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THE PERCEIVED BARRIERS AND FACILITATORS OF THERAPEUTIC WORK WITH ARAB CLIENTS: EXAMINING THERAPISTS' ATTITUDES TOWARDS STIGMA AND RECOVERY FROM MENTAL ILLNESS

by

NADIA HABHAB

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSPHY

2018

MAJOR: EDUCATIONAL PSYCHOLOGY

Approved By:

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Advisor Date

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DEDICATION

"Vulnerability is terrifying, the courage it takes to reveal your heart is one of the most daunting and yet rewarding experiences in life. It will set you free." -Author Unknown

As a young therapist, setting out in her career, I was bursting with grandiose visions about how I would save people. I would save them from their fears, cure them of their symptoms, and heal those who needed healing. I quickly learned that quite often, my goal for my clients and the reward of feeling good for being of service, was far from what would transpire within the therapeutic process. I learned that vulnerability is terrifying. I learned that people will try at all costs to avoid pain and suffering, and most importantly, I learned that my role was not to cure, or heal or fix, it was simply to join my clients in the space of vulnerability. And so, to every soul that has granted me permission to share in their vulnerability, I honor you. Without you, the inspiration for this work would be lost.

ACKNOWLEDGEMENTS

Bradley, your support and love is beyond words. Thank you for making vulnerability look so cool! Your unconditional acceptance, support and selflessness inspire me every day.

I am grateful to all who have allowed me to share my vulnerabilities through this process. My coworkers, past and present and my friends who have become family, your support is unmatched. A woman is only as strong as the women she surrounds herself with. Thank you to all of the strong females in my life for always lifting me up and showing me that vulnerability is bravery; Amal, Faten, Dalia K., Fatima, Maryam, Dalia A, Hana, Julianna, Claudia B. I would like to express my gratitude to my fellow classmates. We have shared in this journey together, and we are forever bonded because of it; Heather, Meghan, Liz, Stef, Ryan, Leah, David, Claudia. In some way, shape or form, you have helped me get to this point. I wish you all the best of luck in your future endeavors. Lastly, I would like to acknowledge Dr. Pernice for your continued support from the very beginning of my graduate career. I remember meeting you for the first time back in 2009 when I interviewed for the Marriage and Family graduate program. At the time, you helped me begin a new chapter in my life, and now, you will help me close it out. Onto the next chapter!

Because I have been supported in my own vulnerabilities, I am able to support others. I am grateful for every soul I have met in my lifetime. Each had something to teach me, about myself, good or bad, about the world and about the resiliency of our hearts

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CHAPTER 1 INTRODUCTION

Immigrants from the Middle East are rapidly becoming one of the largest groups of displaced migrants worldwide. According to the United States Department of Refugee Admissions Program, the United States of America (U.S.) is projected to accept 85,000 refugees for the 2016 and 2017 fiscal years. Additionally, an approximated 34,000 of these individuals will immigrate from South Asia and the near East, with roughly 10,000 from the Middle Eastern country of Syria. (U.S. State Department website accessed on 9/15/2016). Furthermore, a substantial proportion of these immigrants from the Middle East are believed to have been exposed to war, violence, and torture, with many suffering from trauma related mental illnesses. Moreover, pre-migration factors are often amplified by post-migration stressors during and after resettlement into the United States (Dross, 2000; Jamil et al., 2002). Many of these post-migration stressors are related to acculturation, language barriers and economic constraints (Aprahamian, Kaplan, Windham, Sutter, & Visser, 2011; Jamil et al., 2002; Melhem & Chemali, 2014). Unfortunately, the systems of which routinely interact with this unique population, such as hospitals, schools, and community mental health organizations, lack the scientifically sound and culturally relevant tools to provide effective care. Consequently, the complex mental health needs of the immigrant population necessitate providing mental health care that is informed, culturally sensitive and guided by scientific, evidence-based practices.

Help-Seeking and the Arab American

Research on evidence based, culturally sensitive interventions with the Middle Eastern immigrant population is scarce, however, overwhelming consensus in the literature asserts that Middle Eastern immigrants typically underutilize mental health services (Erikson and Al-Timimi, 2001; Jamil et al., 2002; Latzer, 2003; Melham & Chemali, 2014; Siren-Rogers, 2013). Available

research on the subject matter focuses on variables related to help seeking avoidance and stigma surrounding mental illness. Additionally, seeking pharmacological therapies to manage physiological complaints is a commonly cited reason for entering mental health treatment by the Arab cultural group (Erikson and Al-Timimi, 2001; Jamil et al., 2002; Latzer, 2003; Melham & Chemali, 2014). Lastly, research had found that the practice of psychotherapy conflicts with cultural expectations of 'healing' which is believed to be the sole responsibility of the physician, with minimal effort on the part of the consumer (Latzer, 2003; Purhan & Sati, 2013).

Understanding the unique variables that prevent immigrants from accessing mental health care is important, nevertheless, it is important to explore variables that may mitigate barriers to treatment. Unfortunately, the scarcity of available literature on the subject matter poses a dilemma for professionals who frequently interact with this population. Research is limited at best, and largely nonexistent on applicable, effective, and appropriate methods to treat the unique needs of this population (Melham & Chemali, 2014). Conversely, whether members of this population are referred for treatment, or arrive by their own means, what resources do mental health professionals have available, and are current guidelines of health care treatment sensitive to the different needs of this population?

Information about beliefs, perceptions, and behaviors of mental health care use of this specific population may be useful in the development of evidence based models of care. However, the literature has largely overlooked the role and function of the clinician in the delivery of care, when immigrants ultimately decide to seek treatment. The mental health care system appears to be lacking, at least from a research perspective, in appropriate training, culturally applicable diagnostic tools, and overall understanding of how to provide services to this population (Melhem & Chemali, 2014).

Recovery - A Consumer Lead Movement

Connecting the origins of recovery to a single historical/social or political change in health care is a difficult task. Moreover, several simultaneous changes in health care policy and mental health care services facilitated the present-day consumer lead recovery model of health care. The deinstitutionalization of persons with mental illness from psychiatric hospitals in the 1950's, consumer-survivor narratives, and longitudinal research in the sixties and seventies challenged traditional, medical views of recovery (Anthony, 1990; Bellack, 2006; Deegan, 1988, 2007; Farkas, 2007; Harding, Brooks, Ashikaga, Strauss, & Brier 1987)). The construct of recovery arose from consumer-survivor narratives of living with mental illness (Anthony, 1990; Davidson et al., 2007; Mead & Copeland, 2000). Historically, recovery from mental illness was defined as the absence of symptoms and a return to premorbid state, failing to account for consumer beliefs of what recovery means for them.

The President's New Freedom Commission Report (2002) advocated for the use of scientifically proven treatment interventions as the guiding principle mental health care services. This marked a pivotal turning point in the way mental health care was conducted in the United States. Prior to this report, a widely popular medical model of care, focusing on the absence of psychological symptoms primarily through pharmacological treatment was the standard intervention (Bellack, 2006). The medical model contested that recovery from mental illness could only be achieved in the absence of pathology, and a return to premorbid functioning. Additionally, the model posited that adherence to psychotropic medications would be lifelong to manage accompanying symptomology in severe disorders such as schizophrenia. The President's New Freedom Commission Report (2002) arose from increasing criticism of the mental health care system by consumer-survivor groups and their family members of the existing care model. The

report now mandated that not only should treatment be a collaboration between the practitioner and the consumer, and evidence should be the driving force behind interventions. (Bellack, 2006).

In 2004, The U.S. Department of Health and Human Services, in their two-day conference on Mental Health Recovery and Transformation, established a working definition of recovery, which emphasized access for consumers of evidence-based treatments, and the access of social and peer support networks to successfully manage mental health disabilities (SAMHSA, 2004). The new, working definition of recovery that was established mirrored previous consumer narratives of the recovery model. Recovery was defined as a "journey of healing and transformation" and that persons with mental illness should be able to lead "meaningful" lives "in communities of his or her choice" (SAMHSA, 2004). In addition to this definition, SAMHSA (2004) identified characteristics of recovery-oriented services, with emphasis on treatment as a partnership and collaboration between the consumer, the consumers' family members and the clinician. Presently, the Substance Abuse and Mental Health Services Administration's established the Office of Behavioral Health Equity to work creating cultural awareness and competency in mental health and substance use programs (SAMHSA website accessed 1/22/2017).

Cultural Matching – The Role of the Culturally Competent Therapist

Overwhelming consensus in the literature attests that, cultural competence is a key factor in providing excellent care when working with diverse populations (Griner & Smith, 2006; Melhem & Chemali, 2014; Siren-Rogers 2013; Sue, Zane, Nagayama Hall & Berger, 2009). Sue and colleagues (2009) explains that providing culturally competent care is comprised of three factors; the person, the process, and the resources available for care. Griner and Smith (2006) in their meta-analysis paper on multicultural counselling found that studies that were multiculturally sensitive, resulted in more positive therapy outcomes. Additionally, cultural matching between the

therapist and the client appears to mitigate dropout rates and improve scores on outcome measures among the Arab reference group (Siren-Rogers, 2013). Chu and Sue (2016), explain a theoretical model explaining the efficacy of cultural competence in psychotherapy from a theoretical model. The authors postulate that cultural competency is efficacious due the “contextual match” with the client’s external realties and the feelings of being understood (Chue & Sue, 2016). The importance of providing culturally competent care is echoed in the American Psychological Associations Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists. The guidelines implicate the importance of cultural awareness, limiting beliefs and attitudes and to provide support for the use of culturally relevant and applicable interventions and processes (APA, 2002).

Statement of the Problem

In many ways, mental health care has evolved beyond outdated and scientifically unsupported care models. However, there remains a disconnect between the current models of care and culturally sensitive health services available to the Arabic speaking population. Deeply held cultural beliefs and expectations of mental health care conflict with a consumer lead recovery model which guides mental health care practice in the United States. Furthermore, it appears likely that because of this, clinicians who work closely with this population would face unique challenges in providing care. In a meta-analysis of cultural competency and help seeking, Benish, Quintana and Wamplod (2011) suggest that psychotherapy is a predominately ‘Eurocentric’ treatment which may not always connect with culturally held beliefs about help seeking and mental health care. However, the staff who understand the cultural nuances, beliefs and expectations are critical to the birth of culturally relevant and sensitive health care measures (Benish et al., 2011).

Purpose of the Study

The purpose of this study is to explore the barriers and facilitators of providing mental health services to the Arab cultural group from the perspective of the mental health therapist. This will be accomplished by gathering information from practitioners that work exclusively with the Middle Eastern population. The overarching goal is to obtain insight into how treatment with this population is provided given the cultural considerations and expectations of the clients and the available resources the therapist may have to effectively engage the client in treatment. Most importantly, it is through the therapists' narrative of their contrasting positive and negative experiences that we can begin to identify the problems and solutions within the current mental health framework for providing care.

Research Questions

To assess the barriers and facilitators of working with the Middle Eastern population in the domain of psychotherapy, the following research questions will be explored:

1) What are the perceived barriers and perceived facilitators of providing therapy to consumers who identify with the Arab-American cultural ethnic reference group?
2) What practice strategies are therapists that identify with the Arab-American cultural ethnic reference group utilizing to meet the clinical needs of their clients?
3) What are therapists' beliefs about recovery from mental illness

Significance of the Study

Fundamental to the concept of recovery is the idea of collaborative effort in the clients' recovery journey between the consumer and the clinician. Proponents of recovery William Anthony implicated in his narrative on recovery "Professionals do not hold the key to recovery; consumers do. The task of the professionals is to facilitate recovery; the task of consumers is to

recover" (Anthony, p. 18). Mental health providers in the United States who exclusively work with the Arabic speaking population are in and of themselves a unique group of individuals faced with the delicate task of merging Westernized standards of mental health care to consumers who hold culturally specific beliefs about mental health. Furthermore, the influx of immigrants with pre-migration and post-migration stressors and mental health concerns (Aprahamian et al., 2011; Jadalla & Lee, 2012; Jamil et al., 2000) poses a challenge for clinicians working with this population as there are a lack of established, evidence-based research and diagnostic assessment tools available (Melham & Chemali, 2014). Thus, it is through the clinician narratives, knowledge, and exposure to this population that a greater, more comprehensive understanding of the needs of this population can be established, and guide the future direction(s) of health care delivery.

Depression, trauma-based disorders, anxiety, and post migration stressors are some most commonly sighted mental health concerns in Middle Eastern Immigrants to the United States (Melham & Chemali, 2014 p.21). Additionally, the lack of evidence-based research, and culturally relevant, sensitive tools available to clinicians, furthers the divide between Westernized standards and expectations of how mental health care is provided to this culturally diverse group of individuals. It is the goal of the researcher that conceptual frameworks formulated from these narratives will be used to drive future research and develop effective treatment strategies to increase consumer involvement in their care.

Assumptions of the Study

The following assumptions are proposed for the study; The study will employ a qualitative research style approach to gathering insight into the perceptions of the barriers and facilitators of working with this specific population. Due to the nature of the study, neither random selection nor random assignment will be employed. Experts in qualitative research urge that sampling strategies

for research should be reflective of the population at large, and that probability sampling is most effective. However, due to the nature of the study, the sample of participants is represented of something Maxwell (2013, p. 97) calls “purposeful selection” or purposeful sampling. The goal of purposeful selection is to study those members belonging to the population group that will provide the most insight into the phenomena in question. For this study, Arab American therapists’ that work with Arab reference group and provide psychotherapy services will be utilized as this population. The Arab-American therapist will be able to provide unique insight into the phenomena in question that may not otherwise be gathered from a larger more representative sample of all psychotherapists. Another assumption of qualitative research is that participants are interviewed, and data is gathered until data saturation is reached. Data will be collected using open-ended questions, meant to capture the overarching research questions.

Limitations

With any proposed qualitative design, researcher bias poses a threat to the validity of the study and therefore it is important to understand the researcher’s values, preexisting ideas and beliefs when conducting research and drawing conclusions from the data. Additional threats to validity include influences the researcher may have on the setting or participants in the study. While important measures may be put in place to minimize the impact of the researcher on the participants such as avoiding the use of leading questions, it is crucial to consider the influence of the researcher in the setting he/she are studying. An additional limitation of this study comes from the sample strategy used. Generalizability in qualitative research is often also compromised in a qualitative study as participants sampled are not representative of the population at large. Because this study is specific to therapists who work with and provide psychotherapy to Arab cultural group it cannot be generalized to a sample of all therapists.

A subsequent limitation of asking employees to report on perceived work-related barriers are the participant perceived ramifications of participating in the study. Ultimately, this may result in participants either limiting or excluding information, or lack of participation altogether. Lastly, because data will be gathered on site, avoiding, or limiting perceived feeling of coercion to partake in the study must be accounted for.

CHAPTER 2 REVIEW OF THE LITERATURE

Historical Synopsis of the Recovery Movement

Evidence Based Practices (EBP's) are the gold standard in psychological treatment. EBP's encompass service models and treatments found to be effective through empirical research (Essock, Drake, Frank & McGuire, 2003). The American Psychological Association Task Force on Evidence Based Practice defines EBP's as "effective psychological practice that enhances public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention" (APA, 2006 p. 271). A fundamental difference between EBP's and empirically supported interventions alone is that consumer outcomes are of exceptional importance to EBP's. Effectiveness of evidence based interventions utilizing a recovery care model is well documented in the psychological literature. Nonetheless, a discussion of the recovery model is incomplete without first examining the historical and scientific studies that continue to influence the recovery movement.

The multidimensional, multifaceted construct of recovery evolved as a bi-product of empirical data, social and political attitudes surrounding mental illness in the United States (Anthony, 1990; Barber, 2012; Bellack, 2006), coupled with growing frustrations from consumers and their families (Anthony, 1990; Mead & Copeland, 2000) regarding psychiatric treatment for chronic mental illness. Historically, recovery was viewed from within the lens of the 'medical model' framework, and primarily 'outcome' focused (Bellack, 2006). This traditional, medical definition of recovery focused mostly on the absence or elimination of symptoms, where to 'recover' meant to a return to premorbid functioning, ultimately failing to consider the uniquely individualized 'process' of recovery from mental illness (Anthony, 1990, Mueser, Rosenberg, Goodman & Trumbetta ,2002). Furthermore, overwhelming consensus among mental health

professionals was that medication adherence would be lifelong, and the presence of residual symptomatology meant individuals experiencing mental illness would be unable to lead satisfying lives (Bellack, 2006). Therefore, recovery could not be achieved unless a complete remission of the disease or a return to baseline functioning first occurred.

The deinstitutionalization of people with mental illness from psychiatric hospitals in the nineteenth century meant that individuals with severe mental illness could no longer be segregated from the larger urban community. Conclusively, mental health care was shifted from hospitals to smaller community-based health facilities (Anthony, 1990). Unfortunately, a new set of challenges emerged as previously institutionalized persons attempted to reintegrate into communities that were often ill equipped to support individuals with various psychiatric needs. Consequently, growing consumer protests, political lobbying from consumers and their families, in conjunction to longitudinal research in the sixties, seventies, and eighties, challenged traditional, medical views of recovery (Anthony, 1990; Deegan, 1988,). Consumer narratives of recovery suggested that recovery was in fact possible and that consumers could lead satisfying lives, challenging the predominant beliefs about mental illness following the post-institutionalization era (Deegan, 1988, 2007). Unfortunately, available treatment options, and legislative policies were incongruent to consumer reports and empirical data about recovery from mental illness (Farkas, 2007).

Consumer-survivor narratives of recovery underscore the importance of hope and empowerment as necessary to the recovery process. (Andresen, Oades & Caputi, 2003; Bellack 2006; Davidson et al., 2005; Mead & Copeland, 2000). Hope, from a recovery-oriented perspective, emphasizes empowering consumers to acknowledge that recovery is in fact possible, and consumers can facilitate their recovery (Mead & Copeland, 2000). Mead and Copeland (2000) discuss the concept of consumer lead recovery and the importance of collaboration between the

consumer and the mental health provider in the treatment process. The authors suggest that recovery minded health care providers can assist clients' in their recovery journey through educating families and consumers on the recovery process (Mead & Copeland, 2000). In addition to the concept of hope, recovery-oriented care encourages the use of peer and family support networks which have beneficial impacts on self-esteem and self-efficacy (Berkman, 2000; Horowitz, Reinhard & Howell-White, 1996; Pernice-Duca, 2010). Provider expectations for recovery are equally important for consumer outcomes. A study by Salyers, Brennan and Kean (2013), found that positive recovery expectations from mental health care providers, resulted in more recovery facilitating behaviors on the part of the clinician, and greater positive outcomes for consumers. Thus, both client and provider expectations for recovery are equally important to mental health outcomes.

