2017

Iraqi Refugees and Cultural Humility: A Mental Health Professional Training Program

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by

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DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2016

Keene, New Hampshire

Dedication

To all the scientists and clinicians who view themselves as global citizens and have devoted their

lives to the global humanitarian cause,

To all of my educators, especially Mr. Matthew Weimer, who have always encouraged me to

define my horizons globally,

To my mom and dad who have, at every turn, sacrificed their own comfort to ensure that I would

encounter the most impassioned educators,

And to my grandparents, because of everything.

Acknowledgements

Table of Contents

Abstract

This paper describes the development of a thorough nine-hour professional training program targeting the cultural humility of mental health clinicians who are treating new Iraqi refugee communities. I used the 15-step evidence-based *Comprehensive Program Development Model* created by Calley (2009) for the design of the structure, curriculum, and materials for this proposed program (Calley, 2011). The training program is informed by conceptual frameworks of cultural competence and humility, ecological systems theory, and social justice with goals of (a) exploring clinicians' cultural attitudes in order to improve self-awareness at multiple levels (e.g., physiological, psychological, interpersonal), (b) increasing clinicians' knowledge about Iraqi refugee resettlement, and (c) developing clinicians' intervention skills with this at-risk population. The impact of *personal uncertainty* on extremist attitudes and behaviors is described and connected to human physiological fear responses that arise in the context of intercultural encounters. An empirical needs assessment of an exemplary rural New England clinic complements the literature review; the program is designed to be responsive to the needs faced by clinics serving new Iraqi communities. Program structure includes rigorous evaluation and quality improvement mechanisms.

Keywords: Iraqi refugees, posttraumatic stress, mental health, professional training

Chapter 1: Review of the Literature

Although severe human rights abuses have caused wholesale displacement of individuals throughout history, a formal international system for receiving and recognizing politically traumatized individuals as "refugees" has only existed since 1951 (United Nations High Commissioner for Refugees, 1951). Historically, the displacement of whole populations portends of decades if not centuries of diaspora, economic instability, social uncertainty, assimilation, acculturation, intergenerational trauma, and resource allocations that vary based on global political situations over time. Today, despite formal systems designed to organize relief efforts and protect global citizens, displacement remains an immense and devastating undertaking that defies comprehension by individuals without such personal histories. Although populations displaced from around the globe have many experiences in common, the cultural and political demands of pre-migration, the quality and details of survival during migration, and the cultural and political factors of post-migration resettlement introduce enormous variance into the impact of displacement on individual refugees within and between nationalities.

Due to current conflicts in Iraq, the United States is now recognizing thousands of Iraqi nationals as refugees each year (U.S. Department of Health and Human Services, 2012a). As Iraqi families resettle in the U.S., they encounter services ill-designed to meet their general needs as refugees (i.e., medical and mental health care, housing, employment) as well as their specific needs as Iraqis (i.e., religious resources, community, cultural accommodations, language interpretation and instruction). The strain of resettlement in assigned locations can cause Iraqis to seek homes elsewhere—often in communities completely unprepared to receive them. This secondary migration increases the likelihood that community mental health providers will receive service requests from Iraqi refugees despite having rarely otherwise encountered patients

with different worldviews and without the privilege of socio-political freedoms. Refugees often present acute needs for services but greet providers who are underprepared to safely provide them. I have developed a training program tailored to the needs of such providers.

Informed by the concepts of practice-based evidence, cultural humility, and social justice and leveraging ecological systems theory, in this dissertation, I assert the value of a training program targeting clinicians who provide services to new Iraqi refugees, delineate a plan for its development, and produce this program including all necessary materials for its full implementation. The following introduction consists of a broad review of literature regarding Iraqi refugees including their (a) geopolitical realities, (b) mental health in all three stages of migration, (c) various conceptualizations of posttraumatic stress, (d) necessities of mental health services, and the (e) strain on providers who offer them. Following this review, the project's conceptual framework is elaborated. Practice-based evidence is defined and its merits described. The robust conceptual entity of *cultural competence* is discussed at length as a valuable foundation from which the project's *cultural humility* core is evolved. As Ecological Systems Theory is explained and its relevance delineated, readers will be introduced to this newer concept of cultural humility and are persuaded of its appropriateness for this particular project as well as in future endeavors where competence might have once been propagated (Bronfenbrenner, 2005). Vygotsky's *zone of proximal development* is introduced to explain the value of experiential education in cultural work (Cole, John-Steiner, Scribner, & Souberman, 1978). The impact of *personal uncertainty* on extremist attitudes and behaviors is described and connected to human physiological fear responses that arise in the context of intercultural encounters. The conceptual framework is completed with a brief theoretical orientation to social justice as it relates to the topic of and geopolitical commitment to global refugees. It is in this section that I

assert unequivocally a commitment to refugees as an humanitarian enterprise. The introduction closes with a case study vignette from a regional clinic that began serving Iraqi refugees several years ago and a brief description of the project that follows.

