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## **Counseling Arab and Chaldean American Families**

**Julie Hakim-Larson**  
**Ray Kamoo**  
**Sylvia C. Nassar-McMillan**  
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*The last century has seen an increase in the population of Americans of Arab and Chaldean descent. In recent decades, clinicians have articulated the goal of enhancing their knowledge of cultural diversity for the purpose of improving their appreciation for diversity and the quality of their mental health interventions with diverse populations. However, there is currently little systematic empirical research regarding the counseling of Arab and Chaldean Americans, although awareness of the need for such research among mental health professionals has started to emerge. The purpose of this paper is to provide an integrative review of the values and socio-cultural forces that are relevant to the counseling of this population in North America, and to provide some culturally sensitive recommendations for working with American families of Arab and Chaldean ethnicity. In particular, we propose that effective interventions with clients of Arab and Chaldean ethnic backgrounds will need to be informed by an understanding of the everyday sociopolitical contextual background of target clients and the impact of values and acculturation processes on the family network.*

In recent years, Western scholars have developed an appreciation for “diversity” and “multiculturalism,” resulting in increasing attempts to learn about various ethnic groups, including those of Arab and Chaldean descent, and to incorporate this understanding into their culturally sensitive psychotherapy with families (e.g., McGoldrick, Giordano, & Pearce, 1996; McGoldrick, Giordano, & Garcia-Preto, 2005). Like the terms often used for other groups such as Hispanic, European, Asian, Native and African American, the term “Arab American” encompasses many different groups whose heterogeneity stands in contrast to the much promulgated notion of cultures as unique and homogeneous (Miller, 1997). The term Arab is used to refer to Arabic speaking people from the Middle East. Because the modern Middle East represents diverse

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nationalities and peoples, cultures within cultures often develop with variations occurring according to specific language, religion, and village or tribal subcultures. Not all people from the region commonly referred to as the Middle East speak Arabic and thus not all are considered to be Arabs. For example, Iranians speak Farsi, Israeli Jews speak Hebrew, and Turks speak Turkish. Even though most Iranians, Arabs, and Turks in the Middle East are of the Islamic faith, some are of the Christian or Jewish faith (Shabbas & Al-Qazzaz, 1989).

The Chaldeans are one large subgroup of immigrants to the United States from the Middle East. They are Iraqi Catholic Christians who speak a dialect of Aramaic, although Arabic may be spoken as well (Kamoo, 1999). Because of the use of the Aramaic language (not just the Arabic language) and the formation of community enclaves within North America, Chaldean Americans are considered to be a separate but closely related subgroup to the broader category known as Arab Americans. Because of the intertwined culture, the two groups are often considered together.

The Arab American and Chaldean Council of Southeastern Michigan (ACC; 2007) reports that Americans of Arab and Chaldean descent have historically been underserved with respect to mental health services. There are at least two possible reasons that this population has been underserved. First, there is stigma attached to mental disorders and shame that reflects upon the family in Arabic culture (e.g., Abudabbeh & Aseel, 1999). For this reason, many less acculturated immigrants from the Middle East are reluctant to seek mental health services for themselves and their family members; thus, outreach efforts have been initiated by some community mental health organizations such as ACC. Second, because of the influx of refugees from the Middle East in recent decades, the overall population of Arab and Chaldean Americans has increased without a concomitant increase in culturally relevant services that are backed by empirical research (e.g., Haboush, 2007).

Although the U. S. Census Bureau has only recently begun to acquire statistics on individuals of Arab and Chaldean descent, it is currently estimated that these individuals number over 3.5 million in the United States (Arab American Institute, 2007). The largest concentration of Americans of Arab and Chaldean descent in the United States is in the Metropolitan Detroit area of Southeastern Michigan due to early immigration patterns and employment opportunities in the automobile industry in the late 19th and early 20th centuries. Among the more recent reasons for immigration is the need for refuge from the political unrest in the Middle East (ACC, 2007). Based on U.S. Census data, recent estimates from the Arab American Institute (2007) suggest that the current population of Arab Americans in Southeastern Michigan is approximately 490,000. However, Arab Americans are located throughout the United States with additional large urban concentrations in California, New York, New Jersey, Illinois, and Washington, DC. Culturally relevant mental health issues for Arab and

Chaldean Americans that may be encountered by counselors and other health professionals involve acculturation issues and traumatic histories related to immigration, current world events, and political unrest in the Middle East.

The purpose of this review is to provide mental health counselors with background information and recommendations to inform the culturally sensitive treatment of families and individuals with an Arab or Chaldean ethnic background. Understanding the family unit, whether treating one or multiple family members, is especially important in counseling Americans of Arab and Chaldean background because of the complex interplay of cultural and religious values within family life.

