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Emotion Meaning-Making: Identity, Discourse And Social Interaction Among Arab Immigrant Healthcare Providers

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EMOTION MEANING-MAKING: IDENTITY, DISCOURSE AND SOCIAL INTERACTION AMONG ARAB IMMIGRANT HEALTH CARE PROVIDERS

by

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DISSERTATION

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DEDICATION

This dissertation is dedicated to my husband, Kenneth,
and my children, Katie, Aaron and Micah.
You have my love,
my gratitude, and my deep apologies
for the time spent away.

ACKNOWLEDGMENTS

Many people assisted me in getting to this dissertation work. First and foremost, I want to thank my husband, Kenny. His encouragement and interest gave me the courage and the freedom to explore my questions regarding human behavior and culture. His support, love and constancy sustained me over the long haul. My children, now young adults, gave me the needed space and time in which to work out new ways of thinking, often serving as a first audience for the posing of questions and the clarification of ideas. Mostly, my family helped to keep me connected to worlds that matter most. How glad I am to have them in my life.

As my understanding of what it takes to produce good scholarship deepens, so too does my appreciation for my teachers, both past and present, who played direct roles in helping to advance my own scholarship. I must mention a few. Guerin Montilus exposed me to the origins of anthropological theory, and assisted me in my work on the topic of personhood explored in this research. Barry Lyons' in-class emphasis on writing helped me with my own. David Barondess' lectures on the linkages between biology and culture opened up *worlds* of new thinking for me, especially those worlds related to illness experience. Frances Trix inspired my interest in the relationships between language and culture, some of which are explored in this dissertation. Jessica Price's class in advanced methods provided me with solid direction for developing a research question and implementing an ethnographic project. Jacalyn Harden's way of getting her students to ask the question, "for whose benefit", exposed me to the approach of political economy and the particular challenges of conducting ethnographic studies "at home."

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SECTION I

BACKGROUND AND SIGNIFICANCE

PROLOGUE

The questions related to emotion meaning-making explored in this dissertation evolved slowly for me, over a number of years and from a combination of sources. These sources include literature from anthropology and psychology on topics related to identity, illness and emotion and my experience with some of the ways mental health is assessed cross-culturally in formal academic research settings. These exposures have led to my awareness of the debates surrounding mood disorders like depression and to my growing interest in the ways anthropology has approached processes related to arriving at mental health diagnoses. However, these sources are relatively recent ones. On more thoughtful introspection, the kind that takes place with the writing up of a dissertation, I have come to see that some of the earliest and most potent sources for my questions about how to understand emotion cross-culturally may be located in a place and time far removed from the present.

North Yemen 1977

In 1977, at the age of 22, I joined the American Peace Corps to work as a volunteer nurse in North Yemen, a poor, then, mostly unheard of country in the United States, on the southern tip of the Arabian Peninsula. My first morning in Yemen, I remember being awakened well before sunrise by the sound of the first *adhan* (one of five daily calls to prayer for Muslims), broadcast from a minaret just outside my bedroom window. Later that morning, I looked out that same window for my first view of Sana'a,

the capital city. Having arrived the night before in the dark, I was totally unprepared for what I was about to see. The sky was a cloudless, perfect blue, and everywhere, all around, were closely packed, gingerbread-like, towering mud and stone buildings, whose windows, arches and doorways, outlined in sun-reflecting whitewash, gave rise to a sparkling sea of geometry. The view was quite simply…breathtaking.

When I think of Sana'a I remember the dust, the noise and the traffic of the streets in the newer, outer sections of the city and I remember the quiet, narrow passageways, alleyways really, of the older neighborhoods. Here, one could hear low-toned conversations in Arabic and the sounds of cooking from behind high courtyard walls. I remember the smells in these neighborhoods well, cardamom spiced tea, charred bread pulled fresh from stone ovens, *salta* (a lamb stew), and dirt, the odor of which was ever-present in the cool, dry air of this part of the country. So many years later, I can easily conjure images of the people there, men in their *mashadat* (embroidered wool shawls worn variously about the hips, shoulders and heads of Yemeni men), all tucked and twisted, and women, the silky flow of their black *sharhafs* (a full covering, including face) khol-rimmed eyes, finger tips and feet perfumed and henna-stained…

Over the course of my two year stay, I was to work in a number of different health care settings and so a good portion of my interactions with Yemeni people took place around contexts of illness. The patients I saw usually sought care when their conditions were acute, as in cases of physical trauma, or when symptoms associated with the ubiquitous vector-born and infectious diseases present in the region became intolerable or life-threatening. I would also occasionally see patients who were diabetic and in

various stages of renal failure. Thirty five years ago in Yemen there was no advanced life support. The availability of insulin was erratic and renal dialysis non-existent. Never advancing much beyond the use of simple Arabic phrases, such as "Where is the pain?", "What did you eat?", "How many children do you have?" I relied heavily on the assessment of my patients' expressions and bodily postures to gauge their emotional and mental states, their comfort, and their understanding of my Arabic. It was my belief that I could recognize and read these expressions and postures fairly well. While, I don't remember giving much thought to emotions per se at that time, it is safe to say that my confidence about being able to "read" my patients' emotions was based on a view of humans as universally sharing emotions and emotional expression. I had not given any thought to the extent to which culture might shape emotions.

On my return to the United States, I continued to work as a nurse. After more than two decades of practice, my interests turned more towards making sense of human response to illness, and I began graduate studies in anthropology. In time I came to view my work in Yemen differently. When teaching newly diagnosed diabetics there, I don't ever remember stopping much to consider whether my "students" might have had different ideas about the "body", "blood", "persons" or even "selves." The idea that people could have different notions about such basic concepts and that they might have some relationship to the experience of illness, and to the experience of emotion, was nowhere on my radar in those days. At the height of a cholera epidemic, I remember breaking for a meal, squatting down before a communal tray of chicken and rice with a male nurse named Mohammed. Usually eager to help me with my Arabic, Mohammed seemed too tired to talk. I was too tired to *try* to talk. We exchanged weak

smiles and ate together in silence. I remember this moment for some reason...maybe because I remember thinking at the time that the stress of managing the heavy flow of those so acutely ill in some way helped to bridge our communication difficulties, no verbal language required, our smiles conveying some kind of "shared feeling", one born of our being-in-the-trenches together. We may very well have been conveying "something" shared, however I now think back and wonder what it was that led me to assume Mohammed's emotional experience was like mine. I also think of the ways in which I saw and then did not see my patients. Who were they? Who was I? In moving these questions to the present, I now ask, how does who we are, and the cultures and societies we came from, affect the ways we experience both illness and emotion.

In 2004, I took a research position on a longitudinal, mental health study of psychological adjustment among Arab immigrants living in the United States. Now a doctoral student in medical anthropology interested in cross cultural studies of mood disorder, I took the job hoping to gain experience with some of the ways in which psychological processes were assessed within formal academic research settings. As project director, I was responsible for over-seeing data collection in the field and one of my chief duties was making sure that the bilingual Arab American women who collected data for the study understood the study's protocols as they related to research interviewing. The principal means of data collection consisted of an interview containing a number of different psychological tools, some of which assessed for depression and posttraumatic stress disorder, as well as a more global measure of various moods. Over the course of my exposure to the use of these tools with Arab immigrants living and working in an American context, I began to notice instances where it was not always

clear that what we were assessing for was understood by participants in the ways the tools intended. I began to see first-hand how emotion terms divorced from context could result in confusion over meaning. I also came to question the way in which we asked about emotions in the first place and the assumption that emotion terms would or should hold the same meanings, regardless of the contexts in which they were used or spoken about.

Halfway into the study, my questions about how the immigrant experience influences assigning meaning to emotion took a pronounced turn after an important encounter with a colleague who was one of the Arab American immigrant women who collected data for the study. In a conversation around one survey tool designed to assess mood, I discovered that despite our having ostensibly similar professional training and educational backgrounds as health care providers, the two of us held some very different explanations for emotion. The ideas and questions that came out of our discussion were so revelatory and intriguing that I began to familiarize myself with studies of mental disorder in Middle East populations. Given that some of the survey tools being used in this study, in some way, assessed mood, I also began to familiarize myself with the literature from both cultural psychology and anthropology examining emotion. In this work, I encountered scholars whose questions echoed my own and ethnographic portrayals of Arab communities that seemed to make sense with what I felt I was hearing from my colleague. Ultimately, this work provided me with the theoretical tools needed to begin to investigate my questions about emotion.

The following section contains a reconstruction of that key encounter, along with a field note excerpt from that time. This *pre-study* story illustrates how explanations for

emotion may differ among health care professionals with biomedical training and serves as a way to begin to think about the conditions or factors that may contribute to emotion meaning-making.

The Heart Story: One Explanation for Emotion

My colleague, Fatima (pseudonym)[1], left Lebanon during the civil war years in the mid1980's to immigrate to the United States. When she arrived in the United States she was a teenager. After completing her undergraduate degree, Fatima went on to earn a graduate degree in mental health counseling at a large urban American university. At the time Fatima and I worked together on the mental health study of Arab immigrants, in addition to conducting interviews with Arabic speaking study participants, Fatima also worked full time as a mental health counselor in the Arab Community. In the course of our working together, not only did I learn something of Fatima's practice as a mental health care provider, I also came to learn more personal aspects of whom she was, including some of the circumstances of her immigration to this country and of her involvement in her religious community as an observant Muslim. We discovered we had a number of interests in common. We were, both, health clinicians, and we were also both interested in explanations for depression in women.

The following describes the encounter that took place between Fatima and me one afternoon in a coffee shop located in a suburb that was home to a large Arab Community. As part of a smaller qualitative study, Fatima and I had agreed to meet to

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[1] Pseudonyms have been assigned to all participants and biographical data has been scrambled or omitted altogether to ensure confidentiality.

talk specifically about the terms contained in one of the survey instruments, used in the larger study of Arab immigrants, designed to assess mood. Her day off, Fatima arrived at our prearranged meeting location, a large library near her home, *muhajabah* (wearing a *hijab* or head scarf), casually dressed in jeans. At the last minute we decided to drive to a coffee shop nearby. There she could smoke and I, an "ex-smoker" known for the occasional relapse, would be able to indulge if the urge hit…which it did, over and over again that afternoon, in direct proportion, it now seems, to my interest in what Fatima had to tell me.

On the way to the coffee shop we began to talk about our work and we took turns listing for each other our understandings of what might account for the high prevalence of depression in women. I asked her what she had learned from her practice as a mental health counselor in the Arab Community and she asked me what I had learned from mine as a nurse. During this portion of our discussion, although we both spoke about the role of genetics, hormones and neuro-transmitters, we spent much more time talking about possible social and cultural factors related to depression. We spoke of gender role expectations, patriarchy, women's subordination and the problems associated with the high rates of poverty and poor access to education too frequently experienced by women worldwide. During this portion of our conversation our verbal exchange was rapid and smooth, oftentimes the both of us finishing each other's sentences before they were completed. Once in the coffee shop we found a corner table, with an ashtray, ordered coffee, and quickly transitioned to the activities of a formal research interview.

I began by giving Fatima 58 index cards, each containing one of the emotion terms (in Arabic) used in the instrument on mood mentioned above. I then asked Fatima to sort the terms according to the six different mood states assessed for in the survey instrument on mood. After some minor clarifications, Fatima began to sort the cards, completing the task within a few minutes. We then went on to the second activity of the interview involving an audio recorded interview. Here, I asked a number of open-ended questions about the mood states assessed for in the survey. Throughout this portion of the interview, as in our earlier informal conversation about depression in women, Fatima's explanations were familiar ones. When she described what it meant to be depressed, anxious and sad she used terms such as "self-esteem" "guilt" "hopelessness" and "helplessness", in short, conventional psychiatric terminology as is found in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders-V* (DSM-V) (2013), terms familiar to me not only as a western health care professional, but also by virtue of my having lived my whole life in the United States. It was not until the interview was over and the tape recorder was turned off that things got *un*familiar. At that point, Fatima asked permission to talk about her own ideas for research on emotion. The following paragraph contains portions of a field note I wrote at the time.

> She began by quoting a *hadith*, [one source of Islamic faith containing narrative reports on the words and deeds of the Prophet Muhammad] [2]. Fatima explained that this particular *hadith* involved a description of the

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[2] Authoritative collections of *hadith*, or narrative reports on the words and deeds of the Prophet Muhammad, were compiled in the mid-ninth century. The criteria for judging the authenticity of *hadiths* and their narrators is complex (Esposito 1982:6). In Fatima's reference to the heart and meat she may be referring to the following *hadith*: "Beware! There is a piece of flesh in the body if it becomes good (reformed) the whole body becomes good but if it gets spoilt the whole body gets spoilt and that is the heart" (Khan 1980:44).

heart. In this description, the Prophet explains how the heart can 'change position' and that every heart has 'pieces of meat' that can be 'bad' or 'good.' Here, Fatima seemed to hesitate over the best translation of this saying but she went on to explain that while the brain is the organ responsible for most emotion, it is the heart that is responsible for emotions like love and passion. She described how this makes sense as love is 'felt' in the chest and all blood has to flow through the heart to be distributed to the entire body…… Her idea for research involved following heart transplant patients to see if they would display any of the emotion traits formerly displayed by the heart donor. (Field note, March 2005)

Every time I read this field note, I am taken back to that coffee shop and our table in the corner, and I remember all over again, my feelings of confusion and disorientation. I remember struggling to hear *what* she was saying, because, as I see it now, nothing about our interview up to that point, nor in our earlier conversation about depression, prepared me for this explanation of emotion. In fact, up until that moment, I had been thinking that despite some pretty obvious differences in cultural background and experience, we seemed to be so similar in our thinking. We both had been trained in the United States as health care professionals, completing similar course work in anatomy, physiology, biology and psychology. To hear my colleague talk about love as being "felt" in the chest, or as being "metaphorically" housed in the heart would not have seemed at all strange. However to hear her talk about a body part, the heart, as actually physically containing an emotion and that in transferring this heart to another the residing emotion might be transferred as well was something altogether different. In Fatima's ideas for research, I noted that she held, what seemed to me at the time, to be contradictory explanations for emotion and I was left to wonder whether there were certain circumstances in which one explanation was called for over the other.

Over the years I have continued to think of our conversation. I have picked apart the order and the context of our interaction many times. I have thought deeply about who Fatima and I are, our roles, the worlds we come from, the worlds we have experienced personally and professionally and I have thought about the ways in which we must surely bring these aspects of ourselves to our work. These questions concerning identity, the ways we talk about or explain emotions and their potential relationship to social worlds were to eventually inspire the following dissertation.

In the following chapters, I continue my exploration of my encounter with Fatima through the analysis of data gathered from ethnographic field work conducted among the staff of a health care setting located in a large urban Arab American community in the United States. Over a 15 month period, I interviewed immigrant Arab American health care providers and observed their talk and their interactions as they delivered health and social services to a largely low-income population, three quarters of whom were Arab immigrants and refugees. The goals of the research were to better understand how these providers came to assign meaning to emotion, the circumstances in which emotion meanings might change and how emotion meaning-making relates to mental health diagnostic processes.

CHAPTER 1

INTRODUCTION

The anthropology of emotions is a broad area of scholarly inquiry examining the role of emotions in human personal and social life. Here, socio-cultural experiences of emotion are approached from "the perspective of the persons who live it" (Lutz and White 1986:405). While the field's initial theoretical emphases centered primarily on psycho-biological frameworks, subsequent emphases expanded to include approaches focused more on the interrelationships between culture, history, and social and political structure. More recently, theories of emotion within anthropology have placed increased emphasis on the social-relational and communicative aspects of emotions.

Located within the anthropology of emotions is the anthropology of migrant emotions, an area of study focusing more specifically on the emotional experience of immigrants. Migration has been described as an "affectively highly charged and fluid situation," involving aspects of "discontinuity", "rupture" and "radical dislocation" (Ewing 2005:225). As immigrants attempt to manage and negotiate the experience of dislocation, their encounter with certain settings in the "new home" has been found to result in "new articulations of emotional experience and identity formation" (Ewing 2005:226). These encounters and the resulting transformations to identities and emotional experience take place in social contexts with direct implications for individuals, families and communities. One important social context for immigrants involves their encounter with mental health care settings, where the assessment of emotion plays a key role in the treatment of mental illness.

In 2001, the World Health Organization (WHO) projected that by the year 2020 "mental and neurological disorders" would account for 15 percent of the global disease burden (WHO 2001). Major depression alone has been cited as a leading cause of disability in both developed and developing countries (WHO 2001, 2008). While these statements may highlight the serious consequences of mental illness on a global scale, just exactly what they reflect is not always clear. For example, in the case of depression, while there is evidence suggesting that depression is actually under-recognized and under-treated throughout the world (Ballenger et al. 2001), others questioning the seemingly increased global prevalence of depression cite flawed diagnostic categories (Horwitz and Wakefield 2007), processes of pharmaceuticalization (Abraham 2010; Petryna et al. 2006), and ever-increasing medicalization (Conrad and Leiter 2004; Kitanaka 2010) as potentially contributing to an artificially inflated prevalence of the disorder. These debates reveal how processes involved in coming to mental health diagnoses are complex and far from being well understood.

The complexity involved in arriving at mental health diagnoses may be further exacerbated by the increase in migration associated with globalization. Individuals suffering from mental illness often find themselves in cultural contexts far different from home, with health care providers who may not understand their symptoms. The overall increase in global migration also includes an increase in the numbers of immigrant health care providers (Batalova and Lowell 2007). Immigrant health care providers, who have been trained to work within biomedical health care settings, may be practicing in cultural contexts where explanations for emotion and mental illness differ from where they were raised. In leaving one culturally distinct setting to live and work in another,

these providers may be described as being "between culture" (Ewing 2005: 226). Here, experiences from both pre-and post-migration settings continue to be in dialogue with one another, thereby informing one another. Currently, little is known about how the experience of being "between culture," and the experience of dislocation, influences the diagnostic processes of immigrant health care providers. In particular, little is known about the process of how immigrant health care providers come to assign meaning to emotion, one aspect central to the "making" of mental health diagnoses.

Medical anthropologists have long been at the forefront of addressing cultural issues related to mental health diagnoses. Ethnographic investigations, conducted as early as three decades ago, challenged the validity and universality of diagnostic criteria and diagnostic categories (e.g., Gaines 1992a; Kleinman and Good 1985; Kleinman and Kleinman 1985), and other 'now-classic' anthropological studies were able to show how idioms of distress associated with mental illness vary depending on culturally particular contexts (e.g., Good et al. 1985; Jenkins 1991; Scheper-Hughes 1977). Two important developments stemmed from this work. The first can be seen in the inclusion of cultural factors in the *Diagnostic and Statistical Manual-IV (DSM-IV)* (American Psychiatric Association 1994) in which cultural factors had not been included previously (Lopez and Guarniccia, 2000). A second development was the World Mental Health Report (Desjarlais et al. 1996), which acknowledged that mental illness is intimately tied to social worlds (Lopez and Guarniccia 2000).

In anthropology, the study of emotions is an area closely related to cross cultural studies of mental illness. Just as mental illness came to be recognized as being related to social worlds, the scholarship on emotion has also come to place emphasis on the

relationship of emotions to social worlds. Rather than comparing how emotions may be the same or different across cultural contexts (Lutz and White 1986: 428), a number of key studies focus instead on the social contexts in which emotions are expressed in order to understand their meanings (Geertz 1984; Abu-Lughod 1985; Abu-Lughod and Lutz 1990; Rosaldo 1984; White 2005). Especially in the last two decades, anthropological work on emotion has more deeply considered the influence of social structures (Lyon 1995; Reddy 1997) and political economies (Delvecchio Good et al. 2008; Kitanaka 2010; Svasek 2005).

In keeping with these emphases, Geoffrey White (2005) has proposed the concept of "emotive institution" which in its focus on the social contexts of emotional experience examines the conditions or factors that may contribute to how emotions come to take on meaning. White defines an emotive institution (EI) as being composed of culturally constituted activities containing patterns of social interaction, identities and everyday ways of talking about emotion (2005:243). It is through the intersection of these factors that meaning is thought to be assigned to emotion, and it is also here that meanings are potentially redefined and transformed (White 2005: 248).

Using White's concept of EI as a guiding theoretical framework, the goal of this dissertation was to better understand how a group of Arab American immigrant health care providers who diagnose and treat mental illness in one clinic in the United States assign meaning to emotion. My aims for this research were to identify and describe: **(1)** the everyday practices, routines, and social interactions associated with the process of arriving at mental health diagnoses at this site; **(2)** the personal, cultural, and professional factors contributing to providers' identities and the meanings they associate

with various emotions at this site; and **(3)** the everyday speech and communication practices used by these providers when discussing emotion and arriving at mental health diagnoses. A fourth aim involved integrating and analyzing findings from the first three aims for what might be learned about the emotion meaning-making taking place among the providers in this setting.

Using the methods of ethnography, this research first and foremost explores the process of emotion meaning-making through the use of Geoffrey White's concept of EI, a concept which to date does not have a large body of empirical research. Secondly, this research follows Ewing's suggestion to explore the "medical clinic," one setting, frequented by immigrants for help in dealing with the stresses associated with encountering a new society. In such settings, Ewing contends, immigrants are likely to encounter discursive practices that may contribute to "new articulations of emotional experience and identity formation" (Ewing 2005:226). The health care setting (Center) in which this research was carried out provided an especially rich site in which to examine the conditions or factors involved in emotion meaning-making. Situated in a large Midwest metropolitan area, in the heart of one of the largest concentrations of Arab immigrants living in the United States, the Center was initially founded in order to provide health and social services to a rapidly growing population of Arab immigrants and refugees settling in the area. The Center now serves a low-income population more reflective of the surrounding area's ethnically diverse communities (to be discussed more fully in Chapter 2). Nonetheless, most Center staff culturally-identify as Arab, and many are immigrants from the Middle East. Based on ethnographic accounts of Arab immigrants living in the United States (Antoun 1999; Aswad 1996; Howell 2000; Jamal

and Naber 2008; Naber 2006; Seikaly 1999), I thought it likely that these providers would draw on experiences originating in Arab homelands, as well as those of their current American context. As such, and of special significance given this study's use of the EI framework, providers' identities, their ways of communicating, and their patterns of social interaction are subject to the influence of multiple social worlds.

A third area explored in this research relates to anthropological investigations of mental illness. As ethnographic methods are particularly well suited to exploring processes influencing the diagnosis and assessment of persons suffering from mental illness (Good 1997), this study on emotion meaning-making hopefully contributes to a better understanding of a key process involved in mental health diagnosis.

In the following sections, I first situate White's concept of EI within the realm of other scholarship examining emotion in cross-cultural contexts. I then discuss how anthropology has dealt with the principal topic areas contained in EI, those being emotion, discourse, and identity. As I work through some of the more significant debates around these topics, I will introduce specific work found to be relevant to this dissertation research.

Emotive Institution (EI)

As previously stated, White defines emotive institution (EI) as being composed of "culturally constituted activities" containing patterns of social interaction, identities and everyday ways of talking about emotion (2005: 243). According to White, it is within the intersections of these factors that meanings are assigned to emotion and it is also here that meanings are potentially redefined and transformed (2005: 248).

While White uses EI to focus on the social contexts of emotional experience, he makes it clear that the idea of EI first "presumes that physiological, cognitive, and social relational factors converge in jointly producing emotional experience" (2005: 242). According to White, the utility of the EI framework is that it "…pushes for closer attention to the properties of situations, contexts, and institutionalized activities in which emotions obtain social meaning and force" (2005: 248). White points out that a key aspect of the EI framework is how it may be used to focus in on "patterned contexts of emotional experience" (2005:242). White also refers to how discourse on emotion takes place within "culturally informed or constituted activities" that are recurrent (2005:251). Within these recurrent activities are both discourses on emotion and identities engaged in social interaction. The ways in which identities and discourses on emotion are "fixed" or "framed" within these culturally constituted activities becomes integral to how emotions are expressed and transformed (White 2005: 247-248).

Other approaches to the study of emotion have examined emotion in relation to social context. In his review of various disciplinary approaches to emotion, White mentions early work from the culture-and-personality school in anthropology. According to Barnouw, this approach took as its central focus, the ways in which "the culture of a society influences the persons who grow up within it" (Barnouw 1985:3). White points out how this approach neglected to take into account the less bounded and changing aspects of social structure and culture (2005: 244). White also notes work from social psychology, which he says looks to social context for the ways in which biologically based emotions are culturally and socially elaborated (2005:244). He specifically cites the work of Markus and Kitayama (1991), as an example of work, that while focusing on

how emotions may be experienced within social and cultural contexts, relies primarily on "individual-centered paradigms that locate emotional process in the brain" (White 2005:244).

Studies within anthropology have long examined emotional experience in relationship to social forms of organization or structure. Some of this work links emotion to the culturally particular identities formed within variously organized societies (Geertz 1984; Good et al. 1985; Myers 1979; Rosaldo 1984), while other work, as has been mentioned, examines emotion through the lens of social structure and political economy (DelVecchio Good et al. 2008; Kitanaka 2010; Postert 2012; Scheper-Hughes 1985). In works by Abu-Lughod and Lutz, discourse-focused studies on emotion, in particular, operate from the view that emotions are more than expressed cognitions or feelings; they are seen as pragmatic acts that signal perspectives and create effects in the world (e.g., Abu-Lughod 1986; Abu-Lughod and Lutz 1990, Lutz 1982). White points out that in addition to its functioning in face-to-face encounters, discourse on emotions may be examined for its broader role in relations of power and ideology in "reproducing social structural arrangements" (White 2005:247). While White recognizes the contributions of all of these approaches in coming to understand how emotions take on meaning, what he says is missing is an attention to the "constitutive function of communicative practices that operate in culturally defined, socially organized activities" (White 2005:244).

Anthropologist Unni Wikan expresses similar concerns in her article "Beyond the Words" (1992), arguing for ethnographic approaches that go beyond language to approaches that more carefully consider what is happening in social contexts. She

writes, "It may be necessary to attend to the speaker's intention and the social position they emanate from to judge correctly what they are doing" (1992:5). White's concept of EI further extends the work of discourse approaches to emotion and attends to what is happening in social contexts by focusing on the ways in which discourse on emotion works within "proximal zones of everyday experience" to transform social contexts (White 2005:242). In EI's focus on the socially organized activities contained within such zones of everyday experience, socially organized activities are more than settings or scenes in which emotions are expressed; they are "culturally constituted activities within which understandings of self as well as social identities and relations are enacted and defined" (White 2005:243).

White first described his concept of EI in the 2005 edited volume "*A Companion to Psychological Anthropology*" (Casey and Edgerton 2005). In that same volume, Katherine Pratt Ewing considered how the discursive practices present in Western medical clinic settings, as one proximal zone of everyday experience frequently encountered by migrants, may result in new "articulations of emotional experience and identity formation" (Pratt Ewing 2005:226). In describing the experience of migration to be an "affectively…charged and fluid situation" in which immigrants are often "between culture', Ewing argues that the hegemonic cultural practices inherent in the medicalized discourse of Western health care settings are likely to "shape immigrant understandings of their own emotions and are a significant aspect of cultural negotiation and socialization into a new society" (Ewing 2005:231). In this dissertation, I consider Ewing's ideas concerning the fluid character of migration experiences and her identification of Western health care settings, as one place in which immigrants

encounter "practices" which may result in transformed emotion meanings. With these observations in mind, I take up Ewing's suggestion to look at emotions within the context of a health care setting by examining the role that social and interpretive practices play in the emotion meaning-making of immigrant health care providers (Ewing 2005:226). White's framework focuses on the "constitutive function of communicative practices," in other words, how identities and discourse on emotion become fixed or framed within culturally defined, socially organized activities (White 2005:244). In the context of the Center setting, I use EI to identify recurring "culturally constituted activities" and to tease out aspects of providers' identities, their discourse on emotion, and the contexts in which this discourse takes place in order to understand the ways in which providers' emotion meanings are made.

The following sections contain discussions of three key components of EI: emotion, discourse and identity.

Emotion

Disciplines highly interested in the study of emotions, including the neurosciences, biomedicine, psychology and anthropology, approach the study of emotions from different epistemological orientations (for summary see Lutz and White 1990). Differences in these orientations result from a tension between universalistic and relativistic views, where on one end of the spectrum, emotions may be approached as hard-wired instincts, selected for how they contribute to reproductive fitness, and on the other, as cognitions, appraisals, judgments, even moral acts. In addition to the debates on the nature of emotion, there are the debates over where emotions and their

associated meanings are to be found. Emotions may be viewed as interior states, existing in the minds of individuals, and so for some, remain inaccessible to cultural critique. Alternatively, emotions may be viewed as located in outer, more social and public realms.

In addition to cross-disciplinary differences on the nature and labeling of emotions, differences also exist in the ways studies of emotion are and have been approached within anthropology. Prior to and well into the 1970s, anthropologists interested in emotion were heavily influenced by evolutionary, biological and psychoanalytic frameworks. These researchers maintained a view of emotional experience as more or less the same for all human beings and emotions were primarily approached as "inner states," subject to modification by culture (e.g., Benedict 1946; Levy 1973; Meyers 1979; Scheper-Hughes 1977). In the 1980s this view was challenged by scholars who argued that emotions are created within unique cultural contexts, and therefore, are not universal or easily comparable across culture (Good and Delvecchio Good 1985; Obeyesekere 1985; Rosaldo 1984; Lutz 1982). Human categories of thought, talk, experiences and feelings, and expressions and behaviors are thought to be largely, if not completely, determined or constructed by the culture in which one lives. In many of these studies, cultural meanings associated with emotions were looked for within discourse, such as conversation, narratives, storytelling and public texts (Lutz 1982; Abu-Lughod and Lutz 1990).

In the 1990s, some anthropologists objected to what they saw as the overemphasis of the influence of culture and symbol on emotions (Leavitt 1996; Lyon 1995; Reddy 1997). Some of these critics argued for a re-recognition of the reality of

individual "bodies" and the feelings associated with emotions (Lyon 1995). More recently, emphasis has been placed on viewing individuals as existing within social relationships and social structure and research approaches have gone beyond cultural accounts to include the broader picture of social and political economy (e.g. Delvecchio Good et al. 2008; Kitanaka 2010).

Discourse

Discourse is a term that has taken on different meanings within the discipline of anthropology. In their work on emotions, Abu-Lughod and Lutz (1990), describe how discursive approaches allow for a more complex view of the "multiple, shifting and contested meanings" possible in emotional utterances (1990:11). Their definition of discourse includes the language of everyday communicative practices, such as conversation, narratives, storytelling, and public texts, as well as how discourse can function as a form of social practice in relations having to do with power (Lutz 1982; Abu-Lughod and Lutz 1990). Discourse is examined for how it produces and constitutes "the realities in which we live and the truths with which we work" (Abu-Lughod and Lutz 1990:10). Like other discourse-centered approaches, White looks at what emotions and talk about emotions does in "situated uses of language" (White 2005:252), or in the language present within social interactions. White includes this definition of discourse by acknowledging the role of emotion and emotion rhetoric in producing and reproducing relations of power, or, as he states, "in defining or asserting the social identities and relations from which people speak and feel" (2005:247).

The focus on discourse, or language practices, contained in EI makes EI a theoretical tool well suited to exploring how meanings are assigned to emotion in the fluid context of the Center setting. As the experience of migration has been described as a "highly charged and fluid situation" in which both identities and emotions change and take on new meaning (Pratt Ewing 2005:226), this research uses the EI framework to identify the ways in which emotions are talked about by immigrant providers and to identify the social and structural locations in which this talk takes place within the Center setting. In using EI, I consider the ways in which talk about emotion serves to produce or maintain relations of power. I also consider how discourse on emotion reflects resistance, contradiction, and contestation to social practices involved in maintaining the status quo.

Identity

Anthropologists have long found identity to be a powerful concept with which to understand behavior, including behavior related to illness (Luborsky, 1994; Pollock, 1996; Swora, 2001) and emotion (Lutz, 1982; Rosaldo, 1984). Identity has been examined at the cultural level, in the form of the *person* or *personhood*, (e.g., Fortes 1987; Geertz 1984; Luborsky 1994; Mauss 1938) and from the perspective of individuals, as in notions of the *self* (Harris 1989; Sokefeld 1999). *Personhood* has been broadly defined as being a status made up of roles, capabilities, and qualities that are socially negotiated, assigned, or conferred to individuals by various structures within a society (Fortes 1987; Geertz 1984; Mauss 1938). According to Fortes, the ways in which individuals come to know who they are is through an approximation of two vantage points: (1) an individual's own personal experiences of these assigned roles,

statuses, and responsibilities, and (2) in being assigned these roles and statuses by their society, an individual comes to know who he/she is, and further, is able to, sanctioned to, given permission to, show who they are supposed to be (Fortes 1987:251). Similarly, one may look for a society's definition of *personhood*, both in an individual's own ideas of who they are (what Geertz terms as "experience-near") and in the examination of symbolic forms, "words, images, institutions, behaviors…in terms of which, in each place people actively represented themselves to themselves and to one another" (what Geertz terms "experience-distant") (Geertz 1984:225).

The timing of when an individual is granted personhood status, as well as the specific qualifications or determinants of personhood, has been shown to vary among societies. In some societies, a "completed person" is the "product of a whole life," in contrast to some societies that confer personhood status at birth (La Fontaine 1985:134). A society's definition of personhood may begin with a more autonomous, self-determining individual, where the appropriation of roles and capabilities involves moral accountability and individual agency (Dumont 1985; Fortes 1987; Harris 1989; Mauss 1938). In other societies, persons are socially determined instead of being self-determined, and moral worth is assigned not to the individual but to the social forms that serve to maintain the continuity of society (La Fontaine 1985:134). Also, as has been shown in work on physical disability in the United States, just as personhood can be viewed as being bestowed by society, it can also in certain cases be withdrawn by society (Luborsky 1994; Murphy 1988).

The *self* is an aspect of identity that broadly refers to an individual's awareness of being physically distinct or separable from the group (Hallowell 1955). Some work on

the self attends to aspects of agency as part of this definition (Pratt Ewing 1990; Harris, 1989; Sokefeld 1999). Selves take on cultural-level meanings in discussions of the relationship of the individual to the group, or the self to others (Joseph 1999).

Although these cultural aspects of identity have proven to be useful in understanding the relationships between individuals and their societies, questions over where one should look for evidence of personhood and selves have been fiercely debated. In his overview of some of these debates, anthropologist Linger describes anthropologists as falling into two camps, the "representational camp" and the "experiential camp" (2005). Those in the "representational camp" begin with the assumption that identity, like meaning, is a public phenomenon reproduced through symbols and therefore open to interpretive analysis (Linger 2005:187); discourse, thought to be a more accurate way of capturing the multi-vocal, dynamic, and less bounded aspects of culture, is included in this camp (Linger 2005:187-188). In contrast, anthropologists in the "experiential camp" locate identity in more experiential or personal realms (Linger 2005:189), in which the focus is on mental processes, individual experience, and subjectivities (e.g., Rappaport 1997; Sokefeld 1999). Linger describes how experience-oriented anthropologists object to identity being treated exclusively as an "extra personal phenomena" (2005:189). One definition for *identity* emphasizing the importance of individual experience comes from Mattingly et.al. 2008. They explain identity as a process involving the "personalization" of received cultural forms, a process affected by "an individual's social positioning, particularized life trajectory, and the complexity and fluidity of subjective life as mediated through everyday interactions, concerns, and attachments" (2008:9). This last definition for identity clearly places

White's concept of EI, with its attention to how identities and language are situated within everyday experience and social interaction, in this experiential camp.

Taking into account the above ideas on identity, the following section now explores another key aspect of the EI framework, that of the relationship between identity and emotion.

Identity and Emotion

As previously stated, EI utilizes as a foundational premise the view that identities and emotions are linked and mutually constitutive (White 2005). In their 1986 review article on the anthropology of emotions, Lutz and White (1986) refer to studies examining the relationship between emotion and social structure. They write, "…as emotion can be defined as being 'about' social relations; emotional meaning systems will reflect those relations and will, through emotion's constitution of social behavior, structure them" (1986:420). In other words, emotions result from social relations and also work to structure them. Examples of the relationship between identity and emotion can be found in studies examining shame and guilt, two emotions that have been looked at in different cultural contexts for how they are related to social structure and for how they shape social relations (Benedict 1946; Fajans 1983; Lebra 1983). In her description of the way shame works among the Ilongot of the Philippines, anthropologist Michelle Rosaldo argues that as "selves" are derived from social life, so too are affects or emotions. She writes "…affects and conceptions of the self assume a shape that corresponds – at least in part – with the societies and polities within which actors live their lives, the kinds of claims that they defend, the conflicts they are apt to know and their experiences of social relations" (Rosaldo 1984:149). She further states that as

conceptions of the self vary depending on culturally particular contexts, so too will emotions vary. Lutz and White echo Rosaldo's claim, writing, "Such things as the degree of individualism, notions of privacy and autonomy, multiplicity of selves, or sense of moral responsibility which result have important consequences for the way in which emotion is conceptualized, experienced and socially articulated" (1986:220).

Having considered ways in which emotional meaning systems may be shaped by culturally particular forms of social organization and social relations, in the following section I present select work, first from anthropology and then from psychology, examining identity in Arab societies.

Social Organization in Arab Societies

Within anthropology there are those who explore the relationship between the identities and behavior in societies described as "collective." Anthropologists Schweder and Bourne (1984) found behavior of peoples characterized as collective to be more situational and contextual as opposed to dispositional and more controlled by external factors such as roles and norms as opposed to internal factors such as personal attributes. Lila Abu-Lughod's ethnography of the Bedouin community of the Awlad Ali in Egypt (1986), and Suad Joseph's ethnography of Lebanese families living in Beirut (1999a) describe societies emphasizing group needs (in the way of tribe and family, respectively) over individual needs, with members evidencing selves that can be viewed as predominantly interdependent versus independent. Below I describe in some detail the work from anthropologist Suad Joseph on the process of "relational selving" as it takes place within Arab families.

Relational Selving

In her book, *Intimate Selving*, Suad Joseph uses a collection of personal accounts of intimate family relationships to illustrate the ways in which aspects of "selving" are present in Arab families (1999). Joseph defines "selving" as a lifelong process, made up of "contradictions, impinged upon by social and cultural processes, actively engaged by multiple actors in diverse relationships in the microdynamics of their day to day lives" (1999: 2). Joseph argues that Western psychology's premise that "individuation, autonomy and separateness" are psychodynamic necessities for maturity, and thus agency, does not take into consideration the "relational selving" occurring within Arab families (1999:3). Joseph describes "relational selving" as occurring in societies (and she emphasizes that this form of "selving" also takes place within Western societies) where persons are expected to remain close to their families and to be responsible to each other (1999:9). Joseph states that "in societies…where persons achieve meaning in the context of the family or community and in which survival depends upon integration into family or community, such relationality may support the production of what is locally recognized as healthy, responsible and mature persons" (1999:9). Moreover, rather than being a sign of dysfunction, Joseph states that "relationality" may be used to describe a process by which "persons are socialized into social systems that value linkage, bonding and sociability"(1999:9).

Joseph uses the term *relational selving* to describe how persons in Arab societies, often supporting the "family over the person" and "the family of origin over the family of procreation," are "embedded in relational matrices that shape their sense of self but do not deny them their distinctive initiative and agency" (1999:11). She uses the

concept of "connectivity" to describe one dynamic of selving, widely supported in many Arab societies, where a person's boundaries are described as "fluid" (Joseph 1999:12). Within this definition of "selving," persons may be expected to "read each other's minds, answer for each other, anticipate each other's needs, expect their needs to be anticipated by significant others," often shaping their "likes and dislikes in accordance with the likes and dislikes of others" (Joseph 1999:12). In this context, maturity is determined by one's successful negotiation of multiple "connective" relationships. Joseph goes on to describe a more culturally nuanced form of connectivity present in Arab families in her concept of "patriarchal connectivity" (1999:12). She uses *patriarchal connectivity* to refer to the selves produced within the fluid boundaries organized for gendered and aged domination in a culture valorizing kin structures (the institutional arrangements providing the rules of relationships), morality (the values guiding members' behaviors), and idioms (terms used for relatives that evoke rules of kinship) (Joseph 1999:12). Throughout these explanations, Joseph emphasizes that patriarchal connectivity is but "one of a number of culturally subsidized dynamics of selving" and that other forms of relationality involving more "individualist" notions of self may exist in the "same society and even with the same person" (1999:2).

