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Recovery Experiences Amongst Arab American Clubhouse Members: Examining The Effects Of Acculturation, Perceived Family Support, Stigma And Gender On Mental Health Recovery.

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RECOVERY EXPERIENCES AMONGST ARAB AMERICAN CLUBHOUSE MEMBERS: EXAMINING THE EFFECTS OF ACCULTURATION, PERCEIVED FAMILY SUPPORT, STIGMA AND GENDER ON MENTAL HEALTH RECOVERY

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CHAPTER 1 INTRODUCTION

Over the last several decades, mental health reform has been moving towards recovery oriented systems in the treatment of individuals diagnosed with severe mental illness. In 2004, the notion of recovery gained nationwide prominence when The United States Department of Health and Human services recommended that mental health facilities adopt a "recovery" approach in the treatment of serious mental illness (Gehart, 2012). This recommendation led to the development and release of The National Consensus Statement on Mental Health Recovery (Substance Abuse and Mental Health Service Administration [SAMHSA], 2006), which provided further insight about key elements and characteristics of the recovery paradigm. As formally defined by SAMHSA (2006), "mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential". In contrast to historical beliefs regarding the deteriorative course of mental illness, it was now assumed by the recovery model that all mentally ill persons have the ability to improve and live beyond the limitations of their illness (Bellack, 2006; Corrigan & Ralph, 2005).

The official SAMHSA statement also outlined 10 fundamental components of recovery that included key factors such as hope, empowerment, individual/person –centered, peer support, self –direction, and the consumers' personal responsibility for their own self –care. Many of these principles had previously been identified in the recovery narratives of mental health consumers (Deegan, 1988; Mead & Copeland, 2000), thereby distinguishing the recovery paradigm as being the first, consumer–led movement that significantly revolutionized future mental health policy and practice(s) (Anthony, 1993; Gehart, 2012).

Mental Health Recovery of Arab Americans

The racial and ethnic diversity of the U.S. population is steadily increasing, with estimates that over half of all Americans will belong to an ethnic minority group by 2044 (U.S. Census Bureau, 2015). In part, the Arab American population has been identified as one of the fastest growing ethnic groups in the United States. It is currently estimated that approximately 3.6 million Americans are of Arab descent, which has nearly doubled since 1980 when the U.S. Census Bureau first began collecting statistical data on this minority group (Arab American Institute Foundation, 2012). Despite the increasing number of Arab Americans, the majority of mental health research on ethnic groups in the U.S. has primarily focused on Asians, Hispanics and African Americans (Aprahamian, Kaplan, Windham, Sutter, & Visser, 2011; Primm et al., 2010). Given the scarcity of mental health research on Arab Americans, a notable gap exists throughout the literature regarding the experiences of mental health recovery within this ethnic group. Additionally, there are even fewer to no research studies to date, that have examined the recovery of Arab Americans who receive services and support(s) from psychosocial rehabilitation programs such as clubhouses.

Due to the lack of empirical research regarding the specific mental health needs of this population, clinicians and mental health professionals are often challenged with providing culturally congruent services and care to Arab American patients with mental illness (Hakim-Larson, Kamoo, Nassar-Mcmillan & Porcerelli, 2007; Nassar-McMillan & Hakim-Larson, 2003). This issue has been compounded by the increased need for mental health services among the recent influx of Arab immigrants, many of whom are presenting with serious mental health disorders due to pre-migratory war trauma and/or post-migratory stressors related to acculturation and acclimating to life in the U.S. For example, Jamil et al. (2002) conducted research on the mental health needs of Arab American consumers by examining medical records of immigrants from Iraq

and other Arab countries, who entered the United States after the Persian Gulf War in the 1990s. The medical records of 375 Arab Americans from an outpatient clinic were analyzed for the number of symptoms, medical conditions and outcome(s) of treatment. Results from this study revealed that Iraqi refugees demonstrated greater levels of physical symptoms and were more likely to be diagnosed with Posttraumatic Stress Disorder when compared to patients from other Arab countries, which was attributed to their exposure of the Gulf war. Data on treatment outcomes of the entire sample showed that while the majority of consumers demonstrated full remission or partial response to treatment(s), a significant number of patients (33.8%) discontinued treatment altogether. Thus, research on the mental health recovery of Arab Americans is needed for understanding the growing mental health needs of this population, which may in turn facilitate adherence to treatment and provision of culturally appropriate services to this ethnic group.

When compared to other cultures, Al –Krenawi (2005) proposes that Arab populations tend to demonstrate unique differences in perceptions of mental illness and in their approach towards mental health issues, thereby suggesting possible variability in recovery patterns. In particular, mental illness within the Arab culture is commonly perceived to be caused by satanic and supernatural influences (Al –Krenawi & Graham, 2000; Dalky, 2012) and is typically associated with being 'crazy' or 'majnoon' (mad), with very little distinction(s) made between various types of mental illness (Coker, 2005; Hassouneh & Kulwicki, 2009; Youssef & Deane, 2006). Research has also demonstrated that Arabs often perceive mentally ill persons as dangerous and potentially harmful to others (Coker, 2005; Ghanean, Nojomi, & Jacobson, 2011). Due to the stigma of mental illness, Arabs tend to "somatize their psychological problems and express them in terms of physical symptoms…" (Al –Krenawi, 2005, p. 560), in order to avoid stigmatization. Furthermore,

the effects of mental illness stigma have been shown to be greater for Arab females than males (Hamdan, 2009; Hassouneh & Kulwicki, 2009).

Researchers have also demonstrated the paradoxical effect(s) of the family unit on the course and rehabilitation of mental illness among Arab individuals (Dow, 2011). Due to the strong emphasis on familial connectedness within the Arab culture, the behaviors and actions of individual family members are typically perceived as a reflection on the collective family unit (Erikson & Al-Timimi, 2001). For example, Hamdan –Mansour and Wardam (2000) reported that revelation of an Arab family member having mental illness and/or seeking psychiatric treatment(s) could dishonor and bring shame to the family within the Arab community. Similarly, research conducted by Youssef and Deane (2006) found that Arab persons with mental illness were often isolated by their families due to shame and fears of being rejected by the community, which subsequently resulted in discouraging the mentally ill to seek psychiatric care/treatment(s). Conversely, research has found that the family unit in the Arab culture often plays a critical role in the primary care and well –being of ill family members (Coker, 2005; Hassouneh & Kulwicki, 2009). Particularly, the collectivist values of the Arab culture emphasize interdependence within the family, where the decision to seek psychiatric care for an ill member is often made collectively as a family unit (El–Islam, 2008). Thus, the therapeutic relationship among Arab clients tends to be triangular (El-Islam, 2005), as family members are inclined to be equally involved in this process due to cultural values emphasizing family involvement in the lives of individual members (Hakim-Larson et al., 2007).

Receiving mental health services and support(s) often enhances the process of recovery for individuals. However, research findings indicate that most Arab patients tend to underutilize formal mental health services for psychiatric disorders due to various reasons (Kakoti, 2012;

Tobin, 2000; Youssef & Deane, 2006). Several researchers have proposed that the underlying Westernized principles of mental health recovery and care are often incongruent with the cultural mores of different ethnic groups (Hsiao, Klimidis, Minas, and Tan, 2006) and thus, deters their utilization of mental health services. This notion was reiterated in research conducted by Tobin (2000), who revealed that minimal participation in community health services among Arab Australian consumers was attributed both to their limited understanding about the concept of mental health rehabilitation, in addition to inherent perceptions of services/activities as being culturally inappropriate. Furthermore, results indicated that mental health services did not sufficiently address the needs of Arab consumers due to the fact that philosophies of mental health rehabilitation are largely based on Westernized principles of autonomy and independent functioning, which differ significantly from the collectivist practices of the Arab culture. Similar findings have been shown in studies of consumers from other collectivist cultures. Hsiao and colleagues (2006) reported that mainstream recovery principles emphasizing independence and autonomy typically do not align with the needs of Chinese people with mental illness, as their study findings revealed that the mental health and well –being of patients was highly dependent on Confucian ideals of maintaining interpersonal harmony in their relationships with others.

The following sections will provide a historical overview of the mental health recovery movement and will also examine current perspectives of recovery.

Historical Synopsis of the Recovery Movement

Despite initially emerging as a consumer –advocacy movement in the 1930's, the notion of recovery from mental illness did not begin to gain momentum and eminence in the arena of mental health until the late 1980's (Jacobson & Greenley, 2001). During this time, the heightened awareness and recognition of recovery by mental health professionals was largely attributed to

consumer narratives of recovery experience(s) and the publication of a major longitudinal study, which demonstrated that individuals were indeed capable of recovering from severe mental illness (Harding, Brooks, Asolaga, Strauss, & Breier, 1987a, 1987b). This landmark study conducted by Harding et al. seemingly challenged traditional theoretical perspectives that had defined mental illness as being a lifelong condition of "inevitable deterioration" (Jacobson & Greenley, 2001, p. 482), while simultaneously providing impetus for the recovery movement.

Over the course of 32 years, Harding et al. (1987a, 1987b) examined the long –term effects of a comprehensive psychosocial rehabilitation program and mental health treatment(s) on the functioning of 269 psychiatric patients at a Vermont hospital. At the conclusion of this research, otherwise known as The Vermont Longitudinal Study, it was revealed that 68% of 82 participants who initially met diagnostic criteria for schizophrenia were deemed to be functioning at a level that was characterized by most people as being 'normal'. The criteria utilized to measure this level of normalcy or recovery of participants, primarily consisted of an absence of mental illness symptoms, employment, not taking psychiatric medication(s), integration within the community, relating well to others and behavioral functioning lacking any indication of a psychiatric condition. Subsequently, Harding and her colleagues defined recovery as being an 'outcome' of treatment that results in overall improvement(s) in the social and psychiatric functioning of individuals (Harding et al., 1987a, 1987b). According to Retta, Oades, and Caputi (2011), Harding and her colleagues "championed the cause of heterogeneous outcome expectations…" (p. 8) in the recovery of persons diagnosed with severe mental illness. As a result, this seemingly initiated an influx of additional research and literature that examined the possibility of recovery from severe mental illness over the next few decades (Carpenter & Kirkpatrick, 1998; DeSisto, Harding, McCormick, Ashikaga, & Brooks, 1995; Ralph, 2000).

Subsequent research following the Vermont longitudinal study provided further evidence of recovery from severe mental illness. One study in particular, examined long –term outcome(s) of schizophrenic patients at a follow –up period of 13 years (Mason et al., 1995). Mason and colleagues traced a cohort of 58 patients who made initial contact(s) for psychiatric services between 1978 -1980 in Nottingham, England. Results of the follow –up data showed that 17% of patients "achieve 'complete recovery' over the longer term" (p. 602), as measured by an absence of symptoms, not receiving treatment(s) and no indication of social disability. Additional evidence of recovery was also revealed in de Girolamo's (1996) comprehensive review of follow-up data from multiple, long –term studies of schizophrenia published across several decades (1960 -1991). Analysis of this data revealed that approximately 28% of diagnosed individuals reported a full recovery from severe mental illness (as characterized by an absence of symptoms) and roughly 52% of patients reported a social recovery (defined as requiring medication(s) but capable of maintaining relationships and employment).

As part of the burgeoning recovery movement, much of the previous research also revealed significant evidence of cross-cultural variability in recovery outcomes (Sartorius, 2007; World Health Organization, 1973). In particular, the International Pilot Study of Schizophrenia (IPSS) conducted by the World Health Organization (WHO, 1973, 1979) was pivotal in highlighting sociocultural variability of schizophrenia outcomes across the world. This study comparatively examined the clinical course and prognosis of schizophrenia among a sample of 1202 patients located in nine countries. Follow –up assessments of the patients occurred two years after the initial evaluation and then again at the five –year mark. The overall findings revealed significant differences in mental health outcomes between patients worldwide (WHO, 1979), specifically in that 52% of patients in developing countries (Nigeria, India, Columbia) portrayed better outcomes

of schizophrenia when compared to 39% of individuals living in developed nations (Europe, Russia, United States) (as cited in Sartorius, Gulbinat, Harrison, Laska, & Siegel, 1996). Similar findings were indicated earlier at the two –year follow up, when patients in Nigeria and India demonstrated the best outcomes of illness among all groups.

Although the aforementioned research was pivotal in demonstrating cross –cultural variability of recovery (WHO, 1979), it provided very little insight on what specific factors influenced the divergent outcomes. This issue was also reported by Sartorius, Jablensky, and Shapiro (1978) in their review of the two –year follow up data from the WHO study. Sartorius et al. (1978) stated that while some of the variable outcomes were related to clinical (onset type, precipitating factors) and sociodemographic factors (educational level, marriage), a significant portion of these differences remained unexplained. They proposed that social and/ or cultural environmental factors also possibly contributed to the diverse outcomes between people in Western and non-Western societies. However, specific sociocultural influences could not be identified mainly because the WHO study had placed more emphasis on examining clinical variables in their research design (Sartorius et al., 1978; Sartorius, 2007).

Harrison et al. (2001) also revealed evidence of differences in recovery outcomes across cultures worldwide. This study utilized a historical perspective design to examine long –term recovery patterns among cohort samples from three previous outcome studies across the world. Results from this study demonstrated that recovery varied widely by geographical location, with favorable long –term outcomes achieved by nearly half of all living participants (n=1005) in different parts of the world. The researchers proposed that sociocultural conditions strongly influenced variability of symptoms and long –term course of illness, but yet similar to the earlier

research conducted by the WHO (IPSS), the culture-specific variables related to successful outcomes of recovery were not explored by Harrison and her colleagues.

Current Perspectives of Recovery

Throughout much of the recent recovery literature, the construct of recovery has been mostly defined and discussed in the personal narratives of survivors, ex-patients, and mental health consumers with severe mental illness (Deegan, 1988; Corrigan & Ralph, 2005). The emergence of such writings has provided increased awareness and insight into how individuals have managed the challenges of their mental illness and subsequently experienced recovery (Mead & Copeland, 2000; Ridgway, 2001). In particular, consumers have written about specific aspects of their own recovery that helped to "leave mental illness behind them and to move on to being a 'normal citizen' (Ralph, 2000, p. 511)." Recovery in this sense is characterized by empowerment and reclaiming control over one's life, "of which the illness becomes a smaller and smaller part over time" (Davidson, O'Connell, Tondora, Lawless & Evans, 2005, p. 485). This (consumer) perspective of recovery places less emphasis on whether individuals achieve definitive outcomes such as the remission of symptoms and/or a return to premorbid levels of functioning (Davidson et al., 2005; Walsh, 1996). Rather, recovery is depicted as a uniquely personal process of altering one's values, attitudes and skills, in ways that allow individuals to live a hopeful, satisfying and purposeful life regardless of their mental illness (Anthony, 1993).

Researchers have proposed that the Mental Health Consumer/Survivor Movement appeared to challenge earlier conceptualizations of recovery as being outcome focused (Davidson, Tondora, & Ridgway, 2010). Historical definitions of recovery were medically oriented and subsequently based on the elimination of symptoms and reverting to premorbid levels of functioning (Bellack, 2006; Henderson, 2010). Conversely, consumer perspectives of recovery are

more process -oriented and outwardly refute the notion of recovery as being defined by an outcome of services or as an end result. Instead, mental health consumers have repeatedly characterized recovery as a lifelong process (Frese & Davis, 1997), thereby challenging the clinical delineation of recovery as being outcome based.

According to mental health survivor Patricia Deegan (1993), "Recovery is a process, not an endpoint or a destination" (p. 10). Recovery from severe mental illness is described by Deegan as being a non –linear, unpredictable course of small beginnings and challenges that may often lead to setbacks and subsequent attempts to start over again (1988). Deegan also emphasizes that recovery is not synonymous with being cured or an absence of pain but rather, it consists of accepting one's limitations and discovering ways to live a life that is not defined by mental illness (1997). Similarly, the notion of recovery as a process has also been reiterated in the personal recovery narratives of Dale Walsh (1996). In describing his own experiences as both a mental health practitioner, and as a "survivor" of mental illness, Walsh characterized recovery as a lifelong process that occurs "internally within each person with a psychiatric label..." (p. 87) and does not necessarily equate to achieving symptom relief.

Research has also demonstrated that mental health recovery is a multidimensional continuum that is influenced by many different factors. In particular, a qualitative study conducted by Brown (2008) revealed multiple elements among mental health consumers that both hindered, and enhanced their recovery. Participants in this study described the importance of being hopeful, having supportive relationships with others and engaging in meaningful life activities, whereas stigma of mental illness and the lack of trust and/or continuity in relationships with mental health providers reportedly hindered their recovery. Similar influences on the recovery process were also revealed in Ridgway's (2001) examination of several published autobiographical accounts of

recovery. Analysis of the recovery narratives from this study highlighted the multifaceted nature of the recovery process and revealed influential factors that fostered recovery such as the significance of social support(s), active coping, overcoming mental illness and engaging in valued life activities.

Numerous studies have also emphasized the significance of considering cultural factors and beliefs when examining mental health and recovery outcomes in ethnic minority populations such as Arab Americans (Bjornsson et al., 2014; Ida, 2007; Dow, 2011). Stanhope (2002) reports that cultural beliefs and values play a significant role in the course, rehabilitation and outcome(s) of psychiatric disorders, thereby suggesting possible variability in recovery outcomes among individuals from different cultures. For example, Brekke and Barrio (1997) examined differences in symptoms of schizophrenia between nonminority (white) and minority patients and revealed that individuals in the nonminority group were consistently more symptomatic than Latino and African American minority patients. The researchers proposed that certain characteristics of ethnic cultures may serve as a buffer and can lead to more benign symptoms/ course of mental illness for ethnic minorities, as the socio-centric indicators of empathy and social competence were found to be the mediating variables for the differences between the groups. Another study illustrated significant variability in definitions of mental illness and interpretation of symptoms in the narratives of African American, Euro –American and Latino persons with mental illness (Carpenter-Song et al., 2010). These study findings demonstrated that Latino and African American patients showed more resistance than Euro –Americans toward utilizing and complying with mental health treatment(s), due to cultural differences in perceptions of mental illness.

Theoretical Framework

Although researchers have emphasized the significance of sociocultural influences on mental illness across cultures (Calabrese & Corrigan, 2005), very few studies have examined the specific factors involved in the recovery experiences of ethnic minorities such as Arab Americans. Instead, the majority of mental health research on Arab Americans has primarily focused on the cultural beliefs of mental illness and their underutilization of mental health services. Due to differences in perceptions of, and attitudes towards mental illness and treatment(s) prevalent within the Arab culture, it is essential to identify elements specific to the recovery of persons from this ethnic group in order to understand and adequately address their mental health needs. Furthermore, because of the multifaceted and reciprocal nature of the recovery process, it is also important to examine the dynamic interaction(s) between the individual and the factors that either enhance or hinder his/her recovery from severe mental illness.