### CULTURAL BACKGROUND AND VALUES

Large scale Arab and Chaldean immigration to North America began in the late 19th century and proceeded in three major waves (Abudabbeh, 1996, 2005a). Earlier waves of immigrants were more likely to be Christian and less educated, while later waves tended to have more Muslim immigrants, more refugees, and more individuals with higher education (e.g., [Abudabbeh & Hays, 2006](#); [Shabbas & Al-Qazzaz, 1989](#)). The goal of ethnic preservation in more recent waves of Arab Americans has fostered family trends of intra-ethnic marriage, cultivating larger families than average in America, continued use of the mother tongue, and the valuing of Arab traditions (Zogby, 2001). Thus, while the goal of the earlier immigrants (from the 1890s into the early 20th century) was assimilation to the dominant host culture over and above ethnic identification (Zogby, 1990), later waves of immigrants in the late 20th century often focused on maintaining their ethnic identity and cultural traditions ([Abudabbeh & Hays, 2006](#)).

Each new wave of immigrants in the Arab and Chaldean communities has likely struggled with how to reconcile old-world values and those of the surrounding Western, mainstream culture. Like Asian and Hispanic cultures among others, Middle Eastern societies are often described as being collectivistic where independent thinking and individual needs, feelings, and thoughts are discouraged in favor of a submissive approach to the will of the family and larger social group ([Dwairy, 1999](#)). Western values, in contrast, favor the development of an individualistic orientation in which the rights and needs of the individual take priority over those of the social group. As with other collectivistic ethnic groups, there is often a stressful tension between the old world collectivistic values and the individualistic values of contemporary American life in Arab and Chaldean American families.

Arab and Chaldean families also often function according to a set of paternalistic values, where men are viewed as having more power in general than women, especially in matters outside of the family sphere ([Feather, 2004](#); [Glick](#)

& Fiske, 2001). With paternalism, men are viewed as needing to protect and provide for women who are expected to uphold conventional roles including a maternalistic view of nurturing men's emotional and domestic needs.

Arabic tradition and heritage incorporates both collectivistic and paternalistic values (Hakim-Larson & Nassar-McMillan, in press) and these are reinforced by the extended family, a unit cherished as the foundation in almost all Middle Eastern societies regardless of religion or nationality (Nydell, 1987, 2006). Judaism, Christianity, and Islam are all considered to be Abrahamic religions. That is, Abraham of the Old Testament is considered to be an ancestor common to followers of all three religions (Esposito, 2003). Thus, the collectivistic and family values in the ancient scriptures provide a common base for followers of these three major world religions in the Middle East. Family unity, closeness, and solidarity are valued over and above friendships and work life, and in return extended families offer emotional support and financial security in Arab families (Nydell, 1987, 2006). Individuals have limited freedom within their extended families, and the families typically have a multigenerational patriarchal structure marked by authoritarian attitudes and explicit limits placed primarily on females. To preserve family honor and traditions, extended male family members are expected to fulfill any obligations left vacant by the father or a brother. Clearly, men are viewed as heads of household, with great respect accorded to them. To that end, they are usually regarded as the legitimate authority for all matters of family in traditional households (El-Islam, 1983). Such sharply differentiated gender roles and all-male patriarchal power structures have historically been evident in many of the major world religions (e.g., Hinells, 1995).

In addition to the patriarchal family structure, there are cultural norms and traditions that involve a deferred concept of time, rich use of the native dialects that are replete with metaphors and indirect means of expressing viewpoints, thinking in terms of extremes and expressing the concepts verbally and through gestures, and using euphemisms for uncomfortable situations (Nydell, 1987, 2006). For example, the fixed and rigid beginning and endpoints of scheduled appointments and planned social events of Western life may be overlooked by some recent Arab immigrants who are accustomed to greater flexibility and a more relaxed attitude about timing in their heritage culture (e.g., Nydell, 2006). In Arabic culture, accommodations are made for latecomers to events (e.g., serving dinner quite late in the evening with plenty of appetizers served for those who arrive earlier). Should someone be inconvenienced by having to wait for something or someone, individuals may take a resigned attitude and make the Arabic statement "Ma' alish," which translates to "Never mind, it doesn't matter, or it's not that serious" (Nydell, 2006).

Traditionally, both the religious and extended family networks are viewed as sources of emotional support during times of stress for Arab and Chaldean

Americans. Because Islam and Christianity are both integral to Arab culture, religious values provide important contexts in which problems are addressed and resolved (e.g., [Al-Krenawi & Graham, 2000](#)). Additionally, there are many unique traditions that stem from the diversity of the religious subgroups (e.g., *Islam*: Shiite, Sunni, Druze, Alsawi; *Christian*: Maronite, Roman, or Chaldean Catholic; Egyptian Coptic; Orthodox; Protestant) and their intersection with the different nationalities from the various countries within the Middle East (e.g., Syria, Iraq, Egypt, Lebanon, Jordan, Palestine, Saudi Arabia).