A recovery-oriented model of care promotes the importance of collaboration between the consumer and the provider, and fosters a shared, inclusive vision for treatment. Jacob and Greenley (2001) proposed a conceptual model of recovery encompassing internal processes experienced by the individual (hope, healing, empowerment, connection) and the external conditions (human rights, a positive culture of healing, recovery-oriented services) that promote recovery. Healing relates to self-concept and identity beyond the illness. Empowerment is defined as a belief in autonomy and the tools or mechanisms undertaken to facilitate autonomy such as knowledge about the illness, and the ability to make meaningful decisions. Lastly the concept of connection relates to the social aspects, persons, and activities the individual undertakes that promote community inclusion, including supporting individuals impacted by mental illness. The authors conclude that consumer/provider beliefs centered around hope through acknowledging that recovery is possible,

promotes healing and protects against relapse. Conclusively, external conditions help the internal practices in a reciprocal manner (Jacob & Greenley, 2001)

Research on Recovery

Longitudinal research documenting the course of schizophrenia confirms consumer accounts of recovery, highlighting that recovery can occur in the presence of psychiatric symptoms, and with discontinuation of pharmacological interventions (Harding et al., 1987). The Vermont Longitudinal Study of Persons with Severe Mental Illness, was the first long term outcome study to follow the course of severe mental illness throughout the lifespan in persons diagnosed with schizophrenia. Approximately one half-to one third of the $n=168$ patients surveyed over a 32-year period recovered from schizophrenia, with a large proportion of overall participants previously labelled 'chronically ill' demonstrating significant improvements to multiple life domains (Harding et al., 1987). The study measured improvements to social and emotional functioning with a Global Assessment Scale (GAS), assessing functioning in life domains such as employment, social relationships, severity of symptoms, and psychiatric hospitalizations etc. The GAS was utilized as a measure of overall well-being across the course of the study. Research by Harding and colleagues (1987), was instrumental in providing empirical evidence that individuals with severe mental illness could in fact recover, and report leading satisfying lives despite their chronic mental health condition. The historical results of Harding and colleagues (1987) facilitated the advancement of additional longitudinal research on recovery from mental illness.

Comparable long-term outcome studies have demonstrated cross-cultural patterns of recovery occurring at similar rates to that of Harding and colleagues (1987) in countries such as Germany, Switzerland, and Great Britain (Farkas, 2007). A study from Harrison and colleagues (2001) showed improvements to overall social, emotional, and psychological well-being in an

international follow up study at fifteen and twenty-five years. Harrison and colleagues (2001) suggested a "critical window" of opportunity where intervention, if delivered effectively, would minimize the length and chronicity of schizophrenia whereby the shorter the course of the illness, the better the recovery. Harrow, Grossman, Jobe & Herbener (2005) found that upwards of 40% of their sample experienced at least one episode of recovery in a 15 year follow up study comparing schizophrenia with psychotic and nonpsychotic disorders. Conversely, in comparison to psychotic and nonpsychotic disorders, the schizophrenia group of disorders presented with a longer, more severe course of the illness, resulting in poorer outcome (Harrow et al., 2005). A follow up study by Strauss, Harrow, Grossman, & Rosen, (2008) presented similar findings to that of Harrison et al. (2001) wherein, severity of illness resulted in poorer long-term outcome for recovery. Consequently, the emergence of scientific data has provided cross-cultural and longitudinal support for recovery from mental illness, especially in severe and chronic psychiatric illnesses such as schizophrenia.

Public Policy on Recovery

In lieu of consumer narratives and empirical data, The President's new Freedom Commission on Mental Health was established in 2002 to examine mental health service in the United States. The report mandated provisions to mental health care minimizing inequality for persons with disabilities, and improving treatment programs for persons with mental illness. A new system of care was proposed with recovery as its guiding principle. Recovery was defined as: "the process in which people are able to live, work, learn, and participate fully in their communities." (President's New Freedom Commission on Mental Health, 2003 accessed online)

The report advocated for the implementation of recovery-oriented care, and urged against basic symptom management. Additionally, consumer preference and treatment effectiveness

would now be the basis for reimbursement for treatment programs. The report identified six goals as the foundation for the recovery-oriented care service:

1) Americans understand that mental health is essential to overall health
2) Mental health care is consumer and family driven
3) Disparities in mental health services are eliminated
4) Early mental health screening, assessment and referral to services are common practices
5) Excellent mental health care is delivered and research is accelerated
6) Technology is used to access mental health care and information (SAMHSA, 2004)

On the heels of the President's new Freedom Commission report, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2004) set out to establish a definition of recovery that encompassed the essence consumer focused and consumer lead care. SAMHSA (2004) defined recovery as "a journey of healing and transformation for a person with a mental health disability to be able to live in a meaningful life in communities of his or her choice while striving to achieve full human potential or personhood". The SAMHSA conference resulted in mandates to include recovery-oriented care as part of health care treatment in the United States. Additionally, SAMHSA (2004) identified that recovery-oriented care should encompass the following critical components: 1) Self-Direction 2) Individualized and Person-Centered 3) Empowerment 4) Holistic 5) Nonlinear 6) Strengths -Based 7) Peer Support 8) Respect 9) Responsibility 10) Hope.

A complete synopsis of the provisions outlined in SAMHSA (2004) recommendations are beyond the scope of the present study, however, it is worth noting that an emphasis on collaboration between the consumer and the clinician in addition to consumer lead care is at the

basis of the recommendations. Furthermore, a recovery focused care model serves to empower consumers through the emphasis on peer support and community inclusion.

Ecological Theories

Ecological frameworks are useful for understanding the unique, complex, bidirectional relationship between the individual and the ecological setting. Urie Bronfenbrenner's (1977) ecological theory, later renamed the bioecological systems theory, describes lifespan development as an interactive process between the individual and the environment. The theory examines the proximal and distal processes which impact the developing person (Bronfenbrenner, 1977). Comparatively, Kelly's (1966) Ecological theory, an alternate ecological framework popular among community psychologists, explores how the person and the environment interact to promote change within the community they are embedded. Analysis of both theories are useful for understanding the environmental factor that inhibit or facilitate the therapist working in the community-based health care setting, specifically, the therapist providing mental health care services to the Middle Eastern population.

Urie Bronfenbrenner is widely known for his earlier work outlining the environmental systems which interact with the developing child (Jaeger, 2016). However, in his later work, Bronfenbrenner expanded his theories to include characteristics of the person (proximal) which interact reciprocally to the individual's environment. In his earlier work, Bronfenbrenner (1977) defined ecological human development as:

> "the scientific study of the progressive, mutual accommodation, throughout the life span, between a growing human organism and the changing immediate environments in which it lives, as this process is affected by relations obtaining within and between these

immediate settings, as well as the larger social contexts, both formal and informal, in which the settings are embedded"

The core foundation of Bronfenbrenner's (1977) earlier work focuses on five interacting, environmental systems which impact human development; the microsystem, the mesosystem, macrosystem, exosystem, chronosystem. In his later work, Bronfenbrenner sought to incorporate the proximal (situations, people, institutions, social) contexts that interact with distal processes which shape development across the lifespan.

The microsystem, according to Bronfenbrenner (1977), defines the relationship between the individual and their immediate environment (e.g., home, school work, etc.). The microsystem contains the proximal processes which the developing person is actively involved in (Jaeger, 2016). The mesosystem entails the interactions of two settings the individual interacts with. Examples of mesosystems would be the interaction between the teacher and the parent. An exosystem contains systems that do not involve the developing individual. Bronfenbrenner elaborates that while the individual may not be directly involved in structures or settings residing in the exosystem, the exosystem is comprised of major institutions, formal and informal structures such as the media, government agencies where the individual resides. Lastly, the macrosystem refers to the patterns of the culture and subculture such as political systems, schools, legal and educational systems, language, and communication patterns that influence the individual. Macrosystems can involve historical or social events, defined by Bronfenbrenner (distal processes) as events relating to economic downturn and political changes that indirectly affect the individual (Jaeger, 2016). In Bronfenbrenner's analysis of the system, he argues an important point pertinent to the present research questions under investigation, that it is important acknowledge how the system or setting within which the research question is embedded impacts the phenomena in

question. Bronfenbrenner later expanded upon his original theories to suggest the developing child was an active agent in his/her development and included personal characteristics of the child (temperament, attributes, personality, motivation, etc.). The notion that the environment was solely responsible for changes to the individual, were extended to include the ways in which individuals can be active agents of change in the environmental contexts they interact with (Jaeger, 2016).

James G. Kelly's (1970) narrative "antidotes for arrogance" cautions psychological professionals against simple analysis and interpretation of observed phenomena within an ecological setting. Much like the work of Bronfenbrenner, Kelly (1970) addressed the importance of the researcher joining in on the community or ecological context they observe to 'competently' understand the needs of the community. Proponents of this ecological perspective recommend that ecological theory should encompass a heuristic of how a community functions rather than a mere theory that focuses on cause and effect within the system (Kelly, 1970). The shift from the why, to how is what makes Kelly's ecological framework suitable for qualitative study as it allows for exploration of the often complex, context dependent processes that may otherwise be difficult to capture (Toro & Wall, 1991).

Kelly's (1966) ecological theory explores four principles that encompass this framework; the adaption principle, cycling of resources principle, interdependence principle and the succession principle. The adaption principle entails assessment of the social setting and the individuals' relationship to it. Toro and Wall (1991) provide an example of homelessness at this adaption principle level. The adaption principle considers social influences, cultural influences and the person-environment fit, and understanding behavior as bound by both culture and social contexts. The cycling of resources principle explains how resources within the community are marketed, divided, distributed, and utilized. Resources can take the form of personal resources and social

resources. The interdependence principle focuses on how change in one aspect of a system results in subsequent changes in another part of a system to maintain equilibrium and balance. For example, Toro and Wall (1991) explain that the development of a new program for homeless people, may cause changes to existing programs such as closures or modification. Toro and Wall (1991) related the interdependence principle to Bronfenbrenner's mesosystem which involves the interaction of two or more microsystems. Lastly, the succession principle examines the time dimension of the ecosystem by acknowledging that all ecosystems are in constant change and long term as well as short term strategies should be addressed to partake in anticipatory problem solving. Lastly and most importantly, Toro and Wall (1991) underscore the necessity of collaborative, reciprocal exchange between the researcher and the ecological context within which they are embedded. To fully grasp the needs of the system, they suggest the researcher fully immerse themselves in the community in order to better understand the needs of the community, and develop interventions that are appropriate and accepted by the community. Known as indigenous intervention, this concept involves interventions created by researchers embedded in a community setting that are relevant to the needs of the community (Campbell, Patterson & Fehler-Cabral, 2010).

Several key take home points should be noted after an evaluation of these mutually reinforcing theories of behavior within an ecological setting. The context for the data collection is just as important as the data itself. Therefore, it is crucial that the researcher acknowledge and recognize the often reciprocal bi-directional of the phenomena they wish to study and the setting within which the phenomena is embedded. Furthermore, Campbell and colleagues (2010) argue that validity of the intervention cannot be overlooked when assessing intervention effectiveness in order to minimize the discrepancy between scientific interventions that have no basis in

community practice needs. Conclusively, ecologically focused interventions may be useful in addressing the discrepancy between mental health needs and service utilization among the Arab population. Furthermore, providers that work directly with this population may be able to offer insight into the needs of the community in order to guide effective and appropriate intervention.

Mental Health Help Seeking Among the Arab Cultural Reference Group

The underutilization of mental health services by the Arab cultural group in North America is commonly discussed in the literature (Al-Darmaki, 2014; Erickson & Al-Timimi, 2001; Heath, Vogel & Al-Darmaki, 2016; Melhem & Chemali 2014; Youssef & Deane, 2006;). Several variables are frequently cited as potential barriers to help seeking such as stigma (Abdullah & Brown 2011; Jamil et al., 2002) social norms and expectations (Youssef & Dean, 2006) and upholding family honor within the respective community (Dardas & Simmons, 2015). Furthermore, consistently negative expectations and beliefs about help seeking may conflict with 'Westernized standards of care', wherein there is an expectation among this population that the clinician is to be more involved in the care, and for recovery to occur without active involvement on the part of the client (Latzer, 2003; Perihan & Sati, 2012). The implications for these findings lend itself to the growing debate of psychotherapy as a primarily "Western" phenomenon. Erickson and Al-Timimi (2001) discuss that cultural expectations, beliefs and stereotypes of mental illness impact the way Arabs utilize mental health services. Additionally, when mental health treatment is utilized, somatic complaints are a primary motive for help seeking whereas personal, emotional and mood complaints are least likely reasons to seek treatment (Dardas & Simmons, 2013; Erickson and Al-Timimi, 2001; Melhem & Chemali, 2014;). Unfortunately, failure to relate the physical pain to the underlying mood disturbance the use of standard diagnostic measure such as

the DSM V and ICD- 10 may not accurately capture presenting symptomology and lead to misdiagnose (Melhem & Chemali p.9, 2014).

Barriers to help seeking

Social norms. Research on attitudes towards help seeking from the Middle East offers insight into barriers with providing care to the Arab reference group. In a 2016 study on mental help-seeking attitudes in college students from the United Arab Emirates, Heath and colleagues (2016), discussed that avoidance of behaving in undesirable, culturally unacceptable ways (loss of face) was a barrier to help seeking. Despite the modern nature of the United Arab Emirates in comparison to other Middle Eastern Countries, the cultural implications of perceived diminished social desirability, resulted in greater negative attitudes towards counselling. Paradoxically, loss of face was also associated with positive attitudes towards help seeking as perceptions of loss of face also prompted individuals to seek counselling to address negative emotions associated with the latter. The researchers argued that the cultural consequences of experiencing mental health symptoms may increase the likelihood of seeking help to avoid embarrassment, shame, and stigma. While loss of face may facilitate help seeking, it appears the overarching belief is the avoidance of greater social consequences either through engaging in therapy or avoiding it.

In a qualitative study outlining the barriers to help seeking in an Australian, Arab sample, Youssef and Dean's (2006) research spoke to the importance of maintaining family honor within the Arab culture. Respondents in this study reported that upholding family reputation lead to harboring greater negative, mistrustful attitudes of self-disclosure in psychotherapy (Youssef & Dean, 2006). Conclusively, behaving in ways that honor and respect the 'family' in the Middle East meant that individuals often delayed seeking help, avoided discussing family problems, and believed that personal problems could be resolved amongst family (Youssef

& Dean, 2006). These findings correlate with similar accounts within the literature on the perceived utility of psychotherapy within the Arab cultural group (Abdullah & Brown, 2011; Erickson and Al-Timimi, 2001). Additionally, it is common for Arabs to consider and invest in family needs ahead of individual needs (Melhem & Chemali, 2014). Providing culturally competent care means acknowledging the importance of deeply held beliefs about the importance of family.

Gender norms and stereotypes among the Middle Eastern population have been linked with greater negative attitudes towards mental illness (Heath et al., 2016). Whereas women are more likely to harbor positive attitudes towards help seeking, and are more likely to seek help than men (Al-Krenawi, 2005; Heath et al., 2016), women are more likely to experience shame and stigma associated with experiencing mental illness and men are least likely to disclose in psychotherapy (this should be cited too). Additionally, women are expected to conceal mental health difficulties as disclosing or discussing them could lead to loss of social and family support (Al-Darmaki, 2014). Therefore, cultural expectations about gender appropriate norms for seeking mental health services poses a potential barrier to perceptions of health seeking.

With a surge of immigrants fleeing war, trauma, and poverty from the Middle East, many immigrants come to the United States seeking refuge safety and relief from their respective countries. Unfortunately, resettlement in the United States poses a whole host of difficulties with regards to acculturation and the impending social, economic, emotional difficulties that arises. Melhem and Chemali (2014) report immigrants face a plethora of pre-migration and post migration stresses that intensifies the course of any existing mental illness. In a retrospective study of Iraqi refugees, mental illness and trauma, Jamil and colleagues (2002) discuss that refugees face "unique" barriers before and after migration. The authors suggest that stressors include exposure

to disease, war, poverty, violence, and "post migration" stressors. Post-migration stressors are related to acculturation, language barriers and economic constraints. Furthermore, Jamil and colleagues (2002), discuss that as a whole, the Iraqi-Arab subgroup displayed greater "health related problems" and were more likely to be diagnosed with post-traumatic stress disorder. However, refugees in this sample consisted mostly of refugees migrating to America after the Gulf War.

A clear and definite cultural barrier exists in treating Arab Americans with respect to mental illness. Research on the relationship between attitudes towards help-seeking and mental health with the Middle Eastern population demonstrates consistent, barriers to effectively providing treatment. In the Jamil and colleagues (2002) study, much of the retrospective data collected on the reasons why Arab Americans seek mental health services seemed to center around health-related complaints, while full and partial remission of symptoms was documented among the 375 clients attending a treatment clinic that provides services to Arab Americans, most discontinued services. The authors highlight a crucial note that services provided to this population need to be culturally sensitive, and consider migration stressors and difficulties from acculturation that may impact treatment compliance (Jamil et al., 2002).

In a subsequent analysis on problems related to implementing "Westernized standards of mental health care" in a sample of Moroccan women living in Israel, Latzer (2003) discussed that although there was a relationship between cultural expectations and mental illness, clients expected psychiatrists to be more involved in care. Thus, patients appeared to have difficulty adhering to this standard of medical care and according to Latzer, "the patients expected healing without being activity involved in the healing itself" (2003). This was especially true for older vs. younger patients with older patients having greater cultural expectations of the psychiatrist as being "an

omnipotent healer" (2003). In a Turkish study on mental health seeking behaviors, Perihan and Sati (2012) found that prior to seeking treatment in an outpatient psychiatric clinic, more than fifty-six percent of the sample utilized "alternative" methods rather than "conventional psychotherapy". It is unclear in this sample whether cultural stigma or difficulties with cultural expectations of seeking mental health services may have been a factor in these clients choosing other forms of mental health seeking. However, the authors state that the implication of these findings for mental health care professionals is that patients are less likely to seek professional mental health treatment (this feels like it should be cited – but not sure which authors you're referring to. Perihan & Sati?).

Al-Krenawi and Graham (2000) outlined factors to consider when working with Arab Americans. One important factor is the role of stigma on gender when seeking mental health treatment. The authors note that stigma is especially evident for females. Females that seek mental health treatment are at a greater risk of suffering stigma which according to the authors may result in difficulties securing a marriage partner and result in 'labelling' or a negative 'reputation' within the community. Additionally, the authors discuss the importance of the mental health care practitioner to consider the mediating effects of religion on gender and stigma. Al-Krenawi and Graham (2000) suggest that in the Islamic religion, it may be off putting to discuss deep intimate personal secrets about ones' life with one of the opposite gender. Therefore, woman may not be able to make direct eye contact with males, shake hands or share deep personal aspects of self with the male therapist. The authors encourage and strongly suggest that there be gender matching between client and the therapist.

Conclusively, it appears that applying a Western model of mental illness treatment may be difficult due to cultural expectations of treatment, biases towards mental illness and the use of mental health services. Youssef and Deane (2006) discuss that the functionality and usefulness of

psychotherapy is mostly lost among the Arab population. The authors suggest that client's may have difficulties disclosing personal information and may rely on religious leaders to provide guidance from mental health concerns. Thus, it appears as though improving service utilization relies on understanding partly the cultural norms that mediate perceptions of help seeking in conjunction with the association of physical symptoms to mental health symptoms.