In the Method section, I describe the full Comprehensive Program Development Model (CPDM; Calley, 2009, 2011) which I have applied to the training program development process. The CPDM is an extensive model for program development in the mental health sciences and has been adapted where appropriate. The process, procedures, and adaptions of the CPDM are fully explained with deliverable products clearly described and cross-referenced. In the Results in Chapter 3, I fully account for my completion of the fifteen CPDM steps including a quantitative/qualitative needs assessment of the aforementioned case clinic, review of existing programs, cultural self-reflection, the multiple-step implementation plan built using thematic logic modeling, the development of the 9-hour training program including module scripts, pre-/post- evaluations, and clinic follow-up plans, and comments on marketing, credentialing, and sustainability of the program. This extensive Results section is reinforced by a lengthy series of appendices. The document ends with a discussion of the project, its strengths and areas for growth, future directions for the field, and the position of the project and the topic in the current geopolitical climate. The plight of refugees is globally and locally overwhelming. Through the development of this training program, I have endeavored to support clinicians in the early stages of providing services to Iraqi refugees. At points throughout the text and appendices, I explicitly acknowledge my own situation and reflect on my *situatedness*, which have both inevitably informed this process.

Iraqi Refugees

Iraqis have been surviving wartime and political violence for over 35 years: the 1979-1987 Iran–Iraq War was followed by the 1991 invasion of Iraq-occupied Kuwait during the Gulf War, the 2003 War on Terror and finally, the current spike in Sunni-Shi'i sectarian violence (Sassoon, 2011; Tripp, 2007). Although a small number of Iraqis have been resettling in the United States and other Western countries in the years since the Gulf War of 1991, Western nations have recently seen a significant surge of applications for resettlement from Iraqi nationals due to the political unrest and sectarian violence following the 2006 bombing of the Al-Askariyya Mosque (Sassoon, 2011). This attack on an historically important Shi'i landmark launched a violent uprising by Sunni and Shi'i Muslims that resulted in widespread internal dislocation of Iraqis as well as an unprecedented exodus of Iraqis of various ethnicities and religions to nations in and around the Middle East including to Jordan and Syria. A second surge of sectarian violence occurred shortly after the termination of the United States occupation at the end of 2011. The first months of 2012 were marked by multiple car bombings that killed many people particularly in the days leading up the Arab League summit hosted in Baghdad in March of that year. By 2013, Iraq was in a full sectarian civil war with 900 people killed each month and an annual death toll of over 7000—twice that of the year prior. In July of 2013, 500 senior al-Qaeda operatives and high profile criminals escaped from Abu Graib and Taji prisons flooding the already unstable political and social landscape with well-connected and well-resourced extremists (BBC News, 2016). In this upheaval, the Islamic State of Iraq (ISI), the particularly extremist faction of al-Qaeda (which has subsequently evolved into the globally notorious terrorist network known as the Islamic State of Iraq and the Levant [ISIL], Islamic Sate of Iraq and Syria [ISIS], or just the Islamic State [IS]) began taking more public credit for deadly

attacks as they began operating in Iraq and Syria increasingly independently of central al-Qaeda leadership. By 2014, Islamist radicals belonging to ISIL totaled approximately 30,000-50,000 members increasingly recruited from around the world and had taken control of approximately 13,000 square miles of vital infrastructure in Iraq, carried out terrorist attacks in multiple countries in the Middle East, launched a genocidal campaign against the ethno-religious group of Yazidis, destroyed renowned archeological sites, and kidnapped women to use as sex slaves (BBC News, 2016; Wing & Kolodny, 2015). During this period, tens of thousands of Iraqis fled to Jordan and to Syria. By the end of 2015, 3.3 million Iraqis were internally displaced raising the total of "people of concern" to 4.7 million (Internal Displacement Montioring Center, 2015; UNHCR, 2016). This situation and these numbers are conflated by the immediately successive Syrian civil war and consequent global refugee crisis which displaced 4.8 million people to countries in the Middle East and beyond (10% fled to Europe) and 6.5 million people, half of whom are children, displaced from homes inside Syria (World Vision, 2016b). As of August 2016, 10 million people in Iraq and 13.5 million people in Syria have insufficient resources for survival including water, food, basic medical care, and weatherization equipment (World Vision, 2016a, 2016b).