Lila Abu-Lughod's ethnography of the Arab Community of the Awlad Ali (1985) reveals findings similar to Joseph's and also serves to illustrate the relationship between identity and emotions. In her analysis of two conflicting sets of sentiments, one being the everyday language of public interaction and the other being the *ghinnawas,* or lyric poetry, expressed in more intimate contexts, AbuLughod shows members to be embedded in patriarchal relational matrices shaping culturally particular selves. In

public, these selves "strive to portray themselves as potent, independent and self-controlled," displaying sentiments appropriate to the maintenance of honor (Abu-Lughod 1985:253). However, in more private intimate contexts, through the use of the *ghinnawas,* or "little poems", individuals express sentiments of love, loss, and vulnerability (Abu-Lughod 1985:253). In describing the sentiments expressed in public versus the sentiments expressed through the recitation of *ghinnawas,* Abu-Lughod states that both are culturally constructed. She also suggests that "rather than a monolithic cultural ideology shaping sentiment and determining experience, multiple ideologies inform individual experience" (Abu-Lughod 1985:258).

Social organization in Arab societies has also been examined within the discipline of psychology. Just as anthropology has looked at differences in social organization for its relationship to cultural aspects of identity, as in the "relational selving" described by Joseph, the influence of culture and society on identity in the form of "personality," has also been recognized by psychologists who explore the relationship of the individual to the group, or the self to others in collective societies.

Collective Selves

Cultural psychologists have looked at societies characterized as "collective" in works focused on cognition, emotion and motivation (Dwairy 2006; Markus and Kitayama 1991; Singlelis1994; Triandis 1995).[3] In much of this work, the different self-construals (i.e., personality) found within collective societies (most often associated with non-Western, socio-centric societies) are compared to the self-construals noted in

[3] For a summary discussion of the differences and similarities between anthropology and cultural psychology see Rchard Shweder 1990.

"individualistic" societies (most often associated with Western, egocentric societies). Selves formed among collective peoples are described as being interdependent rather than autonomous, energy is seen to be directed towards group goals rather than individual goals, and priority is given to interpersonal responsibilities rather than to justice and individual rights (Dwairy 2002; Markus and Kitayama 1991; Singlelis 1994).

Similar to the findings of Schweder and Bourne (1984) mentioned earlier in this section, work from psychology has also found the behavior of individuals from collective societies to be more situational and contextual (as opposed to dispositional) and more controlled by external factors such as roles and norms (Dwairy 2006). Within this same body of literature from psychology, individualistic societies are characterized as having independent self-construals that are "bounded, unitary and stable," selves that are "separate from social context" (Markus and Kitayama 1994:230). An independent self-construal is described as emphasizing internal abilities, such as thoughts and feelings, being unique, expressing one's self, promoting one's own goals, and using a more direct communication style (Dwairy 2006; Markus and Kitayama 1998; Singlelis1994; Triandis 1995

As has already been commented on, much debate and controversy exists regarding where to best look for identity. One key debate concerns the feasibility of examining inner mental life (e.g., identity and feeling states, or emotion) and its relationship to behavior or culture in the first place. Of more immediate concern for this work, is the use of the terms *collective* and *individualistic* to describe the social organization of a particular society, as these terms are too often applied in ways that obscure the variation within both types of societies. One explanation for the unease

within anthropology in comparing or contrasting collective peoples with individualistic peoples can be found in the topic's association with some of anthropology's early history of collaborating with colonialist projects of the 19th and 20th centuries (DelVechhio Good et al. 2008; Ervin 2005). Objections to the use of such labels as Western (independent) selves and non- Western (interdependent) selves have been raised on the grounds that they are stereotypical, simplistic, and likely to further perpetuate colonial designations (Cohen 1994). For example, in Markus' and Kitayama's description of an independent self as being "bounded, unitary and stable" (1994:230), the use of the descriptor "stable" in particular brings to mind its opposite, "unstable", a characterization once pervasively assigned to non-Western, formerly colonized peoples. In fact, this word usage may be viewed as evidence of the continued presence of colonial institutions in post-colonial times.

Another explanation for unease is that this kind of labeling harkens back to the cultural determinism evidenced in the once popular culture-and-personality school within anthropology. The culture-and-personality school which attempted to explain behavior and psychological dispositions (i.e., national character) through connections to early childhood experiences was associated with such figures as Bronislaw Malinowski, Ruth Benedict and Margaret Mead. The approach was eventually heavily criticized for its use of Freudian assumptions, its lack of clearly described methodology, its neglect of inconsistent data, and its oversimplified characterizations (Barnouw 1985:457).

Oversimplified characterizations and assumed homogeneity of the experience of various groups, including those located within the United States, have been challenged by anthropologists using the lens of political economy (di Leonardo 1984, 1998; Harden

2003; Stack 1974; Sturm 2002), some calling for approaches that go beyond culture, such as "human cognitive apprehensions," to include examinations of particular historical trajectories, material life, and social processes (di Leonardo 1998:74). In light of this critical scholarship, it is clear that any consideration of Arab identities, including Arab immigrant identities, must attend to the particular historical, economic, and political factors making up the environments in which these identities are situated. Following from the EI framework, which proposes that emotion meaning-making takes place within the intersections of identities, discursive practices and social interactions, where identities and emotions are linked and mutually constitutive, consideration must be given to the many factors contributing to identity in a setting.

The following section contains scholarship revealing the complexity of Arab American immigrant identities. I begin with a brief review of the history of Arab immigration to the United States and then follow with a discussion of work describing some of the experiences of Arab Americans as citizens.

History of Arab Immigration to the United States

Immigration patterns and the experience of Arab peoples in the United States have been well described in the literature (e.g., Naff 1993; Sulieman 1999; Cainkar 2009). Scholars describe Arab immigration as occurring within two distinct waves, the first beginning in the late 19th century and the second following World War II. The distinctly different character of these two waves of Arab immigration results from a host of factors, including a combination of political, social and economic conditions in homelands, broader world conflicts, and changing immigration laws and attitudes towards race in the United States (Ajrouch 2007; Naber 2000; Samhan 1999).

The first wave of Arab immigration began in the 1870s, consisting primarily of Christian Lebanese immigrants from the area once referred to as Greater Syria. These earliest Arab immigrants were primarily motivated by economic need and religious persecution experienced under the years of the Ottoman Empire. Largely illiterate and unskilled, many of these first Arab immigrants worked as peddlers, occupations requiring minimal English competency. Their primary objective was typically to save and send money home with the plan of returning home. The event of World War I had the effect of isolating Arab immigrants from their homelands. Subsequent U.S. immigration laws with strict quotas systems on entry into the United States, as well as the proliferation of programs aimed at assimilation, brought about a change in their orientation to life in the United States (Samhan 1999). These first Arab immigrants slowly began to assimilate, participating more actively in all aspects of American life (Suleiman 1999).

The second wave of immigration generally refers to the period post World War II and is characterized as bringing a more diverse group of Arab immigrants consisting of Muslims and Christians. Beginning with Palestinian refugees displaced from the 1948 Palestine War (Naber 2000), this second wave consisted of immigrants from all parts of the Arab world, including North Africa. The largest influx of Arab immigrants in this wave occurred in the 1970s and 1980s (Orfalea 1988:316-317), reflecting the Act of 1965 in which immigration law removed existing quotas and stressed a preference for family unification and skilled workers (Samhan 1999). Compared to the first wave of immigrants, second wave arrivals have been characterized as being more highly educated and economically better off (Suleiman 1999). Still motivated by economic

realities, this group of immigrants also sought to escape a range of regional conflicts: Palestine/Israel; Arab/Israeli; Iraq/Iran; Iraq/Kuwait; and civil wars in Lebanon and Yemen (Suleiman 1999:9). These immigrants were also seeking freedom of political expression (Suleiman 1999:9). As a result of the Gulf War of 1991 large numbers of Iraqi Shia arrived in the United States from the southern portion of Iraq. Although these refugees have been described as diverse, not from one class or political persuasion, many came from remote parts of southern Iraq having little contact with the outside world, including other areas within Iraq (Walbridge and Aziz 2000:328).

An important difference between these two distinct groups of Arab immigrants was in how they saw themselves in relation to American society. First wave immigrants saw their stay in the United States as temporary, and as such their involvement with American society was peripheral. Community life was predominantly organized around homeland religious, village, and family networks (Suleiman 1999; Terry 1999). Efforts were made to downplay ethnicity to outsiders in order to avoid offending their American hosts. In contrast, Arab immigrants coming in the second wave brought with them more well-defined ideas of democracy and expectations of participating fully as citizens (Suleiman 1999).

The 1967 Arab-Israeli War has been called a watershed moment for Arabs around the world. For Arab immigrants living in the United States, the Palestinian defeat served to galvanize increased pride in Arab identity and contributed to a growing sense of Arab nationalism (Suleiman and Abu Laban 1989). Slanted media coverage and United States support for Israel have been described as leading to the unification of members from both the first and second waves (Naber 2000; Suleiman 1999). Since

September 11, 2001, Arab Americans have experienced increased surveillance and investigation by law enforcement officials at all levels of government (Cainkar 2009:169; Howell and Jamal 2009:83; Laird and Cadge 2010).

Arab American Identities and Belonging

Professor of politics, Amany Jamal, and anthropologist, Nadine Naber ,explore the role that domestic and global US policy and institutionalized processes of racialization play in the construction of Arab American identity by first describing the shifting and contested nature of the very term *Arab* and the complexity involved in classifying Arab immigrants and Arab Americans (Jamal and Naber 2008:6). Also writing about race as experienced by Arabs in the United States, Louise Cainkar describes the social status of Arabs as having moved from one of "marginal whiteness to a more subordinate status" similar to the experiences of people of color (Cainkar 2008:46). Cainkar attributes this change in status to the rise of the United States as a global superpower, United States support for Israel in the Arab-Israeli conflict, and United States response to Islamist challenges to American global hegemony, all resulting in essentialist constructions of Arabs as inferior (2009:85). Cainkar also points out that since the "darkening of Arabs" began after the American civil rights movement of the 1960s, when categories of "non-white" and "minority" were defined and set. Arabs in the United States face a "double burden" of being both excluded from whiteness and from "mainstream recognition as people of color" (Cainkar, 2008: 49).

Related to the scholarship on Arabs and race in the United States is work from sociologist Kristine Ajrouch examining intersections of race and religion in the negotiation of identity among Arab immigrants (Ajrouch 2007; Ajrouch and Kusow

2007). Ajrouch has found identity to emerge from social and racial boundaries defining majority and minority status in both host country, with an emphasis on definitions of "whiteness" in the United States, as well as from homeland environments. In their study of Lebanese Shia immigrants to the United States (Ajrouch and Kusow 2007), Ajrouch and Kusow describe how for this group, a minority in their homeland, being assigned as "white" in their host country meant membership in the dominant social status. They also describe how the appearance of religious dress, such as wearing a hijab, and the assertion of an Islamic identity can result in a change of status from "that of "white" to that of "other" (2007:85).

Samhan's review of U.S. racial classification and changing immigration laws describes how racial labels applied to Arab peoples living in the United States are tied to Arab Americans' ambiguous position as citizens (Samhan 1999). Results from the DAAS survey conducted in 2003 and designed to capture a reliable demographic portrait of the social, religious, cultural and political views of Arab Americans living in Metropolitan Detroit, reveal how Arab American identities and citizenship are shaped by the long standing tension between the politics of inclusion and exclusion (DAAS 2009). In commenting on these data, Shryock and Lin describe citizenship to be a kind of identity that is "public in character" (2009:38). They further describe how identity for Arab Americans is both "public and performed" and "constrained and expanded" by assumptions about what both Arabs and Americans can be (2009:28). They describe how Arab Americans, while assigned questionable citizenship status, are at the same time "…expected to display their (suspect) American identity publicly, incessantly and convincingly" (2009:65 Their observations may relate to the findings of Laird and Cage

(2010) in their study of nine Muslim community-based health organizations in the United States. They found that first generation Muslim immigrants were able to use NGOs to mobilize middle class Muslim values in American society in ways that normalized being Muslim in an Islamophobic environment and to "defensively enact American Muslim citizenship and belonging" (2010:225). Although these organizations were identified as Islamic-based and not necessarily Arab, Laird and Cage reveal how these organizations were able to "deploy positively valued faith-based charitable and professional group identities" in ways that counteracted publicly stigmatized identities (Laird and Cage 2010:225).

In the preceding two sections I gave a general history of the overall timeframe and circumstances contributing to the patterns of Arab immigration to the United States. I also describe some common experiences encountered by Arab Americans living in the United States. However, the particular configuration of Arab immigrant settlement within the United States varies widely from place to place, from region to region, and within cities and local communities. In Chapter 2, which describes the study context, I provide a more detailed description of the particular makeup of the Arab community in which the Center is located. This description is necessary in order to best portray the social context in which the providers of interest practice.

Summary

White makes it clear that emotive institutions are more than "institutionalized occasions for the expression of scripted emotions" (White 2005:248). Rather they "…constitute points of articulation between embodied feeling, cultural models of emotions and socially organized activities where emotions and emotion talk do specific

kinds of pragmatic work" (White 2005:248). Following from these ideas, this ethnographic study sought to better understand how the institutional or culturally constituted activities present in one local clinic setting, and the intersections between the social interactions, identities and language practices that take place within them, evoke, define and in some cases transform emotional experience and meaning.

The health care setting of interest here is distinctive in that many of its providers either originate from, or are closely associated with, family networks who originate from Arab-majority homelands in the Middle East. As will be described more in Chapter 2, on the context of the field setting, the Arab world is made of up countries that are extremely diverse, each with their own particular historical trajectories, political economies, peoples, customs and traditions. However, taking into account this great diversity of experience, what immigrants from Arab-majority countries do have in common is a shared language, varying degrees of collective social structure, a shared political history under European colonialism, and the influence of the Abrahamic religious tradition of Christianity, Judaism and Islam (DAAS 2009; Dwairy 2006; Kulwicki 1996; Suleiman 1999). As stated at the beginning of this chapter, immigrants can be said to be "between culture." Living and working in the United States, the Arab immigrant providers in the field setting of the Center, their identities, their ways of communicating and their patterns of social interaction are subject to the influence of multiple social worlds, both those experienced in Arab homelands and those of their current American context.

Chapter 2 describes the context of the field site (Center) as I encountered it, beginning with my first early contacts with the Arab Community (Community). I then sketch out a general description of the city (City) on whose border the Community sits,

giving a more detailed history of the particular patterns of Arab immigration to the region. In describing the context of the Center setting, I talk about areas within the Center providing mental health care. In Chapter 3 I describe the methods used in this research, beginning with how I gained access to the field site. I then more fully describe White's Emotive Institution (EI) framework and how I operationalized it for use in the specific field site of the Center. Based on this conceptual framework I detail how EI informs the principal ethnographic methods of interviewing and observation and guides the analysis of data. Chapter 4 analyzes a series of key interactions that took place in the first phase of my field work when I was conducting formal, face-to-face, in-depth research interviews with mental health care providers on aspects of provider identity and definitions for emotion. Chapter 5 begins with a description of my move to observing in the primary care medical clinic (Medical Clinic) of the Center. In this chapter, I highlight my observations of providers as they interacted with each other and with their clients, as well as aspects of my formal interviews with them in the Medical Clinic setting. Chapter 6 contains a broader discussion of how my findings inform our understandings of immigrant experiences of "disruption," the experience of being "between culture" and the anthropology of migrant emotions. I also discuss how the use of the EI framework contributes more broadly the anthropology of emotions and some implications for the process of making mental health diagnoses.

SECTION II: CONTEXT AND METHODS

CHAPTER 2

CONTEXT

Some of the topics addressed in this research are of an especially sensitive nature. Mental illness continues to be a health problem highly stigmatized in Arab communities and in American society overall. Another sensitive topic concerns the treatment of "identity" in an, arguably, vulnerable, U.S. population, post 9/11. Given the above factors, much biographical data will be scrambled and many details will, out of necessity, be omitted.

I begin this chapter with a description of one of my first encounters with the Arab community where this research took place. This encounter occurred four years before the start of my fieldwork when the ideas for this study on emotion meaning-making were in their nascent stages. This section is followed by a general rendering of aspects of the city on whose border the Arab community is situated and a description of some of the Arab groups who settled in the area. Following this background information I describe the immediate surroundings of the health care setting (Center) in which I interviewed and observed providers, and then finally the Center itself.

Early Introductions to the Community

In the prologue, I explain how my previous work on a mental health study of Arab immigrants living in the United States ultimately led to my research questions. I specifically detail my encounter with Fatima, one of the Arab immigrant women who collected data for that study. Over the course of my four and half year involvement on the mental health study, I was to work with other Arab immigrant women who also

recruited and collected data for the study. These women came from Arab homelands throughout the Middle East: Yemen; Iraq; Lebanon; Syria; and Palestine/Israel. Most worked in some capacity outside of the study while also taking care of their families. Some worked as health care providers, others as teachers, and a number were students, working to complete undergraduate or professional degrees, or else actively retraining for different work as the educational training or credentials they received in their home countries were not recognized in the United States. All lived within the Arab community in which this current study took place. While the design of the mental health study and the specific demands of the work were what brought us together, the more I came to know these women, the more I became interested in their lives. As my relationships with some deepened, I began to experience firsthand some of the places and spaces in which they lived and worked. It was during this period, that my ideas for this dissertation study began to take shape and so it seems appropriate to mention them here in this context chapter.

The following section contains a description of a meeting that took place between me and one of these women, four years before the start of my own field work. This account captures some of my first reactions and thinking about the Arab community in which this study took place and of the Arab immigrants who live there.

A Drive In

Mariam (pseudonym) completed her medical training in her Arab homeland. Caught up in the aftermath of war, a chain of events disrupted her arrangements to complete a residency program and she eventually immigrated to the United States. Now

an American citizen and a divorced mother of two, she had finally abandoned the hope of practicing medicine here and was busy training for an allied health degree. With her background and experience she promised to be a good key informant for my questions around emotion meaning-making among Arab immigrant health care providers.

We scheduled a meeting which was to take place in the afternoon at a public library located in a suburb that was home to the large Arab American community where Mariam lived. I remember thinking that the library seemed especially busy for a sunny Friday afternoon. I noticed that most of the women present, apart from the women who wore ID badges and looked to be library staff, were *muhajabah* (Arabic word for Muslim women who wear the *hijab*, a head-scarf arranged to fit snuggly around the face, covering hair and neck) and a number of women were dressed in floor length tunics or full *abayas* (long, black over-garments, also worn by Muslim women, usually covering all but face, hands and feet). The library was also filled with many school-aged children busy with books, and each other, so much so that we found ourselves without a quiet place to conduct our interview. As it was close to sunset and time for *Maghrib,* or early evening prayer, my colleague, who was an observant Sunni Muslim, suggested we drive to a mosque nearby where she could pray and I could get a look inside.

We each took our own cars with me following from behind and as we drove through the neighborhood we passed out of an older section of the community into a newer, more recently developed section marked by well paved roads, neat curbs and manicured boulevards. We passed a large shopping mall, a well-known national chain book store, a Starbucks, and a number of modern, high-tech looking office buildings. The streets in this section now broadened to include three lanes and I found I had to

work hard to keep up with Mariam who was moving through the thickening rush-hour traffic with some speed. With daylight giving-over to dusk, I could make out her veiled silhouette illuminated by the light from approaching cars, and as she darted back and forth from one lane to another I could see her talking on her cell phone. When we got to the mosque, we found it locked and the parking lot empty. I pulled my car up next to hers, we lowered our windows and she said in an irritated tone that as this mosque was a Shi'a mosque, she should have known it would be closed. She told me she would pray inside her car and then we could be on our way. While waiting in my car, I made a few phone calls of my own and then sat back to think about our drive.

Despite the familiarity of the suburban surrounding and the fact that I was within commuting distance from my own home, what I remember most about that time was feeling out-of-place. In trying to pinpoint the source of my feeling, I was conscious of the fact that I was parked in front of a mosque, this one elaborate and imposing, its arabesque ornamentation and spiraling minarets accentuated by strategically placed exterior spotlights. I also remember thinking about my colleague praying next to me in her car. I remember wondering if it was acceptable for religious Muslim Arab women to be out at night alone and somehow, our rather wild drive through the neighborhood seemed to be at odds with my ideas of religious women as being more reserved and sedate. I found myself wondering how she dealt with the heavy demands of both professional and family life, as I had often felt the strain of juggling these realms in my own life. Were her issues and struggles like mine? On the surface, we seemed to have a lot in common, two multi-taskers with much to fit into a day, on the phone while driving, making any number of routine maintenance stops along the way (on this night, a

stop to pray), both health care professionals, students, and mothers, who made the choice to leave their families for an evening in order to learn what we could about each other and emotion.

The drive I just described took place in 2005. At that time, it had been four years since the events of September 11th. Subsequently, the United States went to war in Iraq, ousted Saddam Hussein, and began a military "stay", which lasted until 2012. Since that drive in 2005, Arab uprisings throughout the Middle East resulted in the overthrow of longstanding autocratic rules in Tunisia, Egypt and Libya. Inspired by these events, significantly more violent and bloody revolutions have occurred in Yemen and more recently in Syria.

Also, in the period since this drive, the United States entered into a period of economic recession, its effects hitting the region of my study and its inhabitants especially hard. Unemployment, lost homes due to bank foreclosures and the drying up of already scarce funding for social services had direct impacts to the daily lives of many of my informants and the lives of their patients, mostly low-income, and many, Arab immigrants and refugees. These events, national and international, these places, Arab homelands and American suburbs, and the effects of a strained local economy all contribute to the back-drop or setting in which my informants work and live and in which this study of emotion meaning-making took place.

Having had some time to think over this earlier drive and my feelings of being far from home, one thing seems clear to me now. Unlike me, on that night anyway, having a good command of the streets, Mariam seemed to be very much at home. Here, she

was host and I was guest. She knew where things were and was leading the way. I took direction from her. I now wonder whether part of my sense of dislocation that night wasn't the result of my thinking that it should have been the other way around. Wasn't this place my home? Or more to the point, how was it now Mariam's home? The question of how an American suburb may have come to be "home" for Mariam, or put another way, how it is that Mariam is an American, throws into question what it means to be an American in the first place and highlights just one aspect of many contributing to the identities of the Arab immigrant health care providers I interviewed and observed and came to know. Evidence of the "working out of identity," admittedly as indicated here in this preview, both mine and my informant's, was to surface repeatedly throughout the course of the fieldwork period and into the present, its explication forming a core piece of this research in my attempt to better understand the emotion meaning making taking place among providers and staff at the Center.

On a more recent return to the mosque of that first drive, I discovered that this mosque sits alongside a number of other official places of worship. I do not remember seeing these structures the first time around and wonder if I can blame the time of day for my miss. This second time I noticed that located next to the mosque was a Protestant church, next to that a Maronite Catholic church, and then across the street an Eastern Orthodox church, each marked off, respectively, by a minaret, a steeple, a cross, and a Byzantine-like dome, all set up high in the sky, in a row, off the highway. These buildings, all architecturally distinct, the result of particular historical, political, cultural and geographic influences, with their high-flying markers signifying distinct religious belief and practice, disturb one's notion of passing through just one more

generic and homogenous American suburban landscape. And as is the case with the identities of my informants, the presence of these different places for worship, and their proximity to each other, suggests a complexity that on first glance, or on first drive by anyway, was not always so apparent to me earlier on.

The City

A once, major, mid-western industrial center, the City, like others of its kind in the Rust Belt of the United States, has experienced steady economic decline beginning in the post WWII years, along with an increasingly pervasive pattern of racial segregation (Sugrue 2008: 257). In the Civil Rights movement of the 1960s, racial unrest and white flight led to a majority African American, albeit declining inner city population (Hartigan, 1999). The metropolitan area as a whole was subject to the well-described pattern of distinct "waves" of Arab immigration to the United States (described in Chapter 1), however the ways in which these waves of immigration manifested themselves in the City, are the result of local historical, political and economic factors.

The first Arab immigrants to the area were Christian Lebanese who arrived in the latter second half of the 19th century, starting as peddlers and then going on to become entrepreneurs who owned their own dry goods businesses (e.g., Naff 2000). In the 1900s, as the City's industrial sector began to grow in response to the rise of the automotive industry, European laborers were attracted to work on production lines. Among these workers were increasing numbers of Arab immigrants, now including both Muslim and Christian Lebanese, as well as immigrants from Yemen, Palestine and Christian Chaldeans from Iraq (Suleiman 1999; Rignall 1999). A diverse group of Arab

immigrants continued to arrive to the area in the periods after both World Wars, with surges seen in Palestinian immigrants following the 1967 and 1982 Arab Israeli wars, Yemeni and Iraqi Chaldeans in the 1960s following regional conflict and civil unrest, and large numbers of Shi'a refugees from the south of Lebanon following the civil war in the 1970's (Terry 1999: 142). Many of these arrivals were unskilled laborers who tended to settle near the factories where they worked. One of these industrial areas, located in a suburb on one border of the City proper, became known as the Arab Community of the City.

As more immigrants and refugees from Lebanon and Iraq, Palestine and Yemen came to live with extended family and kin networks already settled in the area, the area slowly came to take on a distinct Arab cultural flavor and identity. By the mid 1970s, now well assimilated, older Lebanese families, with economic resources, moved out of City centers to more affluent suburbs and settled into middle and upper middle class life (Walbridge and Aziz 2000; Rignall 1999). Other Arab groups living in the Community have also followed this pattern of moving beyond Community borders to surrounding suburbs. By contrast, working class Muslim Arab immigrants, primarily Yemeni and Shi'a Lebanese stayed in the Community. These groups, in particular, have been characterized as providing "cultural continuity" and as "orchestrating a unique kind of assimilation based on an intermediated, generalized Arab/American culture that allows for dialogue across sectarian, ethnic, and national lines" (Abraham, Abraham, and Aswad 1983 in Rignall 2000:54).

Despite the economic decline of the City in the 1970's, Arab immigrants continued to be attracted to the area of the Community whose Middle Eastern grocery

stores, coffee shops, restaurants and mosques provided a buffer in transitioning to life in America. Following the Gulf War of 1991, large numbers of Shi'a Iraqi refugees from southern Iraq were resettled into the area. In the years between 1991 and 2000 as many as three thousand refugees arrived, per year (Rignall 2000). These refugees differed from earlier Iraqi immigrants who arrived in the 1960s and 1970s in several ways. Many had experienced imprisonment and torture under Saddam Hussein's reign. They had come through the intifada uprising and spent years in refugee camps in Saudi Arabia. As a result, many arrived in the United States in poor physical and mental health. Walbridge and Aziz (2000) stress that this group of refugees does not represent one class, political persuasion or one ideology, however those from certain villages in southern Iraq had little contact with the outside world and thus little exposure to different societies (Walbridge and Aziz 2000:328). Most arrived with no English and few occupational skills (Walbridge and Aziz 2000:330). The current day Community is extremely heterogeneous. While religious and socio political divisions ebbed and flowed with changes and events taking place in the Middle East, class divisions and degrees of cultural assimilation have been cited as being of more significance (Rignall 2000: 57).

<u>The Community</u>

My usual route to the field setting involved a twenty minute freeway drive that took me from one side of the City to the other. Once getting off the freeway, a short stretch down a main street in the City proper, took me through a low-income, working class neighborhood. Pothole-ridden and littered with paper scrap, this street is lined with worn-looking, small retail stores, gas stations, automotive repair shops, corner bar-restaurants, and check cashing convenience stores. Behind this shop-lined street are

blocks and blocks of modest, single story homes, interrupted by the occasional, boarded-up building, over-grown empty lot or fenced-in storage yard containing assorted machinery, building supplies and stacked materials.

After about a mile, one begins to see Arabic signage on yet more, small retail stores. Then, almost immediately in crossing the boundary between city, and suburb, the store fronts become newer, bigger and better maintained looking. Middle Eastern food markets, bakeries and restaurants are interspersed with shops selling household goods, some with ornate looking furniture. Smoke shops feature *arghile*, or water pipes, in their shop windows. Women's clothing stores display manikins dressed in ankle length dresses worn over pants. In-between these stores are smaller bank branches, insurance companies, mobile phone stores and the occasional larger, chain drug store. Veiled women and women in full *abayas*, can be seen on the sidewalks and in cars. One also notices prayer beads hanging from car rearview mirrors. I have entered the central hub of the Arab Community (Community).

Present Day: Field Site

The residential spaces in this part of the Community consist, again, of blocks of modest single family homes, a mix of frame and brick construction, on small plots close together. Many of the homes are two storied brick structures, built in the 1940s, with front porches on which sit gliders and chairs for visiting. Many of these homes have well-tended yards, with flowers in the front and, in some, vegetable gardens in the back. These residential tracts are intermittently interrupted by light industry, railways and elementary and secondary schools. During school hours one might see women who are

muhajabah out for exercise, power walking around the athletic fields of their children's schools.

 The Health Care Center

The field site of the health care center (Center) is located in this section of the Community. Founded in the mid 1970's by a group of Lebanese American volunteers, the Center's original mission was to help a rapidly growing population of Arab immigrants and refugees settling in the area, navigate US life and its institutions. As the Center, a nonprofit organization, grew in scope and size, it broadened its mission to provide health and social services to a low-income client population more reflective of the surrounding area's multi-ethnic communities. Emphasizing a commitment to an Arab American heritage, the Center, in addition to offering a variety of mental health programming which will be described in more detail later, offers a wide range of social services: education, employment and training opportunities; community and public health services, including family, pediatric and obstetrical services; cancer screening and education; internal medicine and adolescent health; a federally funded refugee medical assessment program; HIV/AIDS screening, counseling and prevention; and domestic violence and substance abuse programming. In the year of my field work, although the clients seen at the Center came from all sections of the surrounding metropolitan area, as many as 70 % identified as being from Arab descent (taken from Center 2010 fiscal report).

The central campus of the Center itself occupies approximately one half of a city block. With the exception of executive offices and some off-site programming for

families and teens, most of the activities associated with the Center are organized from and located within two main buildings. During the period of my fieldwork, a new satellite clinic offering many of the same services opened across town in a suburb with a distinct and large Iraqi immigrant population, an indication of the Center's continued growth and expansion. Towards the end of my fieldwork period, various Center staff and providers had begun to split their time between the main Center and this newer satellite. Occasionally, I would travel with these providers, assisting them in the transport of staff and supplies.

The two main buildings of the Center are set back off one of the major streets in this neighborhood, and sit facing each other from across a large, busy parking lot with space for about 200 or more cars. This parking lot is always full by 9am on the days the Center is open. After that time, cars can be seen circling the lot for empty spots, then spilling out to park on surrounding city and residential streets. On any given day, one is able to see a diverse mix of people, with an assortment of skin tone, hair texture, facial features and stature. Also on display, is a wide array of fashion and clothing styles, western styles, including jeans and t-shirts, professional looking jackets and suits, and an assortment of ankle length tunics and black *abayas*. Women can be seen wearing a variety of face and head coverings, including the occasional *niqab* style which covers the whole face, *hijabs* made of scarves of many colors, and brightly colored and elegantly arranged turbans. Some men wear long, ankle-length tunics in place of pants, as well as head coverings in the way of *kufia*s or *taqiyah*s, skull caps worn by observant Muslims. Older couples walk together, at times one assisting the other. Men of all ages walk alone, or in groups, or in accompanying women and children, often lead the way.

Women, juggling as many as four young children, some in strollers and some in car seats, can be seen making their way to the building housing programs for mothers and children and the medical clinic. Sometimes women with children were with other women and their children, and then sometimes they were accompanied by husbands, fathers, and grown sons.

Mental Health Care at the Center

My initial access to the Center took place around interviews with select providers with specific mental health training. These providers worked within different mental health programs at the Center, including those designed for adults, children, and families, victims of domestic violence and crime, and programs designed for individuals who had experienced trauma and torture, many of whom were immigrants and refugees. My initial observations were more or less confined to the places within the Center accessible to the public, as the mental health programs and their providers were located within the two main buildings. However, while on route to interviews I was able to get a beginning sense of the range of services that took place in the Center and their relationship to each other. Space devoted to mental health programs differed in that they occupied interior spaces within both buildings, space not immediately accessible from the outside. My first interview took place in the older of the two buildings, which I refer to as Building Old.

Building Old's double-door entrance opens immediately into a large, rectangular waiting area. Positioned around the periphery of this large room are various office doors, with groupings of chairs, their chair-backs to the wall, placed in between. An

open balcony at the level of the second floor overlooks this large open area. My first time in this building, I arrived early in the morning shortly after the Center had opened for business. Despite the early hour, the upper balcony was crowded with men and women of varying age in western dress, with forms in hand. A loud din of conversation filled the whole of the waiting area. I was later told that the activity on the balcony was a regular occurrence, the group consisting of individuals seeking employment or other forms of public assistance. On the lower level, seated in rows of centrally located chairs, were a few older men and women. The women were all *muhajabah* and wore longer tunics. The men wore *kufias* and long tunics. One of the men held a strand of prayer beads.

The main reception or waiting area was situated between the office space designated for a range of social service programs for low income clients and space specifically devoted to three mental health programs. While the social service side of the building consisted of programs designed to meet the needs of low income residents in general, many were specifically targeted for the needs of newly arrived immigrants and refugees. Bilingual staff, many being Arab immigrants, provided help with translation and legal services, employment opportunity and general immigration services, some in partnership with agencies such as the Social Security Administration, Department of Homeland Security, Department of Human Services and the Office of Refugee Resettlement. As my focus was on mental health activities, I did not spend time here other than to note where these programs were located.

Three of the Center's five mental health programs, one providing services for adults, another for children and families and another program focusing on the specific

mental health needs of developmentally disabled children, were located on the opposite side of the large reception area. These programs were physically accessed through a door situated directly behind a main reception desk located within the larger, central waiting area. I noticed no signage indicating that specific mental services were housed inside. Once through this door I found myself in another, much smaller waiting area with yet another receptionist counter. Two veiled women sat beyond the reception counter in this area. Speaking to each other in Arabic, when they saw me, one of them immediately asked me in English how they could be of help.[4] As I sat to wait for my appointment, an assortment of staff and clients began to arrive. A man in his 20s, dressed in western styled clothing came in and sat down. Another man, professionally dressed, in his 60s or early 70's, came in with a worn looking leather brief case. He and the younger man began to consult a calendar, in English, trying to clarify an appointment date. When they had finished speaking, the older man turned to me to ask if I had been helped. I told him who I was waiting for and satisfied with my answer he left down the hall. Another older man who looked to be in his 50s came in and in English notified the receptionists that he had missed his appointment last week and was here to see if he could be seen. He said, "I was told I needed to come here." He spoke in English, and when asked for his name gave an Arabic surname.

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[4] Throughout the Center I was to hear receptionists first greet clients in English and at times in Arabic. I asked receptionists how they decided which language to use. A number of receptionists answered by saying they would first greet all in English explaining that "We/they are in America now and they have to learn to speak English." A more senior receptionist, who had been an infant when she came to the United States, said that she could often tell which clients could not speak English by the way in which they approached the counter with their eyes cast downwards. In these cases, she would greet them in Arabic.

Off to the side of this inner reception desk was a large room filled with as many as eight, 6 x 6ft. work cubicles I was to later find out that these cubicles were assigned to mental health case workers, counselors and assistants. Located on the periphery of this room were private offices, belonging to mental health therapists and administrators. Some of the offices were also used for one-on-one therapy or interviewing. Opposite this large room, on the other side of the reception desk, was an area containing file cabinets used to store frequently used departmental forms such as consents and screening tools, most with Arabic and English translations. Five of my initial interviews were to take place in this mental health space within Building Old, three with mental health therapists and two with mental health case workers. While the therapists, two males and one female, occupied private offices, the two female case workers occupied cubicle space.

Other mental health programs were housed on the opposite side of the parking lot in Building New, a two story building constructed with the past decade. One of these programs was designed specifically for victims of crime (VOC),[5] and the other was devoted specifically to individuals who had experienced torture.[6] Both the VOC program

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[5] The VOC focused much of its resources on issues associated with domestic violence. In my interviews with a variety of staff from this program I discovered that the issue of domestic violence (DV) is a particularly sensitive topic for the Arab Community, one being addressed in schools and in the larger Community. During the fieldwork period I attended two programs sponsored by the Center in which attempts were made to describe and acknowledge DV as a significant health problem. One event was a fund raiser designed to raise money for a women's shelter and the other invited members of the City's legal community to hear an expert speak on aspects of sharia law or Muslim family law, especially related to marriage and divorce.

[6] The program geared for victims of torture reflects the large number of refugees using the Center. Many of the clients seen in this program came from Iraq following the Gulf War in 1991. I wondered if the close proximity that these particular programs had to administrative personnel wasn't an attempt to provide an added layer of protection for these more vulnerable clients.

and the program for victims of torture, along with the offices belonging to therapists who worked within them, were housed on the second floor of Building New, close to the offices of Center administrators. In order to access these offices on the second floor, one had to first pass by a reception counter occupied by a receptionist responsible for greeting visitors and answering incoming phone calls.

Upon arriving at the second floor, elevator doors open onto a quiet, softly lit, 20 by 20 foot reception area. Office chairs with upholstered seats are placed around the periphery of the room. Armchairs are placed around a central coffee table displaying an assorted of health literature. A bilingual receptionist sits at a desk placed in one corner of this waiting space just outside a doorway leading to an interior corridor. This corridor contained yet another smaller waiting area, as well as offices belonging to some of the Center's chief administrators and mental health therapists.

The floors throughout this building are made up of highly polished vinyl tile and the walls are pastel colored neat and clean. In contrast to the general reception and waiting area of Building Old, visitors to this second floor of Building New always appeared to be recognized and approached immediately. Once notified, the providers I was there to see were usually out within minutes to greet me and take me back to their offices. Even after I obtained permission to observe within the medical clinic, which was located on the first floor of Building New, I never felt that it was acceptable to come to this second floor without an appointment or some kind of specific business. It was always quiet here. I rarely saw people in this area who looked as if they might have

been waiting for appointments or seeking some kind of care. The people I did see were professionally dressed male and female Center staff. With the exception of one female case worker, who wore a *hijab* and floor length tunic, these staff usually were dressed in western styled clothing. [7]The interior spaces of this second floor of Building New will be more fully described in Chapter 4 containing my accounts of my in-depth interactions with four mental health care providers who agreed to be formally interviewed. The context of the medical clinic setting where I spent time observing health care providers in the course of their care-giving will be described in Chapter 5.

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[7] I noticed that many of the Arab American female staff in this building wore western clothing and all were polished speakers. I also noticed that while many of the women in lower level positions who did outreach work wore veils, very few in administrative positions were *muhajabah*. This floor contained offices of Center administrators and program supervisors. As such, it may have been a place to receive "outsider visitors" and visiting dignitaries where first impressions were important. This second floor space of Building New offered a real contrast to Building Old, which was darker and physically older.

CHAPTER 3

METHODS

Guided by White's concept of emotive institution (EI), this study employed the ethnographic methods of observation and interviewing, along with collecting select text materials, to examine emotion meaning-making within the Center setting. The following sections describe some of the key initial influences contributing to my questions on emotion meaning-making, my access to the field site, my original plan for addressing my specific research questions, and the data collection adaptations made once in the field. Following these discussions, I examine EI in detail, illustrating how I operationalized it for use in data collection and data analysis.

