“THEY LOOK AT ME LIKE I’M NUTS”:

Exploring Cultural Idioms of Distress and Other Factors that Limit and Enhance Mental Health Practitioners’ Work with Iraqi Refugees

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Abstract

There are approximately 80,000 Iraqi refugees in the United States, many of whom report severe mental illness but face barriers to treatment. Thus, to improve the mental health outcomes of Iraqi refugees, I interviewed mental health practitioners who work with this population. Based on a qualitative analysis of these interviews, I found two main themes in their responses. First, through a focus on cultural idioms of distress, I found that many practitioners misunderstood cultural phrases, while other practitioners demonstrated greater understanding due to their shared Iraqi background. Second, I found that practitioners who relied on the biomedical framework struggled to develop rapport, diagnose clients, and suggest interventions while the practitioners who utilized a holistic viewpoint were more effective in those domains. To address the limitations in cultural knowledge and clinical practices, I created a two-phase intervention based on the findings of this study which may help to make mental health services more accessible and sensitive to the needs of Iraqi refugees.

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I. Introduction

Refugees are people fleeing conflict or persecution, and have been officially recognized by international law since 1951 (Refugees, n.d.). In 2019 alone, 30 million refugees were forced to flee their homes, and of those, 31,250 refugees were resettled in the US (*Refugees in America | USA for UNHCR*, n.d.). Around 80,000 of the refugees who are resettled in the US are from Iraq, where there have been numerous wars and periods of political violence. Iraq has experienced the Iran-Iraq War from 1979-1987, the invasion of Kuwait during the Gulf War in 1991, the US War on Terror in 2003, and the surge of sectarian violence after the 2006 bombing of the Al-Askariyya Mosque (Sassoon, 2011). At the same time, ISIS gained power in Iraq and carried out many terror attacks, which caused many Iraqis to flee. Three million Iraqis have been forced to flee the country as refugees since 2014, and of those, more than 50,000 have been resettled in the US (*Iraq Refugee Crisis*, n.d.). The violence experienced by Iraqi refugees has led to significant psychological distress.

There are an estimated 10,000 Iraqi refugees in Utah, which is a large percentage of the total 25,000 to 50,000 refugees that live in Utah, who are also from Burma, Bhutan, Somalia, Eritrea, the Congo, and Sudan (*Mental Health Facts.Pdf*, n.d.). Most of these refugees live in Salt Lake County, and many display symptoms of mental illness. Refugee populations have high rates of mental illness. For example, Blackmore et al. found in a meta-analysis that 31.46% of refugees report post-traumatic stress disorder and 31.5% of refugees report depression (Blackmore et al., 2020). The rates of mental illness in refugee populations are higher than the general population, as only 6.8% of Americans report PTSD and 7.1% of Americans report depression (*Epidemiology of PTSD - PTSD*, n.d.; *NIMH » Major Depression*, n.d.). Despite high rates of pathology in refugee populations, there are many barriers to mental health treatment for refugees, such as cost, transportation, stigma, and lack of understanding about cultural idioms of distress, or the ways that different cultures understand and express mental illnesses (Shannon et al., 2015).

In many refugee populations there is a large stigma associated with mental illness, especially for refugees who lived in rural areas and were not exposed to Western conceptions of mental illness in their home countries. In Iraqi culture, the stigma around mental illness is mainly

religious, as it is believed that faithful Muslims do not develop mental illness, so when someone has psychological distress, it is seen as the result of supernatural causes and is a source of shame for the family (Shoeb et al., 2007). Due to this stigma, mental illnesses are often conceptualized as physical illnesses in order to receive treatment. Even if refugees can overcome the barriers and seek treatment for their psychological distress, there are often issues with interpretation, cultural differences, and a lack of cultural or linguistic understanding by the provider, which can harm the therapeutic relationship and long-term success of treatment (Flaskerud, 2010). Thus, it is imperative that mental health practitioners have an understanding of their clients' culture, how it impacts their understanding and expression of distress, and the unique struggles that they face in their daily life.

Cultural idioms of distress are a valuable tool to ascertain how well practitioners understand their clients' culture, and how this knowledge can be leveraged to provide better mental health treatment for refugee populations. Accordingly, my research utilizes cultural idioms of distress as a way to understand what factors limit or enhance practitioners' work with Iraqi refugees in order to ascertain how to improve such work and its outcomes. Through semi-structured interviews with case management providers and mental health practitioners who work with Iraqi refugees in the Salt Lake City, Utah area, I asked practitioners about their beliefs about Iraqi refugee's mental health, about their challenges and successes with their clients, and about their understanding of the cultural idioms of distress used by Iraqi refugees. These interviews provide insight into the ways that practitioners understand the cultural context and modes of expression of their clients.

II. Literature Review

Iraq: history and conceptualization of mental health

The immense violence and trauma that Iraqi refugees experienced in their home country as well as while fleeing to the U.S. might lead to significant psychological distress. In fact, Taylor et al. (2014), using measures standardized for Western populations, surveyed 366 adult Iraqi refugees and found that 50% of them reported depression, anxiety, and emotional stress and 31% were at risk for PTSD. While these data are revealing and concerning, they should be considered in light of several factors that could influence the experience and expression of

psychological distress among Iraqis, including religious beliefs held by many Iraqis, the stigma associated with mental illness in Iraq, and the manner in which many Iraqis describe their psychological symptoms.

The conceptualization of trauma and emotional distress by Iraqi refugees must be understood in the context of their religious beliefs, as approximately 95% of Iraqis are Muslim and Islam plays a large role in many Iraqis' lives. Shoeb et al. (2007) reviewed several studies and found that rates of PTSD among Iraqi refugees are neither high nor universal because of a variety of religious beliefs that act as protective factors against emotional distress, including the belief that one's faith in Allah will provide consolation, that since death is divinely ordained there is no need to feel guilt, and that "trauma is accepted as divine will," all of which allow Muslim Iraqi refugees protection from emotional distress. It is important to note that religion not only influences one's reaction to trauma, but also what is considered traumatic and why. For instance, Shoeb et al. (2007) also found that prohibiting Iraqi refugees from praying was incredibly traumatic, due to the importance of prayer in Islam, as was watching their religious leaders be arrested and executed, due to the importance of communal identity in Iraq.

An understanding of the role of Islam in Iraqi refugees' conceptualization of trauma and protection from distress is crucial in order to understand their development of psychological distress and the stigma that surrounds it. After exposure to such religiously constituted traumatic events, many Iraqis develop symptoms of emotional distress or mental illness which carries incredible stigma. In Iraqi culture, it is believed that faithful Muslims do not develop mental illness, so when someone has a mental illness, there is great familial shame and their children are considered unfit for marriage (Shoeb et al., 2007). In fact, one common label for mental illness is *majnoon*, which is derived from the word *jinn* (meaning supernatural spirits in Islam), which demonstrates that mental illnesses are seen as the result of supernatural causes (Shoeb et al., 2007).

Due to this stigma, Iraqi doctors often label anxiety and depression as medical illnesses in order to release the patient from their responsibilities and help them receive treatment, which would not be possible with a diagnosis of a mental illness. The stigma about mental illness in Iraq is not only religious in nature but deeply ingrained in Iraqi culture. A survey conducted by

the Iraqi Ministry of Health in 2011 found that "65 percent [of respondents] declared that psychological problems were borne of 'personal weakness,' and 80 percent affirmed that people with mental health problems are largely to blame for their condition" (Bolton, 2013, p. 880). There is also familial shame in mental illness, as more than half of respondents said they "would feel ashamed if a family member suffered from mental illness" (Bolton, 2013, p. 880). Since only half of respondents believed that mental illness was curable, there is an understandable reluctance to seek treatment (Bolton, 2013).

Due to stigma and the related reluctance to seek psychological treatment for emotional distress, many Iraqis seek treatment for mental illness from traditional healers who use Quranic verses, acupuncture, and special herbs. Through interviews with 178 Iraqi families displaced in Jordan and Lebanon, Schinina et al. (2008) found that many Iraqis only seek help from mental health professionals when their mental illnesses bring about "behavioral and societal dysfunction" (Schinina' et al., 2008, p. 12). This increases stigma since it creates an idea of mental illness being pathological and dysfunctional (Schinina' et al., 2008). Also due to the stigma of mental illness, many Iraqis are reluctant to speak of their feelings of distress. Women are more likely to not share their feelings of distress with their family out of respect for their husbands. It is even more difficult for women to seek treatment, because they may require their husband's consent to do so. However, women do share their feelings with large social groups of other women. Men, in contrast, rarely speak of their distress because they believe it to be due to their economic and living situation and think that it will dissipate once the difficulties decrease. If they do speak of such distress, it is often only with other male Iraqi refugees (Schinina' et al., 2008).

It is also well known that Iraqis describe their anxious and depressed feelings differently than non-immigrant Americans. Thus, existing data that relies on measures designed by Western populations may be misrepresenting the true nature of mental health challenges experienced by Iraqi refugees. Iraqis describe their emotional struggles mainly through the use of descriptive words such as "Dayij" (uncomfortable), "Ka'aba" (melancholia), "al Zillah" (humiliation), "Kalak" (anxiety), "Inziaaj" (uneasiness), "Ihbat" (frustration), "Khawf" (fears), "Daghet" (pressure), "Ta'ab" (tiredness), "Sadma" (shocked), "Insilakh" (uprooting), and "Hasbiya Allah

wa ni'ma l wakil" and "Allah y'in", which both refer to the hope in God's assistance to face trouble and injustice (*Mental Health | Iraqi | Refugee Health Profiles | Immigrant and Refugee Health | CDC*, 2019).

In addition, "Iraqi refugees may manifest mental health problems as physical symptoms, such as headaches, backaches, body aches, or gastrointestinal problems with no physical underlying reasons" (*Mental Health | Iraqi | Refugee Health Profiles | Immigrant and Refugee Health | CDC*, 2019, para. 2). Physical manifestations of mental health issues are common among refugees of many cultural backgrounds but can lead to misdiagnosis by Western medical practitioners.

It is clear to see that Iraqi refugees have their own conceptions of trauma and emotional distress, which is influenced by their Muslim faith, stigma about discussion and treatment of mental illness, and culturally specific ways of experiencing and expressing feelings of emotional distress. Given the unique perspectives and experiences of Iraqi refugees, many wonder if the biomedical model, which is predominant in Western medical settings and frequently used to assess the mental illness of refugees, is the most beneficial approach as it does not take into account many of these cultural factors.

The biomedical framework and its application to refugees

The biomedical framework provides the theoretical basis for allopathic or Western medical practices, including psychiatric diagnosis and treatment. The acceptance of this approach grew widely after World War II and has been the dominant framework since (Krieger, 2011). This framework claims that illness is the result of biological, chemical and physical causes, and emphasizes laboratory research and reductionism. Modern Western psychiatry subscribes to the biomedical framework and often views mental illnesses as having a biological basis and as being best treated through medicines that target the biological cause of pathology (Deacon, 2013). The Diagnostic and Statistical Manual of Mental Disorders (DSM) offers a biomedical framing of mental illnesses, and is used by clinicians to diagnose mental illnesses, including post-traumatic stress disorder, anxiety, and depression (Lafrance & McKenzie-Mohr, 2013). The DSM contains the criteria most frequently used to assess refugees upon resettlement

in the US and is often cited when discussing refugees' high rates of PTSD, anxiety and depression (Taylor et al., 2014).

Most Western mental health providers use the DSM to diagnose and determine the mental illnesses of their clients. The DSM's diagnostic criteria for PTSD include exposure to actual or threatened death or serious injury that the individual experienced or witnessed and this disturbance causes significant distress in the individual's functioning at work or in social situations (*DSM-5 Fact Sheets*, n.d.). The diagnostic criteria for anxiety disorders include excessive and uncontrollable anxiety and worry for an extended period, and additional symptoms such as avoidance of feared situations, fatigue, and difficulty concentrating, all of which cause significant distress (Administration, 2016a). The DSM diagnostic criteria for depressive disorders include depressed mood or anhedonia, difficulty concentrating, fatigue, and other symptoms which cause significant distress in social and occupational settings (Administration, 2016b). The biomedical framework has influenced how mental illnesses are now seen as biological conditions and thus treatable through a framework that privileges structural and neurochemical imbalances over the influence of social determinants of disease (Kleinman, 2013).