Examining mental health recovery within an ecological framework may provide a deeper understanding of this process among Arab Americans, as it emphasizes the interactions between individuals and their environment. In particular, Bronfenbrenner's (1977, 1994) ecological theory of development postulates that individuals are influenced by their surrounding environment, which is comprised of five complex layers or nested systems that change throughout the life span. Within the ecological paradigm, the five systems thought to influence development consist of the microsystem (factors within the individual's immediate environment such as family, peers, workplace), mesosystem (the processes/exchanges between two or more microsystems that the individual is part of), exosystem (interrelations between two or more settings that indirectly influence the individual such as government, neighborhood/community variables) macrosystem (customs, values, belief systems of a culture or subculture, societal influences) and the chronosystem (change or consistency in characteristics of the person and their environment over

time). Bronfenbrenner suggests that human development is significantly affected by reciprocal interactions between the characteristics of an individual and the various elements within these layers. These interactions, otherwise identified as "proximal processes", must occur regularly and over extended periods of time in order to be effective but are considered to be more influential than the environments that they occur in.

It has been proposed that such exchanges may also have similar effects on the course of recovery from severe mental illness (Iwasaki, Coyle, and Shank, 2010). More specifically, recovery could also be conceptualized as a developmental process that is influenced by reciprocal interactions between the environment and characteristics of the individual that occur throughout his/ her life span (Pernice-Duca, Markman, & Chateauvert, 2013). This notion was further reiterated in a comprehensive overview of recovery research conducted by Onken, Craig, Ridgway, Ralph, & Cook (2007), who examined elements of recovery through an ecological framework. According to Onken and colleagues, "the dynamic interaction among characteristics of the individual…, characteristics of the environment…, and characteristics of the exchange between the individual and the environment, …can promote or hinder recovery" (p. 10). Their review illustrated that mental health recovery is heavily influenced by person-centered elements (hope, sense of agency, self-determination), environmental factors (social connectedness, meaningful integration in society) and the nature of the exchanges between these components.

Carlo, Carranza, and Zamboanga (2002) emphasized the importance of utilizing an ecological framework when conducting research on ethnic groups. These researchers provided a detailed analysis outlining various aspects of the collectivist Latino culture within Bronfenbrenner's ecological paradigm. Similar to the collectivist values of the Arab culture, Carlo and colleagues identified the microsystem variable of family (connectedness, interactions) as a

significant influence on the development of Latinos. Additionally, the macrosystem reflects the impact of characteristics of the majority culture on Latinos, such as societal laws, ideals and learning the language of the majority culture, all of which are described as being of importance when examining the effects of majority culture on any minority group. Carlo et al. propose that the process of acculturation (the adaptive change(s) of a cultural group embedded within the ecology of a majority culture) among Latinos is best exemplified as a chronosystem variable, given that it is an influential, gradual process that takes place over time. Although acculturation could also be considered a microsystem variable that is influenced by the exchanges between an individual and his/ her community, the researchers primarily emphasize that influences of acculturation are dynamic and are best understood and examined over the course of time.

As part of the current study, the microsystem, macrosystem and chronosystem influences will specifically be examined within the context of mental health recovery among Arab American consumers. In particular, this study will focus on the individual microsystem (gender), family microsystem (family support) and the clubhouse microsystem (clubhouse interaction(s), level of involvement). At the macrosystem level, the effects of mental illness stigma on recovery will be analyzed among individuals. Given that chronosystem variables encompass temporal change(s) and constancy in characteristics of the person and their environment, the proposed study will examine the overall recovery of individuals and the influence(s) of acculturation within this subsystem, as both elements can be influenced by the dimension of time. The following sections further examine the specific factors that will be explored in the recovery experiences of Arab Americans in the present study.

Influential Factors on Mental Health Recovery

Clubhouse Programs. The practice of psychosocial rehabilitation has repeatedly been identified throughout the literature as having a significant impact on mental health recovery, "as it promotes the rehabilitation and integration of adults with serious mental illnesses into their communities" (Mowbray, Lewandowski, Holter, & Bybee, 2006, p. 167). In particular, the clubhouse model has become one of the most implemented systems of psychosocial rehabilitation for individuals suffering from the debilitating social and psychiatric effects of serious mental illness. Clubhouses are defined as intentional communities that foster development of social relationships and connections with others, community integration, independence, and increased quality of life among persons with psychiatric disorders (Carolan, Onaga, Pernice-Duca, & Jimenez, 2011; Mastboom, 1992), all of which are aimed at enhancing recovery.

Participation in clubhouse programs is voluntary and consumers are identified as members who have been diagnosed with a psychiatric disorder (Pernice-Duca, 2008). With the purpose of providing an engaging and supportive environment, clubhouse staff and members work alongside each other to manage daily operations of the clubhouse involving food preparation, maintenance, and clerical tasks, such as record keeping and reception services (Mowbray et al., 2006). The focus of all clubhouse activities is to improve social functioning and increase members' feelings of self-confidence, in order to enhance their ability to take control of their recovery and be able to lead more of a self-supporting life outside of the clubhouse setting (Mastboom, 1992; Pernice-Duca et al., 2013). In examining the organizational characteristics of 31 clubhouses in Michigan, Mowbray and colleagues revealed that on average, the majority of clubhouses offered a vast array of specialized services and effectively provided members with assistance and opportunities to make their own decisions. Across most clubhouses, the majority of members were perceived to attend the clubhouse primarily for support with finding solutions to their problems (related to finding

living arrangements or employment), rather than having staff members be solely responsible for making the decisions for them (Mowbray et al., 2006).

Current review of the literature suggests a significant gap in research analyzing the effectiveness of clubhouse membership specifically on the recovery outcomes of ethnic minorities such as Arab Americans, thereby warranting examination of this topic area in the present study. Instead, the majority of research has examined clubhouse members as part of an inclusive whole (population), thereby resulting in minimal differentiation and/ or comparison of consumer samples by ethnicity. Overall, studies have demonstrated a positive relationship between clubhouse participation and members' recovery from serious mental illness. Research conducted by Carolan and colleagues (2011) examined members' experiences with interpersonal relationships and social support(s) within the clubhouse environment. Data collection occurred through audio-recorded, semi-structured interviews of approximately 20 active members (attended clubhouse at least three times per week over a six –month period) from a clubhouse located in the Midwest. Interviews were transcribed and the content was analyzed and then coded for major themes by the researchers. Analysis of recurring themes revealed that members identified the clubhouse structure (staff, members, clubhouse environment) as being pivotal in providing social support, comfort, interactions with others and in fostering personal growth and a sense of empowerment in participating individuals. In particular, members described how the clubhouse helped to improve their overall quality of life by providing a flexible environment that emphasizes positive coping and directly responds "to the rehabilitation and recovery needs of the individual" (p. 128). Additionally, many responses specifically identified the clubhouse staff as being instrumental in facilitating resiliency, growth and recovery of most members.

In another study, Tanaka and Davidson (2015) explored the impact of members' experiences with clubhouse activities or the "work-ordered day" (WOD) on their well-being and mental health recovery. This study utilized data from qualitative interviews conducted on 102 members and 24 staff across 5 different clubhouses located in the United States and Finland. The average participation in the WOD among members was approximately five hours daily and 3.5 days per week. Analysis of data revealed that the majority of participants characterized the WOD as providing meaningful experiences that facilitated the development of autonomy (feeling accomplished, developing occupational skills, engaging in productive/meaningful tasks) and positive, supportive relationships with others (collaboration, receiving support, and contributing to the clubhouse community). The researchers proposed that experiences of the WOD are significant for the rehabilitation of persons with serious mental illness, as they contribute to the development of fundamental skills required for living an autonomous and relational life, both of which are conducive to wellbeing and recovery.

The effectiveness of psychosocial rehabilitation on recovery outcomes was also illustrated by the Maine-Vermont Comparison Study conducted by DeSisto et al. (1995). By utilizing a group-matching design, DeSisto and colleagues compared the recovery outcomes of 269 psychiatric patients who received standard inpatient treatment and care, with the outcomes of 269 patients in the aforementioned Vermont Longitudinal Study (Harding et al., 1987a, 1987b) who participated in a rehabilitation program that emphasized self-sufficiency and residential/vocational community placements of consumers. The demographic characteristics (age, sex, diagnosis) of participants in the Maine study were closely matched with those of the Vermont patients, with average follow-up periods of 36 years for the Maine patients and 32 years for Vermont participants. Upon comparison of patient outcomes, overall results indicated that patients in the Maine sample

did not fare as well as the Vermont cohort in measures of overall global functioning, adjustment in the community, and in severity of symptomology. DeSisto and colleagues primarily attributed the outcome differences to the component of community adaptation (involving work, residential and social opportunities) that was implemented as part of the rehabilitation program for individuals only in the Vermont study.

Acculturation. The effects of acculturation on the mental health of ethnic minorities has been frequently examined by researchers for quite some time. Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005, p. 698). One of the most well –known theories of acculturation was identified by John Berry (1997, 2005), who proposed that non-dominant, ethnocultural individuals choose one of four acculturation strategies in their interaction(s) with the dominant host culture. Berry posits that the assimilation strategy occurs when individuals select to completely abandon the traditions of their ethnic culture and become absorbed in the practices of the host culture. In contrast, the strategy of separation takes place when individuals choose to solely maintain their own cultural practices and avoid adopting traditions of mainstream society. These individuals continue to place a higher value on the practices of their own ethnic culture and have minimal interest in engaging with members of the host society (Berry, 2005). Integration refers to the process of maintaining one's heritage culture while interacting and establishing connections with other groups. Berry suggests that integration allows for some degree of cultural integrity to be maintained while individuals simultaneously attempt to become part of the larger societal network. However, marginalization is employed when there is minimal possibility or interest in maintaining both one's traditional culture, and the mainstream culture.

Numerous research studies have illustrated the complex relationship between acculturation strategies and the mental health of ethnic minorities. In part, acculturation (strategy) has been shown to result in either positive or negative effects on the mental health outcomes of acculturating individuals (Amer & Hovey, 2007; Koneru, Weisman de Mamani, Flynn, & Betancourt, 2007). Literature suggests that limited or low levels of acculturation into a host culture results in deleterious psychological outcomes and increased mental health issues among ethnic minorities (El-Sayed & Galea, 2009; Ghaffarian, 1998; Torres, 2010), whereas other studies have demonstrated positive mental health outcomes in individuals that have either integrated (Amer & Hovey, 2007; Baker, Soto, Perez, & Lee, 2012) or assimilated (Jadalla & Lee, 2012) into mainstream U.S. culture. One particular study revealed the psychological benefits of integration among Asian Americans. Baker and colleagues examined the relationship between psychological functioning and acculturative status in a group of 96 Asian American university students. Based on individual assessment of acculturation, participants were classified into one of three statuses as either Asian-identified, Western –identified and Bicultural-identified (integration strategy). The study findings revealed that bicultural Asian Americans demonstrated higher levels of psychological well-being and lower depressed mood when compared to both Asian-identified, and Western-identified individuals. Baker et al. (2012) attributed the differences between the groups as being linked to the increased stressors experienced by individuals who choose "to function predominantly in only one cultural context" (p. 281).

Additional research conducted by Gamst et al. (2002) specifically examined the effects of acculturation status on the mental health outcomes among a sample of 204 Latino American outpatient clients. Measures of ethnic identity and acculturation level(s) were administered to each participant, in order to classify their orientation towards either their Mexican heritage, or the

mainstream Anglo culture. Mental health outcomes of patients were determined by the difference between their Global Assessment of Function (GAF) ratings (from the Diagnostic and Statistical Manual IV) assessed at the time of intake (GAF –intake) and at termination of services (GAF-termination) or by the latest GAF score. Results from this study revealed that clinical outcomes among Anglo –oriented Latino American consumers significantly declined, as these patients demonstrated the least favorable pre/post GAF ratings when compared to individuals within the Mexican-oriented group. Given the observed decline in mental health among assimilated patients, the researchers proposed that these findings challenged conceptions about assimilation as being related to positive psychological outcomes among ethnic individuals.

The negative effects of acculturation were also illustrated by Torres (2010), who investigated the influence(s) of acculturation and acculturative stress on depression outcomes in a sample of Latino adults. The study assessed levels of acculturation, the presence of acculturative stressors (pressures of assimilating into U.S. culture, acquiring and communicating in the English language) and overall coping styles of 148 Latino/ Hispanic individuals and the influence(s) of these factors on depression symptomatology. Study findings revealed that acculturative stress and assimilation into the U.S. culture appeared to be significantly related to marked levels of depression among the majority of individuals. However, active coping styles and maintaining the practices and values of the Latin culture (separation strategy) appeared to serve as a buffer for Latinos who were experiencing moderate levels of depression. Similar to the aforementioned study, assimilation into the host U.S. culture did not result in positive mental health outcomes among ethnic minorities. Instead, Torres proposed that maintenance of one's heritage culture may function as a protective mechanism against exacerbating mental health symptoms that could result from pressures to assimilate into the mainstream culture.

Research examining the effects of acculturation on the mental health outcomes of Arab Americans is fairly limited. However, there exists a substantial amount of literature examining the relationship between mental health symptoms/issues and acculturation of individuals from this ethnic group, which may subsequently be utilized to predict patterns of recovery from severe mental illness. In a comprehensive literature review of studies examining the health of Arab Americans, El-Sayed and Galea (2009) revealed that acculturation, particularly acculturative stress, detrimentally affected the mental health of individuals from this ethnic group. Similar findings were revealed in a study that analyzed the impact of acculturative stress on self–reported symptoms of depression in a sample of 200 elderly Arab Americans (Wrobel, Farrag, & Hymes, 2009). Results indicated that acculturative stress was shown to be a significant predictor of increased depression. Greater degrees of acculturative stress and depression were indicated among individuals with temporary resident or refugee status in the United States. In a similar study, Amer and Hovey (2007) revealed that mental health of Arab American participants was significantly related to their acculturation strategy and experienced acculturative stress. The study findings revealed that higher levels of depression and acculturative stress were evidenced in Christian Arab Americans who separated from mainstream society, whereas less depression was indicated among (Christian) respondents who were more integrated. However, the integration strategy was not associated with better mental health among Muslim Arab Americans.

Several research studies have also portrayed the positive effects of assimilation on the mental health of Arab Americans. Jadalla and Lee (2012) analyzed the relationship between acculturation patterns and both physical, and mental health among a sample of 297 Arab Americans in southern California. Results indicated that Arab American participants who portrayed high levels of assimilation into the American culture reported better mental health

among all participants. In contrast, research conducted by Aprahamian et al. (2011) revealed that the degree of acculturation was not found to have a significant effect on the mental health of Arab American individuals.

Family Support. Within the context of mental health recovery, support refers to a mutual process in which individuals aim to utilize the relationship(s) that they are involved in to fulfill and improve themselves (Mead & Copeland, 2000). In part, research has illustrated the significance of receiving support(s) from family members on recovery, particularly in that the role of the family can either enhance or hinder one's prospects for recovery (Dow, 2011). For example, Topor et al. (2006) examined the influences of supportive relationships on the recovery process of consumers diagnosed with severe mental illness. Examination of consumers' narratives in this study revealed that overall support and involvement of family members was helpful to recovery but at times, family support would infringe on the rights of the recovering individual. In a similar study conducted by EnglandKennedy and Horton (2011), family members' limited knowledge and misunderstandings of the consumers' experiences with mental illness were found to be unintentional impediments to recovery among individuals with mental illness, whereas family participation, acceptance and understanding from family members were found to facilitate their recovery.

Research studies have also illustrated the positive relationship between family support and enhanced outcomes of recovery (Nasser & Overholser, 2005; Nixon, Hagen, & Peters, 2010; Pernice-Duca, 2010). Substantial evidence highlighting the importance of this relationship was demonstrated in the research findings of Pernice-Duca (2010). This particular study explored the influence(s) of various aspects of family network support on the process of recovery in a sample of 169 mental health consumers from 15 clubhouses. The characteristics of family network support

examined in this study included consumers' perceptions of support and reciprocity of support from family members, frequency and satisfaction with contact(s), and the significance of individual family network members as a source of support. The study findings identified family support, perceived reciprocity, and satisfaction with contact(s) as being instrumental to the recovery process among consumers, whereas frequency of contact, importance of family network member and size of family network were shown to have an insignificant effect on recovery. Overall, the quality of interactions with family members appeared to facilitate aspects of the consumers' recovery process more so than the quantity of family contact(s).

Family support was also identified as a significant predictor of recovery from depression in a study by Nasser and Overholser (2005). This study examined the relationship between emotional support from family, friends and spiritual beliefs and outcomes of major depression in a sample of 62 psychiatric inpatients. Participants were interviewed and assessed within 72 hours of their initial intake and were re-interviewed approximately three months after being discharged. The study findings revealed that reported level(s) of family support was significantly related to patient outcomes of depression at follow-up. In particular, patients with higher levels of perceived support from family demonstrated lower levels of depression or complete recovery at the three – month follow up.

Cross –cultural literature regarding the effects of family support on mental health recovery also illustrates trends similar to much of the aforementioned research. Across many cultures, "Family support…is the sheet anchor for treatment and rehabilitation of the mentally ill in the outpatient management" (Wig, 2000, p. 503). In a cross-cultural examination of rehabilitation practices within India and the United States, it was revealed that family involvement and support(s) with both inpatient, and outpatient treatment(s) of mentally ill family members in India, is

considered to be a prerequisite standard of care and serves as a protective factor for people with mental illness (Stanhope, 2002).

Similarly, family support has also been characterized as a necessary component to the recovery of individuals with schizophrenia in Thailand. Research conducted by Kaewprom, Curtis, and Deane (2011) explored the perceptions of recovery from schizophrenia in a sample of registered nurses in Thailand. Semi-structured interviews were administered to 24 Thai nurses, who had provided inpatient nursing care to patients diagnosed with schizophrenia for the duration of at least one year. The interviews sought to examine the nurses' views on characteristics that promote and hinder recovery from schizophrenia. Analysis of the data revealed that all nurses considered a supportive environment as a requirement for recovery, particularly support from family members and the community. Nearly half of all nurses indicated that support and care from family members served as "a powerful facilitator in promoting the recovery from schizophrenia" (p. 325) among patients. The nurses identified a supportive family environment as providing ill family members with love and care in all realms of life, which was deemed to be helpful and necessary for recovery.