Pre-study Influences

As discussed in the preceding prologue and context chapter, the ideas for this dissertation research began to take on more specific dimensions well before actual field work began. My involvement on the quantitative study of psychological adjustment among Arab immigrant mothers and their adolescent children helped to stimulate thinking about the ways in which emotions are assessed in research settings. Importantly, my project responsibilities increasingly brought about my contact with the Arab Community in which this research took place. During this period, while working on the Arab mothers and children adjustment study, I began to attend local conferences and cultural events that either took place in or drew attendees from the Arab community. Some of these events addressed specific health topics; others featured guest speakers with expertise on international politics and contemporary conflicts in the

Arab world. Some events involved critical analyses of the ways in which Arab peoples have been represented in literature, media and popular culture, and still other events included exhibits of artistic works by Arab artists from the United States and around the world. These events brought me into proximity with certain segments of the local Arab Community, including local scholars who were also doing research of interest to Arab populations. Interestingly, very important contacts turned out to be the Arab immigrant women I worked with on the mental health study of Arab immigrants. The personal relationships I formed with these women afforded me new insights and helped to clarify my questions around emotion as I contemplated designing this dissertation research. My relationships with these women also helped me in gaining access to the fieldsite.

Access to the Fieldsite

Issues of access to the Center fieldsite affected the order in which I was able to carry out the planned principal activities of this research, namely interviewing and observing Arab immigrant health care providers as they went about their work. As this order significantly influenced how I came to see the different ways in which various providers talked about emotion, it bears some description.

My original plan had been to begin my observations in an area of the Center where I could observe Arab immigrant mental health care providers and associated Center staff interacting with each other as they went about providing care. After becoming familiar with routines and establishing enough rapport with providers to be able to recruit them for interviews, I planned to begin the first of two formal interviews. The first interview would focus on aspects of provider and staff identity and work history.

Once I had spent more time in the field, I planned to conduct a second interview with the same providers, this time focusing on the topic of emotion and mental health assessment. Over time, I was to learn just how crucial establishing relationships of trust and connection were to doing research in this community. These connections, established slowly in a series of starts, stops and stages, ultimately determined the course of my data gathering activities.

As was required by my university's institutional review board, prior to beginning field work, I sought preliminary permission from the Center to conduct my study. I made a request to the Director, the person in charge of health research at the Center. I began by sending my study proposal containing: a full description of the goals and aims of the study; data collection strategies of interviewing and observation of Arab immigrant mental health care providers and Center staff; and a list of references, including local academics who had experience doing research in areas of mental health, as well as other issues of interest to Arab communities. In my letter of introduction I described how my association with these scholars had developed over the years as I became increasingly interested in intersections of culture, mental illness and of Arab culture. Within two weeks' time, I received an e-mail back from the Director's assistant saying the Center would be happy to assist me in my research and that I was to contact them when I had received approval from my university. Upon receiving university permission, I re-contacted this same administrator, taking care to re-introduce myself and my study. I told him I was ready to begin and I suggested we meet to talk about the study.

The next two months consisted of intermittent communication with the Center, most of which was conveyed second-hand through administrative assistants. Having a

sense that it would be important to be "invited in" I tried a different tack. I sent the Director a direct e-mail saying that I knew he had been away traveling overseas and that I hoped he was well and that his trip had been a productive one. I then mentioned that I was eager to begin my project. I asked if there was anything else he needed from me that might help to further explain the research. I then mentioned two of the women I had worked with on the mental health study of Arab immigrants who also worked at the Center, explaining how I had come to know them, that I had been in their homes and met their families and that they had been to my home and met my family. I suggested that if he had any questions about my character he could talk to these women who were my friends. I received a response back within the hour granting me permission to begin.

This invitation was to be the first of a number of, what I perceived at that time as, mysterious "openings" that occurred over the course of the fieldwork; places whereby I was granted further access to people and spaces within the Center. Sometimes, it was unclear to me as to what exactly brought about these "openings." It may have been a simple matter of time, persistence, or perhaps circumstances having little to do with me specifically. However, looking back, the more significant openings appear to me now to have come about as a result of my attention to more personal aspects of those with whom I interacted. There were places and people that never opened up to me. Out of 19 formal in-depth interviews, only four took place with males. Most of my observational time was spent with female staff, many of them mental health assistants with lesser education and lower status in the Center.

When I finally did obtain permission to begin, I was told by the Center's administration that due to their concern for patient/client confidentiality, I would not be

allowed to observe. I was given a list of five staff members I could contact for interviews and I was asked to confine interviews to one hour. While less than ideal, I accepted this plan, hoping I would establish enough rapport along the way to work out some place in which to observe.

I would describe this initial period of my research activity as probationary, exploratory and unpredictable. I began by interviewing the providers suggested to me, who mostly worked as supervisors of various mental health programs. From there, I cautiously began to identify additional providers to interview, always taking care to first obtain the permission of the Director. During this period, the pace of interviewing was slow. As I met with various staff located throughout the Center, whenever possible I would ask participants about the kinds of programs and activities taking place in the spaces I passed through. I also searched for ways to be seen and involved in the community. I began spending time in the surrounding neighborhood, patronizing local businesses, restaurants, cultural centers, and attending center-related events and activities. So while my progress on the inside of Center was halting at best, my activity in the wider community helped me to meet and talk with people. Through my interactions with them, I began to develop an appreciation for the range and scope of the Center's involvement in both its immediate suburban neighborhood, as well as the larger City proper.

Within the course of four and a half months, I was able to conduct 12 in-depth interviews, ten with providers who worked directly in mental health care settings. I also interviewed one mental health therapist who identified as being a member of a minority group present in Iraq. Although this therapist did not ethnically identify as being Arab, I

included him as a participant, because he was raised to adulthood in Iraq and spoke fluent Arabic.

Five months into the study, I revisited my first interview participant, a Yemeni American mental health therapist who had become a key informant. When asked if he had any thoughts on where and how I might be able to observe providers as they went about their work, he advised me to speak with a different Center administrator. When I explained that I had already tried contacting this specific administrator, a number of times without success, my key informant advised me to "Try, try again!" As I didn't think I had much to lose, I made a direct call to his office, and to my surprise, was able to schedule an appointment for the following day.

My appointment with this administrator was scheduled to take place in an area of the Center where many of my first mental health interview participants had their offices. While waiting for my appointment, I began talking with two of the receptionists with whom I had become familiar as a result of those earlier interviews. On hearing my voice, one of my previous interview participants came out from her office to say hello. The four of us were in the middle of an animated conversation when this second administrator entered the reception area. Mr. G., a middle-aged man of large physical stature and a presence to match, also an immigrant from an Arab majority country in North Africa, was smiling as he came upon the four of us talking and laughing. Emboldened by that smile, once in his office I placed my card on his desk and asked to be allowed to "sell myself" and my study. Mr. G. responded by saying, "Are we not all selling ourselves every day?"

I soon found myself telling Mr. G. the story of my life, this time beginning with my family. As I described, for my very good listener, my experiences of crossing-culture, both personally and professionally, I also talked about what I thought I had learned as a nurse about the experience of illness. An hour later, after a lively exchange of life experiences, again both personal and professional, arrangements had been made for me to begin observing in the medical clinic of the Center. As Mr. G. and I crossed the parking lot to meet the chief medical doctor of the clinic, two of the women I had worked with on the mental health study of Arab immigrant mothers and children saw me and waved. As they called out my name, I felt welcomed for the first time. Around for a little over five months, I had finally been "invited in."

Having described the context of the study setting and the circumstances influencing my access to interview participants and the observational setting of the Clinic, the following section more fully unpacks White's theoretical framework of EI. Here, I describe how I operationalize EI for use in the specific setting of the Center.

EI Operationalized

In Chapter 1, I provided theoretical background from the disciplines of anthropology and psychology on the topics of emotion, discourse and identity, all key components of EI. I also gave historical background on the patterns of Arab immigration to the United States, along with the mention of specific ethnographic work on Arab communities. In the following sections, I explain how I link up these theoretical, historical and ethnographic works to operationalize EI for use in the specific fieldsite of the Center. In the fieldsite, EI was used to provide: 1) more focused direction in determining basic content of in-depth interviews with providers, and 2) guidance in

determining where to look and what to look for once in the position to observe the practices, routines and social interactions occurring among providers. Before describing how I used EI to inform the ethnographic methods used in this study, I further scrutinize White's explanation of his concept in order to more fully unpack its meaning.

White defines emotive institution (EI) as being composed of "culturally constituted activities" containing patterns of social interaction, identities and everyday ways of talking about emotion; it is through the intersection of these factors that meaning is thought to be assigned to emotion and it is also here that meanings are potentially redefined and transformed (White 2005). **Figure 1** below is my schematic rendering of White's definition for EI.

Figure 1: Emotive Institution
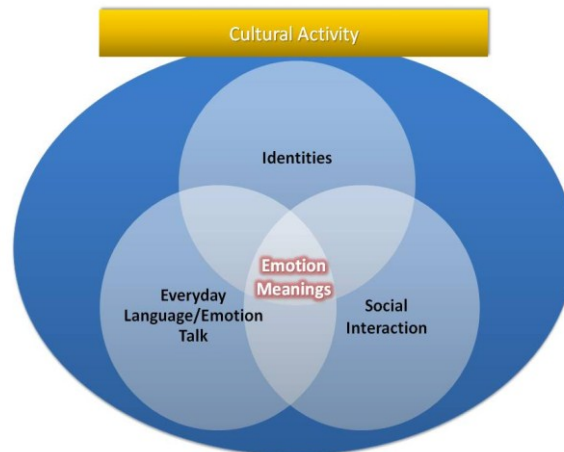
White describes EI as being an interpretive framework that focuses in on the social contexts of emotional experience. Thus, social interactions, their properties, their contexts and the kinds of activities that take place within them, become a primary focus

of this study.[8] White also points out that a key aspect of the EI framework is how it may be used to focus in on "patterned contexts of emotional experience" (White 2005:242). Let me discuss this further.

White describes "culturally constituted activities", (CCAs), a chief component of EI, as containing both identities and discourses engaged in social interaction. White explains how the "mutually constitutive" relationship between identity and emotion results in a "fixing" or "framing" that becomes integral to how emotions are expressed and transformed (2005: 247). White also refers to how discourse on emotion takes place within CCAs that are "recurrent" (2005: 247).Within these recurrent activities are both discourses on emotion and identities engaged in social interaction.

In keeping with the above described components of the EI framework, White uses the categories listed below as a guide for analysis. He states that while these categories are not meant to be seen as set features, they may be used to systematically identify the CCAs present within social interactions, and the relationship between the identities and discourse on emotion contained within them.

- <u>Culturally Constituted Activities (CCAs):</u> Cultural activities at play or in evidence in the interaction. [9]

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[8] As social interaction is such a key element in the EI framework, it was necessary to discuss in some detail my entry into the field as well as subsequent interactions that influenced the data collection process.

[9] "Interactions" take place within broader, more over-arching culturally constituted activities (e.g., biomedicine, biomedical model of disease; discourse of patriarchy and resultant notions of gender roles). I begin with social interactions first because it is through the observation of real human beings in interaction that we are able to identify the broader cultural activity in which these interactions reside. Social interactions result from over-arching culturally constituted activities and also work to further constitute them. Likewise the way in which emotion is discussed is both a product of these same activities, and a constituting or contesting act.

- <u>Temporal Event Structure:</u> The time period within which the interaction took place.

- <u>Spatial Location:</u> The physical location, or space, in which the interaction takes place.

- <u>Focal Emotions</u>: The emotions or explanations for emotion present or referred to.

- <u>Key Identities and Relations:</u> The various "identities" in evidence in the scene and their relationship to each other.

- <u>Specific Communication Practices:</u> The language practices or discourse on emotion present in the scene. Broader definitions of discourse also apply here. (White 2005: 248).

According to White, these categories may be used to identify the ways in which identities and discourse on emotion are "fixed" or "framed" that may then help to reveal aspects of emotional experience (i.e., emotion meaning-making) in a given interaction, or in broader contexts involving larger groups or communities (White 2005: 247). In the following section, I describe how I first practiced using EI and White's suggested categories in the analysis of my interactions with Fatima, first described in the prologue.

A Return to Fatima

In the description of my encounter with Fatima and our different explanations for emotion, hers involving a source of Islamic law and the heart, I left off with these questions. Given Fatima's biomedical training in the United States, how does she manage to simultaneously hold such seemingly different explanations for emotion and what was it about our interaction that brought these different explanations for emotion forth or called them out? Using the analytic strategy outlined in the previous section

above, I now apply White's categories to my interaction with Fatima. I begin, by trying to identify the "culturally constituted activities," or CCAs, present in our interaction. I then muse over how aspects of our identities, our way of interacting and our discourse are involved or implicated in our explanations for emotion.

Culturally Constituted Activities (CCAs):

The religion of Islam, western psychiatric classificatory systems for mental disorder and biomedicine are three CCAs in evidence in our interaction. The scientific research interview itself is another, with one party, the researcher, asking questions, and the other party, the researched, answering questions. The mutually agreed upon decision to conduct the interview within the intimate setting of a coffee house over coffee and cigarettes reflects perhaps another CCA relating to how such topics are to be discussed between colleagues and friends.

Temporal Event Structure

Our interaction took place over a five hour time span. The first two hours involved our travel to the coffee shop and our informal discussion of our work and our own ideas of women's mental health issues. During this portion of our interaction, we both referred to our observations, gained over the span of our years of experience as health care providers. The remainder of the time was spent talking about a range of topics, beginning with Fatima's ideas for research on emotion and then extending to more personal topics.

Spatial Location

Our interaction started at a public library in the Arab Community. In deciding to move to the coffee house, also within the Arab community, the first phase of our interaction took place in the personal space of Fatima's car. In this space, with Fatima driving, we discussed aspects of our own work as health care providers and our ideas concerning depression. Once arriving at the coffee shop, the remainder of our interaction, which included the formal activities of the research study and the subsequent discussion of Fatima's ideas for research on emotion, took place at a corner table, chosen because it appeared to offer the most privacy. When we arrived at the coffee shop, the place was all but empty. As the afternoon progressed more customers were present.

Focal Emotions

Sadness among women was discussed in the context of a discussion of our work settings at the outset of our meeting. A range of emotion adjectives related to the mood states of anxiety, depression, anger, vigor, fatigue and confusion were initiated by me and explored in the formal activities of the sorting of emotion adjectives and in the questions contained in the in-depth open ended interview. Fatima initiated a discussion concerning the emotion of love. In Fatima's explanation, she identified the heart as being the site or place within the body responsible for the regulation and expression of love as compared to the brain which she stated oversaw the rest of the emotions.

Key Identities and Relations

Identities present in our interaction where those of a researcher and research participant. We were both female, professionals, health care providers, coworkers and

American citizens. Fatima was an immigrant to the United States. I was a natural born citizen. Both of us were raised in monotheistic faith traditions. Fatima described herself as Muslim and as being an involved member of her faith community. She also described having close ties with her family who were also living in the United States.

Specific Communication Practices

Communication practices involved an initial, informal conversation between friends and work colleagues around the topic of depression in women. Within the specific research activities, the sorting of emotion adjectives and the in-depth interview on mood states, the primary reason for our meeting, a question and response format was initiated by me, with me directing and introducing western categories and terms for emotion. Fatima's responses to my questions contained similar terms for emotion, along with repeated references to western psychiatric classifications for mental disorder. As Fatima began her explanation for her own idea for research on emotion, she first cited what she identified as being a *hadith,* a report on the words or deeds attributed to the Prophet Mohammed and one source of Islamic law. My use of western psychiatric terminology, as well as Fatima's reference to a source of Islamic law, might both be considered as forms of discourse having to do with power in the sense that, through their use, these discourses potentially work to further (re)produce and constitute "the social identities and relations from which people speak and feel" (White, 2005: 247).

<u>Using EI to Understand Our Interaction</u>

Fatima and I had been talking for hours by the time she told me about her idea for research on emotion. Between coffee, cigarettes, and a range of topics, there had been very few lags in the conversation. It was not until later that night when I was

writing up field notes, that it occurred to me that when Fatima was telling me about her ideas for research on emotion, her use of western psychiatric terminology, so prevalent in the earlier discussions of our work and in Fatima's responses to the questions in the formal semi-structured interview, was completely absent. In Fatima's telling of her idea for research, not only was her language different, our roles were different. I was no longer leading, no longer posing questions drawn from the constructs being assessed for in the survey instrument on mood, and in no longer leading, different forms of discourse entered into our conversation. By taking the lead and presenting her own ideas based on her experience and expertise, how had Fatima assumed a role that differed from her initial role as research participant? Once outside this initial role how did other aspects of her identity become more pronounced, perhaps leading to other explanations for emotion?

A quick examination of Fatima's and my explanations for emotion reveals the presence of two powerful, overarching discourses, that of western biomedicine and Islam. We may reasonably wonder if the presence of these two discourses in Fatima's explanation for emotion is evidence of her biomedical training and her identity as an Arab immigrant who is Muslim.[10] Fatima's identity as a Muslim was in evidence throughout our meeting that day, such as her wearing a *hijab* and her use of certain phrases referencing Allah or the Prophet Mohammed (present though not in evidence in my field note). However, it was when she began to describe her own idea for research

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[10] It is important to recognize that Fatima's references to Islam might more accurately reflect her experience of Islam in the United States (Howell, 2000). If her experience of Islam comes from her current American context, one may ask whether her identity as a Muslim is more accurately an aspect of her being American.

on emotion that her identification with Islam became more fully revealed. As she lays the foundation for her own ideas for research, she draws first and foremost on Prophet Muhammad's saying about the heart. In her explanation, she articulates an understanding of anatomy and physiology acknowledged by western science and biomedicine, but, at this point in our interaction, it is the "heart" of Prophet Muhammad's saying that is used to explain emotion. Furthermore, this heart appears to possess an intrinsic character that, although initially evidenced in the behavior of the donor, may continue to be observed in the behavior of the heart recipient.

References to the heart are plentiful in cross cultural studies of illness (El-Islam 2002; Good,Delvecchio Good and Moradi 1985; Racy 1980). While many studies point to a greater prevalence of somatization in non western cultures as compared to western cultures (Kleinman and Kleinman 1985; Sayed 2003), others claim that clinicians not belonging to a patient's same cultural group often misinterpret metaphorical expressions for somatic complaints (e.g., Pang 1998). As Fatima's idea involved investigating the personal lives of actual heart transplant donors and recipients, her explanation did not strike me as metaphorical. However, the fact that the circumstances in which she would explore her ideas about emotion involve such physical realities does not mean that metaphor is not somehow involved.

In an explanation of the effectiveness of using metaphor therapy for the treatment of emotional illness in Muslim Arab patients, Marwan Dwairy, a psychologist with three decades of mental health counseling experience in Israel/Palestine, describes a form of reasoning and problem solving called *"qiyas"* (Dwairy 2006:18). Q*iyas* is a method whereby a new or contemporary problem is measured by a former

one that has been solved or addressed by the *Quran* or *Sunna*, the *Quran* containing the word of God as revealed to Muhammad, the *Sunna* containing the customary practices of Islam (Esposito, 1982:7). Dwairy has found the use of *qiyas* by Arab Muslims, along with a frequent use of proverbs, to result in special attunement to metaphor as a way of gaining insight (Dwairy 2006:9). Although Fatima's earlier discussion of biology, genetics and societal issues as causal factors for depression are explanations that fall well within the realm of western natural and social sciences, this last explanation for emotion, the explanation which was expressed *after* the formal interview had been officially concluded, is markedly different. Given the above, it seems plausible that she may draw on metaphor, not only as a culturally familiar discursive device, but as a method of reasoning that, in the context of her ideas for research, either pre-empts or is on par with western science.

The above description of my encounter with Fatima contains my reactions, my thoughts and my conjectures, stemming from one, poignant and profound, interaction with a colleague and friend around the topic of emotion. In applying the EI framework to my description of our interaction, my intent is to illustrate how the EI framework can be used to help sort or tease-out elements contributing to the ways in which emotion gets discussed within social interaction, and as a way to begin to think about the many factors contributing to emotion meaning making. I now move to a discussion of how EI was then operationalized for the broader context of the field setting of the Center.

Use of EI in the Center Setting

Given White's definition, I will be looking for the reoccurring CCA's present in the everyday practices, routines and social interactions associated with the process of arriving at mental health diagnoses at the Center site. These are the social interactions of interest. I attempt to identify various aspects of providers' identities and the discourse on emotion present in my interaction with them (e.g., in the case of interviews), and in their interactions with others in the course of their work (e.g., in the case of observations). I will be looking for instances where identities and discourse appear to be fixed or framed together within these social interactions of interest, as well as for evidence of how changing identities and changing social contexts may result in new such fixings and framings. This search is accomplished by an iterative and recursive tacking back and forth between the social interactions, identities and discourse on emotion contained within the CCAs identified in key excerpts taken from my interviews with and observations of providers.

In operationalizing the EI framework for use in the Center, I next present a schematic representation (**Figure 2)** of the three principal domains making up EI, social interaction, identity and everyday emotion talk, and the various sub domains identified as being significant for this particular setting. I then provide a description of where, and how, I look for these domains, and the methods I use for identifying them.

Figure 2: EI Operationalized for the Study Setting
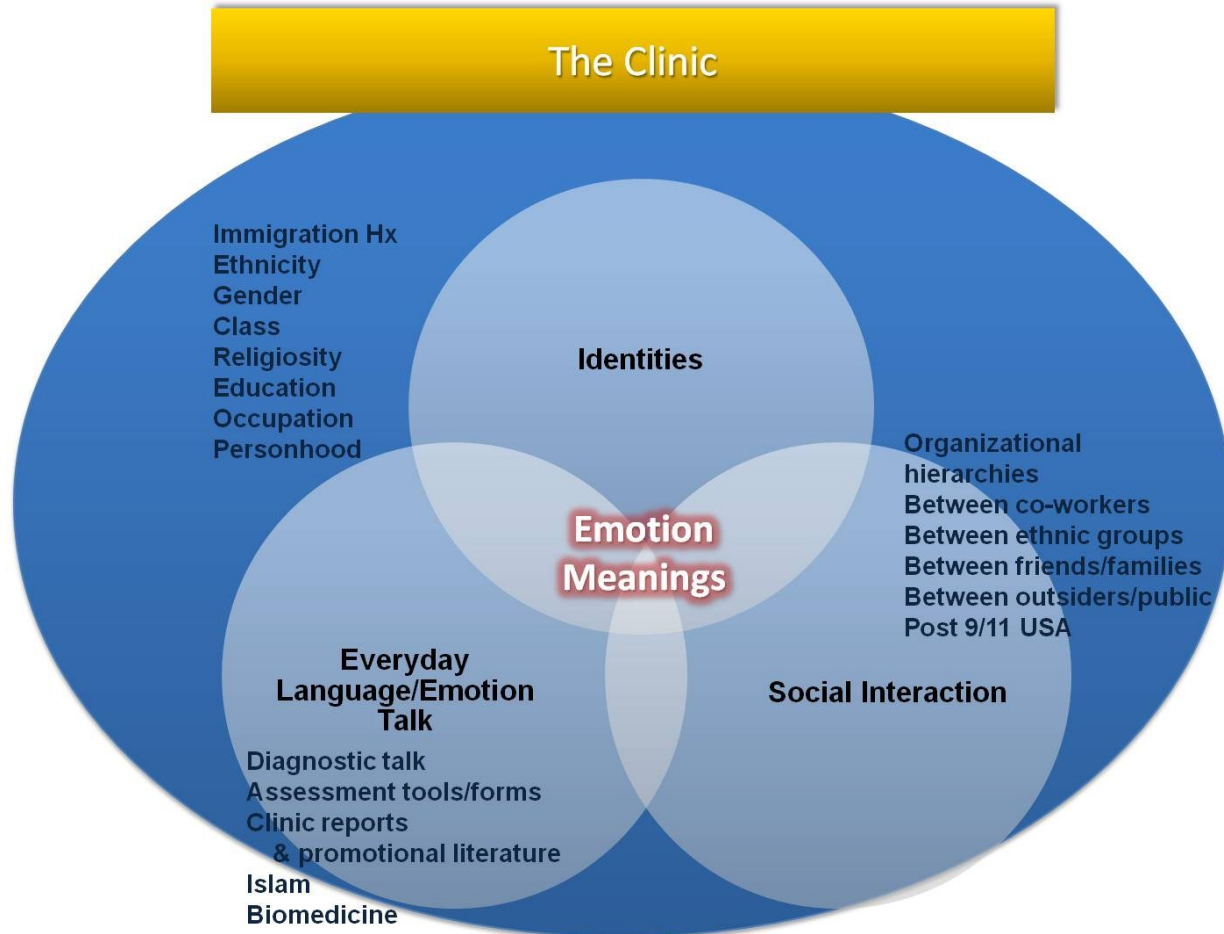
The top yellow bar entitled "Clinic" is intended to represent the CCA's present in the activities and routines of providers at the Center. Placed underneath are the three domains of social interaction, identity and everyday ways of talking about emotion, or discourse on emotion. Below these three primary research domains are listed various sub-domains, drawn from the literatures referred to in Chapter 1. The sub-domains listed under Social Interaction were initially informed from the following sources: various literatures in medical anthropology, my own experiences as a health care consumer in

biomedical settings; and from my experience as a nurse who has worked in a variety of health care settings in the United States. In the sections below, I discuss in more detail these three primary research domains and their related sub-domains (See Appendix A**).**

Patterns of Social Interaction

Patterns of social interaction, which in the Center setting involve the everyday practices and routines of providers, were identified through interviews when participants were asked to describe their work, as well as through observations of providers in action as they went about their normal work routines. The social interactions identified within these practices and routines took place among administrators, providers and related staff, both within formal work routines, as well in less formal interactions inside and outside of work. Interactions between providers and staff were observed in the Clinic with a focus placed primarily on the interactions between providers around care-giving, as opposed to one-on-one therapeutic interactions in private exam rooms. Social interactions between Center staff and the public at large were also observed in Center sponsored activities outside the work place, which took place within the larger Community and were open to the public.

Identity

Questions pertaining to the key research domain of identity, and many of its sub-domains, were primarily drawn from anthropological literature on identity. Specific works on personhood referred to in Chapter 1 (Dumont 1965; Geertz 1984; Fortes 1987; Mauss 1938) prompted questions aimed at eliciting providers' own "ideas of selfhood" (Geertz 1984), or on their "subjective" perspectives of how they saw themselves (Fortes

1987). A short survey containing demographic questions (Appendix B**)** administered to participants prior to a formal audio recorded interview asked providers questions related to gender, ethnicity, religion, job titles and occupation, degrees and credentials held, Arabic fluency and educational background and ethnicity. Less direct "experience-near" (Geertz 1984) instantiations of personhood were also looked within the formal and informal language taking place between participants as they interacted in the course of work routines. Here, language, captured in field notes, was examined for participants' sense of their roles and their capacities within those roles.

More "experience distant" instantiations of personhood, in the way of "symbolic forms, words, images, institutions, behaviors" (Geertz 1984), or what Fortes refers to as the "objective" perspective of personhood (Fortes 1987), the "distinctive qualities, capacities and roles with which society endows a person" (Fortes 1987:251), was looked for in the language captured in interview text and observational field notes. Comments reflecting notions of proper behaviors and attitudes, the opinions of others, the use of plural pronouns such as "you" signaling a proclamation or directive, or some element of righteousness, such as "you must" or "you ought" (Nydegger, 1986: page) were noted. The identification of cultural norms was also looked for in comments appearing to offer explanations for deviations from usual or expected behavior. Again, evidence of personhood was looked for in both in-depth interview responses as well as in the communicative practices found in observational settings.

In addition to cultural forms of identity, other aspects of identity (e.g., class, gender, immigration history, religiosity, education and occupation) were identified in ethnographic work on Arab communities in general (Abu-Lughod 1986; Joseph 1999)

and in Arab immigrant communities located in the United States and Canada specifically (Ajrouch 2004; Aswad 1996; Joseph 1999; Naber 2006(a); Saroub 2005; Shryock and Abraham 2000). In utilizing the "experience-oriented" approach to identity put forward by Mattingly et al. (2008) described in Chapter 1, these sub-domains were thought to be of particular relevance for the Center setting.

Aspects of an interview participant's immigration history were addressed in the Demographic Questions (Appendix B). As stated earlier, my original plan had been to conduct two interviews, one focusing on aspects of immigration history and professional training and current job, the second on emotion and specific cases. Due to time constraints placed on initial interviews by the Center's Director, and the lack of opportunity to first establish some kind of rapport with interview participants, a decision was made to first focus on aspects of the professional training and work. Although I did not explicitly ask for an immigrant provider's specific immigration history, all providers who were immigrants interestingly started their descriptions of how they came to their current positions with some kind of story about their immigration experience.

The identity sub-domains of ethnicity, gender, religiosity and aspects of immigration history were also tapped by Demographic Questions (Appendix B) asking for a participant's country of birth, date they left their country of birth and the date they arrived in United States , as well as gender, ethnic background primary language spoken at home and religion. These sub-domains were not formally asked about in the interview, but were explored through the use of probes where appropriate. Class was assessed indirectly through questions listed in the Demographic Questions asking

participants to describe job titles and occupation, degrees and credentials held, Arabic fluency, educational background and ethnicity.

As was discussed in Chapter 2 describing the field site context, the most prominent ethnic groups making up this particular Arab Community included those of Lebanese, Iraqi and Yemeni descent. Although, class is a multi-factorial designation, these three groups, occupied distinctly different places within the social hierarchy of the larger Arab Community. Those of Lebanese descent most often occupied the top tier of the hierarchy with Iraqi refugees arriving after the Iraq Wars of 1990-91 and Yemeni immigrants occupying lower social status (Shryock and Lin 2009). Explicit and implicit assignments of social status to various Arab immigrant groups by providers were looked for in formal interviews and observational notes of informal conversations taking place among providers.

<u>Everyday Emotion Talk or Discourse on Emotion</u>

Emotion talk or discourse on emotion was looked for in the everyday communicative practices occurring within social interactions of providers as they went about their work routines. Observational field notes were used to describe more formal communicative practices involved in maintaining patient-flow and care-giving routines, such as discussions of the daily schedule, the status of supplies, the location and movement of records, assessment of staffing needs, and discussions around types of visits scheduled for patients. These communication practices took place among front-desk receptionists and patients, front-desk receptionists and CMAs, who were primarily responsible for escorting and moving patients through the routines of a visit, between

CMAs, Clinic doctors and nurses, and other departments, such as the lab and pharmacy, and staff associated with the refugee and adolescent health programs.

Another type of everyday communicative practice listened for were the informal conversations that took place among staff within the same contexts of care-giving. In addition to discussions about work, these informal communications often included the personal narratives and stories of staff on topics of identity, work, family, and current events of interest locally and internationally Communication practices in the form of text -were also found in the clinic's official promotional literature, public annual reports, an online newsletter, specific program literature, teaching materials and various health assessment surveys.

Given Ewing's description of how immigrants' encounters with discursive practices in the medical clinic potentially contribute to "new articulations of emotional experience and identity formation", I needed to initially consider what hegemonic practices could be present in the Center setting. Evidence for biomedical discourse was looked for in providers' and staffs' explanations for emotion and common problems seen in clients, both in in-depth interviews and observational notes. Evidence of the discourse of Islam was looked for in formal and informal conversations with participants on the topics of identity (i.e.; religiosity, gender) and mental health assessment activity. Refer to Appendix A for narrative description.

This operationalized EI framework was then used as a guide in constructing formal interview questions and in deciding where to initially begin to observe in the Center setting.

Data Collection

A total of nineteen in-depth, open-ended and audio-recorded interviews were conducted with Center providers (see Appendix C "Identity and Emotion Interview). All interview and observational participants were consented per one of two IRB approved consents, one requesting interviews only, the other requesting permission to observe with the possibility of a formal interview. Initial interview participants were first identified and then contacted by the Director via email, on which I was cc'd. This email explained that I was conducting research and that I would be contacting these providers individually with a request for an interview. On contacting them, after explaining the study, they were informed that they could decline privately and that their declining would be kept confidential. [11]These first participants began to identify other staff they thought I might be interested in talking with. Upon receiving permission from the Director I began a second tier of interviewing using a convenience sampling strategy of participants who worked within mental health areas of the Center.

In the observational setting of the Clinic, I was first introduced by the medical clinic's supervisor at a staff meeting. After explaining the study, I passed out consents and asked staff to place their signed consents in an envelope. I explained that those not interested in participating in the study simply did not have to fill out the consent, thereby ensuring confidentiality. Over the course of the study one staff member directly

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[11] In the 19 formal interviews I was able to conduct with staff at the Center setting as a whole, participants all had some exposure to the concept of research. Familiarity ranged from a basic understanding of research as a way to learn about something or someone, to participants having had specific roles on research projects, including proposal design and data collection.

approached for participation passively declined participation by not returning a signed consent. This staff member has been exempted from observational field notes.

The following table 1 below lists out the principal data sources of this research.

Table 1: Data Sources

Ethnographic Data	19 in-depth, open-ended interviews (audio recorded) with providers
	Observational field notes (15mths)
	8 months of Clinic observations and informal interviews with providers and staff
	Center sponsored meetings (staff in-services), lectures, awards programs and programs and volunteer events
	Center events (i.e., Arab festival, Arab American Museum programs
Text Source Data	Center promotional literature and online publications
	Formal assessment tools, i.e., intake, admission, psych surveys
	News media: local national, international
	Historical documents

Prior to the in-depth interview, participants were asked to complete a demographic questionnaire (See Appendix B), in which they were asked to identify their current job title and employment status, as well as being asked for their age, gender, marital status, ethnic background, religion, primary language spoken at home, fluency in Arabic, education background, professional degrees and credentials and, if appropriate,

their country of origin and date of arrival in the US. **Table 2** provides a summary of demographic information gained from the 19 interview participants.

Table 2: Demographic Characteristics of Interview Participants

Mental Health Provider (N=9)		Medical Clinic Provider (N=10)	
Education		**Education**	
High School	0	High School	3
Some College	0	Some College	3
BA	3	BA	3
MA	4	MA	1
MPH	0	MPH	0
PhD	1	PhD	0
JD	1	JD	0
Occupation		**Occupation**	
Health Educator	1	Medical Assistant	3
Case Worker	2	Nurse	1
Therapist	5	Health Program Coordinator	4
Attorney	1	Facility Coordinator	1
		Custom Services Rep	1

Country of Origin: Iraq (3) Lebanon (10), Yemen (3), US (3 - first gen Lebanese

Religion: 15 Muslim / 2 Christian / 2 not specified

Gender: 15 female/4 male

Years in USA: 9-35 years

Methods for Data Analysis

Data analysis involved the triangulation of data obtained from the three primary data sources: in-depth, open-ended, audio-recorded interviews; observational field

notes; and text sources. Audio recorded interviews and all field notes were transcribed and closely reviewed multiple times. Interview transcripts and transcribed field notes were formatted into WORD documents and imported into the qualitative software program Atlas.ti6. Twelve separate archival documents consisting of Center operational intake forms, basic health assessment surveys and Center promotional literature were scanned and also imported into Atlas.ti6. A combination of deductive or closed codes (codes based on the research domains adapted from the EI framework) and inductive or open codes (those codes based on additional domains or themes present in the data) were applied to all documents.

Round #1 of coding, coded for identity (including sub-domains) and any mention of emotion (two of the three principal research domains identified in the EI framework). Round #2 consisted of a further refinement of coded sections containing "experience distant" or "objective" instantiations of personhood and references made to collective and individualistically organized societies. At this point, I also identified specific contexts or interactions containing what I deemed to be significantly rich discussions on emotion. These interactions included those within the context of in-depth interviews with participants (highlighting aspects of my interaction with a participant, as well as participants' references to interactions in the past, outside the interview context). Other interactions described were ones I observed within the Clinic setting, both those where I was an active participant in the interaction, as well as those interactions in which I observed from a distance. Descriptive accounts of these interactions were then written out, with attention being given to the circumstances in which the interactions came

about, and to the identification of key excerpts illustrating aspects of identity and definitions for emotion.

Analysis involved a recursive and iterative process of moving back and forth between key excerpts taken from interviews and observational field notes, the EI categories, and additional sources of data from the field. The following two chapters contain findings representing broader patterns of emotion meaning and experience found to be present in the field setting. In Chapter 4, I present findings from my interviews with mental health care providers.

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SECTION III: FINDINGS

CHAPTER 4

INTERVIEWS WITH MENTAL HEALTH PROVIDERS

Emotive institution (EI) helps us to ask "how, when, where, by whom, and toward what culturally defined end emotions are enacted" (White 2005: 248). In doing so, the EI framework helps to reveal the ways that identities and discourses on emotion become fixed or framed within recurring culturally constituted activities (CCAs) that then lead to patterned contexts of emotional experience. In this chapter, I examine in depth how, when, where, and by whom emotions were enacted in the course of my interactions with four providers who each worked in a different mental health program at the Center.

The interactions examined here all took place within the context of formal research interviews[12]. For each interaction, I begin by giving a portrait of each participant provider, and a description of the context in which my interaction with them took place. I then present key interview excerpts highlighting the ways in which participants tell their stories, their perspectives, and their sense-making of my questions related to the topics of identity and emotion. I then use the categories of EI in order to identify the CCAs, the identities and the discourse on emotion present in these excerpts and their relationship to each other. I then speculate on the culturally-defined ends present in participants' responses.

Interview Interaction I

A Yemeni Arab American Therapist

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[12] See Appendix B: Demographic Questions and Appendix C: Identity and Emotion Interview

The love to help, it was there. I wanted to help those who are really paralyzed. They don't have anywhere to go. (Nasser: Int#1, 8-24-09)

Nasser is a middle-aged Yemeni Arab American male who emigrated from Yemen to the United States in his early 20s. He has worked as a therapist at the Center for two decades, focusing on the mental health needs of adults and families.

Nasser was the first person I interviewed. After receiving a recommendation from the Center Director, I sent Nasser a letter introducing myself and laying out the goals of the study. I also described my background, explaining how my experience as a nurse and my two years of living in Yemen had led to my interest in cross-cultural studies of health and illness. After two weeks I called Nasser directly at his office. He answered and, once I told him who I was, he mentioned having received my letter and that he was from Yemen. From that point on our phone conversation was all about Yemen. Nasser wanted to know where I had lived, what I had been doing, and my overall impression of the people and the country. A good twenty minutes later we set up an in-person interview appointment for the following week. Thus began the first of three animated sessions in which we talked about life in Yemen, life in the United States, the experience of immigration, mental illness, and emotion.

On the day of our scheduled interview, Nasser, a small-statured, professionally dressed man with graying temples, came out to meet me in the reception area for clients receiving services from one of three mental health programs housed in this part of the Center. As we made our way to his office, we passed through a large room containing at least eight small work cubicles. I was to later find out that these cubicles

were occupied by case workers and other staff whose jobs revolved around meeting a diverse range of needs of mental health clients, the majority of who were Arab immigrants and refugees. These staff helped their clients negotiate the most basic aspects of living in the United States, such as finding food and shelter, interpreting utility bills, and translating communications with school systems, health care institutions, and, sometimes, local court systems.

Once in Nasser's office we immediately returned to our discussion of Yemen. Looking over a desk covered with stacks of folders, client charts, and other papers, Nasser told me that he had originally come from a village near one of the major cities in the southern portion of what was once formally recognized as North Yemen. Having traveled through this part of country, I was able to visualize small, stone villages built up high overlooking wide expanses of steeply-terraced mountainsides. As Nasser spoke of his childhood, he began to tell me of how he had come to be interested in a career in mental health. He talked about the explanations for mental illness still prevalent in Yemen, some involving malicious or evil spirits known as *jinns* or *shatans*, and of how, while growing up in Yemen and in his travels to other countries in the Arab world, he had frequently witnessed the "dehumanizing" ways in which the mentally ill were treated. As Nasser spoke, I found myself thinking of people I had noticed while living in Hodeidah (Yemen's principal port city on the Red Sea) who seemed to live in the streets and appeared to be mentally ill. I thought about the man I would encounter on my daily route home from the hospital where I worked. Emaciated and in rags he would be lying in the middle of a major street, baking in the extreme, mid-afternoon heat, seemingly oblivious to the surrounding traffic. He would always raise his head to look when I

passed by, and I remembered wondering what he might be thinking and who was more out of place, me or him. As Nasser and I continued to reminisce about our experiences in Yemen, so open and free flowing was our conversation that before I turned on my recorder for the official interview Nasser had already described the circumstances of his arrival to the United States and what had led to his interest in psychology and his choice to pursue a career as a mental health therapist.