Although the biomedical psychiatry framework is the most accepted model currently, there is much criticism about it, as some have suggested there is no specific biological cause for any mental disorder and there is evidence that psychiatric medications for mood disorders produce poor long-term outcomes (Deacon, 2013). In addition, the biological model has not been found to reduce stigma, despite many efforts to market mental illnesses as "diseases like any other" (Deacon, 2013; Pescosolido et al., 2010). Another criticism of the biomedical model in general, and the DSM in particular, is that it medicalizes normal reactions to suffering and unnecessarily labels suffering people as mentally ill, just as past versions of the DSM incorrectly pathologized homosexuality as a mental illness (Flaskerud, 2010). The DSM is also criticized for its categorical nature, as the dividing line between diagnosis and lack of diagnosis may be arbitrary (someone with four symptoms of depression would not be diagnosed as depressed, but someone with five symptoms would), which forces service providers to make subjective decisions influenced by stereotypes (Arnold et al., 2004).

Criticism about the biomedical model of psychiatry and the DSM diagnostic criteria extends beyond its use in general populations to its application with non-Western societies and refugee populations (Flaskerud, 2010). Since diagnostic categories of the DSM reflect a Western biomedical perspective, all other non-Western syndromes are found in the last appendix titled culture-bound syndromes, which ignores the fact that all DSM diagnoses are culture-bound (to Western culture) and "creates the impression that socio-cultural dimensions of diagnosis and treatment are not important" (Flaskerud, 2010, p. 687). Given the DSM's Western perspective, several aspects of the PTSD diagnosis (the one most commonly applied to refugees), in particular, run counter to the experience and worldviews of many refugees. Refugees often present symptoms that do not fit the diagnostic criteria for PTSD, and it is difficult to determine the impact of these symptoms on functioning, because there is no baseline for refugees who constantly undergo trauma and upheaval (Gong-Guy et al., 1991). In addition, many refugees do not have the same cultural conceptions of individual trauma as biomedical practitioners and may instead have a more collectivist worldview. This can lead to difficulty in diagnosis and treatment, as the biomedical model conceptualizes mental illnesses such as PTSD as individual disease states (Mollica, 2009). Overall, there is great criticism about the application of the DSM diagnostic criteria to non-Western populations such as refugees because it is based on a Western biomedical approach and characterizes all other typologies of distress as less important and culture bound.

In addition to the ambiguities of assessment and diagnosis, therapeutic interventions for PTSD, based on the DSM model, are often better suited to Western patients and may not be as beneficial for refugees. Often refugees undergo exposure or desensitization therapy, in which they must continuously revisit and remember their trauma in order to overcome it. Exposure and desensitization therapy may be ineffective for refugees because the traumas experienced are too horrific to revisit and/or involve multiple, intertwined tragedies making them less amenable to the exposure paradigm (Kinzie, 2001). In addition, many refugees are not able to overcome their traumatic past, as many are not yet permanently settled and thus not in a safe place to explore their personal histories (Kinzie, 2001). Finally, the whole notion that confronting and overcoming trauma is a necessary part of healing is a Western concept. Other cultures, such as

many Islamic ones, believe in accepting one's fate, which itself is in Allah's hands. Thus, treatment consistent with the DSM, and advocated by the biomedical model of psychiatry, of identifying and classifying mental illness, is often not beneficial for refugees because it neglects a conception of social and cultural determinants of disease and culturally competent models of healing.

An additional problem with Western interventions for PTSD is that many refugees do not have PTSD alone; they also have suffered incredible losses of family, of support systems, and of ways of living so they may experience comorbid depression and anxiety. Any therapy model addressing this population then, must include trauma and loss, and it must be long term because depression can decrease over time with therapy and medication, but PTSD can be triggered many times and get worse (Kinzie, 2007). In addition, post-conflict biomedical agendas, no matter how well-intended, are operationalized through significant asymmetrical power relations, in which refugees must leverage their trauma as proof of what they have encountered in order to get necessary resources and treatment (Ticktin, 2011). Once refugees are resettled, they must continually present their trauma to fit the expectations of refugee agencies, which work within the bureaucratic confines of state funding and thus the biomedical framework, in order to receive necessary treatment. This process can potentially be retraumatizing and re-triggering to refugees. Given the shortcomings of the Western mental health paradigms and their application to non-Western refugees, the need to incorporate more culturally relevant conceptualizations and treatments is apparent. The rise of cultural competence as a mental health construct underscores and attempts to address how the needs and perspectives of refugees and other marginalized groups can be honored within the broader umbrella of the biomedical model.

Cultural competence

Due to the varied nature of criticism about the biomedical model of psychiatry and the DSM with non-Western populations, cultural competence has arisen as a way to incorporate culturally relevant conceptualizations of emotional distress. To understand cultural competence, a definition of culture is first needed. Such a definition is difficult to create, because culture is not a static construct, but rather a fluid and dynamic term that captures how and why groups of

people participate in routines, rituals and structures in relation to those around them (Gjerde, 2004). In addition, culture "is learned and can change" (Abu-Lughod, 1991) and is impacted by historical events. Current Iraqi culture may be something very different from Iraqi culture fifty years ago (Abu-Lughod, 1991). Another difficulty in defining culture is that culture has been used throughout the history of anthropology to make a group the "other," which often has Eurocentric implications (Abu-Lughod, 1991). Any definition of culture also depends on who is creating that definition and the cultural background they bring to the arena. Since I am a Muslim woman and the child of refugees, my consideration of Iraqi culture is not informed by a sense of otherness, but by a sense of commonality and community as I see myself and Iraqis as belonging to the same *ummah* or community of Muslims around the world. Regardless of this commonality, Iraqi culture is not singular and is experienced and produced on a spectrum of gender, race, socioeconomic class, age, ethnicity and religion. Despite the fact that culture itself is a nebulous concept, mental health clinicians have begun to recognize the importance of considering the cultural context within which their clients are embedded through the use of culturally competent assessments and interventions.

Cultural competence is defined as a model that can provide cross-cultural services that are adapted to the cultural beliefs, values and traditions of a specific group (Pederson, 2002). It grew out of awareness of growing ethnic and cultural diversity in the US and the accompanying health disparities and barriers to treatment for ethnic minorities (Sue et al., 2008). Cultural competence is an ongoing implementation goal as the US becomes increasingly diverse, barriers to treatment for ethnic minorities continue, and mental healthcare providers must understand the history of oppression and injustice that their patients bring with them. There are three levels of analysis in cultural competence: provider and treatment level, agency or institutional level and systems level. At the provider and treatment level, differing models of cultural competence emphasize "(a) the kind of person one [the practitioner] is, (b) skills or intervention tactics that one uses or (c) processes involved" (Sue et al., 2008, p. 429). D.W. Sue's model is the most widely accepted and provides the basis for the APA's multicultural guidelines (Sue et al., 2008). This model emphasizes the practitioner and argues that a culturally competent clinician is

culturally aware of their own values, beliefs, and influence, as well as knowledgeable about their client's worldview (Sue et al. 1982, 1992).

Culturally competent interventions range in their approach, including conducting treatment in the client's native language or having an ethnic and cultural match between therapist and client. They also range in terms of the client's problems and issues, ethnic/racial groups, and intervention type, whether that is individual or group, and treatment or prevention. Culturally consistent adaptations include the use of: (1) language that shows appropriate respect (such as using formal *usted* with Spanish speaking clients), (2) cultural ceremonies, (3) examples that fit the culture, and (4) culturally appropriate techniques such as storytelling (Sue et al., 2008). The effectiveness of culturally competent therapy is somewhat contested, as there are few meta-analyses, but of those that have been conducted, culturally competent therapy is found to have a moderate effect in enhancing a positive outcome for clients (Sue et al., 2008). The variability in results could come from the fact that studies have focused on different participants or treatments (Sue et al., 2008).

A common criticism of cultural competence is that it makes assumptions about groups and homogenizes all people of a group, thus ignoring individual differences. In addition, cultural competence is sometimes seen as an approach in which practitioners should learn everything possible about a culture and then this, in and of itself, will enable them to effectively treat members of this culture. In reality it is impossible to learn everything about a given culture, and cultural competence is meaningless without self-reflection and awareness of one's biases and prejudices and actively working against them (Marsh, 2017). Thus, cultural competence cannot remain static and must be adapted to include critical race theory, intersectionality and provider readiness for change (Khoury & Manuel, 2016).

As the field of psychology has advanced over time, there have been calls for the field to value and understand the unique perspectives of minority groups that have experienced trauma and expressed emotional distress as a result. Cultural competence was arguably one of the first movements to value the experiences of culturally diverse groups and teach clinicians of different backgrounds how to best work with such culturally diverse groups. As important as cultural competence was in bringing the emotional distress of culturally diverse groups to the forefront of

psychological thinking, it is not a perfect framework and has much to improve upon. I believe that such improvement can be achieved through a focus on cultural idioms of distress, which is an understudied aspect of cultural competence and may help bridge the gap between culturally competent clinicians and their clients' unique manifestations of distress. I propose that, in addition to directly asking practitioners about their perceived challenges in working with Iraqi refugees, exploration of their knowledge of cultural idioms of distress may be another avenue that could help illuminate their biases and uncover some of the factors that both limit and enhance their work. Thus, cultural idioms of distress must be discussed more deeply in order to fully understand and improve outcomes for culturally diverse populations such as Iraqi refugees.

Cultural idioms of distress

A focus on cultural idioms of distress provides a theoretical and practical bridge between the biomedical and cultural competence frameworks, so it requires further explanation. The concept of cultural idioms of distress was first defined by Mark Nichter in 1981 based on his work with rural high caste women in India and the words, phrases, and actions they used to express and respond to distress and was meant to complement culture bound syndromes (like *ataque de nervios*). He defined cultural idioms of distress as the ways that people in different cultures express distress, which is culturally constituted and associated with cultural values, norms and themes (Hinton & Lewis-fernández, 2010). Another definition is how people present psychological distress and cultural conflict through bodily symptoms, which may not fit the criteria of Western psychiatric diagnosis (Hinton & Lewis-fernández, 2010). These somatic symptoms that serve as cultural idioms of distress are often misinterpreted by clinicians which can lead to inappropriate treatments, so clinicians must learn to understand the meaning of these idioms, which do not simply indicate disease but are part of "a language of distress with interpersonal and wider social meanings" (Desai & Chaturvedi, 2017, p. 96). Nichter revisited the topic of cultural idioms of distress in 2010 and wrote that they "index past traumatic memories as well as present stressors, such as anger, powerlessness, social marginalization and insecurity, and possible future sources of anxiety, loss and angst" (Nichter, 2010, p. 405). Thus,

cultural idioms of distress explain how people of different cultures experience and express their emotional distress in unique and culturally constituted forms.

The concept of idioms of distress can be expanded to include cultural illness symptoms (such as an *ataque de nervios*, literally an attack of nerves), psychological and somatic complaints (such as being "sad" or having bodily pain), religious involvement (such as spirit possession that causes serious symptoms), accusation of witchcraft assault (such as being attacked by a witch), and acting out behaviors (such as drinking) (Hinton & Lewis-Fernández, 2010). Some idioms are near continuous while some are more episodic in nature (Hinton & Lewis-Fernández, 2010). Cultural illness symptoms are more specific in their causes and symptoms than general idioms of distress. Patients often believe their culturally specific idiom of distress to be their biggest problem (Hinton & Lewis-Fernández, 2010), thus I believe that if these idioms are not understood and addressed by their healthcare providers, clients themselves will feel misunderstood. On the other hand, if providers can accurately address the concerns communicated through idioms, patients will feel heard and their distress may be more likely to decrease.

Cultural idioms of distress, as an aspect of cultural competence, have been operationalized in the Harvard Trauma Questionnaire (HTQ, Wind et al., 2017). The Harvard Trauma Questionnaire is one of many questionnaires used to help clinicians understand the mental health struggles of a refugee population and assess which individuals require treatment prior to resettlement in the United States (Wind et al., 2017). It was developed by the Harvard Program in Refugee Trauma over 25 years ago as "a cross-cultural screening instrument that documents trauma exposure, head trauma, and trauma-related symptoms in refugees" (Berthold et al., 2019). The HTQ contains four parts: experiences of torture and trauma, subjective descriptions of severe experiences of trauma, events associated with head injuries, and symptoms of PTSD and refugee-specific expressions of trauma. The HTQ was created to assess PTSD as defined in the DSM, but it also contains sections on refugee-specific expressions of trauma and culture-specific functioning (Berthold et al., 2019) and thus combines both the biomedical and cultural competence frameworks.