The importance of family support on mental health recovery was also indicated among Albanian American participants in a study conducted by Dow and Woolley (2011). This study explored mental health perceptions, treatment and coping strategies of 12 Albanian American immigrants through semi-structured interviews. Results indicated that the family unit was considered to be the primary source of support and assistance for individuals coping with mental illness. However, participants reported that the role of the family can also negatively impact the ability of individuals to cope and recover from mental illness, particularly in that families may often deny the existence of mentally ill family members. Additionally, the family unit may hinder

the recovery of mentally ill family member(s) by limiting their accessibility to outside professional treatment(s) due to shame and denial of mental illness within the Albanian culture. In turn, this increases the family's burden to care for their ill member and can also harm the mentally ill individuals (Dow, 2011).

Studies have indicated that the Arab family is considered to be the primary source of physical and emotional support(s) for family members with mental illness (Dalky, 2012; El-Islam, 2008; Erikson & Al-Timimi, 2001). Additionally, the family unit is perceived as being the most important social institution whose privacy, cohesiveness and honor must be maintained within the Arab culture (Al-Krenawi & Graham, 2000; Hamdan, 2009; Hassouneh & Kulwicki, 2009). Given the cultures' emphasis on maintaining the integrity of the family unit, there is a common perception that acknowledgment of requiring professional intervention(s) for psychological issues would violate family boundaries and hinder the reputation of the family in the Arab community (Hamdan, 2009; Youssef & Deane, 2006). Research has shown that the importance of preserving the Arab family's honor, often at the expense of the needs of an individual, also interferes with pursuing and seeking mental health services for mentally ill family members (Youssef & Deane, 2006), which may ultimately affect aspects of their recovery. The importance of family honor was also illustrated in the findings of a qualitative research study that examined cultural perceptions of mental illness in a sample of Arab American females (Hassouneh & Kulwicki, 2009). One of the central themes that emerged in this study's findings was that all participants identified the importance of maintaining family honor and privacy of mental illness within the family. The participants described how adhering to these practices was "beneficial within the context of a collectivist culture…" (Hassouneh & Kulwicki, 2009, p. 201) and conducive to the cohesive functioning of the family unit.

Although Arab families also typically bear the primary responsibility of caring for mentally ill family members, research indicates that they may often react negatively to this experience with fear, isolation, helplessness and embarrassment (Dalky, 2012; Kadri, Manoudi, Berrada, & Moussaoui, 2004). In examining the caregiving experiences among 100 families who lived with schizophrenic family members in Morocco, Kadri and colleagues revealed that several families reportedly treated their schizophrenic family member with aggression, distrust and rejection. Approximately 63.9% of family members claimed that they did not give patients important or challenging tasks due to lack of trust and only 37% of patients were reportedly treated like any other family member. Overall, the majority of patients demonstrated poor social integration and did not receive any external social support(s), both of which may suggest less favorable outcomes of recovery among these patients.

Stigma. Stigma of mental illness has been identified throughout the literature as being a significant barrier to recovery from mental illness. Stigma refers to the existence of interrelated components such as labeling, stereotyping, discrimination and separation towards, but is not limited to, individuals with mental illness (Link & Phelan, 2001). Phelan and Corrigan (2001) propose that stigma exists in varying degrees and can either be less or more pronounced. Additionally, researchers postulate that levels of reported stigma (high vs. low) by consumers is related to "the degree to which the participant's culture promotes negative attitudes, beliefs and treatment toward individuals with mental illness" (Mizock & Russinova, 2013, p. 236). Regardless, it is important to understand and address stigma of mental illness, as it can have detrimental effects on outcomes of recovery.

Literature suggests that stigma of mental illness can diminish consumers' feelings of self –worth and self –esteem and may also serve as a barrier to seeking mental health services, all of

which can hinder the recovery process (Corrigan, 2004; Markowitz, Angell, & Greenberg, 2011). Results from a study examining the effects of stigma on recovery outcomes of schizophrenic patients demonstrated that stigma of mental illness lowered self-esteem and hope, which resulted in negative recovery outcomes among individuals (Yanos, Roe, Markus, & Lysaker, 2008). In another study, Drapalski and colleagues (2013) analyzed the effects of internalized stigma on the self-concept, psychiatric symptoms and recovery orientation of 100 adults diagnosed with serious mental illness (schizophrenia, schizoaffective disorder, major depression or bipolar disorder). All participants were recruited from several community outpatient programs and from a Veteran Affairs medical center in Maryland, where they were all receiving mental health services. Participants completed self-report measures of internalized stigma and functioning related to recovery-oriented variables such as self-esteem, self-efficacy and the individuals' overall recovery orientation. The study findings revealed that a substantial number of individuals reported experiencing internalized stigma of mental illness, which was not found to be significantly associated with any particular diagnosis or demographic trait(s). Moderate to severe levels of stigma were reported in approximately 35% of participants, with an additional 46% of the sample reporting mild levels of internalized stigma. Furthermore, increased levels of internalized stigma were significantly associated with low levels of recovery orientation, self-esteem and self-efficacy among individuals. Thus, internalized stigma was deemed to be problematic to the well-being and recovery of individuals with psychiatric disorders.

Conversely, research has also revealed an insignificant relationship between stigma of mental illness and mental health recovery (Whitley & Campbell, 2014). In examining the effects of mental illness stigma on the recovery of participants diagnosed with serious mental illness, Whitley and Campbell revealed that the majority of participants did not perceive stigma as being

a significant barrier to their recovery. Instead, many participants reported engaging in conscious efforts and strategies to 'blend in' as a 'normal person' to prevent experiencing stigma in society, which reflected and facilitated their (ongoing) recovery process.

Only a few studies have examined the effects of stigma on recovery outcomes among ethnic groups but this research also suggests varying effects of stigma influences on mental health recovery. One particular study by Lv, Wolf, and Wang (2013) assessed the impact of both experienced, and perceived stigma of mental illness, among Chinese mental health patients and found no relationship between stigma and course/severity of illness. In contrast, Vega, Rodriguez, and Ang (2010), found that greater levels of perceived stigma among Latino patients with depression hindered their recovery. Participants for this study consisted of 200 Latino adults who were receiving outpatient treatment(s) for depression. All patients completed self-report measures of depression (symptomology) and perceptions of mental illness stigma. Results indicated that patients with increased stigma concerns demonstrated poor management of their depression, lacked adherence to treatments(s) and showed limited acknowledgment of illness symptoms, all of which appeared to negatively affect their recovery. Additionally, patients with high levels of stigma concerns were also less likely to disclose their depression diagnosis to friends and family due to personal fears of possibly being judged or discriminated against.

Although literature on stigma and recovery among Arab Americans is limited, researchers have illustrated the negative effects of stigma on mental illness within this culture (Aldhalimi & Sheldon, 2012), particularly in that individuals who openly admit to suffering from mental illness could bring shame to the family and/or hinder the family's honor in the Arab community (Abdullah & Brown, 2011), which subsequently has been shown to limit utilization of mental health services among this ethnic group (Al-Krenawi & Graham, 2000; Youssef & Deane, 2006). This relationship

was illustrated in a qualitative study by Youssef and Deane (2006), who explored perceptions of mental illness and factors that either facilitated or hindered utilization of mental health services in a sample of 35 Arab individuals in Australia. Analysis of data collected through semi-structured interviews with participants, revealed that stigma of mental illness and shame were identified as being significant barriers to utilizing mental health services by approximately 97% of individuals. Participants described underutilizing services because of the "social stigma attached to anything to do with mental health, as it would imply that they are outside the bounds of normality" (p. 53). Additionally, 74% of individuals reported that stigmatizing views of mental illness in the Arab culture would make them feel patronized and/ or condescended if they were mentally ill and would also hinder the reputation of their family in the community. Stigma was also described by the majority of participants as having especially marked consequences on the marriage prospects of Arab females with mental illness. Thus, stigma of mental illness appeared to have pervasive effects on Arabs' perceptions of mental illness and utilization of mental health services.

Similar findings were also indicated in another study that examined the effects of internalized stigma in a sample of 138 Iranian patients diagnosed with schizophrenia or affective disorder (Ghanean et al., 2011). Participants completed the self-report, Internalized Stigma of Mental Illness Scale and were also asked several open –ended questions regarding personal experiences of discrimination due to stigma of mental illness. Findings revealed that approximately 40% of patients reported experiencing moderate to severe levels of internalized stigma. Responses to the open-ended questions illustrated that the majority of participants reported experiencing discrimination ("They ridicule, insult and harm us; Our society has no capacity for us; I mean there is no cultural understanding in our society", p. 14), social withdrawal and alienation ("nobody in my family knows that I have been admitted…", p. 14) due to their mental illness. Another recurring

theme that emerged from participants' responses was the perception of mentally ill persons as being aggressive and dangerous within the Iranian culture. Ghanean and colleagues revealed that many patients expressed concerns over family members knowing of their mental illness due to the negative consequences of stigma.

Research conducted by Markowitz et al. (2001) also illustrated the negative effects of stigmatic appraisals and shame from family members on the recovery of individuals suffering from mental illness. The researchers revealed that critical comments from family members "induce shame that is directly internalized by the ill family member, thus leading persons with mental illness to think and act in ways that inhibit recovery" (p. 160). Thus, individuals appear to internalize stigmatic attitudes and appraisals from others regarding their mental illness, which can influence the actions and beliefs of these individuals and in turn, could subsequently hinder the trajectory and recovery outcomes of their illness.

Gender. Literature suggests that gender impacts many aspects of mental illness. In part, gender has been proposed to influence risk and prevalence rates of certain disorders, onset and course of illness, diagnosis, treatment and coping with mental illness (Wilhelm, 2014). Similarly, research has also provided evidence of gender diversity in outcomes of recovery from severe mental illness. For example, significant differences in the recovery process were illustrated between males and females in a qualitative study conducted by Schon (2010). Participants for this study consisted of 15 men and 15 women between the ages of 33 to 66 years old, who were diagnosed with severe mental illness (bipolar disorder, personality disorders or psychosis). In-depth interviews were conducted with participants to explore whether gender differences existed in personal strategies and elements that facilitate mental health recovery. Results from this study revealed several gender differences in the recovery process, specifically in that females reported

engaging in strategies that appeared to be more advantageous to their recovery process when compared to male participants. The researchers identified the advantages as being attributed to traditional gender norms and societal expectations, which "seemed to benefit women more than men in a recovery perspective" (p. 563). In particular, the majority of male participants appeared to focus more on recovery processes related to controlling their illness and partaking in traditional masculine roles encompassing independence, occupation and control, all of which align with traditional gender expectation(s) for males but overall, appeared to contribute to struggles during their recovery. In contrast, very few of the women described the need for controlling their illness. Instead, the majority of female participants reported being more focused on finding meaning in their recovery and increasing their understanding of themselves and the contributing factors to their illness. Results also indicated that relational characteristics attributed to gender norms of females appeared to facilitate mental health recovery, as the majority of women participants (but only a few male participants) identified several emotionally supportive relationships and social connections as being pivotal to their recovery. Overall, Schon (2010) concluded that diverse societal expectations and norms based on gender appeared to influence and impact the process of recovery for males and females.

Current review of the existing literature indicates a paucity in research examining gender differences in recovery outcomes of Arab Americans. However, several studies have explored gender normed differences between Arab males and females in behaviors and cultural expectations regarding mental illness, which may subsequently assist in predicting possible outcomes of recovery. One reason given for these (gender) differences is the culturally normed, patrilineal structure on which all relationships, practices and traditions of the Arab culture are based (Beitin & Aprahamian, 2013). Within this structure, preservation of the family's honor is primarily

embedded within the behavioral expectations of Arab females, more so than for Arab males (Cainkar & Read, 2013). Similarly, "a greater number of behavioral prescriptions are imposed on females than males…" (Cainkar & Reed, 2013, p. 92) within this culture. For example, in many traditional Arab societies it is unconventional for women to reveal emotions or psychological difficulties to members outside of the family unit, including mental health practitioners (El-Islam, 2008). Because of the cultural expectations for Arab women to conceal symptoms of mental distress/disorders, researchers have proposed that this may potentially increase their risk(s) for, and duration of psychiatric disorders (Hamdan, 2009; Youssef & Deane, 2006), which in turn may potentially impact outcomes of recovery.

Studies examining Arab gender differences in mental health issues have also illustrated the detrimental effects of mental illness stigma on Arab females when compared to Arab males. In part, research has indicated that stigma of mental illness and receiving mental health services is especially damaging for Arab women, as it could damage prospects for marriage or increase their probability of divorce or separation (Al-Krenawi & Graham, 2000; Ciftci, Jones, & Corrigan, 2013; Dalky, 2012; Hassouneh & Kulwicki, 2009). This issue, among others, were illustrated in the findings of a qualitative study that explored cultural perceptions of mental illness in a sample of Arab American Muslim women (Hassouneh & Kulwicki, 2009). In this study, Hassouneh & Kulwicki conducted interviews on eight Arab –American female participants, in order to explore their perceptions and personal experiences regarding mental illness within the Arab culture. The interview included questions revolving around cultural perceptions of mental illness and the influence(s) of gender on mental disorders. Analysis of the participants' narratives revealed significant gender inequalities regarding mental illness and stigma, particularly for Arab females suffering from mental disorders. For example, participants revealed that stigma related to having

mental illness tends to detrimentally impact Arab females more than males, as it hinders a woman's future prospects for marriage due to beliefs that she will not be capable of having healthy "normal" children. Similarly, participants described that Arab females with mental illness are often perceived as a 'disgrace' or as shameful to her family. However, many individuals emphasized that families would ultimately take on the obligatory burden of caring for a female family member with mental illness regardless of their beliefs and feelings about her illness.

Limitations of Previous Research and Purpose of Proposed Study

Previous research has demonstrated variability across cultures in the factors influencing recovery outcomes. However, there appears to be a paucity of research examining the process of mental health recovery among Arab Americans. As a result, very little is known about the specific elements that can either hinder or enhance Arab Americans' recovery from serious mental illness. Thus, examining the recovery experiences of Arab Americans would provide essential information about the mental health needs pertinent to this growing ethnic group.

Given the significant effects of acculturation, mental illness stigma, family support and gender on Arab mental health, it is imperative to measure and identify the potential influence(s) of these elements within the context of recovery. Based on qualitative methodology, the current study aims to examine key themes and experiences of recovery among Arab American consumers receiving support(s) and services at a local clubhouse organization. Thus, the overarching purpose of this proposed research study will be to closely examine the experiences of acculturation, family support, self–stigma, and the influence of gender on the recovery process of Arab American clubhouse consumers. The research questions for the present study are as follows:

1. Is the recovery process of Arab American clubhouse members affected by their
    reported level(s) of acculturation, or lack thereof, into the mainstream (U.S.) culture?

2. What influence(s), if any, has either the absence or presence of support from family members had on their mental health recovery?

3. How, if at all, has recovery been influenced by perceived stigma of their mental illness?

4. Do gender differences exist in the recovery process among Arab American clubhouse members? If so, what are the differences?

Significance of Study

Mental health literature suggests that Arab Americans are one of the least studied ethnic groups within the United States. In part, very few, if any, research studies have examined Arab Americans' recovery from serious mental illness, particularly from the perspective(s) of clubhouse members. Additionally, emphasis on individuality and autonomy in mainstream recovery models may not appropriately address the recovery processes and outcomes of individuals from collectivist cultures, such as Arab Americans. Therefore, to fully address the mental health needs pertinent to this growing ethnic group, it is necessary to examine and identify specific factors that possibly hinder and/ or enhance Arab Americans' recovery from serious mental illness. In turn, this information could be utilized by clinicians and mental health professionals to provide Arab Americans with culturally congruent services and care.

CHAPTER 2 METHOD

Participants

Participants for this study consisted of 15 Arab American consumers, recruited from a clubhouse located within a metropolitan community in a Midwestern state. Arab American clubhouse members were specifically selected for this study given the paucity of research examining the mental health recovery of individuals from this ethnic group. Selection of clubhouse members was specifically based on the following criteria: self-reported Arab/ Middle Eastern ethnicity, active clubhouse membership, and adequate cognitive skills to participate in a 60 – 90-minute interview (i.e., ability to give consent, comprehend and respond to interview questions without symptom interference). Gender distribution of members recruited for this study was also intentional. The clubhouse manager and staff primarily assisted with both the initial identification, and recruitment of members who were deemed eligible to participate in the study, due to their familiarity with the membership and enrollment at the selected clubhouse location.

Demographic information was collected during the interviews and included questions about the participants' age, marital status, country of origin, religious identification, birth country and immigration status within the United States (if applicable). All members voluntarily participated in the study and provided written consent to release medical information about their psychiatric diagnoses to the Principal Investigator (PI).

The overall sample included seven (47%) adult males and eight (53%) adult females of Arab ethnicity, who ranged in age from 26 to 72 years old (M =49.4). One must be diagnosed with a psychiatric disorder to participate in clubhouse programs. Overall, members' diagnoses consisted of Major Depressive Disorder (n=7), Schizoaffective Disorder (n=3), Anxiety Disorder (n=2), Bipolar Disorder (n=2) and Post Traumatic Stress Disorder (n =1). The majority of clubhouse

members reported living with family (n=1l), whereas four members lived independently. In terms of marital or couple status, members reported being single (n=3), married (n=3), divorced (n=4), separated (n=2), widowed (n=2) or with a significant other (n=1). The educational status of participants varied across the sample. Among the fifteen members, six individuals had less than a high school education, four members had attained a high school diploma, two reported having some college education, and a total of three members had achieved a college degree (Undergraduate and/or Graduate degree).

Demographic data also revealed that most participants identified themselves to be Muslim (n=13) and two members reported to be Christian in their religious beliefs and practices. Overall, the sample was comprised of individuals who originated from Iraq (n=7), Lebanon (n=5), Yemen (n=2) and Jordan (n=1). Of the 15 members, only two were born in the United States. The remaining majority of participants had immigrated to the U.S. and identified the condition(s) of their migration as being either forced or involuntary (n=6), completely voluntary (n=5), or both voluntary and involuntary (n=2). The demographic and cultural characteristics of participants in this study are summarized in Table 1 and Table 2, respectively.