Stigma. The effects of stigma on mental illness appears to be moderated by culture (Abdullah & Brown 2011; Corrigan, 2004; Gearing et al., 2015). Cultural beliefs about mental health recovery suggests barriers to help seeking, and barriers to treatment adherence (Corrigan, 2004). Abdullah and Brown (2011) state that cultural variables should be considered when examining beliefs about mental illness stigma. Differences between and within the various ethnic groups is often predictive of help seeking behaviors (Abdullah & Brown, 2011). Conclusively, the impact of stigma on help seeking tends to be larger in ethnic minorities in relation to Caucasians (Corrigan, 2004). Among the Middle Eastern population, cultural importance is placed on attributes related to family honor, hospitability and concealing emotions. Behaving in ways that honor these values are viewed favorably and individuals will often avoid help seeking to uphold family honor and avoid stigma associated with mental illness.

A sentiment echoed throughout the literature on help seeking behaviors of Arab Americans underscores the role of stigma as a barrier to treatment. The deleterious effects of stigma from mental illness is documented in the work of Patrick Corrigan (2004). Corrigan writes that the stigma from mental illness interferes with help seeking and treatment adherence. Furthermore, individuals will often avoid, discontinue, or fail to comply altogether with treatment to minimize the social and emotional harm that accompanies stigma. Corrigan (2004) differentiates between self-stigma "what members of a stigmatized group do to themselves", and public stigma "what a

naïve public does to a group when they endorse the prejudices about that group". Corrigan (2004) explains that self-efficacy and self-esteem are impaired with self-stigma with the result being shame. Thus, to preserve self-esteem, self-efficacy and avoid shame, mental health treatment is often discontinued. Therefore, help seeking intentions are likely to decrease with increased perceptions of self-stigma, and treatment avoidance and discontinuation is similarly likely to be motivated by public stigma. The implications of Corrigan's research for mental health professionals underscores the importance of effective treatment and intervention programs that can increase help seeking and treatment adherence while addressing the social and psychological impacts of stigma.

Cultural and ethnic variables further complicate the association between help seeking avoidance and stigma. Ethnic background has been shown to moderate the relationship between the latter (Abdullah & Brown 2011; Corrigan 2004; Dalky, 2012; Jamil et al., 2002; Narrow, Regier & Norquist, 2000). Corrigan (2004) discusses that ethnic and racial minorities are more likely to seek alternative forms of help seeking in comparison to Caucasians. Additionally, Caucasians were more likely to seek treatment than African Americans or Hispanic counter parts. Similarly, the research among Arabs, stigma and help seeking shows a similar tend to that of non-white ethnic minorities with a greater avoidance of help seeking (Kira, Lewandowski, Chiodo & Ibrahim, 2014), avoidance of the social and cultural ramifications of being labelled as mentally ill (Heath, Vogel & Al- Darmaki, 2016), and overall unfavorable attitudes towards counselling and disclosure of personal/individual problems (Dalky, 2012; Youssef & Dean, 2006).

The concepts of self-stigma and public stigma (Corrigan, 2004) were used to address perceptions of mental health seeking in a sample from the Middle Eastern country of Jordan (Gearing et al., 2015). The interviewers utilized vignettes depicting an adolescent managing

depression across four separate conditions; gender of the adolescent and whether mental health treatment was pursued. A series of follow up questions relating to stigma were used to address perceptions of stigma in relation to the vignette. Results of this study suggest that gender of the adolescent was correlated to stigma. Being female was correlated with greater perceptions of self-stigma, whereas being male was correlated with increased perception of negative public and social consequences of mental illness. The authors suggest that treatment targeted towards Arabs should work on addressing the negative public perceptions, isolation, and rejection of women with mental health problems. Conclusively, females appear to be particularly vulnerable to the stigma of mental illness which may pose as a barrier to treatment (Gearing et al., 2015).

Kira and colleagues (2014) propose that stigma, specifically the internalized stigma of mental illness, mediates the relationships to what the authors term type III traumas. This framework suggests that discrimination from mental illness, or as Corrigan (2004) termed “public stigma”, differs from type I trauma (single traumatic event) and type II trauma (single sequence of events e.g. sexual trauma) in that they are enduring, pervasive, cumulative, with negative effects that persist throughout the lifespan which the authors concluded are part of a development-based trauma framework (DBTF). Identity traumas influence social roles/norms, personal and perceived physical norms. Additionally, the authors discuss that public or identity stigmas tend to be internalized resulting in greater beliefs about stereotype threats (Kira et al., 2014).

In their sample of *n= 399* Arab American and refugee clients from a community based mental health center participated in the study. Kira and colleagues (2014), found that internalized stigma mediated the negative effect of trauma on mental health, alternatively, resisting public stigma has positive effects on mental health outcomes. Several recommendations were made by the authors including the importance of interventions focused on strengthen trauma resistant

beliefs, and acknowledging and addressing the ongoing effects of internalized stigma from mental illness. Conclusively, longitudinal research design would be better suited to address the effects of this proposed model across the life span.

Information on the social norms and impact on family shame with regards to mental health stigma is documented within the literatures, however, in comparison with cross-cultural research on the effects of stigma on family members, very little research is available on the subject matter from the Arab world. In a study on Moroccan families and perceived stigma in relation to family members, Kadri, Manoudi, Berrada and Moussaoui (2004) assessed the attitudes of *n=100* family members of individuals with schizophrenia. Conclusions from the Kadri and colleagues (2004), study show that many relatives reported a decrease in quality of life and greater psychological symptoms. Additionally, females in comparison to male relatives were viewed as having greater social consequence for experiencing mental illness including rejection, and mental illness was viewed as a barrier to marriage. Thus, families were more likely to conceal the mental illness of a female relative due to these consequences. Increased burden of care on families was a cause for stress and was related to negative mental health symptoms such as depression and decreased coping (Kadri et al., 2004).

Studies from the Middle East commonly address stigma of associating with a mentally ill family member (Dalky, 2012; Dardas & Simmons, 2015, Gearing et al., 2014). In a Kuwait sample of *n=121* family members of Arabs with Schizophrenia, Zahid and Ohaeri (2010) found that care giver burden was often associated with the caregiver having lower educational status, the family member being female and that disruptive symptoms were often associated with greater perceived burden by the family member. Of importance to this study was that frequency of contact with the family member was not predictive of increased burden. The authors speculate norms within this

country mean that families are often large, with many generations of family living in the same home. Therefore, family support is indicated and readily available (Zahid & Ohaeri, 2010).

Stigma, perceived social norms and gender variables are considered as some of the more prominent variables interfering with help seeking behaviors. Cultural expectations of care, and overall little insight into the function of mental illness tends to be expressed in greater somatization of symptoms. When working with this population in a clinical setting it becomes even more important to be cognizant of the array of social, physical, and cognitive factors that may interfere with treatment delivery. Unfortunately, while literature on the barriers of treatment is plentiful, successful health care practices is often under studied and not properly understood due to the barriers.

Facilitators of Treatment

Multicultural competence. Research investigating the underutilization of mental health services within the Arab cultural group and ethnic minorities collectively, offers a disparaging analysis of the cultural and social barriers linked with help seeking. Fortunately, awareness of these barriers has resulted in systemic changes to treatment programs and psychological practice. Multiculturalism and providing culturally competent interventions is widely acknowledged within the literature as beneficial for therapy and mental health outcomes (Bruner, Davey & Waite, 2011; Chu, Leino, Pflum & Sue, 2016; Siren-Rogers, 2015; Sue et al., 2009;). Sue and colleagues (2009) offer several definitions of cultural competencies among them, they acknowledge that multicultural competence extends beyond basic empathy or understanding of cultural differences. Cultural competency, is a match between the client's internal realities, cultural background, beliefs and attitudes, and the ability of the therapist to provide culturally sensitive and appropriate interventions. Alternate definitions, including, process models of cultural competency, discuss the

interactions between the person, the treatment, and the clinician (Chu et al., 2016). Currently, the tripartite model, is the most widely used model of cultural competency and makes up the theoretical frame work for the American Psychological Association's Multicultural guidelines (APA, 2003; Chu et al., 2016).

Originally developed by Sue, Arrendondo and McDavis (1992), the tripartite model offers an organizational framework highlighting the important skills, knowledge, and beliefs of a culturally competent counselor. The authors discuss that a multiculturally competent counselor possesses three key characteristics: a) awareness of personal biases/beliefs/attitudes, b) insight into the views, beliefs, attitudes of the client c) skills and intervention strategies that are relevant, and address the clients' needs. Sue and colleagues (1992) offer recommendations for service delivery to the multiculturally competent therapist among them, the authors stress the importance of continued education and training experiences to enhance their understanding of how to work with culturally diverse populations, understanding the limits of competence and when and where to seek supervision, and stress adequately addressing both the verbal and nonverbal messages and nuances that are culture bound.

Multicultural Guidelines of the American Psychological Association

The evolving cultural mosaic of the United States prompted the American Psychological Association (APA) to develop a task force on the implementation of Multicultural guidelines (APA, 2008). This lead to mandates from the APA to include cultural competence in accredited training programs (as stated in the Siren-Rogers, 2015; Sue et al., 2009). According to the task force, "the guidelines are based on the core assumptions of multiculturalism that call for viewing the individual holistically and within social, cultural, and historical contexts" (APA 2012). The guidelines discuss that psychologists should primarily recognize that they hold beliefs that are

different from cultures that are racially and ethnically different from their own, and strive to educate themselves on the historical and cultural beliefs that differ from their own. Conclusively, culturally competent psychological interventions are necessary for effective and efficacious treatment outcomes and results in greater, positive outcomes and lower dropout rates when addressed in treatment programs (Siren-Rogers, 2015).

The task force makes the following recommendation for providing multicultural care:

- Guideline 1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.
- Guideline 2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness to, knowledge of, and understanding about ethnically and racially different individuals.
- Guideline 3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.
- Guideline 4: Culturally sensitive psychological research are encouraged to recognize the importance of conducting, culture-centered and ethical psychological research among persons from ethnic, linguistic and racial minority backgrounds.
- Guideline 5: Psychologists are encouraged to apply culturally appropriate skills in clinical and other applied psychological practices.

- Guideline 6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices (APA, 2012).

In conclusion, establishment of the multicultural guidelines, emphasizes the importance of social, cultural, and individual differences across research, training, education and psychological intervention. Additionally, culturally competent therapists have positive effects on retention rates and outcome measures in the Arab reference group (Siren-Rogers et al, 2015) lending support to the importance of culturally competent interventions.

Empirical Support for Cultural Competence

Research on cultural competence addresses the importance of client perceptions on mental health outcome. Benish, Quintana and Wamplod (2011) discuss that cultural concerns often contribute to client distress, and the culturally competent therapist adjusts psychotherapy to address the cultural concerns of the client. Early research by Atkinson and Abreu (1992) found that, among Mexican college students enrolled in psychotherapy, perceptions of counsellors' cultural sensitivity resulted in increased ratings of cultural competence. Siren-Rogers and colleagues (2015) utilized a semi structured interview to assess perceptions of cultural competence and incompetence in Immigrant university students enrolled in psychotherapy. Lack of clarity about the therapy process, perceptions of disapproval, and viewing cultural problems as problematic were among the themes expressed by participants of incompetency exhibited by the therapist. In contrast, therapists' demonstrating interest into the client's culture, acknowledging the impact of culture on the presetting problem, empathy, and patience, were reported attributes of culturally competent therapists. Results from this study suggest that covert, perceived microaggressions, intentional or otherwise, impacted clients' perceptions', demonstrating the

importance of multicultural training and awareness for professionals working with diverse populations (Siren-Rogers et al., 2015).

In a study assessing perception cultural competence in children's mental health providers, Keyser, Gamst, Meyers, Der-Karabetian and Morrow (2014) found that perceptions of therapists' cultural competence resulted in positive therapy outcomes. Similarly, in a subsequent article by Chao, Steffen and Heiby (2012) ethnic matching between therapist and client predicted stronger working alliance between therapist and was positively related to recovery outcomes. Additionally, it is worth noting that clients' perceptions of being ethnically matched with their therapist, in contrast, to had the strongest predictor on outcome. Speculatively, beliefs about the clinicians' cultural competence may be just as importance as the actual characteristics of the therapist.

A meta-analytic review on cultural competence and psychotherapy (Griner & Smith, 2006) found that overall, interventions that were culturally appropriate, and matched the cultural needs of the client, were associated with improved outcome measures in psychotherapy. A subsequent meta-analysis (Cabral & Smith, 2011) on therapist's characteristics found that overall, client's preferred therapists' who shared cultural characteristics, however, cultural matching was unrelated to outcome measures of psychotherapy. Conclusively, it appears that interventions that are culturally relevant, appears to have a greater association to outcome measures. Additionally, appears as though the ethnic and cultural characteristics of the therapist may be what initially encourage or promote clients to engage in the process of psychotherapy, specifically in those populations with a greater likelihood to underuse mental health services. Taken together, results on cultural competency addresses the importance of therapists' characteristics, regardless of ethnic variables that facilitate outcome measures. Therapists' that expressed empathy, sensitivity and acknowledgement of the multicultural issues experienced by the clients' in addition with cultural

insight and understanding of the cultural traditions and expectations, resulted in improvements to therapy outcome overall (Cabral & Smith, 2011).

Recovery competency. As previously discussed, the concept of recovery arose from growing social and political dissatisfaction with mental health care coupled with and empirically driven data supporting the construct of recovery. A recovery approach to treatment symbolizes a message of hope and empowerment for the consumer, encourages consumer collaboration in the treatment process, and moves beyond basic symptom management common to the medical model (Andresen, Oades & Caputi, 2003; Bellack, 2006; Davidson et al., 2005; Mead & Copeland, 2000). Additionally, recovery promotes the use of peer and family support networks which have beneficial impacts on self-esteem and self-efficacy (Berkman, 2000; Horowitz et al., 1996; Pernice-Duca, 2010). Provider expectations for recovery are equally important for consumer outcomes and changing expectations can lead to more positive, recovery facilitating behaviors. (Salyers, Brennan, & Kean, 2013).

Competent therapeutic practices that incorporate a recovery-oriented model of care are critical to psychotherapy outcomes (Deegan, 2007; Russinova, Rogers, Ellison & Lyass, 2011). Research demonstrates that the therapeutic alliance has positive psychotherapy treatment outcomes, results in improvements to global functioning, and correlates to a reduction in distressing symptomology (Byrd, Patterson & Torchia, 2011; Makeline & Shaver, 2012; Norcross, 2002; Russinova et al., 2011). The recovery 'minded', and 'competent' therapist facilitates, and assists' clients' in their recovery journey (Anthony, 1990). Recovery competency defines the skills psychotherapists possess that facilitate and promote a recovery oriented model of care (Chen, 2013). These competencies are drawn from recovery frameworks, addressing both broad and specific skills professionals should possess.

The Connecticut Department of Mental Health and Addiction Services (DMHAS), was one of the first states to apply the New Freedom commission's recommendations for recovery (Chen, 2013; Davidson et al., 2007). The DMHAS facilitated a complete overhaul of existing mental health care practice in the state of Connecticut and implemented new guidelines for services provides driven by recovery. This new model of recovery oriented care was formulated by extensive input from consumers, peer supports, families and in collaboration with mental health care providers. Six domains of recovery competencies were recommended. The domains guidelines for recovery-oriented care are as follows: a) consumer and family driven; b) timely and responsive; c) person-centered; d) effective equitable and efficient; e) safe and trustworthy; and f) maximizing use of natural supports and settings; (Chen, 2013). From these values emerged components of recovery driven care such as, overcoming stigma, managing symptoms, support from providers and social networks, offering empowerment and hope to consumers. These components in turn, were used to formulate recovery driven practices (Davidson et al., 2005). Davidson and colleagues (2007) concluded that recovery in and of itself does not refer to specific intervention practices, but rather how consumers choose to manage their illness, and how service providers assist with this process. Additionally, the authors stress that in order to effectively implement a recovery-oriented care model, that recovery promoting services must be the overarching goal of all services, rather than add-ons to existing service models (Davidson et al., 2007).

Chen (2013) explored the recovery competencies required for working with patients in an in-patient, psychiatric hospital setting. A competency framework, constructed from face to face semi structured interviews of consumers in an inpatient psychiatric setting, family members, community mental health providers, support staff and educators encouraging recovery, was

established. Through data compiled in this study, the authors identified eight recovery competencies necessary for work in an in-patient setting; they include the following: 1) reducing environmental tensions by engaging with patients in a manner which allows them to feel safe and nurtured; 2) reducing personal level tensions through allowing patients to equip themselves with knowledge and skills to manage recovery 3) reducing provider level tensions through gaining increased knowledge and awareness of the concept of recovery and recovery processes; 4) setting goals, planning with patients and providing individually tailored care; 5) engaging patients in decision making; 6) fostering hope, empowerment, meaningful life and personal growth; 7) promoting recovery and advocacy; and 8) providing transitional services through connecting patients and families with community resources. In sum, Chen (2013) highlighted the importance of education and training programs that promote a recovery vision of care. Additionally, Chen (2013) argued that while establishing a set of competencies addresses the provider practices which promote recovery, these competencies fail to address broader, organizational level changes that should be considered for successful application of a recovery model of care.

Russinova and colleagues (2011) assessed recovery competencies from perspectives of clients and clinicians in a national sample. The authors defined competencies as a “set of practitioners’ capabilities that represent an amalgam of knowledge, skills and personal characteristics that facilitate recovery” (Russinova et al., 2011). Data was collected from a sample of consumers, peer-support providers, and providers. Consumers and providers listed displaying genuine respect for the client as the most important competency. An average rank across the three groups of the top ten competencies were: helping clients develop skills to manage conditions; seeing clients as persons apart from their diagnosis; helping clients accept and value themselves; listening to the clients without judgement; and believing in client’s potential for recovery.

Consumers rated relational qualities of the therapist (caring, trusting, understanding and nonjudgement), and acknowledgement of the client beyond their illness (respect, nonjudgement) as demonstrating competency (Russinova et al., 2011). From the perspective of consumers and providers, many of the competencies listed underscore the importance of the therapeutic alliance between the consumer and the clinician. The authors conclude that recovery competencies appear to be universal traits/characteristics that are generalizable across different treatment conditions, while still acknowledging the personal preferences of the client (Russinova et al., 2011).

The role of the service providing in fostering recovery attitudes, empowering clients' and inspiring hope is beneficial overall for client outcomes (Chen, 2013; Norcross, 2002; Russinova et al., 2011). Furthermore, the concept of recovery competency holds cross-cultural validity in studies of non-western, and immigrant populations. In a Japanese sample assessing attitudes towards recovery. Chiba and colleagues (2016) found that responses on the Recovery Attitudes Questionnaire (RAQ) presented with factorial, concurrent validity, and internal consistency reliability with Western samples on the same measure demonstrating this cross-cultural applicability of the recovery concept.

Conclusively, a review of the literature highlights that characteristics of the provider, expectations and beliefs about culture and recovery expectations in association with consumer cultural characteristics provide an interesting combination of factors that influence treatment. If the goal is to improve service delivery, provide competent, evidenced based care, and help clients achieve recovery, then this presents with a challenge to the mental health care professional. Evidence within the literature addressing reasons for underutilization of mental health care services among the Arab cultural group describe barriers that influence this trend. However, given

the mental health needs of this population, little information exists about ways to address these barriers.