The cultural competence component of the HTQ can be seen in the many adaptations of the instrument for different refugee groups, each with differing refugee-specific expressions of trauma. It was first created for Indochinese refugees, and due to its high validity, it has been adapted for many different refugee populations, including Japanese earthquake survivors, Croatian soldiers, Bosnian genocide survivors, and Iraqi refugees (Shoeb et al., 2007). The HTQ was recently adapted in order to assess PTSD symptoms and culture-specific expressions of distress in Iraqi refugees (Shoeb et al., 2007). To do so, a new list of traumatic events specific to Iraqi refugees was created, the DSM-IV diagnostic criteria were translated into Arabic and tested for equivalence, and new refugee-specific symptoms of trauma were identified through studies and interviews (Shoeb et al., 2007). This adapted HTQ is to be used in conjunction with Western biomedical assessment measures of psychopathology in order to assess Iraqi refugees for mental illnesses in both a holistic and culturally specific manner (Shoeb et al., 2007). Due to the HTQ's inclusion of cultural idioms of distress and cultural competence, it is often utilized to assess the psychological distress of refugees in a culturally sensitive way and will be used as such in my study.

Overview of Current Study

While the existing literature on cultural idioms of distress and cultural competence illustrate the need for culturally sensitive understandings of psychological distress and its treatment, there is a lack of research on the cultural idioms of distress of Iraqi refugees resettled in the United States, and how provider understanding of such idioms can improve therapeutic outcomes. Given the significant influence that idioms of distress appear to hold in the refugee clients' experience, I believe that expanded provider knowledge of cultural idioms of distress could potentially improve client-provider relations. Since idioms of distress are often refugee clients' biggest complaint and a reflection of their culturally constituted traumas and expressions of psychological distress, if providers can understand and communicate effectively with their clients about these idioms, then this may help to build stronger relationships. Likewise, if they misinterpret or cannot connect with their clients on the basis of these idioms then their therapeutic relationship may suffer. Thus, facilitating practitioners' appreciation of cultural

idioms of distress is crucial to strengthening the therapeutic relationship and ensuring that clients receive culturally competent and sensitive treatment.

The goal of my research is to understand what factors limit and enhance service providers (such as social workers and case managers) in their mental health work with Iraqi refugee clients. Within the field of psychology, many attempts have been made to improve therapeutic outcomes for clients of diverse backgrounds, such as refugees, people of color, and other marginalized groups. Some of these attempts include the operationalization of models of cultural competence and efforts to match clients to therapists of a similar ethnic or cultural background (Sue et al., 2008). Although these strategies are certainly an important step forward, there is still much to be learned about what specifically contributes to or detracts from a positive therapeutic relationship for clients from underserved populations. Once more is known about those beneficial and harmful factors, that knowledge can be shared with providers, who will hopefully be able to better connect with their clients and improve their therapeutic outcomes.

In order to understand the factors that limit or enhance practitioners' work with Iraqi refugee clients, I interviewed practitioners who work with Iraqi refugee clients in a variety of refugee resettlement and service agencies around Salt Lake City, Utah. I chose to interview service providers in Salt Lake City because there is a large refugee population and a wide variety of resettlement services available to refugees. In these interviews, I explored practitioners' knowledge of idioms of distress as a broad concept and their specific knowledge of their Iraqi refugee clients' unique idioms. In doing so, I hoped to explore the extent to which these practitioners understand the culture of their Iraqi refugee clients and the nature of the experiences that brought them to the refugee resettlement agency. I also explored how practitioners view their clients' struggles and how those views impact the therapeutic relationship. Through interviewing practitioners, I aimed to learn more about them, their unique experiences, and how they have come to understand their clients' culture and experiences in the way that they have.

III. Methodology

Overview

This research was conducted through virtual interviews with case managers, interpreters, social workers, and psychiatrists who work with Iraqi refugees in a variety of refugee resettlement and service agencies in the Salt Lake City, Utah area. This area was chosen because I interned at Utah Health and Human Rights, a refugee services agency in Salt Lake City, Utah, in the summer of 2019 and thus had connections to providers in the area and was confident that I could utilize these connections to find willing study participants. Given my connections and the abundance of refugee service providers in the area, Salt Lake City was the ideal location to undertake my research.

In my research, I hoped to explore the extent to which practitioners understand the culture of their Iraqi refugee clients and the nature of the struggles that brought them to the refugee resettlement agency. I conducted individual interviews over Zoom due to the coronavirus pandemic which limited my ability to travel to Utah and conduct in-person interviews, and in an effort to provide flexibility to my participants, all of whom had time constraints. Interviews were conducted with a series of guided questions (see Appendix I), though participants were encouraged to reflect on their own experiences and provide open-ended responses. I also asked follow-up or clarification questions when necessary in order to expand participants' responses and better understand their personal experiences with clients.

Recruitment and Participants

Participants were recruited for this study mainly through emails. I first sent recruitment emails (see Appendix II) to all the refugee service providers who worked at Utah Health and Human Rights, the site of my former internship. I then asked my former mentor, who works in the refugee mental health field in Utah, for refugee service providers who might be willing to participate in my research, and then sent those individuals the same recruitment emails. I emailed thirty-one refugee service providers in the Salt Lake City, Utah area and fourteen of those were willing to be interviewed for my research.

Participants were fourteen service providers who work with Iraqi refugees in the Salt Lake City, Utah area, whose occupations varied from interpreters to social workers to health coordinators to psychiatrists. Eight participants were from Iraq: seven of these were employed as interpreters and case managers, while the last was employed as a women's services coordinator. The other six participants were American-born and Caucasian, four of which were social workers and two were psychiatrists. Nine of the participants were female and five were male (see Appendix IV for participant table).

Data Collection

Fourteen interviews were conducted over private Zoom sessions from June to August 2020. At the beginning of the interview session, I read participants the IRB-approved consent form (see Appendix III) and then sent it to the participant via DocuSign to sign and indicate their willingness to participate in the interview and have it recorded. Participants were given the choice of having video and audio recorded, only audio recorded, or no recording. All participants agreed to recording, and only one participant requested an audio only recording. In order to protect these recordings and the privacy of participants, I uploaded the recordings to the cloud, password protected them, and changed the settings so only I could view them. In addition, the recordings were not shared or distributed, only the auto-generated transcriptions were kept for ease of analysis. I will delete the recordings and all related raw data in a year.

The interviews lasted from twenty to forty minutes depending on the responsiveness of participants and willingness to share their in-depth personal experiences with clients. At the beginning of the interview, I talked participants through the consent forms, gained their verbal and written consent, and then described the purpose and overview of my study (see Appendix I for interview questions). Participants were first asked about the general mental health of their Iraqi refugee clients and the physical manifestation of their clients' emotional distress. The second portion of the interviews focused on provider knowledge of specific cultural idioms of distress of Iraqi refugees drawn from the HTQ. Lastly, I asked participants about their views of their clients' struggles and if there was anything they wished they had known before they began

working with Iraqi refugees. After each interview, I downloaded the auto-generated Zoom transcript and typed and organized my own subjective field notes.

Data Analysis

I analyzed my data qualitatively, using the thematic analysis method. Following Braun & Clarke's (2006) suggestions for using thematic analysis of psychological data, my analysis involved the following phases: (1) generating initial codes, (2) searching for themes, (3) reviewing themes, and (4) defining and naming themes. To protect the privacy of participants, I assigned identifiers to each participant, from 1 to 14, and identified each participant's ethnicity, gender, and occupation. I then coded the most common responses for each question. Finally, I coded for moments of connection and disconnection, which were subjective moments when my own background and biases led me to feel connected with participants or disconnected from them, based on their verbal responses and non-verbal body language (see "Positionality and Reflexivity," below, for further details of this coding scheme.) I inputted these codes into an Excel spreadsheet, and began searching for themes. In order to explore the themes from my interviews, I created various concept maps to help me conceptualize and organize my findings, to identify their most basic, underlying structure (see Appendix IV). Finally, I named the common themes from the interviews.

Positionality and Reflexivity

Due to my personal investment in my work on refugee mental health, the qualitative nature of my research, and my personal relationship with some participants, I approached my research with a reflexive focus. I am invested in my research on cultural idioms of distress because it is of deep personal relevance to me. My mother is a refugee who escaped Idi Amin's dictatorial regime in Uganda who likely experienced trauma during her resettlement journey. Although she does not express her distress through Western symptoms of PTSD, I have always believed that she was deeply affected by her experience and I want to understand how she conceptualizes her distress in terms of her cultural background. The qualitative nature of my research opens the door for my background as the child of a Muslim refugee to influence how I

conducted my interviews and interpreted my findings, as I was a co-creator of these interactions and subjectively interpreted their content. My background influenced the topic I chose to research, which questions I chose to ask participants, how I acted with different participants, how I analyzed my data, and the conclusions I reached. In addition, my background influenced my relationships with participants, as I previously worked with five of the participants at a refugee service agency in Salt Lake City, Utah. This personal relationship likely influenced how I conducted interviews with those participants and how they responded to me in interviews.

Throughout my research, I chose to be reflexive in order to be self-aware, conscious and critical of my biases. I know that my background and personal connection to my research topic means that I have deep-seated beliefs which affect my interviews and data analysis. By utilizing reflexivity, I am choosing to work with my biases to address their impact on my research in a meaningful way that will contribute to my conclusions. Given my background as a Muslim child of refugees, I began this research with multiple biases, including that clients and therapists should be ethnically matched and that the biomedical model is not effective in work with refugees. My long-standing bias towards ethnically matched therapists and clients providing the best therapeutic outcomes stems from my family's negative experiences with culturally insensitive American born therapists and physicians. I acknowledge this bias and understand how it could have negatively impacted my view of the American born practitioners I interviewed. In addition, my cultural background as a Muslim and my knowledge of past research led me to believe that the biomedical conception and treatment of mental illness would not be beneficial for treating refugees with psychological distress. This bias may have been present when I listened to participants discuss their clients' struggles with PTSD, anxiety, and depression. At some level, I doubted the competency of these therapists and felt that they might be missing the most serious mental health issues experienced by their clients. In addition, my unique perspective as a Muslim child of immigrants allowed me to have experiences more in line with the Iraqi refugee clients of my participants, rather than many of the American-born participants I interviewed.

Engaging in reflexivity also includes thinking about power, both in terms of the wider power structures in which one's research takes place, and how power determines who can make

claims and conclusions about other groups. Thus, I paid careful attention to how my research was situated within the broader power structure of the refugee resettlement system's dependence upon the biomedical framework and how that influenced the interview process and the responses of my participants. In addition, I also thought about how little agency refugees have in the resettlement system, as their therapists and case managers often speak for them. My research played a role in this process because I interviewed practitioners about their experience working with refugees instead of interviewing the refugees themselves. This asymmetrical power relationship comes from how the biomedical framework is operationalized to view the practitioner as the expert who can speak about the refugees' experiences with ease because the practitioner fits within the biomedical framework and refugees often reject it in favor of a more holistic understanding of their trauma.

Thus, the conclusions I reached in my research are limited in that the Iraqi refugees themselves did not have a voice to speak about their own experiences. It was especially difficult for me to choose to interview practitioners instead of refugees themselves because of my own positionality within the refugee community. As the child of refugees who arrived in the US with nothing and relied on refugee service agencies to survive, I understand how traumatizing it can be to retell one's trauma constantly in order to access services, so I did not want to force Iraqi refugees to do that for the sake of my research and could not do so ethically. Thus, I decided to interview practitioners while understanding that my research is only a small yet important portion of the research on refugee mental health and cultural idioms of distress.

Due to my positionality within the refugee community and the inherent biases within that relationship, my experience of interviewing practitioners was greatly influenced by my background. This led to moments of connection with participants of similar backgrounds, when I felt understood by people I had never met or only worked with briefly, and moments of disconnection, when I felt isolated from and misunderstood by participants. I analyzed these moments of connection and disconnection because I felt that these moments might translate to practitioners' work with their Iraqi refugee clients whose faith and culture are also my faith and culture. I utilized these moments of connection and disconnection to better understand my

positionality in my research, how that influenced my interactions with participants, and how it may influence participants' relationships with their clients.

IV. **Findings**

The results of my interviews produced two themes, the first of which was the way that exploration of idioms of distress revealed both cultural understanding and cultural misunderstanding on the part of practitioners. The second theme centered around the different ways practitioners approached conceptualizing their clients' struggles: some took a narrow, biomedically focused view, while other practitioners viewed their clients' struggles from a broader, more culturally and religiously holistic perspective.

Cultural Idioms of Distress

Knowledge of Idioms of Distress That Appear on the HTQ

During my interviews, I asked participants if they had heard of the idioms of distress used in the Harvard Trauma Questionnaire. In general, I found three overarching results in terms of practitioner familiarity with idioms: first that most practitioners were familiar with many idioms, second that the American born practitioners were less familiar with the idioms than Iraqi practitioners, and third that there were some idioms that even Iraqi born practitioners did not know (see Appendix VI).

