgur is a Kurdish man from an urban area in Turkey. However, he speaks Turkish rather than Kurdish in his home. He was raised in a large city. He identifies himself as Muslim, but admitted that he is not actively practicing the religion at this time. He describes his family as Muslim and not traditional. He noted that people in Turkish

cities are very “Westernized.” Ezgur moved to the U.S. in order to attend graduate school. He hopes to go back to Turkey eventually, but feels that his job prospects are better here in the U.S. and therefore plans to stay for a while. Ezgur speaks with a very thick non-native accent and struggles with expressing himself in English. He stated that he thinks in Turkish and is constantly translating language in his head when speaking in English. Ezgur has seen one therapist at his university here in the U.S. for a short time. He has also seen one therapist in Turkey. In psychotherapy, he worked primarily on anxiety management.

Arzu is a Turkish woman who was raised in rural Turkey. She moved to the U.S. as a young adult 10 years ago. Her husband is also Turkish. She is the mother of two boys and a girl. Turkish is the primary language in her home, although she is now fluent in English. She struggled to express herself at times in English during the interview. Her accent is quite strong. She moved to the U.S. to support her husband’s career path. She is a practicing Muslim and was raised in a traditional Muslim family. As the wife of an international student, she is unable to attend school or to work in the U.S. She has seen a therapist at a local university hospital due to significant symptoms of depression following the birth of one of her children.

Eshan is a Persian Iranian man who has spent much of his life living outside of Iran. His parents are both Persian Iranians and primarily speak Farsi/Persian in the family home. Eshan was born in Germany then lived in and out of Iran throughout his childhood. His father’s occupation kept them moving often and much of his education was received at European private schools. His family is Muslim, but he is not currently practicing the religion. He moved to the U.S. permanently at age 16. It was his idea to

move to the U.S. and his family hired a guardian in order for him to do so. His parents remained in Iran and still live there. Eshan has been married twice, to non-Muslim White American women, and is now divorced. He has no children. He has seen a therapist here in the U.S. for individual, group, and couples counseling. The focus of the counseling was his anxiety and marital problems.

Nima is a Persian Iranian male who was raised a city in Iran. He considers himself and his family to be Muslim, but noted that he is not “practicing all of it” right now. His family moved to the U.S. when he was a teenager. They speak both Farsi and English in the home since moving here. He noted that adjusting to living in the U.S. was difficult for him and his family. He attributes his struggles with depression primarily to that issue. He has seen one female therapist at a university counseling center to deal with depression and acculturation issues. He has also seen one Iranian therapist who also moved to the U.S. when he was a teenager. Nima spoke with a clear accent, but did not seem to struggle to express himself in English. However, he noted that it was easier to express himself in psychotherapy in Farsi.

Sophia is an Armenian woman from Iran. Her family belongs to the Armenian Orthodox Church and is very involved in the Armenian community in the U.S. Armenian is the primary language spoken within the family, but Sophia is fluent in Farsi, Spanish, and English as well. Her non-native accent is noticeable, but she does not struggle to articulate herself in English. Her family, including her parents and siblings, moved to the U.S. when Sophia was 9 after the revolution in Iran made it difficult for them to stay. She is currently pursuing graduate studies in a large U.S. city. She has seen several therapists in the last few years. Her primary therapeutic concerns have been related to

issues of acculturation stress and symptoms of depression. She noted that the acculturation stress was related to the different expectations of her parents from the expectations of American society.

Jon is a young Iranian Persian man who moved to the United States when he was one year old. He has never been back to Iran. He noted that his family is Muslim, but explained that he is not currently practicing the religion. He considers his family to be very “modern and Westernized.” The family spoke both English and Farsi in the home while he was growing up. However, Jon is working on increasing his fluency in Farsi by taking courses in it at a local university. He worked with a therapist at a university counseling center. He was diagnosed with depression at that time.

In addition to the recruited participants above, two women of Middle Eastern descent who were born and raised in North America asked to participate in the study. They both felt strongly that their ethnic identity impacted their therapeutic experiences and had a strong desire to tell their stories. Their stories will not be analyzed with the rest of the data, but will be noted and discussed separately.

Marie is a Lebanese Arab woman who was born in Canada and moved to the U.S. at age 3. She expressed a strong desire to participate in the study even though she has never been to Lebanon. She reported that her family in many ways is very traditionally Lebanese. Marie was raised mostly by her father, since her mother left when she was very young. She reported that her mother was forced to marry her father by her parents. Marie expressed frustration that she is not considered “Middle Eastern enough” by her Iraqi neighbors, but is considered to be a foreigner by White Americans. Marie’s family is Catholic. She spoke Arabic growing up and remains fluent. She noted that she speaks

English in her home, but speaks Arabic in her neighborhood. She has seen several therapists in individual and group psychotherapy here in the U.S. She has struggled throughout her life with severe and chronic mental illness.

Sahar is a Persian woman who was born and raised in the United States in a very traditional Persian family. She noted that her family is highly involved in the Iranian community in the city where she lives. She speaks Farsi/Persian within her family. She explained that she thinks of herself as an Iranian-American. Sahar's family is Baha'i, not Muslim. She noted that being Baha'i is an important part of who she is and that the faith is an important part of the family's daily life. Sahar has seen two therapists in the U.S. for the treatment of an eating disorder.

CHAPTER IV

FINDINGS

The two interviews with each participant, 26 interviews in all, were analyzed for emergent themes. This process of thematic analysis is described in detail by Glesne (2006). Through careful analysis of the interviews, important information about mental health attitudes and psychotherapy experiences of Middle Eastern persons in the U.S. emerged. In the process of analyzing interviews, it became clear that the two topics presented distinct information; as such the two topics were analyzed separately and will be presented separately. Dominant themes are presented first in each section, with other interesting, but more idiosyncratic findings presented later. The interviews of the two American born participants are summarized at the end of each theme discussion.

Mental Health Attitudes

Each participant in the study was asked to share their cultural understandings of mental illness, mental health, and mental health treatment. Participants were also asked to describe culturally appropriate means of finding relief from psychological distress. Three major themes emerged within the interviews related to mental health attitudes, including: the stigma associated with mental health issues in Middle Eastern culture, the importance of the family in addressing mental health concerns, and the significance of grieving in Middle Eastern culture. Several minor themes also emerged within this topic area, including: changing mental health attitudes in Middle Eastern cultures, traditional mental

health attitudes, and cultural definitions of mental health. These themes will be discussed further below.

Stigma Associated with Mental Illness

Participants were asked to discuss the ways that mental health issues were understood in their families and communities. Overall, most participants described mental illness as something that is misunderstood and stigmatized in their families and cultural communities. Their combined comments suggest that mental illness is a taboo subject in Middle Eastern families and communities. Their comments also suggest that mental illnesses and the people who suffer with them are often negatively labeled when they are discussed. How this stigma was observed and/or interpreted varied across participants.

Lack of understanding. Seven of the participants indicated that mental illness was not understood at all in their families/culture. When asked this question, Harout stated, “It really wasn’t understood, I don’t think.” Sevanah stated, “There’s no special word for mental illness... We don’t think about mental health too much.” Nasim concurred. She stated, “We didn’t talk about it.” Nima added, “Disability is poorly defined and limited to blindness, deafness, etc.” This lack of understanding likely leads to the stigma discussed below.

Sahar, on the other hand, stated that people in her family and culture did acknowledge the existence of mental illness, but denied that it could happen in their own families or to themselves. Sophia agreed that mental illness was thought of as a reality in her community, but was not discussed. Sevanah explained that it would have been

understood as a mental *problem*, meaning that the person was making poor decisions, rather than as a mental illness.

Mental illness is taboo subject. All of the participants indicated that mental illness is a taboo subject that is not discussed outside of the family and often is not discussed even within the family. Sophia stated that, “mental illness and psychological distress were thought of as a reality, but were never discussed with the children.” Nima added, mental illness and/or psychological distress are not openly discussed and accepted in Iranian society.” He explained, “Until recently, I did not know that a few of my cousins suffered from psychological disorders, mainly depression, during their teenage years. Nor did I know that my grandmother had episodes of depression.” Nima added, “My teenage cousin suffered from schizophrenia. Except for her parents and very few relatives, those whose help was essential and inevitable, no one else knew about her illness.” Eshan agreed saying, “The problem is not ignored, but the community does not know about it.”

Jon discussed finding out that his grandmother suffered from severe mental illness, but never got help because it was “a taboo issue.” He indicated that people did not seem to realize how important it was. Nasim added that if someone is struggling, “it very much stays in the house and nobody talks about it.” Ezgur stated, “Usually, when someone is [mentally] sick, they [the family] try to hide it.” Beti indicated that mental illness is less common in Middle Eastern communities or “If people do have it, they don’t always show it.” She added that “here in the U.S. it is easier to admit that you are feeling depressed.” Arzu stated, “I don’t tell my friends that I’m going to psychotherapy. It’s a private thing...I think I still feel a bit ashamed, not comfortable.” Sophia added, “If

someone [in the Middle Eastern community] is seeing a therapist or psychiatrist it is not advertised.” This lack of dialogue likely leads to the impression that people of Middle Eastern descent do not experience mental health problems and leaves people who do experience such problems feeling isolated and alone.

Negative labeling of mental illness. Participants recalled family members discussing mental health issues by using negative labels to describe the sufferers. Eight of the participants specifically recalled people with mental illness being called “crazy,” “retarded,” or “lazy.” They did not specify if these labels were generated in their home country or here in the U.S. However, it was implied that their families brought their mental health attitudes with them when they immigrated. Nasim reported, “I just remember a lot of people talking about people being crazy. That’s the attitude I had when I came to the U.S. There’s one thing, you are normal or you are crazy.” Based upon the reports of these participants, there seems to be no concept of a spectrum of mental health in traditional Middle Eastern communities.

Sevanah also indicated that people with mental illness were considered “crazy” rather than “mentally unhealthy.” Whereas, others said, “there are no words for it in my culture.” Similarly, Shay stated that “there is no such thing as depression.” She explained that elderly people were expected or allowed to display odd behavior, but young people with healthy bodies were simply not understood if they were struggling with psychological problems. When asked how severe mental illness, like schizophrenia, would be understood in her family Beti stated, “They would say, ‘Stay away from them. They are crazy!’ They wouldn’t try to help, because if you hang out with a crazy person then you are considered a crazy person yourself.”

In addition to “crazy,” participants reported that labels such as “stupid” or “lazy” could be used to describe those with mental illness. Nima stated, “Psychological distress is more often viewed as stupidity. It is often ridiculed or viewed as a weakness.” Arzu indicated that she felt weak when she became aware of her struggles with depression. She said, “It’s like a shame on you, how can you do this? Depression, oh that’s nothing...everyone faces problems...you are too fragile.” Jon also talked about feeling that sadness or depression was a “weaker emotion” and that he should be able to “tough it out.” He explained that so many people from the region have suffered cultural traumas, war, and other stressors that an individual would feel weak for being the one who isn’t coping with it well.

American-born participants. The two American Born participants also discussed the stigma associated with mental illness in their families, as well. Their comments are similar to the foreign born participants on this theme. Marie, who was born and raised in North America, indicated that her family simply does not understand mental illness and therefore responds only with harsh words and actions towards people with mental illness.

Sahar, who was also born and raised in the U.S. in a traditional Iranian Baha’i family, explained:

There is inevitably going to be some resentment towards the person who is mentally ill or who is really struggling with something, because it is kind of seen as like a serious vulnerability and a serious weakness, because we are such a tight knit culture. It is kind of like, if you have this problem then the rest of the family has to suffer and the rest of the family has to deal with this problem. It perpetuates the issue even more and it really makes it so much bigger because now you have so many other people who also feel like they are suffering along with you.

This comment suggests that the collectivist nature of Middle Eastern families may represent a risk to persons with mental illness.

If persons of Middle Eastern descent are inextricably embedded within families, and if these families (a) do not understand mental illness, and (b) see mental illness and the person struggling with it as reflecting negatively on the family, the result for the person experiencing mental illness could be much like that of a malignant bacteria within a body: the body uses all its immune resources to attack and eradicate the malignant bacteria to restore itself to health. This sense of isolation in the context of such fundamental belonging (e.g., the bacteria cannot live outside the body) can create tremendous difficulties for the person experiencing mental illness. As might be expected, these family experiences emerged as a major theme as well: the roles of families in responding to mental illness in Middle Eastern culture.

Role of Family in Responding to Mental Illness

The second major theme within the concept of Middle Eastern mental health attitudes relates to the significant role of the family in responding to mental health concerns. All of the participants indicated that no help would be expected from the community or government in the Middle East. They seem to have brought this expectation with them to the U.S. Participants further explained that the family, not the individual, would be responsible for addressing mental health concerns. Participants described both positive and shame-based responses from families dealing with mentally ill relatives.

Family not individual is responsible. All but one of the participants indicated that the family as a whole, rather than the individual, would be responsible for helping the person to find relief from their distress. Nima alone indicated that the person would be responsible if they were capable of identifying the problem and solving it. He added that if the person were not capable, then the family would be expected to step in. Another participant indicated that the immediate family would be responsible for helping an individual find relief from psychological distress. She added that the person would not be able to face it alone, because “it is not their problem. It is the family’s problem.” Nasim added, “It is expected for the family to take care of them.” Arzu stated that the family will say, “This is our problem. We have to solve this together. You are not on your own. You are like together on this.” Nima explained this by stating, “The family is usually negatively affected by that person’s behaviors.” It seemed as though most of the participants actually kept their struggles quiet for as long as possible so that they would not burden the family system. There was even a sense that a mentally ill or depressed person might be resented by the family, due to the fact that their struggles would reflect poorly upon the family system.

There seemed to be some differences between participants responses in terms of whom within the family would be responsible for addressing mental health issues (e.g., elders in the family, the females of the family, the person’s spouse, parents, or father). Jon said, “It would be the parents who have the final say.” Shay explained that the most capable or financially stable person in the extended family would be responsible for taking care of anyone with mental health issues. She added that her father would be the person to make decisions for anyone with problems in their extended family, because of

his advanced education and social position. Arzu added that it is customary for men to help men and for women to help women.

Positive family responses. As discussed above, most of the participants clearly stated that mental health issues are rarely spoken about outside of the family system. Many of the participants described ways that families would respond. Eshan stated that family members would be “supportive and compassionate” towards someone who was distressed. Sophia added, “When someone is distressed others are there for that person, others are extremely worried about that person. My family is very caring and supportive, so people are usually very helpful and loving in the process.”

Several participants described specific family members gathering around the affected person and talking to them about their problems. Arzu stated that “First of all, you talk. There is somebody always to talk to. It’s usually somebody who is more knowledgeable or elders.” Sevanah explained that Iranian families are very close and usually live very close to each other. Therefore, she added that psychological distress is “automatically addressed by family.” Jon explained that individuals would likely feel that they should “just tough it out” so “a lot of times it is family members who kind of have to reach out to the person and tell them ‘Maybe you should seek help.’”

Shame-based responses. According to at least five participants, a person with mental illness might be nurtured and hidden away within the home. As mentioned above, mental illness would not be discussed outside of the family. This likely leads to increased stigma and shame associated with mental illness. Sevanah stated, “There’s a big stigma attached to it, both in my family and where I live...even just going to psychotherapy, that is considered very bad.” She recalled a distant family member who “was crazy.” She

explained that she now believes that this woman had significant post-partum depression, but remembers that the family took care of her basic needs, though not her psychological needs, and kept her hidden from society.