Table 1
Demographic Characteristics of Clubhouse Members
(N=15)

Member	Gender	Age	Psychiatric Diagnosis	Relationship Status	Current Living Arrangement	Education	Religion
1	Female	34	Schizoaffective Disorder	Single	Lives with family	H.S. Diploma	Muslim
2	Female	68	Major Depressive Disorder	Widowed	Lives alone	Less than H.S. Diploma	Muslim
3	Female	65	Anxiety Disorder NOS	Separated	Lives with family	Less than H.S. School Diploma	Muslim
4	Male	53	Major Depressive Disorder	Single	Lives alone	College degree	Muslim
5	Male	46	Schizoaffective Disorder	Single	Lives with family	Less than H.S Diploma	Muslim
6	Female	47	Post –traumatic Stress Disorder	Single	Lives with significant other	Less than H.S. Diploma	Christian
7	Female	57	Anxiety Disorder	Married	Lives with family	H.S. Diploma	Muslim
8	Female	54	Major Depressive Disorder	Divorced	Lives alone	H.S. Diploma	Muslim
9	Female	36	Bipolar 1 Disorder	Divorced	Lives with family	Some college	Muslim
10	Female	72	Major Depressive Disorder	Widowed	Lives with family	Less than H.S. Diploma	Christian
11	Male	32	Bipolar 1 Disorder	Single	Lives with family	Graduate degree	Muslim
12	Male	26	Schizoaffective Disorder	Married	Lives with family	Some college	Muslim
13	Male	61	Major Depressive Disorder	Married	Lives with family	H.S. Diploma	Muslim
14	Male	50	Major Depressive Disorder	Divorced	Lives alone	College degree	Muslim
15	Male	40	Major Depressive Disorder	Divorced	Lives with family	Less than H.S. Diploma	Muslim

Note. H.S. = High School.

Table 2
Cultural Characteristics of Clubhouse Members
(N=15)

Member	Country of Origin	Birth Country	Immigration to the United States	Generational Status in the United States	Primary Language
1	Yemen	Yemen	Voluntary	Second generation	Arabic
2	Lebanon	Lebanon	Voluntary	First generation	Arabic
3	Lebanon	Lebanon	Voluntary	Other	Arabic
4	Iraq	Iraq	Voluntary	First generation	Arabic
5	Lebanon	Lebanon	Involuntary/Forced	Second generation	Arabic
6	Iraq	Iraq	Involuntary/Forced	Second generation	Arabic
7	Lebanon	Africa	Involuntary/Forced	First generation	Arabic
8	Iraq	Iraq	Voluntary and Involuntary	First generation	Arabic
9	Lebanon	United States of America	Not applicable	Second generation	English
10	Iraq	Iraq	Involuntary/Forced	First generation	Arabic
11	Jordan	United States of America	Not applicable	Second generation	Arabic
12	Yemen	Yemen	Voluntary	Second generation	Arabic
13	Iraq	Iraq	Voluntary and Involuntary	First generation	Arabic
14	Iraq	Iraq	Involuntary/Forced	First generation	Arabic
15	Iraq	Iraq	Involuntary/Forced	First generation	Arabic

Note. Involuntary or forced immigration to the United States reflects political/religious asylum and/ or refugee status.

Description of Interview Setting

All interviews were conducted in a quiet room at the selected clubhouse where recruited participants were identified as members. Selection of the particular clubhouse for this study was solely based on the high concentration of Arab American membership at this facility, when compared to the demographics of other clubhouses in the surrounding metropolitan area. Likewise, the majority of clubhouse staff employed at this location were also of Arab ethnicity and fluent in both Arabic, and the English language. Given the high Arab American membership at this clubhouse, the availability of bilingual staff members was advantageous and helped facilitate communication(s) with Arab members who were only proficient in their native language.

The layout of this particular clubhouse included a main office/lobby area, a kitchen, dining room, several meeting rooms and a commons area, where members were able to purchase snacks and socialize. Members were observed to engage in various tasks and activities that were geared to maintain the daily operations(s) of the clubhouse such as preparing and cooking meals, cleaning and clerical duties. Members also participated in daily house meetings and various unit meetings where clubhouse staff and members worked together. Clubhouse staff also provided members with education in basic computer skills and English language instruction. Additionally, the clubhouse offered daily meals and transportation to and from the clubhouse each day.

Measures

Based on qualitative methodology, data was collected from participants through the administration of an in–depth, structured interview protocol that was developed specifically for the purpose(s) of the current study. Researchers propose that qualitative techniques provide unique opportunities to investigate complex phenomenon in ways that could not otherwise be captured through traditional quantitative research methods (Hill, Thompson, & Williams, 1997). In

particular, numerous studies have demonstrated the effectiveness of qualitative methods in exploring personal experiences of recovery (Brown, 2008; Davidson & Strauss, 1992; Ralph, 2000; Ridgway, 2001). These techniques provide invaluable knowledge and vivid information about the recovery process solely from the perspective of individuals experiencing recovery. Thus, researchers are able to preserve the essence of personal recovery experiences while "contributing to the growing body of knowledge and evidence of factors that support recovery" (Brown, 2008, p. 43).

For the current study, the interview protocol was developed within a framework that aimed to identify and analyze key themes of recovery experiences among Arab American clubhouse members with serious mental illness. The content of the interview primarily explored four central areas: participants' perceived stigma of mental illness, support from family members with their illness, level(s) of acculturation and experiences and attitudes toward recovery. The frequency and influence(s) of participants' clubhouse involvement and participation was also examined as part of the interview. In order to adequately assess participants' perceived level of acculturation, a standardized self-report instrument of acculturation was integrated into the interview protocol. Potential gender differences in recovery experiences were analyzed and determined by the response patterns of male and female participants during the interviews. The following sections summarize the primary variables that were examined throughout the interview protocol for the current study.

Clubhouse Participation. Members were presented with a series of questions pertaining to the frequency of their clubhouse participation and involvement. In particular, members were asked to report when they initially joined or became a member at the clubhouse, how many days per week they attended the clubhouse and the number of hours they stayed at the clubhouse.

Reasons for clubhouse attendance and the impact of their membership were also identified by participants during the interview (i.e., "What are four main reasons, starting with the most important reason that you come/came to the clubhouse?", "What would be different in your life if you did not attend Clubhouse?").

On average, members attended the clubhouse at least three days per week and for approximately five hours each day (See Table 3). The length of clubhouse membership for Arab American participants varied and ranged from approximately four months to eight years across the entire sample. All members described the clubhouse as being helpful and important for their recovery. Moreover, members identified various reasons for clubhouse membership and participation that consisted of some of the following: seeking support(s) for mental illness, to help alleviate feelings of loneliness, provision of opportunities to socialize with other members and enjoyment with partaking in clubhouse activities.

Table 3
Clubhouse participation characteristics

Member	Number of Days per Week	Hours per Day	Length of Clubhouse Membership
1	4	4	7 years
2	4	4	3 years
3	2	4 -5	8 years
4	3	5	5 years
5	3-4	5	1.5 years
6	4	5	4 months
7	2	5	7 years
8	4	5	4 years
9	4 -5	5.5	5 years
10	3 -4	5	6 years
11	3	5	3 years
12	3	5	2.5 years
13	3	4 -5	8 months
14	3	5	5 years
15	2	5	8 years

Stigma. The effects of participants' perceived mental illness stigma on their recovery was assessed by a total of 5 open–ended questions within the interview protocol. These items examined clubhouse members' perceptions and personal experiences with stigma of mental illness. The open–ended questions were designed to provide a deeper understanding of the relationship between perceived stigma of mental illness and recovery among clubhouse members. Some examples of these items included "Would you say that you are comfortable with openly talking about your illness...? If no, why not?" and "Have you ever been affected by the negative perceptions or stigma that others have expressed about your illness?" Participants were then probed to discuss whether stigma has hindered their recovery in any way and/or affected the support(s) they received from others. Additional questions focused on perceptions of mental illness within the participants' culture (i.e., Can you please describe for me how mental illness is perceived in your Arab culture"), which was then followed by two probing questions that inquired about the influence(s) of such beliefs on his/her recovery.

Family support. The family support section of the interview consisted of 7 open –ended questions that aimed to examine the effects of receiving support from family members on one's recovery. Initial questions within this section asked participants to identify where the majority of their family members reside, which family member(s) he/she has the most contact with, and the frequency/ nature of such contact(s). Participants were also specifically asked to identify both who they depended on for support (i.e., "Who do you rely on for the following things: emotional support, social support, instrumental support"), and whom they themselves provided assistance and support to within their family network ("Which family members rely on you for things, such as helping them with tasks, cleaning, babysitting, etc.?"). Finally, clubhouse members were presented with several questions inquiring about the degree of family support received throughout

the process of his/ her recovery. Some examples of these items included, "Has anyone from your family been involved with your treatment at the Clubhouse?" which will then be followed up with, "How about in any other treatment setting related to your illness?" and "Do you often wish that your family would become (more) involved with your participation at the Clubhouse?" Participants were also asked to discuss whether they had experienced either positive or negative changes in any familial relationships because of his/her mental illness.

Acculturation. The Vancouver Index of Acculturation (VIA; Paulhus, 2013) was integrated within the interview protocol to provide descriptive information regarding the acculturation level(s) of participants in this study (see Appendix C). The VIA is a 20 –item self-report questionnaire that examines several areas pertinent to the process of acculturation such as social relationships, personal values, and adherence to cultural traditions among participants (Ryder, Alden, & Paulhus, 2000). Moreover, the VIA specifically analyzes acculturative experiences related to the acquisition of American *(mainstream)* cultural practices and values and either the loss, or maintenance of cultural traditions and tendencies of one's *heritage* culture. Some examples of questions on the VIA that assess acculturation into the mainstream U.S. culture include, "I am comfortable interacting with typical American people", "I often participate in mainstream American cultural traditions", and "It is important for me to maintain or develop American cultural practices". Conversely, VIA items such as "I often behave in ways that are typical of my heritage culture" and "It is important for me to maintain or develop the practices of my heritage culture", attempt to measure adherence to one's heritage culture and traditions. Response options on the VIA instrument range from 1 (Disagree) to 9 (Agree). The overall mean of odd –numbered items on the VIA reflect the *heritage* sub-score, whereas the *mainstream* sub-score is represented by the mean of even –numbered items on the VIA assessment. For the current

study, response options were modified to reflect a 5-point rating scale (1 =Disagree, 5=Agree) and responses were primarily utilized to describe participants' acculturative experience(s). The VIA has been found to yield adequate reliability with Cronbach alpha coefficients of .79 and .75 for the heritage and mainstream subscales, respectively (Ryder et al., 2000).

In addition to the VIA, participants were also presented with several open -ended questions further inquiring about their acculturative experience(s). In particular, participants were asked whether they primarily adhered to their cultural traditions and practices; or if they mostly adopted practices of the mainstream American culture; or if they engaged in practices of both cultures equally. Participants were also asked to describe whether they have experienced pressure(s) to adhere to either culture and if so, were then probed to elaborate on their experience(s) (i.e., "Would you say that you feel pressure(s) to fit in to mainstream American society? If yes, has this been stressful for you? In what ways?").

Recovery. The recovery section of the interview was comprised of 14 questions that examined both participants' perceptions of their own recovery, and their opinions regarding recovery in general. This section began with a series of 4 open–ended questions inquiring about participants' familiarity with the concept of recovery (i.e., "Can you tell me if you have heard others talk about recovering from mental illness or 'mental health recovery', "How would you define recovery from mental illness? In your opinion, what does it mean to you?) and their views regarding the recovery process (i.e., "Do you feel that it is possible for individuals to recover from their mental illness? Why or why not?"). Participants were also presented with four additional open–ended questions that specifically examined aspects of their own personal recovery from mental illness. Some examples of these items included "Could you describe some things that have helped or that have positively affected your recovery?" and "What, if anything, do you feel has

hindered or interfered with your attempt(s) to recover from your illness?" A probe followed the latter question, "Would you say that you have been able to overcome most of these setbacks?" Additionally, participants were asked to describe any positive or negative changes in their symptoms and overall psychiatric condition since attending the clubhouse and the degree to which he/she has been able to adequately manage their illness.

The recovery section included six Likert -scale items adapted from a standardized recovery measure (Recovery Assessment Scale (RAS); Corrigan, Giffort, Rashid, Leary, & Okeke, 1999) to further explore recovery orientation ("My illness does not control me", "I am capable of making decisions about my life" and "Recovery from serious mental illness is possible"). Clubhouse members were asked to indicate the extent to which they agreed or disagreed with each item on a 4 –point scale (1 = Strongly Disagree, 4 = Strongly Agree). Negatively worded items were reverse coded (i.e., "My recovery is affected by the stigma associated with mental illness") and an overall mean was calculated to describe the extent of their recovery orientation.

Procedure

Approval to conduct all procedures for the current research study was obtained from the clubhouse administrators and the University Institutional Review Board (IRB). As part of the approval process, the Principal Investigator attended several scheduled visits with administrative staff at the clubhouse site to discuss the study and to review the research protocol and measures. During these visits, the PI was able to observe some of the clubhouse activities and was also introduced to several members who regularly attended the clubhouse.

Participants were primarily identified and recruited by the clubhouse manager and staff during member meetings on site. Interviews were then scheduled with members who expressed interest in participating with the study. Members were asked to provide both informed consent to

participate in the study, and consent to release information regarding their medical diagnosis at the beginning of their scheduled appointment. This medical data contributed to the demographic information of participants and was also utilized in the study to better understand and analyze their recovery experiences, in relation to, and within the context of his/her mental illness. In order to ensure participants' understanding of the research and of their rights as subjects in the study, the informed consent was officially translated in their native Arabic language. Participants were asked about their language preference (either English or Arabic) for both the consent forms, and the interview at their scheduled appointment by the PI, who was fluent in both languages.

All interviews with consenting participants were solely conducted by the Principal Investigator at the clubhouse. Most of the sample requested and/or preferred to have the interview conducted in their native Arabic language, with the exception of one clubhouse member who was fluent in English. Interviews each lasted approximately 60 to 90 minutes in length and were audio-recorded in order to maintain accuracy of obtained information. The recorded interviews were then transcribed verbatim by the PI in the English language. All identifying information such as the name of the clubhouse and participants' names were removed and excluded from the transcripts. Instead, participants were identified by individual study codes (e.g., Member #1, Member #2) in order to further conceal their identities during transcription and analysis.

Trustworthiness and Data Analysis. Trustworthiness and credibility of the data was accomplished in several ways. In order to ensure appropriate selection of participants for the study, the clubhouse manager and staff assisted with the identification of members who met criteria for recruitment and who were willing to partake in the interview process. Data analysis and coding of the interviews occurred with assistance from an expert in the areas of qualitative design and clubhouse programming. Both the expert, and Principal Investigator, independently read and

coded the transcribed interviews to derive a broad list of themes. Following this process, consensus was achieved in the classification of final major themes during several face to face meetings. Determination of all major themes was based on their frequency and pervasiveness throughout the data (Carolan et al., 2011). Additionally, the investigator did not come in to the present study with any pre-existing biases about the research topic that was investigated, as I had no prior experience(s) with clubhouses or with members who attend these facilities for assistance with their mental illness. Finally, direct quotations from the narratives of participants were utilized to corroborate and confirm all major themes identified in the present study.

Data analysis for this study was based on principles of grounded theory, which are designed to develop a framework of integrated concepts that summarize and thoroughly explain a social phenomenon (Corbin & Strauss, 1990; Hill et al., 1997). Theoretical sampling is an intricate component of grounded theory and involves recruiting participants with varying experiences of a particular phenomenon and then using their constructed realities and meanings to explore multiple aspects of the construct under study (Coniglio, Hancock & Ellis, 2012; Starks & Trinidad, 2007). As part of this process, participants are continuously added to the sample until theoretical saturation is reached, which occurs when the collected data fully represents all constructs of the theory being examined. According to Coniglio and colleagues (2012), the grounded theory approach is well suited for research with very limited prior knowledge. Given the scarcity of existing research on the recovery experiences of Arab Americans, a grounded theory approach was deemed appropriate for the purpose(s) of the current study.

The analysis process involved two levels of coding in order to identify and extract major themes that emerged across the interviews conducted in this study. In keeping with principles of grounded theory, the method of constant comparisons (Strauss & Corbin, 1990) was utilized to

analyze and code the collected data. This technique consists of making analytical comparisons between identified incidents or themes throughout the data until core concepts were established. During the initial content analysis, the transcribed interviews were independently read and pre – coded for recurring themes by the expert researcher and myself. This was followed by a collaborative meeting process of examining and comparing similar themes that emerged across the interviews, until mutual consensus was reached on a final classification of major themes. All interviews were then reanalyzed and inter–rater reliability was conducted to determine congruency in coding and in the identification of similar themes (Hill et al., 1997).

CHAPTER 3 FINDINGS

The purpose of the current study was to identify and analyze key themes and experiences of recovery among Arab American clubhouse members with serious mental illness. Specifically, this study focused on four overarching research questions that sought to examine the influence(s) of acculturation, family support, stigma of mental illness and gender on the recovery experiences of Arab American consumers. Narratives were analyzed and multi-coded to extract key recurring themes of recovery experiences across each of the aforementioned factors. Specific quotes from respondents will be utilized to accentuate detailed elements of their lived recovery experiences and to also illustrate major themes. The following sections provide a comprehensive summary of final themes that emerged during analysis and the final coding process.

Research Question 1: Is the recovery of clubhouse members affected by their reported level(s) of acculturation, or lack thereof, into the mainstream (U.S.) culture?

Examination of this particular research question involved multiple levels of analysis. First, the PI and the second researcher simultaneously examined participants' responses on both the VIA (see Appendix C items 53-72), and to the open-ended interview questions on acculturation (see Appendix C items 48-52), in order to identify themes related to acculturative experiences. Total scores from the VIA responses of each participant were recorded to describe whether the acculturation of each individual was primarily reflected by adherence to practices and values of their *heritage* Arab culture, or adherence to *mainstream* American traditions and values, or both. Second, participants' recovery orientation was determined by analysis of their responses to both the Likert –scale recovery items (see Appendix C items 40-45), and to the open –ended questions examining recovery (see Appendix C items 33-38, 46, 47). Analysis and coding of recovery items resulted in the identification of several main themes related to members' recovery experiences that

will be discussed in the following sections. An overall summary of members' scores from the VIA and the Likert –scale recovery items are presented in Table 4.

The following major themes emerged from examining participants' responses to open – ended questions pertaining to their acculturation:

1.) High adherence to Arab cultural traditions and practices among majority of members.

2.) Low identification with U.S./American identity and cultural practices.

Acculturation. Overall, the vast majority of participants reported adhering to cultural traditions and practices of their native culture, as evidenced by their VIA scores and responses to open-ended interview acculturation questions. For instance, VIA scores revealed higher *heritage* scores and low levels of acculturation among the majority of participants (n=10), who mainly endorsed following traditions specific to their native culture (See Table 4). Similarly, the narratives of many clubhouse members also revealed the importance of continuing to follow religious beliefs and practices of their culture and discussed adhering to Arab cultural traditions such as the celebration of holidays (e.g. Eid), eating foods specific to their culture, primarily speaking the native language and an emphasis on interdependence within the family network. These responses revealed that these individuals identified themselves to be mostly "Arab" in their values and cultural mores. The following quote from Member #7 illustrates aspects of this overarching theme:

> My religion and the religious beliefs of my culture are most important to me. I feel like it is very important to maintain my cultural traditions because I don't really feel the need to change my ways. That's what I'm accustomed to and feel that it's fake when you take on traditions other than those of your own culture (Member #7).