Although each family and its individual members may embrace the collectivistic, paternalistic, and religious values differently, there are some beliefs that seem to cross over specific religious and country-of-origin boundaries. Nobles and Sciarra (2000) and Nydell (2006) have summarized some of the commonly held attitudes of people from the Arab world. For example, life events are often seen as being predetermined or the result of "fate." Good fortune is sometimes viewed as God's reward and a blessing for living a good and faithful life, while difficulties are seen as the result of either punishment or as an opportunity to test one's faith. A seeming lack of effort on the part of individuals might be explained away as fulfilling God's original intentions toward the family. Fatalism, which occurs across diverse groups of people of Arab ethnic background, is reflected in the commonly used qualifying phrase, "Insh 'allah" or "God willing..." (Nydell, 2006). In this way, family members may at times absolve themselves of blame or perhaps justify inaction (Nydell, 2006). However, the extended family structure has also traditionally provided the main social arena for more concrete discussion and resolution of personal problems and difficulties (e.g., [Al-Krenawi & Graham, 2000](#)).

#### **IMMIGRATION AND ACCULTURATIVE STRESS WITHIN ARAB AND CHALDEAN AMERICAN FAMILIES**

In contrast to the strong bonds of support among blood relatives in the heritage culture and Arab society ([Nydell, 1987](#)), immigrants to North America may come to the realization that they no longer have the emotional supports that they once had in their extended family systems in their countries-of-origin. Thus, the pre-migratory stresses that sometimes involve wars and traumatic relocation are accompanied by post-migratory stresses that involve acculturation to the new host culture with a concomitant loss of social supports. For example, clinicians working with Arab Americans have noted that sometimes the patriarchal family structure has been disrupted due to the loss of male family members during premigration wars, thus contributing to the stress of making adaptive changes ([Nassar-McMillan & Hakim-Larson, 2003](#)). To alleviate some of the stresses of adapting, one mission of Arab- and Chaldean-American community centers and religious institutions (i.e., churches, mosques) is to

provide a substitute extended support network via social events and gatherings. Another goal of these community organizations is to provide relevant information about resources for immigrant and refugee families. Counselors can utilize such local information in their attempts to formulate treatment goals to alleviate some of the stresses of adaptation and acculturation. According to Berry (2005), 'acculturative stress' in immigrants refers to stress reactions related to the life events and experiences that occur during the process of acculturating to the mainstream culture.

In addition to the heavy burden and grief associated with memories of wartime trauma, many Arab and Chaldean Americans must also contend with the same immigration and acculturative stress issues faced by other immigrants to North America (e.g., Keyes, 2000). This includes the acquisition of a new language by both parents and children which may occur at different rates, learning and complying with laws about child abuse and domestic violence, and becoming knowledgeable about the educational and employment system in their host country. In many cases, it is unclear to recent immigrants how these changes from their heritage culture may impact the decisions they make within the family setting in the mainstream culture. In addition, the media saliency of the current and ongoing sociopolitical tensions in the Middle East may also contribute to the acculturative stress of immigrant families who often still feel an obligation to assist extended family relatives as well as friends back in their country-of-origin.

Contemporary theoretical models have started to address the fact that recent immigrants face multiple dynamically changing socio-cultural contexts and that they must therefore make attempts to adapt to the stresses that ensue. Their relationships with significant others and their social behaviors may vary considerably from one context to another, thus affecting their overall ethnic identity (Yeh & Hwang, 2000). First and second-generation Arab American adolescents, for example, may construct a sense of self that incorporates both a public identity (around friends and while in the mainstream culture) and a private identity (around family and members of the ethnic group) (e.g., Ahmed & Akhter, 2006; Ajrouch, 1999, 2000). Although research in this area is lacking, some Arab Americans have been known to hide or minimize their ethnicity as a self-protective measure due to the possibility of negative repercussions or prejudice while interacting with others in the mainstream culture (e.g., Hakim-Larson & Nassar-McMillan, in press).

As adolescents and young adults attempt to assimilate, intergenerational conflicts may arise in families around issues such as dating, education, and appropriate dress. A double standard exists for matters involving sexuality, and intergenerational family tensions are likely to be especially problematic for daughters as compared to sons (e.g., Nobles & Sciarra, 2000; Shakir, 1997). Problems can also occur due to role reversals, where opportunistic bilingual children and

adolescents translate from English to their own family's dialect for parents and from their own family's dialect to English for other authorities such as teachers and the justice system, editing what has been said to their own satisfaction and self-serving needs (e.g., Nassar-McMillan & Hakim-Larson, 2003).

Some evidence suggests that acculturative stress may be particularly salient for Muslim Arab American families. For instance, Faragallah, Schumm, and Webb (1997) found that life and family satisfaction correlated with religion as well as length of residence and age at immigration among Arab Americans in the United States. Muslims, as compared to Christians, reported lower levels of satisfaction with life in the United States. Longer length of residence in the United States was related to more life satisfaction, but less family satisfaction. Gender role identification among adolescent Muslim girls has also been a focus of the acculturation process with higher degrees of masculinity found among Muslim girls and those girls with longer U.S. residencies (Abu-Ali & Reisen, 1999).