Beti recalled a relative in a similar situation who was also cared for, but isolated and shunned. Harout described a relative who in his words “played the retard card.” He explained that this young man was coddled by the elders and consequently “didn’t get any [psychological] help.” Harout felt that the expectations of this person were so low that he never achieved his potential. Interestingly, Nasim also recalled an aunt that came to visit, because she was not feeling well. The aunt reportedly just stayed in the guest room and cried the whole time that she was there. Nasim stated, “Her needs were taken care of,” but they did not discuss or acknowledge her depression. The family reportedly acted as though she was not even there most of the time. To this day, this relative’s financial needs are taken care of by the extended family, but her emotional needs are ignored and avoided. Nasim further verified this cultural norm saying, “The families tend to take care of them and hide them from society.”

Several participants discussed negative or even harsh reactions from family members towards struggling individuals. Consistent with the conceptualizations of mental illness discussed in the previous section, many families view psychological distress as indications of weakness. Shay shared that her father’s reaction to her depression and suicidality was to say, “You are an idiot. Don’t be stupid. Get over yourself.” This illustration is made more poignant by the fact that her father is a medical doctor trained both in the Middle East and in the U.S.

American-born participants. The two American Born participants also spoke about the significant role of families, rather than individuals or institutions, in the response to mental illness. Sahar stated,

I think [in] our culture, with a seemingly very tight knit group of people, families do tend to really try and go out of their way and help people, but I think a lot of the times we [Middle Eastern families] just don't have the right coping skills. We don't know that resources are out there and we are very independent people. We are very resilient. We feel as though we can solve everything ourselves.

Marie said, "Lebanese families take care of their own," but added that her family is drastically different in this way, because she has been expected to solve her problems on her own. She described being very aware that her family was different than other Lebanese families in their response to psychological suffering. Marie described a very dysfunctional family system that was not nurturing or predictable. She was able to contrast her family with other Lebanese families she knows well, yet also blamed her culture for the abuse/neglect she felt she suffered throughout her life. In her interview she discussed significant physical and sexual abuse within her family system.

Grieving

Another major theme that emerged from the mental health attitude related interviews was related to the importance of grieving in Middle Eastern cultures. This theme is of particular relevance because it was generated spontaneously during the first couple of interviews. After the first few participants mentioned grieving as a time when they felt that it was not only acceptable, but expected, for people to show emotion, the researcher then asked all of the remaining participants to describe grieving in their family/culture. Participants discussed their impressions that grieving is very different in

Middle Eastern cultures when compared to Western cultures. Jon was insightful when he explained that:

This is one of the times that Iranian culture is more open than Western culture... You have to be very outward in your grief and there is a lot of dwelling on it and remembering the person who passed away for a long time. I think in American culture it is much more that you mourn a little bit and then accept that they are gone and move on with your life. Whereas, [in Middle Eastern culture] that it is an insult: if your parents die and you kind of forget about them. You shouldn't do that. On the anniversary of the death you should always try to remember them. It can kind of create long-term grieving that never stops.

According to the descriptions of these participants, there seem to be elaborate culturally or religiously prescribed ways of grieving in the Middle East. Although each participant described slightly different grieving rituals, each described a very specific method of doing so. Nasim described vastly different rituals for grieving for her Zoroastrian side of the family and her Muslim neighbors. However, she was well aware of how each culture expressed grief. She recalled her father's side of the family (Zoroastrian) gathering every year on the anniversary of her grandfather's death and wearing all white to honor him. Her descriptions of her Muslim friends and neighbors' grieving involved "everybody wearing black and crying."

Harout noted that "a lot of black is worn" and that "40 days later there's a ceremony that means like a spirit rest." He expressed the perception that people "get really stuck in a depressed state about it...I've seen relatives wear black for years." Beti added,

My family kind of makes a big deal about everything. They have like six ceremonies when someone dies. First you celebrate the day they die...not celebrate, but grieve on the day they die. Then you have another ceremony like three days after. Then you have another one six days after, then it is forty days after, and then it is like a year after. Every time they wear black and cry. They are

supposed to wear black for a year.... After a year all the family members gather together and get them clothes to take them out of the black.

Sevanah described “lots of crying and loud noises.” Shay said that mourning/grieving is done as a family rather than as individuals. She stated that “we lauded the person” and “had a very elaborate funeral and talked about them.” She explained, “This is just a more reverent time.” Sophia added,

In my family, grieving happens with people around, lots of support, and food, and people around you.... There is also a tradition of wearing black for 40 days after someone’s death. It is a reminder every day for 40 days that you have lost someone dear.... At the end of 40 days there is a memorial service and the family members buy colorful clothes for the immediate family of the deceased and we have a ‘take them out of the black’ get together.

Mima had strong memories of “a lot of crying” whenever someone died. He added that people will “listen to the Koran even though many people are not as religious as they might be. They find comfort in that.” He also described a series of ceremonies: “the first three days, and then the seventh day, and then the fortieth day they have a gathering. The first three days everybody cries and shows their emotion, then every year the immediate family gathers.” When asked about grieving Arzu said, “Oh, we grieve a lot....Yes, we are over-acting everything.” Ezgur recalled “sad faces or wearing black.”

These expressions of grief seem to differ sharply from how grief is experienced and expressed in U.S. culture, in that it is much more specific, outward, and dramatic. It seems to be the one time that people from the Middle East are really given permission to experience and express strong emotion. Nasim said,

It’s okay for you to express your grief, to cry, to wear black for a year to celebrate the certain days, to have gatherings at certain times to remember that person...it’s ok to express emotion, it’s okay to show it...but if you were depressed and nobody has died then I think that is not acceptable. You have to have a really good excuse to be depressed.

American-born participants. Marie did not discuss grieving in her interview.

However, Sahar, the American born Iranian, said that:

if someone passes or if they find that someone has a serious illness that they are not going to be able to overcome, it becomes an issue for the entire family and everyone kind of feels the burden, so people get really sad and very down and they really let it affect every aspect of their life.

She contrasted this approach to grieving with the American style saying, “I feel that Americans’ perspective would be to try and keep positive as much as possible, because positivity might help turn things around.” In spite of with-in group differences in other cultural matters, grieving seems to be one way that Middle Eastern people are similar across sub-groups and differ vastly from Westerners. A U.S.-trained therapist might inadvertently pathologize this type of grieving in spite of its cultural appropriateness.

Changing Attitudes Toward Mental Illness in Middle Eastern Culture

A minor theme that emerged involved a changing mindset in the Middle Eastern population related to psychological issues. Participants suggested that in a variety of ways mental illness is becoming better understood and less taboo in some subgroups of the Middle Eastern population. They also suggested that people are becoming more open to seeing therapists both in the Middle East and here in the U.S. Participants understood this change to be a result of Westernization in the Middle East and acculturation of Middle Eastern immigrants in the U.S. Participants also reported differences in attitudes between younger and older generations, rural versus urban people, and persons with different education levels. Each of these is briefly elaborated below. Participants did not

mention economic status as a significant factor in changing mental health attitudes of Middle Eastern people. The two American born participants did not making comments about how mental health attitudes are changing in their families or communities.

Westernization

One participant clearly stated that her family believed that the concept of mental illness was a “Western crutch.” Others added that mental health treatment is something you do when you are “Westernized.” Arzu noted that as her home country has become more westernized there is less stigma attached to mental health issues. Jon stated that “in Iran it is becoming more and more common as Western influence has come and people are trying to emulate what happens in America.” He added that in the Iranian community here in the U.S. “it is starting to become more open and prevalent and people are more willing to speak about it than they would in Iran even now.” However, he explained that “there is probably still some stigma, especially among my parents’ generation.”

Changing Attitudes Across Time

Participants who have been in the U.S. for a while noted that mental health attitudes have changed in their home countries during the time that they have been away. Arzu indicated that the perception of mental illness and psychological treatment have changed in the Turkish community since she first came to the U.S. She said:

In the last eight years the perception of mental illness changed actually. It kind of developed and it became easier for a person to say, ‘Oh, I have depression. I’m getting treatment and using medication.’ Over these eight years it changed a lot.

Nasim agreed that “now it seems like Iranians in general understand a little bit more.” She cheerfully recalled a conversation that she had with a distant relative who was

appalled at the idea of getting psychological treatment several years ago. This relative felt that only “crazy people” see therapists. Nasim then explained that this woman now talks openly about seeing a therapist. She added that there is now a psychologist who has a popular radio show in Iran. She said that the perception towards mental health treatment has changed a lot as a result of this. She indicated that “Iranians in the U.S. don’t see it as a big thing anymore to say, ‘I’m seeing a therapist.’ I have friends that actually admit that they are seeing therapists.” She also added that her mother had originally been appalled at the idea that she was studying to be a psychologist and worried about what people in the Persian community would think, but now is proud of this fact.

Rural Versus Urban

A couple of participants (both Turkish) made a distinction between rural and urban people when it came to questions about mental health attitudes. Arzu noted that people from cities in the Middle East are more westernized than rural people when it comes to mental health attitudes. When discussing her embarrassment about going to psychotherapy, she recalled a friend in Turkey who said, “Come on relax. In Turkey right now everyone is using antidepressants and everyone is going to a therapist.” However, she added that “in rural areas I don’t think it is a comfortable thing to do.” Ezgur who was raised in an urban area stated, “It is becoming more common in Turkey, especially in my hometown.” Most of the participants in this study were raised in cities in the Middle East. This may be why more of them did not make this distinction and may have contributed to their openness to seek psychological services here in the U.S.

Level of Education

Arzu and Ezgur also made distinctions between educated people and uneducated people noting that the more educated people are the more open they are to mental health treatment. Interestingly, most of the participants in this study have posthigh school educations. This may have been a factor that made seeking psychological services more acceptable to them. This topic was not specifically prompted in the interviews and therefore was not discussed often by participants.

Generational Change

Harout talked about the significant distress Armenians feel related to the Armenian genocide and centuries of persecution in the Middle East before emigrating. When discussing this he distinguished between his generation and his parents' and grandparents' generation. He said, "In the U.S. they are starting to get help, but the previous generation absolutely did not." Sevanah mentioned that the older generation expresses their distress differently than the younger generation. She explained that older Middle Eastern people express psychological distress through anger, whereas the younger generation tried to practice acceptance of distress. Other participants often distinguished between "elders" and "the younger generation" when answering questions about mental health attitudes.

Traditional Mental Health Attitudes

Although mental health attitudes do seem to be changing in the Middle Eastern population as illustrated in the theme above, practitioners working with Middle Eastern

people in therapy will likely continue to encounter some traditional mental health attitudes that are different from mainstream American mental health attitudes. Both the stigma attached to mental illness and the traditional role of the family in responding to mental illness (two major themes in this chapter discussed above) are examples of more traditional mental health attitudes in this population. Two other examples include: a preference for medical explanations over psychological explanations of problems and a belief that religious practices play an important role in mental health.

Medical Versus Psychological Explanations

Five participants indicated that it is more acceptable in Middle Eastern culture to conceptualize mental illness as a medical diagnosis as opposed to a psychological issue. Therefore, they felt that it was more acceptable to see a medical doctor than a psychologist. Sevanah explained that although it would be shameful to see a therapist, “Pill popping for mental illness is very common.”

Ezgur indicated that if there is a strong biological basis of the disorder then you are respected for having that disorder. Your symptoms might then be respected, but not treated. Beti spoke more directly of the perceptions of others stating, “they just see you as a sick person...you don’t get treated the same.” She added that people would say, “Don’t go around her [person with mental illness], because she is so sick.” Beti suggested that people might act as though mental illness were contagious. Two participants were encouraged by their parents to trust the psychologists that they were seeing, once their mental illness became apparent. This seems to suggest that when someone does need and then seek treatment, they are expected to engage in a typical medical model of

relationship with the helping professional. However, this does not seem to erase the shame associated with mental illness within Middle Eastern families.

Six individuals indicated that taking medications is less offensive than psychological treatments, though this solution to psychological distress is still not discussed openly. Sevanah's comments illustrated this attitude when she said, "It is personally appropriate to take medications to deal with psychological problems. You still don't let people know that you are taking medication." Harout agreed that it seemed more acceptable to take medications than to attend talk psychotherapy. Several participants mentioned that they take currently antidepressant medications, but do not tell their families about it.

Religious as Solution for Mental Health Problems

One participant suggested that mental illness might be seen as a lack of sufficient religious practice. Shay explained that in her family/culture, mental illness would be viewed as consequence of giving in to temptation from Satan. She added that someone would be expected to "get over it" because only God can address one's concerns in any case. This comment was consistent with remarks by several participants in the pilot study (Boghosian, 2007), who believed that people who have a strong religious practice would not struggle with psychological problems. All of these comments were made by Muslim participants in the two studies and therefore might not translate to non-Muslim Middle Eastern clients in psychotherapy.

Three participants discussed religious solutions to mental illness and/or psychological distress. Harout and Arzu noted that family members would pray for a

mentally ill person. Ezgar indicated that older people from the Middle East would “try to treat him/her in some religious ways.” Arzu added that fasting and praying would be recommended. Shay noted that the person would be advised to use faith in Allah to deal with their struggles. One would “ask God for the ability to continue reacting normally in their life...to continue doing what they were doing before.” She said that consulting a religious person would be a solution if nothing else was working. Although, this was also considered a last resort, she clearly felt that it would be more culturally appropriate than seeking professional help. Harout described his current practice of using faith and elders in his church to guide him through difficult times. He has substituted these practices for attending psychotherapy and finds it personally more effective.

Other Traditional Means of Finding Relief for Stress

Jon described a cultural value of working hard and making money as a way of staying healthy. He explained that it is most appropriate for his generation to channel their distress into being successful in business. He added that the older generation would encourage this behavior and excuse other problems by saying, “Oh well, he’s doing really well in school” or at work. He said:

In my generation, a lot of people over-achieve to get away from the more emotional problems they have or to prove that there isn’t a problem.... If I become a doctor or a lawyer, it shows that I don’t have any problems.

This is consistent with the experience of Eshan, who reportedly ignored his struggles with anxiety until they interfered with his ability to perform successfully in his career.

Other culturally appropriate means of finding relief from psychological distress were mentioned by each participant. Eshan stated that if people were struggling there

would be “a lot of gathering...eat together, dance together.” Sophia indicated that “Another avenue for seeking help is seeing psychics, because that way the person will get some answers in knowing their future.” Sevanah added that people cope differently with psychological distress. “For the older generation it [distress] is displayed by anger and for the younger generation it is displayed by acceptance...or hidden rebellion.” Harout, who is not Muslim, said, “It was very acceptable to get super drunk.” Turning to substances in times of distress seemed to be more culturally acceptable to the non-Muslim participants. Other sources of relief that were mentioned were taking a vacation, drinking tea, and taking vitamins.

American-born Participants

Marie, who was raised in North America, stated that Lebanese people usually “eat, eat, and eat some more” when they are experiencing psychological distress. Sahar, who was born in the U.S., added that in her family/culture relying upon faith and religious practices would be the most appropriate way to deal with psychological distress. She added that if the problem was severe enough, it would be okay to consult with a trusted medical doctor who values confidentiality.