Until very recently, the United States and its allies have processed relatively few refugee status requests from Iraqis, which some political scientists attribute to the political ramifications of addressing strengths and weaknesses of American military efforts in the region (Sanders & Smith, 2007; Sassoon, 2011). Only as the chaos and mass dislocation of Iraqi citizens after the 2006 bombing became a more visible humanitarian crisis, was the Western world, particularly the United States, compelled to offer aid in the form of relief funding and refugee processing (Sanders & Smith, 2007; Sassoon, 2011; Yako & Biswas, 2014). As Western nations begin

offering aid, they greet a compounded set of issues. As of 2010, Iraqi refugees comprised the largest and fastest growing displaced population in the world; ongoing conflict in the region portends of decades of instability for displaced Iraqis, and now Syrians, worldwide (Jamil, Ventimiglia, Makki, & Arnetz, 2010; UNHCR, 2016; United Nations High Commissioner for Refugees, 2014; World Vision, 2016b).

Iraqis represent the world's largest displaced group with an estimate of 2.7 million internally displaced persons and between .5-2 million who have fled Iraq altogether (Mason, 2011; Sassoon, 2011; United Nations High Commissioner for Refugees, 2014; Yako & Biswas, 2014). Residential arrangements in neighboring countries were originally designed as temporary; during which time, many Iraqis have traveled freely back and forth to deliver goods to family trying to survive in Iraq (Sassoon, 2011). As this conflict has recently intensified, however, these tenuous arrangements in countries such as Jordan, Syria, Lebanon, and Egypt have become politically and financially strained while Iraqi families and the global community have begun to doubt that safe return to Iraq will ever be viable (Mason, 2011; Sassoon, 2011). What began as temporary regional resettlements have become urgent and yet untenable permanent establishment (Mason, 2011). Out of this tension, Iraqi families have begun to seek the formal recognition as *refugees* and the consequent global entitlements offered by the designation.

The United Nations High Commissioner for Refugees (UNHCR), the global governing structure for the designation and distribution of refugees worldwide, defines refugees as individuals who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, or membership of a particular social group or political opinion, is outside the country of his nationality and is unable, or owing to such fear, is unwilling to avail himself of the protection of that country" (United Nations High Commissioner for Refugees, 1951). In 2013,

the year for which there is most current data, the UNHCR identified 10.4 million refugee

populations of concern with an additional 4.8 million in refugee camps in the Middle East alone

(United Nations High Commissioner for Refugees, 2013). At the 1951 United Nations

Convention Relating to the Status of Refugees (also known as the Geneva Convention), the

United Nations committed to this international definition of refugees and agreed that formal

refugee status entitles individuals to several crucial rights, the most politically and historically

significant of which is *non-refoulement* (United Nations High Commissioner for Refugees,

2011).

Non-refoulement is the practice of permanently honoring residency establishments for

refugees—that is, formally recognized refugees will never be deported back to their countries of

origin by Geneva Convention signatories. Formal refugee status is fundamentally an

international legal and political designation that, for many asylum seekers worldwide, takes years

to acquire (Agier, 2008). Experiences in the interim between fleeing one's home country and

establishing permanent resettlement in a destination country are often independently

traumatizing (Baker, 1992). Refugee camps are overcrowded, provide limited material resources,

offer no or minimal medical health and mental health care, and maintain few educational

provisions for children (Agier, 2008; Sanders & Smith, 2007). In the case of many Iraqi refugees

who are highly educated former middle-class professionals, transition began comfortably as they

relied upon sizeable savings accounts (Mason, 2011; Sassoon, 2011). Over time however, these

funds have depleted leaving most Iraqi families in debt prior to their arrival in their permanent

country of residence. Humanitarian aid in conflict zones is always finite and usually insufficient

for the needs of the displaced. Lower-class Iraqis who had no disposable assets at the time of

forced migration from Iraq have struggled to get basic needs met by their interim host countries, many of which are overburdened by the large Iraqi exodus (Mason, 2011; Sassoon, 2011).