The present study attempts to identify ways in which the mental health therapist, identifies the barriers and facilitators are to treatment. A unique contribution of the present study is that it gathers information from a sample of individuals who can offer insight into providing mental health services within a community health care setting. In addition, information will be gathered from practitioners that work exclusively with the Middle Eastern population. The overarching goal is to obtain insight into how treatment with this population is provided given the cultural considerations and expectations the clients may have with respect to the available resources the therapist may has to effectively engage the client in treatment. Most importantly, it is through the therapists' narrative of their contrasting positive and negative experiences that we can begin to identify the problems, and solutions within the current mental health framework for providing care. Lastly, research in the field of help seeking and psychotherapy suggests that psychotherapy is a predominately 'Eurocentric' treatment which may not always connect with culturally held beliefs about help seeking and mental health care. However, the staff who understand the cultural nuances, beliefs and expectations are critical if current treatment programs are to overcome underutilization of services among Arab-American consumers.

Research Questions

To assess the barriers and facilitators of working with the Middle Eastern population in the domain of psychotherapy, the following research questions will be explored:

1. What are the perceived barriers and perceived facilitators of providing therapy to consumers who identify with the Arab-American cultural ethnic reference group?
2. What practice strategies are therapists that identify with the Arab-American cultural ethnic

reference group utilizing to meet the clinical needs of their clients?

3. What are therapists' beliefs about recovery from mental illness?

CHAPTER 3 METHODOLOGY

Purpose of the Study

The purpose of this study was to examine what mental health therapists perceive as barriers and facilitators of working with Arab Americans in a treatment capacity. The research question was: What are the barriers and facilitators to providing psychotherapy to Arab Americans in an outpatient setting, and what role, if any do therapists' play as facilitators or barriers to seeking treatment. The null hypothesis was that therapists' do not perceive any barriers or facilitators to treatment.

Qualitative Research Approach

This research study employed a qualitative design approach to address the research questions. It was assumed that information gathered in this study would be used to inform the research about providing mental health services to the Arab cultural group. Information obtained in this research was anticipated to be useful regarding formulating and aiding future interventions aimed at targeting treatment intervention and evidence-based practices which can better facilitate mental health recovery for this specific population.

Joseph A. Maxwell (2013), a pioneer in qualitative analysis, argues that the importance of a qualitative approach lies in the inductive and flexible nature of the research design process. Maxwell suggests that perceptions, beliefs, and ideas of the population under investigation operate in a reciprocal influence on their environment, facilitating the phenomena under investigation (Maxwell, 2013). Furthermore, qualitative research allows the researcher to join in on the research process at every stage of the research allowing for active construction and reconstruction of the design throughout the data collection process. This can be done through the process of note taking and memoing during the data gather process. Maxwell (2013) posits a qualitative approach permits

for greater inquiry into by allowing the researcher to gain a better understanding of the social and cultural contexts within which the phenomena in question occurs. Additionally, Maxwell (2013) highlights the importance of taking a "realist approach to the qualitative research process" whereby the goal of data collection is to provide a richer, deeper understanding of the phenomena in question through exploration rather than confirmation of pre-existing theory or hypothesis of the phenomena in question.

Insufficient data in the psychological literature exists on the unique barriers and facilitators faced by mental health therapists working directly with the Arab reference group. As previously noted, many immigrants have complex, mental health needs that are often exacerbated by acculturation and adjustment to the United States (Abdullah & Brown, 2011; Erickson and Al-Timimi, 2001). Given the myriad of factors underlying service utilization, a qualitative research design is appropriate to explore the proposed research questions because it allows for discovery, exploration, and theoretical formulation to gain a deeper understanding of the phenomena under review.

The present study used the qualitative method of grounded theory to guide the data collection and analyses process which was originally formulated in the 1960's through work of Barney Glaser and Aselm Strauss. Grounded theory involves identifying categories of meaning from data to establish relationships between them. This is achieved using a constant comparative method, where similarities and differences between data is established and data is coded into smaller units of meaning (Corbin & Strauss, 1990). In grounded theory, the data collection and analysis process are ongoing, which makes it 'grounded' in the setting or context under investigation. Marshall and Rossman (1999) articulate that grounded theory relies on the participants perceptions of the phenomena in question and allows for a dynamic and interactive

experience between the researcher and the participant. Additionally, grounded theory does not rely on a-priori data because the progressive identification of categories and the relationships between and among them, facilitates the emergence of theory development.

Procedure

In accordance with a qualitative approach to research, the present study gathered data from a sample specifically selected to address the proposed research questions. Therefore, neither random selection nor random assignment will be adopted into sampling and recruitment strategies. In contrast, a method known as 'purposeful selection' whereby the individuals selected to partake in this study are deliberately selected to provide insight into the research questions under investigation (Maxwell, p. 97, 2013). In contrast to quantitative methods of sampling, selection of participants is purposeful to gather information that could otherwise not be properly addressed from a representative sample of all psychotherapists. Additionally, purposeful selection allows for the acquisition of data from experts with firsthand knowledge and experience of the phenomena under review, allowing for distinctions that cannot otherwise be obtained from a homogeneous, representative sample.

Ethical approval was obtained from Wayne State University's Institutional Review Board. Written permission for recruitment was obtained the director of Behavioral Health of a community mental health agency in Southwest Detroit providing mental health services to consumers identifying with the Arab, Arab-American, and Chaldean cultural and ethnic reference groups. Purposive sampling was used in this study to recruit professional staff from the community mental health agency. Participants were recruited through advertisements in the various offices, comprising a behavioral health division of the community mental health clinic. Individuals who consented to the interview by responding to the advertisements, were invited to attend a face to

face interview, audio recorded interviews at the agency either before, during or after working hours. The interviews lasted approximately 60 to 90 minutes and participants were informed that the audio recording will be employed for transcribing content obtained in the interview. Informed consent was provided to the participants prior to the interview session outlining the purpose of the proposed study and the rights of the participants. To ensure privacy and confidentiality of participant information was upheld, names were excluded from transcripts and demographic information during the data collection process. Participants were identified by an arbitrary interview number (e.g. participant 01, participant, 02) to further uphold confidentiality.

Participants

Participants in this study consisted of 11 psychotherapists who self identify with the Arab American cultural/ethnic reference group and who reported providing direct psychological services to consumers who identify with the Arabic cultural reference group. Psychotherapists were recruited from an accredited community mental health agency with several locations in the Metro-Detroit Area. To ensure that sampling was purposeful, recruitment was limited to master's and doctoral level licensed mental health therapists providing direct psychotherapy to Arabic speaking clients. As previously stated, cultural competency of the therapist as perceived by the client was one of the best predictors for recovery. The assumption was that matching in terms of culture and language would allow for a more in depth understanding of the social norms/roles and expectations underlying the therapists' perceptions of the barriers and facilitators of providing treatment.

Demographic information was imbedded into the face to face semi structured interview (see table #1). All participants were registered through their state board of licensing as either a licensed counselor, psychologist, or social worker. Psychology was the most frequently cited

licensure (n=5) type among clinicians (45%), with the remaining participants identifying their licensure type as either social work (n=3) or counseling (n=3) (see table #2). Participants ranged in age from 25-44 years old (M=32.2) and all (n=11) participants identified as female. All participants identified as Middle Eastern/Arab American descent. The participanting therapists interviewed in this community sample were comprised of American born, second generation, and first-generation immigrants (see table #1) with the majority of participants being born in a country outside of the United States (n=7) and only four participants being born in the United States; (n=5) identified Lebanon as their country of origin, followed by Iraq (n=2) Palestine (n=1) Yemen (n=1) and Morocco (n=1). All participants (n=11) were bi-lingual (Arabic and English) and two participants (n=2) were tri-lingual (Arabic, Chaldean, and English).

Table 1
Demographic Characteristics of Participants
(N=11)

Participant	Gender	Age	Birth Country	Country of Origin	Age first came to USA	Languages Spoken
01	F	34	Morocco	Morocco	12y	Arabic/Eng
02	F	33	Lebanon	Lebanon	9y	Arabic/Eng
03	F	27	Iraq	Iraq	14y	Arabic/Eng/Chal
04	F	27	U.S.A	Lebanon	n/a	Arabic/Eng
05	F	38	Lebanon	Lebanon	4y	Arabic/Eng
06	F	30	U.S.A	Lebanon	n/a	Arabic/Eng
07	F	31	U.S.A	Lebanon	n/a	Arabic/Eng
08	F	33	Palestine	Palestine	9mons	Arabic/Eng
09	F	44	Lebanon	Lebanon	10y	Arabic/Eng
10	F	25	Italy	Iraq	6mons	Arabic/Eng/Chal
11	F	32	U.S.A	Yemen	n/a	Arabic/English

Note. Eng = English, Chal= Chaldean, y= years, mons=months

Table 2
Job Characteristics of Participants
(N=11)

Participant	Discipline	Licensure Type	Years of Practice	Job Title
01	Social Work	LMSW	8	Clinician/Supervisor
02	Counseling	LPC	5	Clinician/Supervisor
03	Social Work	LLMSW	3.5	Clinician
04	Psychology	TLLP	6mons	Clinician
05	Psychology	LLP	7	Clinician/Supervisor
06	Psychology	LLP	4	Clinician/Case manager
07	Psychology	LLP	4.5	Clinician/Case manager
08	Counseling	LLPC	2.5	Clinician
09	Psychology	LLP	16	Clinician
10	Counseling	LLPC	2	Clinician
11	Social Work	LLMSW	1.5	Clinician

Note. Licensure type is granted through the regulatory board in the state of practice LMSW= Licensed Master Social Worker; LPC = Licensed Professional Counselor; TLLP = Temporary Limited Licensed Psychologist; LLP= Limited Licensed Psychologist; LLPC = Limited Licensed Professional Counselor; LLMSW= Limited Licensed Master Social Worker

Ethical Considerations

Participants were informed at the outset of the study of their rights to drop out of the study at any time they wish. Additionally, it was discussed with participants in the written consent, that their employer would not have access to potentially identifying information including raw data, audio recordings, or demographic information that could link participants to data. Furthermore, participants were informed that there are no negative impacts declining to participate and that participation is optional. Participation in the study would not result in benefits accrued from their

employer such as change in pay, and participation was solely for contributing to research on the subject matter. A subsequent limitation of asking employees to report on perceived work-related barriers are perceived ramifications of participating in the study. Confidentiality and anonymity were guaranteed to the full extent of the law. Lastly, because data was gathered on site, avoiding, or limiting perceived feeling of coercion to partake in the study was accounted for by establishing complete anonymity and the voluntary nature of the study. Because participants were interviewed within their place of employment, it was the responsibility of the researcher to ensure that the interview room used on site were held in private offices used by therapists to conduct psychotherapy. The goal of this was to uphold the same privacy and confidentiality measures employed by therapists in psychotherapy when working face to face with clients.

Interview Protocol

In-depth, semi-structured interviews were developed for this study and administered to study participants. The interview questions were developed to reflect variables commonly cited in the literature as key factors that either promote or deter help seeking among consumers who identify with Middle Eastern ethnic/cultural reference groups. Interviews explored the following: facilitators of providing/promoting care (cultural competency, recovery competency) and barriers to treatment (stigma, social norms) and psychological tools/assessments/interventions approaches to therapeutic work. The interview protocol was pilot tested to ensure questions were clear and if additional probes were necessary to ensure clarity and further elaboration of responses. The following sections outline specific domains included in the interview protocol.

Cultural competency. Perceptions of therapeutic cultural competency was assessed through five open ended questions assessing cultural competency. Formulation of questions assessing multicultural competency was grounded in Sue, Arrendondo and McDavis' (1992)

tripartite model, which subsequently, is the basis for the American Psychological associations multicultural guidelines. Originally developed by Sue, Arrendondo and McDavis (1992), the tripartite model offers an organizational framework highlighting the important skills, knowledge, and beliefs of a culturally competent counselor. The authors discuss that a multiculturally competent counselor possesses three key characteristics: a) awareness of personal biases/beliefs/attitudes; b) insight into the views, beliefs, attitudes of the client; and c) skills and intervention strategies that are relevant, and address the clients' needs. Examples of items assessing cultural competency include: "What are the five biggest challenges in serving clients from an Arab culture or reference group". And "In your opinion, would mental health treatment differ for those who identify closely with Arab culture or 'reference groups." Examples of sub questions included "What are some things that you would change to help you in your work with these clients" and "What are some things that are working for you in serving these client" (see Appendix C).

Recovery competency. Therapist's perceptions of recovery, as well as beliefs about recovery were assessed using five open ended questions. Formulation of open ended questions assessing recovery beliefs and recovery competency are grounded in literature assessing recovery attitudes in consumers, mental health professionals and family members (Anthony, 1992; Mead and Copeland, 2000; SAMHSA, 2000). Commonly cited variables of recovery competent providers include, provider beliefs that recovery from mental illness can occur in the presence of psychiatric symptoms, that recovery requires hope, and acknowledgement of the collaboration between consumes, their families and the mental health provider in the recovery journey.

Several measures assessing recovery for consumers can be found in the mental health literature. The Recovery Attitudes Questionnaire (RAQ-7) is comprised of 7 questions, developed

in collaboration with consumers and providers assessing attitudes about recovery from mental illness (Borkin et al., 1998). The RAQ-7 demonstrates good inter-item reliability of .838 is cross-cultural valid when administered with non-Western mental health providers from Japan. The RAQ-7 reports good internal consistency and test -retest reliability. The two theoretical factors that underlie the RAQ-7 are factor 1 = recovery is possible and needs faith, factor 2= recovery is difficult and differs among people. Items are assessed on a five point likert scale where 5= strongly agree and 1= strongly disagree. Examples of items under factor 1 included "to recover requires faith", and "recovery can occur even if symptoms of mental illness are present". Additional questions included "recovery can sometimes have setbacks", "recovery from mental illness can occur without help from mental health professionals. Being a statistically sound measure, the RAQ-7 was used as a reference point when formulating questions in this subsection. In total, participants were asked two broad questions assessing recovery competency and four sub-questions assessing specific topics related to recovery. An example of question covering recovery competency was "Have you heard of recovery from mental illness? How would you describe it?" and "do you believe that people can recover from serious mental illness such as schizophrenia or bipolar disorder?". Examples of sub-topics included questions such as "What are some barriers to recovery" and "what are some facilitations of recovery and what might support them"? (see Appendix C).

Stigma and social norms. The role of stigma among Arab clients' experiencing mental health symptoms is thoroughly cited in the literature as a barrier to treatment. Perceived stigma and the impact of cultural norms and expectations are associated with impairments to mental help seeking. Stigma as a barrier to treatment was assessed using five open ended questions. In accordance with Corrigan's (2004) concept of self-stigma and public stigma, therapists were asked

questions pertaining to the role, if any, stigma plays on help seeking behaviors of their clients. Therapists were asked to describe relevant social attitudes and social norms that may hinder help seeking. Two questions assessing mental health stigma make up this subsection and included the following “In what ways have you experienced stigma and its’ effects on your clients”, and “In what ways, does stigma affect a person from an Arab cultural or reference group” (see Appendix C).

Approach to therapeutic work: Lastly, participants were asked five open ended questions related to their approach to therapeutic work. Melham and Chemali (2014) discuss that a barrier to providing culturally relevant interventions with the Arab reference group lies in mismatch between client beliefs about the utility of psychotherapy, and the lack of available, culturally relevant, tools and interventions. Availability of tools and interventions will be explored in three open ended questions assessing the topic. Examples of questions assessing the therapists’ approach to therapeutic work included items such as “How do you describe your theoretical orientation or your preferred approach in working with all clients”, and “what do you need to sufficiently meet the needs of your clients? Do you believe you have these resources or skills to currently do that? Why or Why not” (see Appendix C)

CHAPTER 4 FINDINGS

The purpose of this study was to investigate the perceived barriers and facilitators of providing mental health services to clients/consumers identifying with Middle Eastern/Arabic cultural/ethnic reference groups from the perspective of the mental health therapist. The overarching goal was to investigate the extent to which therapists who provide services to this cultural/ethnic reference groups perceive their available resources to effectively engage the client in treatment. The study examined three specific research questions. Responses were audio recorded, transcribed and coded. Coding transcripts involved reading through them multiple times, creating three levels of themes and then then organizing the themes into larger categories. Participants were added to the study until theoretical saturation was obtained. Data analyses was conducted using the grounded theory method known as constant comparison analysis (Strauss & Corbin 1998). Recurring themes of pertaining to barriers, facilitators, therapeutic processes, and recovery beliefs were analyzed from participant interviews and examined by an expert researcher in the field of qualitative research and the principle investigator. Themes will be highlighted using participant quotes in the proceeding section.

Participants: Participants were sampled from a community mental health center located within Metro- Detroit; one of the largest concentrations of Middle Eastern/Arab and Chaldean in the United States (about 350,000 Arab-Americans and 150,000 Chaldeans) (Baker et al., 2003) The community of therapists interviewed were representative of the unique demographic profile of Middle Eastern/Arab cultural/ethnic reference group resettlement in this region of the United States. Census data from the Detroit Arab American study, one of the largest studies conducted of Arab American settlement in the United States (Baker et al., 2003), trace the origins of immigrants in this community to 4 four geographical regions in the

Middle East; Lebanon/Syria (37 percent), Iraq (35 percent), Palestine/Jordan (12 percent). Likewise, the participants interviewed in this community sample of Arab American therapists were comprised of American born, second generation, and first generation immigrants (see table #1) with the majority of participants being born in a country outside of the United States (n=7**),** and they resemble the population distribution within this community; (n=5) identified Lebanon as their country of origin, followed by Iraq (n=2) Palestine (n=1) Yemen (n=1) and Morocco (n=1). All participants (n=11) were bi-lingual (Arabic and English) and two participants (n=2) are tri-lingual (Arabic, Chaldean, and English).

Trustworthiness of Data

Qualitative research expert Joseph A. Maxwell (2013), discusses the importance of the data analysis process being embedded in the data collection process. Maxwell suggests that interviews should be analyzed and transcribed almost immediately after the ‘data’ has been collected as this will help to inform the design of the study and to make the appropriate modifications if necessary (p.105). Thus, data analysis for this present study will incorporate reviewing interview transcripts, memos and observational notes made by the researcher in the form of memoing and note taking. Data analyses will be conducted using the grounded theory method known as constant comparison analysis (Strauss & Corbin 1998).

Interviews were conducted in person by the principle investigator and audio recorded for accuracy. All interviews were then transcribed by the principle investigator and an assistant. Interviews were then read thoroughly by two independent investigators, including the principle investigator. Initial themes were generated by each reviewer by each interview question. A list of first level themes were generated for each question. A second round of transcript reviews were performed by each reviewer to examine themes by overarching domains: Stigma, recovery, family

etc. A second level of themes were generated which collapsed first level themes. Reviewers than exchanged lists of themes and reviewed the transcripts for a third time. A final consensus was reached that reflected the main themes of the study responses.

Overarching Questions

Three main overarching questions guided this study. Specifically, identifying various facilitators, challenges of therapists' serving this cultural reference group, the role of recovery, family influences, stigma and the treatment processes used. The specific interview questions were designed to examine these overarching themes and are outlined along with key themes that emerged through interviews in the proceeding section. Key terms from themes generated will be highlighted from here on out. One key finding throughout all the interviews was the therapist's own cultural or gender identity as significant aspect of identifying barriers and facilitators of treatment.