Conclusion of Mental Health Attitudes

Overall, these themes come together to suggest that the experience of mental illness could be very complex for persons of Middle Eastern descent. While distress related to bereavement is structured to support emotional expression of sadness, distress that does not trace back to a specific, culturally acceptable origin is met with a mix of

present instrumental support but absent emotional support, and even efforts to suppress the visibility of the person experiencing mental illness. All of these family actions represent their participation in broader cultural taboos around mental illness. It was not difficult for participants to recognize mental illness and identify it as a family stressor. Interestingly, however, defining what was meant by “mental health” was not so easy.

Participants were asked to define mental health from a cultural perspective. This question did not generate much dialogue and so is included as the last and least important theme within the mental health attitude section. Participants described mental health as being able to function in society, not standing out, dealing with problems, thinking rationally, being happy, and being well spoken. Three participants added that if one is mentally healthy they would have strong belief in and reliance upon God/Allah to take care of problems and/or not worry about things that are out of their control. This last explanation might be more consistent with an Eastern orientation than a Western one. Overall, defining “mental health” might be an exercise akin to asking the fish to describe water. Mentally healthy is how people are expected to be and any deviation from that is carefully noted and attended to.

Therapy Experiences

All of the participants in this study have personally experienced counseling or psychotherapy in the United States. They are therefore in the unique position of being able to describe the phenomenon of attending psychotherapy in the West from a Middle Eastern perspective. They were each asked to discuss their psychotherapy experiences including their reasons for seeking professional help, their impressions of the experience,

and any cultural issues that arose. Major themes that arose within the broader topic of therapy experiences were: the importance of cultural identity in therapy, the cultural barriers to seeking professional psychological help, the importance of family dynamics in therapy, and suggestions for culturally sensitive practice. One minor theme emerged related to participants' process of seeking and receiving psychological services.

Cultural Identity in Psychotherapy with Persons of Middle Eastern Descent

Participants discussed the role that cultural identity played in their therapeutic encounters. For some, cultural identity was not discussed at all. For others, it was an important topic in the psychotherapy encounters. Participants mused about the role they think cultural identity should play in psychotherapy with persons of Middle Eastern descent. Participants offered opinions about how therapists can include cultural knowledge in meaningful ways and warned against ethnic glossing by oversimplifying what it means to be Middle Eastern. Participants also discussed the importance of taking religion and immigrant status, not just ethnicity, into account when discussing cultural identities in therapy.

Cultural Identity Played No Role in Psychotherapy

Over half of the participants clearly stated that their cultural identity was not discussed or addressed in any way with at least one therapist that they had worked with. Shay stated that “there was never an attempt to understand” my cultural identity. Ezgur stated that his therapist focused specifically upon the issues that he was having at school and did not explore his background at all. He felt that this was a major drawback of his

psychotherapy experience. He said, “She didn’t get any information about my background.... You have to learn your clients background.”

Harout stated:

I don’t think they had any clue of my background or anything like that or understanding Armenians or Lebanese.... I think people think they kind of understand the Middle East and being a violent man or controlling man or whatever. They don’t really have a clue of how many cultures really come from the Middle East, how many different backgrounds or religions or ways the cultures come from that area. I never felt any kind of understanding of that.

He added that only one therapist ever explored his background and how it affected his mental health. He felt that this was the most helpful and effective of all of the therapists that he has worked with over the years. She connected his war-time traumatic experiences as a child to his current need for things to be “super heightened.” Such need for heightened experiences can be common in persons with substance use issues like Harout.

Eshan’s therapist also did not incorporate discussions of culture into his psychotherapy sessions. He reportedly felt that this was not important at the time, but might have been when he was younger and a more recent immigrant to the U.S. Sevanah noted that her therapist was primarily focused upon her presenting issues and problem solving. She said,

I think if I had wanted to talk more about my personal life that would have made a big difference...and cultural differences and how I had been brought up would have made a big difference. I think to some extent, I tried not to mix those too much during the therapy sessions. I felt the issue of being judged and having to explain myself about my relationship with my family, what happens in my life, how I grew up, all of those things.

She admitted that she liked keeping her cultural identity and family history out of the discussion, because it felt emotionally safer to her.

Cultural Identity Played Important Role in Psychotherapy

Other participants felt that their cultural identity played a very important role.

Sophia stated:

My cultural identity played a huge role, because therapy with someone from my background involves not just the person but the whole system, the whole family. I think there were many pressures that I felt at the time from my family and from the American community in which I was raised part of my life. These pressures played a huge role in my mental health and my existence and were part of my cultural identity.

Nasim contrasted her third therapist to the first two, noting that the first two were very problem focused and did not attempt to understand her cultural or family background.

However, the third therapist did ask a lot of questions about her family/culture and attempted to understand her world view. She said, “She would ask and that’s what I liked” about working with her.

Beti also contrasted the two American therapists that she saw. She too noted that the first therapist did not ask any questions about her background and as a result, she felt that the therapist did not care about her. She discontinued psychotherapy with this therapist after a couple of sessions. However, her second therapist asked a lot of questions about her cultural background and even reported conducting Internet searches to become better informed about Assyrian Christians from Iran. This reportedly made Beti feel very cared for by the second therapist whom she felt was much more effective than the first therapist.

Jon stated that although his therapist did not directly address cultural issues, he did address issues related to being an immigrant family in the U.S. He felt that this was very helpful to him and his family. Nima and Arzu stated that their cultural identity was

discussed in psychotherapy, but did not go into any detail about how that affected their psychotherapy experiences. Marie, one of the American-born participants also felt that her cultural identity was discussed, but was unable to explain how it was addressed or how it affected the experience. Overall, those participants for whom cultural identity was not addressed seemed more aware of how they were negatively affected by the absence than those for whom it was addressed were aware of how it helped.

Ethnic gloss. Five of the participants suggested that their therapists did not understand the complexity and diversity of Middle Eastern culture and therefore made incorrect assumptions about them and their families in psychotherapy. When asked what she wished her therapist had understood about her cultural background, Sevanah indicated that she wishes that her therapist understood “how Armenian-Iranians are different from Iranians.” She shared:

When you think of the Middle East you automatically think of the veiled women who don't go out and do anything and the man of the house is doing everything and other typical stereotypes you see on T.V. I had to explain [to my therapist] that not only is my family very different, but also that Iranians are different.... I had to explain myself [in psychotherapy], not just myself but my background... different countries have different types of problems in the Middle East.

Harout had very similar impressions of his therapists understanding. He said:

I don't think they had any clue of my background or understanding Armenians or Lebanese. I think people think they kind of understand the Middle East and being a violent man or controlling man or whatever. They don't really have a clue of how many cultures really come from the Middle East or how many backgrounds or religions or cultures come from that area. I never felt there was any kind of understanding.

Arzu expressed that she wishes that her therapist had “read something about [her] background; [looked on the] internet or anything just to see how our relationships are.”

Two participants worked with therapists that had treated some Middle Eastern clients before. Both participants felt that the therapists “lumped” them together with these other Middle Easterners who were very culturally different from them. Sophia indicated that her first therapist did not understand Middle Eastern culture at all and yet,

The second therapist was more cultured and had a client prior to me who was from the same background and presented with very similar difficulties. Thus, that did not go very well either because he lumped us together and thought her and I were exactly the same.

Clearly, part of understanding Middle Eastern culture is understanding the complexity within it. These therapists understood only enough to make incorrect assumptions, which limited their ability to really understand the individuals who they were treating.

Cultural competence. Several participants stated that having a therapist with cultural competence skills was important and helpful to them. Nasim, Arzu, and Sophia indicated that one of their therapists was culturally knowledgeable and felt that this was helpful. They all contrasted this orientation with another therapist they worked with who did not practice from a multicultural psychology orientation. Arzu stated, “I thought that the first one, he was more understanding...maybe he was more multicultural or something.” Nasim described working with her second therapist:

We talked about it [my cultural background] a lot. She asked me a lot of questions about it. She asked me to talk about how family dynamics are [in my culture]. She knew a little bit about the Persian culture, the Iranian culture, but she would ask and that’s what I liked.... She can’t necessarily become me or become a part of that culture, but she actually tried so that’s what made it more comfortable.

Beti indicated that one of her therapists not only asked her a lot of questions about her culture, but also took the time to research information about Assyrian Christians from the Middle East. She indicated that this effort on the part of the therapist made her feel very

cared for. She stated, “She asked a lot of questions [about my cultural background] all the time and she went on the internet and looked up what it is, which made me feel like, ‘Oh my God, this lady cares.’” These actions reportedly allowed Beti to engage in and benefit from psychotherapy.

Ezgur and Nima discussed the importance of being able to participate in psychotherapy in their original language. They indicated that it was easier to express their thoughts and feelings in their mother tongue. Nima stated:

Even though I can speak English, I think at some points expressing myself and what is going on in my mind, I think I still struggle with that at some points and speaking in Farsi with him at those points helped.

Ezgur did not see a Turkish speaking therapist in the U.S., but has seen one in Turkey. He noted that this was a particularly helpful aspect of the therapeutic experience in his home country when compared with his experience in psychotherapy in the U.S.

Experience of being an immigrant. Two participants who came to the U.S. as children felt that they wished that their therapists would have understood what it was like to grow up in a home with immigrant parents. They indicated that this lack of understanding limited the therapists’ ability to understand them and therefore to help them. They both considered their immigrant status to be an important part of their cultural identity.

Harout indicated that his therapists did not understand that he did not grow up in the typical American home. He described his parents:

They barely spoke English. They didn’t understand this world. They didn’t understand what was going on here. I think those are things that affected me. You go to the park [as a kid] and people understand current events and TV shows, then I go home to a family that absolutely didn’t. They didn’t know anything about SATs or Happy Days or Corvettes. They were still learning to speak English let

alone understanding a capitalist society or anything about this place. There were a lot of inconsistencies, because of that from my parents. They didn't understand this world yet let alone how to raise me in it.

Harout indicated that he wishes that his therapists had understood this dynamic. Jon added:

I don't think he [the therapist] could really appreciate what it was like to start in a new culture and all the issues we have to deal with that a more American family might not have to deal with and the idea of coming to a new country and starting a new life is kind of hard to grasp.... I never really had as much advice or experience from my parents. They couldn't really give me advice about going to high school or college. I had to deal with a lot of things on my own. Little things like prom or college admissions [or] SATs didn't really ever happen to my parents.

Both young men clearly felt that it would have been helpful if their therapists had either understood this reality or inquired about it.

Valuing religious background. Shay alone felt that her religion specifically was not understood and was not valued by her treatment team. She actually attended a Christian-based treatment program and found that many of the religion-based treatment concepts were inconsistent with her Muslim upbringing and orientation. She explained that by the end of her treatment stay she was converted to a Christian faith by these professionals, and, as a result, was eventually disowned by her family of origin. This was a painful experience for her and was an experience that she now views as incredibly harmful to her and to her family. She stated, "I was manipulated at a very impressionable point in my life and my cultural or my family ties were completely and totally disregarded as though they were nonexistent. A religious idea or whatever was more important."

American-born participants. Marie did not feel that her cultural identity played an important role in her psychotherapy experience. She stated that it was not discussed or

explored. Sahar, on the other hand, was encouraged to discuss her culture in psychotherapy. She explained:

I think there's always a side of me that wants to protect my culture as well because there aren't only bad things related to Persian culture. There are so many wonderful things but obviously when you're talking about something that's very painful for you, the bad things do tend to come up more so and so sometimes maybe I wouldn't go into too much detail because I wouldn't want my White therapist to think that I was coming from some kind of crazy culture. So that may have played a part, but I tried to be as open as I could.

However, both American-born participants felt that their Middle Eastern backgrounds were not taken into account often enough in psychotherapy. They both felt that they were assumed to be "just Americans," because they were born in the U.S. Sahar explained:

I was born and raised in the states, but at the same time I feel very Iranian and I love being able to identify with another culture other than just being American. I think, I feel so much more blessed because of it and I feel like I understand a lot of different people a lot better because I can relate to the intricacies of two different cultures very well. I think having had mostly Caucasian therapists and doctors, a lot of the answers to problems and how I should be dealing with things just don't apply because I just can't relate to it. I don't think just as a Caucasian-American would. I am also Iranian and so my thought processes are influenced by the fact that I have this culture and these principles that are different than a lot of other people in the states. So as helpful as a lot of the discussions were with my therapist, a lot of the times it's kind of like, "Well you don't understand, because you're not Persian." You know, they have a lot of helpful insights but they can't 100% identify and so a lot things just didn't apply.

Both American born participants felt strongly about the importance of their Middle Eastern heritage, perhaps more so than some of the foreign born participants, and wanted their cultural identity to play a larger role in psychotherapy. They also wanted their therapists to know more about their cultural norms.

Cultural Barriers to Seeking Psychological Services

Participants discussed a variety of barriers to receiving services. Most of these barriers were intra- and interpersonal, rather than institutional. A cultural value of seeking professional help only as a last resort was discussed. Common distrust of helping professionals was discussed and explained historically. Participants outlined the various concerns that they faced within themselves as they thought about entering psychotherapy. Some institutional barriers were discussed.

Seeking professional help is a last resort. Most of the participants agreed that “taking the problem outside of the family” is only done as a last resort. Most of the participants noted that seeing a doctor or psychologist is only an option if you are experiencing severe mental illness. Eshan stated, “I guess if it is severe enough a physician would take care of it.” Sophia said that generally relief comes from other family members. However, “If the situation is so severe that more help is needed, people do seek counseling or psychotherapy.” Arzu explained that “If things get serious of course they will take you to the hospital...of course they will suggest go to a doctor if there is something wrong with you, but not immediately.” Jon added:

If it is more severe people would be willing to go see or make people get mental treatment, but if it was a lot of the small things or the less important kind of problems people would talk more about it with their friends or their relatives.

Again, problems are only discussed outside of the family in the case of severe mental illness. This cultural norm likely leaves people feeling as though they must be “crazy” if they talk with a psychologist. The study did not directly address how severity would be assessed or what “severe enough” would look like.

One participant discussed being influenced by the cultural value of keeping private information within the family system as she planned to enter psychotherapy. Beti stated, “To be honest, I just didn’t want to open up to anybody. You know what I mean? Especially [to speak openly] to some random person that I didn’t know.” She said that she would have preferred to talk to her grandmother, who was the one taking her to psychotherapy, about what was going on. However, she did not feel that she could say no to her grandmother who was insistent that she go to psychotherapy. She admitted, “I just didn’t want to talk to anyone about what’s going on with me.”

Distrust towards helping professionals. Both Beti and Sevanah mentioned an overall distrust towards the medical profession in Iran, but for different reasons. Sevanah noted that there is no such thing as confidentiality of medical records there, so people do not trust that their mental health concerns would be kept secret. They might also be discriminated against later for having certain conditions. Beti, on the other hand, indicated that non-Muslims were not treated equally or humanely in Iran and therefore do not feel safe seeing any kind of helping professional. They both suggested that they brought this distrust of helping professionals with them to the U.S.

Another concern related to the confidentiality of psychological records here in the U.S. Other participants worried about their family/friends/co-workers finding out that they were in psychotherapy. Sevanah stated, “In the beginning, I never told my mom that I was going and I share everything with my mom.” She also remembered feeling very embarrassed when someone she knew was in the waiting room with her. She said, “We just said hello and then pretended not to see each other.” She added, “Still throughout the whole process, I had the thought in the back of my head that I did not want to be there or

it wasn't a good idea to be there." Given the limited confidentiality in the Middle East several participants expressed concerns that their presence in psychotherapy would not be kept confidential.