Iraqis residing in Jordan, Syria, and Lebanon, which are not signatories to the Geneva Convention and therefore are not committed to practicing non-refoulement, face daily fear of forced repatriation (Mason, 2011; Sassoon, 2011). As Iraqi refugees arrive in the United States, they feel certain for the first time that they will not be forcibly returned to their unsafe and largely dismantled home communities in Iraq. This contributes to a hope that resettling in the U.S. will provide the security they have long awaited but the resettlement system they greet upon arrival is often experienced as disorganized, bureaucratic, insensitive, unrealistic, and frightening (Ivry, 1992; Sanders & Smith, 2007).

In 2012, the most recent year for which there is published data, over 12,000 Iraqi refugees were resettled in the United States (U.S. Department of Health and Human Services, 2012a). Refugees receive a primary placement in a designated U.S. city where they are to establish residency and eventually employment (Office of Refugee Resettlement, 2012; Ott, 2011). Temporary monthly subsidies and limited access to a case coordinator provide some but insufficient assistance (U.S. Department of Health and Human Services, 2014). Refugee placement is determined by the allocation of federal grants to each state for a specific number of refugees per year; the Office of Refugee Resettlement system allocates funds directly to the receiving state (U.S. Department of Health and Human Services, 2012b). This poses significant challenges because many refugees eventually choose to move from their state of primary placement to a secondary location. This secondary migration of refugees within the United States is very difficult to monitor and creates challenges for the receiving communities which neither have the infrastructure nor appropriate funding to support these families. Although there is very

little extant research on secondary migration of Iraqis, anecdotal evidence suggests that many

Iraqi families who are placed in Southern states choose to migrate to Northern states soon

thereafter with the largest Iraqi immigrant community residing in Detroit, Michigan (Ott, 2011;

Yako & Biswas, 2014). Many factors contribute to secondary migration including (a) cost of

living, (b) employment possibilities, (c) fear of violence and discrimination, (d) distrust of

neighboring ethnic groups, and (e) social supports that reside elsewhere. The secondary

migration of refugees within the U.S. creates a situation in which refugees may present for

services at community mental health centers and other health service agencies that are

unqualified and ill-prepared to provide appropriate services (Ott, 2011).

Refugees and Mental Health

Mental health is understood as foundational to health and well-being and as such is a

fundamental human right (Blight, Ekblad, Lindencrona, & Shahnavaz, 2009). Yet, the mental

health needs of refugees are formidable. For many refugees, health and mental health care have

been suspended throughout the lengthy transition from pre-migration to resettlement (Baker,

1992; Chang-Muy, 2009; Michultka, 2009). Each of these stages renders refugees unlikely to

access basic health and mental health care and yet presents individuals with often traumatizing

experiences—the recovery and rehabilitation from which are suspended as refugees attend to the

basic demands of survival (Agier, 2008; Chang-Muy, 2009).

Mental health in country of origin. By definition, refugees have undergone profound

human rights violations including assassination attempts or threats, rape, pillaging and

plundering, kidnapping, and torture during their pre-migration homeland conflicts (Nickerson,

Bryant, Silove, & Steel, 2011). Indeed, 63% of Iraqis reported fleeing Iraq because of a direct

threat to their lives; 89% of those attributed these threats to their tribal, ethnic, or religious

affiliations (Sassoon, 2011). In Iraq, one in every eight children dies before the age of five years (Sassoon, 2011). These abuses often occur during civil unrest that leaves food, water, and other resources scarce (Harding & Libal, 2012). By the time current Iraqis seek asylum elsewhere, they are likely to have survived numerous existential threats through violence and scarce resources.