Seventy five percent of practitioners (11 of the 14) stated that they had heard of all the idioms but one. The most unfamiliar idiom was *insilakh* ('uprooting'), and only 68% of participants (10 of the 14) indicated that they had heard this idiom. Other idioms unfamiliar to both American born and Iraqi participants include *qalb* ('squeezed with feelings of sadness'), *inziaaj* ('uneasiness'), and *hasbiya Allah wa ni'ma l wakil* ('hope in God's assistance'). Thus, while most idioms were familiar to many participants, some idioms were unfamiliar to both American born and Iraqi participants.

In general, the American practitioners knew fewer cultural idioms than the Iraqi practitioners, likely because of their differing backgrounds. For many idioms including *qalbak maqboud,* which corresponds to the heart, *nafsak deeyega* ('constriction of the chest'), *daghet*

('pressure'), and *sadma* ('shocked'), all the Iraqi participants were familiar, while one or more of the American born participants were unfamiliar and had not heard the term. This difference in understanding could be due to the Iraqi participants' deep personal understanding of their cultural idioms of distress compared to the necessity of learning new and unfamiliar idioms for the American born participants. Although the American born participants knew less of the idioms than the Iraqi participants, the Iraqi participants were still not familiar with all the idioms of distress presented. There were certain idioms that Iraqi participants did not understand, including *qalb* ('squeezed with feelings of sadness'), *inziaaj (*'uneasiness'), *hasbiya Allah wa ni'ma l wakil* ('hope in God's assistance'), and *insilakh*, ('uprooting'). All of the aforementioned idioms that were unfamiliar to Iraqi participants were also unfamiliar to the American born participants.

Interestingly, one idiom in particular was better understood by American born participants than Iraqis. All six of the American born participants had heard of the idiom *khawf* ('fears'), while only 75% of the Iraqi participants (6 of the 8) had heard of this term. This difference in understanding indicates that a shared background does not ensure one's understanding of cultural idioms of distress.

Provider familiarity with common idioms is not the only aspect of idioms that is important to consider. In fact, the deeper discussions of idioms of distress which occurred during my interviews revealed broader aspects of cultural ignorance and sensitivity that may have a great impact on the ways that mental health professionals interact with their Iraqi refugee clients. These deeper reflections on cultural understanding are discussed in the next section.

Areas of Cultural Misunderstanding Revealed by Exploring Idioms of Distress

Overall, about half of the participants had some profound misunderstandings about the concept and practice of cultural idioms of distress. With respect to the cultural specificity of the concept of cultural idioms of distress, seven respondents (two Iraqi and five American born) indicated that the idioms used by Iraqi refugees are no different from those used by refugees from other populations. For example, one practitioner described how similar idioms of distress tend to "manifest and show up among most trauma survivors" (Participant 1, June 15, 2020).

Such a response demonstrates a fundamental misunderstanding of cultural idioms of distress, because cultural idioms are inherently tied to the specific cultural, ethnic, and religious context of different groups and how that context influences experiences and understanding of trauma. On the other hand, one Iraqi participant drew the opposite, yet still culturally insensitive conclusion about the specificity of idioms, claiming that all refugee groups' idioms of distress are inherently different from one another, because it "depends on what they [their Iraqi refugee clients] faced before… their problems and their struggles" (Participant 9, July 10, 2020). This also demonstrates a misunderstanding of cultural idioms of distress because idioms of distress are inherently communal, as they are dictated by the culturally constructed trauma experiences of different groups, and thus are not based on what specific struggles individual refugees faced in the past.

Interviews also revealed some practitioners' fundamental misinterpretation of the use of cultural idioms of distress versus cultural phrases. For example, four of the fourteen participants, all American-born, claimed that the Arabic word *inshallah* ('God willing') is a specific cultural idiom of distress not included in the HTQ. One American born participant of the four discussed her Iraqi refugee clients' faith in the following terms, "a lot of them will refer to life as a journey and a process… [due to this view of life] there is a freedom in the lack of control, the sense that Allah will take care of it" (Participant 6, July 7, 2020). Similarly, another participant laughed and asked if I had *inshallah* in my list of idioms. When I said no, she explained that it means "in God's will" and that it's "the answer to everything it seems" since her Iraqi refugee clients leave "everything in God's hands" (Participant 3, June 23, 2020). These two quotes demonstrate a fundamental misunderstanding of the concept and practice of cultural idioms of distress, because idioms are culturally, religiously, and ethnically constituted expressions of trauma and distress for specific groups. In contrast, *inshallah* is simply a cultural phrase frequently used by Iraqis and other Muslims around the world in a variety of everyday settings unrelated to trauma, not a specific idiom of distress.

These clear misrepresentations of the word *inshallah* and seeming lack of respect for such a common phrase led to moments of disconnection for me. On two separate occasions, when I interviewed American born practitioners who misunderstood the meaning of *inshallah,* I

felt like they were condescending and belittling their clients' faith and absolute belief in Allah. For example, when one participant laughed when asking if I included inshallah in my list of idioms, I felt like their attitude was condescending, which hurt me as a practicing Muslim whose experiences mirror those of many Iraqi refugees. If these misunderstandings led to such discomfort and alienation for me, it must be considered how such cultural insensitivity can harm Iraqi refugees and their relationship with their therapist. My feelings during these moments make me think that such cultural insensitivity and lack of cultural understanding likely limit practitioners' clinical work with Iraqi refugees and should be remedied for improved outcomes.

Areas of Deeper Cultural Understanding Revealed by Exploring Idioms of Distress

Through my interviews, I also found that some practitioners had a deep understanding of their Iraqi refugee clients' culture and use of cultural idioms of distress. For example, half of the participants (two Iraqi and five American born) stated that Iraqi refugees' idioms of distress were unique for a variety of reasons, including that they suffer from more physical health and sleep issues than other refugee groups, that their distress is more prolonged, and that their religion is of greater importance. One American born participant explained that for her Iraqi refugee clients, their religion "serves as a protective mechanism in a way that some other cultures don't possess." As such, religion allows them to see their trauma in the following way: "Well, trauma happened, and now I'm going to move on and I'm going to succeed" (Participant 6, July 7, 2020). This participant's explanation of religion as a protective mechanism demonstrates a nuanced and developed interpretation of idioms of distress because it touches upon how idioms are tied to religion and how religion impacts one's experience of trauma.

In addition, some participants demonstrated their cultural knowledge through their understanding of specific cultural idioms of distress. Six of the fourteen participants (four Iraqi and two American born) stated that the idioms provided in the Harvard Trauma Questionnaire were comprehensive according to their work with Iraqi refugees, which demonstrates that many American born and Iraqi practitioners have a baseline understanding of the cultural idioms of distress of Iraqi refugees.

One Iraqi participant demonstrated that her understanding of cultural idioms of distress expanded beyond the baseline, as she shared that the Harvard Trauma Questionnaire was missing the common cultural idiom *nafsy laabana* which she explained as literally translating to "I am nauseated" but when used by Iraqi refugees, it means "I've given up on life" (Participant 10, July 15, 2020). This suggested addition of a specific cultural idiom of distress of Iraqi refugees demonstrates a deep cultural understanding based on a shared background. Because non-Iraqi American born practitioners do not share a cultural background with many of their refugee clients, they could greatly benefit from learning from their Iraqi colleagues about specific cultural idioms of distress.

In summary, in my interviews I found that many practitioners fundamentally misunderstood the concept and practice of cultural idioms of distress and how that differs from cultural phrases. Half of the participants believed that all refugee groups have the same idioms of distress, while the other half claimed that all refugee groups' idioms of distress are inherently unique. This lack of agreement between practitioners suggests that both American born and Iraqi practitioners do not fully understand the concept of idioms of distress and their practice among refugee groups. Such lack of understanding of cultural idioms of distress can be harmful, as most refugees' main complaints are phrased in cultural idioms. As my own experience suggests, if these idioms are misunderstood by practitioners, their refugee clients may feel like they haven't been heard or understood, which could harm the therapeutic relationship greatly. I also found that a subset of practitioners greatly understood their Iraqi refugee clients' specific cultural idioms of distress. Half of the participants demonstrated a baseline knowledge of their Iraqi refugee clients' idioms of distress and one participant was able to suggest a common idiom not included in the HTQ. Practitioner understanding of cultural idioms of distress can help clients feel heard and understood, which is an important component of the therapeutic relationship.

Practitioner View of Clients' Struggles

After discussing idioms of distress, I spoke with practitioners about their views regarding their clients' struggles. During these discussions, many practitioners, both American born and Iraqi, revealed that they had questions about the language, history, and culture of their Iraqi

refugee clients (see Appendix VII). While many clinicians were aware of their lack of culturally specific knowledge, they differed in terms of how they proceeded to interact clinically, given their lack of familiarity with Iraqi culture or specific language skills. Specifically, there were two main patterns that emerged: some practitioners conceptualized their clients' struggles in a narrow, biomedically focused way, while other practitioners viewed their clients' struggles from a broader, more culturally and religiously holistic perspective. These different vantage points provided unique challenges and benefits in terms of practitioners' varying approaches and levels of success in developing rapport with clients, diagnosing them and providing appropriate interventions.

Narrow Biomedical View of Struggles

When asked about the main mental health struggles of the Iraqi refugee population, the majority of participants (five American born and seven Iraqi) responded within the biomedical model, citing their clients' struggles with post-traumatic stress disorder, anxiety and depression. Such biomedically focused responses are understandable as all the participants worked within refugee agencies which utilize the biomedical model to understand and treat their clients' struggles. Although these responses are to be expected because American psychiatry, psychology, and related fields rely heavily on the DSM and the disease model of mental illness, practitioners' use of the narrow biomedical model likely limits their work with Iraqi refugee clients. The biomedical model is largely a Western framework and does not take into consideration crucial sociocultural factors that shape a client's experience and articulation of mental health struggles.

While many practitioners (both Iraqi and American) conceptualized diagnosis within the biomedical model, only those who were American born extended their use of this limited framework as they developed strategies for developing rapport and designing interventions with their Iraqi refugee clients. Many American born practitioners, restrained by the biomedical model, were confused about how to interact with their clients in the presence of other family members. For example, one American born practitioner explained that the biggest difficulty in

developing rapport with her clients is having to navigate her female Iraqi refugee clients' relationships with their husbands:

> A few women are more comfortable coming into therapy with their husband present and that is part of their culture and traditional values so of course we allow them to bring whoever they'd like… but at the same time it can be difficult navigating that when asking the client questions about her symptoms, and my experience is that they look at their husband to answer for them. And so, it's been harder to establish a strong therapeutic alliance when there's that kind of dynamic. (Participant 1, June 15, 2020)

This quote illustrates the therapist's lack of understanding of gender dynamics in Iraqi culture, specifically how the head male of the family is often present in healthcare settings with his wife. This lack of understanding likely hurt the therapeutic relationship between the therapist and client. Similarly, another American participant stated that

> a lot of the evidence-based treatments that I recommend for primarily American patients are just not really feasible [for Iraqi refugees], like exercise is a really evidence-based treatment for chronic pain, anxiety and depression, but exercise is something that's not a concept… the Iraqi refugees look at me like I'm nuts. (Participant 11, July 16, 2020)

This demonstrates a lack of cultural understanding around exercise in Arab culture, specifically how there are high rates of physical inactivity in Arab countries, which are even higher for women, due to a variety of socioeconomic, lifestyle and environment factors (Sharara et al., 2018). This lack of cultural understanding can impair rapport (they "look at me like I'm nuts") and are likely to be ineffective. Standard biomedical treatments may not work for diverse populations. As such, suggesting exercise as a therapeutic intervention for Iraqi refugees may hold little promise.

Another example of American born practitioners applying standard biomedical understandings and interventions to their Iraqi refugee clients without success involves a misunderstanding about religious views on suicide in Iraqi culture. An American born practitioner described how a male client would say "'I'm going to kill myself' or threaten to light himself on fire" (Participant 6, July 7, 2020). When she heard this, the American born practitioner immediately applied her biomedical view of suicidal statements and explained the

available suicide prevention resources and services, as she was taught to do. These resources were not needed, however, because when her client said that he was going to kill himself, he didn't mean it literally. He later said "'I'd never actually do that [die by suicide] because I can't in my religion'" and by saying he was going to kill himself, he was really just expressing his deep resentment with life stemming from past trauma and violence. This resentment "comes out in… self-loathing, self-hatred and threats of harm to [the Iraqi refugees themselves] or others," so by applying the standard biomedical view of suicidal statements, the American born practitioner completely missed the meaning and unique religious connotations behind her clients' statement, which could leave the client feeling misunderstood and isolated (Participant 6, July 7, 2020).

