Second Languages and Second-Guessing:
Mental Health Providers Working in Arabic as Their Second Language

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Abstract

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This qualitative study is focused on understanding the experiences of mental health providers in the United States who speak Arabic as a second language and work professionally in that language. We examine how mental health providers perceive working with Arabic-speaking clients, how they prepare for and evaluate these sessions, and their understanding of successes and challenges. In-depth interviews with four providers were conducted to derive data for this study. The study demonstrated that providers who do not consider themselves fluent in Arabic second-guess the strength of the mental health services they provide. However, all participants highlighted the importance of shared cultural familiarity between client and participant and the use of Arabic to build rapport. Future research should include clients and larger numbers of providers from diverse backgrounds and identities working in different environments to continue to fill the gap in research surrounding Arabic-speaking populations and mental health in the United States.

Keywords: mental health, multicultural counseling, Arab Americans, therapist-client language matching, refugees, Arabic

Second Languages and Second-Guessing:

Use of Arabic by Mental Health Providers Working in their Second Language

Forty-three percent of displaced persons in 2017 came from nation members of the Arab League (United Nations, 2018). Refugees and asylum seekers experience higher rates than population averages of depression and post-traumatic stress disorder (PTSD), possibly as high as 40% (Turrini et al, 2017). As more non-governmental organizations (NGOs), community clinics, and mental health professionals (MHPs) attempt to serve this growing population with a demonstrated mental health need, it is important to evaluate the services and resources provided (Hammad & Hamid, 2021). A specific challenge is language access, which this exploratory qualitative study addresses by interviewing MHPs who work in Arabic as their second language (L2) at NGOs and clinics across the United States that work with Arabic-speaking clients (primarily refugees and asylum seekers). This study is interested in examining how MHPs approach their work with Arabic-speaking clients, their perceptions of successes and challenges, and how language and culture show up in therapy sessions. The study concludes with some recommendations for further study and possible practices for clinics and MHPs to adopt.

Background

Demographics

Arabic is the fifth most spoken language at home other than English in the United States (Batalova et al., 2021). Yet there is limited research focused on mental health services for Arabic-speaking clients in the United States and mental health providers working in the Arabic language

in the US (for this study, mental health providers refers to therapists, counselors, clinical social workers, and psychologists). Much of the available research, especially since the conflicts following the US invasion of Iraq, focuses on sample populations of recently arrived refugees from Iraq and Syria (Jamil et al, 2002; Kira et al, 2008; M'zah et al, 2019). Refugees are specific subsets of the population of Arabic-speaking residents of the United States, and any generalizations of findings in regard to working with other Arabic-speaking populations may have significant caveats including statistically increased likelihoods of suffering from Post-Traumatic Stress Disorder (PTSD) and depression. In a 2014 review, between 8 and 37.2% of Iraqi refugees were found to experience PTSD, and between 28.3 and 75% suffered from depression. These rates are well above the average levels of general populations in both the USA and Iraq (Slewa-Younan et al., 2014). In general, refugees are 10 times more likely to have PTSD than populations in their country of resettlement (Fazel et al, 2005). This means that Arabic-speaking clients, especially refugees, may have greater need for mental health resources, while simultaneously having less native language access.

Language Barriers

The organizations which participants in the present study work for prominently advertise language-matching therapists and clients, either through interpretation or a proficient provider, and providing culturally responsive therapy. Language matching, like any variable in the therapeutic relationship, should not be taken for granted as automatically improving outcomes. A systematic review of studies on language matching found that language matching, as well as matches along

ethnicity, race and gender, were not more effective than therapist-client pairings not matched by language (Flaskerud, 1990).

Beyond language, studies have also focused on identity matching in terms of race, ethnicity, religion, and a myriad of other statuses. A recent meta-analalytic review of client preferences in regards to race and ethnicity matching in mental health services also found little difference in patient outcomes, despite a significant stated preference from clients to work with a therapist who matches their own race/ethnicity (Cabral & Smith, 2011). Another qualitative study of 16 clients from racial and ethnic minorities in the United States working with White, European-American therapists found that even clients who viewed their race, ethnicity and culture as not pertinent to their therapeutic goals, reported struggled at times working with White therapists. The study concluded that, in general, it is advised that therapists directly address cultural differences early in the relationship, but that they work to avoid stereotyping their clients by understanding the many different identities an individual can hold and how they interact (Chang & Berk, 2009). There appears to be a gap in research matching immigration statuses or experiences between clients and therapists, an identity that is key to working with immigrants, refugees and asylum seekers, and possibly their children.

Language is clearly a significant barrier to entry, and likely results in many immigrants not seeking mental health services and not being referred for services by providers (Giammusso et al., 2018). Spanish is the most common language other than English spoken in the US (Batalova, 2021). As a result, much more research has been completed on providers working in Spanish, including those working in Spanish as a second language. Estrada et al. (2018) studied 22 bilingual therapists and their self-perceived confidence in using correct clinical terminology in

Spanish during sessions. The study, which included providers who work with monolingual Spanish-speaking clients at a single community health center in the San Fernando Valley serving low-income clients, found that 68% of the participants struggle to translate clinical therapeutic terms into Spanish approximately one to three times during a session, and that only six participants had received any formal training in clinical Spanish. Perhaps unsurprisingly, counselors who identified as bicultural native speakers of Spanish (17 of the 22 providers) reported less discomfort, while non-native speakers expressed feelings of embarrassment at times, and fears of being seen as incompetent due to linguistic mistakes. Santiago-Rivera et al (2009) found that bilingual Spanish speaking therapists used Spanish to build rapport with clients by using shared Spanish idioms. Providers also noted that clients seemed to present certain emotions in Spanish more than in English. Notably, there is no parallel research available to our knowledge on mental health providers who work in Arabic as their second language. This present study is an opportunity to explore this gap in the research.

In a systematic review of language barriers in healthcare settings (primarily hospitals and clinics) in the US, several countries in Europe as well as South Africa and Saudi Arabia, up to 70% of Arabic-speaking patients avoided or ended conversations with nurses who did not speak Arabic, and half believed the language barrier could cause problems and misunderstandings (Al Shamsi et al., 2020). It is unsurprising that patients and providers are likely to have some level of miscommunication, and both may avoid being as in-depth or open in their discussions due to language barriers. The implications for mental health could be serious, for example not disclosing or discussing suicidal ideation.