Similar sentiments were expressed by a male clubhouse member, who also reflected on the significance of maintaining native cultural values and traditions but also emphasized maintaining respect toward the mainstream culture:

I feel like it's very important to maintain practices of your native culture and beliefs. It's inappropriate for an individual to abandon their cultural practices, their religion...You should keep to your cultural roots but you should also respect the American culture because you live in this country (Member #13).

With regards to the recovery experiences of these 10 members with higher VIA *heritage* scores, eight members positively endorsed recovery oriented items on the Recovery Assessment Scale (RAS) and open–ended interview questions, thus supporting the notion that they perceived themselves to be in recovery. The remaining two members reported lower recovery attitudes and experiences in their responses. This was specifically illustrated by the responses from Member #6, who reported that she *has not been able to overcome most setbacks related to her illness* (e.g. "I feel like it has been very difficult for me"), which was further reiterated by her negative responses to RAS items suggesting that she struggles with making decisions about her life and does not perceive to be in control of her illness. Furthermore, Member #6 endorsed items reflecting perceptions that recovery from mental illness was unattainable for various reasons:

No I don't believe that individuals are able to recover from their illness because people are always faced with problems. The devil interferes with peoples' lives and causes issues, difficulties with their families, problems in their marriages with a spouse who doesn't treat them well and life really doesn't become easier or change for the better (Member #6).

A similar theme of acculturation that was hypothesized to intersect with recovery attitudes, also emerged from member narratives who had low identification with American culture and values. Responses related to this particular theme revealed that while most participants expressed admiration and respect toward the American people and their culture, they were reluctant to fully adopt practices and values of the U.S. culture and did not consider themselves to be "Americanized":

"I don't want to be more Americanized because this is not our way of life. That is how they live and it's different than how the Arabs are. They behave more freely, with more freedom than we do" (Member #6).

The overarching premise of this theme was also reflected across the VIA scores of participants, which revealed that only one–third of the sample (n=5) reported engaging in bicultural tendencies of both their heritage, and the mainstream culture (See Table 4). In regards to recovery orientation, these participants endorsed recovery oriented items on the RAS and responses to open –ended questions reflecting adequate recovery and the notion that mental health recovery is possible. Responses from all of these members identified that they have been able to effectively manage most of their symptoms and also described overcoming the majority of setbacks related to their illness. This notion was illustrated by a female clubhouse member who reported that she has "not had a bipolar experience or heard voices or been in the hospital or anything" over this past year (Member #9). Member #11 also described experiencing favorable progress with symptoms of his mental illness:

> I feel like my condition is much better now than what it was before. I feel normal. I'm not as depressed, or hopeless and i don't really experience fluctuations in my mood. In my opinion I feel like my illness does not exist anymore (Member #11).

Thus, across both the heritage culture, and bicultural identification group, participants reported positive attitudes toward recovery with the exception of two members. This analysis was aimed at understanding if the level of acculturation played a role in influencing recovery orientation. From these initial interview questions, participants did not indicate that their endorsement of cultural heritage or identifying themselves as 'less' American appeared to influence their recovery orientation or attitude that recovery is possible.

Table 4

Level of Acculturation and Recovery Orientation of Arab American Clubhouse Members

| Member | VIA | | Recovery Orientation |
	Heritage	Mainstream	
1	Heritage =5	Mainstream =3.5	3.7
2	Heritage =3	Mainstream =3.5	2.8
3	Heritage =4.5	Mainstream =3	3.3
4	Heritage =5	Mainstream =2.5	3.5
5	Heritage =5	Mainstream =2.5	3.8
6	Heritage =5	Mainstream =2	2.2
7	Heritage =5	Mainstream =2.5	4
8	Heritage =5	Mainstream =2	2.5
9	Heritage =4.5	Mainstream =4	3.7
10	Heritage =5	Mainstream =1.5	3.5
11	Heritage =4	Mainstream =3.5	3.5
12	Heritage =4	Mainstream =3.5	3.7
13	Heritage =5	Mainstream =2	3.8
14	Heritage =4.5	Mainstream =4.5	3.8
15	Heritage =5	Mainstream =2	2.8

Note. Heritage sub scores denote level of adherence to values and practices of native Arab culture; Mainstream sub scores reflect level of adherence to American cultural practices and traditions; Elevated recovery orientation scores suggest greater experiences of recovery.

Presence of a Recovery Orientation. Five major sub -themes emerged to support the overarching theme of Arab American members' identification with a positive recovery orientation (attitudes and experiences):

1. Recovery is an individual process that involves active coping strategies (e.g. taking control over illness).

2. Hope is important for recovery.

3. Clubhouse membership facilitates recovery.

4. Role of family network is instrumental for recovery.

5. Emphasis on medication(s), doctors and absence of illness is essential for recovery.

Participants' narratives revealed several overarching themes reflecting their adherence to cultural practices, while also identifying with experiences of recovery often described by consumers of mental health programs from the mainstream culture. For example, themes that were concurrent with many Western recovery oriented processes included the role of "*having family members for good support*" (Member #9), *hope, access to clubhouse through membership/participation and that recovery is "possible"*. This includes the notion of symptom management and taking an active approach to personal mental health recovery, as illustrated by Member #4:

> An individual needs to change their frame of mind. They need to avoid thinking that they have an illness. They need to try and change their life and be with people, go out to places so that they can try and forget that they are sick so that they can recover. If a person keeps thinking about and focusing on their illness then they will remain ill but if a person tries to distract themselves from their illness, then they can recover and feel better (Member #4).

The importance of an active approach for recovery was also identified by Member #7:

> It [recovery] means that a person's actions are more geared towards recovering from their illness. They do things in their life to feel better. They go out and socialize more with others and make a pact with themselves that they want to get better. A person has to want to take control of their recovery (Member #7).

For many members, active coping encompassed a sense of empowerment and taking control over his/her mental illness. This dynamic was discussed by a male clubhouse member, who explained that "...if a person really wants to recover from their illness and they take control of their illness by carrying on with their lives every day, then there may be a greater chance that they will be normal again... (Member #14)." This theme emphasized the importance of staying "strong" and not succumbing to the adverse effects of mental illness in order to facilitate the process of recovery. The following statement from Member #2 further illustrates this phenomena:

> For me, I think that recovery means that I should not be victim to my illness and that I keep my head up high and live the best life possible. A person needs to be strong in order to recover and not be weak during this process (Member #2).

Several members also reflected on their active participation and membership at the clubhouse as being instrumental to their recovery. In particular, participants described how the clubhouse was a place for them to go to (for support) and also provided opportunities to engage in various activities and develop social relationships with others who also suffered from mental illness. Moreover, it was noted that members mostly experienced positive changes in their conditions and reported that their symptoms became less problematic with clubhouse attendance, as indicated by a male clubhouse member with Schizoaffective Disorder:

> "I feel like my condition has become much better since attending the clubhouse –the changes have been positive" (Member #5).

Member #4 also described experiencing favorable changes in his condition as a result of his Clubhouse participation:

> I have felt a significant difference in my condition and how I've been feeling since attending the Clubhouse. The changes have been positive and the Clubhouse has helped me in many ways...I feel like I have been able to manage my illness (Member #4).

In contrast, recovery themes and experiences that were consistent with participants' heritage culture included the role of the *family network, hope,* and a *high emphasis on medication*

and active participation with a medical professional such as a physician and/or psychiatrist. For instance, the family network was reported to be a significant component for enhancing recovery across a number of interviews, specifically in that family members were identified as being primary sources of emotional and instrumental support(s) for clubhouse members. For many members, hope was also described to be an important aspect of being able to "heal" from mental illness and recover. Some examples of these two themes include the following quotes from members:

> "...my son always drives me here (to the clubhouse), picks up my medications and takes me to my doctor appointments" (Member #10).

> "My hope has also helped my recovery" (Member #2).

Another emergent theme that was also congruent with the heritage culture of clubhouse members focused on the notion that recovery was highly dependent on medication(s) and/or treatment from medical professionals. Responses related to this main theme revealed that a large number of participants believed that medication(s) and treatment for mental illness from a psychiatrist or general practitioner facilitated the recovery process (n =11). This notion was illustrated by Member #11, who proclaimed that "Recovery means to take medication(s) and to not have to see the doctor anymore for your illness". These factors were also identified by members as being significant components for their own personal recovery and in part, were also perceived to be associated with a gradual absence of mental illness and a more favorable quality of life. These sentiments were expressed by a female clubhouse member, who indicated that recovery occurs when an individual is "...being treated with medication. If a person does not take medication then they will remain ill and not be able to live a good life" (Member #8). Another member stated:

> It (recovery) means that I have overcome my illness and that I feel better, that I don't need my medications and do not need to see my doctor anymore. When you recover it means

that the difficulties of a persons' illness have ended and that they are now in a much better place in their life. They are able to live freely again (Member #14).

Member #10 also identified medication(s) and treatment(s) from a medical professional as being instrumental for recovery:

> "...I feel that a person can recover from their illness because when you consistently take your medication and see the doctor then you will eventually start to feel better" (Member #10).

Research Question 2: What influence(s), if any, has either the absence or presence of support from family members had on mental health recovery?

The analysis and coding of data examining the influence(s) of family support on members' recovery, resulted in the identification of the following five sub-themes themes to support the overarching theme of *Family Supports Recovery*:

1. Family support is important for recovery (e.g. Instrumental and emotional support(s) mostly provided by immediate family).

2. Reciprocity of family support is part of the recovery process (e.g. Members are also relied on by family members for various things).

3. Relationships with family members improved or stayed the same (e.g. Familial bonds became closer, family care of members increased, no changes in family relations).

4. Physical absence of family negatively affects recovery.

5. Family can sometimes hinder recovery (e.g. Family members struggle with understanding the members' mental illness).

As previously discussed, the vast majority of participants (n=13) identified family support as being instrumental for facilitating recovery. In particular, clubhouse members reported having the most contact and time spent with individuals from their immediate family such as a spouse, parents, (adult) children and/or siblings. Many of these family members were also characterized

as being primary sources of emotional and instrumental support for clubhouse members. For example, participants described having supportive relationships with immediate family members that were emotionally comforting and highly focused on the members' well –being. This notion was illustrated by the following quotes from two female clubhouse members:

> ...Like my family, they are very supportive of me....My stepmother has been through thick and thin with me. She's very supportive of me and my brothers and sisters are too. My sister will call me to check up on me to see if I took my medications (Member #9).

> "My children...frequently call me and provide emotional support over the phone" (Member #2).

Likewise, immediate family members were also noted to be primarily involved with providing instrumental support(s) to participants such as driving them to appointments, picking up their medications and helping with daily living skills:

> "My daughter, who I live with, mostly helps with driving me to my appointments, obtaining my medications and she takes me places like the mall because I don't drive" (Member #3).

> "My parents both usually cook for me and take care of me at home with laundry and those kinds of things..." (Member #5).

Another main theme that emerged from the interviews was the apparent reciprocity of support that occurred between participants and immediate family members during recovery. Specifically, more than half of all clubhouse members (n=8) described having at least one immediate family member who relied on him/her for support and assistance with various responsibilities. Some clubhouse members discussed having younger children who depended on them for the provision of basic needs such as food and shelter, whereas others described having to provide family members with financial support(s) and/or assistance with household tasks:

> "I think that my entire family, my children and husband mostly depend on me for the cooking, cleaning and basic household chores" (Member #7).

> "My father sometimes will rely on me to run some errands for him or to get his medicine and groceries" (Member #11).

Moreover, clubhouse members also reflected on the quality and nature of their relationships with family members throughout the duration of their recovery. For many participants, relationships with family members remained stable and did not change in response to the participants' mental illness (n=10). Improved familial relationships were reported by several participants (n=3), who described experiencing increased connectedness, support and overall better treatment from family members. These sentiments are expressed in the following quotes from two male clubhouse members:

> "I feel like my family has become closer to me because of my illness. They call me often, on a daily basis, to check up on me" (Member #4).

> "They take care of me more now because of my illness and they seem to be more patient with me. Overall, they respect me and are good to me" (Member #5).

Recovery experiences that are impacted by the physical absence of family members also emerged as a major theme among several participants (n=3), whose families resided in various regions of the Middle East. Although participants reported having frequent communication (phone, internet) with family members overseas, the physical absence of family was still identified as being a hindrance to members' personal recovery. Specifically, clubhouse members perceived limitations in the amount of social and instrumental supports that were available to them due to the physical absence of their family network. These circumstances were characterized as being extremely challenging for recovery and in part, contributed to members experiencing feelings of sadness, loneliness and isolation. This is depicted in the following quote of a female participant with major depression, whose entire family lives overseas:

> I believe that recovery...happens when you are surrounded by your family and they help you. When you have your loved ones around you, your mother and children, you are more likely to recover. It is much more difficult to feel better when you are alone and do not have family nearby to support you (Member #8).

Clubhouse Member #6 also reflected on the negative relationship between her recovery and the physical absence of her immediate family:

> Not being with my...children has hindered my recovery. I feel like the doors to my life are closed right now. All of my issues are because I am without my family. If I had them here with me then I would probably feel much better and then I'll recover (Member #6).

While the narratives of most members identified family support as being important for recovery, another emergent theme revealed contradictory effects of the family network on the recovery process. This notion was reiterated by a male clubhouse member who stated that "...sometimes I feel like family could hinder a persons' recovery" (Member #11). For instance, participants revealed that certain members of their family lacked understanding about the nature of the clubhouse members' illness or were completely unaware that the member even suffered from a mental health condition altogether. Similarly, Member #9 reported experiencing challenges in her relationship with her father mainly because he struggled to accept her mental illness:

> "For my dad, it's very hard to see his daughter sick because he's a very hard person to understand what's been going on with me. He doesn't like to see me like this..." (Member #9).

Research Question 3: How, if at all, has recovery been influenced by perceived stigma of the mental illness?

Examination of open–ended questions specific to the effects of mental illness stigma on members' recovery, led to the identification of four emergent sub -themes that characterize the overarching theme of the *Dichotomous Role of Stigma*:

1.) Pervasive stigma of mental illness exists in the Arab culture (e.g. mentally ill persons are perceived to be "majnoon" or crazy and are treated differently).

2.) Recovery is not affected by high perceived stigma of mental illness in the Arab culture.

3.) Dichotomous impact of stigma (e.g. Members did not experience stigma directly but attempted to appear "normal" and intentionally concealed their illness around others).

4.) Dichotomy of stigma and acculturation (e.g. Mainstream culture perceived to be more accepting of mental illness than native Arab culture).

One of the most significant themes that emerged across the majority of members' narratives (n=14) was the pervasive stigma of mental illness that participants reported as existing in their experiences of the Arab culture. In particular, members described the heightened presence of negative stereotypes towards mentally ill persons in the Arab culture, which specifically involved labels such as "majnoon" (crazy) or "abnormal" to describe these individuals. Because of these negative characterizations, it was noted that Arab individuals may tend to be afraid of people with mental illness and thus, distance themselves from being around those who are identified as mentally ill. Moreover, participants reported that individuals with mental illness are often disregarded, exemplified by the description of being viewed as "weak" and often treated negatively by members of the larger Arab community. The following quote from a female clubhouse member illustrates her perception of the pervasive nature of mental illness stigma in her experience with the Arab culture:

> They [Arabs] think that mentally ill people are majnoon and they are usually afraid of them. They distance themselves from those with mental illness and are not really comfortable being around those who are mentally ill. I think it's wrong to think this way because mental illness is something that is very common (Member #2).

Similar perceptions regarding the negative effects of mental illness stigma in the Arab culture were also described by Member #7:

> Arabs do not really help people with mental illness and instead gossip about that person and ridicule or mock him/her because of their illness. It's as if they write off the individual as not having any purpose in life because they are perceived to be crazy and out of touch with reality (Member #7).

Arab American clubhouse members also conveyed frustrations with the perceived prevalence of

mental illness stigma and stigmatic perceptions in the Arab culture, which they regarded as being

unjust and inappropriate. This notion was exemplified by a male participant diagnosed with Major

Depression Disorder:

> Like I said earlier, they think that a person with mental illness is majnoon, that they are a
> shame to the culture or their family...Mental illness is not something to be ashamed of and
> I feel that these perceptions come from individuals who are probably mentally ill
> themselves. I think that Arabs who think like this should be ashamed of themselves. They
> are the ones who are sick and need to see a psychologist, more so than the person with
> mental illness (Member #14).

Despite the pervasive stigma of mental illness reported within the Arab culture, the

overwhelming majority of participants denied experiencing any direct, adverse effects of such

stigma on their own personal recovery (n =11). Analysis of data related to this emergent theme,

involved the examination of responses to open –ended questions regarding members' experiences

of stigma and recovery. Responses to these questions revealed that participants did not experience

any regression or worsening of their mental health condition(s) in response to personal experiences

of mental illness stigma. In particular, members characterized mental illness stigma and the

negative perceptions of others about their illness as dynamics that motivated them "to not give up"

and to keep actively focused on their personal recovery:

> "These perceptions...have not really affected me because I have the motivation to get better
> from my illness. I want to recover. I want to feel better so I don't let that affect me"
> (Member #2).

> "It's [stigma] not really affected me. I hear it in one ear and it goes out the other. Right
> now, I'm just working on myself. I'm just trying to be better and get educated again"
> (Member #9).

Another main theme that was identified from the interviews focused on the dichotomous

impact of mental illness stigma on members' recovery. These narratives revealed that although the

vast majority of participants reported that their recovery had not been directly hindered by stigma,

it was noted that they intentionally engaged in various behaviors and actions to conceal their illness from others. Specifically, more than half of the sample reported that they did not discuss their mental illness with people outside of the Clubhouse and described attempts to appear "normal" due to fears of being judged and viewed negatively by others (n=9). Clubhouse members also described feeling uncomfortable with disclosing their illness and perceived that other individuals would not be sympathetic towards them upon such disclosure. This phenomena is best described by a statement made by Member #13, who suffers from Major Depressive Disorder:

> Well no one really knows about my illness because I don't really outwardly show my depression. I'll go out and do things and try to behave normally. I don't feel comfortable talking about my illness because people will perceive you to be different. They will say things like that person is mentally ill so don't talk to him. Disregard him. Don't listen to him. Those kinds of things (Member #13).

Similar experiences were also described by Member #11 in the following statement:

> No, I don't ever talk about my illness outside of the Clubhouse, amongst my friends or with other Arabs because the Arab community perceives the mentally ill person as majnoon, any individual with mental illness is majnoon. They [Arabs] don't understand that almost every individual goes through difficult times during their life that may lead to depression, sadness or distorted thoughts (Member #11).