Four participants mentioned not trusting that a psychologist would offer any relief for their problems. Eshan remembers wondering, "If they could really help me. If it was bull shit." Harout added, "Looking back, I have to honestly say that it felt like 'I just don't know how I could benefit from it.'" Shay also mentioned a lack of belief in the psychotherapy process. Nasim also had concerns about the effectiveness of therapy for herself in spite of her own training as a therapist. This lack of buy-in for psychotherapy likely affected the efficacy of the psychotherapy process for these participants.

Difficulty attending psychotherapy. Several participants noted that they do not feel as though their therapist understood how difficult it was for them to attend psychotherapy in the first place. Sevanah indicated that her therapist did not understand how difficult it was

for me to go to each psychotherapy session. I think I talked about it with my therapist, but I am not sure I was able to convey the struggle I had to go through inside my own head every single session just to show up and how I had to make myself go to the therapy session, drag myself, every single time.

Sevanah clearly wished that her therapist had understood that attending psychotherapy itself was a very difficult task for her.

Nasim indicated that she had a very difficult time "opening up in psychotherapy" and felt that "it was in the eighth or ninth session before I was completely comfortable." She indicated that "if my therapist was Persian or from a Middle Eastern culture it might

be easier for me to open up.” Her expectation that she and her culture would not be understood by the therapist hindered her ability to talk openly in psychotherapy.

Harout also had difficulty attending psychotherapy and felt that his therapists did not understand this. He said, “It just was kind of foreign to me. I could see that in this culture it is like people are very ready to just go talk to somebody about it; to get help or get counsel or psychiatric help.” Each of these participants seemed to feel that an American therapist would simply expect them to feel that attending psychotherapy is a normal thing to do.

Concerns as entered psychotherapy for first time. Participants were asked to reminisce about any concerns or worries that they had as they were planning to see a therapist for the first time. Three participants reported that they had no concerns as they actually prepared to attend psychotherapy for the first time. Nima stated that he was not concerned, because his mother told him to go and he was used to following her direction. He admitted that he did not have any expectations of the psychotherapy experience. Jon said something similar in response to this question. He said, “My parent told me to go, so I didn’t really think as much about it.” Shay too noted that she did not have any major concerns about going to treatment other than that she knew that she would have to stop using drugs. She also did not have high expectations of the experience. Each of these participants was an adolescent or young adult when they first went to psychotherapy.

Some participants worried that their therapist would not understand them, their cultural background, or their concerns. Arzu worried:

Can I tell this person my thought? Yeah, I was a little bit anxious actually... ‘What are they going to think?’ because they don’t know me and they don’t know my background. Then also cultural difference was also an issue for me and I

thought because they are American and that I am Turkish of two totally different cultures...So I didn't know if they were going to understand or not.

Sophia also expressed a concern about being understood by her therapist. She stated, "My biggest concerns were that my therapist would not understand my culture and would not understand me, that I would not be able to connect with my therapist."

Several participants suggested that they did not really understand the therapy process or what would be expected of them as clients. Arzu, specifically, had a lot of worries about what psychotherapy would entail and had little knowledge about what was expected of her. Like Arzu, Harout worried about what psychotherapy would be like. He remembered:

The first few times I think I was scared. I was actually thinking 'Wow, you know, what are we going to do.' I think I had a fear of having to actually get honest about stuff and I didn't know how honest it was going to have to go.

Nasim also admitted to being afraid to "open up to" her therapist even though she was planning to become a therapist herself.

Participants wondered if they would be considered to be "crazy" if they went through with seeing a therapist. Nasim said:

I remember not wanting to talk and not wanting to really say anything and not feeling comfortable...I think maybe my family, they say everybody's crazy, so I think that was the idea too. I can't say that it didn't influence me. I did have all the assumptions that probably they are going to think I'm crazy, so I probably shouldn't say anything. I was watching what I was saying.

Consistent with the stigma often associated with mental illness in Middle Eastern culture, several participants indicated that "only crazy people see therapists."

Instrumental and support barriers to receiving services. Participants were asked if there were any barriers to them receiving psychological services once they

decided to seek professional help. Barriers that were mentioned were financial, language, and lack of family support. In response to a specific question about barriers to receiving treatment, Eshan and Shay stated that there were no barriers to receiving psychological services for them.

Four of the participants reported that the only barrier to receiving psychological services was having the means to pay for them. Harout discussed sometimes not having the money or insurance to get help when he was struggling. Sophia stated that, “most places were too expensive.” Nasim found herself settling for a therapist with whom she was not completely comfortable, because the therapist was willing to accept what she could afford to pay. Those participants who were students at the time did not feel that there were any financial barriers to receiving services due to the availability of free services on their campuses.

Other participants described instrumental barriers. Jon felt that dealing with the insurance company and paperwork was difficult for his parents. He expressed that his parents were not fluent in English and did not navigate the system well in the U.S. This might have been even more difficult if Jon himself had also not been fluent in the English language. Nima indicated that his parents’ lack of skills in the English language prevented them from seeking family psychotherapy, because they were not able to find a family therapist who spoke Farsi in their area. Family psychotherapy had been recommended by Nima’s individual therapist. Arzu complained that once she finally got up the nerve to seek help, which was very difficult for her, she got put on a waiting list. This made it difficult for her to stay willing to follow through with seeking help.

Two participants reported lack of family support as a deterrent to seeking psychological services. One participant, Harout, felt that the fact that his family was not supportive or understanding of his need to get help was a barrier to receiving services for him. He suggested that his family had no way of comprehending his need to work with a therapist. He explained that they thought there had to be an ulterior motive and even asked him “Is that lady trying to have sex with you?” He added, “That hurt my feelings...if I ever did try to get counseling or try to reach out it was just not understood.” Arsineh also felt that her mother’s lack of understanding and a cultural value of obeying one’s parents made it difficult for her to seek help.

American-born participants. Sahar like many of the other participants worried about not being understood by a therapist. She explained that her parents did not understand her body image concerns or her disordered eating and so she worried that the therapist would not believe that she really had a problem that warranted treatment. She stated, “I think my biggest concern was that the therapist wouldn’t actually acknowledge that I actually had an issue, even though I felt as though I really did.” Her concerns as she entered psychotherapy clearly arose from her family’s attitudes toward mental health and illness.

The instrumental and support barrier themes were present with the American-born participants as well. Specifically, Marie noted that the therapist she was seeing was at a great physical distance and it was difficult for her to get to the appointments. This barrier was likely more related to socioeconomic status than to culture, given that Marie described difficulties in finding affordable services in her area. Sahar explained:

I had a feeling that my parents wouldn't really receive it very well if I approached them and said that I needed their help, so I had just started the university at the time and went to their counseling center there which is free to students.

She also mentioned that only if mental illness is severe would it be considered acceptable to seek outside help. She also noted that only a trusted professional who valued confidentiality would be acceptable.

Role of Family in Psychotherapy

As mentioned above families traditionally play a large role in the response to mental illness and seeking mental health services is often considered to be a last resort in Middle Eastern families. Participants were encouraged to discuss the role of their families once they sought psychological treatment. Participants also discussed how their family dynamics were often misunderstood by psychotherapists and indicated that individuation and/or acculturation are not culturally appropriate therapy goals due to the collectivist nature of Middle Eastern families.

Participants were asked to discuss who participated in their psychotherapy. They were also asked if they think that having their family participate was helpful or would have been helpful. Most of the participants stated that they attended psychotherapy alone. However, a couple of participants did have some family involvement in the psychotherapy process. The findings regarding clients' preferences were mixed with some wishing they had more family involvement and others preferring no involvement at all. Several participants admitted that they did not tell their parents that they were seeking psychological help.

Family involvement would have been helpful. Five participants felt that it would have been helpful to have their family participate in the psychotherapy process.

For example, Sophia stated:

I think it would have been helpful [to have my family there] because that way maybe they can gain some insight into what I feel/felt and into their own actions. Also, I have a really hard time talking to them about certain things, so psychotherapy would provide space for those difficult topics to be discussed.

Shay felt that her parents were kept in the dark throughout her stay at a residential treatment facility and that it was one of the worst aspects of the experience. She stated, “I wish my family was more involved or at least they were in the loop more...it’s an entire family thing or it’s nothing.”

Nima indicated that family psychotherapy was recommended and that he and his family wanted to do family psychotherapy. However, his parents do not speak English and were unable to find a family therapist in their area who spoke Farsi. He indicated that they are still looking for a family therapist and that he looks forward to this type of treatment.

Jon, who participated in both individual and family psychotherapy, felt that the family sessions were much more helpful than the individual sessions because “sometimes when I would talk about my own life it wasn’t as relevant. Some of the personal issues I dealt with might have been not as useful as the family issues.” He added that the family psychotherapy “was useful because people tended to be a little more civil in front of someone else and more willing to talk things out in psychotherapy.” His comments are more consistent with a collectivist view of the self rather than a more individualist view.

Family involvement would not have been helpful. In contrast to those discussed above, three participants felt that it would not have been helpful to have their family participate in psychotherapy for a variety of reasons. Harout felt that his family was too dysfunctional to participate in psychotherapy in a way that would be helpful. He explained that, “it is just best that I don’t bring certain things up or spend too much time with certain family [members].” He explained above that his family did not understand or support his efforts to seek professional help. Sevanah, again, did not tell her family that she was attending psychotherapy, because she did not feel that it would be accepted or understood. She said that she would not have wanted her mother to participate in her psychotherapy experience even if she was here in the U.S., “for two reasons. First of all, my mom would never participate and then if she did she would be resentful and upset and I would not be comfortable.”

Beti was brought to psychotherapy by her grandmother who wanted her to be able to process her reactions to her parents’ divorce. The grandmother did not participate in the psychotherapy. Beti and her grandmother chose not to tell Beti’s mom that she was seeing a therapist, because they did not want to burden her mom with the fact that the mother’s divorce was having a negative impact on Beti. Beti stated that they feared that her mother would stay with her father if she knew that it was affecting her daughter negatively. Interestingly, Beti stated that she wishes that her parents had become more involved in her psychotherapy towards the end. She said:

I think it would have helped me if some of the things that I said to her [the therapist] she would have actually told my mom.... I wish she would have called them both in and said, ‘this is what your daughter is saying about this whole thing.’

Based upon hindsight, Beti felt that her psychotherapy would have been more effective if her parents had been more involved. She indicated that she feels that many of the issues that she came to address were left unresolved, because they involved her as a member of a family rather than her as an individual.

Family dynamics often misunderstood. Nine of the participants discussed their frustrations with therapists who seemingly did not understand the differences between Middle Eastern and American family dynamics. Sevanah indicated that she did not feel that her therapist understood “how intertwined my life is with that of my family’s.” Sophia added that her therapists did not understand that “my parents have a HUGE influence and are a huge part of my life and that is the way my culture works.” Arzu felt that she was unable to explain her relationship with her in-laws and her difficulties in raising her children here. She indicated that she wishes that her therapist had understood that “the in-laws play very big roles, very very big roles.”

Beti felt that her therapist did not understand the impact of her parents’ divorce on her, because “it kind of makes you look bad in the Assyrian community... That was one of the things that I tried to make her [the therapist] understand.” Jon recalled his mother trying to explain her relationship with her parents [his grandparents] and noted that it seemed very difficult for their family therapist to understand these dynamics. He felt that this limited the ability of the therapist to help his family.

Some participants felt that their family dynamics were not just misunderstood, but pathologized by their therapists even though the “offending behavior” would be seen as totally normal within the Middle Eastern community. For example, Sevanah explained that her therapist expressed concerns about her close relationship with her mother

primarily because they spoke on the phone every day and because Sevanah looked to her mother to help make life decisions. She explained that she has often felt that her relationship with her mother is judged by American peers, whereas it would not be judged at all in her home country. She said, “My friends feel like a mom being involved so much is interfering in your life, whereas I really value my mom’s opinion.” It sounds as though her therapist feared that she had an enmeshed relationship with her mother, which would be conceptualized as a negative and harmful dynamic from a structural family psychotherapy orientation (Minuchin, 1974).

Nasim had a similar experience in psychotherapy. She stated:

I needed to defend my mom and say, ‘Whoa hold on. That’s part of the culture. Every Persian mom does that, 90 percent of them do that, and that has nothing to do with our relationship together.’ So that felt like something I was explaining often [in psychotherapy].

Shay felt that the role of women in her culture was grossly misunderstood. She also felt that the dynamics of her family were grossly misunderstood. Shay explained:

There was never an attempt to understand and often times I felt as though blame was being placed on my parents for being strict, for being too strict...Quite big assumptions were placed on who they were and how my family ran.

All of these participants expressed concerns about their family dynamics not being understood, at best, and being pathologized, at worst.

Acculturation and/or individuation as therapeutic goal. Consistent with discussions of differing family dynamics, participants complained about therapists who seemed to have individuation as a primary therapeutic goal when this would not be considered a positive orientation in Middle Eastern cultures or families. Sevanah and Nasim felt that their therapists wanted them to have more boundaries in family

relationships, whereas both felt that her family relationships were very typical for her culture. Sophia indicated, “I wish my therapist understood that I would not be able to completely disregard my parents’ opinion.” She later added:

I also wished that he would have understood that even though in America we are independent people who make choices without regard for our families, someone who is from another culture may not work that way. And that it is okay with them, this way of being.

Shay also felt that her therapists wanted her to make choices independently of her parents’ wishes. She explained:

I wish that they would have understood the whole entire family dynamic as opposed to ‘you do what is best for you and whatever for your family.’ Culturally, it does matter what my dad has to say about it...I didn’t feel like a lot of what was being said was really applicable, because I can’t just go home and do what I want or look out for myself more or do anything without direct parental involvement

Participants are highlighting the possibility that Middle Eastern cultures may be more collectivist in orientation, whereas American culture values individualism. In collectivist cultures, individuation would not be considered a culturally appropriate therapeutic goal (Sue & Sue, 2003).

American-born participants. Marie felt that it would not have been useful to have her family involved in psychotherapy. She suggested that her family was a large part of her pathology in the first place and seems to have separated herself from them over time. Sahar’s parents were not included in her psychotherapy sessions. She stated, “I just wish we could have come up with a better way to include my parents in the process.” She explained that she thinks that it would have been very useful if her parents had been included. She later added, “I wish there was more communication between like the therapist, myself, and my parents. Sahar also felt that her mother’s reactions to her eating

disorder were pathologized by her therapist. She reflected, that “I think it’s something that if one of my friends was struggling with an eating disorder and they were Persian or whatever, I could totally see their parents having the same exact reaction.”

Suggestions for Culturally Sensitive Psychotherapy and Counseling

Most of the participants felt that the psychotherapy experience overall was very helpful to them. They were each asked to describe what exactly worked for them within the experience and what the therapist(s) did that felt effective. Participants discussed ways in which the psychotherapy experience could have been more culturally sensitive. As described above, several participants wished that their therapists had understood their cultural backgrounds, their tight-knit family dynamics, and how difficult it was for them to attend psychotherapy in the first place. The foreign-born participants also had suggestions related to psychotherapist stance or personality that would be more culturally sensitive, therapeutic methods that would be more culturally sensitive, and the importance of taking trauma histories into account. These will be discussed below. The two American-born participants only suggested increased cultural knowledge and sensitivity.

Therapist style and/or personality. Several participants noted aspects of their therapist’s style or personality as particularly helpful to their progress. These participants seem to be describing skills and attitudes consistent with the common factors of psychotherapy as outlined by Wampold (2001). Common factors include skills and

attitudes that are often present in effective therapy regardless of the therapist's theoretical orientation.