However, discrimination against immigrants and refugees does not seem to be related to the length of residence in the United States (Marsella, Bornemann, Ekblad, & Orley, 1994). For Arab Americans, this may be due to pervasive contemporary negative media portrayals of Arabs in the American media and the relative lack of positive, normative media portrayals of family life for Arab Americans. Shaheen (2001) has documented and described this imbalance and the widespread prevalence of such negative stereotyped images in American films and other media. The extent to which such prejudicial attitudes have been incorporated into the ethnic identities of Arab and Chaldean Americans remains as a direction for future research endeavors.

In working with youth of Arab ancestry, Jackson (1997) identified factors that help determine level of acculturation, including the ability to speak and understand Arabic, being foreign-born, acceptance of Arabic values, not Americanizing one's first name, and maintaining extensive contact with family members and ethnic community members. Clearly, these are important identity influences, given that nearly half of all Arab Americans over 17 years of age speak a non-English language at home among family members, as do one in three Arab Americans under the age of 18 (Zogby, 1990). The vast majority of these individuals also speak English fluently.

Family acculturative stress and the need for social supports may be particularly high for women who are mothers. Hattar-Pollara and Meleis (1995) conducted interviews with women who had immigrated to the United States from Jordan and identified three prominent themes: Stresses associated with daily life, attempts to maintain ethnic continuity, and coping by the re-creation of familiarity. Because of their difficulty with language, these women reported not being able to read or understand news reports, not talking to their neighbors, not helping their children with school work, and not communicating with school



officials as daily stressors. To cope with the feelings of loneliness, being a foreigner, and not belonging, Hattar-Pollara and Meleis (1995) found that many individuals tried to re-create a familiar social environment usually within the context of religious social activities and the church. In doing so, they preserved their ethnic continuity and fostered a sense of belonging. In addition to the feelings of loneliness and social isolation, language difficulties were also related to an undermining of parental authority when the value systems of parents differed from that of the teachers, other students, and the general culture. A main goal of the women was to maintain some ethnic continuity with the Jordanian community. By conforming to the values of the Jordanian community, pride and prestige were attained. Breaking away from these traditions and values could have led to feelings of shame and could have brought dishonor upon these women and their families. Financial success was valued as a source of pride and a competitive attitude was found among the women as they compared and contrasted themselves to others in the community.

#### WAR AND TRAUMATIC STRESS

Wartime sociopolitical events in the Arab world affect Arab Americans and immigrants from the Middle East both directly and indirectly (e.g., [Jamil, Hakim-Larson, Farrag, Kafaji, Duqum, & Jamil, 2002](#); [Jamil, Farrag, Hakim-Larson, Kafaji, Abdulkhaleq, & Hammad, 2007](#); [Nassar-McMillan & Hakim-Larson, 2003](#)). These events may be directly responsible for the involuntary displacement of some members of this group of immigrants or their relatives from their countries-of-origin. In addition, once in their host country, the recent immigrant may be indirectly affected by prejudicial attitudes and stereotypical depictions of the same events in the media on television, radio, and on the internet. Thus, for some, there is an accumulation of non-normative stresses that spans pre-migration, migration, and post-migration life experiences. Thus, it is not surprising that there are Arab and Chaldean American refugees with histories of wartime trauma who have also experienced depression, anxiety, and post-traumatic stress symptoms (e.g., [Jamil et al., 2002](#); [Jamil et al., 2007](#); [Nassar-McMillan & Hakim-Larson, 2003](#)).

The history of conflict, war, and civilian displacement in the Middle East plays a role in the mental health of even those individuals who are exposed vicariously through the impact of trauma on family members, friends, and acquaintances (e.g., [Kira, 2001, 2002](#)). Thus, even though an immigrant or refugee may not have been directly affected by war trauma, secondary traumatization is possible since other close family members and friends may still be in the homeland. The close ties within large extended families and the collectivistic values of Arab and Chaldean Americans may serve to heighten and exacerbate the salience of the traumas that have affected significant others, and some

individuals and families are affected both directly and vicariously. Thus, the impact of history of traumas can be complex, cumulative, and ongoing in nature (e.g., Kira, 2001, 2002).

The American Psychiatric Association, first recognizing post-traumatic stress disorder (PTSD) as a syndrome in 1980, put forth diagnostic criteria that included exposure to a traumatic event, intrusive recollections, avoidance or numbing, and hyper-arousal (American Psychiatric Association, 1994). PTSD symptoms are often accompanied by other comorbid anxiety symptoms and depression. The various countries in the Middle East have experienced a myriad of wars, some small and of short duration and some of longer duration and on a larger scale with a variety of adversaries involved. For example, in recent decades both Lebanese and Palestinian immigrant children and their families have experienced wartime traumas that are linked to anxiety, depression, and post-traumatic stress (e.g., Abudabbeh, 2005b; Abu-Saba, 1999; Awwad, 1999; Baker & Shalhoub-Kevorkian, 1999; Hourani, Armenian, Zurayk, & Abudabbeh, 1986; Jumaian, Hosin, & Rahmatallah's, 1997; Saigh, Mroueh, & Bremner, 1997).