Gaps in Therapy for Arabic-Speaking Populations

Several studies have been conducted in the Middle East on mental health and refugees. McNatt's (2019) qualitative study of Syrian refugees in Jordan and their access to healthcare services for noncommunicable diseases (NCDs) argues that most interviewees reported emotional distress as a primary concern. The study did not examine mental health as a NCD, instead focusing on diabetes, asthma, and hypertension. Turki's (2020) study the following year, also in Jordan, focused instead on UNRWA staff and mental health programs. This cross-sectional study took place via questionnaires, and reveals a widespread perception that refugees are increasingly displaying mental health symptoms, especially depression.

Several scholars have referred to Arab-Americans and Arabs in the US as an "invisible" minority due to a lack of research on this population overall (Naber, 2000; Cainkar, 2007; Jamal, 2007; Amer, 2014). However, there has been an increase in studies involving Arabs in the US since the September 11th attacks, the so-called "War on Terror," and the resulting waves of Arabic-speaking refugees and immigrants that have since emigrated to the US. In the US, M'Zah (2019) surveyed 25 adult Syrian refugees recently resettled in the Atlanta metropolitan area. This study, although small, showed that the main deterrents to seeking mental health assistance were lack of knowledge surrounding resources, as well as stigma. This stigma may be heightened in small immigrant populations due to a perceived lack of confidentiality because of close-knit community connections. Linguistically, Cummings (2017) argues that it is ideal for therapist and client to be matched by language, but that effective work can still be accomplished by incorporating a client's first language into therapy sessions in a controlled manner.

Two older studies in the US focused on Iraqi refugees in the US. Jamil, et al. (2002) reviewed the mental health records of 375 Iraqi refugees at a single clinic and found that Iraqi refugees presented more post-traumatic stress disorder (PTSD) and other health issues when compared to other clients. In 2008, Kira, et al. studied the physical and mental health effects of Iraq War media exposure on Iraqi refugees in the US. This study of 501 participants found that continued exposure to media of the Iraq war is a Type III collective identity secondary trauma for Iraqis which suggests a risk ongoing retraumatization when this media is consumed.

In Europe, several studies involving Arabic-speakers have also been conducted due to the recent influx of migrants from the region. In Sweden, Hadziabdic and Hjelm (2014) interviewed 13 Arabic-speaking, mostly Iraqi refugees on their experiences with interpreters in the healthcare system since arriving to Sweden. The study found that interpreters play a vital role, but that the identities of the interpreter (country of origin, religion, dialect, gender, and any preconceptions of their political views) impact the perceived effectiveness of the interpreter by the client. On the other hand, Hassan et al (2021) interviewed 10 mental health interpreters working in the United Kingdom on their experiences working with refugees. The interpreters reported a sense of pride and accomplishment in their work, but also a sense of invisibility and a lack of recognition. Some participants, coming from similar backgrounds as their clients, felt unsure of what to do with their emotional responses and secondary trauma because of hearing their clients' stories.

Australia, perhaps of note as another country where English is the dominant language with a similar colonial history to the United States (and a participant in the invasion of Iraq), has also played host to several recent studies on mental health and Arabic-speaking refugees. A small study by Slewa-Younan (2020) with 33 Iraqi refugees found that mental health literacy is low

compared to the Australian populace as a whole, and that culturally tailored interventions provided almost immediate improvements in mental health literacy and psychological distress.

Present Study

This study explores the self-perceived effectiveness of mental health providers in the US who are working in Arabic as their second language (L2), whether bicultural or not. In this study, L2 describes providers who are second-generation immigrants who may have learned Arabic as their first language but at this point consider Arabic their L2; native or bilingual speakers who do not consider themselves fluent in clinical or professional registers (such as native speakers who studied at English-speaking universities or who may have grown up in the United States); and providers with different levels of literacy and familiarity with Modern Standard Arabic as opposed to specific dialects of Arabic. Modalities and therapeutic interventions are considered but further research will be needed to flesh out the effectiveness of common interventions being used.

Among 32,000 American college students who studied Arabic in 2016, a notable percentage of these students may achieve professional proficiency and work in mental health fields (Looney & Lusin, 2019). Therefore, it is important to gain a greater understanding of these providers, and the overarching lack of access to Arabic-speaking providers in the US. There are no studies as far as we know that focus on mental health providers who use Arabic as their second language in practice, either in the US or elsewhere. There is a temptation to generalize the findings of studies of other minorities, especially from the relative abundance of studies on Spanish-speakers in the US. While some insights will likely be shared, the distinct linguistic and cul-

tural aspects of Arabic deserve explicit study. Moreover, even the term "Arabic-speaker" is a generalization employed by many studies in their summaries and titles, which risks flattening the different experiences of migrants from different parts of the Arabic-speaking world, or minority identities such as Kurds or Amazigh who likely speak Arabic as a second language.

Finally, the role of the US as a recent invader and occupier of large parts of the Middle East and surrounding region cannot be ignored. The US government's implicit or explicit support of various regimes and occupations, from Morocco to Israel to Saudi Arabia is a possibly pertinent aspect of a therapist-client dyad to consider. Much work has been done in Israel regarding transference and countertransference between Jewish therapists and Palestinian clients and vice-versa (Gorkin, 1986; Srour, 2015). This dynamic has also been transplanted to a US context and explored by Israeli-American therapist Shoshana Ringel (2002) working with a Palestinian client at the height of the Second Intifada. Lara Sheehi and Stephen Sheehi (2022) take a critical view of these "well-meaning clinicians" and argues that military occupation negatively impacts the therapeutic dyad, and at worst furthers colonial projects by pathologizing subjects as individuals suffering from mental health issues as opposed too systemic oppression. Recent studies have also focused on the impact of the global War on Terror and Islamophobia for Arabic-speaking clients (Bushra, 2007; Aggarwal, 2018). However, little if any work has been done on the impact of US imperialism on the therapeutic dyad that has resulted (either directly or indirectly) in the client's resettlement in the US and working with an American provider, most likely of a different heritage and language. It could be argued that in some scenarios this is another example of an occupied subject working with an occupier, albeit in a different context than other studies in Israel and Palestine.