Arriving in the mid-1970s, in the second major wave of Arab immigrants to the United States (described in Chapter 1), Nasser joined his father who had come some years earlier. Like many other Yemeni immigrants who came to the United States in the 1960s and 1970s, Nasser's father arrived alone (having heard that it was not safe to bring families, especially wives) to work in a factory in the City where the Center is located. Nasser spoke of arriving in the United States just before the onset of an exceptionally snowy and cold Midwest winter. Nasser told me that in addition to his shock over the harsh climate, he found life with his father to be equally hard. Nasser described his then-self as a young man eager to experience life. He recounted how this desire to experience and actively participate in American life frequently led to arguments with his father who had very strict ideas of what he should be doing and with whom. As a result, after completing a yearlong English language program, Nasser set off with friends to California. Once there, he spent the next year and a half picking grapes with other immigrants and migrant workers, some from Mexico and others from Yemen like himself. Nasser spoke of this time as being one in which he experienced grueling, physical labor and profound loneliness. After repeated urging from his cousin who was a psychiatrist, Nasser eventually returned to his father and took classes at a community

college. Over the next decade Nasser pursued his education, moving from one educational institution to another. He described how he was always involved with and increasingly drawn to helping other new immigrants from Yemen during that period in his life. Nasser described how at one point he had considered getting a degree in social work but instead decided on psychology, saying that in order to help other immigrants like himself he needed to "go deep."

Experience and Emotion and Clients from Overseas

As we started into the formal interview, well before getting to any specific questions concerning emotion, Nasser spontaneously began to talk about the relationship of emotion to experience. Having already told me about his early days in the United States and of his experience as a farm worker, alone and away from the support of family, Nasser revisited this difficult time in his life. In the excerpt below, Nasser explains how this earlier time led to his being able to "feel that pain" with others.

> From my point of view, my opinion…experience created emotion… When you see somebody with the same experience, once an experience you went to, you feel that pain. It becomes an emotional issue…
>
> …I mean you put yourself working, picking grapes and you remember…and the treatment from the people and the hard, hard work. And you say to yourself what is it? And you see there is no kindness, there is no remorse. You find people just everybody for himself and you come from a country where you work collectively and, and they share and if you have an issue or a problem everybody is going to be around you…And I said…that's…you go to those emotions, you cry sometimes, you know? (Nasser, Int#1, 8-24-09)

Through this emotionally powerful account, Nasser shows how the difficult times he experienced as a new immigrant are relived when seeing his clients. He states, "You feel that pain," the pain of his Arab immigrant clients. Nasser went on to be more specific about the cause of this remembered and felt pain, describing how he was treated by the people he worked with, where everyone was for themselves. Nasser contrasts this way of treating others with where he came from, a place where "you work collectively," where people share, and where, if one has a problem, everyone gathers around. While Nasser was to later give me other explanations for emotion and mental disorder, many referencing Western psychiatric categories and diagnoses, this explanation was his first definition or way of talking about emotion within our interview.

Somewhat later in the same interview session, in response to my asking Nasser to talk about some of the more common problems he sees in his practice, Nasser described the conditions he saw as contributing to the depression experienced by his immigrant clients.

> Well in adults… most of the clients I see typical depression…there are lots of things behind it especially in our days because of economic condition, most of those really lost their jobs and they have families, and also within depression comes also adjustment. Because it is mixed depression, it is the…whole package you see. Is not like say you see you are done today. (Nasser, Int#1, 8-24-09)

In this excerpt, Nasser describes his clients' encounter with the recession that the United States was in at the time of the interview (a recession that hit the City and the inhabitants of the region of the Center setting especially hard), their experience of lost jobs and increased pressure to support families. On top of these more commonly

experienced sources of stress, Nasser also mentions that his clients experienced adjustment issues, exacerbated by the experience of immigration. By Nasser saying it "is not like say, you see you are done today", Nasser indicates that the depression experienced by his clients, in particular, is complex and enduring, requiring time to treat.

As Nasser went on to talk about what was required in treating his Arab immigrant clients, he began to talk about the differences between what his "European" or "American" clients might need and expect from a therapeutic interaction and what might be needed for his clients "from overseas."

> Say….European client, American client comes… 'Tell me your name…what is your license, what degree and this is my problem, one, two, three. Can you help me?' But if you are dealing with someone from overseas, English language is not there, doesn't know nothing about the law, he has adjustment issues, depression resulted from moving from area to area, economic and you are dealing with trust. He looks at you like, 'Oh.' First session, second, third fourth, He is just measuring you. When he feels…trust is there, he opens up. That's how we are. (Nasser, Int#1, 8-24-09)

Here, Nasser explains how, given the circumstances of his immigrant clients, more time may be needed to develop the trust necessary for a productive therapeutic interaction. However, by comparing "American" clients to clients from "overseas" and by saying "That's how *we* are", Nasser intimates that, apart from more immediate circumstances related to the experience of immigration, there are different requirements for therapeutic interactions depending on who his clients are.

Relevant EI Categories

In this section I interpret the above interview excerpts through the lens of the EI framework, using the categories suggested by White (explained in Chapter 3).

Culturally Constituted Activities (CCAs):

In this first interaction, Nasser and I meet for the purpose of a formal research interview. As the research interviewer, I pose questions of my construction with the assumption that these questions will elicit information or data that may be mined for some kind of meaning. As the interviewee, Nasser responds by indicating a familiarity with the conduct of a formal research interview, in and of itself one example of a CCA. References to Western biomedicine as another CCA can be seen in Nasser's use of Western psychiatric nomenclature as in "typical" and "mixed depression," and "adjustment" issues. These terms can be found in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder-V* (DSM-V 2013) under the section entitled "Mood Disorders." [13]

In the above excerpts, the first containing an explanation for emotion, the second Nasser's description of the depression he sees in his clients, and the third an explanation of what his clients might consider necessary for a successful therapeutic interaction, Nasser first situates all explanations within some kind of social context. He then goes on to explicitly comment on the differences he sees in the ways in which individuals, including himself, are actually treated and expected to be treated by those around them. In Nasser's explanation of what he means by emotion being related to experience, he again refers to his difficult days as a new immigrant picking grapes in

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[13] The DSM contains criteria for the classification of mental disorders and is widely used in the US and around the world by clinicians, researchers, health insurance companies and pharmaceutical companies and regulation and policy making agencies.

California. Here, he contrasts a more individualistically oriented place (the United States), where everybody is "for himself", with the more "collectively" organized society of his homeland, where people "share" and "work collectively." In the second two excerpts, he contrasts the different needs of his American clients with his clients "from overseas." When Nasser says, "When he feels…trust is there…he opens up…That's how we are," he is saying that not only is trust something that takes time but something best established within or through relationships. Credentials are not enough. What is more, he is saying that both he and his "overseas" clients require social interaction in order to establish trust because of "who" they are.

The emphasis Nasser places on aspects of social attunement was seen throughout our interview. In my use of the term *social attunement*, here and throughout, I use it to refer to an array of social arrangements, activities, and behaviors through which individuals come to fit, share, or reach accord with one another. Here, I argue that Nasser's emphasis on social attunement may be related to a definition of personhood in which the needs of the group take precedence over the needs of the individual. Given this definition of personhood, activities promoting group cohesiveness or social attunement may be highly valued. As will be illustrated in subsequent case studies of my interactions with providers across the Center setting, in the context of discussions about emotions and emotional trouble, this culturally particular definition for the status of personhood is both an aspect of identity and a CCA. As a CCA, in providers' recurrent enactment of their personhood status (as seen here in my interaction with Nasser, as well as Nasser's description of clients' interactions with therapists), one can see how identities (persons) and ways of talking about emotion (talk emphasizing social

attunement) become fixed or framed. Personhood as an aspect of identity will be discussed in more detail under the "Key Identities and Relations" category below.

Temporal Event Structure

The above excerpts resulted from the first of two interview sessions with Nasser, each lasting about an hour and a half. These excerpts also contain references to other kinds of time, including personal biographical time, social time, the relationship of past time to present time, and different understandings of therapeutic time. To begin, our initial session resulted from a twenty-minute phone conversation in which I introduced the study, and more importantly, Nasser and I discovered our connection to Yemen. Once discovering this connection, a large part of our unrecorded introductory time was spent describing for each other our memories of Yemen. In a sense, the remainder of our interaction was affected by our first reliving for each other personal past time.

In the section above I describe how Nasser locates emotional experience as occurring within social interaction. In his description of these social interactions he also refers to different kinds of time. As Nasser responds to my questions about how he arrived at his present work, he refers to personal biographical time by describing his past, beginning with his childhood, his life as a much younger man, his description of one very hard and socially lonely time in California, then moving on to the time during which he pursued his education, then realizing his goal of becoming a psychologist. In his first explanation for emotion, Nasser talks about emotion as being related to past experience, "once an experience you went to." According to this definition for emotion, one's present experience of emotion is always connected to some past time. Nasser

illustrates this reference to past time by describing how his past difficult experience of picking grapes allows him to now understand his clients. In addition to past time, Nasser also refers to present time in his description of some of the factors contributing to his clients' experience of depression. In saying "especially in our days", Nasser refers to a broader, yet different sense of time as in the nation's "economic" times. In describing what his immigrant clients require in therapeutic encounters, Nasser explains how the uncovering of problems does not occur quickly as in "this is my problem, one, two, three…" nor are problems resolved quickly. Rather, essential trust is not likely to be established in the "first session, second, third, fourth…", but over time.

Spatial Location

As previously described (in Chapter 2), the offices of the mental health providers I interviewed, places or spaces where intake assessments and therapy were conducted, were located well within interior realms of both buildings with receptionists monitoring client and visitor traffic. These interior therapeutic spaces may reflect the Center's consideration for clients who may be stigmatized in seeking treatment for their mental illness. As a therapist, Nasser had a private office. This private space reflects Nasser's status as a more senior therapist, as well as a secure space in which to ensure client confidentiality. References to place were seen, as has been mentioned, in the way Nasser situated his discussions of emotion within the space of social interaction and in how he used place to describe emotions themselves. In referring to experience as creating emotion, Nasser describes experience, emotions, as a place he "went" to. Nasser also implicitly uses place in contrasting his experience of American life with the life he knew at home. In describing his clients' experience of depression he also uses

place in describing how his clients, in "moving from area to area," had been uprooted from "home" spaces.

Key Identities and Relations

Some key aspects of identity and experience present in Nasser's and my interaction were shared. As health clinicians trained in the United States, our formal training and practice has taken place primarily within clinical settings organized according to Western, biomedical understandings of illness and disease. Along with our training we were exposed to ideas of what it means to maintain professional membership in line with the orientations of biomedicine.

Another significant shared experience, albeit in vastly different degrees and ways, was Nasser's and my experience of Yemen, Nasser's home country. Our shared knowledge of Yemen gave us immediate common ground from which to begin our interview. My ability to honestly describe my time living in Yemen as life-changing in a positive way may have contributed significantly to the inclusion of the more personal topics touched on in this interview. I can only imagine what it may have meant to this provider to talk with someone who had positive memories of his native homeland, a country only recently known to most Americans, and frequently portrayed in the media as a place hostile to American interests. This common ground may have also helped to mitigate other differences in aspects of our identities that we did not share, such as

gender, ethnicity, religious background, and most significantly, that of our current roles as researcher and researched. [14]

Aspects of Nasser's identity as an immigrant can be seen in his account of his experiences as a new arrival to the United States, particularly in his description of the time in which he labored as a farm worker picking grapes. However, on a more implicit level, in Nasser's description of this time and of his reaction to the way he and others were treated in California, his statements reveal his experience of different requirements for the status of personhood. Again, as described in Chapter 1, personhood is a socially negotiated aspect of identity, entailing a society's understandings and laws regarding how individuals are represented and treated. A society's concept of personhood will also determine the extent to which individuals are autonomous from, or dependent on, the group. In his statement, "You find people, just everybody for himself and you come from a country where you work collectively and…they share and if you have an issue or a problem everybody is going to be around you", Nasser not only notes that the ways individuals are connected to the group in the United States differ from his home country of Yemen, he reveals his preference for the way individuals *should* be connected to the group.

Nasser alludes to similar kinds of differences in definitions for the status of personhood when he compares his American clients to his clients "from overseas." In Nasser's view, the American clients rely more on professional credentials as a way of

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[14] Nasser and I also had key personal experiences in common that were revealed through the course of the interview conversation, but not presented here through quotes. At younger ages we both had maturing experiences in "foreign" cultural contexts far removed from familiar homelands, their trappings and ways of being. In time I came to see Nasser as a key informant, and I drew on him for advice on how to best proceed with my research at the Center.

knowing or judging competency and perhaps less so on any personal knowledge of or relationship with therapists. In contrast, the "overseas" clients require time, time in which, through social proximity, they come to know or trust a therapist. Also implicit in this expectation is that the therapists themselves must show evidence of their own social attunement.

Nasser's emphasis on the importance of social attunement in understanding the problems of his clients is conveyed in the way he uses his own experience in first defining and talking about emotion. He says, "When you see somebody with the same experience, once an experience you went to, you feel that pain. It becomes an emotional issue…" For Nasser, his ability to be empathetic is evidence of his own social attunement with his clients. This empathy not only gives him credibility as a mental health care provider, it may also be a highly valued, even essential characteristic as a general member or person in his community. I would eventually find this emphasis on empathy to occupy a central place in participants' descriptions of their routes to their chosen vocations. The mention of empathic behavior was also frequently present in participants' initial ways of talking about or defining emotion.

Specific Communicative Practices

In my interactions with Nasser, both before and after our recorded interview sessions, a very fluid back and forth exchange of personal storytelling took place. Our discussion often included talk about Yemen and topics related to the experience of crossing culture…his crossing and at times mine. Again, Nasser's use of personal,

biographical material gave increased credibility to his position as empathetic therapist. He emphasized that he was able to "feel that pain."

Nasser's description of the kinds of mental health problems he encounters with his clients includes the use of Western psychiatric terminology and again the use of contrasts to describe the particular circumstances and needs of his immigrant clients. Standard DSM-V terms like "mixed depression" and "adjustment" were used in response to my questions concerning specific mental health problems. In describing what "mixed depression" means for his immigrant clients, Nasser states that one needs to consider "the whole package," the economy, and adjustment issues, and he describes how the problems of his clients are ones that cannot be fixed quickly, "like say, 'You are done today.'" Implicit in Nasser's statement is not just that the sources for depression in his immigrant clients are complex, but that the ways in which these clients and their problems must be approached are, out of necessity, different, requiring more time in which to develop trust.. For these clients, in particular, time is required. In making this contrast, Nasser shows that he is aware that his immigrant clients have a different understanding of the relationship of the individual to the group and that these understandings will influence the direction and effectiveness of therapeutic encounters.

Rational Thoughts, Anger, and Shame

We continued our interview in a second session one week later. At this meeting, I brought Nasser a book about Yemen written in Arabic. After spending some time translating some of the picture captions and shorter passages for me, we returned to the second half of the interview. In my first question of this session, I asked Nasser to

define emotion. He responded by describing emotion as a "feeling." I then asked him what he meant by "feeling."

> Feeling… is really connected to experience too…Now if I see somebody, he has similar…I…emotion is going to be unfold. I would have that emotion because nobody feels the pain of this person except me because of my experience, because I have been there… (Nasser, Int#1, 8-24-09)

Although Nasser does not explain exactly what he means by "feeling," he does connect it to experience in the same way that he connected experience to emotion. As an example, he refers again to painful experiences, emphasizing his ability to understand because he has "been there."

> Nasser went on to define emotion as being a "reaction to action."

> So emotion can also be conscious or unconscious. Emotion can also be … actually, it is a reaction to action…It could be that I am walking on the street sometimes and somebody gives me that bad look…now I have to react to that…see…it will be emotionally involved...for example…why are they giving me that bad look? Is it because of my color, the clothes – the clothes I am wearing? On the other hand if something good, I am going to be so excited, that the emotion is going to take me there. (Nasser, Int#1, 8-24-09)

In these explanations of "feeling" and emotion as a "reaction to action," Nasser again situates his definition for emotion within a social context. His mention of receiving "that bad look" because of "color" or "clothes" give us glimpses into his own experience, possibly as an immigrant, around issues of identity, belonging, and discrimination, some aspects of which may have been painful to him. As he said earlier, he has "been there."

Up to this point in the interview, Nasser talks about emotions as being related to "experience" and "feelings" and as "reactions to action." In the following explanation for emotion he makes a distinction between being "emotional" and using "rational thoughts." "Rational thoughts" are "positive" whereas "emotional thinking" can lead to loss of control and potentially to conflict.

> We have to differentiate. Always I tell my clients, "Think, be rational, before you jump to the conclusion and become emotional…you have to use, you know rational thoughts, be positive, positive thoughts…For example… if somebody comes and says 'You know your colleague says something about you.' Well, if I am not going to use my rational thinking I am going to jump, I am going to become so emotional. I'm going there and start arguing and engage with that person… Rational thinking can also avoid lots of problems, avoid conflicts. (Nasser, Int#1, 8-24-09)

Mention of "conflict" was to come up at other places within the interview. During the course of the interview, Nasser cited religion as contributing to conflict. Again, in referring to the problems of adjustment encountered by his immigrant clients, Nasser draws on his own experience of discrimination following September 11, 2001.

> It's adjustment. I mean how people are actually looking at you and evaluating you, especially after September 11 and from that until today, I mean I can tell, I mean when I go somewhere I can tell, people who used to be friendly, they are not friendly anymore. (Nasser, Int#1, 8-24-09)

Following our discussion of Nasser's explanations for emotion, I asked Nasser if he would describe an encounter in which some aspect of emotion had been particularly memorable. In the last excerpt of this section, Nasser describes his interaction with a young man who had come to him for court-ordered anger management counseling.

Nasser explained that his client had struck his father in an argument which led to profound feelings of shame on the part of both client and father, and to severely altered relationships within his client's larger extended family.

> He was angry and then he felt sorry… I mean the relationship between him and his father is not like it was before, because the damage was already done. I mean they go out and they talk but you can feel that the father is ashamed and also his son is ashamed… because in our culture, "Your son is doing this to you? Your son did that to you?" is really a shameful situation. (Nasser, Int#1, 8-24-09)

As Nasser told this story, especially in saying, "…because in our culture, 'Your son is doing this to you? Your son did that to you?' is really a shameful situation…", his voice became soft and low and his face took on an expression of incredulity.

<u>Relevant EI Categories</u>

Focal Emotions

Later in the interview Nasser mentions the emotions of anger, regret, and shame. Nasser's story of the father and son argument followed shortly after Nasser associated "rational thinking" with "positive thoughts" and being "emotional" as potentially leading to conflict, possibly anger. Similar to the way in which Nasser would illustrate his different explanations for emotion by situating them within some kind of social interaction, his description of one of the more memorable emotions displayed by a client, that of shame, revealed the extent to which shame is socially experienced in the Arab immigrant community. In the case of the father and son argument, the experience of shame went beyond the father and son to affect the family, the larger community, and

judging from Nasser's demeanor in retelling the story, potentially, the son's therapist.

Key Identities and Relations

In Nasser's definitions for emotion, as "feeling" connected to "experience" and then as "reaction[s] to action," his mention of the "bad look" and "my color," may allude to his experience as an immigrant in the United States. These experiences give Nasser the ability to feel the pain of his clients. He has, "been there." Again, these experiences also place him in the position of being able to be a health care provider and therapist who can empathize.

Nasser's distinction between using "rational thinking" versus becoming emotional seems to place emphasis on the regulation of anger and avoidance of conflict altogether. One explanation for this emphasis may be found in the ways persons are defined within Nasser's experience of the Arab community of his childhood in Yemen as well as his Arab immigrant community in the United States. Again, Nasser's status as a person within these communities may demand that more attention be given to group goals rather than individual ones. While expressed anger may be regarded as acceptable in many societies, it may also be seen as evidence of a lack of maturity or self-control (Abu-Lughod 1985, 1986; Caton 1990:29-32).

In Chapter 1, I mention how first generation Muslim immigrants were able to use NGOs to normalize being Muslim in Islamophobic environments and to enact citizenship and belonging in ways that counter "stigmatized identities" (Laird and Cage 2010:225). In Louise Cainkar's treatment of the social construction of Arabs in the United States, she writes of how Arabs have been characterized as "oppressive, dictatorial and

irrational" (Cainkar 2009:85). She also describes how mainstream American media has portrayed the Arab world as being "a cauldron, chaotic and unstable, containing cities teeming with people driven by emotions" (Cainkar 2009:86). In describing the problems of his clients related to adjustment, Nasser related how his own experiences in adjusting to life in the United States extend to the present day. "It's adjustment. I mean how people are actually looking at you and evaluating you, especially after September 11." In light of this comment and the literatures described above, Nasser's discourse on rational thinking and control of conflict may, in part, reflect a concern to project himself as a "rational" citizen.

Summary

Within the context of my interactions with Nasser around the conduct of a formal interview, I used the categories of EI to reveal recurrent CCAs, and the ways that the identities and discourse on emotion contained within them may be fixed and framed. I discussed the presence of two CCAs, one being Nasser's use of Western biomedical classification for describing the mental health problems of his clients. The second and the most prominent CCA in evidence was a culturally particular definition for the status of personhood emphasizing the group. This CCA was present in most interactions with providers across both settings and will be discussed further in other case studies.

The category of "temporal event structure" reveals how Nasser uses experiences in his past and present to not only show who he is, but who his clients are, as they are the primary focus of his work as a mental health therapist. In Nasser's explanations for emotion, he moves about in time revealing how "identities" are the result of social structure and culture, made up of past and present personal experiences and

relationships, involving solitary journeys and exploration, arguments between fathers and sons, hardship resulting from economic times, and the experience of Arab Americans as citizens in the United States.

As social interaction and "proximal zones of everyday experience" (White 2005:242) are, according to the EI framework, places where emotion meanings are assigned and transformed, the category of "spatial location" helps to locate the emotional experiences Nasser speaks of beyond the immediate context of his office. Nasser places his discourse on emotion within some kind of social context. These social contexts take place in therapists' offices, among families, in his and his clients' experiences of moving from place to place, in grape vineyards, in places far from places thought of as home.

Using the categories of EI to interpret Nasser's sense making of my questions on emotion the following themes were noted: (1) Explanations for emotion were socially situated. In describing for me his definitions for emotion, whether it involved "experience" (Nasser's first spontaneous explanation) or "feeling" or a "reaction to action," all are explained by being placed within some kind of social interaction or context. In locating emotions within social contexts, Nasser draws on personal biographical accounts through which he reveals past experience in his native Yemen, his experience of being an new immigrant in the United States, as well as his more current experience of being a citizen and a mental health care provider; (2) Nasser places emphasis on empathy, one mode of inter-subjectivity, in explaining his work and in defining emotion. Nasser's attention to social context and his use of empathy reflect an emphasis given to aspects of social attunement that may be related to a culturally

particular definition for the status of personhood emphasizing the group; (3) Requirements for successful therapeutic interactions with Arab immigrant clients may vary, in part because of these same requirements for the status of personhood in which aspects of social attunement are highly valued.

Interview Interaction II

A Lebanese Arab American Counselor

> In terms of emotionally speaking they are very fearful, you know they are angry, they are hurt, they got a lot of feelings, the expression of worthlessness, helplessness, hopelessness and so that's where we start our work with them. (Aisha, Int #2: 8-24-09)

Aisha worked within a program designed to assist victims of crime. Our first two interactions were related to our formal interview, and a third interaction took place some weeks later at a fundraiser aimed at raising public awareness of domestic violence. I established contact with Aisha in much the same way as I did with Nasser, first through e-mail, then letter, then direct phone call. Although I had sent Aisha a letter explaining the study, she never received it, so our initial phone conversation included a discussion of the purpose of the study. Aisha told me that the issues faced by her particular clients frequently involved intense emotions and that she would be open to discussing her work. As we set up an appointment I told her I would e-mail the study's consent forms along with the sheet of demographic questions as a way of providing another explanation of the study before we met for the in-depth interview.

On the morning of our scheduled interview, I checked in with the receptionist on the second floor of Building New and sat in the very quiet and the very empty reception

area located just outside the Director's office. Within minutes, Aisha, an attractive woman in her thirties, professionally dressed in fashion-forward Western-style clothing, came out to greet me. With a warm smile she extended her hand in formal greeting, introduced herself, and welcomed me to the Center. Aisha then took me back to a modest, neat office located off a long narrow corridor. In her office was an L-shaped desk, on top of which sat a computer monitor and keyboard, as well as a number of framed pictures of children of various ages. Two comfortable chairs were located on the visitor side of the desk. A large file cabinet was positioned against the wall off to the side of the desk. In contrast to Nasser's paper-laden desk, the only papers on top of Aisha's desk were the filled-out consent forms and demographic questions I had sent to her the week before our meeting.

On scanning Aisha's demographic information I discovered that she had come to the United States from Lebanon at the age of one and that she identified as Muslim and Arab. In telling me about how she had come to her current work, Aisha explained that she completed her graduate education in mental health counseling after she was married while having children. Aisha spoke of how a graduate school internship experience working as a victims advocate in the local court system eventually led her to her current job as a therapist working with victims of crime. Aisha told me that 70 percent of the clients served by her program were victims of domestic violence. Aisha explained that not all victims of crime required mental health services, but when they were called for, she and another staff member in the same program were qualified to perform psychological assessments and conduct therapy.

Biomedicine Replicated in Discourse on Emotion and "Tools"

The quote placed at the beginning of this section and repeated here is part of Aisha's response to my asking her to comment on a typical day. After describing the general screening process that her clients go through, many of whom are victims of domestic violence, she said:

> In terms of emotionally speaking, they are very fearful, you know, they are angry, they are hurt, they got a lot of feelings, the expression of worthlessness, helplessness, hopelessness. And so that's where we start our work with them. (Aisha, Int #2: 8-24-09)

In response to me asking Aisha to describe the different ways she assessed the emotional status of her clients, Aisha described forms used by her department, as well as others throughout the Center, to assess various health problems, including those specifically associated with immigration and acculturation. Aisha then told me of how, after considerable effort, she had recently managed to acquire funds from the local county mental health division to purchase "assessment tools" to do cognitive and personality testing with her clients. As she told me about these tools, Aisha went over to her file cabinet and carefully pulled out a number of unopened shrink-wrapped packs of paper forms. Among them was an assortment of cognitive tests for children and adults, personality inventories, and psychological assessment tools for depression and anxiety.[15] Her expression and voice conveying a sense of great pride and a victory won, Aisha explained that these surveys were needed as she and her staff were frequently called on to testify in court on behalf of their clients. She said:

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[15] Among these surveys were Beck's anxiety and depression inventories, Bender-Gestalt Test, WISC 4 for children and WAIS-3 for adults (both cognitive tests), and Toni-3 and TAT.

"They really want some scientific evidence…You know, to collect the data…I felt it was needed in my program. I really set forth that this was needed in my program and I wanted to help clients too so that they can better understand kinda what's going on. You know, when you have a tool, you can say come on down let me tell you what I found through this testing. And for us as professionals to ensure that the diagnosis is right and that we are right on target with helping them. I just feel it's very important. So this has been a long time thing in the program and I just got the equipment recently." (Aisha, Int #2: 8-24-09)

Relevant EI Categories

Culturally Constituted Activities (CCAs)

A key CCA present in the above excerpts is biomedicine. References to biomedicine as an overarching cultural system can be found in Aisha's reference to Western psychiatric classifications of mental disorder as a way of describing the emotions of her clients. As has been mentioned in Chapter 1, Western psychiatric classifications, such as are found in the DSM-V, have been linked to a definition of personhood emphasizing individuality and autonomy (Gaines 1992; Rose 1990).

Focal Emotions

During our first conversation over the phone, Aisha told me that her work involved dealing with intense emotions. Aisha mentions fear and anger as well as "worthlessness, helplessness, hopelessness" to describe the feelings of many of her clients. These emotion terms are discussed in more depth later in "Specific Communication Practices."

Key Identities and Relations

The social identities present in Aisha's and my interview interaction include our shared identities as American citizens, our identities as U.S.-trained, health care providers, and our identities as women. Having immigrated to the United States from Lebanon at the age of one, Aisha has spent her whole life in the United States. Again, as noted above, it has been argued that a Western definition of personhood, as a cultural aspect of identity, informs Western psychiatric classifications of mental disorder upon which psychological assessment tools are based.

Specific Communicative Practices

Aisha's use of the terms "worthlessness," "helplessness," and hopelessness," references specific language found in the DSM-V and in the language of psychological instruments assessing depression and anxiety. In subsequent formal and informal interviews with other providers, I heard these same terms to describe affective states involving extreme or prolonged sadness. For example, when Nasser contrasted how "American" clients and clients from "overseas" might behave in initial counseling sessions, he said the following as a way of describing what "American" clients might say. "Okay, look. This is what I have. I am depressed. I have depressive moods, loneliness, sadness, hopelessness." (Nasser, Int#1, 8-24-09). In this instance, Nasser uses these terms to illustrate for me how familiar many of his "American" clients are with the technical language of psychology and at the same time how much a part of American popular lexicon these terms are. In doing so, Nasser's example also serves to situate him as an American in that same context.

In a similar way, Aisha's use of these terms also places her in an American context, the result of her having lived most of her life in the United States. Her use of these terms may be part of an acquired professional discourse taken from her mental health training, a discourse she may assume I share as a health care professional. These terms may also be seen as one example of how emotion terms function as a form of social practice that produces "realities" and "truths" (Lutz 1982; Abu-Lughod and Lutz 1990), or as White says, "relations of power" that define "the social identities and relations from which people speak and feel" (2005). In Aisha's use of these terms, biomedical descriptions and definitions are reproduced and applied to the feelings of individuals, regardless of whether these individuals have the same understanding of identity as persons or explanations for sadness. In these ways, these terms can be seen to define the ways that people "speak and feel."

We may also see evidence of what White means when he talks about identities and discourses on emotion becoming "fixed" or "framed" within reoccurring CCAs. In this case, the CCAs of biomedicine or Western psychiatric classifications of mental disorder and a culturally particular understanding of personhood are linked to the repeated use of the terms as a way of classifying sadness or as a way to talk about depression. This "fixing and framing" may result in new emotion meaning for both immigrant health care providers and their clients.

Aisha's pride over her newly acquired psychological tools indicates that she views them as legitimate and valid methods for providing proof of one's state of mind and as a way of describing and documenting problems. According to Aisha, the assessments garnered from these tools will not only guide treatment, they may be used

to facilitate advocacy within U.S. legal systems, especially in circumstances involving domestic violence. However, again, the tools Aisha mentions having recently acquired were all initially designed and tested within Western contexts. As these tools will be used with Arab immigrant clients who may come from cultural contexts with different explanations for emotion and mental disorder, one may question whether the use of these instruments will function as a valid measure of their emotional status.

In the above excerpts we find evidence that Western biomedical terminology and Western psychiatric classificatory language is used by providers, including Aisha, who are concerned with finding the best ways to care for a diverse but mostly Arab immigrant client population. We also see in this discourse, examples of how biomedical explanations for mental disorder, based on Western conceptualizations of personhood, are replicated and perpetuated. While these terms and tools are part of the care-giving practices at the Center, just how these terms and assessment tools actually map onto clients' suffering (and their understandings of what is taking place) may be quite different. The next two excerpts illustrate the complexity of applying discourse based on the definitions of personhood in one culturally particular setting, to another.

Conflict in the Parking Lot: Identities and Discourse between Cultures

I began this account with an excerpt in which Aisha describes some of the emotions that her clients, as victims of crime, experience. The following excerpt was part of Aisha's response to me asking her to define emotion:

> Emotion is tied to a number of things, thoughts and behavior, I mean it's connected to a number of things…It has to do with a person's background, their culture, their education level, I mean, how you tie emotions to day-to-day things really has to go to each person individually, because I think

everyone defines it a little differently…So in working with our clients I really try to understand where the client is coming from. Not that basic emotion like I'm looking at that person and they're really sad, or whatever feelings they are having at that moment, but rather *why* are they having these feelings, *why* do they feel the way that they feel. (Aisha, Int #2: 8-24-09)

In this explanation for emotion, Aisha emphasizes the need to see persons as individuals who not only react because of "basic emotion" but also because of "a number of things," "a person's background," "education," "day-to-day things." She went on to talk about the importance of looking beyond her client's basic emotions, to think about "why…they feel the way that they feel", or to question what is it beyond themselves that contributes to how they are feeling. Aisha then began to relate her definition of emotion to the problem of domestic violence. Aisha discussed how in order to understand domestic violence in the Arab community one also needed to understand all the ties, "the religion, the culture, their upbringings."

At my prompting, Aisha relayed an interaction she had with a client in which the emotions the client expressed were particularly memorable. She began to talk about this client whom she described as being severely abused, "physically, emotionally, verbally… guns to the head" abused, and for eight years her husband "would isolate her". Aisha explained how her client had been brought to the Center by a neighbor and how, after much effort, Aisha had been able to secure safe space for her client in a shelter. Aisha went on to describe a day when this client came to the Center with a family member. On her way back to work after lunch, Aisha discovered her client surrounded by a cluster of family members in the Center's parking lot. Aisha described how members of her client's family began to verbally attack both Aisha and her client

and about how, since she was bound by confidentiality rules protecting her client's private or personal health information, she had only been able to talk with select family members. Wanting information, members of her client's family, in Aisha's words, "went berserk." As Aisha went on to describe this interaction, her verbal expressions were emphatic.

> So we couldn't talk to the family, of course, and she did not want the sister to be a part , but she did agree to let her husband come upstairs so that they could meet and discuss this, but the family attacked us outside…verbally attacked. 'You guys are ruining our home. What are you guys doing? We're taking care of this etc…' She (Aisha's client) had signed consent for us to talk to him. (Aisha, Int #2: 8-24-09)

Relevant EI Categories

Culturally Constituted Activities (CCAs)

Biomedicine as one CCA is again evident in Aisha's explanation of the need to get beyond a "basic emotion" like sadness to discover why her clients feel the way they feel. In her use of the term "basic," Aisha draws on a biomedical explanation for emotion where the source or reason may vary, but not so much the "feeling" or even the expression. However, Aisha's attention to context, such as "background" and "their culture," places her definition within a distinctly social frame. According to Aisha, it is in these contexts that one must look for the source and meaning of her clients' emotions.

Another CCA, in the form of culturally particular definitions for the status of personhood, is present in Aisha's description of the parking lot conflict. As previously mentioned in Chapter 1 and in the discussion of my interaction with Nasser, the ways in which identity in the form of personhood is socially negotiated are related to the relationship of the individual to the group (Fortes, 1987:250). Aisha's emphasis on

individual feelings and her reference to U.S. federal health regulations protecting the privacy of personal health information, known as the Health Insurance Portability and Accountability Act (HIPPA),[16] may be viewed as evidence of the influence of a definition for personhood emphasizing rights of individuals. Aisha's reference to "religion," "culture" and "upbringings" and her description of her client's family's reaction, "you guys are ruining our home…we are taking care of this," may indicate the presence of a different conceptualization of personhood, one in which the needs and the integrity of the family or group determine appropriate action, less so the rights and needs of individuals (Kulwicki et. al. 2010:729).

Key Identities and Relations

Aisha is a Western-trained mental health therapist who, with the exception of her first year of life, has spent the whole of her life in the United States. As an Arab American close to the experience of immigration, she may have simultaneous membership in two kinds of societies, the more collectively organized society of her country of origin, her family and the Arab American immigrant community, and the more individual-oriented societies of her professional group and of American society as a whole. The clients and families referred to in the above excerpts may also have memberships in differently organized groups. While the conflict present in Aisha's and her client's encounter with family in the parking lot may have been due to a very real threat of violence, a more implicit, but equally significant, explanation for the conflict

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[16] Here, I refer to the US Department of Health and Social Services Privacy Rule known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") which addresses the use and disclosure of individuals' "protected health information" (U.S. Dept. of Health and Social Services 2013)

may be attributed to the presence of different criteria for personhood status which determines the rights and responsibilities accorded individuals by their societies. In Aisha's discourse on emotions and in her description of the problems of her clients we see similar conflicts.

Specific Communicative Practices

Aisha's choice of language in her first definition for emotion employs an understanding of emotions and persons that appears more Western in character. This explanation for emotion is not surprising as Aisha has spent most of her life and received her mental health training in the United States. However, in talking about the emotions of her clients, she states that in order to really understand these emotions and how domestic violence unfolds within the Arab Community one has to situate the problem within the context in which it resides, one involving "religion" and "culture" and "upbringings." One wonders if by this explanation Aisha is explicitly acknowledging that the ways in which her Arab immigrant clients are situated in relationship to their communities are different from those of her clients who are American-born. In one setting with me, she may employ discourse on emotion that is separate from any kind of social context, based on a more idiocentric or Western way of defining personhood. However, when explaining the problem of domestic violence as it occurs in the social contexts of her Arab immigrant clients, as the identities and ways of relating cannot be assumed to be the same, one might expect to hear discourse on emotion that reflects that complexity.

In both of the above excerpts, understandings of personhood, as one aspect of identity, are mixed. While Aisha's description of the emotional conflict in the parking lot illustrates the very real threat of domestic violence to an individual's sense of mental and physical safety, in her description of the conflict, one sees a literal knot of conflicting ideas about the place of individuals, rules of engagement, identities and language. In describing how she "couldn't talk to the family" and of how her client had "signed consent for us to talk to him", Aisha references U.S. legal protections regarding rights to keep private personal health information. Her mention of these rules emphasizes a more Western or individualistic view of her client as an individual who has rights that may supersede those of her group, her community, even her family. Aisha's attempt to comply with health information regulations regarding privacy comes into direct conflict with a different understanding of the rights and the place of individuals, as evidenced by the family saying "We are taking care of this." On one hand, Aisha talks about how in order to understand how people feel and why, you have to understand the ties connected to the "religion, the culture, their upbringings." On the other hand, this "connectedness" is not taken into account in the implementation of HIPAA rules and regulations which effectively remove the "individual" from the community. One may wonder how the difficulties of dealing with domestic violence are further exacerbated when attempts are made to remove individuals from the very places from which they derive so much of their identity.

The various identities highlighted above (i.e., Western-trained biomedical mental health care provider, and cultural forms of identity, as in personhood) may also be viewed for how they are related to discourse and certain relations of power. Aisha's

references to biomedical explanations for emotion, and then her way of talking about the problem of domestic violence, in the words of Abu-Lughod and Lutz, all work in some way to produce and constitute "the realities in which we live and the truths with which we work" (1990:10) Another significant social form of identity present in the above two excerpts has to do with gender. The majority of Aisha's clients who are victims of domestic violence are female. Females in patriarchal societies, such as those found in the Middle East, are expected to defer to male authority (Aswad 1996; Kulwichi et al. 2010). Aisha's own complex experience as an Arab American female was to be more fully revealed later in our interaction.

The following section details my next two encounters with Aisha in which her own personal experience with domestic violence and power takes center stage.

Claiming Expertise and Asserting Authority through the Rhetoric of Domestic Violence

Two weeks after our original meeting, Aisha agreed to meet with me a second time so that I could clarify some of her responses and ask a few more questions. A few minutes late for our meeting, Aisha apologized, saying that her day had been a hard one. Aisha explained that the special circumstances and needs of her clients often resulted in her having an unpredictable schedule. As she began to talk in more detail about the problems associated with domestic violence, Aisha revealed that she herself had been a victim of domestic violence. At this point, Aisha became tearful. As she spoke about the difficulty of getting her family to understand the conditions of her marriage, how domestic violence had affected her children, and of the lack of support

from Islamic religious authorities, Aisha's tone became flat, her facial expression blank, and her gaze seemed to be directed towards some place beyond the room we were in. We remained in Aisha's office that day for well over an hour. During this time I took no notes nor did I audio-record our conversation.