Issues to consider in the treatment of such wartime traumatization include the external event itself, personal meaning of the event, predisposition to risk, range, quality, and intensity of defenses, quality of past and current relationships, and second generation traumatization (Lanyado, 1999). Family secrecy, bereavement and loss, trauma, and memory also may play roles in recovery from anxiety, depression, and PTSD. Other issues to address, particularly with children and adolescents, are the need for validation of the emotional experience, clarification of the relevant events, and interpretation (e.g., Melzak, 1999). Working with children separately from their parents has also been advised, so as to break the cycle of perpetuating denial of the situation. Thus, within some family contexts it will be especially important to assess which family members may need individual treatment in addition to conjoint or family treatment.

#### **MENTAL HEALTH SERVICES IN THE ARAB AMERICAN COMMUNITY**

The continued growth in population of Arab and Chaldean Americans, along with correspondingly increased needs for health services, have led health professionals to seek a greater understanding of this ethnic group in an effort to provide culturally competent care (Sakr, 1999). Unfortunately, to date, few studies exist that have looked at their mental health diagnoses in the United States. Those that have examined diagnoses have found anxiety, depression, and post-traumatic stress disorder to be among the more prevalent disorders in Arab and Chaldean Americans seeking treatment (e.g., Abudabbeh & Aseel, 1999; Hakim-Larson, Kamoo, & Voelker, 1998; Farrag, 1999; Jamil et

al., 2002). Refugees who have left behind professional careers and have trouble transferring credentials (e.g., medical or legal) may suffer from self-esteem issues and depression ([Nassar-McMillan & Hakim-Larson, 2003](#)). Substance abuse, gambling, or other addictions may also exacerbate these conditions (Berry, 2003a; 2003b).

To help address the specialized mental health needs of Arab and Chaldean Americans, programs have been established in some large cities throughout the United States. For example, the Naim Foundation provides social, health, and educational services to the Arab community in Washington, D.C., while Detroit area organizations such as the Arab American and Chaldean Council (ACC) and the Arab Community Center for Economic and Social Services (ACCESS) provide a gamut of services for Arab and Chaldean Americans. Similar organizations exist in New York such as Tamkeen and The Arab American Family Support Center Staffed with bicultural and bilingual, and often trilingual, professionals, these agencies provide culturally appropriate services and help to facilitate contact with the broader mental health system.

Currently, these centers continue to thrive in the delivery of services and the effect they have had on the mental health needs of this population. From 1996 to 1997, the ACC documented over 4,000 participants in their mental health program, representing approximately one percent of the population in the metropolitan area, and fully more than 400% above their contracted amount. In contrast, more recently, the 2006 Arab American and Chaldean Council Annual report documented over 30,000 Behavioral Health services provided in Southeastern Michigan in 2005 (ACC, 2006).

#### **SYMPTOMS AND HELP-SEEKING BEHAVIOR IN ARAB AND CHALDEAN AMERICAN FAMILIES**

The physical symptoms of emotional distress may first come to the attention of the primary health care providers in Arab American and Chaldean families rather than mental health professionals (e.g., [Al-Krenawi & Graham, 1999](#)). There are several barriers to the help-seeking behavior of Arab and Chaldean families that have been proposed and these are described further below. Among these are the stigma associated with mental illness, the potential for shame and dishonor to the family, and the fatalistic belief that life problems must be accepted as God's will. As addressed further below, some traditional families may be more likely to seek help from healers or religious and community leaders than from health professionals. Nonetheless, this is changing and more first- and second-generation families of Arab and Chaldean ethnicity are being referred for and are successfully receiving mental health services (e.g., [Jamil et al., 2002](#); ACC, 2006).

To better understand the clinical presentation of symptoms within Arab culture warrants an understanding of the manner in which the culture views the mind and body. In Western societies, personality and the psychological constructs that comprise the mind are clearly differentiated from the body. Eastern, including Arab, cultures often do not subscribe to this duality, regarding the mind and body holistically. Because the mind is not perceived as a separate entity, distress is not reported psychologically using mentalistic terms involving the mind and moods. [Dwairy \(1999\)](#) addressed this idea when he spoke of Western clinicians often viewing “somatic expressions of distress as somatization of psychological problems” (pg. 911). Support for this viewpoint comes from studies conducted by the World Health Organization (WHO; [1973, 1979](#)) in which clinical distinctions were found between cultures in the expression of various psychological disorders. Within collectivist Eastern societies, depression was found to often present somatically, in contrast to reports of moods as seen in more Westernized cultures.

