“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.

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. 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 (*Mental Health Facts.Pdf*, n.d.). Most of these refugees live in Salt Lake County, and many display symptoms of mental illness. 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 (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.

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 client's 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.

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.

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 any specific struggles individual refugees faced in the past.

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.

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.

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.

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.

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.

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.

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. 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.

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 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.

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.

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. Phase two of the intervention will focus on the soft skills that American born practitioners should acquire and will include Iraqi practitioners providing training to their American colleagues at different refugee resettlement agencies. They will share their lived experience of living in Iraq, resettling in the US, and how their specific

idioms of distress manifest in their daily lives and how these idioms are related to their religion and cultural history.