For example, Sophia stated that she appreciated one of her therapists for having a flexible style in psychotherapy. Another participant felt that having an understanding therapist was really important to her. Sophia agreed that having a therapist who cared and understood her made the difference for her in a positive way. Eshan thoroughly appreciated having his symptoms/condition explained to him in a way that made sense to him. Arzu felt that having a nonjudgmental and unbiased person to talk to was very important. Jon, who described his therapist as “a pretty good therapist,” noted that he was “not cold and distant” and was “usually a kind of friendlier figure.”

Having a therapist with good listening skills was important to several participants. Beti noted that it was really helpful to be listened to. Shay indicated that she liked a therapist who allowed her to make her own connections in psychotherapy rather than offering her the therapist's insight into her problems. She stated, “I have learned that the way I figure things out about myself is talking through them and so that was how it was effective and helpful.”

Nasim appreciated that her therapist gently pushed her to go deeper into her issues rather than allowing her to keep everything very superficial in psychotherapy. She explained how the therapist would respond to her discomfort with difficult therapeutic content.

She would let it go, but what helped is she would bring it back later and she would kind of push me to talk about it. So that helped because she got to know me, that I say no to everything at first and I need that extra push.

Nasim also appreciated that her therapist asked her immediately about her previous psychotherapy experience. The second therapist inquired about what Nasim had liked and not liked about her previous experience. This allowed her second therapist to avoid the mistakes of the first therapist. Similarly, Sevanah liked having a therapist who checked in with her often about the progress of their work together and her reactions to specific interventions. This approach likely allowed her to avoid continuing with culturally inappropriate interventions and to move forward in a more meaningful way.

Three participants indicated that helping professionals who were too cold or rigid in psychotherapy were unhelpful. These participants suggested that a warm therapeutic alliance would be more culturally appropriate for them. Sophia described her first therapist saying, “We just did not connect emotionally. He had a rigid way of looking at the world and did not understand me and where I come from.”

One participant, Ezgur, felt that his therapist was “so professional and it put up some boundaries between me and her.” He added that he feels that people in Turkey are more “warm and open” than people in the U.S. He indicated that this observation held true for his two therapists, one in the U.S. and one in Turkey. He indicated that his American therapist remained too focused upon his presenting problem and did not gather much information about who he was as an individual. He said, “You have to learn your client’s background.” He clearly felt that his American therapist did not do this and that his Turkish therapist did.

When asked about what did not feel effective about psychotherapy, Harout said, “It just wasn’t personal enough.” He added:

Sometimes the personal ones that knew more about my life and knew names of people in my life and knew what was going on, they had a bigger impact. May of them you kind of feel like there was a point where they were looking at their watch and I don't think I got much help from that.

Several participants clearly felt that impersonal and/or rigid therapists were not effective for them and would prefer a more flexible and welcoming style in psychotherapy.

Specific therapeutic methods. Several participants described specific therapeutic methods that they felt were particularly helpful to them. Ehsan, Arzu, and Ezgur described methods that are consistent with a broad cognitive-behavioral approach to psychotherapy originally outlined by Beck in 1967. Arzu described having her distorted thoughts about herself challenged by her therapist. Her therapist helped her to understand that depression negatively colored her world view as well as her self-concept. Arzu felt that this conceptualization continues to be useful to her. Ezgur felt that learning relaxation techniques and behavioral activation techniques were particularly helpful to him when he was struggling with academic-based anxiety.

As discussed earlier, Jon felt that family psychotherapy was a particularly effective approach to psychotherapy for him. Also, Sophia, Shay, and Beti all felt that it would have been helpful if their parents had been more involved. Several participants felt that the use of psychoeducation was a useful aspect of their therapeutic experience. Harout stated, "I felt like therapists were able to give me enough guidance to make it through little parts of my life." Eshan, in particular, appreciated the psychoeducation he received from his psychologist.

One participant felt that the use of metaphors was an important intervention for her. Another participant felt that her therapist's openness to other ways of expressing

oneself, besides talk psychotherapy, was very helpful. She explained that her therapist allowed her to use art to express herself and added that this allowed her to open up in a way that she could not have otherwise done.

Presence of trauma histories. Two participants felt that their therapists in the U.S. did not understand the realities that they and their families had faced before coming here and that this lack of understanding negatively affected the psychotherapy experience. Jon felt that therapists working with Middle Eastern participants should consider the possibility that their patients may have had traumatic experiences in their past and might not bring them up in psychotherapy, because to them these experiences seem normal. He added:

If you didn't really know historical context, if you didn't really know what was going on you might not ask those sorts of questions. Iranians wouldn't really say, 'Well this happened to me and I have all these problems because of this.'

He later explained that the patient would likely not connect psychological problems with experiences of trauma because everyone they know will have experienced similar traumas. He said:

Most of the community here has some sort of issues with politics and even in my own family there's been a person in my family that has been executed and just a lot of these issues that you wouldn't really think about if you were American you have to deal with with an Iranian person.

Harout and several of the pilot study participants (Boghosian, 2007) also discussed the importance of therapists acknowledging experiences of trauma when working with persons of Middle Eastern descent. This topic was not assessed directly by the interview questions and may benefit from further inquiry.

Path to Receiving Psychological Services

One minor theme that emerged related to the process of pursuing psychological services. Participants were asked questions about what led them to seek psychological services in the first place. There were not major patterns in terms of diagnosis, but most of the participants discussed acculturation issues as part of the reason they sought psychological services. The participants also discussed how they chose the psychologist(s) that they worked with in psychotherapy. Convenience, rather than cultural considerations, seems to be the primary factor in these decisions.

Reasons for seeking psychological services. Participants in this study sought professional help for a wide variety of psychological problems. Several participants' issues were directly tied to cultural adjustment. For example, Ezgur was having difficulties with completing his graduate studies in a foreign language and became very overwhelmed. Jon, on the other hand, went to psychotherapy with his family when they were having difficulties in adjusting to life in the U.S. Mima also attributed his struggles with depression and anxiety to adjustment issues after moving to the U.S. He stated, "I was sort of overwhelmed by all the changes...everything sort of stressed me out." Arzu felt that her transition to life in the U.S. and lack of social support led to severe depression.

Shay sought out-patient psychotherapy and eventually residential treatment to treat substance abuse issues and other issues related to risky behaviors. She explained that she

didn't ever feel like I fit in anywhere, because in Egypt we were 'the Americans, the doctor's daughters so we weren't like everybody else...so I never felt like I fit

in there, but we spent so much time there. That was really hard and then in California, the only people that I would fit in with were the people that were selling hash or something like that.... I never felt like I fit in there either.

This comment suggested that Shay's substance use issues were likely related to cultural adjustment, because she found that drugs were a way of coping with feeling like an outsider. Also, drug dealers and users, to Shay, seemed less concerned with cultural differences and accepted her more readily than others had. Harout also sought services on a variety of occasions for substance abuse issues.

Some participants sought therapy in university settings. Nasim first attended psychotherapy as part of her training to become a therapist herself. She later attended psychotherapy again, because she was having a hard time during her graduate studies. Sevanah went to a university counseling center to deal with anxiety and depression during graduate school. Like Ezgur and Nasim, she became very overwhelmed during this time. She found that she was pushing herself too hard and missed the emotional support of her family and community.

Other participants went to therapy to address specific interpersonal difficulties. Beti went to a couple of different therapists to deal with the emotional repercussions of her parents' divorce, which is not a common or accepted occurrence in her community. Sophia went to psychotherapy on two different occasions to deal with "depression and trying to get over my ex-boyfriend." She noted that she also sought help with negotiating the differences between her parents' ideas on dating and American norms without disrespecting her parents' wishes. Eshan went to individual and group psychotherapy following significant "stress from work and marital problems."

How chose where to receive services. Most of the participants seem to have sought services based mainly upon convenience and financial ability. Eshan, Shay, and Jon went to the outpatient therapist that was on their insurance panel list. Nasim, Ezgur, Nima, Sophia, and Sevanah went to the counseling center at the university they were attending, where services were provided for free. Nima later found an Iranian therapist in the town where his parents live and worked with him for a while.

Beti went to two therapists that were recommended by the pastor of her church. Harout said that he found therapists through recommendations from friends. Arzu said that her family physician recommended the therapist that she saw. When Shay needed a more intensive treatment option, her parents found a residential treatment facility online. She expressed that she feels that they did not understand their options well and were not informed consumers.

American-born participants. Marie, who was raised in the U.S., has attended group and individual psychotherapy to address mood issues. She has a reported diagnosis of bipolar disorder. She expressed the opinion that much of her mental illness was caused by issues within her family and culture. She expressed that she both loves and hates being an Arab woman, because of the abuse and neglect that she experienced within her family. Sahar, the other American-born participant, sought mental health treatment for a severe eating disorder. Marie sought services primarily based upon what she could afford or what was recommended by other professionals. Sahar stated that she went to the counseling center at her university because it was convenient and free.

All of the 13 participants suggested that issues of cultural adjustment or acculturation issues between generations were at least partially responsible for the

psychological distress that lead them to psychotherapy. Most of the participants reported that they did not expect to be able to find therapists who shared their cultural background and therefore did not try. Each of them seem to have sought treatment with the person most available and convenient to them rather than trying to find an expert in working with people of Middle Eastern descent or a multicultural psychologist. These findings suggest that any therapist or counselor in the U.S. has the possibility of treating a person of Middle Eastern descent.

CHAPTER V

DISCUSSION

Multicultural psychology is a growing movement within the psychology field. Pedersen (2004) referred to it as the fourth wave of psychology, because multicultural considerations are permeating the field of psychology in such a manner as to change it indelibly. The American Psychological Association (1993, 2003, 2006, 2010) has specified that psychologists, who are predominantly White, must attend to cultural considerations in practice, research, teaching, and training. Psychology has evolved to meet these challenges by making changes to definitions and practice of general competence (e.g., operationalizing cultural competence) and calling for changes in how we implement interventions (e.g., cultural adaptations).

Prompting these changes were decades of research with the largest ethnic minority populations within the U.S. (Latino/a, Asian American, African American, American Indian). The available body of research has been used to provide information about how to provide culturally competent psychotherapy to these populations. However, relatively less is known about how to provide culturally competent services to other ethnic minority populations in the U.S, such as persons of Middle Eastern descent.

The psychological literature that does exist related to working with Middle Eastern people in counseling and psychotherapy comes exclusively from the perspective of therapists who work with this population. The purpose of this study was to explore from clients' perspectives how to begin to provide culturally competent psychotherapy to persons of Middle Eastern descent.

Middle Eastern Mental Health Attitudes

The findings of this study suggest that persons of Middle Eastern descent seem to have some qualitatively different mental health attitudes from majority Americans. Mental illness seems to be stigmatized in many Middle Eastern families here in the U.S. and in the Middle Eastern region. Families seem to play a much larger role in responding to mental illness in Middle Eastern cultures when compared to majority American culture. However, how they respond is often by taking care of basic needs and ignoring psychological needs. Attitudes towards mental illness seem to be changing in Middle Eastern cultures by moving closer to majority American values.

Stigma Association with Mental Illness

The findings of this study suggest that mental illness is often stigmatized within Middle Eastern cultures. Although mental illness is associated with some stigma in the majority American population as well, there does seem to be qualitative differences in the intensity of the stigma described by these patients when compared to majority Americans (Carpenter-Song et al., 2010). The role of the family structure in maintaining the stigma also seems more profound than in the majority of American culture. Persons of Middle Eastern descent who are suffering from mental illness may be labeled negatively by those closest to them. Their issues will likely not be discussed in helpful ways within the family and will not be discussed at all within the community. These individuals may also be viewed as a shame and/or a burden within Middle Eastern families. Similar conceptualizations of and responses to mental illness have been described within

traditional Asian American families, as well (Zane, Morton, Chu, & Lin, 2004; Zane & Sue, 1996).

Stigmatizing mental illness commonly leads to minimization of psychological problems and a lack of awareness of psychological services (Zane et al., 2004). These factors seemingly can lead to increased psychological problems and decreased support. The findings of this study suggest that persons of Middle Eastern descent may therefore wait to seek psychological services until the severity or chronicity of their problems are much worse than those of majority Americans. The novel task of finding a therapist may be even more difficult to accomplish in the context of great psychological distress.

Role of Family in Responding to Mental Illness

The findings of this study suggest that the family plays a major role throughout the life of a person of Middle Eastern descent. Participants of this study seemed to view themselves as a person within a system rather than as individuals. This collectivist identity contrasts sharply with the individualist identity assumed by most therapeutic approaches. Dwairy (2006) discussed the collectivist nature of Middle Eastern families and the importance of understanding this dynamic when conducting psychotherapy with this population. This dynamic is common in other minority groups in the U.S. and is well documented by Triandis in his book *Individualism and Collectivism* (1994).

The findings of this study suggest that Middle Eastern families, rather than individuals or communities, are responsible for identifying and addressing psychological problems. Some participants described loving and supportive responses to psychological pain from immediate family members. However, traditional Middle Eastern families

commonly seemed to address mental illness by ignoring it and hiding the sufferer from the outside world. This cultural norm is seemingly caused by, and then perpetuates, the stigma associated with mental illness discussed above. It seems atypical for Middle Eastern people to discuss private matters outside of the family group. Therefore, seeking outside help is done only as a last resort. Aversion to outside help and hiding of sufferers are cultural norms typical also in Asian cultures (Zane & Sue, 1996).

Grieving in Middle Eastern Cultures

Grieving is one way that mental health attitudes seem to differ between Middle Eastern persons and the majority American population. Participants in this study, regardless of ethnic or religious background, outlined detailed and prescribed ways of grieving in their cultures. The specifics were somewhat different depending upon religious background, but were similar in that there were elaborate rituals that would be conducted on specific days following the death of a loved one.

These grieving rituals seemed qualitatively different from how grieving is conducted and experienced in the majority American population (Kübler-Ross, 1969), not only because they were so structured and prescribed, but because grieving is experienced as a family/community rather than as an individual. Individual stages of grieving as outlined by Kübler-Ross would likely not make sense within a Middle Eastern family. However, outlining group stages of grieving might be more culturally appropriate.

Based upon these findings, it also seems as though a cultural group that is normally expected to hide psychological pain is suddenly allowed, and even expected, to emote dramatically following the death of a loved one. This theme was not expected and

was not initially prompted by the researcher. However, after the first few participants described their grieving rituals in the context of describing how psychological distress is experienced, the researcher began asking about grieving. All of the following participants did not hesitate before answering this question with detail. Future research should assess grieving among persons of Middle Eastern descent more specifically.

Traditional Versus Changing Mental Health Attitudes

Mental health attitudes appear to be changing in Middle Eastern cultures, though participants provided different presumed etiologies for these changes. For younger, more acculturated, educated, and/or urban persons of Middle Eastern descent, mental health attitudes may be somewhat similar to majority American mental health attitudes. It will be important for professionals to take acculturative status into account, because more traditional Middle Eastern families' mental health attitudes will likely differ more from majority mental health attitudes when compared to more acculturated persons of Middle Eastern descent. It should be noted that older Americans are less open to mental health treatment than younger Americans (Kyaien, 2009), so the changes noted in the Middle Eastern population are not atypical.