Lastly, responses across a number of interviews also described a dichotomy of mental illness stigma and acculturation. Narratives related to this particular theme revealed that a large number of participants had identified the mainstream U.S. culture, as being more accepting of his/her mental illness when compared to their native Arab culture (n =12). For instance, clubhouse members described the American culture as being more accepting, compassionate and sensitive to the needs of an individual with mental illness. In contrast, members did not perceive their own Arab culture to be as accepting of his/her mental illness and characterized the cultural dynamics as being highly judgmental and insensitive towards an individual with mental illness. Evidence of this dichotomy is noted in the following statement by Member #4:

The American/ Western culture would be more accepting of my mental illness because the Americans are more oriented towards the needs of the individual, they are more empathetic and compassionate when it comes to dealing with mentally ill people. It's not that Arabs lack compassion or empathy –it's mostly that the American culture is more open to understanding mental illness (Member #4).

Member #14 also discussed similar perceptions regarding mental illness in the mainstream culture:

The American culture is more accepting. They don't shame or reject the individual with mental illness and they don't label him/her as crazy. They don't get involved with the personal business of others. They don't question why you are seeing a psychologist or why someone is taking medication for their illness. I believe that the American culture is more open –minded and accepting of mental illness (Member #14).

Similarly, one particular member reflected on the challenges of the Arab community with accepting mental illness and attributed this to a lack of awareness and knowledge about such disorders:

We are in a very bad place in the Arab community when it comes to perceptions of mental illness. The Arabs don't have a good understanding of mental illness. There are many people who are mentally ill and suffer from these conditions but yet, there still seems to be a lot of ignorance within this community (Member #5).

Research Question 4: Do gender differences exist in the recovery process among Arab American clubhouse members? If so, what are the differences?

For this particular research question, the narratives of male and female members were analyzed and compared in order to ascertain whether divergent themes emerged in the recovery experiences between the two genders. The following themes emerged in the analysis of gender differences in the recovery of Arab American members:

1. Males perceive outcomes of recovery to be associated with illness severity.

2. Males deliberately attempt to conceal their illness.

3. Recovery of male members is facilitated by active engagement in activities.

4. Hope is important for the recovery of female participants.

5. Religion/God ("Allah") plays a significant role in the recovery process of female members.

Two male members discussed recovery to be strongly associated with illness severity (n=2). These participants reflected on how the trajectory of one's recovery is highly dependent on the nature and severity of his/her mental illness, specifically, that more severe conditions result in less favorable outcomes of recovery. This notion was illustrated by Member #11, who stated that recovery "...largely depends on the severity of one's illness. The severity and type of mental illness varies from one person to the next, so it depends on the illness and how it manifests" (Member #11). Participants also emphasized that individuals with more chronic forms of mental illness experience a diminished quality of life due to the increased amounts of treatment(s) required for their condition:

> I think that it (recovery) depends on the illness that an individual has. Some illnesses are so severe that a person cannot recover from them and cannot live a normal life. There are different types of mental illness –some are strong and some are not as bad. I think that when you have a more severe condition like schizophrenia, which requires a lot of treatment, then a person is not really able to live a good life (Member #5).

Concealing the illness also emerged as a dominant theme among six male clubhouse members. The narratives revealed concerns related to the stigma perceived in the Arab culture toward psychiatric illnesses. Responses emphasized the importance to appear "normal" and without any physical attributes that may expose their mental illness to others. Specifically, these analyses uncovered the discomfort many male members have in openly sharing or discussing their illness with others outside of the Clubhouse, particularly with members of the Arab community. This notion was exemplified by Member #15, who reported that he does not disclose or discuss his illness with others "because they will have the impression of me that I am majnoon. Anything I say will be perceived as being abnormal, majnoon...so I don't even talk about my illness. For the

most part, participants justified engaging in these behaviors due to concerns that stigmatic perceptions of their illness from others could possibly hinder their self-worth and adversely affect their mental health condition, thus worsening their symptoms. The following statement from Member #14 exemplifies this sub-theme:

> I feel that my demeanor and physical appearance does not reflect or give off to others that I suffer from mental illness. I don't look like someone who is mentally ill. I try not to expose my illness to others. It's not something to be ashamed of but I feel like it would not help me feel good about myself (Member #14).

Recovery was also perceived by male participants as an *active process* rather than an attitude or change in perspective (n =4), as compared to female clubhouse members. Being actively engaged in a variety of vocational and social activities signified greater active participation in caring for one's psychological and mental health. For instance, participants emphasized the importance of being involved in daily activities such as socializing with others, running errands, travelling and exercising, as some of the factors enhancing their recovery. These narratives reflected the importance of "doing" rather than simply changing one's mindset. In the absence of engaging in these activities or tasks, members described experiencing adverse effects such as isolation and increased symptoms of depression due to their lack of activity. Thus, mental health recovery for these participants was fairly dependent on keeping themselves consistently occupied, as indicated by Member #4:

> "I want to recover so I keep myself engaged with others. I travel and I try to change my life for the better. I try to go out and go places often to feel better" (Member #4).

The importance of active coping for recovery was also discussed by Member #14:

> I feel like it is up to the individual to help him/herself to recover from their illness and to try and make his/her life better. They should travel, exercise, socialize with others and do things that make them feel better. You can't only rely on the doctors and medications to change your life (Member #14).

In contrast, narratives of female clubhouse members emphasized the importance of relying on a higher power and hope for facilitating recovery (n=4). Specifically, some female members described "Allah" (God) as essential to their recovery. For example, one female member reported "...that God has recovered me from all my illnesses..." (Member #9). Religion was also characterized as instrumental for managing symptoms of the mental illness and assisting female members with the process of healing:

> "Allah (God) has also helped me deal with this illness. I always pray to Allah to help me heal" (Member #6).

> "My religion and my belief in God has helped my recovery....I feel better particularly when I pray and read the Quran" (Member #7).

Female participants also impressed upon the importance of a positive perspective by maintaining a sense of hope, which appeared to serve as a way to manage the effects of their illness. These members discussed the importance of "hope" in facilitating recovery. For example, members' responses emphasized the critical presence of hope, and perceived that in the absence of hope, one may not potentially experience recovery:

> I believe that recovery ultimately depends on the individual and how they approach their illness. If they want to cry and be depressed and not be hopeful, then they won't recover. But if a person wants to be happy and positive about recovering, then maybe he/she will get better (Member #7).

Hope also intersected with a reliance on religion, as illustrated by Member #3, who stated that "If an individual has the...hope to recover then they will. Religion also makes a person feel hopeful and you have to believe that God will help you heal...".

CHAPTER 4 DISCUSSION

For many individuals suffering from serious mental illness, the road to recovery is often characterized as an arduous, ongoing journey that is typically influenced by numerous factors that can either hinder or facilitate this process (Markowitz et al., 2011). In particular, researchers propose that recovery involves dynamic interactions between various elements such as the characteristics of an individual and community that occur within society (Onken et al., 2007). This notion suggests that mental health recovery is best examined within an ecological framework, given that recovery is highly influenced by the exchanges between individuals and various environmental influences. However, much of the recovery literature is based on research that has primarily focused on the recovery experiences of mental health consumers from the mainstream culture. Very few studies have examined the recovery of individuals from various ethnic groups in the U.S. such as Arab Americans. As a result, very little is known about the recovery experiences of Arab Americans with serious mental illness, particularly those who receive treatment(s) and support from psychosocial rehabilitation programs such as clubhouses. Research suggests that because of this notable gap in the recovery literature, many clinicians are limited in their knowledge of Arab Americans' mental health needs and in part, may experience challenges with providing this growing ethnic group with culturally appropriate services and care (Nassar-McMillan & Hakim –Larson, 2003). Therefore, it is imperative to examine the recovery of Arab Americans within an ecological framework in order to specifically identify their mental health needs.

Overall, the findings from this qualitative study revealed several major themes in the recovery experiences of Arab American clubhouse members with serious mental illness. In particular, themes that emerged in relation to acculturation and recovery suggested that participants

identified recovery -oriented experiences that were specific to both their native culture, and also the mainstream culture, independent of their adopted acculturation strategy. Additionally, family support was identified as being instrumental to the recovery of the sample of clubhouse members, whereas the stigma of mental illness, although reported as highly pervasive in the Arab culture (Youssef & Deane, 2006), appeared to not directly hinder members' experiences of recovery in this study. Lastly, gender differences emerged in the recovery experiences between men and women. The following sections will discuss these findings, as well as limitations of the study, implications, and future research.

Acculturation and Recovery

Several themes emerged in the examination of narratives related to acculturation and recovery of Arab American clubhouse members. First, acculturation data suggested that the majority of clubhouse members primarily adhered to practices and traditions of their native Arab culture. Similarly, low identification with practices and values of the mainstream culture was also indicated by the vast majority of participants, with the exception of a small number of members who endorsed items indicative of adherence to customs/traditions of both the mainstream, and heritage (Arab) culture, which is often referred to as bicultural orientation (Berry, 1997). Of particular interest was that no one from the sample had endorsed items that suggested full assimilation into the U.S. culture. Overall, recovery –oriented items were endorsed among the majority of members who both solely adhered to practices of their heritage culture, and also by members who reported adopting bicultural strategies of acculturation. In contrast, items reflecting lower recovery experiences were endorsed by only two clubhouse members who reported solely adhering to practices of their heritage culture. These findings may suggest that recovery is experienced across various levels of acculturation, and maintaining adherence to one's native

culture does not contradict notions that recovery can occur. The current research findings are also reflective of studies demonstrating that maintaining practices of one's heritage culture appears to serve as a buffer against exacerbating psychiatric symptoms (Torres, 2010). Further, there is some emerging evidence that bicultural orientation was associated with clubhouse members discussing greater recovery experiences, which is an area warranted for further study. In contrast, two clubhouse members who were immersed within their Arab native culture reported lower recovery experiences, which is also an area worth exploring in future research. Overall, the aforementioned findings propose that acculturation may or may not be a dynamic element in the process of recovery and thus, should be closely examined when examining recovery in ethnic groups.

An in-depth analysis of participants' narratives revealed recovery experiences reflecting both the Western culture, and their native Arab culture. First, similar to Western recovery narratives, clubhouse members characterized recovery as being an *individual process* involving *active coping* strategies. This particular theme reflected a sense of empowerment among Arab American consumers, who identified the importance of taking control over their mental illness by actively coping (i.e. socializing with others, maintaining positive thoughts, "staying strong") with the adverse effects of mental illness. These findings have also been identified throughout much of the mainstream recovery literature, where studies have found that greater recovery was positively associated with consumers' orientation toward empowerment over his/her mental illness (Corrigan, Giffort, Rashid, Leary & Okeke, 1999; Ralph, 2000). Thus, for Arab American members in this study, active coping and empowerment served to facilitate the process of their recovery from serious mental illness. This finding was also especially pervasive among male clubhouse members as compared to females.

Second, Arab American consumers believed hope was important and made recovery *possible*. The element of hope has also been depicted as a fundamental component for recovery experiences among consumers from the mainstream culture (Deegan, 1988; Mead & Copeland, 2000; Onken et al., 2007) SAMHSA, 2006). For Arab American members in this study, hope appeared to provide optimism that they would overcome challenges related to their mental illness and in part, achieve favorable outcomes in their recovery. Overall, hope is characterized as an important feature that appears to exist beyond mainstream experiences of recovery.

Third, clubhouse membership was also illustrated by Arab American members as being instrumental to their recovery, which is another theme that seemingly coincides with Western recovery –oriented experiences (Mowbray et al., 2006; Tanaka & Davidson, 2015). The identification of clubhouse as being a central aspect to Arab Americans' recovery was not surprising, given that almost all participants regularly attended the recruited clubhouse several times per week and reported experiencing positive changes in their symptoms/ illness with clubhouse attendance. For many members, the clubhouse was a place for them to be during the day, in addition to also providing members with support(s) and opportunities to foster social relationships. Similar clubhouse experiences were noted in prior research, which also revealed positive effects of clubhouse membership and participation on the recovery experiences of individuals with serious mental illness (Carolan et al., 2011).

Another emergent theme involved the role of family support on clubhouse members' recovery. Specifically, Arab American members identified immediate family members as being primary sources of emotional and instrumental support(s). These familial relationships were characterized by participants as being pivotal for facilitating their recovery and also involved reciprocity of support, where participants were also relied on for support by family members. The

significance of family support on members' recovery experiences will be further discussed in latter sections.

Lastly, nearly all clubhouse members interviewed in this study discussed the importance of medications and treatment from medical professionals as important to their recovery. Recovery appeared to be highly contingent on medications and receiving reliable and consistent care from professionals in the medical community. This specific theme appeared to reflect recovery experiences congruent with the members' native culture (Al -Krenawi & Graham, 2000; El -Islam, 2008), given that westernized consumer narratives of recovery place less emphasis on the need for medication(s) and on being cured from mental illness (Davidson, et al., 2010; Deegan, 1993; Walsh, 1996). Conversely, recovery experiences of Arab American consumers in this study appeared to be highly based on the medical model of treatment for disorders and less focused on recovery as a life –long process. This notion coincides with prior research literature indicating that Arab individuals with mental illness typically expect to be 'cured' of their symptoms with medicinal treatment(s) and without having to divulge many details about their personal difficulties or lives (Al -Krenawi & Graham, 2000; Hakim -Larson et al., 2007). Thus, the aforementioned findings suggest that mental health services for Arab individuals should encompass aspects of the medical model, given that medical treatment(s) are perceived to be instrumental to their recovery.

Family Support and Recovery

One of the main overarching themes that emerged among most members was a high emphasis on the role of the family network for support during the process of recovery. As previously mentioned, findings revealed that support from family members was identified as being instrumental for facilitating the recovery of most participants. This was mainly reflected in the fact that immediate family members were described as being the primary sources of instrumental and

emotional support(s) for the vast majority of clubhouse members. Participants characterized their familial relationships as being closer because of his/her mental illness and involved an element of reciprocity in support(s), where participants were also relied on by family members for assistance with various things. These themes coincide with the findings of previously discussed research, which also identified family support and perceived reciprocity of support(s) as being related to greater recovery for mental health consumers (Pernice –Duca, 2010; Topor et al., 2006). For consumers who perceive themselves to be equally involved in supportive relationships with family members, it is proposed that they may be more willing to rely on, and receive assistance from family members for their illness, which subsequently contributes to favorable outcomes of recovery (Pernice –Duca, 2010).

Evidence of the importance of family support and reciprocity of support on Arab Americans' recovery was not surprising in this study, given that prior research has shown that the Arab family plays a critical role in the primary care of family members with mental illness (El-Islam, 2008; Okasha, 2003). In particular, researchers suggest that the family network in the Arab culture "is the main social institution that...contributes much more than the Western family to mental development, illness behavior, illness pattern and illness management" (Okasha, 2003, p. 42) of its' family members. This dynamic is largely attributed to the fact that the Arab culture is one that emphasizes collectivism and interdependence between individuals within a family network, which focuses on maintaining cohesive functioning of the family unit as a whole. Within the context of mental health recovery, it appears that the role of the Arab family is an intricate component of this process. This notion was further reiterated in the findings of the present study, in that the physical absence of immediate family also appeared to negatively affect consumers' recovery. In regards to this particular theme, several members identified experiencing significant

challenges to their recovery due to circumstances where all of their immediate family lived overseas and thus, were not able to provide participants with tangible supports to assist with their recovery.

In contrast, findings revealed that family members could also hinder the recovery of Arab American clubhouse members. Responses related to this particular theme demonstrated that participants were negatively affected by family members who lacked understanding and limited knowledge about their mental illness. For example, one female member reported that her recovery was initially hindered by her family's limited awareness about the nature of her illness or as she stated, they "didn't understand what was going on with me or what I was going through" (Member #9). This dynamic was also illustrated in a previously mentioned study, which discovered that relatives often unintentionally impede the recovery of an ill family member through misunderstandings and insufficient knowledge about mental illness and the process of recovery (EnglandKennedy & Horton, 2011). Thus, when family members lack awareness and understanding of a relatives' mental illness, they may unknowingly behave in ways that can heighten stress and exposure to adverse events for the ill family member, all of which can potentially hinder recovery.

Stigma of Mental Illness and Recovery

Several themes emerged from examining the impact of mental illness stigma on the recovery of Arab American clubhouse members. One major theme in particular, revealed that stigma of mental illness is purported to be highly pervasive in the Arab culture. Specifically, it was noted that mentally ill persons may often be treated negatively and are typically characterized as being "majnoon" (crazy) or "abnormal" in the Arab culture. This identified theme was also reiterated in the findings of a previously mentioned study, which found that 97% of Arab

individuals associated mental illness with being "majnoon" (Yousef & Deane, 2006). Despite the high cultural prevalence of stigma that purportedly exists, the majority of Arab American consumers in this study reported that their personal recovery was not directly hindered or adversely affected by the stigma of mental illness. One possible explanation for this could be attributed to the fact that participants were all receiving mental health services and treatment(s) (at the clubhouse) and were in the process of recovery themselves, which may have helped buffer the adverse effects of stigma related to their mental illness. In contrast to previous research findings (Tobin, 2000; Yousef & Deane, 2006), stigma of mental illness did not appear to hinder the utilization of mental health services for Arab consumers in this study, which in part, may contribute to greater recovery.

Another theme illustrated that while stigma was not identified as being a barrier to Arab Americans' recovery in this study, it was revealed that several members consciously engaged in behaviors and actions that were geared towards hiding their illness and appearing to be "normal" around others. In essence, participants appeared to exhibit dichotomous effects of mental illness stigma in that they specifically denied experiencing stigmatic barriers on their recovery, but yet, they engaged in purposeful behaviors to conceal their mental illness given the pervasive stigma in the Arab culture. Consequently, these behaviors may have limited members' exposure to stigmatic reactions and events from others in the Arab community and may have facilitated recovery. Similar findings were also revealed in prior research, which found that mental health consumers from the mainstream culture also engaged in conscious strategies to blend in and appear "normal" (Walsh, 1996; Whitley & Campbell, 2014). Researchers proposed that these behaviors reflected elements of active recovery.

Lastly, the narratives of Arab American consumers identified recovery experiences that encompassed a dichotomy between mental illness stigma and acculturation, which is an area that warrants further study. Narratives related to this specific theme indicated that the vast majority of participants perceived the U.S. mainstream culture to be more accepting and compassionate towards mentally ill individuals when compared to their native Arab culture. This particular finding was interesting given that not a single clubhouse member in this study had (willingly) assimilated into the U.S. culture, as previously indicated. Moreover, members' perceptions of greater mental illness acceptance among their U.S. counterparts could possibly be explained by the pervasive stigma of mental illness that reportedly exists in their native Arab culture (Aldhalimi & Sheldon, 2012).