American born and Iraqi practitioners alike described a personal lack of awareness of their Iraqi refugee clients' background, including specific dialect, religion, and culture (see Appendix VII). Despite this similarity, only the American born practitioners responded to this lack of knowledge by continuing to apply the Western biomedical model to the development of rapport and use of interventions with their Iraqi refugee clients, who were often unfamiliar with this framework. When the American born practitioners saw that their approach was not working with Iraqi refugee clients, they continued to work within the biomedical model, attempting to make it fit with their clients. These practitioners did not make the crucial realization that they must alter their perspective, from firmly biomedical to more culturally and religiously holistic, in order to create stronger relationships with their Iraqi refugee clients and suggest more beneficial interventions.

Broad Holistic View of Client Struggles

In contrast to the group of practitioners who viewed clients' struggles through a biomedical lens, a subset of practitioners viewed their clients' struggles through a broad holistic view based on lived experiences and sociocultural factors. This broad holistic view could be seen in three major ways: a more social and culturally focused understanding of client struggles beyond the biomedical framework, a focus on their clients' struggles instead of their own struggles as practitioners, and an expansion beyond the formality of the interview itself to

develop a personal relationship with me. By moving beyond a reliance on the DSM for diagnosis, these practitioners were able to focus on the many social and cultural issues their clients faced during resettlement instead of just focusing on biologically based mental illness. In addition, by focusing on their clients' struggles instead of their own struggles, these practitioners were able to understand the barriers that stopped their clients from seeking treatment and devise strategies to overcome those barriers. Lastly, by moving beyond the traditional formality of an interview and connecting with me personally, the practitioners were able to strengthen their relationship with me and make me feel at ease. The three facets of practitioners' broad holistic view of client struggles will be explored below.

A More Social and Culturally Focused Understanding

When asked about the main mental health struggles of their Iraqi refugee clients, two participants, one American born and one Iraqi, did not discuss their clients' struggles as diagnosable disorders found within the DSM, but rather discussed their clients' struggles with stigma, lack of familiarity with mental health services, and disillusionment about living in the United States (see Appendix VII). As the Iraqi participant described, her Iraqi refugee clients "have all the trauma and the experience that they had back home… they have been told, when they go [to the US], their problems will end, and then they find it's not as easy as they have been told and they have to work and go through struggles, learn a new language and find out the system" (Participant 12, July 30, 2020). This quote demonstrates how this participant views her clients' struggles through a holistic lens and focuses on their social and emotional resettlement issues rather than solely their biomedical psychiatric issues like post-traumatic stress disorder. Such a holistic viewpoint is important because it takes into account all the issues that refugees face and that impact their lives which may work better than focusing on biomedical issues because many refugee groups do not conceptualize emotional distress in terms of biological symptoms and treatments. This holistic view can be seen not only with Iraqi participants, but also American born participants, as one American born participant described how many of her Iraqi refugee clients

> have a sense of disillusionment around living in the United States, especially after having particular feelings about their past experiences of war in their home countries and also the United States' involvement. So many Iraqi refugees will come and state, 'I'm here because you brought me here, I'm here because you started a war in my country, and it ruined my life and our country's being as a whole.' So, there's a sort of a thinly veiled anger toward America. (Participant 6, July 7, 2020)

This quote demonstrates that some American born practitioners have a holistic view of their clients' struggles similar to that of the Iraqi practitioners, which likely helps the therapeutic relationship with their clients, who also view struggles more holistically.

Focus on Client, not Self

Differences in practitioners' breadth of focus were not only limited to adherence to the medical model but were observed in terms of self-focus vs. client-focus as well. There was one question in particular which elicited this difference in attention. When participants were asked about the challenges *they* encounter when they try to understand their clients' mental health struggles, eight participants, all Iraqi, responded with issues related to *their clients'* experiences. Specifically, they discussed the heightened stigma about mental illness that their clients face and a lack of trust about mental health services within the Iraqi community. One Iraqi participant described the impact of stigma as how "culturally… our people, specifically the Iraqis and in general Middle Eastern, when you talk to them and say 'I suggest you see a therapist', 'I'm not crazy' is the response you get from them, so culturally if you are going to see a therapist, you are crazy." She goes on to explain how she uses her Iraqi background to help her clients overcome that stigma by

> explaining the difference between being stressed, we all live some type of stress, and they understand it better because we share the same background, same culture… [and] explaining the role of a therapist, I say "look at this therapist as a friend you just chit chat with… and to vent to, because even when you talk to a friend you don't say everything, you hide some details, but when you talk to a therapist you don't need to hide anything." (Participant 10, July 15, 2020)

This nuanced approach to stigma was driven by a holistic perspective shared by all the Iraqi participants that enabled them to look beyond their own concerns, to the role of religion in their clients' lives and its impact on their mental health challenges. By looking at their clients' struggles in a holistic way and taking into account their religious background, the practitioners were able to see beyond their own challenges and understand how different aspects of their clients' identities make it hard for them to access mental health treatment. By doing so, the practitioners have uncovered stigma as one of the main barriers stopping Iraqi refugees from accessing mental health treatment. In addition, they have also learned how to help their clients overcome that stigma in a culturally sensitive way so they can access the treatment they need.

In direct contradiction to the broad holistic view of the Iraqi practitioners that focused on their clients' struggles, all of the American born participants focused on their own challenges, including lack of cultural understanding and needing to have an interpreter (see Appendix VII). This narrow view makes sense given that the American born participants' training focused more on how to diagnose and provide interventions than how to examine the social and cultural factors that can impede their clients' help-seeking behaviors. Such a narrow view limits the American born practitioners as it keeps them from understanding the serious barriers that prevent their clients from seeking help. Without knowing those barriers, the American born participants may struggle to overcome them and provide needed treatments to their clients.

Expansion Beyond Formal Interview Structure

Iraqi participants extended their holistic approach beyond their work with clients to their interviews with me. Almost all of the Iraqi participants connected with me on a personal level based on our similar backgrounds. All of the Iraqi participants could tell that I was Muslim from my traditionally Islamic name and Arabic pronunciation, which many of them corrected in a kind and genuinely helpful way. This immediate connection made me feel more comfortable during my interviews. I imagine that such commonality also makes Iraqi refugee clients more comfortable when they meet with their service providers. In addition, one of the participants whom I previously worked with shared that the clients I had grown close to missed me and frequently asked where I was. This kind gesture made me feel understood and cared for despite

the physical distance. Another touching interaction involved an Iraqi participant who I had never met and emailed solely on the recommendation of my mentor. During our interview, he immediately asked if I was Muslim because of my name and asked where my family was from because he assumed that I was Iraqi. When I told him that my family was actually from India, he was shocked because he said I looked exactly like his daughter. He then proceeded to pick up a framed picture of her and show me how similar we looked. This interaction made me feel like we were connected in a way that I never felt with the American born practitioners I worked with for a whole summer.

All these individual moments of kindness when Iraqi practitioners moved beyond simply answering my questions to addressing me as a person culminated in three moments of connection when I felt understood by practitioners I'd never met or only worked with briefly. These moments of connection, when the Iraqi practitioners went beyond the traditional formal scope of interviews and acknowledged the crucial personal aspects of our interaction, were so powerful for me that I can only imagine how much power they hold for newly arrived refugees. In contrast, I can also imagine how alienating it must be for Iraqi refugees to be misunderstood by their therapist. Thus, it is imperative that practitioners seek to implement more moments of connection through deeper understanding of how culture and religion impact their clients' lives and making an effort to create a personal connection outside of formal therapeutic relationships.

In summary, in my interviews, I found practitioners viewed their clients' struggles in two broad ways: through a narrow biomedical lens or through a more culturally and socially holistic lens. Some practitioners applied a narrow biomedical focus view to their diagnoses of clients using the DSM, their attempts at rapport building, and their design of Western interventions that do not fit their clients' needs. In contrast, a subset of practitioners applied a culturally and socially holistic model to their view of client struggles beyond the biomedical model, beyond themselves, and beyond the formal interview structure. The practitioners who viewed their clients' struggles through a narrow biomedical lens had more misunderstandings with their clients in terms of interventions and cultural norms, which could have impaired the therapeutic relationship and outcomes. In addition, they attempted interventions that were not successful with their clients. In contrast, the practitioners who had a broad holistic view were able to

connect with their clients and overcome their social barriers to treatment, which likely helped the therapeutic relationship and outcomes. Thus, an emphasis should be placed on practitioners developing a more culturally and socially holistic view of their clients' struggles.

V. Discussion

My research demonstrated two main findings: many practitioners misunderstand their Iraqi refugee clients' idioms of distress and some clinicians attempt to apply a misguided Western perspective to diagnosis, rapport building and treatment. Through my research, I found that some practitioners misunderstood their Iraqi refugee clients' cultural idioms of distress and how they differ from common cultural phrases, which I believe might lead to confusion and discomfort on the part of the client. I also found that some practitioners viewed their clients' struggles through a narrow biomedical lens which did not fit their clients' holistic conception of their experiences and struggles. Use of such a narrow biomedical lens led to confusion about how best to develop rapport, diagnose clients, and suggest interventions, which may hurt the therapeutic relationship. Finally, while my research did reveal some areas of misunderstanding and constricted practices between clinicians and their Iraqi refugee clients, it also suggested that many providers do have knowledge about the cultural idioms of distress used by this population and also show great sensitivity and innovation when interacting with their clients. After completion of my research, I realized various limitations of my research, which inspired hopes for future research and suggestions for practitioners. I also reflected on my initial biases drawn from personal experience and how those have changed through this process.

Reflections on Initial Biases

Throughout my research, I have always been grounded in my family's story, in knowing that they didn't receive services that fit their cultural, religious, and ethnic identity. I want to remedy these shortcomings for other refugee families, so they don't experience the pain my family felt. While reflecting on my biases for this discussion section, I thought back to a conversation that I had with my mom about my *nana* ('grandmother') and how she was treated by the medical system as a Muslim refugee woman. I'd always known how her marginalized

identities made it harder to survive and thrive in this country, but I'd never really considered how discrimination in the medical field had a direct impact on her quality of life. In 2004, when I was only five years old, my *nana* suffered a heart attack. Like most women, she showed atypical signs, such as fatigue and neck pain, which are actually quite frequent in women. Since these symptoms aren't common in men with heart attacks, she did not receive treatment until it was too late and went too long without oxygen going to her brain. After this, my *nana* was undeniably different, she kept forgetting things, behaving strangely, and speaking in weird phrases that no one understood. My mom was concerned about my *nana*, thinking that she was depressed. When they went to the doctor, he recommended antidepressants and exercise. These treatments went completely against my *nana's* cultural and religious upbringing, so she continued to suffer in silence, until she left us far too early, and left me with scrambled memories of the person I loved most.

For the longest time, whenever I would think about how my *nana* was failed by her white American born doctor, I would reaffirm my internal commitment to ethnically matched practitioners who do not abide by the biomedical framework. I kept thinking that if only her doctor had been a person of color, they would have understood that her trauma and distress was so tied up in her upbringing as a Muslim girl in Uganda and her later life as a woman of color and refugee that treating it as simple depression would never work. I imagined that if that had been the case, she could have received treatment that utilized her faith as a protective measure and took into account her rich cultural background. The more I thought about my wish for my grandmother to have been treated by a physician of color, the more I realized that I wouldn't have cared who treated my *nana*, or where they were from, as long as they understood who she was and how she could have been helped. It wouldn't have mattered if the doctor was Muslim or Middle Eastern if they could have given my grandmother a better quality of life and given me more valuable time with her. I don't think it was until I made that realization that I finally confronted my initial bias about cultural matching of practitioner and client. I came to see that practitioner background is important but not as important as cultural knowledge, understanding, and respect, which is what we should be fostering in practitioners who work with marginalized communities.

I still believe that the power of a shared connection, whether that be religion or culture or ethnicity, can make someone feel comfortable, at ease, and like they belong, and I do not think that should be discounted. However, I have also come to realize that knowledge of specific cultural connotations and idioms is a crucial aspect of creating therapeutic relationships. In my interviews, I found that most of the practitioners who were aware of specific cultural connotations and idioms were Iraqi, but that could simply be reflective of my sample of participants (see Limitations section below). Therefore, I think that practitioner education on cultural idioms of distress and the ways in which culture influences the experience and expression of trauma would be more valuable than ethnically matching practitioners and clients.