By interviewing mental health providers working in Arabic as their second language at organizations serving displaced persons, this exploratory study seeks to better understand how providers approach and prepare for sessions with Arabic-speaking clients, and how they perceive the successes and challenges of these therapeutic encounters. The vulnerable status of these clients, the projected increase in refugee resettlement in the US from Syria and Iraq, along with the overall lack of availability of Arabic-speaking providers, make it even more urgent to evaluate services provided and how to improve them. Further research needs to be completed involving a broader range of providers and clients, including native Arabic-speakers and clients who are not refugees or asylum seekers as their needs may differ in some ways.

Methods

The current study is a qualitative study based on semi-structured in-depth interviews[1] with mental health providers who consider Arabic their second language but work professionally in Arabic.

Sampling

Participants were recruited through purposive and convenient sampling. Specifically, the researcher sent e-mails and made phone calls to organizations around the US advertising themselves as providing mental health services to Arabic-speaking refugees and asylum seekers. We sought to interview individuals who met the following inclusion criteria: 1) Individuals who provide therapy sessions to Arabic-speaking clients; 2) are at least 18 years old; and 3) The provider

[1] See Appendix B for Interview Guide

does not consider Arabic their dominant language. A sample size of 4 was determined to be a preliminary first step in obtaining a range of perspectives from participants, while recognizing that such a small study is not meant to be representative (Small, 2009). It is important to note that there are relatively few Arabic-speaking providers in the US (there are no statistics available on this subject), which also limits the number of interviews that we were able to conduct. Hence, as an exploratory study, four interviews was deemed adequate. However, there will certainly be a need for further, more in-depth studies of Arabic-speaking mental health providers in the US and the impact of their work with Arabic-speaking clients.

Procedures

Potential participants who met inclusion criteria and were interested in participating in the interviews were provided information about the study, including the risks and benefits. Verbal consent was obtained prior to participation. Some participants were recommended by their supervisors, which may have placed some pressure on them to participate. To protect against this, participants were also told repeatedly the interviews are completely optional and confidential. Participants were asked at the beginning of each session whether they had any questions about the study or consent form. Interviews occurred at the preferred time of the participant and were conducted over Zoom and were audio recorded. Interviews lasted approximately one hour. The interviews explored the following areas of questions: participant background, their relationship to Arabic, their experience with the language and Arabic-speaking clients during sessions, including challenges and successes. This study was reviewed and approved as exempt by the Institutional Review Board at the University of Washington.

Analysis

The present study follows a Grounded Theory approach (Glaser & Strauss, 2017). Interviews were recorded and transcribed automatically by Zoom. Once the researcher edited and corrected the transcripts while registering to the audio, the participant's name was removed and the audio files were deleted in accordance with the consent form sent to participants. Immediately following the interviews, the researcher created interview summaries with initial observations to highlight and synthesize salient points. These were shared with his thesis supervisor and used to inform any future interviews. The researcher used an open coding process that included a mix of predetermined codes and codes that emerged from the data through the coding process. This allowed for the researcher to develop a codebook that included *a priori* codes based on constructs and ideas of interest related to the study as well as *a posteriori* codes developed from open coding. The coding process and the summaries allowed the researcher to identify the main themes that resulted from the in-depth interviews.

Results

Participant characteristics

The researcher conducted four in-depth interviews with Arabic-speaking mental health providers at community health organizations in Washington, California, and Michigan that advertise providing mental health services for Arabic-speaking clients. The participants ranged in experience from several months to over ten years. Two participants identified as male, and two identified as female. Three identified as Muslim, and one as Christian. Two participants were the children of immigrants from Syria and Palestine, who consider Arabic their first language growing up, but

described a process of English becoming their dominant language once they started school. One participant was from Somalia (which is a member of the Arab League and lists Arabic as an official language) who was resettled in the US as a refugee. He considered Arabic his second language. The final participant was from Iraq who grew up speaking both English and Arabic and moved to the US in 2008 as a refugee. She considered herself equally fluent in both languages and did not consider Arabic her dominant language in the therapy room. One interview participant had a master's degree, and all participants had a bachelor's degree.

Themes

Three major themes were identified by the researcher, all of which relate at times to both building rapport and improving care, and breaking rapport and causing therapists (and perhaps clients) to "second-guess" the care being provided. First, native language use is a powerful means of building rapport between client and clinician, whether the clinician speaks fluently or not. Second, all clients identified cultural awareness and familiarity, sometimes assumed by the client, to be just as or more important than language in building rapport. Finally, degree of language fluency, or lack therof, can play a role in the client-provider relationship. Lack of fluency can be detrimental to building rapport. Asking clients for clarification when the clinician does not understand a word, phrase, or entire story can break rapport, and the two participants of Arab ancestry both identified that their lack of complete fluency can be a challenge to the client's perception of their competence. Especially related to this last theme, second-guessing of care provided, or ability to provide care, appears to rise when providers work with clients who speak significantly different dialects than their own.

Use of Native Language in Therapy Room

All interview participants agreed that a client's use their native language in therapy sessions is critical to the therapeutic process. The participant originally from Somalia responded that if a counselor can speak the same language as the client, "It opens the window for you to be able to help the client because it brings a minimum of understanding of each other, and it also brings trust."[2] The participant originally from Iraq echoed this belief by sharing that clients will feel more "comfortable to tell you about their harms or secrets" if you share a language. Another participant shared that the "relief" he sees in clients when they realize their provider speaks Arabic energizes him to do sessions in his second language despite the challenges.

Only one of the organizations in which interview participants work has institutional access to professional interpreters. The participant from that organization stated a belief that interpreters are "important and essential, but [the clients] will be more conservative with interpreters and will not share a lot of things." Despite not having a lot of experience with interpreters, the other participants stated that they believe their organizations should in general have better access to interpreters. However, they could foresee many challenges in using professional interpreters, although there are also challenges when family members (often children) are used as interpreters in certain circumstances.