Less than a month later I was to interact with Aisha again at a Center-sponsored fundraiser designed to raise awareness of domestic violence as a public health issue. The fundraiser took place at a large banquet center in the Community. A number of Center staff, some of whom were now familiar to me, were checking people in and handing out programs inside the main entrance when Aisha came into the reception area, dressed in a long evening gown. In greeting, Aisha kissed me on both cheeks and brought me into the main banquet room. Glancing about the room, I noticed tables closest to the center stage were already filled, most occupied by important dignitaries and guests of honor. Other tables were marked by table cards on which could be seen the names of well-known local health care corporations and businesses. At the start of the formal program there must have been over 300 people in attendance.

Once seated, I looked over the printed program outlining the events of the evening. In addition to the names of several local politicians, judges, health care administrators, and leaders in the Arab community, I also noticed that Aisha was listed on the program as a speaker. When it came time for her to speak, Aisha began by listing out some descriptive statistics illustrating the scope and character of domestic violence. She then began to describe her own personal experience with domestic violence. At the conclusion of her portion, she received a standing applause from the audience.

<u>Relevant EI Categories</u>

Key Identities and Relations & Specific Communicative Practices

Aisha's public presentation of her experience with domestic violence placed our second interview interaction, the one in which she unexpectedly revealed her experience of domestic violence to me, in a new light. Prior to her public testimony at the fundraiser, I had come to view her revelation to me as being a more spontaneous disclosure of self, an emotional reaction to a hard day, and perhaps, as evidence of the quality of our interaction, one in which rapport was established as a result of our shared experience as health care professionals, as women, and as mothers of children. While I do not rule these out completely, her second, public revelation of her experience with domestic violence led me to re-examine our interaction.

I now wonder how Aisha's description of her experience of domestic violence, expressed both to me and to the public, serves to assert aspects of identity that she deems important, autonomy, survival, strength, and authority. These aspects of identity, highly valued in American society as well as in Arab societies (Abu-Lughod 1985; Caton 1990; Joseph 1999), counter stereotypes of Arab women as submissive and downtrodden. However, Aisha's use of the discourse of domestic violence to assert these aspects of identity also reveals contradictions. Aisha is educated, professionally accomplished, and in her present position, politically powerful. But while powerful at work and in public, at home with her husband, her family and with her religious leaders, it is a different story, according to Aisha. However, her experience of domestic violence

allows her to empathize with her clients, gives her stature as a witness to violence, and places her in the position to advocate for victims of domestic violence.

Hearing Aisha's public testimony also leads me to wonder how her story relates to her status as an Arab American living in the United States, how might Aisha use the rhetoric of activism too legitimize her status as a citizen in a setting where the experience of Arab Americans as citizens has been described as "ambiguous" (Cainkar 2009; DAAS 2009), and at the same time help to normalize being Muslim and Arab in an increasingly Islamophobic United States.

Temporal Event Structure / Spatial Location

Like Nasser, Aisha's responses to my questions about how she came to her work included references to personal, biographical time. However, in describing her route to her position at the Center and her experience of domestic violence, both time and place were distinctly placed in relation to her role as a wife, a mother, a family member, and as a member of larger communities. Aisha described her education as taking place before and after her wedding and before and after she had children. Her account of her experience of domestic violence, while placed firmly within the immediate context of her marriage, was also placed in the contexts of her extended family, the Arab community, and the larger American society. While Aisha's descriptions, her framing of significant life events in relation to these roles, may well reflect larger societal expectations placed on her because of her female gender, those of her Arab community and of her American society, they may also have to do with cultural definitions for personhood

status, which determine both her roles and responsibilities in relation to her family and community.

Another aspect of spatial location of significance to our interaction relates to the location of Aisha's personal office. As previously described, the second floor of Building New contained offices belonging to mental health providers and key administrative staff. This space always appeared to be well monitored and quiet when I was there for an appointment. Other than an occasional staff person passing through, I never saw anyone waiting in this reception area. Aisha's office was one of a number of offices leading off a narrow hallway on this second floor. I was to discover that one-on-one meetings with severely traumatized clients were held in those offices. This space will be described more fully in the account of my interview with a third provider.

<u>Summary</u>

Within the context of my interactions with Aisha, I noted the following themes: (1) Aisha uses biomedical explanations for emotion and mental disorder in her assessment of the mental health status of her Arab immigrant clients. These explanations, informed by a Western understanding of personhood, are thus replicated among a clinical population that may have different explanations for emotion based on different requirements for personhood status. However, Aisha also emphasizes the importance of an understanding the social contexts in which her Arab immigrant clients live. Her description of the parking lot conflict, and the conflict that domestic violence represents for the Arab American and Arab immigrant community, indicates that she may recognize a lack of fit in applying Western explanations for emotion and mental disorder to her

clinical population. This lack of fit in applying discourse from one cultural setting to the troubles of individuals from another culturally distinct setting may be a place to look for transformed emotion meanings; (2) In revealing her own personal struggles, Aisha both asserts and contests identity and claims authority and inclusion as a professional and as an American citizen; (3) Rapport and trust in this setting are established over time, with contact and through relationship. For both Nasser and Aisha, multiple contacts, in the way of letters, e-mails and follow-up phone calls, were required prior to my obtaining consent for interviews. The importance of establishing relationship through an emphasis on social attunement was also present in the stories staff and providers told to me about how they came to work at the Center.

Interview Interaction III

An Iraqi Mental Health Therapist

> I know what the people, my clients, what kind of difficulties they've been through. I understand it, I feel it, I know it, because I'm one of them…all the stories he or she is telling me…every word of it, every emotion, every tear, every embarrassment…(Ador, Int #9: 1-14-10)

I met Ador, a mental health therapist from Iraq, by accident four months into interviewing. I had been waiting for another interview participant in the again very quiet reception area just outside the Director's inner office. Up to this point in my fieldwork, I had not directly spoken with nor met face to face with the Director. All of the negotiating over the specific details of my research activity had taken place via e-mail and phone, and quite often the Director's responses to me were delivered secondhand. In meeting with other interview participants in this area of the Center, I would at times pass by the

door which led to his office, thinking that if I ran into him I might at least be able to remind him of the study and that I was actively engaged with Center staff. Even on those days when the outer receptionist's desk was empty and I could see that his door was open, I could not bring myself to enter into this innermost sanctum. To do so without an official appointment, which up to this time had not been extended to me, would have seemed to me to be a form of trespassing into the personal, private space of one of the Centers' highest ranking officials.

On this day, the Director happened to step out into the outer reception area. As we were the only ones in the reception area I said hello and on seeing me, the Director gave me a smile of recognition and asked how things were going. I explained that I was there for an interview, that the staff members he had initially suggested to me had been very helpful and responsive, and that those interviews had led to others. At this point, the Director invited me in, through the door, to a smaller reception area just outside his office. Motioning for me to sit down on an elaborately upholstered couch, he continued to ask me about my progress. Encouraged, I talked about wanting to observe providers as they went about their work. As we began to strategize about how observation might be accomplished, a tall, large-statured man who looked to be in his early to mid forties came down the hallway. On seeing him, the Director flagged him over and introduced him to me as Ador, a therapist, who did "important work" with clients who had experienced torture. The Director then explained that I was doing research on mental health providers and he said that Ador would be a perfect interview candidate for my study. With that introduction, Ador and I shook hands, and Ador motioned for me to

follow him down the hall to his office so that he could check his calendar to set up a time when I could interview him.

Seated at a desk inside Ador's office, I handed over the study consent form and demographic sheet and explained the study. I went over my background, telling him that I was a doctoral student and that the study was my dissertation research. As a way of explaining how I came to conduct the study, I also told Ador about my background as a nurse and that I had lived in the Middle East. As Ador filled out my list of demographic questions he told me that he was also working on a doctoral degree, one involving a specific form of Christian counseling. He began to speak of his Christian faith saying that he also served as a leader in his faith community. Ador went on to tell me about other aspects of his life, including how he had been raised in a Catholic family in Iraq and that he had completed his undergraduate university education there. Ador spoke of living in Jordan for three years before being allowed into the United States as a refugee. Ador described this time as a time when he was earning good money but that he did not "save." His visa expired, his job gone, Ador went on to describe this time as one where he really "hit bottom." He spoke of how he lost his family, God, his religion, "everything." Ador then described how he met a Christian Iraqi in Jordan who brought him to a community where he began his "journey with Jesus." Ador spoke of how he could not talk about his faith belief at work as most of the other providers were Muslim and that there were times when he felt to be alone.

A Refugee and a Tool of God

A few days later, I returned for the interview. This first excerpt is part of Ador's response to my asking him to describe how he came to his current position at the Center.

> And I'm working now the same program in the rehabilitation center for victims of torture, and that's a tough one, yeah because I myself has trauma experience during the war between Iraq and Iran and being an Iraqi who lived in Iraq for the last forty years… so I experienced all the traumas in Iraq. I know what the people, my clients, what kind of difficulties they've been through. I understand it, I feel it, I know it, because I'm one of them. (Ador, Int #9: 1-14-10)

As part of Ador's explanation for how he came to his work, Ador described his approach to doing therapy, which he called "formational counseling."

> We go to the deep structure of the self and form it again. We try to find where the deficit is, we try to find where the wounds are and we try to do something about it through counseling, through prayer, and through relationship. (Ador, Int #9: 1-14-10)

Ador went on to describe the approach of "formational counseling" further:

> …they took like the heart of the things…understanding the self, all the layers of the self, and focusing on the early childhood experiences. And going through lifespan experiences and from the psychoanalysis we understand now the first, the early childhood experiences set the stage for the life of the person. What kind of responses and what kind of injuries and what kind of dysfunctional behavior, what kind of emotional reactions will have during his or her life. (Ador, Int #9: 1-14-10)

The next comments are Ador's response to me asking him whether he thought his route to his work as a mental health therapist was typical. He responded with,

…I'm not typical, no…I'm not normal…I'm gonna change the whole attitude in the Arab world, Arabic leaders and Arabic speaking world regarding counseling because we have a big stigma about counseling and about this field. And now I can see how I'm gonna be used, I'm gonna say it as a Christian, how God can use me as a tool in this field, I have a vision now of that. (Ador, Int #9: 1-14-10)

Relevant EI Categories

Culturally Constituted Activities (CCAs)

One prominent CCA evidenced in the above responses, as well as throughout our interaction, relates to our discourse around professional authority. Here discourse is used in its broader sense as a form of social practice having to do with power. Professional authority refers to how the holding of specialized knowledge places individuals in positions to judge the actions and lives of others who do not hold that same information. In my first meeting with Ador, prior to the formal interview, I introduced myself as a heath care provider and academic researcher who had spent time in the Middle East. I also mentioned that the research I was doing at the Center was part of my dissertation as a doctoral student in anthropology. It was not unusual for me to refer to my professional background with study participants. I revealed professional as well as personal details in explaining the study and as a way of giving myself, and my request for interviews, added weight and legitimacy and as a way of establishing rapport. During my interview with Ador, I remember being aware of sitting in an office down the hall from the Director's office. Ador's large physical stature, the nature of his work with an extremely vulnerable group of Arab immigrants and refugees, along with the personal introduction from the Director who had, as yet, not expressed much interest in me or my activities may have led me to feel that I had entered into

some inner circle where the "true" "hard" work with the most "fragile" of clients was taking place. These factors all most certainly contributed to my desire to establish professional legitimacy.

Ador may have responded, in part, to my attempt at establishing professional authority by asserting his own. He described how he was also currently in a doctoral program for a specific form of pastoral counseling. A back and forth flexing of educational credentialing and professional authority ensued, with me referring to my interest in and knowledge of the global exportation of Western biomedical categories and definitions for mental illness, and Ador talking about the various approaches to psychotherapy he was exposed to in his training, such as "person-centered therapy," "humanistic" therapy, and "existentialist" theories emphasizing humans as experiencing beings. He went on to further enhance his professional status with additional forms of authority. In accenting his status as a refugee, Ador claimed specialized knowledge of one who understood the experiences of his clients, because as he stated, he was "one of them." Ador's mention of his role as a leader in his religious community, along with his mention of his sense of being a "tool" of God in performing his special work, were yet other examples of specialized authorities. Discourse of professional authority as a CCA, and as an aspect of power, was evident in Ador's definitions for emotion, and in the way he contrasted his definitions with those of his largely Arab immigrant clients.

Another CCA, present in the form of discourse, can be found in Ador's reference to Western theories of personality development. In his explanation of formational counseling, Ador's use of the term *self* portrays individuals, first and foremost, as separate and autonomous entities. This self, being "at the heart of things"

he described in intra-psychic terms as being composed of layers, with an "inner" and hence private domain. This self is determined by experiences in early childhood that endure, are consistent, affecting one's "responses," "behavior," and "emotional reactions" "for the life of that person" (Dwairy 2006) and as less determined or influenced by social context.

Temporal Event Structure

The demographic information and interview excerpts highlighted here were taken from my interactions with Ador around two meetings points, one introductory session lasting a half an hour and the second lasting an hour and a half involving the in-depth interview. Over the course of the interview, Ador, like Nasser, made reference to personal biographical time, both past and present and historical time in his mention of the Iraq Iran War. Ador also clearly demarcates the time before and then after his religious awakening, and the time before and then after his mental health training, when, as I will describe shortly, he came to accept a different explanation for emotion.

Aspects of time are also present in Ador's emphasis on Western theories of personality development, whereby "early childhood experiences" and "injuries" "set the stage" for "behavior" and "emotional reactions" later in life. In addition to this emphasis on the importance of past time in relation to the problems of his clients, Ador also refers to the future in his hopeful statement "I'm gonna change the whole attitude in the Arab world…I can see how I'm gonna be used…I have a vision now of that." (Ador, Int #9: 1-14-10)

Spatial location

Two aspects relating to spatial location stand out in a consideration of my interview with Ador. The first aspect pertains to the immediate physical surroundings of our interaction. As noted earlier, our interview contact took place on the second floor of Building New, in Ador's personal office, just down the hallway from the Center Director's personal office. Therapists associated with programs designed to assist clients who were victims of torture and violent crime also had offices on this same floor (Aisha's office was on this floor as well). In contrast to other reception areas I visited within the Center, this quiet, clean space did not have the same feel of public space. During the times I was there, the area was usually monitored by a female receptionist whose desk was positioned at the doorway connecting the larger waiting area to the inner hallway with individual offices. As described earlier, my perception of this space as being monitored and controlled may have been the result of my own concern over the progress of my research project. This tone may have also been intentional, a calculated strategy to create space in which especially vulnerable clients might feel safe and protected. The monitored-ness of this space may have also be an attempt to control access to staff and administrators.

A second aspect related to spatial location can be seen in the way Ador uses his description of his work and his explanations for emotion to both distance himself from, as well as to align himself with, his co-workers and the clients he treats. A fuller discussion of the different ways Ador locates himself within his work will be discussed in the following section "Key Identities and Relations."

Key Identities and Relations

In the course of our social interaction, as in other interactions, aspects of both my and Ador's identities were revealed. Moving beyond our identities as researcher and research participant and our identities as health care providers, having identified myself as a doctoral student, Ador also claimed a similar identity in describing his status as a doctoral student in a particular form of counseling. As discussed earlier, the assertion of professional identity and authority was evident throughout our discussions of emotion and mental health problems. A consideration of the ways in which both of our social positions and identities "fix or frame" Ador's definitions for emotion will be discussed in more detail later in this section.

Throughout our interview, Ador frequently referred to his experience as a refugee. When Ador first described his work, his statement "I am one of them" asserted an affiliation with his Arab immigrant clients, many of whom were refugees. This affiliation was stressed in explaining to me the source of his special knowledge and insight into the problems of his clients. However, a short time later, in a discussion of whether the way in which he came to his work was typical, he separates himself from his Arab clients and his Arab colleagues when he asserts his religious identity.

Ador's identity as a Christian was revealed within minutes of our meeting and occupied a central place throughout the whole of our interaction. Ador's religious identity includes a sense of being an instrument of God's specific plan or design. In his statement, "God can use me as a tool in this field," Ador speaks of how being a Christian therapist he will change "Arab" attitudes towards counseling and mental illness, because as he said, "We have a big stigma about counseling and about this field."

In wondering over what to make of Ador's strong assertion of a Christian identity to me within the context of a research interview, I refer to the work of sociologist Kristine Ajrouch (mentioned in Chapter 1) examining intersections of race and religion in the negotiation of identity among Arab immigrants (Ajrouch 2007). Ajrouch has found identity to emerge from social and racial boundaries defining majority and minority status in both host country (with an emphasis on definitions of "whiteness" in the United States), as well as from "homeland" environments. In a study of Lebanese Shia, immigrants to the United States, Ajrouch describes how this group, a minority in their homeland, came to "embrace" being assigned as "white" in their host country (Ajrouch 2007:7). The resulting boost to their self-esteem that came along with white status gave them greater confidence in expressing other aspects of their identity, such as veiling, at odds with "Christian ideals of whiteness" (Ajrouch 2007:7).

In applying these findings to my interaction with Ador, it is possible that in his homeland of Iraq Ador's identity as a Christian placed him in a minority group with lower status. Indeed, Ador describes this discrimination as one of the reasons he fled as a refugee.[17] In immigrating to a host country where the majority religion is Christianity, a characteristic found to correspond to the ideal of whiteness (Ajrouch 2007; Samhan 2005), Ador's identification as a Christian in an American context may contribute to an elevated sense of self-identity and self-esteem. We may see evidence of this self-esteem in Ador's use of his Christian identity to explain his personal approach to therapy. He used this same Christian identity to separate himself from other staff at the

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[17] Ador identified as belonging to a minority Christian group in Iraq. In clarifying this background with me he stated that he was not Arab.

Center, as in "… I'm not typical, no… I'm not normal…I'm gonna change the whole attitude in the Arab world," and to distinguish himself from clients, many of whom were Arab and Muslim. By separating himself from his "Arab" clients and his mostly Muslim Arab colleagues, or, by taking a stance as "outsider" to them, Ador may be asserting, what his experience as an Iraqi immigrant in the United States has taught him to emphasize an "insider's" status, as both a Western-trained professional and as a Christian. Conversely, while Ador's identity as an immigrant and refugee seems to contribute to a sense of belonging and affiliation in his work at the Center, despite his openness about his Christian faith belief, this might not be the case within the larger post-9/11, American society, in which an Iraqi identity may be problematic. At other times, while his Christian identity may contribute to a greater sense of belonging in a majority Christian host country, as he states, that same identity also contributes to a sense of isolation and difference at work.

Specific Communication Practices

Professional language relating to the field of mental health can be seen in the use of the term "stigma" and in Ador's use of a psychoanalytic framework for talking about personality development. Already mentioned are broader forms of discourse including Western understandings of personality development, mental illness or disorder, and the discourse of Christianity, all of which may be seen to be related to Western requirements for personhood status, with its emphasis on autonomous selves, the product of individual feeling, experience, and relationship. [18]

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[18] While Christianity has been linked to the rise of individualism (Dumont 1985) and the more Western notions of personhood evidenced in Western psychiatric classification (Gaines, 1992), whether or not Ador's personal faith

A Changed Definition for Emotion

This section contains a number of excerpts containing Ador's definitions for emotion. Some are lengthy in order to preserve and convey meaning. The first excerpt contains Ador's response to my question, "How do you define emotion?"

> Emotion, I define it as this powerful drive for living…However, it's been ignored and put away, I know that's a universal thing because we don't understand our emotion, we try to hide them as if they're not even existed. And this is the big problem. (Ador, Int #9: 1-14-10)

The next excerpt is taken from Ador's response to my question of whether his definition for emotion had changed over time**.** Ador explained that before he received his mental health training, he used to think of emotions in the same way that he finds many of his Arab immigrant clients to think about emotions. He further explains that his clients' explanations are in need of correction as they do not fully understand what emotions are.

> …before being involved in the mental health field, emotion for me was only the positive ones, love and joy and these kind of, and I see now, the majority of Arabs now, when I say emotions *shar* in Arabic, right away they think about love… because the word in Arabic, *mu-shar* which is emotions, it's related to the love feelings. So I have to spend time to cognitively make them understand what are the rest of the emotions, which is fear, anxiety, joy, happiness, hate, anger, and all of the rest of the emotions… they put all their emotions in their thinking part, it's not the feeling part, they think they're feeling. (Ador, Int #9: 1-14-10)

Ador went on to explain further.

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belief can be seen at all as being related to an acceptance of western biomedical explanations for personality development and approaches to counseling is interesting but completely speculative.

> **…**they see it more as thoughts more than anything else. There's more than the thinking part of our emotions, there's the biochemical part of it and there's the environmental part of it and there's the relational part of it, you know, they don't see that, they don't know about, like there's a chemical part making me feel depressed. They don't understand that. (Ador, Int #9: 1-14-10)

Later in the interview I asked if there had been times when the standard mental health assessment tools or treatments Ador had been trained to use seemed not to fit or work with the clients he treated. Ador answered by saying that he felt that the assessment tools used at the Center did a good job of identifying problems and that they helped point the way to appropriate treatment plans in a way that seemed to echo Aisha's evaluation of her newly acquired survey instruments as aiding her clients, some of whom were victims of extreme violence,

Given Ador's description of how his definition for emotion had changed since receiving his mental health training and his detailed description of what his "Arab" clients considered to be emotion, I probed further. I began by talking about differences, noted in the literature, between the ways emotions are expressed in collective versus more individualistic societies. I asked him what he thought about this distinction and whether it made sense as an explanation, given what he was seeing in his practice. As I spoke about these differences, Ador shook his head in the affirmative, and he said he knew what I was talking about, that he used to believe that, but not now. He went on to describe for me one explanation for emotions that he did not see as being valid.

> And there is like… 'We Arabs…our emotions are different because we have this strong family relation or tribal relationship and we can go always to our, this big tent you know that contain our problems and we can

always process that through this relationship.' However, I now-I believe that we humans are all the same in a certain point. We're all the same. We are structured the same way. (Ador, Int #9: 1-14-10)

Ador went on to further elaborate what he meant by "We are structured the same way." In the following explanation for emotion, Ador clarifies for me that what his Arab immigrant clients lack are the right words to explain and describe their emotions.

… there is this society that give titles and words and so that they can describe the emotion. They describe the process of these emotions and their effect on their life, versus these societies that they don't have that, they don't have that privileged of expressing in words what's happening in their emotions and in their behavior and in their normal life situation.

…They can't translate that into words. So if they can't translate that they themselves believe that it's not existent, versus those who really understand that, the map of our being… they put words and theories and definition for all the feelings, for all the processing, for all the developmental stages and all of that…in a very communicative way. So the one who express it they can really know what he or she's talking about and the one who is listening he is understanding what he is listening to, versus those societies, they don't have that, they don't have this privilege…they don't understand this map of our human existence. (Ador, Int #9: 1-14-10)

Relevant EI Categories

Culturally Constituted Activities (CCAs)

In the first grouping of excerpts from my interview with Ador, I discussed the presence of professional authority as a CCA, a form of discourse placing individuals in positions to judge the actions and lives of others who are not in possession of certain knowledge. In the current set of excerpts, Ador portrays his Arab clients as lacking in both privilege and understanding when it comes to identifying and making sense of

emotions and their effects on their lives. Ador's professional authority, gained from advanced education in mental health care in the United States as well as from his other roles and identities as a male, Christian American, who happens to be an immigrant and refugee, gives him a powerful voice and a position from which to define emotions for his clients and to correct misguided thinking.

Ador's explanations for emotion are primarily biomedical (another prominent discourse and CCA), referring to inherent "drives," that while influenced by social relations, are largely biochemical and universal in nature. Ador's reference to the "the big tent" "family" and the "tribe," above is used by Ador as his example of how universal emotions are socially and culturally processed. Biomedical explanations and western psychiatric classificatory designations, both shaped by culturally specific requirements for personhood status emphasizing individuality and autonomy, inform the very "titles," "words," and "theories" providing the "map of our being," our explanations for who we are, and why we behave in the ways we do. In Ador's explanation for emotion, one sees what Ewing refers to in her description of immigrants' encounter with the "hegemonic cultural practices" of health care systems in Western settings (Ewing 2005:231). In such settings, immigrants encounter "discursive practices…that may…position the migrant in relations of authority and power in ways that contribute to new articulations of emotional experience and identity formation in the new home" (Ewing 2005:226). Ador's encounter with the "discursive practices" of Western health care, "practices" encountered in his mental health training," now place him in a position – a powerful one – to critique the explanations for emotion of his immigrant clients. In the context of the field setting of the Center, immigrant clients' interactions with their Western-trained immigrant providers

become key places to look for how ways of defining and talking about emotions become "fixed or framed," potentially resulting in new or transformed meanings.

Focal Emotions / Communication Practices

At the outset of the interview, Ador referred to "tears", "embarrassment", "injuries," "difficulties," and "wounds" to describe the nature of his work, the problems of his clients, and the fact that, as a refugee himself, he was familiar with the traumas experienced by his clients. Although not explicitly stated, these terms allude to negatively valenced emotions, which in the context of war and torture may include intense fear, sadness, and anger. In the above excerpt containing Ador's explanation for how he used to think about emotion, Ador uses the terms "*shar"* and "*mu-shar,"* terms related to *sha-oor,* an Arabic word for emotions or feelings I was to hear from providers throughout the Center setting. As my interviews were conducted in English, this was an instance where a mental health provider spontaneously used an Arabic term for emotion in the course of our discussion. I was to hear a variation of *sha-oor* from one other mental health provider when I asked him to tell me how he would ask, in Arabic, how his clients were feeling. This provider explained that he might say, *"Kayf, tashuru,"* which he translated as one way to ask, "How are you feeling?" (Saleh Int #10: 1-21-2010)

Ador's mention of the words *shar* and *mu-shar* were to later stimulate much thinking about the various ways providers framed their explanations for emotion to me. At the time of our interview though, what was of primary interest to me was Ador's description of how his way of thinking about emotion had changed since receiving his training. According to Ador, prior to becoming "involved in the mental health field" he

associated emotion with "love feelings", in much the same way he now finds his Arab immigrant clients do. Implicit in Ador's description of how he has to spend time getting his clients to acknowledge what he describes as being "the rest of the emotions…fear, anxiety, joy, happiness, hate, anger" is that there is a correct way of understanding emotions. In Ador's response to my asking him to comment on the differences in the way certain emotions have been observed to be either emphasized or de-emphasized in differently organized societies, he states his belief that humans are structured the same, and that all that is lacking for his Arab immigrant clients is exposure to the correct "theories" and the correct "words" to understand what they are feeling and why. In other words, one could interpret from his answer that regardless of social and cultural context, emotions and emotion meanings are best explained by Western theories of personality development and biomedicine.

<u>Summary</u>

Within the context of my interactions with Ador around the conduct of an in-depth interview, the following themes were noted: (1) Similar to Nasser and Aisha, personal challenges are used by Ador to emphasize professional legitimacy and authority. Ador states from the outset that as a refugee he "experienced all the traumas in Iraq." He knows the "difficulties they've been through", because he is "one of them"; (2) Different aspects of past, present, and future identities were accentuated in Ador's responses to my questions about the nature of his work and emotion (e.g., in one explanation Ador speaks of being like his Arab refugee clients, he is "one of them." At other times, he separates himself from them, as when he discusses their incomplete explanations for

emotion). Ador's explanations reveal the dynamic, and at times, seemingly contradictory ways identity and discourse on emotion link up within the context of real-time social interaction; (3) Biomedical explanations for emotion and Western theories of personality development are emphasized and perpetuated. According to Ador, what is lacking for Arab immigrant clients is proper language and exposure to certain ways of conceptualizing and communicating about a range of emotion categories.

Interview Interaction IV

A First Generation Arab American Case Worker

> Sometimes you need to talk to someone who doesn't know you.
> (Samira, Int#12: 2-11-10)

I interviewed Samira, the fourth provider highlighted in this chapter, five months into the field work period. We met at a wedding that took place in the Community. Seated at a table with two other mental health providers I had already interviewed, Samira, a woman in her early twenties, identified herself as being involved in a Center associated research project involving Iraqi immigrants. When I asked her if she would be open to being interviewed, Samira gave me her card and we were able to set up a meeting the following week.

Samira is a first generation Lebanese Arab American who had an internship at the Center while working on her undergraduate degree in psychology. As Center supervisors became aware of her research experience, her internship evolved into her

current position as both research assistant and mental health case worker. In describing her position, Samira told me that she had always known she wanted some kind of career in psychology. She talked about how her experience of witnessing a friend's brief marriage and divorce had led to her current plan of becoming a marriage and family counselor. Samira went on to say that she did not know of anyone in the Arab Community who was professionally trained to respond to the specific needs of married couples and that most couples were referred to the sheik for help. She said, "If you have a problem you go to the *shaykh*, because he is holy" (Samira, Int#12: 2-11-10). Samira then described how, in her opinion*, shaykhs* were not trained in the techniques that were available to help people deal with things like depression, anxiety, and the problems that can come up in relationships like marriage, and she added that not everyone in the Arab Community is necessarily religious. Samira then added, "…sometimes you need to talk to someone who doesn't know you" (Samira, Case Worker: Int#12: 2-11-10).

As we spoke of how Samira came to her work, we began talking about how mental illness is perceived in the Arab Community. In describing how individuals can benefit from the techniques of psychotherapy, Samira spoke of the challenge she faced in getting her Lebanese-born parents and other members of her family to understand her plans for a career in psychology. In the quote below, Samira talks about how psychotherapy is sometimes viewed by some members of the Arab immigrant community.

> I am Muslim. I don't know if you know, but it's not highly, like if you tell people you are going into psychology they think you are crazy. Like what is it that you can do that other people, friends and family, can't do. They

don't understand that there are techniques, there are types of therapy that can really help, and that people are born with disorders. So they believe that God created them this way and this is the way it is supposed to be. (Samira, Case Worker: Int#12: 2-11-10)

In addition to describing how her family viewed psychotherapy, Samira talked about how mental illness was stigmatized in the Arab Community. "Therapy," Samira explained, is viewed as something for "crazy people" (Samira, Case Worker: Int#12: 2-11-10). Samira also spoke of how depression and anxiety were viewed by her parents.

> It's normal to be depressed, to have anxiety, to be aggressive. They think these things are normal. They are normal but to a certain extent. …..They believe that these are things you can just deal with. Depression….it is not an imbalance. Something happened that made you depressed and you have to figure a way to get out of it. That's how they think. There is no way you can be depressed biologically or through genetics. (Samira, Case Worker: Int#12: 2-11-10)

As we began to talk more specifically about emotion, Samira began to describe the ways in which people in the Arab Community would or would not talk about emotions or feelings. The following excerpt is part of her response to my asking her whether people would say they were "sad":

> They wouldn't say 'I feel sad.' They would use words like 'I feel tired, I feel weak, low energy.' They don't use the emotion…they use the physical, like 'I'm so tired, like my body can't take it. I feel like I don't want to get up.' Are you happy? Sad? No. And it's hard to actually ask them because…they will always turn it into something. They use the physical, 'I don't want to get up.' Happy, sad, they don't use…They can't say 'I feel sad'…it's always what you can see. They can't say… 'I didn't go here' or 'I didn't do this.'… It has to be a physical thing…I don't know why. I don't know. (Samira, Case Worker: Int#12: 2-11-10)

Samira explained how her parents and her aunts and uncles do not talk about feelings like "happy" or "sad." Below, she contrasts this way of explaining emotions with

the way her brother and sister talk about how they feel. Samira goes on to further contrast her siblings ways of talking about feeling with the way "Western…young adults…that were born and raised here" talk about feelings.

> And it's weird, because we were born and raised here, but we're still not as, we don't talk about our feelings as much as you think like Western, like young adults would that were born and raised here. And I don't even do that sometimes with my family, because it's just not acceptable…they would probably laugh at me. …I think it has to do with feeling embarrassed to say you know I am feeling sad, I am feeling left out….it's vulnerability, you don't want to make yourself feel vulnerable. (Samira, Case Worker: Int#12: 2-11-10)

<u>Relevant EI Categories</u>

Culturally Constituted Activities (CCAs)

Biomedical explanations for emotions and mental disorder are key CCAs evidenced in Samira's discussion of certain emotions and the benefits of psychotherapy. In her discussion of depression, anxiety, and aggression, Samira clarifies for me that "to a certain extent" these feelings or emotions "are normal." However, after some point they become something not normal, due to something "biological," some imbalance, genetics. Biomedical discourse as a CCA will be discussed further in "Specific Communication Practices."

Temporal Event Structure

My interaction with Samira began at a social event, a wedding at which many Center staff were present. The actual interview interaction, which took place approximately one week later, within a two hour time, was my shortest interaction with a participant in the Center setting. I never interacted with or saw Samira again in the

course of my fieldwork. However, one significant take-away from my interaction with Samira is how time appears to factor into the ways her explanations for emotion and mental illness in ways different from those of her parents and her Arab immigrant clients. Recognizing that American society is extremely heterogeneous, as a first generation Arab American, Samira had spent her formative years exposed to the ideas and values of her family, as well as to those of the broader American society. Her use of biomedical explanations for emotion and mental illness may be best explained by her undergraduate training and research experience and by her having spent the her childhood in the United States. While she sees that her immigrant clients talk about emotion and feelings like sadness and anxiety in terms of physical feelings instead of using emotion terms, she is not sure why her clients talk this way. In describing herself as being different from her parents, she also recognizes that she and her siblings are still different from others, "Western…young adults," in their same age group in the way they talk about feeling. This revelation indicates that while formative time spent exposed to certain values and beliefs may play a significant role in emotion meaning-making, there may be other equally significant factors involved.

Spatial Location

Our interview took place in Samira's private office within Building Old. Spatial location may also be seen in the way Samira locates herself as a first generation Arab American. In contrasting the ways her parents view emotions and emotional trouble with her own, and in her statement, "…sometimes you need to talk to someone who doesn't know you", we see how Samira sets herself apart at some distance from her parents and from those who may "know" her. This distance may be seen to reflect a more

implicit understanding of personhood, an understanding differing from her parents and perhaps from that of her Arab immigrant clients, with different rules and responsibilities regarding how individuals are connected to the family, group, or larger society. At the same time, Samira is a young adult and still somewhat of an adolescent by U.S. standards. As she attempts to figure out what she believes, and who in essence she is, she moves back and forth between many different realms. As a first generation Arab American close to the immigrant experiences of her family and as a young adult, in addition to being, as Ewing so aptly describes it, in a place that is between culture (Ewing 2005:226), Samira, may be somewhere in between establishing her own sense of self as separate from her parents.

Focal Emotions

In the above key excerpts, Samira refers to sadness, anxiety and aggressiveness, noting that frequently Arab immigrant clients, "will always turn [emotion] into something…physical." In saying that an emotion, such as sadness, is turned "into something…physical," Samira's observations are similar to Ador's in that she seems to be saying that her clients do not recognize physical feelings as being related to emotions or feelings that may be thought about and then dealt with or understood. Implicit in this description is her acceptance of biomedical explanations for emotion and mental illness. Samira also attributes the reason she and her clients may not want to admit to feelings as "sadness" or "being left out", to a concern not to be seen as vulnerable.

In their examinations of poetry in tribal Arab societies of northern Egypt and Yemen, Lila Abu-Lughod (1985) and Steven Caton (1990) found autonomy and self-control to be qualities essential for the establishment and maintenance of honor, an important aspect of tribal identity. Suad Joseph (1999), in her description of "relational selving" as a cultural aspect of identity in Arab families, writes that although the needs of the family or group are uniformly privileged over individuals, aspects of autonomy and individuality are also important in Arab families, often co-existing alongside deference given to the group. Samira's observation that she, along with her parents, and her clients, may not want to be perceived as being vulnerable, reflect aspects of identity determined by rules regarding the ways in which individuals are connected to the family, group, or tribe.

Key Identities and Relations

Samira is a first generation Arab American who articulates her sense of being different from her parents in her acceptance of psychology as a scientific discipline with practical applications for solving the problems found within human relationships. Part of Samira's sense of being different from her parents may have to do with differences in ideas about the origins of emotional trouble. According to Samira, her parents describe emotional trouble as being a normal part of daily life, or as coming from God, and that it is up to individuals to work our these "normal" troubles for themselves within their own families. Samira contrasts her parents' way of defining emotion and mental illness with her own, which include physical causes such as biological imbalances and genetics. Here, she reveals her acceptance of biomedical explanations for emotion and mental illness. Samira's statement "sometimes you need to talk to someone you don't know"

hints at another implicit and potentially significant difference between herself and her parents, that having to do with how they see individuals as being connected to their families or community and potentially over what constitutes or defines community in the first place. Implicit in her statement, "sometimes you need to talk to someone you don't know", is that not only is it acceptable to seek advice from outsiders or strangers, to do so means that one has access to or associations with entities beyond the community's or family's purview. Samira also talks about people going to the sheiks for advice because sheiks are holy, and that this might not be helpful as not all people are religious. The fact that Samira considers the possibility that a Muslim Arab American might not be religious may be another indication of just how much she may differ from her parents.

Specific Communication Practices

The CCA of Western biomedicine may be seen as one example of broader overarching discourse that has the power to shape identities and understandings of emotion. In Samira's discussion of emotions, we see the influence of biomedical discourse in two ways. First, when Samira contrasts the way her parents and some of her Arab clients view sadness, anxiety, and aggressiveness with her own explanations involving biology and genetics, we see the legitimacy she grants biomedical explanations for emotions. In the context of the clinic setting, the discourse of biomedicine might also be said to simultaneously result from, and influence, identity in the form of personhood. When Samira describes the way she differs from her parents over who might be appropriate people to go to with problems, the family, or a trained therapist outside the family, or as she says, "someone who doesn't know you", she

reveals that there may be different ways of talking about emotion and different ways of defining problems or illness in this clinic setting.

Illness has been described as being a "particular condition of persons" (Pollock 1996:321). In the context of Samira's observations, this statement means that both the identification of problems, including the ways of referring to them and treating them, may be based on culturally particular criteria for who is ultimately granted personhood status. Illness may, at the same time reflect one's being out-of-sync with a society's criteria for personhood status. In Samira's responses to my questions, we see the intersection of language (biomedical explanations for emotion and mental illness) and identity (Samira's implicit understanding of personhood, in which the rights of individuals may receive more attention than those of the group, at least in comparison to her parent's understanding of this aspect of identity). In this intersection, we see an example of how identity and emotions become, as White says, "fixed or framed" within the recurring CCA of biomedical discourse. This fixing and framing becomes a place, according to White, where meanings are assigned and perpetuated and, in the case of Arab immigrant providers and clients, are potentially redefined and transformed.

<u>Summary</u>

Within the context of my interactions with Samira around the conduct of an in-depth interview, the following themes were noted: (1) Differences exist in the Arab American community over what constitutes mental trouble, whether emotions are part of everyday living or are illnesses, a debate present in the larger American society. Differences also exist over the source or causes of emotions or feelings like sadness,

anxiety and aggressiveness (i.e., are they part of normal everyday life, or from God, or are they evidence of biological pathology) and then what can be, or should be done about them. While Samira's explanations for emotion and mental illness are biomedical explanations, she is aware that her explanations differ from those of her parents and some in the larger Arab American community in other ways. For example, she is aware that the ways in which she talks about emotions or feelings as a first generation Arab American differ from her American contemporaries' ways; (2) Who one talks to about emotional or mental trouble may be determined by definitions of personhood resulting from the ways in which individuals are connected to their group, family or community. Generational differences over who is considered to be an acceptable audience for discussions about emotional or mental trouble may be an indication of changing or altered definitions of community and personhood, thus potentially leading to transformations in emotional experience and meaning.