Mental health during migration. In one study, humanitarian aid workers in Jordan identified Iraqi symptoms as some of the worst among refugee communities they have treated in their careers (Harding & Libal, 2012). Refugees present severe hyper- and hypo-arousal, intrusive nightmares and flashbacks, depression, anxiety, and psychosomatic symptoms that impede their adjustment to new living conditions and are difficult to treat (Nieves-Grafals, 2001). Depressive symptomatology occurs in 42-89% of displaced populations with one study finding that 73% of a sample of Iraqi refugees in the U.S. met criteria for a depressive disorder (Jamil et al., 2010). Significant symptoms of posttraumatic stress occur in over 50% of Iraqi refugees (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). Prior torture experiences, thought to occur in 13-20% of refugees contribute the largest variance in posttraumatic stress (PTS) symptoms (Steel, Silove, Bird, McGorry, & Mohan, 1999). Although the rate of PTS symptoms in Iraqi refugees is similar to the rate of contemporary Iraqi non-refugee immigrants, refugee treatment response is significantly lower (14.4% compared to 44.4%) suggesting that the divergent experiences between refugees and immigrants may not impact the development of posttraumatic stress but render the symptoms more recalcitrant to treatment (Jamil et al., 2010). Although refugees do not typically endorse suicidal ideation, they do report feelings of despair, demoralization, guilt and hopelessness (Briggs & Macleod, 2006; Kunz, 1981).

Mental health in resettlement. Acclimating to a country of resettlement often causes immense acculturative stress for refugees. Acculturative stress is defined as the social and psychological distress that often accompanies the process of transitioning to living in a culture different than one's own native culture (Yako & Biswas, 2014). The process of acculturation to new environments produces a tension for immigrants in which on the one hand, they are invested in the "maintenance and development of one's ethnic distinctiveness by retaining one's cultural identity" and on the other, they "desire to seek interethnic contact by valuing and maintaining positive relations with the dominant society" (Roysircar-Sodowsky & Maestas, 2000, p. 135). Acculturative stress is often marked by symptoms of anxiety and depression (Yako & Biswas, 2014). Poverty, loneliness, and continued conflict in the country of origin exacerbate symptoms of acculturative stress and appear to be related to more severe PTS presentations (Silove et al., 1997). Specifically, health complications, asylum and welfare status processing issues, and loss of culture and social support are three post-migration factors that, combined, contribute to a significant 14% of variance in PTS symptoms (Steel et al., 1999). Although drug and alcohol use is culturally prohibited for Iraqis, and thus self-medicating and addiction are uncommon in older generations, substance use and abuse appears to be increasing among younger generations. In the single year between 2004-2005, the number of registered addicts rose in Iraq from 3000 to 7000 (Ahmed & Amer, 2012). There is currently no known data for Muslim refugees in the United States where alcohol is far more readily available.

Refugees and mental health service utilization. Despite acute need, refugees are disproportionately underrepresented among mental health service utilizers in the United States and worldwide; this is particularly true of new members of the American Muslim community (Amri & Bemak, 2013; Gong-Guy, Cravens, & Patterson, 1991; Miller & Rasco, 2004;

Thomson, Chaze, George, & Guruge, 2015). There are numerous cultural and logistical factors that account for this phenomenon. Western conceptualizations of mental health and illness are unfamiliar and at times culturally inconsistent with the worldviews of refugees (Blight et al., 2009; Goździak, 2004). Refugees may not utilize mental health services because they do not realize or understand the services or because the Western models of mental health do not feel culturally relevant (Van der Veer & van Waning, 2004).

Underutilization of mental health services can also be explained by logistical demands of accessibility (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Franks, Gawn, & Bowden, 2007; Gong-Guy et al., 1991; UNHCR, 2002). Accessibility of services presents profound barriers to the acquisition of necessary treatment (Bischoff et al., 2014). Refugees may resettle in areas without sufficient mental health providers, with poor or no access to transportation or childcare to keep appointments, or may have few financial resources to pay for services; these challenges are particularly acute for refugees settled in rural areas (Bischoff et al., 2014; Gong-Guy et al., 1991). Service utilization among refugees raises three vital questions: (a) how can mental health providers in the United States and similar Western nations provide meaningful services in a manner more consistent with varying cultural definitions of mental health, illness, and suffering? (b) how can providers reach refugees for whom accessibility factors impede behavioral health service utilization? and (c) how can providers responsively meet the needs of the comparatively few refugees who do seek mental health services? It is with this final question that the current project most contends.

Cross-cultural mental health services. Cross-cultural services of any kind place unique challenges on providers. Among these challenges are diverging cultural meaning-making and value systems, power differentials and perceptions, role confusion, miscommunication leading to

misunderstandings, and diagnostic and treatment uncertainty (Michultka, 2009; Roysircar, 2003). These challenges are magnified when the client and clinician do not share a common language. Cross-linguistic services can be sluggish, frustrating, and intimidating for providers who have no preparation or experience working through interpreters (Cushing, 2003; Michultka, 2009).