Fully appreciating the complexity of psychological disorders and psychiatric illness warrants an examination of the role of primary care medicine. Because Arab and Chaldean clients often perceive and interpret their psychological symptoms as physical ailments, they are more likely to visit a physician rather than a mental health professional, often after they have exhausted the help of the nuclear family itself ([AlKrenawi & Graham, 1999](#)). Encapsulating mental health services within those of a general medical facility may reduce the stigma associated with mental health services. Even in the United States, long-held cultural beliefs about mental health and illness prevail. [Abudabbeh \(2005a\)](#) reported that Arab Americans in Washington, DC were found to be more likely to call in to a mental health radio program for help than they were to come in person. Those who did come in person were likely to come in only once requesting specific advice for themselves or for someone else.

#### **PSYCHOTHERAPY ISSUES AND APPROACHES WITH ARAB AND CHALDEAN FAMILIES**

Therapeutic interventions may be met with obstacles due to the stigma of mental illness in traditional and more recently immigrated families ([Abudabbeh, 1996](#)). Factors such as shame, honor, dependence, the role of family, and degrees of acculturation continue to have a pervasive influence on the perceptions of those needing services. Within the Islamic faith, the fatalistic view of predeterminism may prevent Muslims from even beginning any treatment ([Nobles & Sciarra, 2000](#)). Similarly, even within Christian, Chaldean or non-Muslim groups, this notion of fatalism may be upheld, in that individuals often feel that there is little they can do to change or alter the life situations in which they find themselves. Maintaining family honor and avoiding shame that

will reflect on the entire extended family is a crucial goal for many immigrants from the Middle East (Haboush, 2007).

Among Bedouins, Al-Krenawi (1999) found that men explained their mental health symptoms as caused by God's will, while almost all the women attributed their symptoms to sorcery. Often, mental illness is attributed to supernatural powers, and can be exemplified in the "evil eye" phenomenon (Alsughayir, 1996), a belief mentioned in the Koran and upheld within Islam (Al-Krenawi, 1999), although Christians from Arabic-speaking cultures and people from other cultures will often refer to being given the evil eye also as a cause of their misfortune. Because the belief in the evil eye is so common among people from the Middle East, warding off the envy associated with it occurs in the form of various decorations for dwellings that include the depiction of an eye, or medals or charms that are worn or placed on children. As noted by Nydell (2006), it is important in communicating with individuals of Arab ethnicity to give the impression that the speaker is not looking upon children or possessions with envy, but rather wishes the individuals and their families well.

These matters highlight non-Western cultures' use of external realities to symbolically represent distress, thereby explaining why traditional healers are often utilized when problems arise. Members of the community may also look to religious leaders for counsel (Jackson, 1995). Thus, clinicians need to consult the natural network of healers in their clients' lives and will need to work with Imams and priests to help ensure successful mental health service delivery.

Amer (2006) has recently suggested some ways that clinicians can overcome barriers to treating their recent Arab American immigrant clients. Clinicians can begin by asking for help and consulting others in the community while gathering relevant information. Trust will need to be built gradually in the relationship as the mental health needs of the client and family are assessed. Amer noted that during this process it is important to avoid diagnostic labels such as "depression" and instead focus on enhancing positive values such as family happiness, peace, and harmony as goals.

It may be important for counselors working with children to first develop an alliance with the parents and convey the empathic message that the parents have good intentions for their children before going on to try and influence a change in parenting style (Haboush, 2005). In the Arab American subculture, parents put family life at the top of their priorities and expect to maintain their traditions and family honor. The counselor can first develop an empathic alliance with the parents around these goals before attempting to show how some changes and adaptations to the mainstream culture can be made without sacrificing the parents' needs and goals.

In a case seen by one of us, an adolescent Chaldean girl was referred by her parish priest for therapy for unresolved grief after the death of her aunt and then

her mother. The parish priest was instrumental not only in finding appropriate services for the girl but in helping her to resolve the feeling that she was being punished by God for not being a better niece and daughter. This case highlights the role of religion and how it may be utilized along with more traditional means of therapy.

Al-Krenawi and Graham (1999; Al-Krenawi, 1999) have described the integration of a modern therapeutic approach with cultural rituals in the Middle East. When experiencing a problem or a disease, Bedouin-Arabs first sought help from family and friends, then a general medical practitioner within the local health care system, then a traditional healer, and were finally referred by the general practitioner to a psychiatrist for further evaluation. Both symbolic expressions as well as physical symptom explanations given by the client were addressed by the practitioners. In doing so, Al-Krenawi (1999) described an ethnically sensitive approach to addressing the issues by taking into consideration the individual's degree of culture centeredness while not abandoning a general mental health framework. Even as such, there is often reluctance to share personal information with someone perceived as a community member or leader.