Barriers of Treatment

Q1: What are the perceived barriers and perceived facilitators of providing therapy to consumers who identify with the Arab-American cultural ethnic reference group?

Questions from the semi-structured interview specifically addressing perceived barriers and facilitators were as follows: *Q19: What are the top 5 biggest challenges in serving clients from Arabic cultural and ethnic backgrounds, and Q20: What are the 5 biggest sources of help assisting you in your work with these clients (see Appendix C).* While these specific questions were presented to participants to elicit specific responses related to perceptions of the barriers and facilitators of the therapist's work, themes of barriers and facilitators began to emerge from participant responses on alternate questions as well, specifically, questions pertaining to mental health stigma (Q15-16, see Appendix C) and questions related to therapeutic techniques (Q11

see Appendix C). Therefore, across these interviews, participant responses reflected facilitators and challenges to serving this reference groups. Four major themes emerged in these interviews:

1) Therapists who perceived clients as identifying closely with the Arab cultural reference group were perceived to underuse mental health services.
2) Therapists perceived gender to play a role in the strength of the therapeutic alliance between themselves and the client.
3) Therapist perceived family support as mediating specific treatment outcome: i.e., low levels of family support for engaging in psychotherapy was perceived as resulting in poor client outcomes.
4) The community mental health setting was perceived as a contributing factor to perceived stigma experienced by clients.

Therapist perceived an overwhelming need to provide greater psychoeducation about mental health causes and treatment to the Arab reference group in this community to help overcome cultural myths or negative perceptions of mental health providers.

Acculturation: Participants reported that identifying closely with the Arab culture/reference group was a perceived barrier of using psychotherapy services (n=9). Participants cited factors related to acculturation stress, and non-acceptance of Western beliefs as prohibiting clients' from remaining in treatment and predictive of the types of services clients utilized within the community mental health sector. Acculturation barriers were commonly described as difficulties with transportation, lower socioeconomic status, and minimal English language skills. The impact of acculturation on the therapeutic process is highlighted in the following statements by Participant #1:

> "Serving the Arab population comes with its own challenges and one of them is poverty. It's impossible to effectively treat someone as a therapist and they have other significant basic needs. I can't really do therapy with someone who's worried about food stamps getting cut off".

Additionally, overidentification with the Arab culture and rejection of Western beliefs and about mental illness was perceived as a barrier to the therapeutic alliance in general, and specifically related barriers in rapport building between the client and the therapist. This finding is expressed in statements from Participant #5 and Participant #8:

> "I've noticed that clients that I work with have been in the US for longer, who have been born and raised or have come here at younger ages, and who may be experiencing a bit more assimilation, although they still are tied to their culture, they still carry those beliefs and those traditions. they are more inclined to work towards change… sometimes they are more likely to open up earlier within the therapy process than later, just because they're able to build that trust" (Participant #5).

> "I think that the younger generation is becoming more Americanized... They are very open, and they learned how to talk about it (mental illness) as opposed to the older people who just stay quiet and don't want to talk but you know that they have things to share" (Participant #8).

Clients perceived as identifying closely to the Arab cultural group/reference group, were more likely to be perceived as passive and demonstrating greater resistance to treatment.

> Participant #4: A lot of times you get this orientation of victimization and that's sometimes difficult to speak to with them, in the sense that it's tied into seeing things from a different

perspective…. So, they just kind of feel victimized a lot, and it's hard for them to see ways that they've contributed.

Participant #5: "Because those that identify very strongly with the traditions are, for lack of a better word, a little bit harder to break. They may be less likely to make changes, their ideas or their beliefs are so strongly embedded, that it makes work a lot harder".

Conclusively, level of acculturation was attributed not only to perceived client self-disclosure in psychotherapy, but related to secondary, post migration stressors that may limit client involvement in psychotherapy.

Gender: Male gender was often cited as a barrier to the therapeutic alliance with female participants noting difficulties providing counselling services with these clients. Frequently cited barriers included problems with role confusion and non-acceptance of the female therapist as an expert or authority on mental illness. Participant #8 stated:

"They (men) can be quite challenging, I think that most of them are more receptive to what I say because I'm a professional, but then again, it's kind of a catch-22 because I am a woman."

Participant #4: "I find that my Arab-American male clients are more guarded, more defensive in therapy and so you have to kind of tailor to that, you have to be understanding of that. So, there is a different approach that you have to take and awareness that you have."

Roll confusion was perceived as transference among male clients towards female therapists and was related to less self-disclosure in psychotherapy with male clients specifically. Participant #10 stated:

"I think it's hard for them (male clients) to separate that I am a professional, not your daughter, not your cousin, not your niece or something, because I am young. It's hard for them to

differentiate that. I've never really had a problem with the women, they talk, they're not afraid to talk".

Participant # 1 discussed that transference was observed among male clients as assigning 'family labels' to therapist, specifically if the therapists was younger than the male client:

> "If a male client says you are like my daughter, I try to explore what that means…he might feel this way because I am younger than him".

Participant #7 stated, "I get (described as) "sister" a lot from male clients, it's almost like they don't have a language for who you are to them".

Although commonalities were found in therapists' narratives of perceived differences between Arab male and female clients, one participant (Participant #6) stated that there were "no differences" between the groups and that the gender of the client did not impact perceptions of the therapist's role in psychotherapy.

Family Support: Consistently noted among participants (n=11), was that family support was perceived to be a barrier and facilitator to mental health treatment. As a barrier to treatment, family members were perceived as contributing to the emotional distress clients experienced in seeking mental health treatment. Participant #3 stated:

> "…they may not tell their families that they come to therapy, the family might convince them that they are crazy for getting treatment".

Perceived criticisms from family members and within interpersonal relationships was cited as reasons clients from the Arab culture were more inclined to keep treatment a secret.

> Participant #6: "I've had clients who have been in relationships and can never tell their partner that they were in therapy, because then the partner would think they were crazy, they wouldn't want to be with them".

Participant #5: “A lot of clients keep their treatment secret. They don’t share with others, even sometimes among their family that they’re in treatment, just because of the stigma attached to the mental health treatment… I have a client who has been a patient probably 20 years, and only one member of her immediate family knows that she receives mental health treatment”.

Participant #5 and participant #1 also noted that keeping treatment secret was not just limited to interpersonal relationships and that clients would sometimes decline communication and coordination of care with family physicians, a practice routinely applied in the community mental health setting. This was particularly true among family physicians who were Arabic speaking.

Participant #5: “I have clients, and this has happened many times, clients who refuse to allow communication with their primary care physician, because they see a primary care physician who is from the community, or they know maybe the receptionist or the nurses who work at that primary care physician in the community”.

Additionally, cultural, and social norms regarding upholding family honor and avoidance of speaking negatively about family problems were perceived as barriers to self-disclosure in therapy. Participants spoke about the perceived emotional distress female clients experience caused by cultural norms surrounding discussing family with a professional. (Participant #1):

“…some Arab families believe that your family’s problem should stay within the family and revealing them to a therapist is you breaking that rule. They feel shame if they say that I told someone else. Some of the causes, (of mental illness) from what I’ve seen are infidelity in marriages, domestic violence, substance abuse is a huge one where families try to cover for each other. (Describing an example of a specific client) …this woman had fainting spells and severe anxiety and for the two years I was seeing her she never reported any problems in the home. She would say “everything is good I don’t know why this is

happening to me". So, one day, I think I asked a question (about her marriage) and it hit a nerve with her, and she's like "well, I don't know if I should say this because my husband is revered in the community, but this happened".

Participant #2: "I think sometimes when it comes to treating female clients from the culture, they can face a lot of cultural barriers or misogyny. But it's really important to understand how the client is and can be liberated in their own way and be able to see the positives of how their battling those things in their own way and not in the way that you perceive as liberating or how they should be handling".

Stigma and the Community: The impact of perceived stigma as a barrier to treatment was addressed in interview questions 15, 16 and 16a (see Appendix C). All participants (n=11), reported that perceived stigma of mental illness was a barrier of providing mental health services to their Arab and non-Arab clients. However, therapists noted some unique cultural differences in the causes and maintaining influences of stigma with clients from the Arab cultural group. The community mental health setting itself was reported to be a contributing factor to perceived stigma clients' experience with (n=5) therapists' reporting that the treatment setting itself can promote and maintain feelings of stigma. Participant #1 discussed that the community of clients' that seek treatment is made up individuals who are inter-connected and interrelated. This was reported as a contributing factor to perceived stigma of seeking mental health treatment. Below are some comments from participants highlighting this issue within this community:

Participant #2: "We have clients who don't want to wait out in the waiting room and want to be hidden kind of in the back, so that's like a huge very literal example of stigma".

Participant #5: “We have individuals who ask for appointments at certain days, during certain times just to avoid being seen or being around other people from the community who may see them at the mental health clinic”.

Participant #1: “We work with a small community and sometimes they’re worried that I (the therapist) might know someone”.

Participant #4: “A lot of Arab clients come in really resistant and sometimes it’s hard for them to even come in, and it is a challenge for them to seek treatment.”

In addition to residing in a small community of inter-related individuals, the participants noted that specific to the Arab culture, lack of exposure and education about mental health services facilitated stigma among their clients’. Specifically, participants noted differences in cultural norms surrounding medication versus partaking in talk therapy supported by the following comments by Participant #2:

> “Mental health is kind of a new concept in the Arab world. So, it’s new to them here (Arab clients) but I feel like it’s been normalized in the form of a pill… I find people are more comfortable in saying that they take psychiatric medication rather than come to therapy…we believe a little bit more in pill form, the pill is an actual physical solution. It’s rooted in the belief that medicine is more effective than talk therapy”.

In describing how lack of psychoeducation increases perceived stigma of having a mental illness and help seeking behaviors, Participant #10 stated:

“Our community is not really educated on “Hey, you have a mental illness, go get help.” We’re more educated on “If you have the flu, go to the Doctor. If you have a toothache go to the Dentist. If your eye hurts, go to the eye Doctor.” We’re not big on “Hey, go to the

psychiatrist for your mental health, you need see a therapist to take care of your mental health."

This belief was shared by Participant #7 who expressed that clients are perceived as resistant to psychotherapy due to lack of information about the perceived usefulness of talk therapy and the therapists' role in treatment:

"I am often told (by clients), "how are you going to help me?". "The doctor will give me medicine for my sleep problem, for my thinking problem, but how are you going to help me by talking".

Therapists' attributed greater request for medication to insufficient information about psychotherapy and fears about breaches to confidentiality. This is best summed up in the following statement by Participant #9 who provides home based parent and child interventions to Arab families:

"When we (client and therapist) go to DHS (the department of human services) for their case, or when we go to the primary care physician, they introduce me as their friend. Even when I go to the school to see their children because the children display negative behaviors, they always introduce me as their friend. I play along, because of course I need to keep confidentiality, unless they sign a consent to release information, and I can't say I'm their therapist".

Facilitators of Treatment

Analysis of participants perceived facilitators of providing therapy with the Arab population was assessed specifically through open -ended question #20 (see Appendix C), however, examination of facilitators to treatment was not limited to this question and was

sometimes interwoven in responses to questions pertaining to perceived barriers of treatment. Therapist resulted in the emergence of three major themes:

1) Family support is a protective factor for mental illness and treatment compliance.
2) Shared culture between the client and the therapist is a facilitator to treatment
3) The community network can encourage clients to seek treatment

Family Support: The role of the family was viewed as a facilitator when family members were perceived as supportive, involved in treatment, non-judgmental. All therapists interviewed (n=11) discussed that the family could reduce or even eliminate clients' perceptions of stigma and promote client recovery. Participant #6 discussed that "getting the family on board, even if it's just one person" would assist clients with complying with treatment. The contrasting, facilitating role of family members was described by Participant #5 as a "double-edged sword", where family support could empower clients to seek treatment but were perceived as a barrier to recovery if family roles were not clearly defined.

> Participant #5: "the nature, the dynamics of the Arab families – unfortunately, there's a lot of enabling that goes on and although that comes from a good place, that comes from a place of wanting to take care of each other. And in the Arab culture there's a lot of emphasis on the unity of the family, and one-person kind of taking care of the next".

Participant #8 discussed that family acceptance of mental illness, and symptoms can remove barriers to help seeking:

> "once the family accepts that these people (have these things, these illnesses then it will be fine. And then the person with the illness won't think it's shameful".

Participant #1 explored that family support in the Arab culture can be protective for clients with severe mental illness:

"Definitely a support system that is present for the Arabic clients is the family and support that families give each other… In the Arab population at least, it's rare when someone is kicked out of the house, they can be the wildest, the family will still make sure they are sheltered and provided food, sometimes the recovery doesn't happen immediately, and it takes years, but eventually we get there, and I think the support system can also help with the medication compliance".

The Therapist: Participants in this study cited the therapist as a facilitating and supportive resource for clients specifically within this community. The facilitating influence of the therapist on treatment was perceived to be related to sharing the same language and having insight into the culture. Participant #10 noted that being able to speak the same language assists with treatment because the context of words is lost in the English translation. Participant #3 discussed that coming to the United States as a refugee provides her with the insight into the barriers some of her refugee clients experience with resettlement into this community. Participant #2 discussed that in addition to speaking Arabic, Arab therapists possess an understanding of the cultural practices and norms, that a non-Arab therapist may be "shocked by". Participant #2 also noted that some Arab youth, face unique mental health issues in incorporating the family focused Arab culture with the Individualistic Western culture:

"…especially with my youth clients who are dealing with like double identities, as you know as Arabs and Americans. It's kind of like "My family is super conservative, but I'm also westernized" and there's this clash, like "what am I going to do?... I really try to work on with my clients and maybe kind of reconciling both of those identities".

The role of the therapist as the expert on both the Western and Arab culture was reported to be a facilitator to treatment. Additionally, one therapist noted that speaking Arabic, and sharing

Arab values, but being from a different country than the community she commonly serves, was viewed as a facilitating factor because she was perceived as being more trustworthy. Participant #1 stated:

“One good thing about me is that I am Moroccan, and I don’t live in this city, so they know (the clients) they’re not going to be running into me at family gatherings or I don’t know a cousin or a friend that knows them, or a friend of a cousin, so because I’m from a different background, sometimes people are more comfortable”.

However, one participant discussed that not sharing the same religion as a client, or being from a different country was perceived as a barrier to treatment if the therapists are perceived as untrustworthy.

Participant #7: “Trust is a big thing to them (Arab Clients). It will start off with simple questions like, oh you speak a certain dialect, what country are you from? Then they want to know from which part, and some countries, like Lebanon for example or Iraq, different religions populate different villages It’s a very fine line between self-disclosure, and a barrier to the therapeutic relationship”.

Community Support: As previously noted, the community was perceived as a barrier to treatment through transmission of false notions about mental health treatment. Paradoxically, the community was perceived to be a supportive and facilitating factor as well. Participant #4 noted “I find that the culture really does influence initiating treatment, continuing treatment, accepting treatment”. Participant #1, in referencing one of her client’s resistance to remaining in treatment noted that a member of the community warned her against seeking treatment because “…they will take your kids away”. However, positive messages about mental health treatment, and community

members informing one another about treatments was perceived as a solution to spreading misinformation about mental health treatment. This was outlined in Participant #10's comments:

> "I really feel like it's word of mouth in our community… I feel like if other people said "Hey, my son needed help, I got him help, he's a lot better…" and so on and so forth. If people just keep telling other members of the community, "it's no problem", then we can end the stigma against it".

In addition to sharing information about the positive benefits of mental health treatment, participants noted that sharing information about mental health treatment in community organizations such as a church or a mosque (Participant #5) is a way to overcome false notions within the community about mental health treatment.

Therapeutic Interventions

Research Question #2: What practice strategies are therapists that identify with the Arab-American cultural ethnic reference group utilizing to meet the clinical needs of their clients? This research question was assessed through interpretation of participant responses to open ended questions about therapeutic techniques, and beliefs about available resources available to the therapist to sufficiently meet the needs of their clients. Analysis of client narratives and development of themes using the method of constant comparative analysis between the therapists and an expert researcher was used to drive recurring themes. Research question #2 was assessed through open ended questions 7-11 and question #20 (see Appendix C). The proceeding themes emerged from Therapists' narratives about mental practices strategies.

1) Expressing nonjudgement of cultural issues enhances client commitment to treatment\
2) The therapist educates the Arab client on mental illness and mental health treatment

3) The shared cultural and clinical experiences therapists' share facilitates therapeutic consultation.
4) There is a need for culture specific trainings and treatment programs with the Arab population

All participants (n=11) interviewed in this study described their practice strategies as 'eclectic', and dependent on the needs of the client. Therapists' noted the use of a variety of interventions including cognitive behavioral therapy, narrative therapy, person-centered strategies such as genuineness and empathy as well as the use of motivational interviewing. Furthermore, (n=5) participants noted that they also provided case management services beyond psychotherapy to address client needs related to transportation, translation, accompanying clients to doctor appointments, and maintaining social assistance benefits. Additionally, all participants (n=11) noted that they felt comfortable treating severe psychiatric illnesses, and mood disorder and trauma related disorders (Q10- 11a-c, Appendix C). When asked about the causes of mental illnesses among the population they treat, some therapists ascribed genetics, and intermarriage among the Arab cultural group as responsible for the transmission of severe psychiatric illnesses (Participant #1, 2, 6 and 3), while other participants noted that illnesses are caused by both environmental and genetic factors (Participant #4,5, 6, 7, 8,9) specifically war-exposure (trauma) which participants noted to be a common diagnosis among refugee clients. This is summarized in participant #10's comments on what some of the causes of severe psychiatric illnesses are among the Arab population:

"I would definitely say it's genetics as well as the environment that people are in. Definitely trauma, of course. I feel like trauma is the biggest indicator when it comes to psychiatric and mental illnesses."

Commonalities were found among participants relating to providing psychotherapy to the Arab cultural group. Some participants (n=4) perceived themselves to be a support for clients within their communities, particularly the female clients. Regarding newer refugee and immigration clients' participant #9 stated "I'm the only who understands them and supports them in a foreign country". The following statements highlight the theme as the therapists providing support within their community.

In addressing cultural concerns about keeping family secrets and upholding confidentiality which was a previously cited barrier to treatment, therapists discussed that taking a stance of "nonjudgement" was a common strategy in treating these issues. This is highlighted in the following statement by Participant #10:

> "Again, since I am Arabic speaking, and since I come from a Middle-Eastern background, just being able to empathize them in a unique way, may be better than someone who is Caucasian or someone who is African American because I come from the same Middle-Eastern background".

Non-judgement of client issues was perceived to be as a therapeutic skill useful for addressing cultural and community beliefs that perpetuate stigma from mental illness. Therapists' discussed that 'nonjudgement' was used to overcome resistance to psychotherapy and foster trust in the therapeutic relationship. The importance of the non-judgmental, accepting stance is highlighted in Participant #5 comments:

> "I think in general as a therapist, you have to come from a nonjudgmental and empathic stance. Particularly with the Arab-American community, they tend to be a judgmental community. So, when you provide the opposite of that, it just

increases their comfort and when a client is less guarded they are more susceptible to the treatment that you're giving them and so there's less resistance."