I also began this research with the bias that the biomedical framework is not well-suited for work with refugees because of its Western bias and lack of cultural sensitivity. During my research, my views on the biomedical framework have expanded in more complicated ways as I discovered that the biomedical framework itself, though flawed, is not the real issue when it comes to working with refugees; rather, it is the operationalization of the biomedical framework that can cause problems. For example, if the American practitioner who treated my *nana* for her emotional distress had understood how mental illness is so stigmatized in Indian and Muslim communities, he could have approached the subject more delicately and in a way that my grandmother understood. In addition, if that practitioner had been more knowledgeable about how standard biomedical interventions may not work for refugee populations, he could have suggested more culturally appropriate interventions that could have greatly helped my *nana*. Similarly, if American born practitioners understood their Iraqi refugee clients' cultural idioms of distress and cultural phrases better, they might better understand the broad sociocultural factors impacting their clients' lives and experiences of emotional distress. This understanding coupled with knowledge about culturally appropriate interventions could lead to better therapeutic relationships and outcomes.

Clinical Suggestions

In order to address the shortcomings in practitioner knowledge of idioms of distress and expand their view beyond the biomedical model, I propose a two-phase intervention that I

believe would help practitioners better understand their clients and offer more beneficial solutions. Phase one of this intervention will include distributing background readings written by Iraqi or Iraqi-American authors to American born and Iraqi practitioners alike to provide information on their Iraqi refugee clients' background, history, and culture and how those factors influence their experience and expression of trauma. One subset of background readings would outline the history of Iraq, the conflicts that have taken place, the major beliefs in Islam, and the impact of religion on Iraqi culture and Iraqis' lived experience. Another subset of readings would define cultural idioms of distress as a broad concept, how it came to be and how idioms can manifest (see Appendix VIII for a list of suggested readings). The phase one background readings will provide practitioners with the hard skills required to understand their Iraqi refugee clients' backgrounds and their influence on lived experiences of trauma and emotional distress. However, these background readings alone will only provide a portion of the information that practitioners require, as they must also understand the soft skills required to work with Iraqi refugees, which phase two will address.

Phase two of the intervention will focus on the soft skills that American born practitioners should acquire in order to successfully work with Iraqi refugee clients. These soft skills include how to build rapport with Iraqi refugee clients, how to have a more holistic view of client struggles, and how to suggest culturally appropriate interventions. Phase two of the intervention will include Iraqi practitioners providing training to their American colleagues at different refugee resettlement agencies. They will begin by sharing their lived experience of living in Iraq, resettling in the US, and the struggles and successes they have had to date. These Iraqi practitioners will also share how their specific idioms of distress manifest in their daily lives and how these idioms are related to their religion and cultural history. In doing so, they will also share how their idioms of distress differ from common cultural phrases, such as *inshallah*, and how important that distinction is. The Iraqi practitioners should also teach the American born practitioners to become more comfortable with asking their clients to explain or conceptualize their use of cultural phrases like *inshallah* instead of simply assuming what their clients mean. Hopefully this lived experience will more deeply solidify the cultural and religious information that the American born practitioners learned through the background readings. I do

acknowledge, however, that the re-telling of one's resettlement journey can be traumatizing and difficult. This proposed intervention would thus be contingent upon their willingness and carried out with sensitive precautions. In addition, the Iraqi practitioners will be compensated accordingly for their work and time.

Then, the Iraqi practitioners will move on to teaching their American born colleagues how to build rapport with Iraqis by moving beyond the traditional formal structure of therapy and incorporating more personal connection. This could be done by having American born practitioners ask their Iraqi refugee clients more background questions about their lives, families, backgrounds and interests. The American born practitioners could then share stories about their own backgrounds and attempt to create a deep personal connection and relationship with their clients, which could help the clients feel more at ease and welcome. The Iraqi practitioners should also teach that another way to build rapport with clients is by asking clients how they would like to conduct sessions when cultural misunderstandings arise. For example, if an Iraqi refugee woman brings her husband to her therapy session, instead of simply being uncomfortable, the American born practitioner should ask her client how to proceed, who the questions should be directed towards, and what the role of her husband will be in the session.

The Iraqi practitioners will also teach their American colleagues to have a more holistic view of client struggles, which would stem from asking clients about their backgrounds and extend to thinking about how their clients' struggles are not only biologically based, but also deeply related to their cultural, religious, and ethnic background and current sociocultural issues. Such a holistic view requires practitioners to look beyond the biomedical framework and understand their clients' broader issues with resettlement and adjustment to life in the United States and how those issues may influence their experience and expression of emotional distress. In order to do so, practitioners may begin to think about how their clients' manifestation of DSM diagnoses such as depression stem not only from genetic and biological factors, but also perhaps from disillusionment about living in the US, a sense of being uprooted from their lives and families or a lack of trust within their own community.

Once practitioners have a more holistic view of their clients' struggles, they can begin to develop and suggest more culturally appropriate interventions that do not rely on the biomedical

model and instead address the sociocultural factors that are impacting their clients. For example, American born practitioners should be taught that some common biomedical treatments for mental illness, such as exercise and psychiatric medication, are not effective for Iraqi refugees, and thus should not be suggested (Sharara et al., 2018). American born practitioners should also be taught to consider and suggest more culturally appropriate interventions that take into account their clients' lived experiences, backgrounds and social identities. One such intervention is narrative therapy, which allows clients to holistically conceptualize their life's struggles and successes in their own culturally and religiously constituted way (Neuner et al., 2004). In addition, narrative therapy may feel more comfortable for Iraqi refugee women who are unwilling to share intimate details of their trauma with their therapist while their husbands are in the room but are more willing to share their broad life story. Such culturally sensitive therapies may make clients feel more welcome which could improve the therapeutic relationship and potentially also improve therapeutic outcomes for Iraqi refugee clients.

It is crucial that these interventions are taught by Iraqi practitioners and delivered to their American colleagues for a variety of reasons, including that the Iraqi practitioners are able to share their lived experience and vast breadth of knowledge on their culture, and most importantly, this would upend the existing power hierarchy in refugee resettlement agencies. In many refugee resettlement agencies, the immigrant practitioners, such as Iraqis, are employed in positions with less power and prestige, such as caseworkers and interpreters, while the American born biomedically trained practitioners are often employed in positions with greater power, such as therapists and psychiatrists. Thus, flipping this power hierarchy would not only provide valuable knowledge to American born practitioners, but would also empower the refugees, giving their lived experiences the credibility and focus that is deserved. In culmination of all my suggestions, I have created a deliverable for use in refugee resettlement agencies that work with Iraqi refugee clients, which includes a detailed description of the suggested intervention (see Appendix VIII).

Limitations

Although this study has illustrated important points about cultural idioms of distress and practitioner view of client struggles, there are some limitations surrounding social desirability and lack of generalizability of the findings. The issue of social desirability may have arisen within my interviews because five of the participants knew me personally through my work in Utah. These participants may have been trying to answer in ways that they thought I would want to hear. On the other hand, our familiarity with one another may also have facilitated rapport and a willingness to disclose more personal information in a more genuine way. In any case, it is important to note that the interviews were not anonymous and five out of fourteen were conducted with people with whom I had previously worked. In addition, due to the small sample size of eight Iraqi and six American practitioners, it is difficult to draw firm conclusions about between group comparisons. There was also sampling bias, as only fourteen of the thirty-one individuals that I emailed agreed to be interviewed for my project. This could mean that the fourteen participants who agreed to be interviewed by me were already more culturally sensitive and interested in their clients' cultural idioms of distress, which could have skewed my results. If this is true, then it could mean that the larger population of practitioners in Salt Lake City have less knowledge about cultural idioms of distress and greater adherence to the biomedical model, so this may have interfered with my ability to draw conclusions from my data.

Directions for Future Research

Through my research, I discovered that practitioners vary in their understanding or lack of understanding of their Iraqi refugee clients' specific culture, idioms of distress and cultural phrases. I also found that practitioners vary in their view of client struggles, either by using a narrow biomedical lens that led to difficulties with diagnosis, rapport building and interventions, or by using a broad socially and culturally holistic view which led to connections with clients and the ability to break barriers to treatment. Since my research on cultural idioms of distress within Iraqi refugee populations in Utah is exploratory and hypothesis generating, I hope that future larger studies will attempt to replicate and confirm my findings in a quantitative and confirmatory way. I hope that these studies will be nationally representative by interviewing

practitioners around the United States. Future research should also consist of large studies on cultural idioms of distress with other refugee groups. Lastly, I hope future studies will compare the therapeutic results of American born practitioners working with refugees and ethnically matched practitioners working with the same population. I hope that these studies would be able to explore my qualitative findings through a more quantitative and statistical analysis.

Although it is far beyond the scope of my study, I hope that one day my studies and others like it on cultural idioms of distress and the mental health of refugee populations will lead to a new way of looking at mental health that spans beyond simply the biomedical view of DSM diagnoses and biologically based treatments. Instead, this new view of mental health will take into account biological factors of mental illness while also equally valuing the cultural, religious, and ethnic factors that can influence an individual's experience of trauma and the best treatment of that trauma. These modifications of the medical experience for refugees would help re-settle the resettlement structures overall, making the process more sensitive and accessible for many. Maybe then more refugees like my grandmother will feel heard and be able to live out the rest of their lives more comfortably.

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VII. Appendices

Appendix I: Interview Questions

Part I: Mental Health (open ended)

1. In general, what are you seeing as the main mental health struggles of the Iraqi refugee population?

2. What works best when you try to understand your clients' mental health struggles in the context of their cultural background?

3. What are the challenges you have encountered when you try to understand your clients' mental health struggles in the context of their cultural background?

Part II: Physical symptoms (open ended)

1. Iraqi refugees may manifest mental health problems as physical symptoms, do you see this in your clients?

2. (If "yes" to #1) What are the main physical ailments mentioned by your clients that seem to have no physical underlying cause?

Part III: Idioms (closed): I will now read a list of local idioms of distress of Iraqi refugee disclosed through the use of the Harvard Trauma Questionnaire. Please tell me if the population you work with has ever used these words:

1. Dayeg (which means poor concentration, lack of initiative and physical symptoms such as headache and breathlessness) Yes No

2. Qalbak maqboud (which corresponds to the heart) Yes No

3. Qalb (being squeezed with feelings of sadness and anxiety) Yes No

4. Asabi (which is derived from asab, nerves, and describes irritability and nervousness) Yes No

5. Nafsak deeyega and mahnouk (which mean constriction of the chest and a choking sensation and relates to feelings of tension due to daily hardship and can physically manifest as shortness of breath) Yes No

6. Nafseetak ta'abana (which means that a person's soul is tired and relates to anxiety and depression) Yes No

7. Inziaaj (which means uneasiness) Yes No

8. Ihbat (which means frustration) Yes No

9. Khawf (which means fears) Yes No

10. Daghet (which means pressure) Yes No

11. Ta'ab (which means tiredness) Yes No

12. Sadma (which means shocked) Yes No

13. Insilakh (which means uprooting) Yes No

14. Hasbiya Allah wa ni'ma l wakil and Allah y'in (which both refer to the hope in God's assistance to face trouble and injustice) Yes No

15. Other than those terms, what concepts and words have you heard Iraqi refugees use to express mental distress?

16. Which concepts seem to be most problematic and disruptive in their lives?

17. Are the Iraqi refugees' idioms of distress much different from the other refugee groups you work with?

Part IV: For translators

1. How do you translate the words and concepts that Iraqi refugees use to describe mental distress to the therapists?

2. Are there some concepts and words that can't be translated?
    a. Follow-up: What do you do then?

Part V: Conclusion

1. Is there anything you wish you'd known before you began working with this population?

Appendix II: Recruitment Email

For service providers who work with Iraqi refugees in Utah:

We are currently in the process of looking at the cultural idioms of distress of Iraqi refugee populations. In that process, we are seeking permission to interview service providers. If you choose to be a part of this study, we will schedule a time to meet with you over Zoom. There will be no compensation for the interview but there is the potential benefit of us being able to document and distribute a list of common cultural idioms, which may benefit providers.

If you are willing to participate in the study, please contact Nadyah Spahn at nasp6573@colorado.edu to set up a time to interview and sign a consent document.

Appendix III: Consent Form

Title of research study: Iraqi Refugees' Cultural Idioms of Distress

IRB Protocol Number: 20-0240

Investigator: Nadyah Spahn

Sponsor: Dr. Jennifer Schwartz

Purpose of the Study

The purpose of the study is to illuminate the cultural idioms of distress of Iraqi refugees. This knowledge is currently localized in the service providers who work with Iraqi refugees and see how their unique culture manifests in their expression of emotional distress, but it is not well disseminated. I will gather that localized knowledge through interviews with service providers who work with Iraqi refugees, and then create and disseminate a report which could help other service providers refer refugees to culturally appropriate treatment.