Another approach is for the mental health counselor to take more of an active role while allowing the client to be more passive (Al-Krenawi & Graham, 2000), often seen with non-Western interventions such as fortune telling and Koranic healing. Nassar-McMillan and Hakim-Larson (2003) found that clinicians working with Arab and Chaldean American clients mentioned the need to sometimes conduct home visits and to personalize their relationships as a means of developing rapport. Hospitality and the gracious acceptance of food or a beverage seem to be useful adjuncts in developing rapport with Arab Americans (e.g., Abudabbeh, 1996, 2005a; Haboush, 2005). Seemingly countertransference, this type of non-traditional strategy puts the focus on the relationship more than on the problem (Al-Krenawi & Graham, 2000). From there, alliances and the tenets of a therapeutic relationship may be forged (Durst, 1994). Within the patriarchal structure of the family, it is important that appropriate rapport and joining occurs with the members of the family who are in authority.

Both gender of clinician and client are an issue as well, especially among more traditional Muslim clients. While greetings of hello and goodbye are considered proper, handshakes with a woman might be considered improper by a pious Muslim male and handshakes between a male and Muslim female are the woman's choice during greetings or departures (i.e., she is the one who decides) (Nydell, 2006).

Therapeutic approaches that seem to be best for traditional Arab and Chaldean American families are those that are short-term, concrete, structured, and goal-oriented, while in-depth, emotional insight oriented approaches seem

to be contraindicated for less acculturated and more recent immigrant families (Abudabbeh, 2005a). Even though one client is identified as the target client, given the cultural significance of the family's role in the life of the individual, therapeutic interventions may need to include accommodations for the potential involvement of other family members in the process when possible. Because of the disruption to the extended family support network after immigration, it may not always be possible to involve relevant family members; nonetheless, exploring their roles historically within the family may be useful as part of the therapeutic process (Nobles & Sciarra, 2000).

Couples therapy has been found to be an important and more accepted treatment modality for Arab Americans since the motivation to maintain marriages is strong and divorce is discouraged (Abudabbeh, 2005a). In contrast, family therapy may be more challenging since individuals may be afraid to shame others in the family by overtly revealing and discussing the family's problems (Abudabbeh, 2005a). Similarly, Nobles and Sciarra (2000) suggest that clinicians acknowledge the indirect nature of family communication and intimacy in Arab American families by not asking family members to directly confront each other which may lead to emotional distress and resistance.

In general, family systems therapy is considered beneficial for several reasons (Sue & Sue, 1999). First, the emphasis is on the family as a whole and not on one particular individual. This can help to minimize potential feelings of threat to the power and authority of male adults during the treatment process. Second, the focus on concrete issues may afford members the opportunity to focus on problems that exist in the here and now, rather than on abstract issues that are more prominent in insight oriented therapies. Last, the notion that family structures and dynamics may be historically passed from one generation to the next is especially germane and acceptable in Middle Eastern culture, tradition, and history. Family therapy approaches seem to be a natural choice and a 'good fit' for American cultural subgroups that uphold more collectivistic values (Haboush, 2005).

Because there are an increasing number of community resources available to help Arab Americans as noted earlier, more men and women are seeking professional help and consultation for such problems as anxiety, depression, post-traumatic stress, intergenerational conflict, gender-related problems, learning disabilities and attention-deficit hyperactivity disorder, marital problems, and legal difficulties (Abudabbeh, 2005a). When couples seek help, the problems may include abuse issues, religious differences, cultural difference issues including between one Arab ethnic background and another, mental illness in one partner, and premarital counseling (Abudabbeh, 2005a).

**ARAB MUSLIM, LEBANESE, PALESTINIAN, AND IRAQI/CHALDEAN  
AMERICAN FAMILIES**

Arab Muslim Americans have nationalities that span the range of Arabic speaking countries in Asia and North Africa. As mentioned earlier, some evidence suggests that Arab Muslim Americans may be less acculturated to American life and less satisfied overall with their lives in the United States than their Arab Christian counterparts (Fragallah, Schumm, & Webb, 1997). Because of religious differences with the dominant Christian religion in Western society and differences in the wearing of traditional clothing (e.g., the *hijab* or head scarf worn by women), Arab Muslim Americans are sometimes more overtly identifiable as members of a minority group and thus may be more susceptible to being the target of discriminatory or prejudicial practices. Arab Muslim American girls and women who wear traditional clothing may also face stressful issues regarding their dress in the workplace (Ali, Yamada, & Mahmood, 2006) or at school. In addition, intergenerational conflict within the family may result when a member of the older generation disagrees with the clothing choices of a member of the younger generation. Thus, the stresses associated with being the target of discrimination either directly or indirectly may be one of the treatment issues that needs to be addressed with some Arab Muslim American clients (Amer, 2006).