One of the second-generation interviewees shared that in his personal life he sometimes uses Arabic phrases or words if he wants someone to "understand exactly what I'm saying." He believes a similar experience happens with clients:

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[2]Interview quotes have been edited for clarity

> "Me telling you in English, 'I'm going to break your bones' is different than me saying it in Arabic because it doesn't hold as much weight. And so, when parents will come in and throw statements around like 'I'll break his bones' or something, it is not something that I'm worried I need to go and call [Child Protective Services]. And [the clients] aren't sitting there thinking 'Oh, this is a therapist, he just told me he is a mandated reporter.' So it's like a level of comfort… and not to project onto my clients, but personally if I can speak to somebody in my native language and be vulnerable, I think I would be more appreciative."

The same participant later clarified that he will usually put "cultural context" in parentheses in his notes if he includes comments or situations like the one above in case somebody has access to the notes in the future to "hopefully pause for a second and ask, 'What does that mean in a different paradigm, a different culture?' instead of just taking it at face value." Other participants also echoed the importance of understanding shared phrases and specific responses or statements that should be given. For example, if a therapist mentions a deceased husband of a Muslim client, they should immediately say the phrase *Allah yarhamu* ("May God bless him," or loosely translated as "May he rest in peace"). Using these cultural touchstone phrases may help to build rapport, even for providers with weaker Arabic proficiency.

Cultural Familiarity and Shared Cultures

All participants in this research study have intimate connections to countries in the Arab League and to emigration to the US, either as adult immigrants themselves or as the children of immigrants. Participants did not view their clients and themselves as coming from a monoculture, but rather cultures that share many traditions, beliefs, and ideas. For example, all participants mentioned a shared stigma around mental health and seeking help and believed that their own experi-

ence with that cultural belief is a bridge towards clients coming from cultures with similar negative beliefs around mental health and illness.

One participant shared that they think they self-disclose with Arabic-speaking clients more than with other clients due to the fact that they must be upfront about their language proficiency. This leads to questions like "Where are you from?" He explained that though he is not against self-disclosure ("I think it can be very helpful"), he has to be careful with Arabic-speaking clients because his impression is they feel more familiarity with him than clients from other backgrounds. "I have to be smart and wise… to understand why they are asking." He concluded that it is also a common experience for minorities who meet, whether in a therapy room or not.

"I'm Sorry, I Don't Understand." Impact of Lack of Native Fluency.

Besides the Iraqi participant who considers herself fully bilingual, all participants mentioned the challenge of working with clients from diverse linguistic backgrounds or who speak dialects that differ substantially from the main dialect they are familiar with. Both the second-generation participants shared that they feel most confident working with clients from Syria or Palestine, the countries of origin for both participants' parents. One participant shared, "Let's say I'm working with a client that is Palestinian… I would be able to understand them 100% and they would understand me."

When participants were asked how they respond to clients when they did not understand something the client said, answers varied. The participant originally from Somalia said that he believes asking for clarification is "actually the key to work with our clients" in order to understand the small and large differences between different cultures from the same general region.

For clients from different dialects, participants shared that they would have to prepare more and that sessions might have to be longer in order to accomplish the same amount of work.

Both second-generation participants both expressed concerns about being seen as competent by immigrant clients who only speak Arabic. “I probably have an accent when I speak in Arabic… and don’t get taken seriously [by some clients]." The other second-generation participant shared that their “sweet spot” is when a client has a working understanding of English, which allows him to fine-tune his use of Arabic or English in a session depending on the subject matter or terms needed. Working with clients that only speak Arabic has “been extremely difficult for me personally to conduct sessions,” but the provider feels that the only other option is to “turn them away” due to a lack of other Arabic-language resources. Both second-generation participants also agreed that speaking Arabic with clients “feels good” because it helps them improve their own Arabic language skills.

Although all participants believe that a provider speaking Arabic, even as their second language, helps to build rapport (one participant described it as a “shortcut”), a couple providers agreed that if a provider does not understand what a client is saying, that can break rapport.

> “What breaks rapport is when [lack of fluency] hinders how [clients] get understood, because they now have to use a lower level of vocabulary. They’re not giving me a thesis on their life, like a full breakdown. They kind of have to dumb it down for me and still sometimes I’ll say ‘I didn’t understand this word, can you translate?’ And then, they kind of will stop and they’ll translate. They were really talking about something important to them and I’m like ‘I’m so sorry, can you explain that?’”

However, the participant originally from Somalia disagreed, saying, “I’m not afraid to ask them, you know, ‘I’m sorry, I don’t understand that, can we begin from zero, can you slow

down?’” Except for the participant originally from Iraq, all providers admitted that they occasionally ask clients to slow down in order to fully understand what is being shared by the client. This was especially the case for the two second-generation participants who are most used to their parents’ accents from Syria and Palestine.

Discussion

Research Question

The present study seeks to gain a fuller understanding of the challenges and possibilities of mental health providers (MHPs) working in Arabic as a second language. This small study presents a glimpse into the experiences of four interpreters at three non-profit organizations in Washington, California, and Michigan that advertise mental health counseling for immigrants, refugees, and asylum seekers (among many other services). The three main themes identified by analyzing the in-depth interviews are the importance of native language use during therapy, the importance of cultural familiarity despite any language gaps, and the challenge of providing care if one does not have native fluency in a language.

A related major finding is the concept of second guessing, especially among the two second-generation providers. Both expressed doubt about the quality and extent of the care they can provide to Arabic-speaking clients, especially if the client’s dialect substantially differs from their own, or the counselors deem the work “too complex” for their level of Arabic. When another provider is more proficient in a client’s dialect they will attempt to transfer the client, but often there are simply not enough Arabic-speaking provides both within an organization and the broader community. One provider shared his frustrations with feeling as though he is not ideally

suited to work with some clients, like any mental health provider, but feeling as though there are no resources to turn to:

> "There was a client who had a child on the autism spectrum, and I didn't know how to help them…The mom spoke in Egyptian dialect and my understanding was a little weaker than if it was Syrian dialect, and I felt like I couldn't really help her. And Then I was like, well, I also don't have anywhere to refer you to because I didn't know of any Arabic-speaking providers who work with autism… And even when I want to make a reference to like a psychiatrist, another doctor, or a physical therapist, I just kind of sat there, I went on Google and I was like 'Arabic-speaking blah blah blah' and obviously it doesn't really turn up with any results."

Limited resources are not unique to Arabic-speaking clients, of course. However, all providers cited lack of language resources, culturally responsive therapists, and cultural stigma around mental health as the major barriers to overcome in order to provide better services to Arabic-speaking clients.