We expect that you will be in this research study for one hour.

We expect about ten people will be in this research study in Utah.

Explanation of Procedures

In this study, you will receive a message setting up a Zoom meeting to discuss the interview questions. That message will also include the consent form, which we will go over. Then in the Zoom meeting, which will last about one hour, I will ask a series of ten interview questions about the general mental health struggles of the Iraqi refugee population, the physical health struggles they experience, the cultural idioms of distress utilized, and how that is translated to providers. You will have the option to be video recorded, and any video recordings will be password protected in the cloud. At the end of the survey, you will be given the option to help us gather contact information for other providers in the Utah area.

Voluntary Participation and Withdrawal

Whether or not you take part in this research is your choice. You can leave the research at any time and it will not be held against you.

Potential Benefits

We cannot promise any benefits to you or others from your taking part in this research. However, possible benefits may include having a useful summary of the common cultural idioms of Iraqi refugees.

Confidentiality

Information obtained about you for this study will be kept confidential to the extent allowed by law. Research information that identifies you may be shared with the University of Colorado Boulder Institutional Review Board (IRB) and others who are responsible for ensuring compliance with laws and regulations related to research, including people on behalf of the Office for Human Research Protections. The information from this research may be published for scientific purposes; however, your identity will not be given out.

If you agree to be video recorded, the videos will be password protected on the cloud for a year, after which they will be deleted.

Questions

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the research team at 303-596-1335 or nasp6573@colorado.edu.

This research has been reviewed and approved by an IRB. You may talk to them at (303) 735-3702 or irbadmin@colorado.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research subject.
- You want to get information or provide input about this research.

Signatures

Your signature documents your permission to take part in the interview portion of this research.

I agree to be video recorded during the interview.

___ Yes.

___ No.

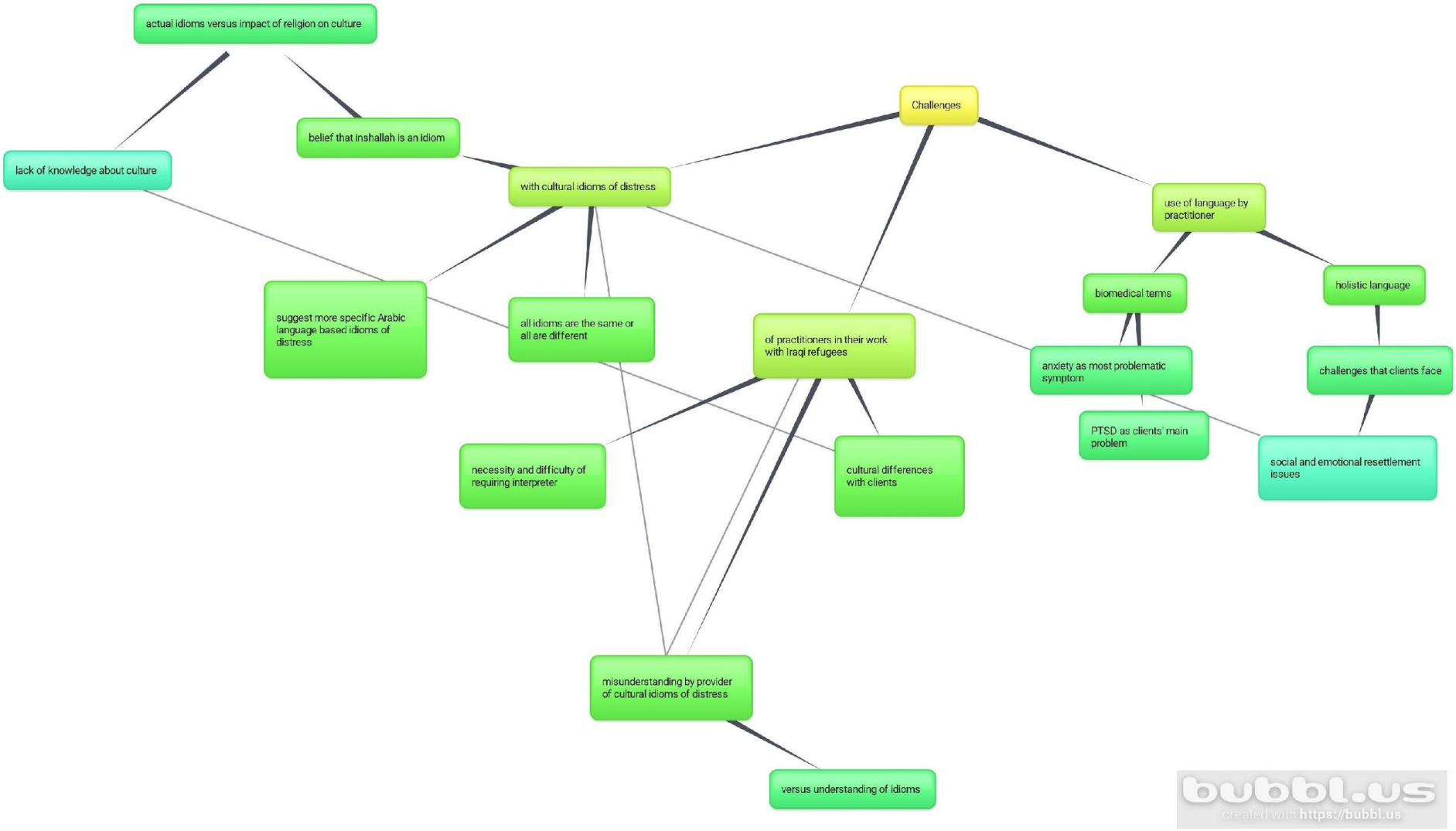
Signature of subject Date

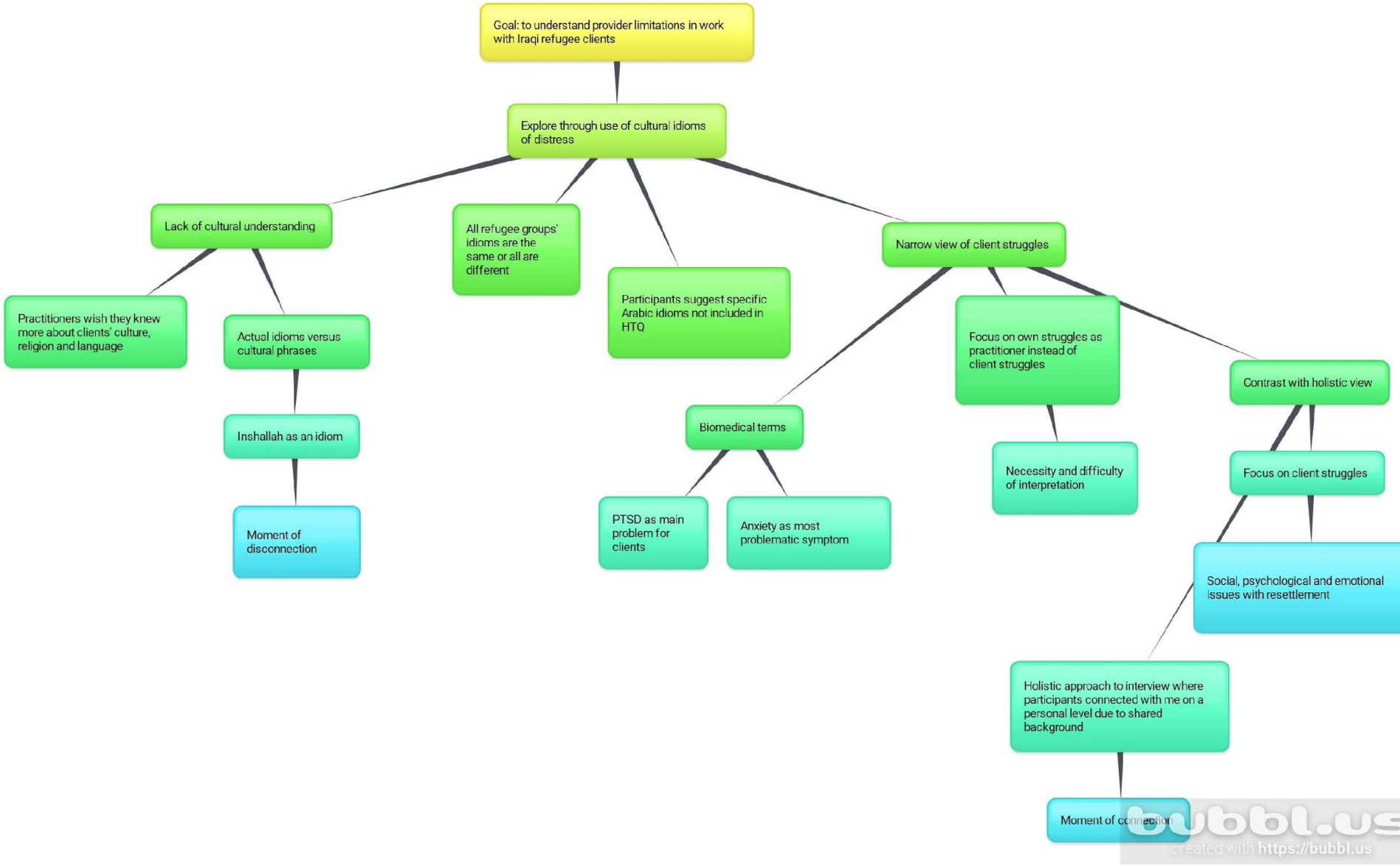
Printed name of subject

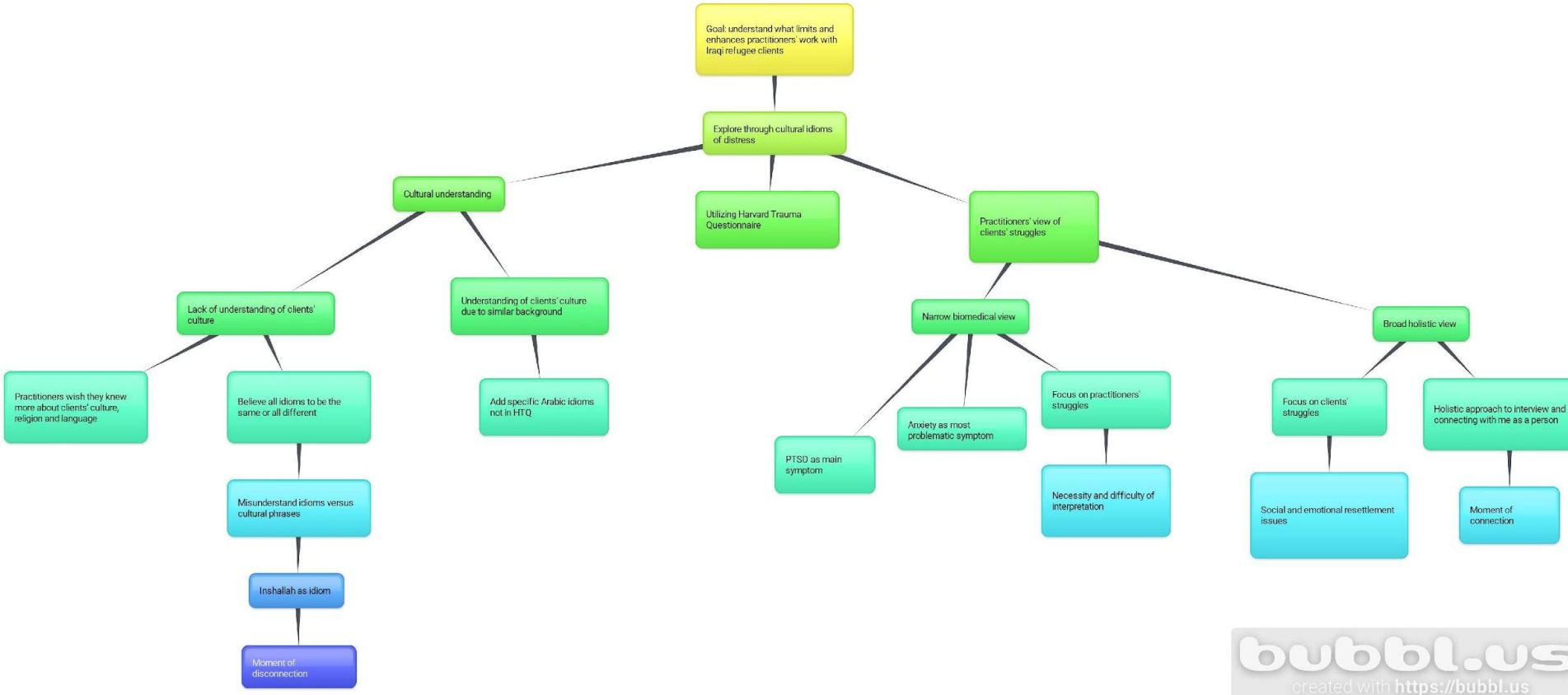
Signature of person obtaining consent Date