Psychoeducation: As previously discussed, a perceived barrier of help seeking with clients from the Arab culture group was believed to be due to lack of psychoeducation about therapy and mental illness. Participants stated that education about mental illness was a practice strategy used to overcome this barrier and 'devalue' the perceived stigma around diagnosis and help seeking.

Participant #7 "I try to present them with research and information"

Participant #8 "I try to relate it to a health concern. There are a lot of people out there that have diabetes and high blood pressure and whether you are not feeling well emotionally and physically, there is a treatment and if you continue with the treatment throughout your life you will feel fine from it."

Participant #1: "We do a lot and it actually devalues the stigma so if they learn that with schizophrenia, that it's not their fault, or something that I can control, so when we do work on devaluing, what I consider a cultural aspect and even some that I consider oppressive

Participant #5 "With the Arab-American client, again, the things that they're disclosing, even things that aren't necessarily related to mental health, also can carry a lot of stigma as well. So, the therapist is surveying, in a way, as a as a confidant, as a facilitator of change, as a resource for information (providing a lot of psychoeducation), and really as a treasure chest of skills that are to be learned" (Participant #5)

Therapeutic consultation: Among the practice strategies discussed by participants utilized to address the needs of the Arab client, peer consultation and supervision was listed by (n=7) participants as a resource they had to assist them in their therapeutic work. Participants

discussed that their fellow coworkers offered insight into treatment while simultaneously offering support. This is highlighted in Participant #5:

> "All of my fellow therapists that I work with have been a really great source of support for me, and being that they also understand the culture, they can look at it through the same lens, but also from their own clinical lens. So being able to bounce ideas off them and get their feedback, I think honestly, that's really what I value the most and I think that's what's helped me the most, is knowing that I have highly skilled clinicians that I can go to for peer support".

While many participants noted that they utilized each other as an informational and supportive resource, in general, there was non-agreement amongst therapists' about availability of culturally sensitive and appropriate materials to effectively work with the Arab population. Participants (n=3) participants reported that they felt they had the resources they needed to sufficiently meet the needs of their clients, while others expressed some dissatisfaction. Participant #1 discussed that she often needed to "think outside the box" when implementing some therapeutic models because they do not sufficiently meet the needs of her clients, while Participant #5 highlighted "there's a lot of times where we may have to make accommodations or do things differently than we normally would".

Recovery Beliefs

Research Question 3: What are therapists' beliefs about recovery from mental illness?

This question was assessed through the analysis and coding of open-ended interview question 12, 13, 14, 17 and 18 (see Appendix C). The same analysis method employed in the previous research question was used for analysis purposes. The following four themes emerged from the data:

1) Therapists' did not differentiate between Arab and non-Arab clients on recovery
2) Recovery for the Arab population is defined as maintenance and stability
3) The family and community network provide strengths and challenges to clients' recovery
4) The therapist's role in client recovery is to provide a safe space for disclosing secrets.

Arab-American Recovery Beliefs: On average, participants did not differentiate between recovery patterns for Arab versus non-Arab clients and held positive attitudes about recovery from mental illness. Participants were asked if clients specifically, from the Arab culture could recover, the following statements were expressed by participants when asked if client's specifically from the Arab cultural group could recover:

There appeared to be some universal acknowledgment that people, regardless of culture, can experience recovery. Therapists often noted reinforced a medical approach to recovery and noted the need for the continuation of medication for life (eg., *If they keep taking their medications and keep coming to their appointments, I do think they can be functioning* #3). In contrast, two therapists noted that regardless of cultural orientation, consumers living with severe mental illness such as schizophrenia and bi-polar disorder could not recover. Participant #6 attributed this belief to not encountering any clients in her experience that had recovered from a severe psychotic illness, while participant #10 discussed that she believed clients, especially with severe psychiatric disorders could not recover and would need medications for the rest of their lives. Although medications may be necessary for severe illnesses, these responses reflected greater unidimensionality of the consumer as compared to a holistic view of other ways in which recovery from mental illness can occur.

Defining Recovery: Similarities among participant definitions of recovery was also found. Recovery from mental illness was more likely to be defined and perceived as maintenances and stability with participants noting that compliance with medication was important to recovery:

> Participant #4: “For me, recovery means maintenance. It means being committed to the treatment, and compliance.”
>
> Participant#3 “they definitely can cope with their symptoms and live close to what we call a normal life by complying with their treatment.”

One participant stated that recovery can be achieved in the long term in the absence of medication (Participant #7). A few participants (n=3) defined recovery as journey. This is highlighted in the following statements”

> Participant #10: (Recovery is) “a person being able to manage their mental illness and accepting it and continually getting the help that they need… I think recovery is a long journey, there’s no finish line. I feel like recovery takes its time and it’s for life.”
>
> Participant #5: “I think I look at recovery as a lifelong process, it’s not anything that has a finite place where we can say someone is recovered.”
>
> Participant #2: So, I always explain to my clients when their concerned about recovery, that progress is not a linear line and I do I do the physical “line.” *simulates an up an own motion with finger. It’s okay if you make progress now, if you go back down, like totally fine.”

Conclusively, for this group, the recovery process is defined as maintaining stability and complying with treatment using medication, and the recovery journey is defined as a life long process.

Family and Community Networks: Specific to the Arab culture, some therapists noted that while there was no difference between the Arab culture and other cultures in terms of the ability to recover from mental illness, that recovery for Arabs can be dependent on unique cultural factors. Family and community networks was most often cited as a contributing, mediating factor to client recovery. Participants noted overall, that when family was involved in treatment and acceptance for seeking treatment was perceived from the community, that clients had better outcome. The following statements speak to this:

> Participant #6: "I would definitely say that family support is essential, it's crucial (for recovery)".
>
> Participant #2: "We have really positive things like we have family support like no other… I think involving your family, because it is a huge part of every culture, and helping your client's family understand and get where the client is coming from and accept that person is really helpful (for recovery)".

Although participants noted the dual role the family plays as a barrier and facilitator of treatment, regarding recovery, some participants noted that cultural norms around family unity and maintaining a family network can be helpful against some of the negative, secondary effects of severe mental illness. This is noted in the following comments:

> Participant #9: "family support plays a big role in the Middle-Eastern culture. Unlike the Western world, I think that being socially accepted, accepted in the family, supported in the family, I think that will help Arabic people recover".
>
> Participant#1 (on what the family contributes to patient recovery) … "will sometimes it's that their immediate needs are being met for example you, shelter, so they can pay attention to recovery. sometimes they can't work for a period, and families are there to provide for

them…unconditional support I think, unconditional acceptance, knowing that someone is always got your back I see other communities and see other members of society who don't have that and wish that they had someone they could go.

Therapists' also discussed that family support can help increase patient compliance to treatment through providing transportation to appointments and ensuring clients comply with medication. Participant #8 states "most of them have transportation to come here and they have supportive families, while Participant #5 discussed families offer "Support. And support can mean different things, it can be in helping with getting them to treatment, it can be helping them in terms of making sure they're on their medication, or taking their medication, it can be just providing reinforcement, you know reinforcing the changes that are being made, reinforcing the individual's progress."

The community network was a variable cited by participants as helping to either facilitate or impede client recovery. Participants stated that within this specific community, clients are interconnected either through marriage, or involvement in other community networks such as religious organizations. Therefore, acceptance from the community for seeking mental health treatment can in turn facilitate the recovery process.

Participant #1: "villages of people resettle here, that is very common, and we see similar issues …because you have a very small group of people that migrated …and who intermarry."

Participant #3: "…in this area a lot of people are related or know each other, and some of our client's run into their relatives here in the office. There's no way around that. Some clients have asked for us not to schedule us on certain days that other clients are here, and

we really do try to do that, but it's interesting because they're all coming for the same reasons, to get treatment, but they care about being judged for it."

Participant #4: "So the Arab-American population still suffers from this negative stigma about mental health, so a lot of them don't seek treatment, and if you're not seeking treatment then you're not really getting the help that you need. So, I find that the culture really does influence in initiating treatment, continuing treatment, accepting treatment."

Some participants noted that a way to overcome the cultural limiting beliefs about mental illness that limit participation in a mental health program, and a way to promote and normalize engaging in treatment is for community organizations was with psychoeducation:

Participant #3: "as a culture, maybe religious groups could help by talking about it with family members to make it okay to have a mental illness."

Participant #5, on facilitating recover: "I think, for example, somebody's involvement in a church. Somebody's involvement in a mosque. Something bigger than just the family, or bigger than just the treatment site, having another source of support. Having another source of support within the community, somewhere else to go for assistance. Somewhere else to go just to be around other individuals. Aside from a faith-based community center, it could be like a clubhouse. Somewhere where an individual can be themselves aside from just being somebody's brother or somebody's son, and aside from being somebody's patient or client."

Participant #6 suggested that using group therapy is a way to offer community support: "People are reluctant to go to groups (group therapy) but I think it's community. If the stigma were not as bad as it is, and people were to go to groups (group therapy), people

would feel better and make friends and have someone walking along in this journey with them to recovery."

Participant #8 discussed that in the group therapy she conducted she had success "I try to engage them (in treatment) I have a men's group and women's group and I try to get them to be social and discuss their emotions."

Therapist's role in recovery: Participants in this sample described the importance of the community and family networks in client recovery. A recurrent emerging theme came from analysis of participant narratives was that some therapists viewed themselves as part of the community support network for clients.

Participant #1: "I think providing a safe space to explore what the challenges and the barriers are, and I think the safe space is a huge thing for a lot of our clients knowing that this is a place where they can say things and not have to worry about hearing them again in the community."

"Participant #5: "With the Arab-American client, again, the things that they're disclosing, even things that aren't necessarily related to mental health, also can carry a lot of stigma as well. So, the therapist is surveying, in a way, as a as a confidant discussed that differences between generations also influences the therapeutic approach utilized."

Participant #6: "You know a lot of these people have doubts, they don't get it (support) from outside, so if you don't always put on you're A-game and make them feel like they're safe in that room and that it's a positive experience for them then recovery would definitely be hard"

CHAPTER 5 DISCUSSION

The consumer lead recovery movement advocates for the use of evidence based, collaborative treatment approaches (Anthony, 1990; Davidson et al., 2007; Mead & Copeland, 2000), In many ways, mental health care has evolved beyond outdated and scientifically unsupported care models due growing pressures from consumers, family members, lobbyist and even mental health care professionals (Anthony, 1990). However, there continues to be a disconnect between the availability of recovery focused treatment models and the needs of the evolving ethnic tapestry of the United States of America. Census data has noted that immigrants from the Middle East are expected to exceed 85,000 in the coming fiscal year (U.S. State Department website accessed on 9/15/2016). This is in addition to census data estimating that nearly 3.5 million Arab-Americans currently reside in the United States (Brittingham, & De la Cruz, 2005).

The Detroit Arab American study (Baker et al., 2003) was the largest known census study on Arab Americans to date and the Metro-Detroit area is home to the largest concentration of Arab resettlement in the United States. With the mental health needs of Arab immigrants thoroughly documented in the literature (Aprahamian et al., 2011; Erikson and Al-Timimi, 2001; Latzer, 2003; Melhem & Chemali, 2014; Siren-Rogers, Jamil et al., 2002;), and a substantial proportion of these immigrants from the Middle East are believed to have been exposed to war, violence, and torture. Moreover, pre-migration factors are often amplified by post-migration stressors during and after resettlement into the United States (Dross, 2000; Jamil et al., 2002). Many of these post-migration stressors are related to acculturation, language barriers and economic constraints (Aprahamian et al., 2011; Jamil et al., 2002; Melhem & Chemali, 2014). Additionally, deeply held cultural beliefs about receiving treatment for mental health symptoms results in underutilization of treatment for

fear of stigma and rejection by family members and members of the Arab community (Al-Timimi, 2001; Jamil et al., 2002; Latzer, 2003; Melham & Chemali, 2014; Siren-Rogers, 2013). Conclusively, when an individual does decide to seek mental health treatment, the preferred treatment is often a pharmacological intervention as psychotherapy conflicts with cultural expectations of 'healing' which is believed to be the sole responsibility of the physician, with minimal effort on the part of the consumer (Latzer, 2003; Purhan & Sati, 2013). Unfortunately, the scarcity of available literature on providing psychotherapy with the Arab cultural group poses a dilemma for professionals who frequently interact with this population (Melham & Chemali, 2014).

This study investigated the barriers and facilitators of providing mental health services to the Arab cultural group from the perspective of Arab-American therapists from a Midwestern community and home to one of the largest populations of Arabs in the United States. Three main overarching questions guided this study. Specifically, identifying various facilitators, challenges of therapists' serving this cultural reference group, the role of recovery, family influences, stigma and the treatment processes used. Several recurrent themes emerged from analysis of open-ended interview questions formulated from literature on the mental health needs, and service utilization of the Arab cultural group within the United States and internationally.

Barriers and Facilitators to Treatment

Themes that emerged from participant data resembled preexisting literature on help seeking trends of the Arab cultural group. Regarding barriers to providing mental health services, participants noted that therapists who perceived clients as identifying closely with the Arab cultural reference group underuse mental health services. This finding supports previous data on the use of mental health services within Arab countries and among first and second-generation immigrants

to the United States (Latzer, 2003; Melhem & Chemali, 2014; Perihan & Sati, 2012). Additionally, therapists perceived gender to play a role in the strength of the therapeutic alliance between themselves and the client. Specifically, participants noted that male clients were less likely than female clients to self-disclose in psychotherapy, resulting in transference family relationships onto female therapist. The implication of this finding was discussed among participants to be perceived as related to a lack of psychoeducation about therapy and mental health services in general. The implications of this suggest that the role of the therapist may be poorly defined within the Arab culture, thus hindering the therapeutic process and self-disclosure in therapy. Melham and Chemali (2014) discussed that religion mediates the preference for same-sex therapist among Arabs. The authors discuss that particularly among Muslim women, it is religiously and culturally inappropriate to disclose personal details to the opposite gender in psychotherapy. Thus, viewing the therapist as a family member may act as a way to uphold this cultural belief. In accordance to previously conducted research on family support and mental health help seeking among Arabs, therapists in this study perceived family support as mediating factor specific to treatment outcomes: i.e., low levels of family support for engaging in psychotherapy was perceived as resulting in poor client outcomes.

Regarding supportive, or facilitative aspects of treatment, analysis of participant narratives uncovered some recurring themes. First, consistently cited among participants was that family and community networks were perceived as a facilitator when family members were supportive, involved in treatment and expressed non-judgment about mental illness. All therapists interviewed (n=11) discussed that the family could reduce or even eliminate clients' perceptions of stigma and promote client recovery. Participants also discussed that a factor unique to the Arab cultural group was that family support protected individuals from some of the secondary effects of mental illness

through providing shelter, food, and even transportation to treatment. These findings are consistent with literature on mental health recovery (Mead & Copland, 2000) and literature pertaining to the importance of family relationships to the Arab cultural group (Dardas & Simmons, 2015). As one participant cited within the Arab culture “we have family support like no other” (Participant #5). In addition to family support, and of interest to this particular study, participants perceived the role of the therapist as a supportive resource for clients within this particular community. While some participants alleged that possessing an understanding of the language and cultural practices was a facilitative aspect of treatment, other participants noted that the role of the therapist as the expert on both the Western and Arab cultures provided unique insight into the needs of clients in this particular community, which could not otherwise be understood by a non-Arab therapist. As previously noted, the community was perceived as a barrier to treatment through transmission of false notions about mental health treatment. Paradoxically, the community was perceived to be a supportive factor when transmission of positive beliefs about mental health treatment were shared among community members. In sum, the supportive, facilitating aspects of providing mental health treatment with the Arab reference group can inversely serve as a barrier to treatment.

Practice Strategies

Analysis of open ended questions about practice strategies commonly used among this group of participants revealed participants were more likely to apply an eclectic mix of therapeutic techniques and not ascribe to any one particular school of psychotherapy. All participants in this group noted that they felt comfortable treating severe psychiatric illnesses (schizophrenia, bi-polar disorder, etc.) as well as milder to moderate forms of mental illness. Additionally, participants were more likely to perceive the causes of severe psychiatric illness within the culture as related

to trauma and transmitted through the family genetically with inter-marriages which participants perceived to be common among the community.

Responses to questions about therapeutic techniques, and beliefs about available resources to meet the needs of the Arab client resulted in the emergence of some conflicting themes. Consistently stated among participants as a useful therapeutic technique in working with the Arab cultural group having a 'nonjudgmental' approach, which was perceived to enhanced the therapeutic alliance. In addressing cultural concerns about keeping family secrets and upholding confidentiality, therapists discussed that taking a stance of "nonjudgement" was a common strategy used. Appearing trustworthy to clients, either by being from a different country (Participant #1) than the members from this community was factor also mentioned. In addition to this, participants noted that psychoeducation about mental illness, about maintaining client confidentiality and about psychotherapy was a practice strategy used to 'devalue' the perceived stigma around diagnosis and help seeking. The implication of this finding suggests that greater education around confidentiality and privacy could mitigate Arab clients' fears about self-disclosure.

Lastly, peer consultation and supervision were recurrently discussed among participants as a resource they had to assist them in their therapeutic work. Participants perceived that coworkers were a good support and resource because they were able to share in the understanding of the Arab culture, while possessing knowledge about clinical and therapeutic techniques and strategies. Findings were mixed regarding the availability of resources used to address the needs of the Arab client. Two participants noted (Participant #6 and Participant #8) that the agency and the community provided all of the resources necessary to address the needs of the clients, while other participants noted that specifically within the community mental health framework, that therapists

are having to make ‘accommodations’ to meet the needs of their clients (Participants #1 #5, #7). Previously cited literature on culture fair resources to address the needs of the Arab-Americans, suggested that there are currently insufficient resources available to meet clinical needs of these individuals (Melham & Chemali 2014). Although some participants echoed this concern, others noted that they could look to the community for supports and resources if needed. This discrepancy may be related to either insufficient knowledge and exposure to community resources to meet the needs of clients, or to the perceptions of the clients’ hold about the resources available to them.

Recovery Beliefs

Overall, participants expressed positive, supportive attitudes about recovery from mental illness and therapists did not differentiate between Arab and non-Arab clients with regards to recovery from mental illness. Two participants (Participant #6 and Participant #10) discussed that they did not believe individuals could recover from mental illness. However, this belief was perceived as stemming from lack of exposure to clients who had recovered than actual attitudes about recovery. Similarities among participant definitions of recovery was also found. Moreover, recovery from mental illness was more likely to be defined and perceived as maintenance and stability, with participants noting that compliance with medication was important to recovery. In addition to family and community support networks acting as both a barrier and facilitator to treatment initiation, some therapists noted that family and community networks was a mediating factor to client recovery. Participants stated that when family was involved in treatment and acceptance for seeking was perceived from the community, that clients had better outcomes. Lastly, a recurrent emerging theme came from analysis of participant narratives was that some therapists viewed themselves as part of the community support network for clients as a “confident”

(Participant #5), and through providing a "safe space…and not have to worry about hearing them (secrets) in the community" (Participant #1).