The largest proportion of Arab Americans is of Lebanese ethnicity and the Christian faith (Arab American Institute, 2007). Some Lebanese and Syrian families have been in North American for generations extending back to the late 19th century. Thus, for those families that have become more acculturated over generations to Western individualistic traditions, treatment approaches can easily incorporate more autonomy relevant goals and insight-oriented techniques (Haboush, 2005). Identity issues for Lebanese and Syrian Americans are likely to be linked to their religion and family, even more than to their nationality; Haboush (2005) notes for example that Maronite Catholic Christians (the largest Christian group in Lebanon and among Arab Americans) prefer to see themselves as descended from the Phoenicians rather than from the Arabs and as leaning more toward a Western/Christian identity than an Arab/Islamic identity even though their language and culture are of Arabic origins. In addition to assessing the extent to which the family members identify themselves as more Western or more Arab, the counselor will need to assess generational status, the length of time since immigration, and the family's reason for immigration (Haboush, 2005).

Like Palestinian, Iraqi, and Iraqi/Chaldean American families, some more recent immigrant Lebanese American families have been traumatically affected by a series of wars and are thus mistrustful and cautiously afraid of being attacked by others, leading them to feel as if they are under threat of "siege"



(Haboush, 2005). Currently, efforts are underway to assess for such histories of trauma in Arab American clients and to effectively treat it in survivors who immigrate to the United States (e.g., Kira, 2001).

Palestinian American families present a challenging and unique situation to counselors because of their feelings of being a dispossessed people, their complex relationship with the Israelis, and the ongoing nature of sociopolitical events (Abudabbeh, 2005b). According to Abudabbeh (2005b), the longstanding cumulative trauma experienced by Palestinians has oftentimes been minimized or neglected by trauma experts because it has had to compete with the trauma of the Holocaust. Understanding the history of the conflict with the Israelis is integral to understanding the Palestinian American family, since "Palestinian Arabs differ from other Arab immigrants in their culture of diaspora, homelessness, and carrying a transgenerational legacy of not being given their due justice" (Abudabbeh, 2005b, p. 494). Under these circumstances, it is especially important for the clinician to thoroughly assess for past traumas and explore the family's premigration experiences in their village and the challenges that had to be overcome to get to other countries or refugee camps before coming to the United States.

In addition to Palestinian refugees, the United States also has a sizable population of refugees from Iraq. In the mid-1990s, clinicians in the Arab American community started to notice a large influx of refugees from Iraq in their mental health clinics (Nassar-McMillan & Hakim-Larson, 2003). Although immigrants from Iraq, especially Chaldean Christians, were also part of the first wave of Arab Americans in the late 19th and early 20th centuries, more recent waves in the late 20th century included Iraqi people from diverse socioeconomic and religious backgrounds who were fleeing warfare or political oppression (Jamil, Nassar-McMillan, & Lambert, in press). Within this more recent group were many families who were directly or indirectly (i.e., vicariously) affected by wartime traumas including torture and executions. Research studies have shown a high rate of depression, anxiety, and post-traumatic stress disorder in this more recent group of immigrants from Iraq (e.g., Jamil et al., 2002; Jamil, Nassar-McMillan, & Lambert, 2004; Jamil, Nassar-McMillan, Salman, Tahar, & Jamil, 2006; Takeda, 2000). Treatment strategies include a multidisciplinary wraparound approach that provides a variety of diverse services to support the affected families and manage the symptoms (Kira, 2002). First- and second-generation adolescents with families from Iraq are particularly prone to depression, and research studies are currently underway to address their mental health needs (e.g., Bouffard, 2004).

### CONCLUSIONS AND RECOMMENDATIONS

Clinicians and mental health professional organizations now recognize that it is in clients' best interest to incorporate an understanding of cultural factors into therapeutic work. As such, we have provided an overview of some currently available information on Arab Americans to help orient mental health counselors in their attempts to provide services. While additional research is clearly needed, a few recommendations seem to emerge from the available literature (e.g., Erickson & Al-Timimi, 2001). It is important that mental health counselors first educate themselves about the culture and think through the potentially unique impact of the Arab American subculture on their clients given the current sociopolitical context.

Issues related to discrimination, degree of acculturation, and acculturative stress are likely to emerge, as well as the more familiar therapeutic issues involving the psychosocial development of individuals and routine family adjustments and stresses. It can be especially useful for mental health counselors working with families to reframe the conflicts and events in light of their understanding of the traditional cultural expectations for the roles of the various family members (Haboush, 2005). Thus, counselors can highlight how the intergenerational and gender role problems encountered during acculturation reflect the positive values associated with the role of parents in socializing their children. These values include the need to preserve a sense of family honor within the broader collectivistic community. By first joining with the parents in this empathic manner, counselors will be in a better position to support appropriate changes that are necessary to adapt to the mainstream culture. As Erickson and Al-Timimi (2001) caution, mental health professionals would do well to carefully critique their own assumptions and values as they develop their treatment plans and set goals for clients, especially those who are recent immigrants. In doing so, the focus should be on developing an empathic understanding of the client's history.

In addition to differences in language including the interpretation of specific words and the concept of time, religious values and attitudes about relationships may differ from that of the clinician. Observant, culturally aware, and sensitive mental health counselors will therefore need to simultaneously consider these differences and the current standards of the profession before making clinical judgments. In this way, they will be better poised to provide effective mental health services.

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