Printed name of person obtaining consent

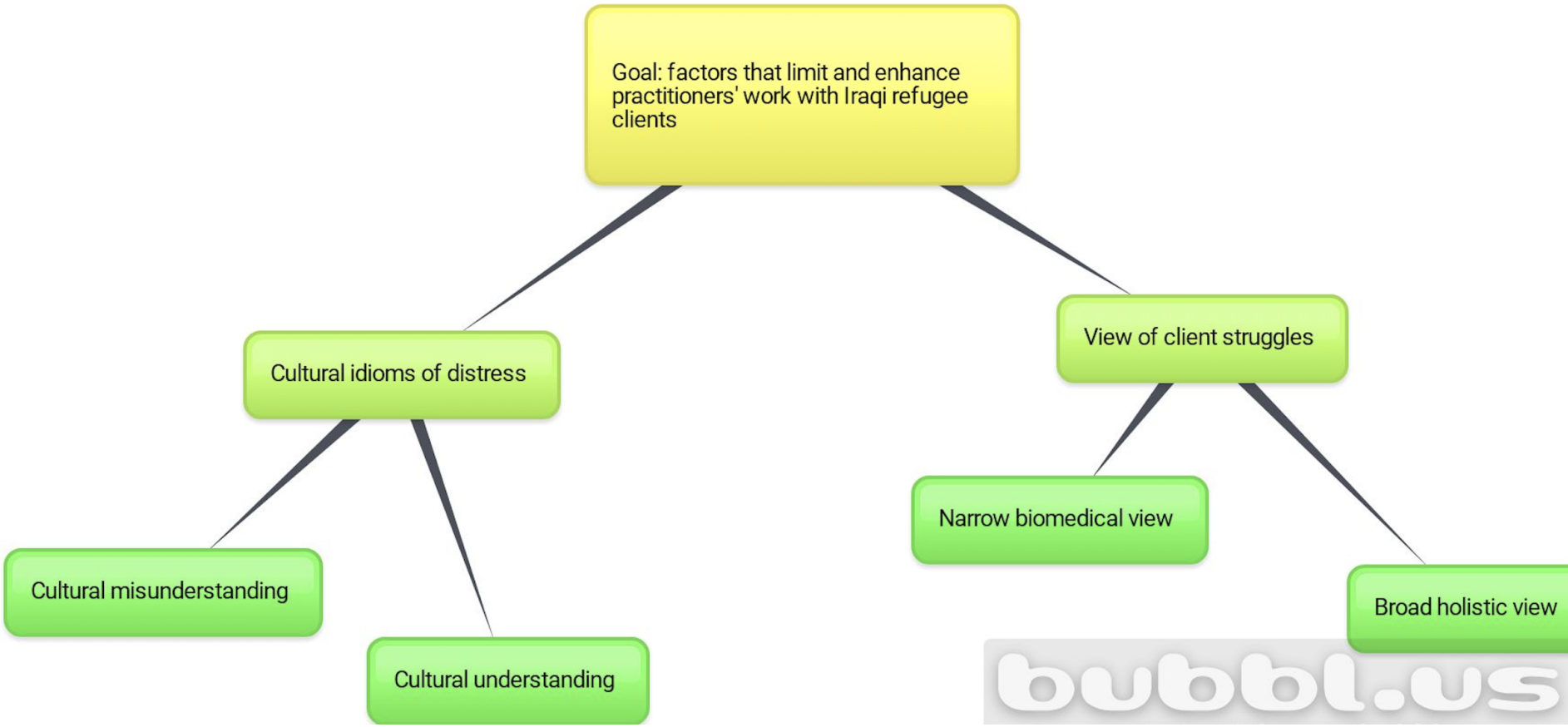
Appendix IV: Concept Maps (initial, second, third, and final)


actual idioms versus impact of religion on culture
belief that inshallah is an idiom
lack of knowledge about culture
with cultural idioms of distress
Challenges
use of language by practitioner
biomedical terms
holistic language
suggest more specific Arabic language based idioms of distress
all idioms are the same or all are different
of practitioners in their work with Iraqi refugees
anxiety as most problematic symptom
challenges that clients face
PTSD as clients' main problem
social and emotional resettlement issues
necessity and difficulty of requiring interpreter
cultural differences with clients
misunderstanding by provider of cultural idioms of distress
versus understanding of idioms
bubbl.us
created with https://bubbl.us


Goal: to understand provider limitations in work with Iraqi refugee clients
Explore through use of cultural idioms of distress
Lack of cultural understanding
All refugee groups' idioms are the same or all are different
Participants suggest specific Arabic idioms not included in HTQ
Narrow view of client struggles
Practitioners wish they knew more about clients' culture, religion and language
Actual idioms versus cultural phrases
Inshallah as an idiom
Moment of disconnection
Biomedical terms
PTSD as main problem for clients
Anxiety as most problematic symptom
Focus on own struggles as practitioner instead of client struggles
Necessity and difficulty of interpretation
Contrast with holistic view
Focus on client struggles
Social, psychological and emotional issues with resettlement
Holistic approach to interview where participants connected with me on a personal level due to shared background
Moment of connection
bubbl.us
created with https://bubbl.us


Goal: understand what limits and enhances practitioners' work with Iraqi refugee clients
Explore through cultural idioms of distress
Cultural understanding
Utilizing Harvard Trauma Questionnaire
Practitioners' view of clients' struggles
Lack of understanding of clients' culture
Understanding of clients' culture due to similar background
Narrow biomedical view
Broad holistic view
Practitioners wish they knew more about clients' culture, religion and language
Believe all idioms to be the same or all different
Add specific Arabic idioms not in HTQ
PTSD as main symptom
Anxiety as most problematic symptom
Focus on practitioners' struggles
Focus on clients' struggles
Holistic approach to interview and connecting with me as a person
Misunderstand idioms versus cultural phrases
Necessity and difficulty of interpretation
Social and emotional resettlement issues
Moment of connection
Inshallah as idiom
Moment of disconnection
bubbl.us
created with https://bubbl.us

Final Concept Map



Appendix V: Participant Table

Participant	Background	Occupation	Gender	Relationship
1	American born	Social worker	Female	Yes
2	Iraqi	Women services coordinator	Female	No
3	American born	Social worker	Female	Yes
4	Iraqi	Interpreter	Male	No
5	Iraqi	Social worker	Female	No
6	American born	Refugee health coordinator	Female	No
7	American born	Social worker	Male	Yes
8	Iraqi	Case worker	Male	No
9	Iraqi	Social worker/interpreter	Male	No
10	Iraqi	Case worker/interpreter	Female	Yes
11	American born	Psychiatrist	Female	No
12	Iraqi	Health promotion program coordinator	Female	No

13	Iraqi	Case worker/interpreter	Male	Yes
14	American born	Psychiatrist	Female	No

Appendix VI: Summary of knowledge of cultural idioms of distress as indicated by percentages and frequencies for total participants, Iraqi participants and American participants

Idiom	Frequency total	Iraqi frequency	American frequency
Dayeg (‘poor concentration, lack of initiative… headache and breathlessness’)	100% (14)	100% (8)	100% (6)
Qalbak maqboud (‘the heart’)	93% (13)	100% (8)	83% (5)
Qalb (‘squeezed with feelings of sadness and anxiety’)	88% (12)	88% (7)	66% (4)
Asabi (‘irritability and nervousness’)	100% (14)	100% (8)	100% (6)
Nafsak deeyega/ mahnouk (‘constriction of the chest and a choking sensation’)	93% (13)	100% (8)	83% (5)
Nafseetak ta’abana (‘soul is tired, relates to anxiety and depression’)	100% (14)	100% (8)	100% (6)
Inziaaj (‘uneasiness’)	88% (12)	88% (7)	83% (5)
Ihbat (‘frustration’)	100% (14)	100% (8)	100% (6)
Khawf (‘fears’)	88% (12)	75% (6)	100% (6)
Daghet (‘pressure’)	93% (13)	100% (8)	83% (5)
Ta’ab (‘tiredness’)	100% (14)	100% (8)	100% (6)
Sadma (‘shocked’)	93% (13)	100% (8)	83% (5)
Insilakh (‘uprooting’)	69% (10)	75% (6)	50% (3)
Hasbiya Allah wa ni’ma l wakil and Allah y’in (‘hope in God’s assistance to face trouble and injustice’)	88 (12)	88% (7)	83% (5)

Appendix VII: Summary of client struggles as indicated by population (Iraqi or American), question, and responses*

Question	Responses	Participant Population		
		Iraqi	American	Total
In general, what are you seeing as the main mental health struggles of the Iraqi refugee population?	Anxiety, depression	88% (7)	50% (3)	71% (10)
	PTSD	38% (3)	83% (5)	57% (8)
	Other	63% (5)	67% (4)	64% (9)
What are the challenges you have encountered when you try to understand your clients' mental health struggles in the context of their cultural background?	Stigma and lack of trust	100% (8)	33% (2)	71% (10)
	Cultural differences and need for interpreter	25% (2)	100% (6)	57% (8)
Is there anything you wish you'd known before you began working with this population?	Dialect, culture and religion	38% (3)	0% (0)	21% (3)
	Language, culture and religion	0% (0)	83% (5)	36% (5)

Responses are not mutually exclusive

Appendix VIII: Deliverable of suggested two-phase intervention

In order to help American born practitioners learn more about their Iraqi refugee clients' culture, holistic conceptualization of their experiences and struggles, and how to best build rapport, diagnose and suggest culturally appropriate interventions, I suggest a two-phase intervention that includes both hard skills and soft skills. My hope is that if this intervention is implemented in a refugee resettlement agency, it will help American born practitioners work better with their Iraqi refugee clients and potentially improve therapeutic relationships and outcomes.

The first phase of the intervention includes teaching American born practitioners hard skills through distributing background readings about Iraqi culture and history. These readings will be split into two subsets, one focusing on the history of Iraq and conflicts, the main beliefs in Islam and how religion impacts the lived experience of Iraqi refugees, and the second focusing on defining cultural idioms of distress as a broad concept, how it came to be and how idioms can manifest. Suggested readings include (Nichter, 2010) for an overview of cultural idioms of distress, (Bolton, 2013) for an overview of mental health in Iraqi, (*Iraq Refugee Crisis*, n.d.) for information about Iraqi refugees, and (*Mental Health | Iraqi | Refugee Health Profiles | Immigrant and Refugee Health | CDC*, 2019) for information about the mental health of Iraqi refugees.

After practitioners gain the hard skills of cultural knowledge through their background readings, there will be a second phase devoted to Iraqi practitioners teaching their American born colleagues the soft skills of how to develop rapport with their Iraqi refugee clients, how to diagnose and how to suggest culturally appropriate interventions. Before this phase begins, the Iraqi practitioners will be consulted for their willingness and permission to teach their American born colleagues because re-sharing one's resettlement story can be traumatizing and difficult and no practitioner should be forced to do so if they are comfortable. If Iraqi practitioners are comfortable doing so, they will then share their lived experience of being in Iraq and resettling in the US, along with how their idioms of distress manifest in their lives and how those idioms are related to their religious, cultural and historical background. The Iraqi practitioners will also share the difference between their idioms of distress and cultural phrases, such as *inshallah.* This lived experience should help solidify concepts in readings and connect religion, culture and history to experiences and expressions of distress.

As part of the second phase, the Iraqi practitioners will teach their American born colleagues how to build rapport with their Iraqi refugee clients, by asking clients more personal life questions and then sharing more personal stories to create connection and a deeper relationship. Next, the Iraqi practitioners will teach their American born colleagues how to have a more holistic view of their clients' struggles by learning to look beyond the DSM and take into account their clients' resettlement issues like disillusionment, feeling uprooted, and lack of trust and how those may impact their lives. Lastly, Iraqi practitioners should teach their American born colleagues how to suggest culturally appropriate interventions, such as narrative therapy, instead of standard biomedical treatments such as exercise or psychiatric medication, which may not be effective for Iraqi refugees.