Gender Differences and Recovery

Several gender differences were identified in the recovery experiences between male and female clubhouse members. Common themes that emerged primarily among male participants were that recovery outcomes were associated with illness severity, recovery was associated with active engagement in activities and that males reported conscious attempts to conceal their mental illness. Conversely, female clubhouse members identified factors such as hope and religion/God as being instrumental for their recovery.

First, several male members revealed perceptions that recovery outcomes were highly dependent on the nature of an individuals' mental illness, specifically in that more severe conditions such as schizophrenia resulted in less favorable outcomes of recovery. In regards to this particular theme, male members appeared to polarize recovery from mental illness and did not appear to view recovery as a process. Conversely, the narratives of female participants did appear to illustrate recovery as a process, which for them, was facilitated by hope that recovery is possible.

Moreover, female members indicated that hope enhanced their ability to manage the effects of their mental illness. Of particular interest is that the element of hope has previously been identified as one of the fundamental components of recovery, by both SAMHSA, and prior research findings (Jacobson & Greenley, 2001; Ridgway, 2001). For many individuals in recovery, hope is a critical aspect that often incites action(s) towards overcoming challenges related to one's mental illness (Onken et al., 2007).

Another identified theme that was also illustrated in the findings of a previously discussed study (Brown, 2008), was that active engagement in activities or "doing something" was deemed important by male members for managing their illness and recovery. Specifically, male clubhouse members impressed upon the need to constantly be active by going out and engaging in various activities either alone, or with other people. Male participants reported improvements in their symptoms when they were able to keep themselves occupied with meaningful activities, which also appeared to provide them with a sense of purpose in their lives during recovery. In contrast, female participants appeared to identify religion as an activity that they consistently engaged in such as praying to "Allah" (God), which helped facilitate their recovery. However, religion was not identified by any male clubhouse members as being important for their recovery.

Lastly, male participants emphasized the need to actively conceal their mental illness from others, whereas female participants characterized themselves as being more open about their illness. As previously discussed, male members discussed being uncomfortable with openly disclosing their mental illness and expressed a desire to appear "normal" around others outside of the clubhouse setting. On the other hand, many female participants reported feeling comfortable with identifying that they were mentally ill and openly discussed their illness and treatment(s) with others. For male participants, this theme reflected their need to be in control of their illness because

exposing their condition to others would purportedly hinder their recovery, which coincides with prior research discussed in Chapter 1 (Schon, 2010). The identification of this theme was surprising given that prior research has demonstrated that gender inequalities exist mostly for females with mental illness in the Arab culture. As previously discussed, research suggests that it is unconventional for Arab females to openly discuss having mental illness in traditional Arab societies, given that stigma of mental illness detrimentally impacts Arab females more so than Arab males (Youssef & Deane, 2006; Hassouneh & Kulwicki, 2009). However, the findings of the current study revealed contradictory effects, where Arab males reported more stigmatizing concerns with concealing their mental illness when compared to Arab females.

Strengths and Limitations

One of the main strengths of the current study was that almost all interviews with clubhouse members were conducted in their native Arabic language by the Principal Investigator. This aspect was extremely beneficial for enhancing rapport, obtaining accurate responses from participants and sustained the flow of communication during the interviews, all of which would have been somewhat difficult to accomplish with the use of a translator. Another inherent strength to this study was that all interviews were conducted at the clubhouse, which provided members with a familiar setting that they were comfortable in and that also focused on their recovery. Additionally, acquiring recovery data through qualitative interviews was also a strength of this study. In particular, the ability to observe participants' body language, facial expressions and emotionality during the interview process provided a deeper understanding and insight into the meanings of their responses and lived recovery experiences.

A limitation of the study is the interview process, since it may be difficult to ascertain whether the responses of some members were intended to create a more favorable image of

themselves during the interview. However, many of the participants were candid about their experiences given that the Interviewer provided participants time to reflect and answer questions in a honest manner. Further, simply being a member of the clubhouse may have enhanced participants' knowledge about the experiences of recovery. Future studies may compare responses of ethnic clubhouse members and non-clubhouse members. Given that the working community of the clubhouse espouses the goals of recovery through its' daily work-ordered day methodology, it is quite likely that participants, independent of their level of acculturation, internalized such messages. This again will be advantageous to examine in future studies using a larger sample and quantitative methodology.

Recruitment of Arab American participants for this study may have also served as a possible limitation. Participants were not randomly selected for the interviews and were recruited from only one clubhouse location, which was specifically selected because of its' large Arab American membership. These factors, in addition to the small sample size of participants, pose challenges with generalizing the findings of this study to other Arab American (clubhouse) populations in the United States. However, the purpose of this study was not to generalize to other clubhouses or Arab American consumers, but to examine participants' experiences of recovery. Lastly, another limitation inherent to this study involved the lack of a comparison sample, or a group of clubhouse members of a different ethnicity or race. By having a comparison group in this study, one could have easily identified specific similarities and differences of Arab Americans' recovery when compared to the recovery experiences of other ethnic groups.

Conclusions and Directions for Future Research

The findings from this study provided significant insights into the recovery experiences of Arab American clubhouse members with serious mental illness. Factors such as family support,

stigma of mental illness, acculturation and gender differences were all identified as being part of Arab Americans' recovery experiences when examined within an ecological framework. Overall, identified themes revealed that Arab Americans' recovery experiences were both congruent, and divergent from recovery –oriented processes that have been documented in westernized research studies.

Of particular interest in this study, was the overarching theme suggesting that recovery for Arab American consumers was mainly associated with principles of the medical model that emphasize an absence of illness and reverting to premorbid levels of functioning (Bellack, 2006). Conversely, this notion of recovery differs significantly from that identified by the recent Mental Health Consumer movement, which conceptualizes recovery as being more process –oriented and less focused on being cured from serious mental illness (Deegan, 1993; Walsh, 1996). This finding reflects differences in recovery experiences among Arab consumers and may assist clinicians with the provision of culturally congruent services and care to individuals from this ethnic group. Because of such differences, future research should continue to focus on identifying culture – specific factors that influence recovery of various ethnic groups in order to better understand their mental health needs.

Given the significance of the family network in the Arab culture, future recovery research should also include perceptions of family members regarding the recovery experiences of relatives with serious mental illness. Furthermore, with the increased migration of Arab individuals with mental health disorders from the Middle East, ongoing, future research examining the recovery experiences of this ethnic group is clearly warranted and would greatly contribute to the research literature.

APPENDIX A

HIC APPROVAL

WAYNE STATE UNIVERSITY

IRB Administration Office
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Detroit, Michigan 48201
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http://irb.wayne.edu

NOTICE OF EXPEDITED APPROVAL

To: Layla Habhab
College of Education

From: Dr. Deborah Ellis or designee _C. Zolondek / 2-2_
Chairperson, Behavioral Institutional Review Board (B3)

Date: September 29, 2015

RE: **IRB #:** 083415B3E

Protocol Title: Recovery Experiences amongst Arab American Clubhouse Members: Examining the Effects of Acculturation, Perceived Family Support, Stigma and Gender on Mental Health Recovery

Funding Source:

Protocol #: 1508014258

Expiration Date: September 28, 2016

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

The above-referenced protocol and items listed below (if applicable) were **APPROVED** following *Expedited Review* Category (#5 #6 #7)* by the Chairperson/designee *for* the Wayne State University Institutional Review Board (B3) for the period of 09/29/2015 through 09/28/2016. This approval does not replace any departmental or other approvals that may be required.

- Revised Protocol Summary Form (revision received in the IRB office 09/28/15)
- Revised Research Protocol (received in the IRB office 09/28/15)
- Medical records are not being accessed therefore HIPPA does not apply
- Research Informed Consent - English & Arabic Versions (revision dated 09/28/2015)
- Data Collection Tool: Questionnaire

° 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

APPENDIX B

INFORMED CONSENT

Recovery Experiences Amongst Arab American Clubhouse Members

Research Informed Consent

Title of Study: *Recovery Experiences amongst Arab American Clubhouse Members: Examining the Effects of Acculturation, Perceived Family Support, Stigma and Gender on Mental Health Recovery*

Principal Investigator (PI): *Layla Habhab*
College of Education
586-918-5050

Purpose

You are being asked to be in a research study of the recovery experiences among Arab American clubhouse members because you are identified as being a clubhouse member of Arab American descent. This study is being conducted by Wayne State University at the Behavioral Health Network Clubhouse in Detroit, Michigan. The estimated number of study participants to be enrolled for the Wayne State study is about 15. **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 influence(s) of perceived family support, stigma of mental illness, acculturation and gender on recovery from mental illness. The obtained information from this study will help us learn more about the process of recovery and mental health needs of Arab American clubhouse members with serious mental illness.

Study Procedures

If you agree to take part in this research study, you will be asked to participate in an audio-recorded 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 room at the Clubhouse. The interview questions will be personal and will ask about your clubhouse participation, family support, perceptions of mental illness stigma, attitudes toward recovery from mental illness and your cultural practices and beliefs (acculturation). You have the option to not answer certain questions and still participate in the study. In order to protect your identity, your name and any identifying information will remain anonymous and will not be connected to your interview. With your consent, information about your medical diagnosis will be obtained from your medical records. This will allow us to better understand your recovery experiences in relation to your illness. No documents or files will be removed from your medical records at any time during this process.

Benefits
As a participant in this research study, there may 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:
- *Emotional risks:* You may possibly experience mild emotional distress in response to answering certain questions for the study (i.e., feelings of sadness, anxiety). If

Recovery Experiences Amongst Arab American Clubhouse Members

this should occur during the interview, you are able to stop the interview at any time.

o *Social risks:* You may experience a possible breach of confidentiality since there will be a recording of your interview. In order to minimize the potential for this risk, your name and identity will not be connected to your interview. The recording of your interview will be stored in a secure location and will then be immediately destroyed after it is transcribed. All transcribed data will exclude any information that could identify you. Your name will not be shared with anyone and you will be identified in the research data by a study code that is unrelated to any of your personal information.

The following information must be released/reported to the appropriate authorities if at any time during the study there is concern that:

o you disclose illegal criminal activities, illegal substance abuse or violence

There may also be risks involved from taking part in this study that are not known to researchers at this time.

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.

If 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. All names and identifying information will be deleted from all transcripts. You will be identified by a specific ID number in the research records that will not be related to any of your identifying information. Your personal information will not be released without your written permission. The PI will have sole access to all audio-recorded information and you will have the right to review the audio recording of your interview.

Voluntary Participation/Withdrawal

Taking part in this study is voluntary. You have the right to choose not to take part in this study. If

Recovery Experiences Amongst Arab American Clubhouse Members

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 *Layla Habhab* at the following phone number *586-918-5050*. 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.

Recovery Experiences Amongst Arab American Clubhouse Members

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 witness**   Date

_____   _____
Printed of witness**   Time

_____   _____
Signature of person obtaining consent   Date

_____   _____
Printed name of person obtaining consent   Time

*Remove LAR reference if you don't intend to consent participants that have or may have a LAR.

**Use when participant has had this consent form read to them (i.e., illiterate, legally blind, translated into foreign language).

APPROVAL PERIOD

SEP 29 '15   SEP 28 '16

WAYNE STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

_____   _____
Signature of translator   Date

_____   _____
Printed name of translator   Time

خبرات الشفاء بين أعضاء نادي العرب الأمريكيين

موافقة مستنيرة على بحث

عنوان البحث: تجارب الشفاء بين أعضاء نادي العرب الأمريكيين: فحص أثر التبادل الثقافي والدعم العائلي المتوقع، والجنس (ذكر أو أنثى) والشعور بالعار على تعافي الصحة العقلية

الباحث الرئيسي (PI):

ليلى حبيب
كلية التربية
586-918-5050

الهدف

يطلب منك أن تشترك في دراسة عن تجارب الشفاء بين أعضاء نادي العرب الأمريكيين لكونك عضوا في النادي من أصول عربية. تجري هذه الدراسة من قبل جامعة واين ستايت في نادي شبكة الصحة السلوكية في مدينة ديترويت في ميتشيجان. العدد المقدّر للمشتركين الذين سيسجلوا في الدراسة التي تجريها جامعة واين ستايت هو حوالي 15 من جميع أنحاء الولايات المتحدة. **يُرجى قراءة هذا النموذج وطرح أي أسئلة قد تخطر لك قبل الموافقة على الاشتراك بهذا الدراسة.**

في هذه الدراسة البحثية، سنفحص تأثير(ات) الدعم العائلي المتوقع والشعور بالعار من الأمراض العقلية والتبادل الثقافي والجنس على الشفاء من الأمراض العقلية. ستساعدنا المعلومات المستقاة من هذه الدراسة على فهم أوسع لعملية الشفاء واحتياجات الصحة العقلية لأعضاء النادي من العرب الأمريكيين المصابين بأمراض عقلية خطيرة.

إجراءات الدراسة

في حال موافقتك على الاشتراك بهذه الدراسة البحثية، سيطلب منك أن تُجرى معك مقابلة مسجلة صوتيا تستغرق بين 60 إلى 90 دقيقة. سيتم الإتصال بك من قبل شخص مدرب لترتيب وقت محدد للمقابلة. ستجري المقابلة شخصيا مع هذا الشخص في غرفة هادئة في مبنى النادي. ستكون أسئلة المقابلة شخصية وسُنسأل عن اشتراكك بالنادي والدعم العائلي ومفهومك للمرض العقلي والشعور بالعار وموقفك من الشفاء من المرض العقلي وممارساتك الثقافية الإجتماعية واعتقاداتك (تبادل الثقافات). سيكون لديك الخيار بعدم الإجابة على أسئلة معينة ولكن ستبقى مشتركا بالدراسة. من أجل حماية هويتك سيبقى إسمك وأي معلومات تعريفية عنك سرية ولن تقترن بمقابلتك. وبموافقة منك، سيتم الحصول على معلومات تتعلق بتشخيصات طبية عنك من سجلاتك الطبية. وهذا سيتيح لنا فهم أوضح لتجاربك في المعافاة بما يتعلق بمرضك. لن تزال أي وثائق أو ملفات من سجلاتك الطبية في أي وقت خلال هذه العملية.

الفوائد

كمشترك في هذه الدراسة البحثية، قد لا يكون هناك فائدة مباشرة لك؛ مع ذلك، فالمعلومات المستقاة من هذه الدراسة قد تفيد أشخاصا آخرين حاليا أو في المستقبل.

المخاطر

خبرات الشفاء بين أعضاء نادي العرب الأمريكيين

باشتراكك في هذه الدراسة، قد تتعرض للمخاطر التالية:

o **مخاطر عاطفية**: من المحتمل أن تتعرض إلى ضيق عاطفي معتدل عبر إجابتك على بعض أسئلة الدراسة (مثال، شعور بالحزن والقلق). في حال حصول مثل هذا الأمر، يمكنك إيقاف المقابلة في أي وقت تشاء.

المخاطر الإجتماعية: قد تتعرض إلى اختراق ممكن للسرية بسبب تسجيل المقابلة. من أجل التقليل من احتمال حصول مثل هذه المخاطرة، لن يربط إسمك وشخصيتك بمقابلتك هذه. وسيحفظ تسجيل المقابلة في موقع مؤمن ويتم تدميره بعد نقل محتوياته كتابيا. لن تشمل أي تسجيلات منقولة كتابيا أي معلومات قد تعرف عن شخصيتك. لن نعطي إسمك لأي كان وسيتم التعريف بك في أي معلومات بحثية برمز دراسي ليس له أي علاقة بأي معلومات شخصية تخصك.

المعلومات التالية يجب التصريح/الإبلاغ عنها إلى الجهات المختصة أثناء إجراء هذه الدراسة في حال وجود أمر مثل:

o صرحت بارتكابك أعمالا إجرامية أو تعاطي غير قانوني للمخدرات أو

إحتمال وجود مخاطر كامنة من الاشتراك بهذه الدراسة لم تكن معروفة سابقا من قبل الباحثين.

تكاليف الدراسة
الاشتراك بهذه الدراسة لن يكلفك شيئا.

التعويض
لن يدفع لك مقابل اشتراكك بهذه الدراسة.

السرية

جميع المعلومات التي تُجمع خلال مدة هذه الدراسة ستحفظ تحت السرية للمدة التي يتطلبها القانون. سيُعرّف شخصك في هذا البحث تحت إسم مشفّر أو برقم. لن يصرّح بأي معلومات تدل على شخصك بدون إذن مكتوب منك. مع ذلك فإن راعي هذا البحث وهو مجلس المراجعة المؤسسي (IRB) في جامعة وين ستيت أو الوكالات الفيدرالية والتي لها إشراف قانوني مناسب [مثال، إدارة الدواء والطعام (FDA)، مكتب حماية الأبحاث البشرية (OHRP)، مكتب الحقوق المدنية (OCR)، ...الخ] قد تقوم بمراجعة سجلاتك.

عندما تكشف أو تناقش نتائج هذا البحث في المؤتمرات، لن يشمل هذا أي معلومات تفشي بهويتك.

في حال استعمال تسجيل صوتي لك لأهداف بحثية أو تدريسية، سيتم إخفاء هويتك أو تمويهها. سيتم تدمير جميع التسجيلات الصوتية فور تدوين المعلومات التي تحتويها. جميع الأسماء والمعلومات المعرّفة سيتم حذفها من جميع المدونات. سيتم تعريفك برقم هوية محدد في سجلات البحث بحيث لن يشير هذا إلى أي معلومات تدل عليك. لن يُصرّح بأي معلومات بدون إذن مكتوب منك. سيكون الباحث الرئيسي (PI) هو الوحيد المخوّل بالوصول إلى المعلومات المسجلة صوتيا. لك أنت الحق بمراجعة التسجيل الصوتي للمقابلة.

الاشتراك/الإنسحاب الطوعي

خبرات الشفاء بين أعضاء نادي العرب الأمريكيين

الاشتراك في هذه الدراسة طوعي. لك الحق في عدم الاشتراك في هذه الدراسة. إن قررت أن تشترك في هذه الدراسة تستطيع أن تغير رأيك لاحقا وتنسحب من الدراسة. لك الحق في الإجابة على الأسئلة التي تختار أن تجيب عليها. لك الحرية في الإنسحاب من الاشتراك بهذه الدراسة في أي وقت. قراراتك لن تغير علاقتك الحالية أو المستقبلية مع جامعة وين ستيت أو شركائها أو أي خدماتٍ لك الحق في تلقيها.