The findings of this study suggest that traditional mental health attitudes will likely include more stigma and shame associated with mental illness and more reluctance to seek treatment. Traditional mental health attitudes will also likely involve a preference for medical rather than psychological explanations for problems. More traditional families may also prefer religious explanations and solutions to psychological distress.

Therapy Experiences of Persons of Middle Eastern Descent

The findings of this study suggest that diverse persons of Middle Eastern descent are seeking psychological services in the U.S. Middle Eastern clients often experience cultural barriers (intra- and interpersonal) before entering treatment. These clients will likely present with concerns about the therapy process and may not have the support of their families in seeking help. Middle Eastern clients will likely need to be conceptualized and treated within a family system rather than as individuals. Therapists who do not understand Middle Eastern identity development in all of its complexity will likely not be optimally effective.

Cultural Identity

Study findings suggest that a Middle Eastern cultural identity is complex and that persons of Middle Eastern descent value an understanding of their cultural identity. Middle Eastern culture is not well understood in the U.S. Lack of understanding of the complexity of Middle Eastern identity likely leads to its exclusion from the therapy dialogue. Although participants in this study expressed frustration with the lack of understanding of their cultural backgrounds, ethnic glossing and stereotyping by helping professionals leads to even more frustration for Middle Eastern clients than when culture was not addressed at all. The findings of this study suggest that understanding a Middle Eastern cultural identity in the U.S. will include understanding: religious background, ethnicity, nationality of origin, immigrant history, and family dynamics. Participants seemed to equate a willingness to explore and understand their cultural backgrounds with caring from therapists.

Study participants were aware of the researcher's knowledge about Middle Eastern cultures based first upon her introduction to the interviews and second upon her own Middle Eastern background (last name is easily identifiable to other people of Middle Eastern descent). This may have lead to less dialogue about the importance of this topic, because its importance was assumed in the interview discussion. Also, interview questions did not prompt discussions of how participants label themselves culturally or ethnic identity development. Future research could focus upon these important issues more specifically.

Cultural Barriers to Treatment

Participants in this study entered therapy with major misgivings. This suggests that Middle Eastern clients will likely enter therapy with similar concerns. First, clients will likely carry the cultural stigmas of mental illness, and therefore of themselves, into therapy. Clients may feel shameful about seeking treatment and uncertain about speaking to a nonfamily member about private matters. Clients may be coming to therapy without the support of their families. In fact, they may keep the fact that they are seeking psychological services a secret from those they are closest to.

Clients of Middle Eastern descent may also enter therapy without understanding the process or what will be expected of them. They may be skeptical about the therapy process. Clients may also not expect an American therapist to understand their cultural background or their family dynamics. Clients may not expect therapy or counseling to help them. It will be important for psychologists working with this population to explain the process fully and to expect what may feel like resistance at first. Treatment

acceptability is believed to be a key factor in treatment adherence and positive outcomes (Cross-Calvert, & Johnston, 1990; Tarrier, Liversidge, & Gregg, 2006). Therefore, it will be important for psychologists working with this population to address the cultural barriers that clients enter therapy with.

Role of Family in Psychotherapy and Counseling

Given that Middle Eastern families are very tight-knit and collectivist in nature (discussed above), it is not surprising that families can play an important role in the treatment of Middle Eastern clients. Supportive family members can make it much easier for an individual (particularly adolescents) to enter and stay engaged in treatment. However, families can also make it difficult for persons experiencing distress to seek psychological services. When treating a person of Middle Eastern descent, it will be important to explore with each client the role that makes the most sense for their family to play in the treatment process. Family therapy will often be a particularly good therapeutic intervention with persons of Middle Eastern descent, whether as a main modality or as part of a treatment plan. It should be noted that not all family therapy orientations will be a good fit for Middle Eastern families (e.g., structural family therapy) without cultural adaptations. McGoldrick et al. (2005) offered recommendations for conducting culturally sensitive family therapy with a variety of Middle Eastern subgroups.

The findings of this study suggested that it will be important to conceptualize more traditional Middle Eastern clients not as individuals, but as members of a family. Family dynamics should be explored fully and early on in therapy. Family dynamics

should be explored without biases or judgment. It will be important for psychologists to have an awareness of how culture has influenced their understanding of what family dynamics are acceptable versus which are not, so as to not incorrectly pathologize culturally different ways of being. What may look like enmeshment (Minuchin, 1974) in family relationships should not automatically be pathologized (Dagirmanjian, 2005; Dwairy, 1998; Jackson, 1997; Jalali, 2005).

Psychology as a field developed in a time and place that promotes individualism (Dwairy, 2006). Many treatment goals in Western psychotherapy include individualist concepts such as self-actualization, self-esteem, empowerment, and individuation. Such concepts are likely irrelevant within the collectivist family dynamics of Middle Eastern culture and therefore may be culturally inappropriate therapy goals for this population (Dwairy, 2006; Erickson & Al-Timimi, 2004; Kaeni, 2006).

Enmeshment between family members has been vilified by psychologists since the mid-1970s (Minuchin, 1974) and is inconsistent with the individualism valued in mainstream American culture. However, the findings of this study suggest that enmeshment is considered to be normal and healthy within Middle Eastern families. This finding is supported by other experts in working with this population in counseling and psychotherapy (Dagirmanjian, 2005; Dwairy, 1998; Jalali, 2005; Kaeni, 2006). What appears to be enmeshment may, in fact, be interfering with functioning of the family or it may not. Therapists working with this population should seek to explore what is working versus not working within a specific family culture rather than automatically pathologizing what appears to be enmeshment.

Treatment Process

Overall, the findings of this study suggest that persons of Middle Eastern descent are not only participating in counseling and therapy in the U.S., but that they are often moderately satisfied with the therapy experience. There does seem to be some variability in terms of what leads persons of Middle Eastern descent to therapy, but acculturation stress as defined by Dressler and Bernal (1982) seems to be a common factor. Persons of Middle Eastern descent will likely pursue services with finances and distance as priorities, so any therapist in the U.S. can expect to treat someone with a Middle Eastern background.

Other Findings

In the course of conducting the literature review, it became evident that previous attempts to address this topic have focused upon specific subgroups within the larger Middle Eastern population (e.g., Arabs and/or Muslims). The ethnic, religious, and national diversity of this small sample suggests that a wide range of Middle Eastern people are seeking psychotherapy in the United States. Interestingly, only one study participant fit the description of being Arab and Muslim. Even this participant was unique in that she had an American mother who converted to Islam later in life. The rest of the participants were either ethnic and/or religious minorities from the Middle East. A major observation from the study process, then, is that there is a need for a clear definition of the more global ethnic term “Middle Easterner” as well as a need for more research addressing subgroups within this population. Psychologists working with this population

will need to understand the immense complexity of Middle Eastern identity and the diversity of the Middle Eastern American population.

It is unclear why there were so few Muslims (6) and Arabs (2) involved in the study, when Arab and Muslim organizations were more easily accessible to recruitment fliers through their numerous cultural and religious organizations here in the U.S. Their relatively low participation in this study may be due to the fact that more ethnic and/or religious minorities have emigrated from the Middle East in recent waves of emigration (Dwairy, 2006). It may also have been due to the identifiably Armenian last name of the researcher, which was clearly stated on the recruitment fliers. Arabs and Muslims may have felt uncomfortable speaking to a cultural outsider. It is also possible that ethnic and religious minorities from the Middle East are more open to either counseling/psychotherapy or to participation in research. Regardless, the ethnic or minority status of all of the participants in their home countries highlights the need for further research to understand Middle Easterners who do not fit the typical Arab and Muslim status so that we may broaden our knowledge-base in multicultural psychology.

In spite of the diversity of the sample, participants seemed to discuss similar experiences and viewpoints in their interviews. This suggests that there are some cultural similarities across the Middle Eastern subgroups that may be important for American psychologists to understand. However, all of the participants stressed that it is important for psychologists to understand the cultural differences within the Middle Eastern population rather than making assumptions based upon common stereotypes of people from the Middle East or assuming that everyone is Muslim and/or Arab. Therapists who

took the time to understand the specific cultural backgrounds of these participants appear to have had stronger therapeutic alliances with them than therapists who did not do this.

It is also interesting that the American-born participants shared such similar experiences and viewpoints as most of their foreign born counterparts in the study. The two American-born women actually seemed more invested in their Middle Eastern identities and heritage than several of the foreign-born participants. Perhaps the concept of ethnic identity is a more important thing to assess in psychotherapy than acculturation status for this population. For example, one foreign-born participant, who spoke with a very thick non-native accent, was clearly not invested in a Middle Eastern identity. Based upon his own report, he likely would care less about culturally tailored treatment than either of the American-born participants.

Ethnic and religious minorities from the Middle East were also highly invested in preserving their cultures. This likely carried over from needing to preserve their minority cultures as non-Muslims or non-Arabs in the U.S. One participant explained that her Assyrian culture has been similar since biblical times due to this phenomenon. She also mentioned that it would never be sanctioned for her to marry outside of the culture for this reason. Sophia who is Armenian, Iranian, and Christian also mentioned this cultural norm. Abu-Baker (2006) discussed this cultural norm among Muslim and Arab people as well. American therapists may not understand why later-generation Middle Eastern people are so invested in their cultural heritage and might pathologize this orientation unknowingly.

These participants, and those in the pilot study (Boghosian, 2007), seemed to feel that Americans are very individualistic, whereas perceived Middle Eastern culture as

more collectivist. There is support for this finding, that Middle Easterners are more collectivistic than majority Americans, in at least one comprehensive meta-analytic literature review (Oyserman, Coon, & Kemmelmeier, 2002). Participants also did not seem to expect Americans to understand their cultural heritage. This expectation was likely based upon a culmination of experiences while living in the U.S. According to these participants, Middle Eastern people will not necessarily look for cultural experts to treat them, so any therapist could expect to treat someone from this population.

Counseling centers in particular will likely treat members of this population and should be prepared to provide culturally competent services to them. It is important to note that study participants who worked with therapists that they did not perceive as culturally competent felt that psychotherapy was not helpful to them.

The findings of this study seem to support recent recommendations (APA, 2006) in the field related to moving towards evidence-based practice in psychology. These recommendations involved the combined use of (a) clinical judgment and skills, (b) current research (empirically supported treatments), and (c) client characteristics/ preferences in the treatment of any client (Spring, 2007). The findings of this study suggested that use of any of these three skill sets alone would not be the most effective approach when working with clients of Middle Eastern descent, and that it is the combined use of them that will be most effective when working with this population.

Recommendations for Counselors/Psychotherapists

Working with Middle Eastern People

The purpose of this study was to begin to explore how to conduct culturally sensitive psychotherapy and counseling with persons of Middle Eastern descent. The findings of this study can be used to generate recommendations for therapists working with this population. Relevant recommendations will be presented under the broad categories of cultural competence of attitudes, knowledge, and skills (Sue et al., 1982). . It should be noted that not all recommendations fit neatly beneath only one heading.

Attitudes

This section will discuss the recommendations for therapists working with persons of Middle Eastern descent in terms of the therapeutic stance that will be most culturally sensitive. An attitude of flexibility and nonjudgment was important to the study participants. Reflective listening skills were also described as important. Many of the attitudes that participants appreciated in their therapists were consistent with the common factors of psychotherapy outlined by Wampold (2001). The common factors are a set of skills that are common to most, if not all, effective therapy modalities that are purported to lead to change.

“The Common factor model proposes that there exists a set of factors that are common to all (or most) therapies, however identified and codified, and rather than the ingredients specific to the particular theories” (Wampold, 2001, p. 23). Wampold (p. 25) summarized several common factors from the work of Frank and Frank (1991), including: “an emotionally charged, confiding relationship with a helping person,” a

“healing setting,” a “rationale, conceptual scheme, or myth that provides a plausible explanation for the patient’s symptoms,” and “ ritual or procedure that requires the active participation of both client and therapist.”

Another way of thinking about the stance that these participants appreciated in a therapist is outlined by Ponterotto (2010). It seems as though his concept of Multicultural Personality (MP) traits is quite consistent with the attitudes described by these participants as effective and culturally competent. This theory, though it is not specific to therapists/counselors, emphasizes the importance of cognitive flexibility, an appreciation for other worldviews, empathy, and good communication skills in people who are competent in multicultural situations.

It will be important for therapists who work with persons of Middle Eastern descent to explore and understand their own biases and stereotypes of Middle Eastern people. Participants in this study were aware of and affected by the biases of their therapists. Exploration of one’s own biases is often recommended by experts in working with minorities in therapy (Ridley, 2005; Sue et al., 1982; 2007). This recommendation is in line with those from experts who work with persons of Middle Eastern descent (Abudabbeh, 2005; Abudabbeh & Aseel, 1999; Bushra et al., 2007; Erickson & Al-Timimi, 2004; Kelly & Aridi, 1996; Khalid, 2006; Rehman & Dziegielewski, 2003; Vartan, 1997).

Respect for cultural and religious differences is fundamental to practice with Middle Eastern people. Having a therapist who was willing to understand the complexity of Middle Eastern cultures was very important to these participants. Participants did not appreciate feeling judged or mislabeled by their therapists due to lack of understanding of

the complexity of Middle Eastern identity. Therapists with some experience with some Middle Eastern subgroups in psychotherapy seemed to be more prone to ethnic glossing. Trimble (1990) defined ethnic gloss as when psychologists utilize broad ethnic labels to identify participants or clients, which limits the understanding of their cultural and individual complexity. Participants who experienced this felt that this negatively affected the psychotherapy experience.

The incredible diversity of the study participants and the heterogeneity of the Middle Eastern population also suggest that the generally recommended attitudes for clinicians will be especially important when working with clients of Middle Eastern descent. For example, an attitude of curiosity, flexibility, and openness to other ways of being/knowing will aid a therapist working with this population in avoiding the traps of ethnic glossing and or imposing one's own biases/values upon the client. These attitudes will allow the therapist to better understand the world view of the individual they are working with and to explore the importance of cultural identity as part of the psychotherapy process.

Knowledge

This section will summarize the things that a psychologist working with persons of Middle Eastern descent will need to know in order to provide culturally competent treatment. First of all, it will be important to keep in mind that the nationality, religion, or ethnicity individually will not necessarily capture the cultural identity of a Middle Eastern. Knowledge about diverse Middle Eastern history, cultures, and religions will be an important part of working with people of Middle Eastern descent. Gregg (2005),

McGoldrick and colleagues (2005), and Dwairy (2006) provide useful summaries of Middle Eastern history and culture. A dimensional perspective on Middle Eastern identity is provided earlier in this document as well. Also, internet searches on specific ethnic, religious, and/or national backgrounds of specific clients can net valuable information as one participant in the study noted.

The study findings suggest that there is a lack of dialogue about mental illness in Middle Eastern communities. Therefore, people suffering from mental health issues or psychological distress may feel alone and not know how to get help. Institutionally, agencies may seek to more actively engage potential clients through community events that provide general education about mental health topics and health seeking.

There also does not seem to be a concept of a spectrum of mental health problems in Middle Eastern communities. Therefore, one is either sane or “crazy.” This cultural mental health attitude may contribute to the negative stigma associated with mental health treatment that participants described. Practitioners planning to work with persons of Middle Eastern descent will benefit from awareness of these cultural barriers to treatment, so that they are not missed or pathologized and can be addressed therapeutically.