Discussion and Chapter Summary

In this chapter, I used the EI framework to identify and then examine the social interactions, identities, language practices, and their relationship to each other, present within my interview interactions with four Arab American mental health care providers. These interview participants held positions within four separate mental health programs at the Center: program for adults; a program for children; a program for victims of crime; and a program designed specifically for victims of torture. The first three participants were immigrants from the countries of Yemen, Lebanon and Iraq. These participants all had advanced degrees in areas of mental health care and, as I later found out, often represented the face of the Center to the public. Not only were they socially skilled

speakers, they were all fluent in spoken Arabic, two being fluent in both spoken and written English and Arabic. The fourth informant, interviewed a few months later in the fieldwork period, was a first generation Arab American who described her Arabic as being good enough to get her point across. While the first three immigrant providers all came from Arab homelands, one as a young child, and the other two as young adults, one of these providers did not identify as Arab but as a member of a minority Christian group present in his home country. I chose to include this provider in my sample of formal interviews as he was raised to adulthood in an Arab country, is fluent in Arabic, and who, like many of his clients who are Arab and from his same home country, is a refugee. As such, he offered interesting perspectives on what was involved in conducting therapy with Arab immigrant clients.

In all four interview interactions can be found: (1) some kind of story of personal struggle; (2) explanations for emotion and mental illness informed by understandings, both explicit and implicit, of different understandings of the relationship between individuals and the group, as in concepts of personhood; and (3) participants' attempts at asserting and contesting identity.

The first feature consists of an account of some kind of personal struggle. While the accounts of personal struggles emphasized in my interactions with these specific mental health providers were all unique, the ways in which they were described can be seen as being related to, or reflective of the ways in which these informants convey aspects of identity and in how they talked about emotion beyond the biomedical and Western psychiatric definitions for emotions that they received in their mental health training in the United States.

Accounts of personal struggles arose at different points within interview interactions, and all were in some way related to the experience of immigration and the working out of identity. I had no specific question that asked for an informant to fully tell his or her immigration story. First questions focused on an informant's work history, how they became mental health providers, what was involved in getting started in their professional careers, and whether they felt their experiences were typical or atypical. In response to these opening questions, the two male participants who immigrated as young adults immediately began to share their immigration stories. They spoke about the actual experience of leaving their home to come to the United States and of the experience of encountering a new and different society. While these informants emphasized different struggles, (one centered on religious belief, the other having to do with perhaps power, race, and class), both described experiences of feeling marginalized. The two female informants, one having come to the United States as a young child and the other a first generation Arab American, also revealed personal struggles related to the experience of immigration, but their struggles appeared to revolve more around generational and other differences related to gender roles and their relationships to the group in negotiating cultural worlds. In these accounts of personal struggle, we see some specific examples of what Ewing means when she describes how immigrants frequently must manage or negotiate disruption (Ewing, 2005).

Secondly, my interactions with these providers involve explanations for emotion and mental illness informed by different understandings, both explicit and implicit, of the relationship between individuals and society. In all four interviews terms associated with

biomedicine and Western science were frequent, with both categories granted outward authority. As might be expected with most mental health care providers receiving their clinical training in the United States, references were made to Western models for personality development, biomedical models of disease, and categories for mental illness derived from Western notions of persons. However, providers' emphasis on aspects of social attunement as in the placement of explanations for emotion with some kind of social context, and emphasis given to empathy, may also reveal the influence of different criteria for the status of personhood, one in which group and community has significant influence.

Thirdly, I also noted that identity claims made by participants were at times conflicting, reflecting the contestation of identity, different positionalities, and different subjectivities. These important aspects of identity will be further explored in the following two chapters.

These interview interactions were presented more or less chronologically. While the focus of each analysis is intended to reflect what I saw and heard and thought about in the first phase of the fieldwork, these analyses cannot be truly separated from what I was to eventually witness and experience in the second phase of the fieldwork when I was able to observe health care providers in the medical clinic setting. The observational and interview data from the second phase came to inform my understandings of these initial interviews, and vice versa. The following chapter describes my observations of providers in the medical clinic setting.

CHAPTER 5

TRANSLATING EMOTIONAL WORLDS

> Like I told you, this medical, it's … it's big and there's a lot of things we have to learn and to see. For me, every day it's a new day for me, sometimes I meet new people, some of them they communicate good, some of them not, some of them they understand me wrong. It's hard because it's happened, it's happened, it's happened with me.
>
> Sometimes, you know, if you heard me in Arabic, I say, 'Hi…*Ah-lan ya Albi',* like 'Welcome my heart'… I have like a nice way in speaking with people. I don't know. This is me. I like to be like that. (Shada: Int#16, 4-19-10)

This chapter focuses on my observations in the Center's medical clinic (Medical Clinic). There I observed and interviewed a diverse group of providers as they delivered primary care services to a predominantly low-income client population. The above excerpts are taken from my interview with one of these providers, a certified medical assistant named Shada, and are included here, as they capture sentiments expressed by many providers in this setting. In the first excerpt, Shada alludes more broadly to the complexity of working in health care and then more specifically to the challenges of communicating with the diverse client population seen in the Medical Clinic. In talking with me, she went described in detail some of the ways she attempts to communicate with her clients, many of whom are new immigrants and refugees, at times using a soothing tone when speaking, at times joking, and then at times giving advice. Shada also mentions instances when she might have been misunderstood by her clients and had perhaps misunderstood clients herself. As she says, communicating in the Center

setting can be hard, and the potential for misunderstanding is real. She knows. She has experienced misunderstandings herself.

In Shada's greeting of "Welcome, my heart," one can see how despite her encounter with diversity and the potential for communication mishaps, she operates under the assumption that she has things in common with her clients. Shada's reference to the "heart" in this discussion on emotion is also by now somewhat familiar. In Fatima's idea for research on emotion, the heart played a central role, especially when it came to emotions like love. In my interviews with some of the providers who worked in this second setting of the research, I would also hear references, both explicit and implicit, made to the heart as a source of emotion.

In the preceding chapter, the categories of EI were applied to data gathered from interactions involving formal research interviews and the analysis focused on the discourse of emotions present in those interview interactions. In this chapter, the categories of EI are applied to my observations of providers as they interacted with each other in the course of care-giving. Here, I focus on the everyday practices and social interactions associated with the process of delivering care. In identifying and describing the personal, cultural, and professional factors contributing to providers' identities, I look at how identities are related to the everyday speech and communication practices in their interactions. Again, I use the categories of EI to assist me in identifying the CCAs, identities, and discourse on emotion present in a series of relevant excerpts taken from my formal interviews with the providers in this setting as well as in my observations of these providers. In doing so, the EI framework helps reveal the ways that identities and discourses on emotion become "fixed" or "framed" within culturally

constituted activities (CCAs) that then lead to patterned contexts of emotional experience.

Two kinds of interactions are profiled in this chapter. In the section "Mothers and Others" I focus on one provider's interactions with the families of two clients who have significant cognitive impairments. In a discussion of this provider's explanations for what was taking place for these clients, I explore her discourse, reflecting cultural ideals of mothers and the place of family in caring for those unable to care for themselves, and her discourse emphasizing aspects of social attunement, specifically empathy. I then consider the ways in which the particular identities and discourse on emotion present in these interactions may be fixed and framed that result in patterned emotional experience.

In a second section, "Trying on Language / Revealing Selves," I focus on providers' interactions with each other. In one interaction, I observed a provider as she told the story of her troubled marriage to her co-workers. In a second interaction, I describe the interactions of providers as they relaxed together on a slow day at the Medical Clinic. In both interactions, I explore how providers' interactions with each other result in discourse on emotion reflecting individual subjectivities informed by personal circumstances and personal aspects of identity. I also discuss how changing, or newly taken on aspects of identity are reflected in discourse on emotion and how this discourse may work to further shape providers' identities and emotional experience.

Before I discuss these interactions, I lay out the context of the Medical Clinic, beginning with the providers who work there and my rationale for choosing to focus on

one specific group of providers, the Clinic's certified medical assistants (CMAs). I then describe the physical layout of the Clinic itself, with attention given to what I have come to call the "Back Hallway," the large inner hallway within the Medical Clinic proper. It was in the spaces of the Back Hallway that I observed CMAs and other staff as they engaged in a variety of care-giving activities.

The Providers

Providers with different backgrounds and training worked in the Medical Clinic setting. I begin this section by first discussing the Medical Clinic providers more broadly and I then focus on the certified medical assistants (CMAs), the group of providers I spent the most time with and learned the most about.

Most providers in the Medical Clinic, like those in the previous chapter, are immigrants from Arab homelands in the Middle East, from the countries of Lebanon, Yemen, and Iraq. While some of the providers working in the mental health programs at the Center had advanced degrees in mental health, most of the providers working in the Medical Clinic had little formal health training other than what they had received on the job. Some of the providers without specific health training had completed university degrees and technical training in areas unrelated to health care including information technology, computer design, economics, and business. Some of these providers completed degrees and training in their various Arab homelands prior to immigrating while others had received education and training in the United States. For some providers, working at the Medical Clinic was their first job in the United States; for others, working at the Medical Clinic was their first job ever. At the time of my fieldwork,

a number of staff and providers were taking college-level courses or technical training at night while working in the Medical Clinic during the day. Continuing education was an ongoing topic of discussion for many of the staff and providers.

A common pathway into the Medical Clinic for providers without specific health care training was through language and volunteering. Bilingual fluency in English and Arabic was an essential skill in this setting, especially for providers who directly interacted with clients. Most of these providers spoke of getting started in the Center by volunteering. Some of the providers were current, as well as former AmeriCorps volunteers. Americorps is a two-year, federally funded program whereby volunteers receive a small stipend and money towards further education. Some younger staff members were current AmeriCorps volunteers, and some of the full-time employees of the Medical Clinic were former AmeriCorps volunteers. As the stipends associated with this program are relatively small, AmeriCorps worked well for younger, single individuals who were living at home with families. However, I also heard from slightly older staff members, some married and in their thirties and forties, who spoke of AmeriCorps as helping them to engage in their first work experiences in the United States.

In talking about their work histories, it was also common to hear providers talk about having moved from program to program within the Center. Frequently these staff credited the Director as personally recognizing talents and offering them opportunities to grow and develop new skills. Many staff spoke of the Director in very positive terms, using the word "empowered" to talk about how the Director had encouraged them to advance and to take on new challenges and responsibility.

Shada, the medical assistant referred to in the introduction to this chapter, was one of a group of CMA providers, all female, who along with the Medical Clinic's main reception staff were responsible for moving clients through an assortment of health-related diagnostic and care-giving activities. CMAs were licensed through technical training programs, ranging from four months to a year depending on the level of certification needed. This training offered several program areas in which one could specialize. One line of training focused primarily on dealing with the various reception and intake activity associated with a health care visit, including the handling of routine communications, such as basic greeting and phone communication skills, determining clients' specific health care requests, appointment booking, and insurance and billing processing. Another line of training focused more exclusively on providing direct care to clients. This training prepared CMAs with the skills necessary for determining a client's chief complaint or reason for seeking care, obtaining initial components of a health history, and performing a variety of diagnostic tasks including the taking of routine vital signs and simple blood tests. These CMAs were also qualified to administration a wide range of medications, including vaccines and in-clinic treatments involving respiratory and wound care, and the administration of electrocardiograms.

While I also observed and interviewed other providers who worked within the Medical Clinic setting, it was the CMAs in particular who, being the first providers to interact with clients, were responsible for establishing the rapport and trust required for competent care-giving. A large part of the job for these CMA providers was the translation of a host of languages, including American slang, a range of Arabic dialects, the language of biomedicine, and the language of the emotional worlds of their clients.

These providers used their own understandings, experience, and training to interpret their clients' symptoms and complaints and then forwarded these interpretations on to the doctors and nurse practitioners who were in positions to make formal diagnoses and treatment decisions. In CMAs' roles as culture brokers and teachers, they were intermediaries between clients and the Medical Clinic's organizational routines, which placed them in strategic positions to be able to comment on the affective climate of the care-giving occurring in this setting. For these reasons, I focused most of my observational time on the interactions involving these CMAs

Over the course of eight months, I followed and observed the ways in which these CMAs spoke in their interactions with the clients. I listened to them when they described the circumstances of their clients to each other and to me. I listened to them comment on their working conditions, and I watched how they interacted with each other to get work done. And I listened to these providers as they shared with each other and with me their everyday lives and concerns.

The following section describes the general physical layout of the Medical Clinic. Here I focus on the Back Hallway, the large inner hallway where the bulk of the Medical Clinic's care-giving activity takes place. In this description, I introduce a number of key providers, paying attention to the way they access this primary site of care-giving, the kinds of work they engage in, where that work takes place, and finally, how they interact with clients and each other. Following this description I will then set into a more detailed examination of the two sets of interactions of interest.

The Medical Clinic: Spaces of Translation

On entering the Center building where the Clinic is housed, one steps into a modern, light-filled foyer containing a few chairs, potted floor plants, and a main reception desk. This main desk is usually occupied by a staff person, often female, fluent in Arabic and English, who greets visitors, provides directional information, and handles all incoming calls. Off to one side of this desk is a single elevator, the most direct way of accessing the Director's office and the mental health programs for victims of crime and torture located on the second floor (described in the previous chapter). On the other side of the main reception desk is a long hallway, off of which are public restrooms and also a kitchen for employee use. This same hallway also leads to a narrow corridor off of which are a series of small offices, the Clinic's laboratory, and the back entrance to the Clinic's pharmacy. At the end of this corridor is the Back Hallway of the Medical Clinic, the area in which the bulk of care-giving activity, aside from the more private individual exam room activity, takes place. This lesser-known route to the Medical Clinic's principal site of care-giving is the route taken by most of the providers and staff who work at the Medical Clinic, and functions as a sort of service entrance. This route is occasionally used by newer clients who, unfamiliar with the routine check in procedures of the Medical Clinic, or in the case of some immigrants, the routines of any health care facility, are simply seeking the most direct route to their providers. This route is also used by long-time, established clients, and their family members, who may not have appointments, but wish to visit with staff, have their blood pressure checked or ask a question. The presence of these "unofficial" visitors in the Back Hallway results in a particular mix of clients, family, staff and strangers and will be discussed in more detail later in this chapter.

Reception Room

To the right of the main reception desk, one sees the "official" entrance to the Medical Clinic, two double glass doors, through which can be seen portions of the Medical Clinic's Reception Room. While the Medical Clinic officially opens at 9 a.m., clients often arrive early, and rather than sitting in the outer initial waiting area, they enter the Reception Room to wait. As in my earlier description of the Center's parking lot, both clients and the reception staff in the Reception Room display a range of looks and dress. Females, including many of the Medical Clinic staff in this area, are frequently *muhajabah*, wearing longer tunic tops over slacks, or else floor-length skirts and tunics. Some female clients, especially Yemeni clients, are dressed in full *abaya*s, with various facial coverings obscuring all but eyes. Male clients display a range of dress styles, jeans, suits, tunics, and head coverings.

The Reception Room is divided into two areas by a main check-in counter that runs the entire length of one side of this room. On most days as many as four receptionists sit behind this counter. The three full-time receptionists are bilingual Arab immigrant women in their early twenties and early thirties. Sitting in front of computer monitors and telephones, in addition to greeting and checking in those who have appointments for the day, these receptionists schedule new and follow-up appointments, field questions, at times consult with the Clinic's main doctor to see if a client might be worked into the day's schedule, check insurance, explain fee scales to clients, and conduct cash transactions for those without insurance, which are most clients. Located just behind these receptionists is a floor-to-ceiling, sliding shelving system containing hundreds of client charts. Behind this shelving system are the offices

of some of the supervisors of various programs housed within the Medical Clinic, including the offices of the supervisors of the refugee and cancer screening programs.

As mentioned earlier, receptionists, along with staff in every area in the Medical Clinic, spend a large part of their day interpreting and translating. At the check-in counter, receptionists and clients quite frequently communicate in Arabic. Not only are many of the clients non-English speaking immigrants, many are unfamiliar with the routines of a health care appointment in the United States and the need to present general identification and insurance verification. On a number of occasions I witnessed receptionists connecting customers with programs providing free or low-cost medications or alerting newer immigrants to forms of general assistance that they were unaware they qualified for. When this desk got busy, as it often did, staff from other areas in the clinic, including the CMAs, would pitch in to answer phone calls and assist with clients.

Communication between receptionists and clients also frequently took place in English. In the case of clients who were non-English and non-Arabic speakers (i.e. Spanish speaking clients and clients who were refugees from Africa), communication frequently took place in English, where neither receptionists nor clients were able to communicate in their first languages. Sometimes receptionists would initiate greetings with clients in Arabic at other times English. When I asked the receptions staff how they decided which language to use in greeting clients, some receptionists said that they always began in English, saying, "We are in America now and clients have to learn to speak English." Other receptionists said they could often tell by a client's demeanor, as

in if eyes were averted and gazes were downward, whether or not clients would be able to understand English well.

Translation efforts were also frequently observed between Arabic speakers with different dialects. It was common to hear a Lebanese receptionist enlisting the help of a Yemeni or Iraqi co-worker in trying to understand the Arabic of a client from an Arab homeland other than her own. These kinds of translation challenges were constant, so much so that my own questions about Arabic use, grammar, and pronunciation were never treated (at least outwardly) as being the least bit disruptive. On the contrary, my questions frequently generated extended conversations around language that drew in the perspectives and commentary of other staff within earshot.

A different kind of translation exchange involved those which took place between Medical Clinic receptionists and the male family members of some of the female Arab clients. Often I observed female clients come into the Reception Room and take a seat while their male escort, a husband, a father, father-in-law, or a son, came up to the desk to check them in for their appointments, to make requests on their behalf, or to clarify questions related to appointments. During some of these exchanges, a male escort might talk across the Reception Room with his female family member; at other times these exchanges were conducted more privately.

The client waiting area had chairs placed about the periphery of the room as well as in rows in the center. These rows faced a large flat-screen television broadcasting health-related programming in English which ran continuously during clinic hours. Along the wall is a window, with a ledge and sliding glass panes, that opens into the Clinic's

pharmacy. There is a single door leading to the Back Hallway, the inner Medical Clinic area where clients are seen by providers. CMAs appear at this door, call clients by name, and escort clients through the door to a large staging room where they begin the activities associated with most routine office visits. On the staff side of the check-in counter, this same Back Hallway is accessed by a larger entryway through which CMAs, other Medical Clinic staff, and receptionists continually move back and forth in the course of conveying and seeking information necessary for the provision of care. Once a client has been checked in and paper work completed, a receptionist places a client's chart on a nearby ledge and rings the bell to alert the CMA staff that a client is ready to be seen. The following section describes the Back Hallway where clients were moved about by CMAs in the course of most routine health visits.

<u>The Back Hallway</u>

The Back Hallway is a large hallway located in the interior of the Medical Clinic. Most of my observational time was spent within this hallway, a semi-public space[19] in which new refugees and clients seeking primary care services moved about as they progressed through the different stages of their appointments. The principal areas of care in this hallway consist of the Activity Room, the Triage Station, the Midwifery Corridor, [20] and, down at one end of the hallway and around the corner, an area

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[19] In a description of the Back Hallway, the terms "public" and "private" come to take on different meaning depending on the ways individuals define themselves and on whom they are interacting with. Goffman (1959) and his ideas of the difference between the "front" and the "back" in face-to-face interactions come to mind, however, in the analysis of the way this particular space was used, I focus more on the ideas of identity their relationship to various modes of inter-subjectivity.

[20] The midwifery program was associated with one of the larger health care institutions in the City, renting four exam rooms in one of the corridors off the Back Hallway. Many of the clients coming to these midwives were Yemeni women who preferred to be seen by female providers. Two, bilingual Yemeni Arab American MAs and one bilingual receptionist were part of this program. While these staff interacted

designated for a women's cancer screening program. Interspersed off this same main hallway, in between these major areas of care-giving, were corridors with individual exam rooms, staff offices belonging to the full-time MD, the nurse practitioner, the director of adolescent health care, and the director of the Medical Clinic. Given the research permission parameters for this study, I include no observation of providers interacting with clients in individual private exam rooms.

As was previously mentioned, frequently, longtime clients and sometimes family and friends of both staff and clients would appear in the Back Hallway to visit, to see if they might speak to the doctor, or to find one of the regular staff for help interpreting an wide array of documents written in English, like lab results, prescriptions, utility bills, and an assortment of official looking letters. In contrast to the areas providing mental health care, where space, outside of the initial waiting area, is divided into cubicles and individual offices, the "Back Hallway" contained a more free-flowing range of care-giving activity and social interaction. This space was a place in which intersections of clients, families, and providers overlapped.

Not all spaces located in the Back Hallway evidenced this mix and flow of interaction. Clients using the midwifery program (a program administered by a large health care corporation in the City, separate from the Center) were usually not called to the Back Hallway until exam rooms were ready for them (perhaps out of concern for the modesty of clients, many of them Yemeni women). In the Reception Room I noticed that

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with the Clinic staff and I was able to observe and interact with them as they went about their work, as they were part of a separate health care institution, my IRB did not allow me to formally interview them for this study. The few observations I do include of these providers were ones made in areas accessible to the public.

when clarifying reasons for visits with male family members who would be accompanying and speaking for their women at these appointments, the receptionist for the Midwifery Program usually spoke in lower, more hushed tones. Appointments for the cancer screening program, where clients were able to obtain referrals for cost-free mammograms, were made directly by the staff in that program and not through the Medical Clinic's main receptionists. These clients were instructed to proceed right through the Reception Room to the Back Hallway.

Activity Room

The Activity Room is a large, bright room with many windows and long collapsible tables that allow for easy reconfiguring of the space for various programming. While this room also serves as a place for staff training and occasional social events, the room's primary function is being an initial staging area for most routine health visits. Here CMAs took vital signs, collected medical histories, and elicited clients' "chief complaints" or their reason for seeking health care. On busy days, such as the mornings devoted to seeing newly arrived refugees, whole families, consisting of parents and children as well as other refugees, might be present at the same time in this room. In order to better convey the activity of this space I will recount one of my first visits to this space, describing the staff's interactions with clients.

On my first day at the Clinic, I observed four female Lebanese American CMAs interact with a group of twelve recently arrived Iraqi refugees as they moved through the initial stages of a federally required health exam, a condition of their being granted asylum in the United States. Placed on top of the tables were stacks of unused, opened

charts and piles of empty plastic specimen containers. On one side of the room were three rolling blood pressure cuffs, each placed next to a chair, and a scale for measuring height and weight. On the other side of the room was a long counter, on top of which was placed equipment for checking blood glucose and hemoglobin, boxes of lances, alcohol wipes, and gloves, a sharps container, and hand sanitizer.

On this morning, three of the CMAs working in the Activity Room were women in their forties who had immigrated to the United States as young adults. Two of these CMAs were *muhajabah* and were dressed in differently colored scrub outfits. The fourth CMA, and the youngest, was Leila. Single and in her early twenties Leila had immigrated with her family as an infant. Over time I discovered that while fluent enough in spoken Arabic to conduct basic components of the pre-exam work-ups, Leila would frequently enlist the other CMAs for help with more complicated conversations.

As the CMAs readied the room for the first clients, an Iraqi immigrant family of five, two parents and their three children, I began to talk to Leila, who was busy labeling specimen containers. Once she finished with her labeling task and all looked to be organized, Leila, took a seat behind one of the tables, pulled out her cell phone, and began to text. As she texted, I asked her about what was going to happen in the room, and she began to tell me about the program for new refugees. During our conversation, I noticed Leila repeatedly pulling at the portion of her *hijab* located just underneath her chin. As we continued talking, another CMA also dressed in scrubs, who was not wearing a *hijab,* came into the room and looked around. Seeing Leila, this CMA said something in Arabic, laughed, and then left the room. Leila turned to me and explained that she had just started wearing a *hijab* and that she was still getting used to the feeling

of it. She explained that the CMA who had laughed had said that her itchy neck was a sign that she wasn't supposed to be wearing a *hijab*. Leila laughed and then explained that although her own mother did not wear a *hijab*, she had decided to wear it for religious reasons and that her older brother had told her he was very proud of her.

Once more clients began to arrive, I watched these CMAs interact with their Iraqi clients. Addressing their clients in Arabic, CMAs used short phrases, frequently seeking clarification and when doing so would make eye contact. At times, some of the Arabic speaking refugees would begin to speak in English and in doing so conversations begun by CMAs in Arabic would then switch to English.

Once clients complete this initial stage of their health appointment in the Activity Room, a CMA escorts them to an exam room where they are seen by a doctor or nurse practitioner. In the case of families with young children, often all would be seen in one exam room together. In the case of non-Arabic speaking practitioners, CMAs would remain in the exam rooms to act as interpreters. If there was no open exam room, CMAs would escort clients to another smaller waiting area, located in an open alcove along the hallway. This alcove is also a place where clients wait to be called to the Medical Clinic's laboratory for blood work, to the Triage Station for some kind of injection or treatment, or for to await further direction from the doctor. I also saw this inner waiting area used as a sort of holding area for new refugees who, often having to wait for long periods of time in the main Reception Room, would be moved here by staff as a way to make them feel as though their visit was progressing.

Triage Station

Almost directly across the hall from this waiting alcove is another alcove, known as the Clinic's Triage Station. No more than eight feet square, the Triage Station was one of the busiest places in the Back Hallway. On one side of the space is a counter with cabinets above and below and a sink. A chair for clients sits adjacent to this counter. Directly across from the sink, on the opposite side of the space, is a refrigerator on whose door is an inventory of its contents: vaccines, an assortment of medications, and specimen containers needing refrigeration. Taped to the interior-most wall, in between the sink and refrigerator, are various guidelines for immunizations, flu vaccines, pregnancy test routines, and injection and hand-washing techniques. A file organizer holding different educational handouts on various vaccines with English and Arabic translations is affixed to the wall above the desk area. When privacy is needed, a curtain is slid across the opening to the alcove.

Despite its small size, the Triage Station is a central hub of care-giving. Adult immunizations and a variety of medications are administered here, along with pregnancy tests, as many female clients needed to provide official documentation in order to receive Medicaid coverage for prenatal care. Forms for all the lab work done at the Medical Clinic are filled out here. Clients without insurance have to pay for lab work, so in addition to providing care in this space, CMAs would frequently explain fees and conduct money transactions involving cash and credit cards. If clients were unable to pay, there might be communication back and forth between CMAs and the Medical Clinic's primary medical doctor or nurse practitioner about which tests were most essential or whether this was a case in which funds for special-needs cases could be used. Lab results were also delivered to the Triage Station and CMAs were responsible

for placing results in charts, notifying clients that their lab results were in and ready to be picked up, and making sure that more urgent or abnormal results were brought to the attentions of the doctor or nurse practitioner.

The Triage Station also served as a central communications and gathering place for both staff and clients. Located midway along the Back Hallway, this space provided a good vantage point from which one could maintain a sense of what was going on in the rest of the hallway. Its open alcove was easy to access, and frequently the CMAs working in this area were approached by long term clients who might be visiting the Center for reasons other than medical ones (again, using the unofficial or staff access to the Back Hallway via the lesser-known corridor). CMAs were frequently approached by clients and family members they did not yet know but who, due to word-of-mouth in the Community, would be sought out for care. CMAs would tell me of new clients telling them that they came from the same village in Lebanon as the CMA, or that they had heard they had known the same people.

The Clinic's doctor and nurse practitioner would frequently come to the Triage Station to write additional orders or to touch base with clients whom they had already seen in order to further clarify their instructions. At times, I witnessed as many as six people in this small space, a mix of clients, family members, and various providers moving in and out performing different tasks. Multiple conversations in Arabic, in English, or a mix, frequently took place. I also observed many occasions when these separate conversations would dwindle as all in this cramped space came to listen to the most compelling, the most interesting, or quite frequently the most humorous story being told. The mention of compelling stories brings me to Khadija, the most senior

CMA at the Medical Clinic. Khadija, through her actions, displays many of the interesting aspects of social life at the clinic; she is a key figure in the interactions to be described in this chapter. The following contains a more extended description of her circumstances and personality.

In her forties, Khadija emigrated from Lebanon in her teens, newly married. She had been a CMA for fourteen years and had worked at the Medical Clinic for six. Now divorced, Khadija was a single parent and the primary bread winner for her family. While other CMAs would handle the activities of greeting clients and taking them through the different stages of a health visit within the Back Hallway, Khadija usually stayed close to the Triage Station overseeing most adult treatments and lab work. She worked closely with the Clinic's primary doctor, who was also an immigrant from Lebanon. Their exchanges were for the most part conducted in Arabic, and although I was unable to make out most content, the rapid, synchronous, often affectionate back and forth of their exchanges signaled ease and familiarity. The Clinic's doctor often sought out Khadija for her assessment of what was going on with a client, and many times I would observe how they would consult with each other over how to best use limited resources to meet the needs of individuals with special circumstances. The two formed a strong working team.

Khadija's command of spoken English was halting. However, over the course of our many conversations, in and outside of the Clinic, she was usually able to understand the content of my questions and my reasons for asking them. Always moving and busy, as she listened to my many questions and comments sometimes she would laugh and tell me I was "talking philosophy." At other times, when tired from a

busy day at work or after a busy night at home with her family, she would warn me off, saying, "I don't want to go deep." There were also times when after trying her best to make herself understood she would go off to find a better English speaker than herself to make sure I understood her message.

Khadija had a distinctive and contagious laugh, one heard throughout the "Back Hallway" on the days she worked. She was usually the first one to find the humor in a situation and, as I was to discover, was known to instigate practical jokes, usually at the expense of her co-workers (Khadija was the CMA who commented on Leila's discomfort with her new *hijab*). My sense was that some of the staff, especially those who occupied positions of more authority, at times viewed Khadija's behavior as irreverent; however, I also observed these same staff members seeking her input when it came to care. Khadija was also extremely generous. She frequently brought staff fresh cuttings from her garden, figs or tea leaves for someone's aches and pains mentioned the day before. Also, making ends meet was a common topic of conversation among CMAs, and I noticed that Khadija would often pass on to other staff extra food and household items she would find on sale. In contrast to her more boisterous side, these offerings were quietly made. Khadija's demeanor with clients was also careful, gentle, and respectful. These qualities made her a clear leader, and many staff, especially new and younger staff, sought her advice.

Having described the physical layout of the Clinic and a few of the principal providers responsible for care, I next move to the analysis of two key interactions, the first focusing on providers' interactions with clients and the second focusing on providers' interactions with each other. For both interactions, I first provide context by

describing the key providers in the scene and the circumstances leading up to the interaction. I also reference related interactions and include the voices of other providers in the setting through relevant excerpts taken from my interviews with them. I then, as in Chapter 4, apply the categories of EI.

Interaction I

Mothers and Others

> Yeah, you belong to this family, I hate to...live lonely and you work and no life and I don't know. (Bassima: Int #18, 7-29-10)

It was Week # 5 of observing and I arrived at 9 a.m. on one of the mornings set aside to see clients who were new refugees. I entered the Back Hallway via the Reception Room where I noticed only a few waiting clients. Once in the Back Hallway, I made my way to the Triage Station. I knew that in addition to taking care of left over business from the day before, Khadija would be busy preparing vaccines and immunizations based on the report she has received from the coordinator of the refugee program. On this morning, well before getting to the Triage Station, I heard the sounds of intermittent moaning and garbled speech. I noticed a group of people sitting in the inner waiting alcove area, a middle-aged man, a woman, and two adolescent teenagers. I then located the source of the moaning as coming from a young woman in her late twenties who, by the way she moved and sounded, appeared to be physically and cognitively impaired. She had a short, cropped hair style and was wearing a purple sweat suit and orthopedic shoes, and she was pacing the hallway. Once I got to the Triage Station, Khadija told me that this group was a family who had just come from Iraq

who had been traveling for many days. I noticed that when the young woman would wander too far down the hall from the rest of the family, one of her siblings would get up and gently try to lead her back to the group. At times the young woman would resist these efforts, her moaning becoming louder. As I watched two of the girl's siblings attempt to monitor or accommodate their sister's desire to move about, I saw the mother get up and go to her. Putting her arm around the young woman's waist, she began to stroke her daughter's forearm and shoulder. The young woman's restlessness and moaning subsiding, I saw her slip comfortably into her mother's arms.

Standing next to Khadija, who had tried to intervene by offering the young woman some candy, I told her how moved I was by this mother's gentle response to her daughter and that I could only imagine how tired this mother must be with the whole process of immigrating to a strange country. In response to my comment, Khadija pointed to the bottom of her own feet saying, "The heaven, the god, goes into the mother because she is the mother." Both Leila, who had joined us at this point, and I laughed and said we didn't understand. Khadija attempted to explain further, in Arabic to Leila, in English to me, saying that mothers, because they care so much and because they suffer, they are good. Not satisfied with her translation, Khadija went off to the staff in the Reception Room for help. She approached several Lebanese and Yemeni staff members before Leila finally realized what Khadija had been trying to say. Leila explained that mothers are so revered, that after they die, they are placed above heaven. In this way, heaven sits below them, below even their feet. Confirming Leila's translation, Khadija later told me that the *Quran* mentions mothers many more times than it mentions fathers, proof, she explained, of their importance.

Khadija's relaying of this saying was one of the many statements I was to hear from providers and CMAs (many of whom were mothers themselves) about the important role of mothers and more generally about the importance of family. The following interview excerpts further reflect this emphasis on the family.

> …it's good to stay with your family, you become more stronger, you know, you need somebody behind you, to push you, to advise you, to give you a lot of advice. (Bassima: Int #18, 7-29-10)

> This is the whole life, the parents. (Shada: Int #16, 4-19-10)

On another occasion in the Back Hallway, near the Triage Station, I observed Khadija intently listening to the wife of a client who had come in for medical care. This interaction occurred on a morning when the Medical Clinic was extremely busy and the Back Hallway was packed with clients and family members. I noticed that Khadija had suspended her usual busy pace to listen, at some length, to the concerns of this one woman. Curious, I later asked Khadija to tell me what they had been talking about. She explained that the wife of her Lebanese immigrant client, had been describing her husband's long history of mental impairment, impairments that had prevented him from finding work in the United States. Khadija explained further saying that the wife had told her how her extended family, also in the United States, even her children, had over time, slowly withdrawn financial and emotional support for their parents. Khadija told me that she was going to let the Medical Clinic's doctor know that this client, in her view, qualified for special funds set aside to help in cases of extreme need. When I asked Khadija how they decided which clients qualified for this kind of assistance, Khadija

thought I was questioning her client's need. Clearly agitated, she exclaimed, "Anne, this man is not right! His wife says he has never been right. He works washing dishes and they have no other help. He thinks this place is like Lebanon, that he can walk down the street and people will give him food and take care of him. He does not know that it is different here. He needs help!"

<u>Relevant EI Categories</u>

Culturally Constituted Activities (CCAs)

Khadija's reactions to two different clients, each having special needs related to cognitive impairments, reveal cultural ideals for how and by whom, individuals, unable to care for themselves, are to be treated and cared for. These cultural ideals may be related to a definition of personhood in which individuals are expected to direct energy first to the needs of the group or family and in return be taken care of by them. In the first interaction Khadija responds to my comment about the mother of an older, physically and cognitively impaired child. Her attempt to translate the saying about mothers explicitly emphasizes the role that she saw this mother as having in caring for her child with special needs. Khadija's use of the saying also emphasizes more implicit cultural ideals about mothers and families in general. Mothers are patient caregivers, willing to take on the sufferings of their children and their families at the expense of fulfilling their own wants, and in the end are placed "above heaven" as their reward. Family members also have responsibilities to each other, as was seen in the attentive way in which the cognitively impaired young woman's siblings watched after her in the hallway.

In the second interaction, Khadija again revealed her expectations concerning the responsibilities of family and the larger community in caring for those with special needs, in her reaction to their absence. Khadija's special attentiveness to her client and her agitated response to my question indicates that in her estimation both the family and community have transgressed a cultural norm and have not done right by her client. These transgressions may have contributed to her decision to tap special funds for those clients evidencing extreme need. One wonders what Khadija considered to be the most urgent need, her client's lack of financial resources or, in his estrangement from family, his lack of social resources. Khadija's statement, "He thinks this place is like Lebanon, that he can walk down the street and people will give him food and take care of him. He does not know that it is different here," indicates that she knows that her expectations of family and group are not necessarily shared by Americans.

This same CCA concerning a definition of personhood in which individuals are expected to give primacy to the needs of the group and less so the needs, wants and aspirations of individual group members may also be reflected in the way space in the Back Hallway was utilized. There providers worked in open spaces easily accessible to clients and family members. The small size of the Triage Station itself, despite the many activities that took place within it and the many staff who had access to it in the performance of care-giving, may be an indication that the size of the space, which results in many crowding together, is not seen as being disruptive or as conflicting with expectations of individual privacy. As clients wait together in the Back Hallway for the next stage of their visit, their stories are frequently addressed to whomever happens to be in their immediate surroundings, and advice from providers and "others" is at times

mixed together. The character of this hallway becomes significant as the ways in which it is used may reveal ways of problem-solving based on culturally defined perceptions of the responsibilities that individuals have to the larger group. There CMAs interacted with clients as responsive health care providers, yet they also act out obligatory, expected responses in their roles as members of the community. In this particular health care setting, providers' dual roles as providers and community members served to enhance the other.

A contrast to the way these areas of the Back Hallway were used can be found in the midwifery corridor, a short hallway consisting of four exam rooms, and in the space further down the hall and around the corner utilized by a cancer screening program. Rented by a leading health care organization in the City, the space used by the midwifery program, staffed by Caucasian American, predominantly English-speaking, certified midwives, had a much different tone and climate. Clients using this program were moved from the main Reception Room directly into individual exam rooms. I never noticed these clients waiting in the Back Hallway areas and I never overheard discussions related to care from these providers, or from the CMAs who worked specifically with the midwives and who were also employees of the larger outside health care organization. The same can be said for the clients coming in for services offered by the cancer screening program. These clients were seen in their own separate waiting area down around the corner at one end of the Back Hallway. The health assistants for this program were supervised and trained by the RN who oversaw the program. Both programs, however, also had extenuating circumstances that may have led to the different ways space was used. Many of the clients using the midwifery services were

Yemeni women whose notions of modesty resulted in them preferring care from female providers. Also, as cancer continues to be a highly stigmatized health condition in Arab communities (Mellon et. al. 2012; Schwartz et. al. 2004), extra provisions for privacy may have been instituted in order to promote as well as to facilitate access to cancer screening measures.

Focal Emotions

Empathy, found to be prominent in my interviews with mental health providers in the last chapter as an explanation for emotion and as a way of describing how providers were uniquely qualified to do their work, is also present in Khadija's explanations to me concerning her two clients and their families. In the first scenario, Khadija described a mother's suffering and how her acts of caring would be rewarded. In the second scenario, Khadija displayed a strong reaction to the lack of support and compassion shown to her client by his family and his community. In Khadija's descriptions to me, in her tone, in her insistence that I understand the saying about mothers, and in her reaction to her second client's lack of understanding through her statement "It is different here," there was a knowingness about Khadija's manner which led me to believe that she may have experienced similar circumstances or feelings herself.

This same emphasis on empathy, as well as repeated references to caring, were also noted in my formal interviews with other providers in this setting, in their responses to my questions asking them to describe their work, and frequently as part of their first way of talking about emotion. The following excerpts are all providers' first responses to

my question asking them to define emotion. The first excerpt below comes from my interview with Khadija.

> Emotion is when you feel and help…If I feel about you, you need help ...the feeling is, let me move...this person to help him. I never help person with[out] feeling. I can't help people without feeling. Sometimes, you know? (Khadija: Int #15, 3-19-10)

The next excerpt comes from my interview with Shada, the CMA mentioned at the beginning of this chapter. A member of a large, close family, Shada immigrated to the United States from Lebanon a decade ago in her twenties, leaving behind her parents, a number of siblings, and a job she loved as a florist. Soon after arriving in the United States, Shada got engaged and then married, a period she describes as being too busy for her to pursue work outside the home. She remained at home until her two children reached full-day school age and then enrolled in a six-month medical assistant program which led to an internship and eventually to a full-time position at the Center. When we met, Shada had been working in the Clinic for close to three years.