يحق للباحث الرئيسي أن يفصلك عن هذه الدراسة بدون موافقة منك. سيتخذ الباحث الرئيسي قراره ويعلمك إن كانت هناك ضرورة لعدم استمرارك. القرار الذي سيتخذ هو لحماية صحتك أو سلامتك أو لأنك لم تتبع التعليمات الواجبة لتكون جزءا من هذه الدراسة.

أسئلة

إن كان لديك أي أسئلة عن هذه الدراسة الآن أو في المستقبل، بإمكانك الإتصال بـ*ليلى* حبحب على رقم الهاتف التالي *586-918-5050*. إن كان لديك أسئلة أو مخاوف حول حقوقك كمشترك في هذا البحث، بإمكانك الإتصال برئاسة مجلس المراجعة المؤسساتي على الرقم 1628-577 (313). إن لم تتمكن من الإتصال بموظفي البحث أو إن أردت التحدث مع غير موظفي البحث، بإمكانك الإتصال أيضا بداعم مواضيع الأبحاث في جامعة وين ستيت على الرقم 1628-577 (313) لبحث المشكلة أو الحصول على معلومات أو لكي تدلي برأيك.

خبرات الشفاء بين أعضاء نادي العرب الأمريكيين

الموافقة على الاشتراك بدراسة بحثية

من أجل الموافقة طوعيا على الاشتراك بهذه الدراسة، عليك أن توقّع على السطر أدناه. إن اخترت الاشتراك في هذه الدراسة يمكنك أيضا الإنسحاب في أي وقت. بتوقيعك على هذا النموذج، فأنت لا تتخلى عن أي من حقوقك القانونية. إن توقيعك أدناه يدل على أنك قرأت كامل نموذج الموافقة أو تمت قراءته لك، بما في ذلك محتواه من الفوائد والمخاطر، وبأن جميع أسئلتك قد تمت الإجابة عنها. ستعطى نسخة عن نموذج الموافقة هذا.

_____ بتاريخ	توقيع المشترك
_____ الوقت	كتابة إسم المشترك
_____ بتاريخ	توقيع الشاهد**
_____ الوقت	كتابة إسم الشاهد**
_____ بتاريخ	توقيع الشخص الذي حصل على الموافقة
_____ الوقت	كتابة إسم الشخص الذي حصل على الموافقة

*قم بإزالة أي إشارة إلى ممثل مفوّض قانونيا (LAR) إذا لم تنوي طلب الموافقة من المشتركين الذين قد يكون لديهم أو لديهم بالفعل ممثل مفوّض قانونيا.

**استعملها فقط إن تمت قراءة نموذج الموافقة للمشترك (مثال، أمّي، قانونيا مصنّف أعمى، مترجم من لغة أجنبية).

صفحة 4 من 4

حروف الإسم الأولى للمشترك _____
تاريخ النموذج 04/2015

تاريخ التقديم/المراجعة: 2015/28/9
رقم إصدار البروتوكول: 2

APPENDIX C

INSTRUMENT

Q.1   INTRODUCTION

Thank you for allowing me the time to speak with you today. I am honored to talk with you about your experience(s) at the clubhouse and to learn more about your overall journey throughout this process. The purpose of this interview is to enhance our understanding of how one's recovery may be influenced by various factors such as the level of family support, stigma of mental illness, gender, and acculturation into the mainstream (U.S.) culture.

I will be recording our conversation to make sure that I do not miss anything. Please be assured that all information you provide me with today is confidential and therefore, will not be shared with anyone at the clubhouse or with other services that you may be currently receiving. No one else will hear the recording. Once the study is completed, the recording of this interview will be erased. This recording will not include your name or any identifying information about you so that no one will know who you are. *Please let me know if you would like the recording to be turned off at any time and for any given reason during the interview.*

Q.2   Do you have any questions?

Q.3   O.k. then, let's get started…

[ICEBREAKER]

Q.4   I'm going to ask some questions about you and things you like to do in your spare time. How do you like to spend your time when you are not at the Clubhouse? What are some of the things you like to do in your spare time?

Now I am going to ask you about how you spend your time at the Clubhouse.

CLUBHOUSE PARTICIPATION

Q.5   When did you join the Clubhouse?

Month _____ Year _____

Q.6   How often do you come? How many days per week?

How long do you stay? How many hours?

Q.7   What are some of the reasons you joined this clubhouse?

Q.8   When you were attending, how many days per week did you go?

Q.9   How long did you stay? How many hours?

Q.10   When did you stop going? (approximate month, year)

Q.11   What are some of the reasons you stopped going to this clubhouse?

Q.12   What are some of the reasons you originally joined this clubhouse?

Thank you for sharing your thoughts. Now, I would like you to think about some of the reasons you gave and try to list them in order of importance.

Q.13   What are four main reasons, starting with the most important reason that you *come/came* to the clubhouse?

1.

2.

3.

4.

Q.14   What would be different in your life if you did not attend Clubhouse?

Q.15   Many people who attend to clubhouse do so to get support for a mental health condition or illness. Tell me a little about what it is like for you living with a mental illness on a daily basis?

Q.16   Would you recommend clubhouses to others seeking recovery from their illness?

<u>MY MENTAL ILLNESS</u>

Q.17   When was the first time you thought there was something going on with your mental health? How old were you?

Q.18 What do you believe caused your mental illness?

Q.19 What role do medications for your mental illness play in your life?

Q.20 Has anyone treated you differently because of your mental illness? If so, in what ways?

> **PROBE:** *Have you been treated in positive or negative ways?*

If no, would you say others with a mental illness are treated differently? If yes, in what ways?

Q.21 In your opinion, are people with mental illness able to live a good, rewarding life?

PERCEPTIONS OF MENTAL ILLNESS STIGMA

Now I would like to discuss your opinions about mental illness in general and how you feel that your illness is viewed by others.

Q.22 Would you say that you are comfortable with openly talking about your illness with friends and people outside of the Clubhouse setting? If no, why not?

> **PROBE:** If yes, inquire about whether there is fear about being judged.

Q.23 Have you ever been affected by the negative perceptions or stigma that others have expressed about your illness? For example, have you experienced a setback or worsening of your condition due to the opinion(s) or remarks from others? Did you receive less support(s)? Or do you feel as if you have not really been affected at all?

Q.24 Can you please describe for me how mental illness is perceived in your (Arab) culture? Are individuals with mental illness treated differently?

PROBE:
-How have these perceptions or beliefs helped you?
-How have these perceptions hindered you from getting better?

Q.25 In comparing your ethnic culture and the western culture you are currently living in, which culture are you most comfortable saying is more accepting of your mental illness? Why is that?

SUPPORT FROM FAMILY MEMBERS

In this next section, I would now like to learn more about your relationship(s) with family members.

Q.26 Where do most of your extended family members (e.g., parents, siblings, aunts, uncles, grandparents) live?

>   **PROBE:** Out of state, country? In the area?

Q.27 Which of your family members do have the most contact with?
>   **PROBE:** How often, what do you do, etc.

Q.28 Who do you rely on for the following things:
>   *Example of*:   Emotional support
>   Social support
>   Instrumental support

Q.29 Which family members rely on you for things, such as helping them with tasks, cleaning, babysitting, etc.? Do you have someone who depends on your help? Tell me about who they are and what you do with them.

Q.30 Have you experienced any change(s) in your relationship(s) with family members because of your illness? Tell me about this.

>   -For example, have they become closer or more distant with you?
>   -Has your illness changed how they (family members) <u>treat you</u>?

Q.31 Has anyone from your family been involved with your treatment at the Clubhouse? How about in any other treatment setting related to your illness? For example, driving you to appointments, picking up medication(s) for you. <u>*(If NO, go to next question)*</u>

Q.32 Do you often wish that your family would become (more) involved with your participation at the Clubhouse?

<u>PERSPECTIVE(S) OF PERSONAL RECOVERY</u>

I really appreciate all of the feedback that you have provided so far. I know that we have talked about some personal issues and your family. For this next part, I would like to gather some information about your thoughts on mental illness and a concept called "recovery." I'd like to ask you some general questions before we begin.

Q.33 Can you tell me if you have heard others talk about recovering from mental illness or "mental health recovery"? **(If no, go to Q.35)**

Q.34 If so, where did you hear about it? What were your initial thoughts or feelings about recovery at the time?

Q.35 How would you define recovery from mental illness? In your opinion, what does it mean to you?

Q.36 Do you feel that it is possible for individuals to recover from their mental illness? Why or why not?

Now I would like to ask you some questions specifically about your illness, symptoms and the treatment and/or managing of your condition since you began attending the clubhouse.

Q.37 Have you experienced any difference or change(s) in your condition or how you have felt since attending the Clubhouse? Have the changes been positive or negative for you?
> **PROBE:** Do you feel that your symptoms have become less problematic for you each time that they occur?
> **PROBE:** Would you say that you have been able to adequately manage your illness most of the time?

Q.38 Are you currently pursuing any personal goals in your life? If no, are you interested in pursuing personal goals in the future such as working at a job, attending school, etc.?

Q.39 For this next part, I am going to read some related statements and I would like for you to please respond as to whether you Strongly Agree, Agree, Disagree or Strongly Disagree to each question.

Q.40 Do you strongly agree, agree, disagree or strongly disagree that having family support is an important part of recovery?

For each of these questions, have the person briefly elaborate on why they agree or not.

> Strongly Agree …………4
> Agree …………………...3
> Disagree ………………..2
> Strongly Disagree ……...1

Q.41 My illness does not control me.

> Strongly Agree ………...4
> Agree …………………..3
> Disagree ………………..2
> Strongly Disagree ……...1

Q.42   There are people in my life who I can depend on.

> Strongly Agree ………..4
> Agree ………………….3
> Disagree ……………….2
> Strongly Disagree ……..1

Q.43   I am capable of making decisions about my life.

> Strongly Agree ……….. 4
> Agree ………………….3
> Disagree ……………….2
> Strongly Disagree ……. .1

Q.44   My recovery is affected by the stigma associated with mental illness.

> Strongly Agree ……….. 1
> Agree ………………….2
> Disagree ………………. 3
> Strongly Disagree ……...4

Q.45   Recovery from serious mental illness is possible.

> Strongly Agree ……….. 4
> Agree ………………….3
> Disagree ………………. 2
> Strongly Disagree ……...1

Q.46   Could you describe some things that have <u>helped</u> or that have <u>positively</u> affected your recovery?

Q.47   What, if anything, do you feel has <u>hindered</u> or <u>interfered</u> with your attempt(s) to recover from your illness?
   PROBE:
   > -Would you say that you have been able to overcome <u>most</u> of these setbacks?

ACCULTURATION

Now I would like to learn more about your cultural practices and values, in addition to also asking you some questions about your personal sense of belonging, both within your own culture, and/or in the U.S. culture.

Q.48   What language do you mostly speak at home? If English is NOT the primary spoken language, what are some of the reasons why?

Q.49   Do you continue to follow any of your family's cultural traditions or values? If so, which one is most important to you? Why do you continue to do so?

If no, what is one main reason you have not continued to follow these cultural tradition or values?
>   *-For example, do you experience pressures from family members or the community? Do you feel a personal sense of obligation to adhere to your culture?*

Q.50   Would you say that you feel pressure(s) to fit in to the mainstream American society? If yes, has this been stressful for you? In what ways?

Q.51   I'm going to read some statements and I would like you to choose one that best describes you:
>   *I view myself as American more so than Arab or Arab –American …….. 1*
>   *I see myself as an American who follows some Arabic traditions and who is proud of my Arab background …….. 2*
>   *I see myself as being mostly Arab in my culture and values ………. 3*
>   *I do not view myself as being either American or Arab……………. 4*

Q.52   Many people of different cultural backgrounds often choose to adopt and follow the American values and beliefs in place of their own heritage culture. In other wards, they become *"Americanized"*. What are your thoughts about this?
PROBE:
>   -Would you consider yourself to be "Americanized"? Or do you feel as if you engage in the practices of both cultures equally?
>   -If not, would you want to be more Americanized? Please describe.

Now I'm going to read several statements to you and I would like for you to tell me how strongly you Disagree or Agree with each statement using a 5 –point scale. 1 means that you disagree with the statement and 5 means that you agree.

1	**2**	**3**	**4**	**5**
Disagree				**Agree**

Q.53   I often participate in Arab cultural traditions.

Q.54   I often participate in mainstream American cultural traditions.

Q.55   I would be willing to marry a person of Arab ethnic background.

Q.56   I would be willing to marry a (non –Arab) American person.

Q.57   I enjoy social activities with people of Arab ethnicity.

Q.58   I enjoy social activities with typical American people.

Q.59   I am comfortable working with people of Arab ethnicity.

Q.60   I am comfortable working with typical American people.

Q.61   I enjoy Arab entertainment (e.g., movies, music)

Q.62   I enjoy American entertainment (e.g., movies, music).

Q.63   I often behave in ways that are typical of the Arab culture.

Q.64   I often behave in ways that are 'typically American'.

Q.65   It is important for me to maintain or develop the practices of the Arab culture.

Q.66   It is important for me to maintain or develop American cultural practices.

Q.67   I believe in Arab values.

Q.68   I believe in mainstream American values

Q.69   I enjoy typical Arab/ Arabic jokes and humor.

Q.70   I enjoy typical American jokes and humor.

Q.71   I have friends from my Arab ethnic background.
Q.72   I have friends who are mainstream American.

DEMOGRAPHICS: TELL US ABOUT YOURSELF

For this next section, I would like to ask some general questions about yourself.

Q.73   Which gender do you identify with?

       Male ………. 1
       Female ……...2

Q.74   How old are you?

Q.75   What is your relationship status? Do you have a significant other?

Yes
No

Single …………………………1
Married ……………………..2
Divorced …………………......3
Separated ……………………..4
Widowed ……………………5
Significant other……………...6
Don't know/ No response …. 7

Q.76 Do you have any children?
Yes …. 1
No ….. 2

Q.77 If yes, how many of your children are over 18? Under 18?

Q.78 What is your current living situation?

Q.79 Which religion do you identify with?
Muslim ….. 1
Christian … 2
Druze …… 3
Other ……..4 (please specify)

Q.80 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) _____

Q.81   What country were you born in? **(If born in the U.S. go to Q.84)**

Q.82   If you were born outside of the United States, how old were you when you came
to the U.S?

Q.83   Was your immigration or visitation to the United States:
Completely voluntary……….. 1
Involuntary or forced (e.g., refugee, religious/ political asylum)….. 2
Both voluntary and involuntary …..3
Other (please explain) ………4

Q.84   Which of the following best describes your generational status in the U.S.?
First generation …………………..1
(I am the first person from my family to immigrate to the U.S.)
Second generation ……………… 2
(My parent(s) were the first family members to move to the U.S.)
Third generation………………… 3
(My grandparent(s) were the first family members to come to the U.S.)
Fourth generation and beyond….4
(My great –grandparents were the first family members that came here)
Other (please explain) …………..5

Q.85   Finally, could you tell me what it was like for you to participate with this interview and
answer these questions?

*In closing, I would like to thank you very much for your time today and for allowing me
this opportunity to learn so much about you and your personal experiences during your
recovery. You have provided us with such valuable information that will enhance our
understanding about some of the challenges that individuals encounter during their recovery
from mental illness.*

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ABSTRACT

RECOVERY EXPERIENCES AMONGST ARAB AMERICAN CLUBHOUSE MEMBERS: EXAMINING THE EFFECTS OF ACCULTURATION, PERCEIVED FAMILY SUPPORT, STIGMA AND GENDER ON MENTAL HEALTH RECOVERY

by

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August 2016

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Recovery from serious mental illness has been conceptualized throughout much of the recent literature as being a multidimensional continuum that is influenced by multiple factors. This notion of recovery has mostly been defined by the personal narratives of survivors, ex –patients and mental health consumers with serious mental illness, who have identified specific factors that have either enhanced or hindered their own personal recovery. While these narratives have provided valuable information about the recovery process, there currently exists a paucity in research examining the recovery experiences of individuals from various ethnic groups, such as Arab Americans. The current qualitative study aimed to identify and examine key themes and recovery experiences among Arab American consumers within an ecological framework. Specifically, this study examined the influence(s) of acculturation, family support, stigma of mental illness and gender differences on Arab Americans' mental health recovery. Participants for this study included 15 Arab American consumers (seven males and eight females) from a local clubhouse, who were diagnosed with various psychiatric conditions and were between the ages of 26 to 72 years old. Data was collected through semi-structured interviews with each individual

participant and all interviews were audio -recorded and transcribed verbatim. Findings from this study suggested that participants identified recovery –oriented experiences that were specific to both their native Arab culture, and the mainstream culture, regardless of their acculturation strategy. Moreover, the majority of clubhouse members characterized family support as being instrumental to their recovery experiences and stigma of mental illness was not identified to have direct, adverse effects on members' recovery. Gender differences were also revealed in the recovery experiences of male and female participants in this study.

AUTOBIOGRAPHICAL STATEMENT

EDUCATION

Wayne State University	Detroit, MI
PhD Candidate, Educational Psychology	2009 –Present

Wayne State University	Detroit, MI
M.A. School and Community Psychology	1999 -2001

University of Windsor	Windsor, Ontario Canada
B.A. Honors, Psychology	1994-1998

WORK EXPERIENCE

Warren Consolidated School District Special Education Department   August 2001 –Present
School Psychologist
Responsibilities include: conduct comprehensive psycho-educational assessments of students presenting with cognitive, academic and/or socio-emotional difficulties, collaborate with colleagues to determine student eligibility for Special Education services, participate in student intervention meetings, assist with developing and implementing behavior intervention plans, crisis intervention, facilitate social skills groups for students, co-facilitated parenting program, participate in various district committees, coordinate student referrals to outside agencies and consult/collaborate with teachers, administrators and parents regarding students.

INTERNSHIPS

Common Ground   The Sanctuary   February 2016 –Present
Therapist
Provide individual and family therapy, develop treatment plans and therapeutic interventions for adolescents admitted to the residential program, complete progress notes and documentation of behaviors, assist with daily activities and supervision of clients, facilitate group therapy sessions/activities, attend various mental health trainings and seminars.

The Children's Center   Behavioral Health Services   June 2001 –August 2001
Therapist
Provided individual and family therapy, conducted psychological assessments on children with various disorders and disabilities, performed intake assessments, developed treatment plans with other health care staff, maintained comprehensive documentation of sessions, coordinated and developed crisis intervention plans, obtained individual supervision by doctoral level psychologists and provided families with referrals to outside agencies.

Troy Public School District   Special Education Department   March 2001 –June 2001
School Psychologist
Conducted psycho-educational evaluations of students referred for learning, behavioral and/or social-emotional difficulties, report writing of assessment findings, participated in IEPT meetings, gained exposure and knowledge of new standardized assessments, collaborated with colleagues regarding best practices, contributed to the development of student behavior plans and received individual supervision.