Relation to Previous Research

Three of the research participants identified as Arab-American, including two second-generation participants and one adult immigrant. The fourth participant identifies as Somali (with the caveat that Somalia is in the Arab League and shares many cultural and historic ties with other Arab League countries) and as an American citizen, having immigrated as an adult. Arab-American identity spans back at least to the 1800s, and includes both a history of assimilating to dominant mainstream American culture, as well as maintenance of linguistic and cultural identity through multiple generations (Ajrouch & Jamal, 2007; Rouchdy, 2002; Samhan, 1999).

A study of Arab-Americans in Milwaukee suggests that different generations of Arab-Americans are interested in learning Arabic as cultural identity maintenance, especially the chil-

dren of Arab Muslim immigrants in recent decades (Seymour-Jorn, 2004). This appears to correlate with the experiences of the two second-generation study participants, who both expressed pleasure in using and improving their Arabic through mental health counseling, but also fears of being seen speaking with "an accent" or otherwise not "Arab enough."

Several counselors spoke of the "relief" clients appear to feel upon realizing they can communicate in Arabic directly with their provider. This aligns with previous research that shows that lack of English, and especially the pressure to learn English in order to acculturate, is as significant a predictor of depression for Arabic-speaking migrants as citizenship status, country of origin or other demographic variables (Wrobel, et al, 2009). Acculturation, the complex process of psychologically adapting when one or more culture comes into sustained contact is a major stressor for immigrants that is sometimes not as widely acknowledged as "practical stressors" related to citizenship, finances, housing, and so on (Amer, 2013). Mona Amer (2013) provides a helpful illustration of the different factors related to acculturation for Arab-Americans and their mental health outcomes (see Fig. 1).

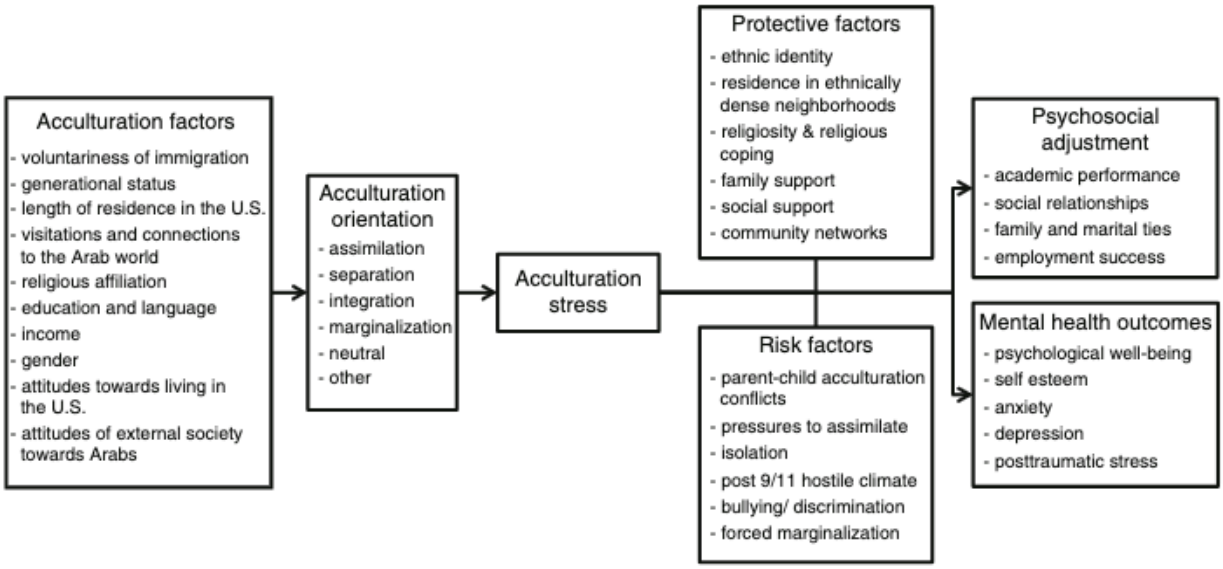

Fig. 1 (Amer, p. 154, 2013)

Limitations

This small study is not meant to be all encompassing. It intends to understand the experiences of MHPs working within organizations that are tailored to immigrants who speak Arabic, especially refugees and asylum seekers. As a result, there are several key limitations. First, there is no formal evaluation of the language proficiency of participants beyond self-disclosure. Second, all participants learned Arabic at least partially as children. Third, my identity as a White man with no Arab heritage may have influenced the interview process and my own reading of available research[3]. Lastly, the study does not attempt to interview clients or administrators. These limitations provide ample opportunities for future research to build upon and address in wider studies.

Interview Participant Suggestions for Improving Services

At the end of the interviews, participants were asked a variation on the "Magic Wand Question" from solution-focused therapy (SFT) to find out MHP recommendations for improving services for Arabic-speaking clients (Wells & McCaig, 2016). Participants had two overall suggestions for improving services for Arabic-speaking clients: reducing cultural stigma around mental illness and treatment, and increasing the amount of culturally and linguistically appropriate resources for Arabic-speaking clients.

All the participants referred to cultural stigmas surrounding mental illness and seeking therapy. Each expressed concerns that many people are not seeking treatment due to a fear of being seen as "crazy." One participant believed that having an Arabic-speaking provider, specifical-

[3] See Appendix A for a Reflexivity Statement

ly someone from the Arab community, may help a client and their family address mental health stigma and lead to better treatment. Another participant agreed, stating that having a provider who is familiar with cultural stigma surrounding mental health may allow for the stigma to be addressed from a culturally responsive vantage:

> "If a client comes from countries where there is no therapy or counseling, and where people may see that person as crazy if they talk about feeling depressed or traumatized…you have to educate [the client] first about counseling itself in this country, what it is and how it helps you and people here, not only immigrants but Americans across the board. You have to do psychoeducation about the diagnosis, the current symptoms, to help them understand the treatment plan and accept therapy."

Two other interview participants suggested that having more Arabic-speaking counselors of different cultural backgrounds may help acculturate Arabic-speaking clients to their new country of residence because "America is a melting pot" and it may "broaden a client's perspective." However, the clear preference among interview participants is that clients are matched as much as possible with providers who speak their language and come from a similar cultural background.