> Each one, like you said, has different emotion, like maybe sensitivity or feelings…maybe I'm gonna say each people or each person has his own or think about his way or find a way for emotion. For me, maybe you're gonna ask me, Do you care about people? .. Like in my job I care about people, I try to help people as much as I can. (Shada: Int #16, 4-19-10)

Maha was a 20-year-old AmeriCorps volunteer who worked in an adolescent health program. Maha was nine years old when she came to the United States with her family. One of her main responsibilities was to administer a survey to adolescents designed to assess for health risk behaviors. Maha and I were to have many discussions about what it is to be a young Arab American in the United States.

Emotion. Well….It depends on how sensitive a person can be…defining emotions is that if you really care sometimes…When I say that it means, like, if I see someone, like, saying they're having a problem or they're crying, I cry with them, not knowing why, because I just tend to be very emotional. I just don't know what's going on but I do cry because I care so much about that person, even though I don't know that person. Like, for me it's just being emotional is like, I help out people…" (Maha: Int#17, 5-27-10)

This next excerpt comes from my interview with Nadine. Nadine emigrated from Yemen at the age of 19 and has lived in the United States for over three decades. She is married with grown children. She began working at the Center as a volunteer and over the years had come to take on different roles with increasing responsibility. When I met her, Nadine was working full time as a facilities administrator. In addition to dealing with all sorts of regulations regarding the operation of a health care facility, she also functioned as a part-time receptionist and customer relations representative.

Like I said, different emotions are happiness, sadness, neutral sometimes too, you know. Sometimes emotions are heartless too. You can be really heartless and not sympathize, and, you know, those are your emotions, too. (Nadine: Int # 19, 8-12-10)

Lastly, in my interview with Bassima, a newer CMA who came to the Clinic for her internship, Bassima responded to the same question (I will describe her in more detail in the second interaction).

Emotion, like feeling. You care about somebody. You feel bad or happy or sad or mad or anything about somebody…… if it's emotion to hate or love somebody, you have emotion in both way, or hate, or love, or like, or nothing. (Bassima: Int #18, 7-29-10)

These explanations for emotion, as discourse on emotion, will be further explored in the section Specific Communication Practices.

Temporal Event Structure

The two interactions with clients' families took place over the course of two separate mornings as these clients moved through different stages of their health exams. In Khadija's interaction with the family of Iraqi refugees, she assisted them before and after they met with the doctor, providing immunizations for all family members, and processing ordered lab work. Khadija also assisted the mentally impaired male client and his wife as they moved through the various stages of the husband's health appointment.

The excerpts containing providers' explanations for emotion were taken from formal interviews conducted over an eight-month period while observing in the Clinic setting. These interviews were conducted in private and lasted anywhere from one to two hours.

Spatial Location

As mentioned above, these interactions, both Khadija's with her clients, and Khadija's with me, took place in the Back Hallway, in the alcove used for waiting clients and in the Triage Station almost directly across the hall from this waiting alcove, places where staff, clients, and families intermingle and meet in an overlapping flow. Within this space, providers, clients, and their families are able to view each other as they wait for the next stage or activity associated with their visit. It was within these spaces that Khadija was able to view the interactions of the first family and the mother with her

daughter. In the space of the Triage Station, the wife of the client with mental impairments and medical issues was able to directly approach Khadija with her questions and concerns.

Key Identities and Relations

Khadija's mention of the saying regarding how mothers are to be rewarded reveals the highly regarded role and place of mothers in Arab society, the high expectations placed on them, and the importance of family in general (Aswad and Bilge 1996; Kulwicki et al. 2010). Also revealed is an emphasis on empathy and compassion as forms of social attunement. Khadija's description of this particular mother's "special burdens" indicates that Khadija viewed the young woman's impairments as being significant and as adding to this mother's many responsibilities. In both cases, however, I got the sense from Khadija that family members are not only expected to assume responsibility in cases of family members having disabilities: the family is the first, best and expected resource in caring for disabled family members. In the case of the impaired young woman, I wondered whether her siblings' seemingly matter-of-fact response to her wandering about the hall may be taken as an indication of an acceptance of who she is and of her secure place within the family.

Like Khadija, the other CMAs in this setting spoke of helping others as a key aspect of their job as health care providers. However, as already mentioned, for these providers, caring and empathy may also be seen as a requirement of their belonging to their Arab Community. As clients access CMAs in the Back Hallway, they not only access health care providers who are viewed as holding specialized knowledge, they

may be also accessing subordinates, young women, daughters, and sisters. Thus, these providers' responses to their clients must be seen for how they relate to the larger Arab Community. Here, in addition to relating to clients as professionals, as experts in positions to offer health advice, CMAs may also be expected to relate according to other more significant primary relationships. These more significant relationships may help to explain the overlapping mix and flow of providers, clients and families in the Back Hallway. As subordinates, access to these CMAs may not involve the same kinds of boundaries found to often exist between clients and health care providers in other biomedical settings.

Specific Communication Practices

In a consideration of the frequency with which empathy, compassion, and caring were referred to both explicitly and implicitly in providers' assessments of their clients and in their explanations for emotion, I return to a discussion of the term *shaoor.* First referred to in Findings, in Chapter 4, in my interview with Ador, he used variations of the term *sha-oor* as a way of explaining how he used to think about emotions before he got his training in mental health.

> …before being involved in the mental health field, emotion for me was only the positive ones, love and joy and these kind of, and I see now, the majority of Arabs now, when I say emotions *Sha*r in Arabic, right away they think about love… because the word in Arabic, *mu-shar*, which is emotions, it's related to the love feelings. (Ador, Int #9: 1-14-10)

By way of review, Ador went on to describe how his Arab clients did not think about the "rest of the emotions, such as fear, anxiety, joy, happiness, hate, anger" and

he talked about having to spend time with his clients to get them to understand the rest of the emotions.

> So I have to spend time to cognitively make them understand what are the rest of the emotions, which is fear, anxiety, joy, happiness, hate, anger, and all of the rest of the emotions… they put all their emotions in their thinking part, it's not the feeling part, they think their feeling…(Ador, Int #9: 1-14-10)

At the time of my interview with Ador I was in the early stages of fieldwork and his use of the Arabic terms relating to emotion went unnoticed. As I entered more fully into the worlds of the providers in the second setting of the Medical Clinic, I began to notice that, in response to my question about emotion, providers would immediately begin to talk about "caring" and "feeling" and empathy and compassion were emphasized. While being able to empathize was also emphasized in my earlier interviews with mental health providers, with this second set of providers these aspects seemed to be even more emphasized. I also noticed that specific, more negatively valenced emotions, such as anger and hate, were not mentioned as often or, if mentioned, were done so secondarily. I began to wonder if providers in the Clinic understood what I meant by the word "emotion." When interviewing mental health providers, they often listed a variety of different emotions, especially when referring to various mental illness diagnostic categories. I began to ask providers for the Arabic term for emotion and *sha-oor* was the first term mentioned, described as a word for "emotions or feeling." At times I would probe participants' responses further, asking such questions as "What is it that makes you cry?" My questions about specific

emotions such as anger, jealousy, and fear were usually first met with a request for the specifics of the interaction in which they occurred.

It was not until much later, while transcribing interviews, that I discovered that the term *"sha-oor"* had been referred to twice in my earlier interviews with mental health providers. The first time was with Ador and the second time with another male therapist named Saleh. Upon this discovery I began to wonder about Ador's reference to this term for emotion, a term he used to explain how he used to think of "emotions" as being about "positive" emotions of "love and joy" and that he found his Arab immigrant clients to be similar in their thinking. With this discovery, I began to wonder whether Medical Clinic providers' initial responses emphasizing empathy caring and were somehow related. While my lack of Arabic does not equip me with enough linguistic knowledge to more fully investigate these questions, Ador's explanation for how he used to think about emotions and the nature of Medical Clinic provider's first explanations for emotion stimulated thinking about the differences I noted between the ways the providers in the two settings responded to my questions about emotion.

Over the course of 15 months, especially in the latter half of the field work period when I was following providers in the Medical Clinic, I observed a range of emotional expression, both verbal and behavioral. Talk included anxieties over keeping up with the demands of a busy schedule at work and at home, as well as anxiety over finances and children. At times providers voiced irritation and anger over conflicts related to the job, to home, and over the hardships faced by many of their clients. Providers also expressed sadness at the long distance nature of their relationships with family overseas and at times over the loss of certain traditional life ways. Clearly participants

experienced and spoke about negatively valenced emotions. While these emotions were expressed in front of me and discussed with me in the day to day, they were not emphasized first in providers' explanations for emotion within the context of formal interviews. Anger in particular, if mentioned at all, was spoken about as an emotion to be avoided and controlled.

The following few excerpts contain references to the emotions of anger and hate. The first excerpt comes from my interview with Rima, one of the health educators at the Medical Clinic. Rima immigrated to the United States over two decades ago and is now divorced with grown children. She started as a volunteer at the Center and over the years held positions in a number of different programs. At the time of my fieldwork, Rima was in charge of overseeing other volunteers at the Medical Clinic and also functioned as the supervisor of a related health program. In addition to formally interviewing Rima, I was also able to accompany her as she provided community outreach to parents of elementary school-aged children in the surrounding Arab Community. During these times, Rima told me more about her life before coming to the United States. She spoke of being raised by her mother who, after the death of her husband, Rima's father, insisted on raising and providing for her children on her own as opposed to relying on the support, and terms, of extended family. In describing how much her mother valued her independence and of how hard her mother had to work to support her children, Rima glowingly described her mother as being her main role model.

The interview excerpt below was part of Rima's definition of emotion.

Emotion is part of our life, this is natural because we are human but I won't let my strong emotions control me because if they control me they control my life...so emotions is natural but the way how we control example anger, I don't want anger to take over me, but love, compassion, sympathy, that's fine, I go extra miles for that to help a client, with maybe I can say like positive emotion and negative emotion, positive emotion I cherish it, if it will have positive impacts on me and on others. (Rima: Int #13, 3-15-10)

This next excerpt is taken from my interview with Bassima. Here, I ask Bassima if some emotions were more "okay" to show than others.

You cannot show your emotion if you hate somebody but it's good to show your emotion if you love somebody, you can tell him I love you, I missed you, anything, but you cannot tell somebody I hate you, you can hide your emotion and don't talk to somebody anymore, you cannot tell him I hate you in your face, you can hide your emotion. (Bassima: Int #17, 5-27-10)

The following third excerpt was in response to my describing for one provider my observation that providers seemed not to say much about the emotion of anger. Mariam was a community outreach worker who came from Iraq with her husband more than twenty years ago.

We don't talk about [anger] because we can't. We don't have the freedom. We must protect the family. (Mariam, Health Educator: Fieldnote, 9-20-10)

As I began to think more deeply about providers' responses to my question asking them to define emotion, I began to think about the way in which I, as researcher asked about emotion in the first place. Within formal interviews, I first asked about emotion as a de-contextualized entity (see Appendix C) existing apart from social interaction. In my informal interviews with providers, when I would ask about specific

emotions, they frequently responded by asking me to place the emotions I asked about within some kind of social interaction. They wanted to know the circumstances and more about the people involved. This importance of social context in discourse on emotion can be seen in the following two statements.

> Alone we don't know our mood. We only know our mood when others come to us in our homes. (Khadija: Fieldnote, Week #17)

Khadija's statement that we know *"our mood"* only through others *"when others come to our homes"* came up in a casual lunchtime conversation where we had been discussing how we as women balanced the demands of family and work (an interaction to be described in more detail in Chapter 6). Khakija seemed to be saying that our emotions are best known through relationship, through interaction with others, "others" being emphasized. The following interview excerpt from Shada illustrates how discourse on emotion may vary when she refers to the "special emotion and feeling" for family. Here, her comment indicated that feelings may be shown, or expressed or perhaps talked about differently in public realms, outside the family.

> Maybe I have a problem from inside, my heart is breaking and nobody know. I can't show this for anybody, I can't show it…Outside I'm different…like outside my home. Between my family, I have a special emotion and feeling against [for] my family...(Shada: Int#16, 4-19-10)

In wondering what to make of these statements revealing an emphasis on empathy, the importance of social context and social attunement, providers' concern to control anger, or to hide it, and references made to the ways emotions may be

expressed differently depending on social context, I again refer to the work of Lila Abu-Lughod (1985) and Steven Caton (1990) on anger (presented in my discussion of my interview with Nasser). Did providers' ways of talking about anger reflect concerns about vulnerability and the importance of self-control?

Summary

In this first interactional setting entitled "Mothers and Others," EI categories were applied to my observations of two key encounters in which one CMA provider, Khadija, interacted with clients. Interview excerpts, drawn from a range of providers in the Clinic context, were used to further explain and illustrate themes related to identity, social interaction, and the discourse on emotion present in these two key encounters. The patterns involving discourse on emotion were found to emphasize: empathy and caring; providers' preference to place discussions of emotion within social contexts; a concern to avoid expressing anger, or at least to control it; and a de-emphasizing of more negatively valenced emotions by providers without mental health training. These patterns in discourse on emotion were found in a couple of different interactional contexts observed early on in my time in the Clinic setting involving one CMA's (Khadija) encounter with two clients and then her interactions with me as she explained to me about what was going on. These patterns were also present within formal interviews with a range of providers. Again, interviews were conducted in English. I posed questions that asked about work history and providers definitions for emotions. I include these distinctions as my interactions with providers were ongoing, some taking place earlier in the fieldwork period when we knew little about each other, others

occurring later after months of observation when we had come to know each other better.

It is possible that the patterns of discourse on emotion mentioned above may be related to a culturally particular definition of personhood in which group needs or more collective needs are accentuated over those of individuals. Emphasis on empathy and caring support social attunement, as they both may be viewed as contributing to group cohesion. The use of this discourse may also reflect cultural rules regarding ways in which emotions are to be disclosed, or discussed in public realms versus private realms. Providers' request to have me place discussions of emotion in some kind of social context may be similarly related to a definition of personhood emphasizing group or interaction over individual interior feeling.

While the concept of personhood may be a key aspect of identity related to the discourse on emotion and the emotion meanings reflected in the above interactions, as was noted in Chapter 1, ethnographic work on Arab immigrant and Arab American identities in the United States (Naber 2006b; Shryock and Abraham 2000; Ajrouch 2004; Joseph 1999) reveals how identity is shaped within contexts influenced by the intersection of specific histories of immigration, geographic regionalities, religious identifications, gender, race, and class. Along with these factors, in the following second interaction, I consider how material realities, personal circumstances, and subjectivities are also present in providers' discourse on emotion.

Interaction #2

Trying on Language/ Subjectivities and Selves

I think they just worry a lot about what others think …….They need to be at least who they are and be happy with what they think. I have a lot of people…they just can't be themselves… you should just be who you are…
(Maha, Health Assistant: Int #17, 5-27-10)

God knows but it's totally different here. Okay, you have a right, you are a woman, okay...but you are not less than the man, you are not second greater to him, so you are the same, equal. You-you have rights and you have responsibilities and he has rights and he has responsibilities. So this equality, it socially and mentally made me realize something like look at the human being as a human being. It's not for me anymore. It's man and woman. It's a human being who has the right to live happy and respected.
(Rima, Health Educator: Int#13, 3-15-10)

The interview excerpts and descriptions of providers' interactions with each other contained in this section illustrate how aspects of identity, material realities and personal experience are reflected in language use. The above quotes were taken from my interviews with two providers, Maha and Rima. As stated previously, Maha emigrated with her family at the age of ten. In her early twenties, Maha's main work at the Center involved conducting a health risks assessment with all children and adolescent clients under the age of twenty-one seen at the Medical Clinic. Her statement above was part of her description of her work at the Center. Over the course of observing at the Medical Clinic, Maha and I had many conversations about the experience of being young and Arab American in the United States. In her statement above, Maha tells me that the way she responds to her adolescents' worries about fitting in is to tell them that they should be okay with what they think and with who they are. They should "be themselves." In the interview excerpt below, Maha describes for me how adolescent Arab Americans' experience is often far different from that of their parents.

…for Arabs especially I think it all goes to their parents and their culture because they're growing here, they're seeing different things, here and they want to act on that. For example, they want to go to the movies, they want to go shopping, they want to go bowling, ice skating, all this stuff, but their parents haven't done stuff like that before and to their parents it might seem like you're trying to be, 'Why do you want to do this, you're trying to be like, why you want to be like other kids, we're not Americans…and the kids are just, like, kind of being confused, like they're living two lives, life out of school where they are with friends who are different, from different backgrounds, different ethnicities, kind of being more open to a lot of things…(Maha: Int#18, 5-21-2010)

The second quote at the beginning of this section came from my interview with Rima, one of the health educators described earlier in this chapter. Rima described how she found attitudes towards male and female gender to be different in the United States compared to her homeland of Lebanon. Rima states that although "you are a woman…you are not less than the man," and even though both men and women have their own "responsibilities," according to Rima, in the United States, men and women are "the same, equal." Rima goes even further to describe how individuals have rights, not because they are either male or female, but more importantly because they are human beings. Beliefs and attitudes concerning gender, gender roles, place, and belonging were common topics of conversation among providers. The accounts below describe a series of interactions related to one CMA's experience of changed status as the result of divorce.

Shortly after I began observing, a new CMA started working at the Clinic. Bassima had been in the United States less than a decade. She emigrated from Lebanon immediately after getting married and then spent her first years in the United States at home caring for her young children. When Bassima's husband suddenly told

her he no longer wanted to be married, Bassima, alone and away from the rest of her family, was left without the means to provide for herself and her children. With the help of a Center program offering employment services, Bassima was able to use the two years of nursing training she had completed in Lebanon to transition into an intensive medical assistant program. Coming to the Clinic was part of an internship experience required by her program.

When Bassima first started at the Clinic, she was quiet and withdrawn. Over the following six months, among the company of the CMAs and reception staff, I watched as she transformed into a warm, open, helpful co-worker. Bassima was smart, she caught onto routines and language quickly, and as I came to know her better I discovered that she possessed a wonderfully dry sense of humor. These qualities were especially apparent in the clever way Bassima would string together and practice her growing English vocabulary.

In the Triage Station I was frequently present when the CMAs would discuss the ups and downs of relationships, romantic ones (their own and others) and those relationships involving extended families, parents, in-laws and children. Marriage, the fallout from divorce, the character of "men," the management of work and family life, especially the management of children, and struggles to make ends meet were frequent topics of conversation. At these times, conversations would be conducted in a mix of Arabic and English. There were also occasions when expressions would become serious and talk would convert to Arabic only. It was on one such occasion, again, in the small space of the Triage Station, that I watched as Bassima revealed to her co-workers the personal circumstances surrounding her marriage. While I was to learn most of the

details of Bassima's story later, as she spoke I watched her listeners who, with the exception of intermittent short acknowledgements of encouragement and sympathy, a cluck of the tongue, or a murmur, remained silent. At times, spoken low and clear, I heard the word *ayb,* the Arabic word for shame.

The following describes the interactions of a gathering of CMAs. It was the end of the first week of Ramadan. On that particular morning, the Clinic was slow and already staff were complaining of being tired from fasting and late-night feasting. Khadija, Bassima, Leila and I were in the Triage Station when Saleh, the male staff person who manages one of the health programs in Clinic, passed by down the hallway. A Lebanese American immigrant in his late thirties, Saleh is an integral, well-liked member of the Clinic staff. He had recently been promoted to the official role of coordinator of his particular program, a big job. Seeing Saleh, Khadija quickly hopped out of the Triage space and followed him down the hallway. Squaring her shoulders back and thrusting out her chin, Khadijah said in English, "Saleh walks like this. He is coordinator now." All present laughed, including Saleh, who stopped to turn around and face the group. Then Khadija said, "Before, he walked this way." Here, Khadija hunched her shoulders, lowered her head, and changed her gait into a slow trudge. At this, Bassima, in her dry, matter-of-fact way said in English, "It is self-esteem."

As Saleh continued on down the hallway, Bassima got up and walked over to the sink where Leila was standing. In a sullen mood that morning, Leila was again texting on her cell phone. Bassima jokingly pushed Leila out of her way. When Leila stepped back, Bassima spoke to her in English, saying that she was a "pushover." Bassima then said something in Arabic and Leila answered her with a scowl saying in English, "I don't

care. They don't pay me much, so I don't care." Khadija and I looked on as the two went back and forth in a short mixed burst of Arabic and English about how to behave. Looking at both Khadija and I, Bassima said again in her dry, matter-of-fact way, "When I was married, I had a husband and children. I was rich. I didn't care." In response I asked, "You had the important things?" Bassima shook her head in the affirmative. She next said, "Then my husband wanted a divorce, and I," Bassima said, hunching her shoulders in imitation of Khadija, "No self-esteem."

<u>Relevant EI Categories</u>

Culturally Constituted Activities (CCAs)

In the opening first quote of this section, Maha says of her young adolescent clients, "They just worry a lot about what others think." She goes on to say, "They need to be at least who they are." Maha's emphasis on being oneself may reflect how Maha has come to see herself in relation to others, in other words, her understanding of personhood status, one in which emphasis is placed on individuality, autonomy, and freedom of expression. Maha's explanation of the differences between the experiences of first generation Arab American children and their parents (described in ethnographic studies of Arab immigrants living in the United States, e.g., Ajrouch 2004; Naber 2006b; Saroub 2005), and of the confusion felt by first generation adolescents with the living of "two lives", one in the home and the other in school with friends outside of the family, may shed light on how Maha's own experiences have resulted in an understanding of personhood different from her parents or extended family.

Rima's explanation of rights being accorded to individuals as a virtue of being human versus the roles they have been assigned by society may reflect an understanding of personhood status similar to Maha's. When one is encouraged to trust one's own sense of self, and when one's innate humanness is thought to be the first and foremost criterion in the determination of one's rights, less so role and associated responsibilities, how might these emphases reflect the way in which Maha and Rima have come to, first define their communities, and then how they have come to see themselves in relationship to these communities?

In slightly different ways, Bassima's statements also reveal changing notions of understandings of personhood. Beginning with her description of the period in her life when she was married with children, a time when as she says she was "rich," Bassima reveals her understanding of a highly valued expectation or norm for those of female gender in her community. For her, the change in her marital status represents the loss of an important role, a loss perhaps all the more exaggerated and keenly felt because her husband "wanted a divorce." This particular change in status has resulted in, as Bassima said, a loss of self-esteem. Similarly, Bassima's hint of irony in her use of the word "self-esteem" may reveal her awareness that expectations of individuals responsibilities to their communities in the United States differ from those in her homeland context. What does it mean for Bassima to use this ubiquitous American expression in which the "self" is accentuated?

Temporal Event Structure/Spatial Location

The interview excerpts come from one-on-one interviews with two providers who have spent significant time in the United States. Maha, as a young adult, arrived as a

child, thus spending her formative years in the United States. Rima arrived as a young adult and has been in the United States for over two decades. In their comments are implicit references to how time may have influenced their sense of place and belonging. In contrast, Bassima arrived to the United States as a young adult, spending her initial years at home with children. Her altered marital status and personal economic circumstances resulted in her move from a more private, interior home space to the more public, outer contexts of school and work. Bassima's firsthand, personal experience of or contact with American society is much more recent. Spatial locations are also reflected in how Bassima moves through her experience of abandonment and loss.

The featured interactions involving Bassima took place in the early days of Ramadan, within the course of a slow work day in the Triage Station, a site in the Back Hallway in which the CMAs both work and socialize. The character of the Triage Station as a space is significant to the ways in which interactions unfold in that while being a designated workspace, it is also a place of safety and intimacy, one allowing for personal stories and the disclosure of feeling and emotions.

Key Identities and Relations

The providers featured here were all Arab Americans of Lebanese descent. Three of these providers were single parents with dependent children who worked out of the need to support their families. The interview excerpts came from two very different providers, Rima being an older, divorced, a single parent, who came to the United States as a young adult and Maha, being single, never married, who came to the United States with her family at the age of nine, and spending much of her formative

years in public school in the United States. The three CMAs in the featured interaction represent a multi-generational group of women. Khadija, was the most senior CMA, a respected member of the Medical Clinic staff whose demeanor, life experience, and wisdom gave her authority and power. This authority allowed her to joke with Saleh, a male who had just recently landed the new title of coordinator. In her playful banter, Khadija demonstrated her equivalent status. Bassima is a woman who had recently experienced the loss of her marriage, a key aspect of her identity, and who had fallen on financial hard times. As she moved through the traumatic experience of abandonment and loss of status, she began to re-establish her sense of self, becoming, at least with her coworkers, increasingly more verbal and reflective of her experience. In this one interaction, she demonstrates her growing proficiency with spoken English, and at the same time instructs her co-workers and me, on the nature of happiness and loss. Her use of the word "self-esteem" may signal a different or newer understanding of self.

Leila, the youngest CMA was raised in the United States. She looks most to and frequently stayed physically closest to Khadija, her elder, for daily direction. Her open display of dissatisfaction about her position at work, and her statement about not caring, because she did not feel that she was being paid much, may reveal a sense of identity less reliant on the evaluations of others, including her seniors.

Focal Emotions and Specific Communication Practices

In the gathering together in the Triage Station, providers' communication practices involved informal causal talk used to unload, to connect, to teach, to establish intimacy and to confirm common ground. Implicit in Bassima's use of English

expressions with her coworkers, in front of me, one sees references made to the emotions of pride, as well as loss of pride, shame, sadness, and happiness. The talk or discourse, however, is most revealing about identities, both new and old.

In Bassima's statement that at one time, she "didn't care" in the way Leila may not now "care," Bassima may have been referring to a time when she took certain things for granted, being married, being taken care of, being close to family. For her, things have changed. "I had a husband and children. I was rich" reveals culturally expected and highly valued roles for her gender. However, the hint of irony in Bassima's use of the term "self-esteem" may signal that, like Rima, Bassima may now be coming to question the association between rights and status and culturally designated roles assigned to women. Her use of "self-esteem" may also reveal a changing sense of self, one in which an individual's unique qualities are more significant aspects of identity. Maha's explanation of how life for Arab teens is different from those of their parents and her advice to her clients that they should "be who they are" also reflects an emphasis on individuality.

Summary

In CMAs' trying out language in the form of new words and phrases with each other in an informal setting, the EI framework helps to tease out how new discourse on emotion comes about in the course of social interaction. Revealed is the complex character of identity, how it is influenced by individuals' relationship or connection to their communities, as in the socially negotiated concept of personhood as well as by personal circumstances, material realities, and individual subjectivities. The interactions

and in interview excerpts presented above contains discourse on emotion that may be reflective of changing and fluid identities, altered fixings and framings that then lead to differently patterned contexts of emotional experience.

SECTION IV: DISCUSSION

CHAPTER 6

DISCUSSION

This dissertation research sought to deepen understandings of emotion and its role in human personal and social life by exploring the process of emotion meaning-making as a piece of the immigrant experience. Affectively charged and fluid, often involving conditions of disruption and dislocation, the experience of migration offers a fertile place in which to examine the roles that social and interpretive practices play in constituting emotional experience (Ewing 2005:226). In choosing to focus on the particular setting of the Center, I followed the suggestion to explore the medical clinic, a place in which, being "between culture," immigrants encounter and engage in discursive practices likely to shape and potentially transform understandings of emotion (Ewing 2005:226).

Situated within a large immigrant community, the Center's Arab immigrant health care providers of mental health and primary care services are well positioned to discuss the emotional experiences associated with migration. In addition to having experienced the particular circumstances of their own migration, they encounter an often related set of experiences in their interactions with the immigrant clients for whom they provide clinical care. Similarly, as Arab Americans, these providers experience dislocations resulting from who they are perceived to be in American society. To better understand such positioning and its role in emotion meaning-making, Geoffrey White's concept of EI was applied to a series of interactions involving these providers. With EI's focus on the ways in which emotions are socially constituted in everyday experience, this framework

was used to tease out factors involved in how these providers come to assign meaning to emotion in this setting.

In the prior two findings chapters, I employed the categories of EI to select key interview excerpts and observational data gathered from social interactions involving providers with specific mental health training and other providers working in the Center. EI categories were used to identify: the everyday practices and social interactions associated with the process of arriving at mental health diagnoses and the delivery of primary health care at the Center setting; personal, cultural and professional factors contributing to providers' identities and the meanings they associate with various emotions; and the everyday speech and communication practices involving emotion present in providers' acts of care-giving. In searching for patterns of emotional experience, I looked for instances in which identities and discourse on emotion appeared to be "fixed" or "framed," for what might be learned about how providers came to assign meaning to emotion.

This chapter discusses some of the key patterns (and their variations) in providers' emotion meaning-making, what they may reveal about who these providers are, how they think and talk about emotions, and what may be learned more broadly about the experience of being "between culture" and the anthropology of migrant emotions. I consider providers' individual circumstances as well as the cultural and social factors contributing to the interactional contexts studied.

Conditions of Arab American Citizenship and Emotion Meaning-Making

As was stated in the introduction, the experience of dislocation has been described as being a significant feature of the migrant experience (Ewing 2005).To

further contextualize, I described scholarship exploring the experiences of Arab immigrants in the United States (e.g., Ajrouch 2007; Antoun 1999; Saroub 2005; Suleiman 1999) and the conditions and contexts in which their identities as citizens are located, performed, and negotiated (e.g., Ajrouch 2007; DAAS 2009; Jamal and Naber 2008; Samhan 1999; Shryock and Lin 2009). Some of this literature describes how the convergence of certain historical, cultural, social, and political factors contributes to Arab Americans experiencing particular kinds of discrimination and marginalization in the United States. As such, providers' locations in the larger as well as more localized American contexts represent a potent source for ongoing dislocation. In Chapters 4 and 5, using the EI categories helped reveal how providers refer to past, present, and future time in their sense-making of who they are and their emotions. In short, the dislocations of discrimination and marginalization described in these literatures must be taken into account as potentially contributing to the current, everyday, social interactional contexts in which providers' emotional meaning-making takes place and shapes practice. Indeed, the key role that an "ambiguous" status as American citizens (Naber 2000; Samhan 1999) plays in providers' accounting for and discourse on emotion can be seen in the following examples.

In one of his explanations for emotion, Nasser spoke of how he would instruct his clients to use "rational thinking" instead of being "emotional," which could lead to conflict. One may wonder how the history and development of negative portrayals of Arabs in the United States, in which the terms "irrational" and "emotional" (Cainkar 2009:85-86) are used to depict Arabs and Arab societies, plays into this explanation of emotion. In describing the problems of his clients related to adjustment, Nasser related

how his own experiences in adjusting to life in the United States extend to the present day. "It's adjustment. I mean how people are actually looking at you and evaluating you, especially after September 11." In light of the literature on Arab American experiences, Nasser's discourse on rational thinking and control of conflict may reflect a concern to project himself as rational citizen and also show immigrant clients how to do the same. Nasser's case illustrates how Arab immigrants' experience of citizenship within American society shapes emotional discourse, extending beyond immediate personal experience, to other social realms, including professional social interactions. Nasser's case thus further expands our understanding of a particular important emotional experience of immigrants and how this quest for citizenship can play out in multiple realms of an immigrant's life over time.

Ador's ways of positioning himself within an American context may also be seen in his discourse on emotion. In his case we see how religious practice and faith belief are aspects of identity that, depending on the setting, either confer or deny social status (Ajrouch and Kusow 2007; DAAS 2007; Joseph 1999; Samhan 1999). Early on in our interview, Ador distinguished himself as not being Arab and asserted his Christian identity. In his homeland of Iraq, Ador's identity as a Christian placed him in a minority group, a group assigned low status and frequently experiencing discrimination. In immigrating to a host country where the dominant religion is Christianity, a characteristic also found to correspond to the ideal of "whiteness" (Ajrouch, 2007; Joseph, 1999), Ador's identification as a Christian may contribute to his inclusion in a majority group which is assigned dominant status. By separating himself from his Arab clients and Arab Muslim colleagues, by taking a stance as an "outsider" to them, he may be asserting

what his experience as an Iraqi immigrant in the United States has taught him to emphasize, inclusion in a dominant status as a Christian.

One may also wonder whether these assertions relate to Ador's current explanations for emotion that strongly reflect Western psychology's emphasis on interiorities, biological drives, and a progression of universal developmental stages culminating in an ideal autonomous and agential being (Dwairy 2006:57; Joseph 1999:3). Ador admitted to having had different understandings of emotion before he received his training as a mental health counselor, ones similar to the ways he states he finds many of his Arab clients to think about emotion. Yet now, his discourse on emotion reveals his acceptance and embrace of Western biomedical explanations. Ador explained how in spite of how "Arabs" talk about emotions as being processed through community relationships, what Ador refers to as being the "big tent," he now believes all humans to be "structured the same" (Ador, Int #9: 1-14-10) (pg.152). Ador even talked about how he needed to correct the ways his clients think about emotion.

> So I have to spend time to cognitively make them understand what are the rest of the emotions, which is fear, anxiety, joy, happiness, hate, anger, and all of the rest of the emotions… they put all their emotions in their thinking part, it's not the feeling part, they think their feeling…(Ador, Int #9: 1-14-10)

In this excerpt, one sees how Ador has accepted the dominant, medicalized discourse of his Western psychological training. One also sees a good example of what Ewing refers to when she describes how immigrants' encounters with "hegemonic cultural practices" present in medical clinic contexts potentially shape immigrant understandings of emotions (Ewing 2005:231). Ador's own encounter with Western biomedicine is

potentially passed on to his clients when, through his therapeutic interactions with them, he attempts to correct their understandings of emotion. However, Ador's emphasis on Western biomedical explanations for emotion may be the result of other factors associated with his experience as an Iraqi immigrant living in the United States. In light of Arab Americans' position as ambiguous citizens, just as emphasizing a Christian identity may be part of Ador's attempt to negotiate a more secure membership in American society, Ador's emphasis on Western biomedical explanations for emotion places him within another U.S. group with dominant status, that of a Western trained health care practitioner. Claims of membership in this professional group, one social aspect of Ador's identity, may be seen as contributing to his status as a legitimate American citizen. Like Nasser, Ador's discourse on emotion, and his assertion of various identities, further reveals the ways in which immigrants' experience of citizenship may frame and shape their interactions in American society and their emotional experience. Again, these revelations concerning projects of immigrant citizenship and their relationship to emotional experience in personal and professional life serves to further expand our understanding of migrant emotions.

In a last example of how the experience of being marginalized, if not "invisible" as citizens may relate to providers' discourse on emotion, I return to Aisha and her public disclosure of her experience with domestic violence. Having spent most of her life in the United States, compared to Nasser and Ador, Aisha is more distanced from the experience of immigration. In her descriptions of the problems faced by her clients, Aisha recognizes many factors as contributing to emotional experience. Aisha refers to biological universals and she also gives considerable weight to background, culture,

and personal experience. In Chapter 4, I discussed how Aisha's use of the discourse of domestic violence may serve to contest and resist aspects of identity assigned to her by virtue of her gender, both as an American and as an Arab woman. Aisha's use of this discourse, with its emphasis on individual rights and autonomy may also serve to position her more firmly as a citizen in a society in which the dominant discourse values these characteristics, at least outwardly. Although Aisha holds an important position in the Center from which she has a voice (as in her work with clients, and as a representative of the Center in more public forums), as her own story of domestic violence reveals, within her family it may be a different story concerning how her voice can be expressed. Like Ador's case, Aisha's story also advances understandings of migrant emotions as it reveals how immigrants may highlight different identities and make use of different discourses on emotion as the result of being *between* culture. In their efforts to position themselves more firmly as citizens, one also sees how immigrant healthcare providers may adopt discourse on emotion that is evidence of one's *being* American, even when deeply personal subject matter (e.g., religion, domestic violence) are involved.

To return to thinking about how EI is a useful approach for this project, in the above examples, the categories of EI help to advance our understanding of migrant emotions as they reveal the ways in which immigrant providers' encounters with American society and their experience of others' presumptions of who they are supposed to be, may result in their accentuating different, and in some cases, newly taken on aspects of identity. EI's emphasis on social interactional contexts not only draws attention to the many possible identities present in an interaction, it forces us to

think about *why* certain aspects of identity are called forth or highlighted, how these identities relate to providers' discourse on emotion, how they shape practice, and towards what social and culturally defined ends their discourse on emotion may be directed. In thinking about how providers' experiences as Arab Americans in the United States, both pre and post 9/11, may relate to their emotion meaning-making, the following insights from Michelle Rosaldo (referred to earlier in Chapter 1) seem especially apt. "…affects and conceptions of the self assume a shape that corresponds – at least in part – with the societies and polities within which actors live their lives, the kinds of claims that they defend, the conflicts they are apt to know and their experiences of social relations" (Rosaldo 1984:149).

Next I continue to discuss key patterns in providers' emotion meaning-making, patterns alluded to in the previous two findings chapters but more fully examined here. These key patterns were observed across various parts of the Center setting, the most prominent pattern being providers' emphasis on aspects of social attunement. This emphasis on social attunement is further analyzed here in order to illustrate how the emotion meanings of immigrants arise within complex, everyday human interactions made up of both cultural and social level definitions of identity, as well as personal experience.

Patterns of Social Attunement

First mentioned in Chapter 4, the term "social attunement" described the importance I saw providers give to an array of social arrangements, activities, and behaviors, through which individuals come to fit, share, or reach accord with one

another. This emphasis on social attunement was related to three patterns in providers' discourse on emotion: (1) providers' tendency to socially situate their explanations for emotion; (2) providers' emphasis on the family and (3) providers' discourse highlighting aspects of inter-subjectivity, in particular, empathy. My approach to understanding these patterns, and their variations, brought me into deeper conversation with literatures from anthropology on the topics of cultural aspects of identity, such as personhood (Fortes 1987; Geertz 1984; Luborsky 1994; Mauss 1938)Fortes 1987; Geertz), and "relational-selving," (Joseph 1999), empathy (Hollan and Throop 2011), and the centrality of family in Arab societies (Aswad and Bilge 1996; Joseph 1999).

<u>Attention to Social Context</u>

In the findings chapters, I gave numerous examples of providers' discourse on emotion containing the terms "caring", "feeling" and "helping." I explain how this discourse occupied a central place in providers' explanations for how they came to their work and in providers' initial explanations for emotion. I also noted how providers, when asked to define emotion more generally or to describe a specific emotion, would frequently place their explanations within some kind of social setting or interaction. While these overarching patterns were seen among all providers, there were some interesting variations that may be explained by differences in providers' training, as elaborated below.

The Arab immigrant providers in the Center all received their health training in the United States. Whereas, most of the mental health care providers interviewed had advanced education in areas related to psychology and mental health counseling, the

specific health training of most of the providers interviewed in the Medical Clinic setting, involved technical medical assistant training or on-the-job training in the United States. In addition to these forms of training, some providers had received undergraduate degrees in non health-related fields prior to coming to the United States. These differences in health training and educational background in general, must be considered for the ways in which they personally and culturally shape providers' discourse on emotion.

Providers with specific mental health training more readily referred to and at times would list out examples of specific emotions (e.g., love, anger, sadness, anxiety) apart from social context. This way of talking about emotions was especially noted in the case of sadness and anxiety where providers used these terms to refer to symptoms of pathology related to DSM categories of mental disorder. These same providers frequently mentioned a range of issues related to immigration, such as adjustment, altered family relationships, the economy, and response to trauma and torture as sources for these emotions. Also, when mental health providers were asked to define emotion more broadly, they would frequently first discuss emotions in biological terms, referring to universal "drives" and "feelings" that translated into behavior or action. However, two of these providers, Nasser and Aisha, also defined emotion in terms of "experience" and mentioned the importance of social context and "culture" in their definitions for emotion, further underscoring the ways in which providers' own unique and personal experience of immigration influence their emotion meaning-making.

In contrast, providers in the Medical Clinic setting (described in Chapter 5), those providers without specific mental health training, all framed their first explanations for emotion in terms of "caring," "helping" and "feeling." When asked about specific emotions, Medical Clinic providers were more likely to ask about the details of context first, often requesting to be filled in on what was going on and who was involved before commenting on a particular situation or emotion. I found this contrast intriguing and it made me place greater weight on thinking about social attunement as my data analysis proceeded. I believe that further work could be done to explore these differences more going forward and consider the relevance of drawing this type of distinction, both for Arab immigrant healthcare providers and possibly for immigrant healthcare providers more generally.