Strengths and Limitations

One of the limitations of this current study was that there were no male participants. In general, a therapist from the Arab cultural group, providing psychotherapy in Arabic and English in the United States is comprised of a limited group of individuals, and while some themes emerged that were gender specific, this meant that the principle investigator was unable to obtain contrasting or comparative information about these themes. However, this female only sample may be indicative of cultural beliefs about careers in mental health in general. Additionally, it is plausible that this sample may not be representative of the entire population of Arab-American therapists in the United States being a female only sample. Nevertheless, because the female participants in this study noted that they often had difficulties establishing rapport with male clients, and that male clients were perceived as more likely to transfer family roles onto the therapist, a possible explanation for this could be that Arab males in general, are less likely to find mental health treatment and even the profession appealing. Furthermore, because qualitative research calls for adding participants until theoretical saturation is reached, participant selection is highly dependent upon the perceptions of the principle investigator and qualitative expert offering assistance with the data. It is possible that a larger sample of individuals may have supported or dispelled many of the themes that emerged from the participant narratives.

A subsequent limitation of this study was the interview and coding process. With any proposed qualitative design, researcher bias poses a threat to the validity of the study and therefore it is important to understand the researcher's values, preexisting ideas and beliefs when conducting research and drawing conclusions from the data. Additional threats to validity include influences

the researcher may have on the setting or participants in the study. While important measures were put in place to minimize the impact of the researcher on the participants such as avoiding the use of leading questions and having some pre-established, scripted research questions, as with all qualitative studies, it is important to consider the influence of the researcher in the setting he/she is studying. An additional limitation of this study comes from the sample strategy used. Generalizability in qualitative research is often also compromised in a qualitative study as participants sampled are not representative of the population at large. Because this study is specific to therapists who work with and provide psychotherapy to Arab population it cannot be generalized to a sample of all therapists. Furthermore, because participants were sampled from a specific community with a large concentration of Arab resettlement, it is possible that the findings of this study may not generalize to other subsequent communities in different parts of the United States, or to other more Westernized countries. However, being that participants were sampled from a community with one of the densest populations of Arabs in the United States, it is more likely that the data captures a representation of overall barriers and facilitators of working with this particular reference group. This statement is supported by previous literature on the mental health needs of Arabs in the United States and abroad (Al-Timimi, 2001; Baker et al., 2003; Jamil et al., 2002; Latzer, 2003; Melham & Chemali, 2014; Siren-Rogers, 2013).

A subsequent limitation of asking employees to report on perceived work-related barriers are the participant perceived ramifications of participating in the study. Ultimately, this could have resulted in participants either limiting or excluding information, or lack of participation altogether. Some participants discussed that they wanted to be sure to represent their community and the Arab culture in a favorable light, specifically because of misleading, or negative information that may be available about this particular reference group since 9/11 (Participants #1, 2 and 5).

Despite some of the limitations listed, this study provided some significant, important insights into the role of the Arab-American therapist in mental health treatment. Strong positive relationships between the therapists' and the clients were noted to be a protective factor against perceived stigma from family members, but also from the community. In this regard, therapists can be a community support for clients through their knowledge of mental illness, diagnosis, treatment and deeply held cultural beliefs about mental illness. Additionally, overarching themes in this study suggested that despite the literature, therapists did not differentiate on a whole that Arab clients recovered any differently from mental illness. In fact, participants generally maintained a very positive and process-oriented approach to mental health recovery. An additional strength comes from participant suggestions about ways to promote mental health treatment within the Arab cultural group. Participants noted that getting the family to 'buy into treatment' specifically with regards to severe psychiatric illnesses, would result in unwavering, lasting support and improve treatment compliance.

Conclusions and Directions for Future Research

The findings from this study provide insight into the unique position of the Arab-American therapist. In essence, the Arab-American therapist is the bridge between Western standards of practice and the Arab client's expectations and beliefs about mental illness and help seeking. The Arab therapist is an expert not only on the cultural traditions, expectations and norms, but can also serve as community resource and support Arab clients, and to organizations looking for education and information about treatment approaches with this population. Additionally, the community mental health agency can offer support by 'breaking bread' and educating the community and the families on the benefits of mental health treatment, this would result in greater acceptance of mental illness and reduced stigma overall.

The first step to dismantling these barriers could be through informational interventions targeting the Arab-American population. A cornerstone of evidence -based practices lies in the ability to disseminate interventions (Essock, Drake, Frank & McGuire, 2003). On a global scale, interventions that provide psychoeducation about the causes of mental illness, and available treatment options, while dispelling false notions about mental illness within the Arab community, could promote help-seeking while simultaneously reducing stigma. Additionally, within the community mental health framework, service delivery could be improved by incorporating suggestions from mental health professionals within the Arab-American as a way to provide more culture fair treatment and interventions. The mental health needs of Arab immigrants to the United States are extensively discussed in the mental health literature and because of this, we as mental health professionals must respond accordingly.

APPENDIX A

IRB APPROVAL

WAYNE STATE UNIVERSITY

IRB Administration Office
87 East Canfield, Second Floor
Detroit, Michigan 48201
Phone: (313) 577-1628
FAX: (313) 993-7122
http://irb.wayne.edu

NOTICE OF EXPEDITED APPROVAL

To: Nadia Habhab
Theoretical & Behavior Foundations

From: For Dr. Deborah Ellis or designee S. Millis, Ph.D/SC
Chairperson, Behavioral Institutional Review Board (B3)

Date: November 14, 2017

RE: IRB #: 106417B3E

Protocol Title: The barriers and facilitators therapeutic work with Arabic clients: Examining Therapists' perceptions of stigma and recovery from mental illness

Funding Source:

Protocol #: 1710000937

Expiration Date: November 13, 2020

Risk Level / Category: Research not involving greater than minimal risk

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The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#7)* by the Chairperson/designee *for* the Wayne State University Institutional Review Board (B3) for the period of 11/14/2017 through 11/13/2020. This approval does not replace any departmental or other approvals that may be required.

- Revised Protocol Summary Form (revision received in the IRB Office 11/09/2017)
- Research Protocol (received in the IRB Office 10/24/2017)
- Medical records are not being accessed therefore HIPAA does not apply.
- Behavioral Research Informed Consent (revision dated 11/09/2017)
- Flyer for Potential Participants
- Data Collection Tool (1): Survey
- Please note: This submission was reviewed under the IRB Administration Office Flexible Review and Oversight Policy, therefore the expiration date is 11/13/2020.

- Federal regulations require that all research be reviewed at least annually. You *may* receive a *"Continuation Renewal Reminder"* approximately two months prior to the expiration date, however, it is the Principal Investigator's responsibility to obtain review and continued approval ***before*** the expiration date. Data collected during a period of lapsed approval is unapproved research and can never be reported or published as research data.
- All changes or amendments to the above-referenced protocol require review and approval by the IRB **BEFORE** implementation.
- Adverse Reactions/Unexpected Events (AR/UE) must be submitted on the appropriate form within the timeframe specified in the IRB Administration Office Policy (http://www.irb.wayne.edu//policies-human-research.php).

NOTE:

1. Upon notification of an impending regulatory site visit, hold notification, and/or external audit the IRB Administration Office must be contacted immediately.
2. Forms should be downloaded from the IRB website at **each** use.

*Based on the Expedited Review List, revised November 1998

Notify the IRB of any changes to the funding status of the above-referenced protocol.

APPENDIX B

INFORMED CONSENT

The Barriers and Facilitators of Therapeutic Work with Arabic Clients

[Behavioral] Research Informed Consent
Title of Study: *THE PERCEIVED BARRIERS AND FACILITATORS OF THERAPEUTIC WORK WITH ARABIC CLIENTS: EXAMINING THERAPISTS' ATTITUDES TOWARDS STIGMA AND RECOVERY FROM MENTAL ILLNESS*

Principal Investigator (PI): *Nadia Habhab*
College of Education
519-564-5005

Purpose

You are being asked to be in a research study of the perceptions of barriers and facilitators of therapeutic work with individuals who identify as Arabic/Arab American. This study is being conducted at 62 W. 7 Mile Road, Detroit MI, 48203. The estimated number of study participants to be enrolled is about 15 throughout the United States. **Please read this form and ask any questions you may have before agreeing to be in the study.**

In this research study, we will examine the barriers and perceived facilitators of the Arab American therapist providing psychotherapy with the Arabic population, approaches to therapeutic work, including strategies, techniques and tools Arabic/Arab American therapists are using to provide psychotherapy/counselling, and beliefs about stigma and recovery from mental illness. The obtained information from this study will help us gain insight into how treatment with this population is provided, your perceptions the cultural expectations of your clients, and the resources available to you to better service the mental health needs of Arab Americans.

Study Procedures

If you agree to take part in this research study, you will be asked to participate in an interview that will last between 60 to 90 minutes. You will be contacted by a trained interviewer to schedule a specific time for the interview. The interview will be conducted in –person with the interviewer and will take place in a quiet, private room at Arab American and Chaldean Council, 62 W building. The interview questions will ask about your therapeutic work, your beliefs about recovery from mental illness, perceptions of mental illness stigma, and the impact of cultural practices on your clients' recovery. You can choose to not answer questions, while still participating in the study. In order to protect your identity, you will remain anonymous, and your personal information will not be linked to the interview. You will be asked to provide demographic information about your gender, ethnicity, and license type. You can choose to answer all, some or none of these demographic questions. The interviews will be audio recorded to maintain accuracy of obtained information. Audio recordings will not contain any names or identifying information.

Benefits

As a participant in this research study, there be no direct benefit for you; however, information from this study may benefit other people now or in the future.

Risks

By taking part in this study, you may experience the following risks:

Breach of confidentiality: The interviews will be audio recorded to maintain accuracy of obtained information. There is a risk that your voice can be identified from the audio recordings. Additionally, you will sign and write your name on this consent form, which identifies you as taking part in this study.

Emotional risks: You may experience mild emotional discomfort when responding to questions for this study such as anxiety or nervousness..

Study Costs

Participation in this study will be of no cost to you.

Compensation

You will not be paid for taking part in this study.

Confidentiality

All information collected about you during the course of this study will be kept confidential to the extent permitted by law. You will be identified in the research records by a code name or number. Information that identifies you personally will not be released without your written permission. However, the study sponsor, the Institutional Review Board (IRB) at Wayne State University, or federal agencies with appropriate regulatory oversight [e.g., Food and Drug Administration (FDA), Office for Human Research Protections (OHRP), Office of Civil Rights (OCR), etc.) may review your records.

When the results of this research are published or discussed in conferences, no information will be included that would reveal your identity.

Audiotape recordings of you will be used for research or educational purposes, your identity will be protected or disguised. Audio recordings of your interview will be destroyed after all information has been transcribed. Names and identifying information will be deleted from these transcripts. You will be identified by number only (e.g. 001). Additionally, only the principal investigator will have access to these audio recordings. Audio recordings, this consent form, as well as any personal notes collected by the investigator will be kept in a separate locked cabinet at a different location that can only be accessed by the principle investigator. Additionally, the audio files and the consent forms will never be stored together as an added precaution. You have the right to request copies of transcripts of your interview or audio recording for your inspection/review.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If you decide to take part in the study you can later change your mind and withdraw from the study. You are free to only answer questions that you want to answer. You are free to withdraw from participation in this study at any time. Your decisions will not change any present or future relationship with Wayne State University or its affiliates, or other services you are entitled to receive.

The PI may stop your participation in this study without your consent. The PI will make the decision and let you know if it is not possible for you to continue. The decision that is made is to protect your health and safety, or because you did not follow the instructions to take part in the study

Questions

If you have any questions about this study now or in the future, you may contact Nadia Habhab or at the following phone number 519-564-5005. If you have questions or concerns about your rights as a research participant, the Chair of the Institutional Review Board can be contacted at (313) 577-1628. If you are unable to contact the research staff, or if you want to talk to someone other than the research staff, you may also call the Wayne State Research Subject Advocate at (313) 577-1628 to discuss problems, obtain information, or offer input.

The Barriers and Facilitators of Therapeutic Work with Arabic Clients

Consent to Participate in a Research Study

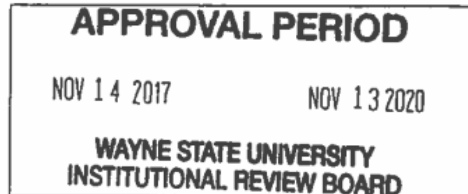
To voluntarily agree to take part in this study, you must sign on the line below. If you choose to take part in this study you may withdraw at any time. You are not giving up any of your legal rights by signing this form. Your signature below indicates that you have read, or had read to you, this entire consent form, including the risks and benefits, and have had all of your questions answered. You will be given a copy of this consent form.

Signature of participant — Date

Printed name of participant — Time

Signature of person obtaining consent — Date

Printed name of person obtaining consent — Time



APPENDIX C

INSTRUMENT

Barriers and Facilitators of Providing Therapy to Arab Clients

Thank you for agreeing to meet with me today. I intend to learn more about your experiences and the work you do serving your community. The purpose of this interview is to explore the barriers and facilitators of providing mental health services to the Arabic population from the perspective of the mental health therapist. We hope to gain insight into how treatment with this population is provided, your perceptions the cultural expectations of your clients, and the resources available to you when working with this population.

In an effort to make sure that I have not missed anything, I will be recording our conversation. All the information that you provide to me is confidential and will not be shared with your employer or members of your agency. No one else will hear this recording, and upon completion up the study, this recording will be erased. This recording will not include any identifying information about you and at any time. Feel free to let me know when you would like me to stop this recording during our interview.

Do you have any questions?

O.k. let’s begin.

Demographic Information

I am going to start off by asking some questions about yourself and your work.

1) What gender do you identify with?
   Male -1

   Female- 2

2) How old are you?

3) What is your country of origin?
   Algeria

   Bahrain

   Iraq

   Egypt

   Lebanon

   Jordan

   Kuwait

   Libya

   Morocco

   Oman

   Palestine

   Qatar

   Saudi Arabia

   Syria

   Tunisia

   United Arab Emirates

   Yemen

   Other (please specify) ____________________

4) What country were you born in? (if not born in the U.S.)
   a) How old were you when you came here?

YOUR CURRENT EMPLOYMENT

5) Where do you currently work? *What is the name of the agency, location?*

a. What do you do at __________ ?
b. How long have you been at________?
c. How long have you been doing this job at _______?
d. Are there other jobs or roles you had at _______? If so, can you briefly describe them to me?

6) Tell me more about what you currently do at ________. *What is your licensure type? Social work? Psychology, Counselor, etc.*

APPROACH TO THERAPUETIC WORK

Now I am going to ask you some questions about the work you do, and your approach to therapeutic work.

7) How do you describe your theoretical orientation or your preferred approach in working with all clients? *For example, do rely more on cognitive behavioral strategies? Humanism? Are you equally using many theories and techniques as in eclecticism (a mixture of techniques)?*

8) What do you believe are your strengths as a therapist?

9) If you had all the time and money, how would you strengthen your therapeutic approaches or skills?

10) What type of psychiatric or mental illness disorders do you mostly comfortably treat?
    e. *Probe: dsm disorders, probe life stress conditions, traumas*

11) What do you believe are some of the causes of psychiatric or mental illness that you see in your clients? *That is, how might you explain the causes of their mental illness?*

a. *What is your main approach in treating some of these conditions?*
b. *What do you need to sufficiently meet the needs of your clients?*
c. *Do you believe you have these resources or skills to currently do that? Why or why not?*

RECOVERY

Now I will be asking you some questions about mental illness and a concept known as recovery

12) Do you believe that people can recover from a serious mental illness such as schizophrenia or bipolar disorder?
    a. Why or why not?

13) Do you believe clients specifically from Arab cultures can recover from a serious mental illness?
    a. Why or why not?
    b. What are some of the barriers?
    c. What are some of the facilitators of recovery? *What might support or help them more than other type of clients from different cultural backgrounds?*

14) In your opinion, would mental health treatment differ for those who identify closely with Arab culture or 'reference groups." *Reference group is another way of saying people who identify with an ethnic or cultural groups and worldviews.*
    a. *Why or why not?*

MENTAL HEALTH STIGMA

For this next section, I will be asking you questions related to stigma and mental illness.

'Stigma is defined as a visible scar; however, it is a word that has often been used to describe the effects of negatively labeling someone which leaves a lasting scar. Stigma can be experienced as a negative condition that can adversely affect how someone seeks treatment, perceives themselves based on the beliefs society holds about psychiatric disorders. People living with a psychiatric disorder can in turn internalize these beliefs and messages and further inhibit effective help seeking or treatment'.

15) Given the understanding we have about mental health stigma, in what ways have you experienced stigma and its effect on your clients or clients in general?

16) In what ways, if any, does stigma affect a person from an Arab cultural or ethnic reference group?
    a. In what ways if any, do you perceive stigma of a mental illness is more or less impactful?

RECOVERY COMPETENCE

Earlier, we discussed recovery from mental illness. I asked you some questions about your beliefs and opinions about recovery. I appreciate your feedback thus far and I am interested in understanding more about your beliefs about recovery.

17) Tell me, if anything, have you heard about recovery from a mental illness.
    a) *How would you describe it?*

    b) In your experience, can people with a mental illness recover? Why or why not?

18) What are some of the things that may promote recovery for a client from an Arab cultural or ethnic group? What about things that would inhibit recovery?
    a. What role does the therapist play?
    b. What role does that person's family play?
    c. What other things might help or hinder recovery for this person?

19) What are the top 5 biggest challenges in serving clients from Arab cultural and ethnic backgrounds?

20) What are the 5 biggest sources of help in assisting you in your work with these clients?
    a. What are some things you would change to help you in your work with these clients?
    b. What are some of things that are working for you in serving these clients?

I would like to thank you very much for your time today and for allowing me the opportunity to learn about your experiences and the work you do.

APPENDIX D

FLYER

Flyer for Potential Participants

THE PERCEIVED BARRIERS AND FACILITATORS OF THERAPEUTIC WORK WITH ARABIC CLIENTS

You are invited to Participate in a research study assessing the perceived barriers and Facilitators of therapeutic work with Arabic clients.

My Name is Nadia Habhab, I am a PhD candidate in Educational Psychology at Wayne State University and I am attempting to collect data for my doctoral dissertation. The purpose of this study is to gather information about the therapeutic approaches Arabic Therapist take when working with clients from Arabic backgrounds. The goal is to obtain insight into how treatment with this population is provided given the cultural differences and expectations of the clients and the available resources the therapist may have to effectively engage the client in treatment.

If you provide psychotherapy/therapy/counselling to Arabic/Arab-American individuals, and you are Arabic/Arab-American you are invited to participate in this study.

The study will involve a 60-90 minute, face to face interview. The interview will be audio recorded to maintain accuracy of obtained information. Participants will not be instructed to disclose personally, identifying information and participation is completely voluntary.