Regardless of the cultural identity of the counselor, all participants agreed that formal courses on counseling in Arabic would be beneficial for both counselors and clients. None of the interview participants had ever studied counseling in a formal sense, and the two second-generation providers had limited understandings of formal Arabic (also known as Modern Standard Arabic or *Fusha*). Interview participants provide clients with a mix of English and Arabic clinical terminology depending on context and their perception of a client's needs. Three out of four participants mentioned that they avoid certain clinical terminology in Arabic due to cultural stigma around mental illness, and instead either use the English term or talk around it (for exam-

ple, not saying the technical translation for “depression” but using words like “sadness” and “hopelessness”). The provider originally from Somalia differed in their approach, however, and uses technical clinical terms in Arabic routinely. A formalized course on providing counseling in Arabic may standardize some of these approaches, although future research would be needed to determine best practices.

Conclusion

This limited study presents a glimpse into the experiences of four interpreters at three non-profit organizations in Washington, California, and Michigan providing mental health counseling in Arabic as their second language. The major findings of this study are that higher levels of fluency appear to correlate with higher confidence in quality of services provided. Regardless of self-declared language fluency, all participants strongly agreed that their cultural familiarity and shared culture with Arabic-speaking clients assisted them in building rapport and trust, and encouraging clients to continue in services despite cultural stigma around mental illness.

However, the lack of resources overall for Arabic-speaking clients both within organizations themselves (all organizations report having long waitlists) and in the broader community represent significant challenges to providing linguistically and culturally appropriate services to Arabic-speaking clients. Future studies should cast a wider net, interviewing more providers, administrators and especially clients on their experiences. Without accurate statistics available, it appears likely that most Arabic-speaking mental health providers are either immigrants themselves from an Arab League country or the children of immigrants. Future studies can also help fill the gap of research around migration identity matching between client and mental health

provider. Future studies should aim for a more nuanced and diverse approach to cultural identities, subcultures, and minorities among both clients and providers.

Appendix A: Reflexivity Statement

A professor asked me early on as I began laying the groundwork for this study, “Why is someone with your name studying this subject? Readers will want to know.” I am a White, straight, cisgender male from an upper-middle class family who grew up in Vienna, Austria from 1995-1998 (ages 5-8) and in East Jerusalem, Palestine from 1998 to 2002 (ages 8-12). This formative time in my life happened to coincide with part of the Second Intifada, and as a result of living in a Palestinian neighborhood, I chose to study Arabic at the international school I attended. Once in college, I began studying Arabic again, and it quickly took over my academic life. After college, I lived in Nablus, Palestine for two years as an English teacher, and then in Amman, Jordan as an English teacher through the Fulbright program. During the second year of my Masters of Social Work program at the University of Washington, I received a Foreign Languages & Area Studies scholarship which allowed me to study mental health in Arabic intensively with the Qasid Institute in Amman, Jordan. Afterwards, I began my second practicum at Refugees Northwest in Seattle, WA, and have been providing mental health counseling in Arabic during the course of writing this thesis.

This study did not start out from an objective place. My identities and experiences have led me to this subject and exert influence over my views on mental health counseling, multicultural counseling, and the positionality of mental health providers. Brian Bourke (2014), in a paper titled "Positionality: Reflecting on the Research Process,”, asked himself the following questions “as a White man studying issues of race” (which I have adapted for my own circumstances):

1. What role did my positionality as a White man studying race in therapy play?
2. How did I use my positionality in different spaces?
3. Did my positionality influence the interactions that I had with available research and with participants?

I have reflected on these questions and others during this process. Perhaps most critically is my self-interest in the subject. My own investment in intensively learning Arabic for over a decade and spending years living and working in Arabic-speaking countries almost certainly leads me to want to believe that counseling in Arabic as my second language is a valuable and worthy pursuit. However, it is worth noting that I began providing mental health counseling in Arabic with many concerns about my ability to do so, both for linguistic and identity reasons (“Would clients feel comfortable working with a White man?” I wondered), and I was ready for the effort to fail and to pursue other arenas. It was the result of some early successes and challenges in my own counseling efforts that moved me to want to interview other people in similar positions. My main goal was to understand and learn from what others have experienced in order to provide ethical and effective care to clients who speak Arabic.

Efforts I took to acknowledge my positionality included referencing my identities as a White man with no Arab ancestry in the initial email contact with organizations and possible in-

terview participants. Like most of the providers interviewed, I also self-disclose to clients I provide therapy to about my identities, and attempt as much as possible to leave open the door for clients to ask to be transferred to other providers for whatever reason. During the coding process, the use of both predetermined codes and codes that arose from the interviews was an effort to mitigate my own biases and beliefs, and not read into interviews what I hoped to see. Providing coded interviews and discussing them with my thesis advisor was also a means of limiting as much as possible the impact of my positionality on the project. However, my identities and experiences have undoubtedly impacted the research done here, and should be taken into consideration by any readers, and are not meant to be viewed as free from criticism.

Appendix B: Interview Guide

Mental Health Providers Who Speak Arabic as a Second Language Working With Arabic-Speaking Clients

In-Depth Interview Protocol

Remind interviewee the interview can stop at any time and they can decline to answer any questions. ** Start BOTH audio recorders and let participant know we are recording.

Today is DATE: _____ and TIME: _____, and this is interview with participant ID _____.

My name is Seth Thomas. I would like to thank you for agreeing to be part of this in-depth interview today. During this interview, I am going to be asking you a few questions related to your identities, migration, your relationship to Arabic, and your experiences working with Arabic-speaking clients and organizations that serve refugees and asylums. The services provided to this population are understudied, and any information you provide could help improve services and interventions, and inform future research.

For the questions that follow, it is important that you provide us with honest answers that truly reflect your opinions and perceptions. This is not a test and there are no right or wrong answers. We are interested in your opinions.

If you feel uncomfortable answering any question, you can decline to answer. We want to know your opinions, but we also want you to feel comfortable sharing them. Remember, your answers are completely confidential and no one will be able to link your responses to you. No one will ever know what you, in particular, said because your name will not be associated with your responses.

We really appreciate your help in improving services provided to Arabic-speaking refugees and asylum seekers in mental health settings.