Negatively Valenced Emotions

Another pattern related to providers' emphasis on social attunement involves the ways negatively valenced emotions were discussed or sometimes not discussed by providers. In Chapters 4 and 5, I show how negatively valenced emotions were mentioned by different providers, however, the frequency and the ways in which these emotions were referred to varied among providers. Explicit references to sadness, anxiety, depression, and anger were made by mental health providers, both independently from, and in the course of, describing the specific mental health problems of clients. Anger and irrational thinking were spoken about by two male therapists as potentially leading to conflict with relationships within families and the broader community. Nasser's story of the son hitting his father in anger and the larger community's experience of shame is an example of how one provider situated an

explanation for emotion within a social context and also of how uncontrolled anger was described as being destructive to the family and larger community.

In the Medical Clinic setting, most of the providers I observed and interviewed were female. In response to being asked for definitions of emotion, negatively valenced emotions were mentioned less frequently by these female healthcare providers and often were mentioned after terms such as "caring," "feeling," and "helping." Of the negatively valenced emotions brought up by these providers, sadness was the most frequently mentioned. Hate and anger were mentioned by two Medical Clinic providers; however, these emotions were mentioned secondarily as things to control or to hide. As alluded to, while attending a local conference, I unexpectedly ran into one of the health educators I had interviewed early on in my fieldwork. I told her of my observation that providers in the Medical Clinic seemed not to mention emotions like anger much and I asked her what she thought. Coming close and dropping her voice low she said with some emphasis, "We don't talk about it [anger] because we can't. We don't have the freedom. We must protect the family" (Mariam, Health Educator: Fieldnote, 9-20-10). Below, I will further consider the broader meanings of this strong statement.

<u>Discourse Emphasizing Family</u>

Discussion of family and family life occupied a central place in providers' discourse with me, with each other, and with clients. To give just a few memorable examples, Nasser described his relationship with his own father and later went on to explain how a case of uncontrolled anger had led to irreparably damaged relationships for one family at the Center. Samira mentioned how her decision to become a mental

health counselor was not understood by her family. She spoke at length about her parents' attitudes towards mental health services, describing how they would ask her what she thought strangers could do that family could not. Aisha spoke of her frustration in getting her family to recognize her personal (and broader professional) experiences with domestic violence. Her description of her work with victims of domestic violence in the Arab community reveals the complexity of dealing with violence that takes place within families in a community that considers the family to be the first and best source for help.

References to family were also plentiful in the Medical Clinic setting. As part of Shada's response to my asking her to define emotion, she illustrated the importance of family in saying, "Maybe I have a problem from inside, my heart is breaking and nobody knows. I can't show this for anybody, I can't show it…Outside I'm different…like outside my home. Between my family, I have a special emotion and feeling." (Shada, CMA: Int#16, 4-19-10). Besides at moments of extreme feeling, mention of family often occurred spontaneously within the course of regular work routines. Medical Clinic providers' conversations frequently centered on worries about children, the special feelings they had for parents, the sadness they experienced when they were separated from their families living overseas, and the great joy and feeling of belonging they experienced during their summer visits to their homelands.

As I became more aware of providers' emphasis on social attunement, I began to notice the ways in which empathy, one aspect of social attunement, seemed to have special significance. Empathy was explicitly referenced by providers in their interviews and visibly enacted in their interactions with clients and each other. These displays of

empathy struck me as being not only important to providers' roles as health care providers, but also as something potentially more central in their social interactions overall. In the next section, I explore empathy as a way to think about factors contributing to providers' overall emphasis on social attunement. I focus on how empathy is approached within anthropology more broadly and then give examples of the ways empathy was conveyed by providers in the Center setting. I then offer two different explanations for providers' emphasis on empathy. One is based on a culturally particular aspect of identity in which "relationality" is highly valued and in which the boundaries of "selves", being fluid, involve an emphasis on responsibility for others (Joseph, 1999). The other explanation takes into account the social and political realities of being Arab American in the United States. These explanations result from EI's attention to what is going on in social interactional contexts, who is involved (providers as health care providers, providers as Arab immigrants, and providers as citizens of a larger American society), and what is being said or conveyed about emotion (empathy).

Empathy

Empathy has been broadly defined as the capacity to adopt the emotional perspective of another (Engelen and Rottger-Rossler 2012). Most scholars, who study empathy, including anthropologists, acknowledge the biological and evolutionary origins of empathy (Engelen and Rottger-Rossler 2012; Hollan 2012; Preston and Hofelich, 2012; Throop 2012) The term "basic empathy" is usually used to refer to "all those sensory and perceptual mechanisms that allow us to determine that another person is angry, sad…or in some other emotional or intentional state" (Stueber 2006); whereas

"complex empathy" refers to "conscious attempts to know and understand why other people act in the way they do" (Hollan 2012:71).

Anthropologist Douglas Hollan distinguishes complex empathy from basic empathy in the following way. Complex empathy refers to "cognitive, emotional and imaginative capacities that allow us to use our own, first-person, folk psychological knowledge and experience as actors to model and understand the experience of others" (2012:71). Hollan states that this definition for complex empathy emphasizes the cultural and historical nature of empathic awareness and knowledge, and "the fact that the subjects of our empathy are people who think, act, and feel in very specific culturally and historically constituted moral worlds where we ourselves, as empathizers, are similarly bound and constrained" (2012:71). Hollan argues for ethnographic work examining the ways in which basic (biological) empathy "becomes culturally elaborated, and either expressed or suppressed, in specific social and moral contexts" (2012:71).

Through his ethnographic work on the different ways empathy is conveyed among the Yap, a small community in the Pacific Islands, anthropologist C. Jason Throop also looks at complex empathy, arguing that empathy, as one mode of inter-subjectivity, may be differently valued across contexts (Throop 2012:410). In this vein, both Throop and Hollan emphasize the need to better understand the factors, social, cultural, political, and economic, that give rise to different forms of empathy or that result in the suppression of them. These scholars also consider how concepts of personhood, which, in defining the rules for how permeable or impermeable the boundaries of the "self" are, determine "what is appropriate to know about people and what is not," thereby resulting in the modes of empathy used in any given society (Hollan and Throop

2011:7). [21] Next are some good examples of what I came to identify as evidence of providers' use of empathy and the social locations in which it occurred.

Empathy in the Center Setting

In addition to the use of the terms "caring," "feeling," and "helping," providers used their own experiences to imagine, to ascertain and then to respond to the emotional experiences or feelings of their clients. The four mental health providers profiled in Chapter 4 talked about how their own personal struggles granted perspectives that helped them to relate to and understand their clients. Many of these personal struggles were related in some way to providers' own immigration experiences. In my interviews with Nasser and Ador, I learned that they both immigrated as young adults from Arab homelands, Nasser to join his father, Ador as a refugee. Nasser described the loneliness of being a new immigrant in a strange country, forced to work among people who did not support or care about him. In one of his definitions for emotion, Nassar said, "When you see somebody with the same experience, once an experience you went to, you feel that pain" (Nasser, Int # 18-24-09). In his explanation of the importance of using "rational" thinking, Nasser described the way someone might first react to being judged because of their "color." In his use of this example to talk about an intense emotional reaction, it is plausible that Nasser may be referring to experiences of being judged by his appearance. In the context of talking about the

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[21] In Hollan's point that as the "subjects of our empathy are people who think, act, and feel in very specific culturally and historically constituted moral worlds, where we ourselves, as empathizers, are similarly bound and constrained", he describes the particular challenges faced by those who attempt to study empathy in cross cultural contexts. Hollan's comment forced me to think about how I, as a non Arab, American-born researcher, came to identify providers' enactments of "empathy" in the first place and to consider how necessary it is to be "bound and constrained" by similar "moral worlds in order to recognize acts of empathy when they take place.

adjustment issues his clients face in adapting to life in the United States, Nasser described how he was still adjusting and he intimated that being accepted was an ongoing issue, especially after September 11, 2001. As a refugee, Ador talked about how the trauma of having to leave his home country resulted in him knowing how his clients felt, many of whom were also refugees. "I know what…my clients, what kind of difficulties they've been through. I understand it, I feel it, I know it, because I'm one of them….every word of it, every emotion, every tear" (Ador, Int #9: 1-14-10). Ador's mention of his feeling of being isolated and alone because of his religious beliefs also conveys his experience of being seen as different. Ador's and Nasser's display of empathy in their explanations for their work and in their discourse on emotion reveals how the dislocating experiences associated with immigration may continue to shape the emotional experience of immigrants.

In revealing her own experience of domestic violence, Aisha explained how she understood the circumstances and feelings of many of her female clients. While her experience of having arrived in the United States as a young child differed from the immigration experiences of Ador and Nasser, Aisha described how there had been times when, in her own experience with domestic violence, she had not received support from her family and her larger community. In Samira's explanation of the ways her Arab immigrant clients talk about or, in her words, do *not* talk about "feelings," as a first-generation Arab American, Samira comments on her own expectations for the ways in which feelings should be talked about and acknowledged. Samira also comments on how her expectations of a more open discussion of feelings differs from those of her parents, differences that have not always been easy for her (and them) to understand or

accept. In Aisha's and Samira's use of empathy to understand the experiences of their clients, one sees how the disruptions and dislocations associated with migration extends to the emotional experiences of family members, even those more removed from the direct experience of immigration.

I also noted instances of empathy in the Medical Clinic setting, in providers' interactions with each other and also in their explanations of their clients' circumstances. In Khadija's explanation for emotion, she said, "Emotion is when you feel and help…If I feel about you, you need help. . .the feeling is, let me move…this person to help him. I never help a person with [out] feeling. I can't help people without feeling" (Khadija: Int #15, 3-19-10). Khadija's description of how mothers will be rewarded in the afterlife may reflect her own experience of motherhood, in which as a single mother, she has had the bulk of the responsibility of providing for her family. In her explanation to me of why the family of a mentally ill client needed help because, as she said, "He does not know that it is different here," Khadija uses her own experiences to ascertain how her client's wife and relatives might be feeling. This same empathic perspective-taking was evident in the responses of the CMAs in hearing Bassima's story of her troubled marriage. In giving Bassima the opportunity to speak with little interruption, CMAs' short utterances of acknowledgement and encouragement, and especially their use of the word "*ayb*," or shame, not only reflected sympathy and support but also showed understanding of Bassima's experience of loss.

In Chapter 5 I described Khadija's interactions with two immigrant families, a recently arrived family of refugees with a cognitively impaired daughter, and the family of an immigrant client with mental health issues. These cases show how CMAs are on

the front line of caregiving at the Center and how they draw on their own experiences of immigration to assist their immigrant clients. In their interactions with each other, as described in the interaction entitled "Trying on Language/Revealing Selves", we see how in addition to supporting their clients, they also support each other. In the experiencing of themselves, through and with each other, they become different, no longer quite the same women they were. These changes to their sense of self, in part resulting from empathic behavior with immigrant clients and coworkers, have potential implications for their ongoing interactions within health care institutions and in their broader communities that merit further investigation, a topic I will return to later on.

In the following section, I further link the above empirical evidence related to the patterns of social attunement (including empathy) with the broader literature in a discussion of how cultural and social factors may be implicated in providers' emphasis on social attunement.

<u>What to Make of the Pattern of Social Attunement</u>

Following Ewing's advice, I went to the "clinic" to see how immigrants' encounters with the discursive practices in such settings, result in changes to identity and articulations of emotional experience. Anthropological literature examining the relationship between the ways individuals are connected to their communities and cultural level definitions of identity, provide a useful thread in considering the above major pattern of social attunement. From analyzing the empirical data, I found that these providers' implicit understandings of personhood and selving are based on primary value being given to the family or group as the important units of society, less so

individuals. I now further explore how this important conclusion from my study fits within the broader anthropological literature on related topics. According to the literature on cultural level definitions of personhood (e.g., Fortes 1987; Geertz 1984; Luborsky 1994; Mauss 1938), and "relational selving" (Joseph 1999), one might expect to see these socially conferred aspects of providers' identities reflected in their discourse on emotion, as well as in their behavior.

Suad Joseph's culturally nuanced accounting of the dynamics of "relational selving" as it is unfolds within contexts of Arab families, offers one explanation for providers' emphasis on social attunement (1999). Given providers' attention to social context and emphasis on family, relationality may be highly valued, even required for providers' memberships in their communities, be it family in homelands or family in their current local American context. If providers represent, in part, "selves" "embedded" within intimate relational matrices of the family, in which the boundaries of self are more fluid, where one has the responsibility for others, and where the expectation is to know what one may be thinking and needing, it makes sense that this same sense of self might be reflected in providers' explanations for their work. This same emphasis may also be reflected in providers' definitions of feeling states, or emotions, and in the ways in which I saw empathy accentuated. Providers may view acts of empathy as being part of a health care professional's code of ethics. However, as "relational selves" "embedded" within intimate family matrices, providers may be expected to be tuned in to, to *show* that they are tuned in to, the feeling states of those for whom they are responsible.

In addition to these cultural level explanations for providers' emphasis on social attunement, one must also take into account the social and political realities of being Arab American in the United States. In Chapter 1, I cited literature describing how Arab Americans have been often assigned an "ambiguous" status as citizens, one in which they are expected to "display their (suspect) American identity publicly, incessantly and convincingly" (Shryock and Lin 2009:65). Laird and Cadge's study of Muslim community-based health organizations in the United States (2010) further illuminates Arab Americans' experiences as "ambiguous" citizens and at the same time offers another potential explanation for providers' emphasis on empathy. They found that first generation Muslim immigrants were able to use positively valued, faith-based, charitable and professional group identities in ways that counteracted publicly stigmatized identities in American society (2010:225). Although the Center setting is not a faith-based organization, it is known for its commitment to serving a large Arab immigrant and refugee population and that many of its providers are also Arab immigrants. Providers' emphasis on empathy may also be related to providers' attempts to deal with, or "neutralize" a stigmatized Arab American identity in an anti-Arab, post 9/11 United States.

The importance of social attunement may influence what emotions are more readily displayed in certain interactional contexts. In my earlier discussion of the differences observed in providers' use of negatively valenced emotions, I described how certain providers appeared to emphasize the importance of controlling anger. I also described how female providers in the Medical Clinic, appeared to avoid discussions of anger, emphasizing more socially lubricating emotions such as caring. Literature on the

experiences of Arab Americans and concerns over citizenship was earlier offered as one possible explanation for Nasser's emphasis on the importance of controlling anger. Another explanation may be found in work from anthropology on the concept of personhood mentioned in Chapter 1. In societies where understandings of personhood are derived from an emphasis given to the group over individuals and where behavior may be more controlled by external factors such as roles and norms as opposed to internal factors such as personal attributes (Schweder and Bourne 1984), an emotion such as anger may be perceived as a threat to group integrity and as such may be less culturally sanctioned. While work from psychology on collective societies has offered a similar explanation (e.g., Dwairy 2006; Markus and Kitayama 1991), additional ethnographic work on two different Arab communities reveals that this explanation may be too simplistic.

In her analysis of the two conflicting sets of sentiments present among the Bedouin community of the Awlad Ali, Abu-Lughod states that individuals, when in public, "strive to portray themselves as potent, independent, and self-controlled" (1985:253). Abu-Lughod describes sentiments appropriate to this image as including expressions of "anger, attribution of blame, and denial of concern" (1985:253). Abu-Lughod also states that "respect is accorded the person who struggles with powerful vulnerabilities and passions to be a member of Awlad Ali society…a person with honor" (1985:258). Steven Caton's work on Yemeni poetry (first mentioned in Chapter 4) echoes Abu-Lughod's findings on vulnerability and also sheds light on the importance of self-control in establishing one's identity as a tribesman (1990:29). In these two explanations, control of anger may have less to do with maintaining group integrity and more to do

with self control, an important aspect of "a person with honor." These different explanations, derived from ethnographic work on personhood, and studies conducted among Arab communities within the Middle East and among Arab immigrants in the United States, illustrates the complexity of trying to understand the sources for emotional behavior, let alone the many factors that may contribute to these immigrant providers' emotion meaning making.

So far in my analysis of social attunement, I have considered some social aspects of providers' identities as well as cultural aspects of identity as in personhood and Joseph's explanation of the process of "relational selving" in Arab families. Joseph's "relational selving", in particular, helps to explain why an awareness of social attunement may be prioritized in providers' discourse on emotion. At the same time, Josephs' work also reveals how aspects of individuality and agency may exist alongside the more dominant "relational selving" occurring within Arab families. So, while both cultural and social factors may help to explain the patterns of social attunement observed in providers' emotion meaning-making, as Joseph explains, they are not the only factors at play, nor do they necessarily explain the many instances in which providers' explanations for emotion emphasized aspects of individuality and agency, aspects that may be seen as resisting or countering more dominant aspects of identity. The next section describes some of these instances as a way to further illustrate the shifting and complex nature of identity present in providers' emotion meaning-making.

The Role of Individuality and Agency in Providers' Emotion Meaning-Making

Aspects of identity that may be seen as resisting or countering a more dominant emphasis on "relationality", or simply as co-existing alongside relationality, can be found in many providers' explanations in which "individuality" and "agency" seemed to be emphasized. For example, a reference to autonomy, perhaps an indication of resistance, can be seen in Rima's statement that "It is different here… It socially and mentally made me realize something…It's not for me anymore…It's man and woman. It's a human being who has the right to live happy and respected" (Rima, Health Ed: Int #13, 3-15-10). In this statement, Rima speaks of how she has found gender roles and expectations to be different in the United States as compared to those experienced in her Arab homeland. In Rima's description of her mother (whom Rima describes as a primary role model because of the strength with which her mother took control of her family after the death of her husband), attributes of independence and autonomy are revealed as hardly being confined to Western or American societies (also noted in the works of Abu-Lughod 1986; Joseph 1999; Mahmood 2005). In modeling her mother's enactment of agency, Rima may have incorporated this aspect of identity into her own self. As a divorced single mother, Rima has had to navigate much of her life, and her children's lives, on her own. Perhaps she has learned to embrace independence out of certain economic realities. In her nearly two decades of life in the United States, her own experience of her mother's agential self may have been reinforced. Again, the case of Rima reveals how immigrant identities are complex, shaped not just by overarching "culture" but also by particular family dynamics, personal experience and material economic realities.

In explaining what she tells her anxious adolescent clients, Maha, the young health educator and adolescent herself by most American standards said, "They need to be at least who they are and be happy with what they think… You should just be who you are" (Maha, Health Ed: Int #17, 5-27-10). What does Maha's statement reveal about her understanding of her relationship her family or community? Might this understanding be a reflection of her having spent half her childhood in the United States, a place in which "being who one is" is emphasized first, over family or group? When Samira spoke of the need for more family therapists in the Arab community she said, "Sometimes you need to talk to someone you don't know," someone apart from family. How might Samira's statement reflect an understanding similar to Maha's, where individual desires and feelings are given greater priority, or even first priority over the group? These statements, both from younger providers, one an Arab American immigrant, the other a first generation Arab American, reveal how immigrants' experience of dislocation, resulting from encounters with American social structures and institutions, may result in new understandings of the ways individuals see themselves in relationship to their communities, changes that may be reflected in articulations of emotional experience.

In a similar vein, let us consider what Bassima's play on the words "self-esteem" might mean. A much more recent immigrant to the United States than Maha, and having emigrated as a young adult, what other factors may account for her use of this ubiquitous American expression "self-esteem?" Has the urgency of her personal circumstances resulted in a new attention to, or way of, considering the "self?" Khadija, as a divorced single parent, has also had to take control of her family's destiny as an

income earner. Is her agency also derived from economic necessity…and concerns with basic survival?

Lastly, by making public her own experience with domestic violence, Aisha, in the most visible of ways, may be seen as challenging cultural norms and expectations regarding who holds authority. As was mentioned earlier, her public declaration can be viewed as her way of enacting and legitimizing her status as an American citizen. Her declaration might also be a reflection of her being raised in the United States where she has been taught to emphasize individuality and autonomy as part of being an American.

In the above examples, EI helps to reveal how for these providers, their ongoing "selvings" may involve *shifting* notions of individuality and agency, the result of cultural aspects of identity found in Arab homelands, as well as these providers' encounters with American society in which the dominant paradigm emphasizes, or to use Joseph's word, "valorizes" independence and individuality. In the realm of the anthropology of migrant emotions, this shifting underscores the fluid character of both identity and emotion meanings within the immigrant experience of being "between culture."

In summary, the explanations for social attunement can be found in cultural realms involving aspects of identity such as "personhood" and "selving," as defined anthropologically. Other plausible explanations for these patterns were found to be related to certain social and political realities involving providers' experiences as Arab Americans. Variations in these patterns were found to be related to education, class or social status, gender, and personal trajectories involving relationships within family, including divorce, domestic violence, and providers' individual proximity to the experience of migration. Providers' emphases on aspects of individuality and agency,

again, underscore the fluid character of both identity and emotion meanings within the immigrant experience of being "between culture."

Emotive Institution's Contribution to the Anthropology of Migrant Emotions

The concept of EI, informed by literatures from anthropology, psychology, and interdisciplinary scholarship on Arab American experience in the United States, was used to identify and make sense of how the different kinds of culturally constituted activities, containing identities, communication practices and social interactions contribute to providers' explanations for emotion.

The analysis of the pattern of providers' emphasis on social attunement, and the variations to those patterns, illustrates how emotion meanings arise within complex, everyday human interactions. On one hand, EI helps to reveal how these patterns may be related to cultural level definitions of identity, as in personhood, relational selves, and personality, all aspects of identity fundamentally related to the ways in which providers are seen, and see themselves in relation to their primary groups. As was shown, providers explain emotions in ways that reveal awareness and an attention given to important social others such as family. Empathy, as one mode of inter-subjectivity in which empathizers use a first person perspective and an awareness of social context to understand the feelings of others, was pronounced in the setting, evidence I argue of providers' knowledge of their responsibility to their significant others. These patterns were in line with ethnographic studies conducted among Arab peoples (Abu-Lughod 1986; Aswad and Bilge 1996; Caton 1990; Joseph 1999; Kulwicki 1996) and on cultural aspects of identity (Fortes 1987; Geertz 1984; Joseph 1999; Mauss 1938).

In applying the categories of EI to the social contexts and the relational factors making up the everyday scenes and activities in which providers' discourse on emotion examined here took place, a complex picture emerges. Herein lies the true utility of EI. EI's biggest contribution to investigations of emotion lies in its powerful attention to the meaningful properties of situations in which emotions are enacted. Applied to providers' interactions at the Center setting, EI reveals how, in addition to culture, providers also draw from personal experience and social networks, reaching back to past experience in Arab homelands as well as their current American context in their discourse on emotion. Depending on what was going on in these interactions, providers' assertions of personal and social identities also reveal the use of individual agency, resistance to cultural level norms defining gender roles, and the oftentimes precarious position that many Arab Americans experience as citizens in the United States.

EI's Contribution to Understanding Processes of Mental Health Diagnosis

As assessments of emotion are thought to play a key role in the process of arriving at mental health diagnoses, a process that is still not well understood, an important aim in using EI was to deepen our understanding of the ways providers' use cultural knowledge and personal experience in their explanations for and assessments of emotion. As initially stated in Chapter 1, accurate mental health diagnoses may be especially relevant to communities where the mental illness of individuals is not perceived as being set apart from family experience and where there are concerns about stigma.

It bears repeating that the immigrant health care providers who participated in this study differed in many key respects including, their educational backgrounds, specific health training, past and current social circumstances, gender, proximity to the experience of immigration, their countries of origin and in the circumstances that led to their arrival in the United States. However, I found that an attention to social attunement was pronounced across the Center setting. Again, providers tended to situate their explanations for emotion within social contexts and socially valued, socially lubricating emotions, were most often emphasized by many providers. As the mental health providers at the Center were not observed in their private, one-on-one, interactions with clients this study is unable to comment on whether, or how, these patterns may be present or change over time in the course of actual therapeutic activity, a valuable direction for future work. However, in applying EI to the interactions of the providers themselves, the presence of these patterns point to potentially important implications for providers who are in positions to assess, diagnose, and treat mental health problems of Arab immigrant clients.

As social context appears to be central in providers' explanations for emotion, surveys designed to assess for the presence of specific mood disorders, such as depression and anxiety, where emotions are listed apart from social context, may not be very meaningful for clients whose understandings of emotion are influenced by cultural definitions of identity emphasizing the group. Placement of emotions within the social contexts that have meaning for a client may yield more accurate assessments. Also, the knowledge that Arab immigrant clients may view the expression of certain emotions as more appropriate for public contexts, or for individuals identified as outsiders, regardless

of how they individually may be feeling, may be an important consideration in mental health providers' assessments of clients' verbal or written responses regarding their emotional states. Again, as cultural aspects of identity, such as personhood and selving, may privilege families or groups over the individual, resulting in selves whose boundaries are more fluid and where connection to group members is prioritized, mental health providers may need to expand or reconsider their definitions of what constitutes optimal mental health.

Areas for Further Exploration

As previously described, my access to the Center evolved over time and shaped how I came to know about social interactions in this setting. I first conducted 1:1 interviews with high-ranking, socially articulate providers, most of whom were supervisors of various health programs located throughout the Center. During this initial probationary period, in addition to concentrating on developing rapport and establishing trust, I began to become familiar with some of the ways these providers spoke about emotion, the emotion terms they used, and their ways of describing the circumstances of their immigrant clients. As time went on, I was given permission to observe in the Medical Clinic. Once in the Medical Clinic I was able to spend lengthy periods of time doing ethnography there. In this period, I spent much time observing and interacting with the CMAs, a group of lower status, female health care providers. One thing I was not expecting was the extent to which my position as an observer allowed me to see how these women interacted with each other, how they talked about work, how they got work done, and how they shared with each other their everyday personal lives and concerns.

Guided by EI's attention to social interactional contexts, I was able to attend to the ways in which CMAs interactions with each other may have influenced their shifting and changing senses of self, their emotion meaning-making, and thus, their practice. Studies focusing on immigrant health care providers' interactions with each other represent a potentially rich area for future work in the anthropology of migrant emotions. Based on what I learned in this study and what currently exists in the literature on immigrant healthcare, I learned that exploring the experiences of "lower status" immigrant health care providers especially requires more attention. To further illustrate, I next highlight two topics in which further exploration of providers' interactions with each other may provide deeper insight into emotion meaning in an immigrant health care context.

<u>Shifting or Blended Definitions of Biomedicine</u>

Over time I came to see that the Center's mental health providers appeared to be very much at home in the world of western psychology. Their acceptance of biomedical explanations for mental illness and emotions was notable, and they frequently used these explanations with authority. Yet, while one explanation for providers' familiarity and comfort in using biomedical explanations may be found in the fact that all mental health providers, as well as most of the Medical Clinic providers, received their health training in the United States, this study has shown how this explanation is not complex enough. EI reveals how discourse on emotions, including the discourse of biomedicine on emotion, arises within complex contexts, involving culturally constituted activities containing identities, social interactions as well as language practices. The primary focus of this study was not to probe for presence of differing interpretations of

"biomedicine", as addressed elsewhere in the anthropological literature (e.g., Lock and Nguyen 2010; Payer 1996). However, I now see that a more targeted exploration of providers' shifting or blended conceptualizations of biomedicine, their relationship to emotion meaning making, and the ways in which they may result from their interactions with other providers with whom they practice, represents a fertile potential area for future research.

<u>Religious Belief in Explanations for Emotion</u>

Another topic of interest among many Arab immigrant healthcare providers that I would explore further is religious belief and its relationship to understanding emotions, healthcare, and social life more broadly. Explicit references to religious belief were present in providers' explanations for emotion in the form of mentioning "God" and in their more implicit reference to sources of Islam. Khadija's mention of the *Quran* and the saying about how mothers will be rewarded in the afterlife is one example. Topics related to religion, such as comparing Islam with Christianity and Judaism, were frequently discussed within my informal conversations with CMAs. CMA's conversations with each other frequently centered on differing interpretations of Islam, its teachings and its application to daily life.

Sharine Hamdy's ethnography on the rising public health problem of renal disease in present day Egypt (Hamdy 2012) reveals how intersections of Islamic belief, biomedicine, and past and present political and economic factors are all implicated in attitudes towards organ transplantation. In particular, Hamdy's attention to the presence of multiple and differing understandings of Islam, their relationship to various historical,

political and economic realities, and their influence on what are thought to be acceptable ways of dealing with a disease, offers direction in a consideration of how the religious interpretations of Islam held by the Muslim Arab immigrant providers in this study may factor into their emotion meaning-making. Although Hamdy's revelation that the understandings and practices associated with Islam may vary within the same society is not new (e.g., Ewing 1997; Mahmood 2005; Scott 2007) a sharper focus on Islam as practiced in the United States and on the personal religious beliefs and practices of providers in this study may help to reveal a more accurate picture of the ways providers' bring diverse religious identities and interpretations to bear on their emotion meaning making.

Further Exploration into the Nature of "Disruption" in the Immigrant Experience

As stated throughout, "disruption" is a term that has been used to describe immigrants' experience of leaving behind familiar homelands and life ways and their encounter with new institutions in the new society. In some cases, this is not a linear journey but one in which people move back and forth on a regular basis and/or consistently draw upon ideas and ways of living from multiple contexts. In light of this back and forth movement, what does it really mean to be "between culture"? Observation of the interactions of providers with each other in the Center setting also led me to wonder about the exact nature of these disruptions, and specifically about the positive outcomes that may result from immigrants' experience of disruption. In the cases of Aisha and Bassima, two providers who were open about their encounters with domestic violence and the social repercussions of divorce, EI helps to reveal how, at least for these providers, their encounter with certain discourses present in American

society may have assisted them in coping with extreme personal challenges to their, and their family members', sense of self and well being. Also, their ability to use these discourses with each other in the context of their work place may have further enhanced their ability to apply these discourses in meaningful ways in their own lives. Further exploration into the nature of "disruption" in the experience of immigrants thus offers further insight into the experience of immigration and the anthropology of migrant emotions.

<u>Narrative approaches in Combination with EI</u>

As I neared the end of the dissertation write up, I read Andrew Beatty's article advocating for narrative approaches in writing about emotion (Beatty 2010). In Beatty's critique of why many of the "standard" ethnographic approaches to emotion fail to convey the contextual richness of emotions, the ways in which emotions "participate in manifold relationships formed over periods of time" (2010:430), he makes the case for the use of narrative. Beatty argues that as narratives serve to "locate emotion in…the indivisible flow of action, character, and history" they assist in revealing deeper dimensions of emotion (2010:440). Beatty's ideas on the use of narrative as an approach to emotions has me thinking about the ways EI might be used in conjunction with the kind of exploration of emotions that narratives are capable of providing. Deeper exploration into the stories and relationships of individual providers potentially promises more enhanced understandings of migrant emotions.

Concluding Thoughts

In the Prologue, I described how my encounter with a colleague, Fatima, furthered my interest in explanations for human emotion meaning-making. Our coffee shop conversation involved a mix of professional and more personal topics, as well as conversations resulting from the activities of a formal, audio-recorded, research interview. Our identities and experience as health care providers may have given us a shared language with which to begin talking about emotions; however, as I was to discover, there were clearly differences in our explanations for emotions. These differences became apparent when, in pressing the "off" button on my tape recorder, our discussion moved beyond the activities of the research interview.

With the interview over, the dynamics of our interaction changed. We assumed different roles, certain aspects of our identities became less pronounced while others became more fully revealed, and Fatima's way of talking about emotions, in particular, changed. While these changes were not all immediately apparent to me, what I walked away with that day, what was most striking to me at the time, was how Fatima's explanation involving the heart offered such a dramatic contrast to the way she had spoken about emotions earlier, and how the change in her discourse on emotion seemed to coincide with the pressing of the "off" button on my recorder. These two factors were what initially drew me to White's concept of EI when I discovered it in my reading of the anthropology of emotion literature. As I began to use EI to make sense of Fatima's words, the more I began to notice the multiple aspects of our identities that had been in evidence that day at the coffee shop. The more I began to pay attention to the changing dynamics of our interaction, the more White's concept of EI began to resonate for me.

Throughout fieldwork and in the writing up the dissertation I kept my memories of my encounter with Fatima close. Indeed, this meaningful interaction set the stage for what became my research program and my current contribution about the use of EI to make sense of emotion meaning-making in a particular immigrant healthcare context. By doing so, I hope to have provided new knowledge for and advanced the anthropology of migrant emotions literature.

APPENDIX A: RESEARCH DOMAINS, DATA SOURCES AND METHODS

Domain Variable	Source	Measure or Method
Practices, Routines and Social Interactions Present in Diagnostic Processes	Fieldnote text	Observation of providers' routine diagnostic and care-giving activities, with attention given to providers interactions with each other, with clients, with health care institution, family and friends and with public
	In-depth interview text	Interview questions on description of providers' work, routine activities, description of cases, common problems, treatments
	Text Source	Gathering of printed descriptions of patient care routines/ programs, clinic mission statement, printed clinic assessment forms/survey instruments and protocols/staff training documents
Domain Variable	**Source**	**Measure or Method**
Identity Cultural Level Definitions of identity (i.e., personhood, self)	Fieldnote text	Cultural aspects of identity looked for in informal interviews and observation of discourse on emotion present in staff interactions. Cultural aspects of identity identified as discussed in Chapter 1 Pg 10—12 (Geertz, Fortes) and according to definition put forth by Mattingly et.al. Pg. 12).
	In-depth interview text	Same as above
	Text source	Clinic history, local histories of Arab immigrant groups, literature on Arab American identity

Social aspects of identity Personal	Fieldnote text	Informal interviews and observations of staff involved with diagnostic routines
	Demographic questions	Immigration hx , marital status,-family hx
	In-depth interview questions	Same as above
Professional	Fieldnote text	Observation of provider and staff interactions, informal interviews
	Demographic questions	Description of professional training, educational training, work history,-current job description
	In-depth interview text	Same as above
Gender	Fieldnote text	Observation of provider and staff interactions, informal interviews
	Demographic questions	Gender question
	In-depth interview text	Explanation of gender roles, customs, norms , and expectations present within interview text
Ethnicity	Fieldnote text	Observation, informal interviews
	Demographic questions	Ethnic self identification
	In-depth interview text	References to ethnic, community/political/religious memberships
Domain Variable	**Source**	**Measure or Method**
Discourse on Emotion	Fieldnote text	Observation and identification of discursive practices on emotion present within informal interviews provider

		and staff diagnostic and care-giving activities and other work routines and practices
	In-depth interview	Interview questions asking for definitions, descriptions, origins and meanings of emotions in actual patient cases
	Text Source	Center and Clinic promotional literature, formal assessment tools and routine health visit

APPENDIX B: DEMOGRAPHIC QUESTIONS

ID _____

Date _____

1. Name_____

2. Current job title_____

3. Contact information:

 Phone number _____

 Address   _____

                      _____

                      _____

4. Date of Birth_____   5. Gender: ___male ___female

6. Country of birth _____   7. Date left country of birth_____

8. Date arrived in the US _____   9. Other countries lived in:

                                             _____

10. Ethnic background _____   _____

                                             _____

11. Religion _____

12. Marital status: 13. Education:

 (1) ___ single   (1) __ less than high school

 (2) ___ married   (2) __ high school graduate

 (3) ___ separated   (3) __ some college

(4) ___ divorced   (4) __college graduate

(5) ___ widowed   (5) __higher than college graduate

(6) ___ never been married

14. Employment status**:**   15. Degrees / credentials held:

   ___full time__ part time   _____

16**.** Primary language spoken at home _____

17. Do you read or write Arabic?

   ___ yes

   ___ no

APPENDIX C: IDENTITY AND EMOTION INTERVIEW

Introduction: My study investigates how we come to assignor give meaning to emotion and how emotion meanings change. My study focuses on three main factors thought to contribute to emotion meanings, that of identity, everyday language practices and social interaction. [Center] is a good site in which to study this topic because as many of the health care providers culturally identify as Arab, and are immigrants from the Middle East, their identities, ways of communicating and patterns of social interaction are subject to the influence of experiences originating in Arab homelands, as well as those in their current American context.

The chief purpose of my interview with you today is for me to learn more about you and how you view your work.

Q1. With this in mind, I would like to begin by asking if you would please tell me about how you became a _____?

Q2. Can you tell me about your experiences in this field?

- How long have you worked in this field?

- Can you tell me about your training?

Q3. Can you tell me about your experiences in getting started working as a health care provider?

Q4. In what ways do you think your experience was typical or atypical?

If it is ok, I would like to ask you about your work as a health care provider in the Arab Community…and at the [Center].

Q5. Can you describe your current work at the clinic?

Q6. What are the most common problems you see in your patients?

Q7. Can you describe for me the different ways you assess the emotional status of your patients.

Q8. As the topic of my study is emotion, I would like to ask how do you define "emotion" exactly?

Q9. Do you think your definition has changed over time? If yes….how?

Q10. Can you describe a recent case or interaction with a pt-client in which some aspect of emotion was especially "memorable"…. or "stood out" for you.

a) What made it stand out?

b) How was the pt behaving?

c) How was the family behaving?

d) What did you think the main problem was?

e) What did the pt see as the main problem?

f) What did the family see as the main problem?

g) How was the problem treated? If you can remember, what kinds of things did you say? What happened? If the problem was resolved, how was that evidenced?

Q11. As you think about the standard mental health assessment tools or treatments that you are familiar with or were trained in, can you tell about the times they have not seemed to fit, or work with the patients you see?

I have no more questions at this time. I would like to ask you if you can think of questions or areas I have missed that might be helpful? Do you have anything else you want to add?

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ABSTRACT

EMOTION MEANING-MAKING: IDENTITY, DISCOURSE AND SOCIAL INTERACTION AMONG ARAB IMMIGRANT HEALTH CARE PROVIDERS

by

ANNE KATZ

August 2013

Advisor: Dr. Sherylyn Briller

Major: Anthropology

Degree: Doctor of Philosophy

This dissertation sought to deepen understandings of emotion and its role in human personal and social life by exploring how a group of Arab immigrant health care providers, involved in the diagnosis and treatment of mental illness in one clinic in the United States, assign meaning to emotion. Affectively charged and fluid, often involving conditions of disruption and dislocation, the experience of migration offers a fertile place in which to examine the roles that social and interpretive practices play in constituting emotional experience. Due to increases in patterns of migration associated with globalization, mental health diagnoses are often arrived at within increasingly diverse and complex health care settings, where both patients and providers may have differing explanations for emotion and mental illness. Currently, little is known about how the experience of migration influences the diagnostic processes of immigrant health care providers. In particular, little is known about how meaning is assigned to emotion, one aspect central to the "making" of mental health diagnoses.

Guided by Geoffrey White's concept of "emotive institution" emphasizing the social contexts of everyday emotional experience, ethnographic methods reveal how cultural and social factors, as well as personal experience, all converge in these providers' sense making of emotions. These findings are used to think about why deeper understandings of the process of emotion meaning-making are especially relevant to the anthropology of migrant emotions and in the consideration of mental illness as a serious global health problem.

AUTOBIOGRAPHICAL STATEMENT

I returned to graduate school in medical anthropology after 25 years of clinical practice as a registered nurse and while in the midst of raising a family. My nursing practice began as a Peace Corps volunteer in North Yemen in the late1970s, where I worked in a hospital located on the eastern shore of the Red Sea. This was my first experience living far away from home in a culture very different from my own. Upon returning to the United States I continued to work as a nurse. Over the next two decades, my practice took place in a wide range of health care settings (urban/rural, institution/home, critical care/hospice), where I was to witness a wide range of illness presentation. As a home health nurse, my encounter with the ethnically diverse communities of Metropolitan Detroit served to further enhance my interest in my patients' individual stories. My sense that these stories might be used to better understand and respond to the experience of illness more broadly, ultimately led me to medical anthropology.

My current research interests include psychological anthropology, emotions, Arab culture, gender and applied medical anthropology. Having spent the last four years in a cancer research setting, a more recent research interest includes examining the ways in which recruitment and inclusion policies associated with clinical trials are interpreted and play out among health care providers.