All interviews will be held at 62 W 7 Mile Road, in Detroit MI. If you would like to participate please feel free to contact me to arrange a meeting time via e-mail at nadia.habhab@wayne.edu or my adviser, Dr. Francesca Pernice at francescapernice@wayne.edu or call 519-564-5005

Sincerely,

Nadia Habhab

APPROVAL PERIOD

NOV 14 2017 NOV 13 2020

WAYNE STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

REFERENCES

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical Psychology Review, 31,* 934-948. doi:10.1016/j.cpr.2011.05.003

Al-Darmaki, F. R (2014). Predictors of counseling center use among college students in the United Arab Emirates. *International Perspectives in Psychology: Research, Practice, Consultation*, Vol 3(1), 48-61. doi:10.1037/a0035160

Al-Krenawi, A. & Graham, J. R. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health and Social Work, 25*, 9-22. http://dx.doi.org/10.1093/hsw/25.1.9

Al –Krenawi, A. (2005). Mental health practice in Arab countries. *Current Opinion in Psychiatry, 18,* 560-564. http://dx.doi.org/10.1097/01.yco.0000179498.46182.8

American Psychological Association (2002) Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists. Retrieved From http://www.apa.org/pi/oema/resources/policy/multicultural-guideline.pdf

American Psychological Association (2006). Evidence-Based Practice in Psychology. *American Psychologist 61*(4) 271-285. DOI: 10.1037/0003-066X.61.4.271

Andresen, R., Oades, L. and Caputi, P. (2003), The experience of recovery from schizophrenia: towards an empirically validated stage model. *Australian and New Zealand Journal of Psychiatry, 37*: 586–594. doi:10.1046/j.1440-1614.2003.01234.x

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*, 11–23. doi:10.1037/h0095655

Aprahamian, M., Kaplan, D., Windham A.M., Sutter, J.A., Visser, J. (2011). The Relationship Between Acculturation and Mental Health of Arab Americans. *Journal of Mental Health Counseling. 33*(1), 80-92.

Atkinson, D. R., Casas, A., & Abreu, J. (1992). Mexican-American acculturation, counselor ethnicity and cultural sensitivity, and perceived counselor competence. *Journal Of Counseling Psychology, 39*(4), 515-520. doi:10.1037/0022-0167.39.4.515

Baker, W., Howell, S., Jamal, A.A., Chih Lin, A., Shyrock, A., Stockton, R., et al., 2003. Preliminary Findings from the Detroit Arab American Study. The University of Michigan.

Barber, M.E., (2012) Recovery as the New Medical Model for Psychiatry. *Psychiatric Services. 63*(3):277-9. doi: 10.1176/appi.ps.201100248.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal Of Counseling Psychology, 58*(3), 279-289. doi:10.1037/a0023626

Berkman, L. F. (2000). Social support, social network, social cohesion and health. *Social Work in Health Care, 31*(2), 3–14. doi:10.1300/J010v31n02_02

Bronfenbrenner, U. (1977). Toward and Experimental Ecology of Human Development. *American Psychologist, 32*(7), 513-531.

Bruner, P., Davey, M. P., & Waite, R. (2011). Culturally sensitive collaborative care models: Exploration of a community-based health center. *Families, Systems, & Health, 29*(3), 155-1701. doi: 10.1037/a0025025

Byrd, K. R., Patterson, C. L., & Turchik, J. A. (2010). Working alliance as a mediator of client attachment dimensions and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 47*(4), 631-636. doi:10.1037/a0022080

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*, 537–55 4. doi.10.1037/a0025266

Campbell, R., Patterson, D. and Fehler-Cabral, G. (2010), Using Ecological Theory to Evaluate the Effectiveness of an Indigenous Community Intervention: A Study of Sexual Assault Nurse Examiner (SANE) Programs. *American Journal of Community Psychology, 46:* 263–276. doi:10.1007/s10464-010-9339-4

Chao, P. J., Steffen, J. J., & Heiby, E. M. (2012). The effects of working alliance and client-clinician ethnic match on recovery status. *Community Mental Health Journal, 48*(1), 91-97. doi:10.1007/s10597-011-9423-8

Chen, S. S. (2013). Administration and policy in mental health and mental health services research: The development of recovery competencies for in-patient mental health providers working with people with serious mental illness. *Human Sciences Press*. doi:10.1007/s10488-011-0380-x

Chiba, R., Umeda, M., Kyohei, G., Miyamoto, Y., Yamaguchi, S., Kawakami., N. (2016). Psychometric properties of the Japanese version of the recovery attitudes questionnaire (RAQ) among metal health providers: a questionnaire survey. *BMC Psychiatry, 16*: 32. doi https://doi.org/10.1186/s12888-016-0740-x

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice, 47*(1), 18-29. http://dx.doi.org/10.1037/pro0000055

Corbin, J., and Strauss, A. (1990). Grounded Theory Research: Procedures, canons, and evaluative criteria. *Qualitative Sociology, 13*, 3 – 21. Doi:

https://doi.org/10.1007/BF00988593

Dardas, L. A., & Simmons, L. A. (2015). The stigma of mental illness in Arab families: a concept analysis. *Journal of psychiatric and mental health nursing, 22*(9), 668-679. doi: 10.1111/jpm.12237. Epub 2015 Jun 29.

Davidson, L., Tondora, J., O'Connell, M. J., Kirk, T. J., Rockholz, P., & Evans, A. C. (2007). Creating a recovery-oriented system of behavioral health care: Moving from concept to reality. *Psychiatric Rehabilitation Journal, 31*(1), 23-31. doi:10.2975/31.1.2007.23.31

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11-19. doi:10.1037/h0099565

Deegan, P. E. (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal*, *31*, 62–69. doi:10.2975/31.1.2007.62.69

Dross, P. (2000). Survivors of Politically Motivated Torture: A Large, Growing and Invisible Population of Crime Victims. *Office of Victims of Crime Report*. Washington D.C: Office of Justice Programs, U.S. Department of Justice.

Erickson, C. D., & Al-Timimi, N. R. (2001). Providing mental health services to Arab Americans: Recommendations and considerations. *Cultural Diversity And Ethnic Minority Psychology*, *7*(4), 308-327. doi:10.1037/1099-9809.7.4.308

Essock, S. M., Drake, R. E., Frank, R. G., & McGuire, T. G. (2003). Randomized Controlled Trials in Evidence-Based Mental Health Care: Getting the Right Answer to the Right Question. *Schizophrenia Bulletin, 29(1), 115-123.* doi:10.1093/oxfordjournals.schbul.a006981

Farkas, M. (2007). The vision of recovery today: what it is and what it means for services.

World Psychiatry, 6, 68-74.

Gearing, R. E., MacKenzie, M. J., Ibrahim, R. W., Brewer, K. B., Batayneh, J. S., & Schwalbe, C. S. (2015). Stigma and mental health treatment of adolescents with depression in Jordan. *Community Mental Health Journal, 51*(1), 111–117. doi: 10.1007/s10597-014-9756-1

Gonzalez-Torres M.A.; Oraa R.; Aristegui M.; Fernandez-Rivas A.; Guimon J. Stigma and discrimination towards people with schizophrenia and their family members: a qualitative study with focus group*; Social Psychiatry and Psychiatric Epidemiology); 2007 Vol. 42 Issue 1, p14-23, 10p.* doi:10.1007/s00127-006-0126-3

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. Psychotherapy: Theory, Research, Practice, Training, 43, 531–548. http://dx.doi.org/10.1037/0033-3204.43.4.531

Harding, C. M., Brooks, G. W., Ashikaga, T., Strauss, J. S., & Brier, A. (1987a). The Vermont longitudinal study of persons with severe mental illness, I: Methodology, study sample, and overall status 32 years later. *American Journal of Psychiatry, 144,* 718-726.

Harrison, G., Hopper, K., Craig, T., Laska, E., Siegel, C., Wanderling, J., & ... Wiersma, D. (2001). Recovery from psychotic illness: A 15- and 25-year international follow-up study. *The British Journal Of Psychiatry, 17*(8) 506-517. doi:10.1192/bjp.178.6.506

Harrow M, Grossman, L.S., Jobe T.H., Herbener E.S., (2005). Do patients with schizophrenia ever show periods of recovery? A 15-year multi-follow-up-study. *Schizophrenia Bull.* 2005; doi:31:723734

Heath, P. J., Vogel, D. L., & Al-Darmaki, F. R. (2016). Help-seeking attitudes of UAE students: Examining loss of face, stigma, and self-disclosure. *The Counseling Psychologist*, 44, 331-

352. n DOI: 10.1177/0011000015621149

Horwitz, A. V., Reinhard, S. C., & Howell-White, S. (1996). Caregiving as reciprocal exchange in families with seriously mentally ill members. *Journal of Health and Social Behavior, 37*(2), 149-162. http://dx.doi.org/10.2307/2137270.

Jacobson, N. Greenley, D. (2001) What is recovery? A conceptual model and explication. *Psychiatric Services*, *52*(4), 482-485. doi:10.1176/appi.ps.52.4.482

Jadalla, A., & Lee, J. (2012). The relationship between acculturation and general health of Arab Americans. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society, 23*(2), 159-165. doi: 10.1177/1043659611434058

Jaeger, E.L., (2016). Negotiating Complexity: A Bioecological Systems Perspective on Literacy Development. *Human Development. 59*. 163-187. 10.1159/000448743.

Jamil, H., Hakim-Larson, J., Farrag, M., Kafaji, T., Duqum, I., & Jamil, L. H. (2002). A retrospective study of Arab American mental health clients: Trauma and the Iraqi refugees. *American Journal Of Orthopsychiatry, 72*(3), 355-361. doi:10.1037/0002-9432.72.3.355

Kadri N, Manoudi F, Berrada S, Moussaoui D. (2004). Stigma impact on Moroccan families of patients with schizophrenia. *Canadian Journal of Psychiatry. 49*:625-9. doi: 10.1177/070674370404900909

Kelly, J. G. (1966). Ecological constraints on mental health services. *American Psychologist, 21(6)*, 535-539. doi:10.1037/h0023598

Kelly, J. G. (1970). Antidotes for arrogance: Training for community psychology. *American Psychologist, 25*(6), 524-531. doi:10.1037/h0029484

Keyser, V., Gamst, G., Meyers, L. S., Der-Karabetian, A., & Morrow, G. (2014). Predictors of

self-perceived cultural competence among children's mental health providers. *Cultural Diversity And Ethnic Minority Psychology, 20*(3), 324-335. doi:10.1037/a0035762

Kira I., Lewandowski L., Chiodo L., Ibrahim A. (2014) Advances in systemic trauma theory: Traumatogenic dynamics and consequences of backlash as a multi-systemic trauma on Iraqi refugee Muslim adolescents. *Psychology 5:* 389–412. doi: 10.1177/1078390314542873

Latzer Y. (2003). Traditional versus Western perceptions of mental illness: women of Moroccan origin treated in an Israeli mental health center. *Journal of Social Work Practice 17*(1):77-94. doi: 10.1080/026505303200007150

Marshall, C., Rossman, G. B., (1999) Designing qualitative research. 3rd ed. London: Sage Publications.

Maxwell, J.A., (2013). *Qualitative Research Design: An Interactive Approach Third Edition.* Thousand Oaks, CA: Sage.

Mead, S., & Copeland, M. (2000). What recovery means to us: Consumers' perspectives. *Community Mental Health Journal*, *36*, 315–328. doi:10.1023/A:1001917516869

Melhem, I. & Chemali, Z. (2014). Mental health of Arab Americans: Cultural considerations for excellence of care. In R. Parekh (ed.). *The Massachusetts general hospital textbook on diversity and cultural sensitivity in mental health:* Current clinical psychiatry (pp. 3-30). New York Humana Press.

Milkulincer, M., & Shaver, P. R. (2012). An attachment perspective on psychopathology. *World Psychiatry*, *11*(1), 11–15. doi:10.1016/j.wpsyc.2012.01.003

Mueser K.T., Rosenberg S.D., Goodman L.A., Trumbetta S.L., (2002) Trauma, PTSD, and the course of severe mental illness: An interactive model. *Schizophrenia Research (53):*123–

143.

Narrow, W., Regier, D., Norquist, G. et al. (2000). *Social Psychiatry and Psychiatric Epidemiology* 35: 147. https://doi.org/10.1007/s001270050197

New Freedom Commission on Mental Health. Achieving the Promise: Transforming Mental Health Care in America. Accessed online http://govinfo.library.unt.edu/mentalhealthcommission/reports/comments_011003.pdf

Norcross, J. C. (Ed.). (200 2). Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs. New York: Oxford University Press

Paquette, D., & Ryan, J. (2001). *Bronfenbrenner's Ecological Systems Theory*. Retrieved October 23, 2012, from http://pt3.nl.edu/paquetteryanwebquest.pdf

Perihan, G., & Satı, U. (n.d). Help-Seeking Behaviors of Turkish Patients Prior to Accessing a Psychiatric Polyclinic. *Archives Of Psychiatric Nursing*, 26145-154. doi:10.1016/j.apnu.2011.08.002

Pernice- Duca. F. (2010), Family Network Support and Mental Health Recovery. Journal of Marital and Family Therapy, 36(1), 13-27. doi: 10.1111/j.1752-0606.2009.00182.x

Proposed Refugee Admissions for 2017 (2016, September, 15) Retrieved from https://www.state.gov/j/prm/releases/docsforcongress/261956.htm

President's New Freedom Commission on Mental Health. (2003). Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: Author.

Rogers-Sirin, L., Melendez, F., Refano, C., & Zegarra, Y. (2015). Immigrant perceptions of therapists' cultural competence: A qualitative investigation. *Professional Psychology: Research And Practice*, 46(4), 258-269. doi:10.1037/pro0000033

Russinova, Z., Rogers, E. S., Ellison, M. L., & Lyass, A. (2011). Recovery-promoting professional competencies: Perspectives of mental health consumers, consumer-providers and providers. Psychiatric Rehabilitation Journal, 34(3), 177-185. doi:10.2975/34.3.2011.177.185

Santrock, J. W. (2011). *Life-span development.* New York: McGraw-Hill.

Strauss, G. P., Harrow, M., Grossman, L. S., & Rosen, C. (2010). Periods of recovery in deficit syndrome schizophrenia: A 20-year multi–follow-up longitudinal study. Schizophrenia Bulletin, 36(4), 788-799. doi:10.1093/schbul/sbn167

Salyers, M. P., Brennan, M., & Kean, J. (2013). Provider Expectations for Recovery Scale: Refining a measure of provider attitudes. *Psychiatric Rehabilitation Journal*, 36(3), 153-159. doi:10.1037/prj0000010

Sirin-Rogers, L. (2013). Segmented Assimilation and Attitudes Toward Psychotherapy: A Moderated Mediation Analysis. *Journal of Counseling Psychology* (60), 3, 329-339. DOI: 10.1037/a003245

Sue, S., Zane, N., Nagayama Hall, G.C., Berger, L.K. (2009). The Case for the Cultural Competency in Psychotherapeutic Interventions. *Annual Review of Psychology, 60*, 528-548. 10.1146/annurev.psych.60.110707.163651

Sue, D. W., Arredondo, P. and McDAVIS, R. J. (1992), Multicultural Counseling Competencies and Standards: A Call to the Profession. *Journal of Counseling & Development, 70:* 477–486. doi:10.1002/j.1556-6676.1992.tb01642.x

Substance Abuse and Mental Health Service Administration. (2004). *National consensus statement on mental health recovery* (Pamphlet). Retrieved from http://store.samhsa.gov/shin/content/SMA05-4129/SMA05-4129.pdf

Toro, P. A., & Wall, D. D. (1991). Research on homeless persons: Diagnostic comparisons and practice implications. Professional Psychology: *Research And Practice, 22(6)*, 479-488. doi:10.1037/0735-7028.22.6.479

Youssef, J. & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion & Culture, 9*, 43-66. http://dx.doi.org/10.1080/13674670512331335686

Zahid, M. A., & Ohaeri, J. U. (2010). Relationship of family caregiver burden with quality of care and psychopathology in a sample of Arab subjects with schizophrenia . *BMC Psychiatry*, *10*, 71. http://doi.org/10.1186/1471-244X-10-71

ABSTRACT

THE PERCEIVED BARRIERS AND FACILITATORS OF THERAPEUTIC WORK WITH ARAB CLIENTS: EXAMINING THERAPISTS' ATTITUDES TOWARDS STIGMA AND RECOVERY FROM MENTAL ILLNESS

by

NADIA HABHAB

May 2018

Advisor: Dr. Francesca Pernice

Major: Educational Psychology

Degree: Doctor of Philosophy

This study examined the barriers and facilitators of working with Arab Americans in a treatment capacity from the perspective of the Arab American therapist. Participants were asked about the practice strategies as well as resources available to them when working with this unique population during a semi-structed face to face interview. The impact of stigma and recovery was also assessed. This research study employed a qualitative design approach to address the research questions. Participants were sampled from a community mental health center located within Metro- Detroit; one of the largest concentrations of Middle Eastern/Arab and Chaldean in the United States. Participants in this study consisted of 11 female psychotherapists, who ranged in age from 25-44 years old (M=32.2) and self-identify with the Arab American cultural/ethnic reference group and who reported providing direct psychological services to consumers who identify with the Arabic cultural reference group. Data analyses was conducted using the grounded theory method known as constant comparison analysis (Strauss & Corbin 1998). Recurring themes pertaining to barriers, facilitators, therapeutic processes, and recovery beliefs were analyzed from participant interviews. Overall, participants expressed positive, supportive attitudes about recovery

from mental illness and therapists did not differentiate between Arab and non-Arab clients with respect to recovery from mental illness. Additionally, family and community support were cited as both a barrier and a facilitator to treatment. Participants expressed the need for greater psychoeducation from providers for the Arab population in order to increase family involvement in treatment, and decrease cultural norms that prohibit help seeking among Arab-Americans.

AUTOBIOGRAPHICAL STATMENT
NADIA HABHAB M.A., LLP

PROFESSIONAL EXPERIENCE

Arab-American & Chaldean Council (ACC) (Detroit MI) August 2013 – Present

Clinical Therapist – (Bilingual Arabic/English)

- Provide bilingual (Arabic/English) psychotherapy, crisis intervention, psychological testing, individual and family counselling.
- Assist with case management services including coordinating and linking clients with community based resources, employment, housing, and social services.
- Complete clinical case record keeping for each case assigned using electronic medical record systems**.**
- Collaborate within a multidisciplinary team including case managers, psychiatrist, nurse and program evaluators, social workers and other mental health professionals
- Participate in community based outreach activities including collaborating with local school districts to provide translation/mental health services 'in house'.

Greater Essex County District School Board November 2011- Sept 2012

Psychology Clinical Internship

- Completed a non-paid Psychology Internship under the direct supervision of a fully licensed Psychologist
- Provided psychological services to children including administering and evaluating cognitive and academic assessments

EDUCATION

Wayne State University September 2012-Current

Degree: PhD Educational Psychology (School Psychology Concentration)

Wayne State University 2009-2012

Degree Obtained: Master of Arts in Counseling Psychology

University of Windsor 2004 - 2009

Degree Obtained: Psychology – Honors/Thesis B.A. (H)

PROFESSIONAL DEVELOPMENT/VOLUNTEER WORK

- CBT certified Oct, 2017
- Presented lecture on working with Arab immigrants with trauma exposure: clinical considerations (Oakland County District School Board) May 2016
- Topics in Complex Trauma. St Louis MO, (Sep 9-12/2014)
- Ongoing attendance of trainings/courses/lectures on trauma, psychotherapy and treatment as part of my professional development