Getting to Know Participant

I'd like to start off by asking about your relationship with Arabic, and how it intersects or does not intersect with your identities.

2. **Can you tell me about your relationship with Arabic?**
   Probe 1: How did you learn
   Probe 2: What dialects do you speak?
   Probe 3: How would you rate your conversational fluency in Arabic?
3. **How would you describe your background and identities?**
4. **Have you formally studied a clinical register of Arabic?**
   Probe: Can you tell me about any experiences where translation or terminology has come up during a session?

Preparatory experiences with Arabic-Speaking Clients

5. Tell me about your experience working with Arabic-speaking clients?

Probe 1: How have they been referred to you?

Probe 2: Generally, how would you describe the demographic of Arabic-speaking clients you work with?

5. How do you prepare for working with Arabic-speaking clients?

Probe: How do you prepare for working with English-speaking clients?

6**. Have you noticed any differences at all, however small, in the services you provide depending on whether a client speaks Arabic or not?**

Role of Language in Therapy

I'd like to ask your opinions about the role of language in therapy.

7. What role does native language play in a therapy session in your opinion?

8. How does it feel to use Arabic during sessions with Arabic-speaking clients?

Probe 1: Does the client ever bring the issue of language or dialect up?

Probe 2: If you have not understood something a client has said, how have you responded?

9. What has your experience been working with clients from a dialect that differs substantially from your own?

Probe: What role does English play if the client also speaks some English?

10. Have you used interpreters before in your work in general? How has that experience been in comparison to working in Arabic?

11. Can you tell me about your experience of writing clinical progress notes in English?

Probe: Do you have an approach to translating a client's own words into clinical notes?

12. Beyond language, what is your opinion of matching cultural identities and experiences as much as possible between clients and providers?

Probe: If they do not match, how important is cultural familiarity or humility on the provider's part? On the client's part?

Interventions and Modalities

I'd like to ask a few questions about interventions and modalities now.

12. In general, how do you measure progress with clients who speaks Arabic as successful or not?

13. What modalities or interventions do you tend to use?

Probe 1: Does your organization tend to push for one approach or another?

Probe 2: How do you take into consideration what the organization is asking for, and what you believe is best for the client if there is a difference?

14. How do societal pressures or structural issues, such as racism, sexism, homophobia or transphobia, Islamophobia, immigrant status, mental health stigma, conflicts in country of origin, or family separation come up during sessions?

Probe:

15. [If provider is an American citizen and client comes from a country that the US has invaded or financed military oppression or occupation of] **I'm curious about feelings that come up for you as an [insert identity] provider who has worked with clients from [insert country].**

Probe: Have you ever felt unable to serve an Arabic-speaking client for whatever reason?

Recommendations

Now I want to ask about any recommendations you have on how services can be improved for Arabic-speaking refugees and asylum seekers at your organization/practice and in the US generally.

16. Are there any major recommendations you have to improve mental health services provided to Arabic-speaking clients?

17. Do you and colleagues or supervisors discuss and implement ways to improve services?

Probe 1: Can you think of an example?

18. If you could wave a magic wand and change one aspect of mental health services and Arabic-speaking clients in the US, what would you do?

BIBLIOGRAPHY

Aggarwal, N. K. (2018). Transference and countertransference in addressing Islamophobia in clinical practice. *Islamophobia and Psychiatry*, 135–145. https://doi.org/10.1007/978-3-030-00512-2_12

Al Shamsi, H., Almutairi, A. G., Al Mashrafi, S., & Al Kalbani, T. (2020). Implications of language barriers for Healthcare: A systematic review. *Oman Medical Journal*, *35*(2). https://doi.org/10.5001/omj.2020.40

Amer, M. M. (2013). Arab American acculturation and ethnic identity across the lifespan: Sociodemographic correlates and psychological outcomes. Biopsychosocial Perspectives on Arab Americans, 153–173. https://doi.org/10.1007/978-1-4614-8238-3_8

Batalova, J., Hanna, M., & Levesque, C. (2021, February 11). *Frequently requested statistics on immigrants and immigration in the United States*. migrationpolicy.org. Retrieved January 31, 2022, from https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-2020

Bourke, B. (2014). Positionality: Reflecting on the research process. *The Qualitative Report, 19*(33), 1-9. https://www.proquest.com/scholarly-journals/positionality-reflecting-on-research-process/docview/2486198787/se-2

Bushra, A., Khadivi, A., & Frewat-Nikowitz, S. (2007). History, custom, and the Twin Towers: Challenges in adapting psychotherapy to Middle Eastern culture in the United States. *Dialogues on Difference: Studies of Diversity in the Therapeutic Relationship.*, 221–235. https://doi.org/10.1037/11500-025

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology*, *58*(4), 537–554. https://doi.org/10.1037/a0025266

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, *365*(9467), 1309–1314. https://doi.org/10.1016/s0140-6736(05)61027-6

Flaskerud, J. H. (1990). Matching client and therapist ethnicity, language, and gender: A review of research. *Issues in Mental Health Nursing*, *11*(4), 321–336. https://doi.org/10.3109/01612849009006520

Hadziabdic, E., Hjelm, K. Arabic-speaking migrants' experiences of the use of interpreters in healthcare: a qualitative explorative study. Int J Equity Health 13, 49 (2014). https://doi.org/10.1186/1475-9276-13-49

Hammad, J., & Hamid, A. (2021). Migration and mental health of Arabic-speaking communities. *Mental Health, Mental Illness and Migration*, 271–302. https://doi.org/10.1007/978-981-10-2366-8_37

Hassan H, Blackwood L. (Mis)recognition in the Therapeutic Alliance: The Experience of Mental Health Interpreters Working With Refugees in U.K. Clinical Settings. Qualitative Health Research. 2021;31(2):399-410. doi: 10.1177/1049732320966586

Giammusso, I., Casadei, F., Catania, N., Foddai, E., Monti, M. C., Savoja, G., & Tosto, C. (2018). Immigrants psychopathology: Emerging phenomena and adaptation of mental health care setting by native language. *Clinical Practice & Epidemiology in Mental Health*, *14*(1), 312–322. https://doi.org/10.2174/1745017901814010312

Glaser, B. G., & Strauss, A. L. (2017). *The discovery of Grounded Theory: Strategies for qualitative research*. Routledge.