It will be important for professionals working with persons of Middle Eastern descent to be aware that Middle Eastern communities and families tend to be more collectivist, rather than individualist like majority American culture. Individualism is defined as:

a social pattern that consists of loosely linked individuals who view themselves as independent of collectives; are primarily motivated by their own preferences, needs, rights, and contracts they have established with others; give priority to their personal goals over the goals of others; and emphasize rational analyses of the advantages and disadvantages to associating with others. (Triandis, 1995, p. 2)

and collectivism is defined as:

a social pattern consisting of closely linked individuals who see themselves as part of one or more collective (family, coworkers, tribe, nation); are primarily motivated by the norms of, and duties imposed by, those collectives; are willing to give priority to the goals of those collectives over their own personal goals; and emphasize their connectedness to members of their collectives. (Triandis, 1995, p. 2)

The observation that Middle Eastern cultures are more collectivist than majority culture in the U.S. was also mentioned by experts in the field (Dagirmanjian, 2005; Dwairy, 1998, 2006; Erickson & Al-Timimi, 2004; Jalali, 2005; Kaeni, 2006) when writing about working with Middle Eastern people in counseling and psychotherapy.

The collectivist nature of Middle Eastern families and communities seems to reinforce silence about mental health problems. People do not seem to want to burden the family system or shame their loved ones. It seems as though this phenomenon of silence may lead to more internalizing problems among Middle Eastern people in the U.S. and in the Middle East. Future research should address this possibility. Interestingly, internalizing disorders have been found to be more common among ethnic minority youth in the U.S. than among majority youth (Anderson & Mayes, 2010).

Also, this study suggested that family dynamics are different among Middle Eastern cultures when compared to majority American culture. Participants felt that psychotherapy was negatively affected when the therapist did not understand or respect this. Experts in working with persons of Middle Eastern descent in therapy have also suggested this (Abudabbeh, 2005; Carolan et al., 2000; Dagirmanjian, 2005; Dwairy, 1998, 2006; Erickson & Al-Timimi, 2004; Jackson, 1997; Jalali, 2005; Kaeni, 2006; Nassar-McMillan & Hakim-Larson, 2003).

According to these study participants, in Middle Eastern culture seeking help is perceived as weak or ignorant. It is atypical and somewhat culturally inappropriate to speak to someone outside of the family (Abudabbeh & Aseel, 1999; Dagirmanjian, 2005; Erickson & Al-Timimi, 2004; Jalali, 2005; Nassar-McMillan & Hakim-Larson, 2003), and yet speaking to people within the family seemingly comes with costs as well. This dilemma likely leads to symptom minimization and secrecy. In addition, Middle Eastern people with mental health issues are often cared for by their families. According to these study participants, suffering relative's financial and basic needs are taken care of. However, their mental health issues are often not addressed specifically. Their mental health is also not discussed outside of the family and most often are not even discussed within the family. Mental illness is definitely not discussed around children. These traditions likely add to the perception of shame and confusion about mental health issues.

Middle Eastern people who do seek help will likely come with major obstacles (internal and external) including, shame, guilt, lack of support, distrust, confusion, and fear. These attitudes may affect the therapy process. Middle Eastern clients may also enter psychotherapy expecting to be judged not only by their family and community, but also by the therapist. Middle Eastern people will likely not expect to be understood by their therapist. They may not expect psychotherapy to work. Having this knowledge may lead to increased understanding and may limit incorrect labeling of what appears to be resistance in psychotherapy.

Mental health attitudes seem to be changing in Middle Eastern communities and in some cases are moving in the direction of those of the majority culture. It will be important for helping professionals to be aware that persons from rural areas, with lower

SES, or who are more traditional may have significantly different mental health attitudes from majority American culture, whereas other persons from the Middle East may require relatively little cultural adaptation. It will be important for practitioners working with this population to have knowledge about acculturation assessment and research (Chun & Akutsu, 2003; Rivera, 2008). It will also be important to be knowledgeable about ethnic identity development among minority populations in the U.S. (Bernal & Knight, 1993; Helms, 1986, 1989, 1995; Phinney & Rotherham, 1987).

A psychologist working with persons of Middle Eastern descent should also know that grieving looks qualitatively different in ME cultures when compared to majority U.S. culture and should not be pathologized. In Stroebe, Hansson, Stroebe, and Schut (2001) crosscultural differences in grieving are explored, but grieving in Middle Eastern cultures is not included. Davies (2002) described some of the rituals associated with grieving specifically in Islamic populations. However, due to limited information about this phenomenon, future researchers should further explore the qualitative nature of grieving in the Middle East and how it differs from majority American culture. In the meantime, therapists and counselors working with this population should be aware that does tend to involve more outward expressions of emotion, may last longer, and may be accompanied by prescribed and specific rituals/rites that are readily apparent (e.g., wearing black for 40 days).

Having a therapist who understood that their client might not have grown up in a “typical American home” was important to some of the study participants. In order to provide competent treatment to persons of Middle Eastern descent, it may be important to have knowledge about immigrant experiences in the U.S. and how they can affect the

therapy process (Mirkin & Kamyra, 2008). It may also be important to be aware of the different experiences of immigrant children in the U.S. (Bernak & Chung, 2003).

Several participants suggested that trauma experiences may be minimized, because they are so common in Middle Eastern communities in U.S. It may be important to have an awareness of this tendency as one is assessing for trauma histories.

Montgomery and Foldspang (2006) found that Middle Eastern refugee children had a different symptom profile related to trauma exposure than is postulated in the DSM criteria. It is possible that post-traumatic stress manifests itself differently in persons of Middle Eastern descent.

Skills

This section will discuss some of the therapeutic techniques that are recommended for culturally competent psychotherapy with persons of Middle Eastern descent. The findings of this study suggest that persons of Middle Eastern descent may be different from majority culture in qualitative ways and may require cultural adaptations in order to psychotherapy and counseling to be most effective. Cultural adaptations are systematic modifications to the therapy process to make it more appropriate and effective for culturally diverse clients (Smith et al., 2010). Further research on this topic is likely required before cultural adaptations specific to Middle Eastern people can be developed.

It will be important for therapists and counselors planning to work with persons of Middle Eastern descent to be skilled in multicultural competencies. In fact, general multicultural competence skills seemed more effective with these participants than specific knowledge about certain Middle Eastern populations. Guidelines published by

the American Psychological Association (1993, 2002, 2003, 2006) summarize these skills most efficiently. Other helpful references published in the last 10 years include:

Atkinson, 2004; Bernal et al., 2003; Brammer, 2003; Canino and Spurlock, 2000; Carter, 2004; Constantine and Sue, 2006; Cuellar and Paniagua, 2000; Hays, 2001; Palmer, 2002; Pedersen et al., 2002; Ponterotto et al., 2001; Pope-Davis and Coleman, 2001; Ridley, 2005; Smith, 2004; Strous, 2004; and Sue and Sue, 2003. As mentioned above, basic therapeutic competencies (Norcross, 2002; Wampold, 2001), went a long way with these participants, as well. Psychologists who are skilled in both multicultural and general counseling competencies are more likely to provide effective treatment to persons of Middle Eastern descent.

Persons of Middle Eastern descent will likely enter therapy with lack of knowledge about the therapy process. Therefore, therapists who work with Middle Eastern clients would do well to carefully explain necessary paperwork and the therapeutic process in detail in the first session and not assume that the client has an understanding of what will be expected of them. It is very important to explain confidentiality rights and limitations, especially with clients from Iran and other countries where health records are not confidential. It will also be useful to explain the differences between types of helping professionals early on in the therapy experience.

Persons of Middle Eastern descent will also likely enter therapy with misunderstandings and concerns about mental illness and mental health treatment. Therapists who work with Middle Eastern clients in psychotherapy may benefit from asking their clients about their concerns about psychotherapy during the intake process, so that these concerns can be addressed early on in psychotherapy. It may be helpful to

ask specifically about the concerns discussed above, since the client may not feel comfortable voicing these concerns with a relative stranger. Lack of buy-in for psychotherapy should not be pathologized and should be explored and addressed in the first few sessions to prevent premature psychotherapy termination. When treating young Middle Eastern clients, it may be useful to ally with the parents to promote treatment acceptance.

Participants in this study highlighted the tremendous diversity among the larger Middle Eastern population. This study suggested that many variables must be taken into account in order to provide culturally competent treatment to persons of Middle Eastern descent. Ethnic identity development, acculturation status, socioeconomic status, education level, nationality, rural versus urban upbringing, and psychopathology should all be taken into account as part of an initial assessment of any patient of Middle Eastern descent. Dwairy (2006) adamantly recommends this type of holistic assessment as well. Not only would one be limited by a more singular focus, but the absence of holistic assessment was viewed quite negatively by several study participants and limited their engagement in the therapy process.

In addition, acculturation stress should be assessed and explored rather than assumed. Acculturation stress is the distress or discomfort that results from adapting to a new culture, which usually involves the loss of social support and identity (Smart & Smart, 1995). Given that persons of Middle Eastern descent may minimize trauma symptoms, therapists working with this population should also explore experienced trauma and discuss the possible effects of trauma experiences (Dagirmanjian, 2005; Vartan, 1997). Psychoeducation about trauma may help to destigmatize and normalize

the experience of trauma symptoms. However, psychologists should be mindful that persons of Middle Eastern descent may manifest trauma symptoms differently than diagnostic criteria suggest (Montgomery & Foldspang, 2006).

Participants in this study did not expect therapists or counselors to understand the complexity of Middle Eastern identity. However, they expressed frustration as they discussed the common mistakes they encounter here in the U.S. related to their cultural identities. For example, it seemed particularly frustrating to be mislabeled in terms of ethnicity, nationality, or religion. One participant described being impressed when a therapist performed internet searches to learn information about her cultural background, including culture/religion/nationality. Seeking this type of knowledge when working with persons of Middle Eastern descent is a crucial skill (Abudabbeh & Aseel, 1999; Azary, 2006; Dagirmanjian, 2005; Erickson & Al-Timimi, 2004; Jalali, 2005; Kelly & Aridi, 1996; Nassar-McMillan & Hakim-Larson, 2003; Sayed, 2003; Tahmassian, 2003; Vartan, 1997) described by experts in this field.

The therapeutic relationship seemed important to participants in this study. They preferred a warm and caring person, who did not judge or hurry their process. Problem-focused or solution-focused psychotherapy without taking time to build therapeutic alliance and to explore the holistic experience of the client may not be relevant. Additionally, cognitive behavioral therapy methods were very well accepted if the therapist was warm and caring. Abudabbeh and Hays (2006) have outlined a culturally adapted form of CBT for Arab clients.

Family therapy has been recommended for minority clients from collectivist-oriented cultures (McGoldrick et al., 2006). Therapists working with persons of Middle

Eastern descent should be open to the idea and discuss the possibility of family psychotherapy with their clients. Even if family psychotherapy is not chosen, family dynamics should be explored in an open and nonjudgmental way. Participants in this study had mixed feelings about family participation in their therapy, so client preferences must be carefully assessed. However, most of them agreed that it was or would have been useful. Family therapy has been recommended for work with clients of Middle Eastern descent (Abudabbeh, 2005; Carolan et al., 2000; Dagirmanjian, 2005; Dwairy, 1998; Erickson & Al-Timimi, 2004; Hall & Livingston, 2006; Jackson, 1997; Jalali, 2005; Nassar-McMillan & Hakim-Larson, 2003).

Group therapy may be particularly difficult for persons of Middle Eastern descent, due to difficulties with speaking to nonfamily members about private issues and perceived stigma associated with mental health issues. Al-Mutlaq and Chaleby (1995) highlighted the difficulties of working with Arab patients in the group psychotherapy format. Jalali (2005) also noted that group therapy is contraindicated with Iranian clients. However, several participants in this study seemed to benefit from group therapy. In these cases group therapy may have helped to normalize and destigmatize what they were experiencing (Yalom, 2005). Future research should focus upon the cultural acceptability of group therapy for Middle Eastern clients.

One participant reported that the use of metaphors was particularly useful to her in psychotherapy. Dwairy (2009) recommends using metaphor therapy with Arab and Muslim clients. Grieving may be one powerful metaphor to be used often in therapy with Middle Eastern people, considering that during the grieving process Middle Eastern people seem to be able to have intense emotional experiences that are not tied to shame or

weakness. Grief, as a concept, could be extended to many situations outside of the loss of loved-ones. For example, acculturation stress itself has been postulated as a form of grieving over the land, people, and culture left behind (Smart & Smart, 1995). This might allow for clients to have authentic emotional experiences in therapy within a culturally appropriate framework.

Some patients of Middle Eastern descent may benefit from help with finding a therapist who can speak their native language. Several participants felt that they would have been better equipped to articulate their thoughts/feelings in psychotherapy with a therapist who was fluent in their primary language. This was also recommended by several experts in working with Middle Eastern patients (Jackson, 1997; Kaeni, 2006; Khalid, 2006; Sayed , 2003).

Table 7 summarizes recommendations for therapists and counselors working with persons of Middle Eastern decent. Recommendations are included for all three dimensions of multicultural counseling competence as outlined by Sue et al. (1982): attitudes, knowledge, and skills. Recommendations in bold print are supported by findings of this study. Recommendations in regular print are implied or represent opportunities for future research.