Gorkin, M. (1986). Countertransference in cross-cultural psychotherapy: The example of Jewish therapist and Arab patient. *Psychiatry*, *49*(1), 69–79. https://doi.org/10.1080/00332747.1986.11024308

Jamil, H., Hakim-Larson, J., Farrag, M., Kafaji, T., Duqum, I. and Jamil, L.H. (2002), A Retrospective Study of Arab American Mental Health Clients: Trauma and the Iraqi Refugees. American Journal of Orthopsychiatry, 72: 355-361. https://doi.org/10.1037/0002-9432.72.3.355

Kira I., Templin T., Lewandowski L., Ramaswamy Vidya., Ozkan B., & Mohanesh J. (2008) The Physical and Mental Health Effects of Iraq War Media Exposure on Iraqi Refugees, Journal of Muslim Mental Health, 3:2, 193-215, DOI: 10.1080/15564900802487592

Looney, D., & Lusin, N. (2019, June). Enrollments in Languages Other Than English in United States Institutions of Higher Education, Summer 2016 and Fall 2016: Final Report. Retrieved November 25, 2021, from https://www.mla.org/content/download/110154/2406932/2016-Enrollments-Final-Report.pdf.

McNatt, Z.Z., Freels, P.E., Chandler, H. *et al.* (2019). "What's happening in Syria even affects the rocks": a qualitative study of the Syrian refugee experience accessing noncommunicable disease services in Jordan. *Conflict and Health* **13,** 26. https://doi.org/10.1186/s13031-019-0209-x

M'zah, S., Lopes Cardozo, B. & Evans, D.P. (2019). Mental Health Status and Service Assessment for Adult Syrian Refugees Resettled in Metropolitan Atlanta: A Cross-Sectional Survey. J*ournal of Immigrant and Minority Health,* 21, 1019–1025. https://doi.org/10.1007/s10903-018-0806-6

Orsini Estrada, Jodi L. Constantine Brown & Lexi Molloy (2018) Bilingual Therapists' Confidence Using Clinical Spanish Language Terminology, Journal of Teaching in Social Work, 38:3, 324-341, DOI: 10.1080/08841233.2018.1468384

Ringel, S. (2002). To disclose or not to disclose: Political conflicts in the countertransference. *Smith College Studies in Social Work*, *72*(3), 347–358. https://doi.org/10.1080/00377310209517664

Rouchdy, A. (2002). Language Conflict and Identity: Arabic in the American Diaspora. Language Contact and Language Conflict in Arabic, 31(1), 151-166.

Santiago-Rivera, A. L., Altarriba, J., Poll, N., Gonzalez-Miller, N., & Cragun, C. (2009). Therapists' views on working with bilingual Spanish–English speaking clients: A qualitative investigation. *Professional Psychology: Research and Practice*, *40*(5), 436–443. https://doi.org/10.1037/a0015933

Samhan, H. H. (1999). Not quite white: Race classification and the Arab-American experience. InM. W. Suleiman (Ed.), Arabs in America: Building a new future (pp. 209–226). Philadelphia:Temple University Press. (16) (PDF) Arab American Acculturation and Ethnic Identity Across the Lifespan: Sociodemographic Correlates and Psychological Outcomes.

Seymour-Jorn, C. (2004). Arabic language learning among Arab immigrants in Milwaukee, Wisconsin: A study of attitudes and motivations. Journal of Muslim Minority Affairs, 24(1), 109-122.

Srour, R. (2015). Transference and countertransference issues during times of violent political conflict: The arab therapist–jewish patient dyad. *Clinical Social Work Journal*, *43*(4), 407–418. https://doi.org/10.1007/s10615-015-0525-6

Sheehi, L., & Sheehi, S. (2022). *Psychoanalysis under occupation: Practicing resistance in Palestine*. Routledge.

Slewa-Younan, S., Uribe Guajardo, M. G., Heriseanu, A., & Hasan, T. (2014). A systematic review of post-traumatic stress disorder and depression amongst Iraqi refugees located in western countries. *Journal of Immigrant and Minority Health*, *17*(4), 1231–1239. https://doi.org/10.1007/s10903-014-0046-3

Slewa-Younan, S., McKenzie, M., Thomson, R., Smith, M., Mohammad, Y., & Mond, J. (2020). Improving the mental wellbeing of Arabic speaking refugees: An evaluation of a mental health promotion program. *BMC Psychiatry*, *20*(1). https://doi.org/10.1186/s12888-020-02732-8

Small, M. L. (2009). `how many cases do I need?' On Science and the Logic of case selection in field-based research. *Ethnography*, *10*(1), 5–38. https://doi.org/10.1177/1466138108099586

Szoke, D., Cummings, C., & Benuto, L. T. (2020). Exposure in an Increasingly Bilingual World: Native Language Exposure Therapy With a Non-Language Matched Therapist. *Clinical Case Studies*, *19*(1), 51–61. https://doi.org/10.1177/1534650119886349

Turki, Y., Saleh, S., Albaik, S. *et al.* (2020). Assessment of the knowledge, attitudes, and practices (KAP) among UNRWA* health staff in Jordan concerning mental health programme pre-implementation: a cross-sectional study. *International Journal of Mental Health Systems* **14,** 54. https://doi.org/10.1186/s13033-020-00386-3

Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017). Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. *International journal of mental health systems*, *11*, 51. https://doi.org/10.1186/s13033-017-0156-0

United Nations. (2018, June 25). Global forced trends displacement in 2017 - UNHCR. https://www.unhcr.org/5b27be547.pdf. Retrieved February 8, 2022, from https://www.unhcr.org/5b27be547.pdf

Wells, K., & McCaig, M. (2016). The magic wand question and recovery-focused practice in child and Adolescent Mental Health Services. *Journal of Child and Adolescent Psychiatric Nursing*, *29*(4), 164–170. https://doi.org/10.1111/jcap.12159

Wrobel, N.H., Farrag, M.F. & Hymes, R.W. Acculturative Stress and Depression in an Elderly Arabic Sample. *J Cross Cult Gerontol* 24, 273–290 (2009). https://doi.org/10.1007/s10823-009-9096-8