Study Limitations

Participants in this study self-selected by responding to requests to participate and may differ in important ways from persons who would not choose to participate in such research. Also, the small sample size and qualitative methodology limit the generalizability of the results to the broader Middle Eastern population. All of the study

Table 7

Recommendations for Therapists Working with Persons of Middle Eastern Descent

Attitudes	Knowledge	Skills
Flexibility, open-mindedness, and non-judgment	Awareness of common factors literature	Mastery of therapeutic interviewing and listening skills
Awareness of own biases, worldview and privileges	Knowledge about White privilege literature	Explore clients worldview and values rather than assuming/imposing majority views
Respect for cultural and religious differences	Seek information about different cultures and religions	Verify information you have learned about client's culture and religion; don't assume
Willingness to understand complexity of Middle Eastern identities	Knowledge of ethnic, religious, socioeconomic, political diversity in Middle East	Explore cultural identity with Middle Eastern patients; do not assume Arab Muslim identity
Awareness that Middle Eastern people may differ from White Americans in important ways	Knowledge about how psychology historically has pathologized minorities	Check assumptions with patients; encourage patients to point out differences that arise
Awareness that Middle Eastern people may differ from White Americans in important ways	Absence of dialogue about mental health issues in Middle Eastern communities	Psychoeducation throughout process; don't assume family or patient have same mental health attitudes as you
Openness to other worldviews and ways of being	Middle Eastern cultures tend to be much more collectivist than U.S. culture	Do not pathologize enmeshment; explore family dynamics with open-mind; individuation should not be goal of therapy; consider family therapy as option
Awareness that Middle Eastern people may differ from White Americans in important ways	Lack of spectrum of mental health issues in Middle Eastern awareness; patients and their families may not see gray area between sane and "crazy"	Psychoeducation on psychological disorders as they are understood in American culture; discuss prevalence rates and prognoses
Awareness that Middle Eastern people may differ from White Americans in important ways	Mental illness and psychological distress carry significant stigma and same in Middle Eastern culture	Sensitivity to the difficulty of attending therapy in the first place and possible cultural barriers to treatment
Awareness that collectivist cultures often address problems in different ways	It is uncommon to discuss problems with nonfamily members	Be patient; do not pathologize what may look like resistance

(table continues)

Attitudes	Knowledge	Skills
Awareness that Middle Eastern people may differ from White Americans in important ways	Symptoms are often minimized to protect family or because it is culturally inappropriate to complain	Psychoeducation on symptoms related to depression, anxiety, trauma, etc.
Awareness that there are significant within-group differences in any minority group	Mental health attitudes are changing in Middle Eastern cultures	Assess for acculturation, socioeconomic status, and ethnic identity development
Awareness that norms for grieving vary between cultural groups	Grieving in Middle Eastern cultures is qualitatively different from majority U.S. culture	Do not pathologize overt emotionality during grieving of ritualized grieving rights
Express an explicit attitude of nonjudgment	Middle Eastern people may expect to be judged negatively by the therapist	Explore expectations of therapy
Awareness that life experiences differ between regions	Knowledge about immigrant experiences is important	Do not assume that all patients had a typical American childhood
Awareness that internalizing disorders can be more common in collectivist-oriented family systems	Internalizing disorders may be more common in Middle Eastern people	Assess for internalizing disorders and expect minimization of symptoms
Awareness that minority people sometimes differ in their symptom presentations	Trama symptoms may be minimized in Middle Eastern cultures	Assess for trauma symptoms. Offer psychoeducation on typical trauma symptoms and effects
Awareness that psychotherapy is a White phenomenon	Middle Eastern clients may have low expectations of the efficacy of psychotherapy	Explore ambivalence about attending psychotherapy and clearly explain process
Awareness that Middle Eastern people may differ from White Americans in important ways	Family dynamics are different in Middle Eastern cultures	Do not pathologize enmeshment automatically. Explore family dynamics without assuming majority dynamics
Awareness that ethnic identity is an important part of personal identity	Middle Eastern identity is complex and many dimensions of it will likely be important to your client	Research the specific ethnic, religious and national background of any Middle Eastern client
Attitude of flexibility and curiosity	Knowledge of MCC literature	Use MCC skills as outlined by Sue et al. (2009)

(table continues)

Attitudes	Knowledge	Skills
Awareness that Middle Eastern people may differ from White Americans in important ways	Knowledge of interpersonal psychotherapy skills; Middle Eastern clients expect a close relationship with a helping professional	Focus upon therapeutic alliance before engaging specific therapeutic interventions; get to know person's history, family system, and ethnic identity before focusing upon presenting problem
Openness to using empirically supported treatments	Medical model may be preferred; knowledge of empirically supported treatment	CBT interventions are well-received once rapport and trust building is secure
Awareness that Middle Eastern people may differ from White Americans in important ways	Middle Eastern culture dictates respect for parental figures and compliance with parental wishes is expected	Ally with parents of Middle Eastern child clients; consider family therapy as an option

participants had willingly seen therapists in the U.S. and may differ in important ways from those who have not sought mental health treatment when it comes to mental health attitudes. Therefore, findings should not be generalized to persons who are court ordered or otherwise mandated to treatment.

The use of phone interviews limited the researcher's ability to make behavioral observations of the participants. Behavioral observations are often an important part of qualitative methodology. Without them it is difficult to assess the full range of the participants shared experience. Another major limitation of the study related to the depth of the study itself. In order to answer two major questions (What are the mental health attitudes of persons of Middle Eastern descent living in the U.S.? and What are the therapy experiences of persons of Middle Eastern descent living in the U.S.?) some depth was sacrificed for breadth.

Future research should explore the definition of family in Middle Eastern systems (e.g., who is included in the definition of family). For example, everyone in this study

talked about family, but the interviews did not elicit descriptions of who is included or what the relative impact different family members have on behavior. The relative weight of the opinions of different types of family members was also not assessed.

Future research should also explore the prevalence rates of mental illness in the Middle Eastern American population. Every participant in this study had psychological needs great enough to seek professional help and most recalled a family member with significant mental illness. However, no good numbers exist for prevalence rates for mental illness among the Middle Eastern population in the U.S.

Also, this study did not explore Middle Eastern ethnic identity directly. It was discussed often, but was just as often implied as a result of the researchers understanding of and connection to the topic. Interview questions did not assess this topic area and participants were not asked to discuss how they label themselves culturally or to describe their ethnic identity development process. Future researchers should address these questions directly.

Conclusions

In the introduction to this manuscript, I indicated that I felt that my family was qualitatively different from majority American families as a result of my Middle Eastern heritage. Had you asked me at the writing of that sentence to describe the specific ways in which my family was different, I likely would have had no concrete answers in response. As a result of conducting this study, I now have a better idea of what I meant when I made that statement seemingly a long time ago. Looking back, I am aware that my family seemed closer than other families in my predominantly White community and

that our sense of connection to our history was deeper. I have always been very interested in and connected to the stories of my ancestors and value preserving and honoring those stories. The importance of religion in daily life and in defining identity also seemed to be stronger, as well.

I am also aware, upon reflection, that my family did not discuss mental health issues. I have always assumed that this was due to the lack of psychological problems in my family, but now wonder if that does not quite explain the silence. I am also aware that the elders in my family did not speak of the traumas that they experienced before immigrating to this country. They did not speak of these things to members of my generation or to the one before me. However, I know that my grandfather, great-grandmother, and great-aunt all experienced significant traumas before emigrating here from the Middle East following the Armenian genocide. Unfortunately the details of their stories died with them due to this cultural norm of silence.

As an apparently White female of Armenian descent (on my father's side) and a second generation American, I am in many ways more similar to majority Americans than my grandfather's generation or to the participants in my study. Yet I find that the mental health attitudes, cultural norms, and family dynamics discussed by my participants feel hauntingly familiar to me. I began this process by simply asking in a graduate multicultural counseling class, "What would culturally competent therapy look like with someone like my grandfather?" The goal of this study was to explore the differences in mental health attitudes between persons of Middle Eastern descent and majority Americans and to begin to understand how to conduct culturally competent therapy with persons of Middle Eastern descent.

This study suggests that Middle Eastern cultural identity is complex and often cannot be defined solely in terms of ethnicity, religion, or nationality. Instead it is often defined by all of those qualities with different individuals placing emphasis upon each category differentially. Given that recent waves of immigration to the U.S. from the Middle Eastern region have included many ethnic and religious minorities, this study highlighted the importance of not assuming that all persons from the Middle East are either Arab or Muslim. This is further underscored by the fact that immigrants to the U.S. from the Middle East are predominantly Christian (Awad, 2006) and so the characteristics of the Middle Eastern population in the U.S. do not necessarily reflect the general characteristics of the Middle Eastern population in the Middle East.

The findings of this study suggested that there are important qualitative differences between Middle Eastern cultures and Western cultures in terms of mental health attitudes. Major differences include the stigma associated with mental illness, the role of the family in responding to illness, and the importance of grieving in Middle Eastern cultures. These differences in mental health attitudes directly relate to the provision of psychological services with persons of Middle Eastern descent.

The findings of this study also suggest that diverse persons of Middle Eastern descent are attending psychotherapy and counseling in the U.S. and that cultural adaptations are likely necessary to provide optimal treatment to them. Developing cultural adaptations for persons of Middle Eastern descent will require further research with this population. In the meantime, important recommendations for therapists working with this population can be derived from the findings of this study and are discussed in depth above.

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APPENDICES

Appendix A:
Map of the Middle East
(United Nations, 2004)



Appendix B:
Interview Questions

Interview #1 Questions

1. Tell me about how mental illness and/or psychological distress were understood in your family/culture.
2. What do you understand “mental health” to be?
 - a. PROBE: How do you know someone is mentally healthy?
 - b. PROBE: What does mental health look like?
3. When someone is distressed (not mentally healthy), what happens for that person?
 - a. PROBE: What happens within the family?
 - b. PROBE: What happens within the community?
4. When someone is mentally ill or psychologically distressed, who is responsible for helping the person to find relief?
5. What are the ways that people who are distressed find relief?
 - a. PROBE: How would psychological distress or mental illness be treated in your home country or your traditional culture? If not psychotherapy counseling, why not?

Interview #2 Questions

1. Somewhere along the way you wound up in psychotherapy. Tell me about how you got there.
 - b. PROBE: How did you choose the place you went to for services?
 - c. PROBE: What were your biggest concerns as you planned to enter psychotherapy?
 - d. PROBE: What barriers to receiving services did you encounter?
2. What was the experience of psychotherapy like for you?
 - e. PROBE: What worked?
 - f. PROBE: What didn't work?
 - g. PROBE: Who participated in your psychotherapy? What was that like?
3. Tell me about your therapist.
 - h. PROBE: How was it to work with that person?
 - i. PROBE: Were there any cultural issues that helped or got in the way of your relationship?
 - j. PROBE: What do you wish your therapist had understood about your cultural background?
4. What role did your cultural identity play in psychotherapy?
5. What do you wish had been different in your psychotherapy experience?
 - k. PROBE: How would you improve the experience?

In hindsight, what misconceptions did you have about the psychotherapy process before entering psychotherapy/counseling?

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- Work in conjunction with other therapists, nurses, doctors, dieticians and direct care staff in order to provide residential care

Supervisor: Tera Lensegrav-Benson, PhD.

August 2009 – August 2010

Primary Childrens Hospital, Salt Lake City

Position: **Psychology Intern**

Responsibilities:

- Conduct individual and family therapy with child and adolescent clients in an outpatient setting
- Attend monthly multidisciplinary staff meetings
- Perform psychological and psycho-educational assessments

Supervisor: Matthew Wenner, PhD.

May 2006 – August 2009

Avalon Hills Eating Disorders Adolescent Treatment Facility, Petersboro, UT

Position: **Therapist**

Responsibilities:

- Lead didactic and process therapy groups several times per week with 6-12 clients
- Conduct individual and family therapy with several adolescent clients per week
- Attend weekly multidisciplinary treatment team meetings in order to plan treatment
- Work in conjunction with other therapists, nurses, doctors, dieticians and direct care staff in order to provide residential care
- Perform psychological assessments when warranted

Supervisor: Benita Quakenbush-Roberts, PhD.

May 2007 – August 2009

Avalon Hills Eating Disorders Adult Treatment Facility, Paradise, Utah

Position: **Therapist**

Responsibilities:

- Lead didactic and process therapy groups several times per week with 6-12 clients
- Conduct individual and family therapy with several adult clients per week
- Attend weekly multidisciplinary treatment team meetings in order to plan treatment
- Work in conjunction with other therapists, nurses, doctors, dieticians and direct care staff in order to provide residential care

Supervisor: Dave Christian, PhD.

Fall 2005 - Spring 2006

Brigham City Hospital, Cardiac Rehab Program

Position: **Practicum Therapist**

Responsibilities:

- Conduct brief individual therapy with adult cardiac patients
- Consult with physicians and social services about patient services
- Conduct stress management group with adult cardiac patients
- Perform brief psychological assessments and mental status examinations

Supervisor: M. Scott DeBerard, PhD.

Fall 2005 - Spring 2006

Utah State University Counseling Center, Logan, Utah

Position: **Practicum Therapist**

Responsibilities:

- Conduct individual and group therapy with college age adults
- Clients were college students seeking help for eating disorders, anxiety, PTSD, interpersonal problems and marriage problems
- Conducted two 6-week stress management therapy groups with college students struggling with anxiety

Supervisor: LuAnn Helms, PhD. & David Bush, PhD.

Fall 2004 - Spring 2005

Utah State Psychology Community Clinic, Logan, Utah

Position: **Practicum Therapist**

Responsibilities:

- Conduct individual therapy with children and their families
- Conduct assessments of children for ADHD, learning disabilities and depression

- Clients were primarily children and adolescents with behavior management problems
- Conducted empirically supported parent training techniques

Supervisor: Gretchen Gimpel, PhD.

Spring 2004 - Summer 2004

Utah State Psychology Community Clinic, Logan, Utah

Position: **Practicum Therapist**

Responsibilities:

- Conduct individual therapy with adults
- Clients were adults seeking help with anxiety, depression and learning disabilities

Supervisor: Susan Crowley, PhD.

Fall 2005 – Spring 2006

Utah State University, Logan, Utah

Position: **Volunteer Therapist**

Responsibilities:

- Participated as a volunteer therapist in a study examining outcome following treatment of children diagnosed with conduct disorder
- Followed two different manualized treatment protocols with child clients (6 sessions each)

Supervisor: Brian Bushman, M.S.

January 1998 – January 2000

The McDonald Center, San Diego, California

Position: **Volunteer Group Facilitator**

Responsibilities:

- Facilitated group sessions for patients who were in the after-care phase of treatment
- Spent one year working with a co-ed adolescent group, then worked with an adult women's group for the second year. Groups usually consisted of 6-12 patients and had two volunteer facilitators
- Attended one week-long training session and once-a-month Saturday training sessions

Supervisor: Michael Gabriel, PhD.

RESEARCH EXPERIENCE

January 2004 – December 2006

Cache County Memory Study, Logan, Utah

Position: **Program Coordinator**

Responsibilities:

- Coordinate the post-mortem diagnostic portion of the Cache County Memory Study
- Train interviewers
- Schedule and attend research meetings
- Conduct post-mortem telephone interviews with family members of study participants in order to obtain diagnostic information
- Data entry
- Peer-edit the interviews of colleagues
- Attend case staffing meetings
- Work with interdisciplinary team to rate interviews/make diagnostic decisions
- Follow up rating of interviews with primary physician's staff in order to attain participant medical records

Supervisor: Joann Tschanz, PhD.

August 2002 – May 2003

Project FULFILL, San Diego, California

Position: **Research Assistant**

Responsibilities:

- Analyzed qualitative data from Project Fulfill, a qualitative study of literacy and mentoring experiences
- Presented findings at the 2003 WPA convention in Vancouver, BC.

Supervisors: Patricia Scollay, PhD. and Barbara McDonald, PhD.

TEACHING

UNIVERSITY INSTRUCTION

Spring 2005	Instructor, Introduction to Psychology Utah State University Extension, Ogden
Spring 2006	Instructor, Introduction to Psychology Utah State University Extension, Bridgerland
Summer 2007	Instructor, Multicultural Psychology Utah State University Extension, Ogden
Spring 2009	Instructor, Introduction to Psychology Utah State University Extension, Bridgerland

COMMUNITY/GUEST LECTURES**Local High School**

Fall, 2005	Lecture on Mental Health Issues and Suicide Prevention
Spring, 2006	Lecture on Parenting Issues
Fall, 2006	Lecture on Parenting Issues
Fall, 2008	Lecture on Eating Disorders and Body Image
Fall, 2009	Presented information to teachers following school tragedy

Utah State University

Fall, 2005	Guest lecture in abnormal psychology class
Spring, 2006	Guest lecture in introduction psychology class
Spring, 2008	Guest lecture in introduction psychology class
Spring, 2009	Guest lecture in media and body image class

SPECIALTY TRAININGS AND WORKSHOPS

Utah State University Counseling Center Conference

Spring, 2004	Leslie Greenberg, PhD. “Emotion-Focused Psychotherapy”
Spring, 2006	Teresa LaFramboise, PhD. “Becoming Multiculturally Competent”
Spring 2007	Carolina Yahne, PhD. “Motivational Interviewing”
Fall, 2005	Allies on Campus Training (GLBTQ allies)

Avalon Hills Annual Conference

Spring 2008	Jason Luoma, PhD. “Learning ACT”
Spring 2009	Steven Hayes, PhD. “ACT Experiential Workshop”

FELLOWSHIPS, HONORS AND AWARDS

2003-2004	Presidential Fellowship, Utah State University (\$12,000)
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