Clinicians are challenged still further when the presenting client is a refugee who has survived severe human rights transgressions that far exceed the experiences of most Western mental health staff. Clinicians meeting with refugees for the first time may react with strong emotions and defensive self-protection to the severity of presenting symptoms and historical content. By either immersing themselves in the gruesome details of the clients' stories or disengaging through numbing, invalidation, or rigid reliance on protocol, clinicians struggle to maintain "optimal distance" (Michultka, 2009; Van der Veer & van Waning, 2004). Providers confront daunting presenting content, acute symptoms, systemic confusion, and their own cultural identity in a manner that can be overwhelming and frustrating (Michultka, 2009; Van der Veer & van Waning, 2004).

Initial treatment with refugees is necessarily a slow process (Harvard Program in Refugee Trauma, 2016d; Mollica, 2009). This occurs in part due to linguistic barriers that make communication sluggish but also as a function of the complexity of the issues faced by refugees (Nieves-Grafals, 2001). The paramount first step for initial treatment is alliance formation (Nieves-Grafals, 2001). Depending on the system in which providers practice, systemic time constraints on treatment can truncate treatment before case management, relationship development, and trauma containment goals are achieved (Nieves-Grafals, 2001). Clinicians must navigate this situation in a respectfully curious and flexible manner but, doing so can be difficult under competing professional pressures (Van der Veer & van Waning, 2004).

Much self-growth on the part of mental health staff is necessary in order to treat refugees without causing harm. Successful treatment is safe treatment; clinical safety with refugees requires clinicians to expand intellectually, experientially, and self-reflectively (Lansen & Haans, 2004; Reavy, Hobbs, Hereford, & Crosby, 2012; Van der Veer & van Waning, 2004). While some of this learning can occur in vivo, there are necessary foundations that help orient clinicians so as not to inadvertently cause harm to clients: receptivity to the experiences, awareness of one's own cultural development, valuing and respecting human difference, and knowing basic information about a client's cultural worldview and history (Arredondo, 2003; Arredondo-Dowd & Gonsalves, 1980; Hendricks, 2009; Roysircar, 2003; Roysircar, Dobbins, & Malloy, 2010). Work with refugees demands more professional patience and personal flexibility than that with most other clients. Without supports and training, providers may react by disengaging from clients and by extension, further disenfranchising some of the most disenfranchised individuals in the world.

Rural Mental Health Vignette

In 2013, a small rural community in New England began receiving an unprecedented secondary migration of Iraqi refugees, many of whom immediately sought mental health services from the large regional community mental health center. Although this agency had long had a formal diversity initiative honoring the region's long history of particularly French-Canadian immigration dating back to the 1850s, providers were unprepared for 21st century arrivals of Muslim refugees (J. Myall, December 1st, 2016, personal communication). In the years since 2000, the number of residents with Arab or Sub-Saharan ancestry, generally settling in urban communities, increased from 3,300 to 12,000—almost quadrupling. The number of Iraqi individuals, who were more likely to settle some distance from urban centers, increased from 39

individual to an estimated 650 people over that same period (J. Myall, December 1st, 2016, personal communication; United States Census Bureau, 2000; United States Census Bureau, 2014). Most agency mental health providers, from whom many of these refugees sought services, had rarely worked cross-culturally and had never worked cross-linguistically.

Refugee families began presenting for services with highly acute symptoms derived from entrenched historical trauma, stresses of migration, and the terrors of ongoing conflict affecting loved ones still in Iraq. These patients rapidly overwhelmed existing systems for intake, assessment, and treatment. As the agency endeavored to meet the demands of the refugee patients, staff clinicians seemed to become frustrated and afraid.

During this time, I was satisfying my clinical practicum as a member of the home and community treatment (HCT) and outpatient and substance abuse (OP) teams, both of which began receiving referrals from Iraqi refugees. As clinicians began clamoring for administrative and clinical support, I was invited to assess the programmatic issues related to meeting this unprecedented need. The issues faced by the clinic were complex and demanded attention at multiple levels: (a) the logistics of service delivery, (b) the practices of clinical work with refugees (Iraqi Muslims in particular), and (c) the unique cultural self-awareness and personal reactivity specific to cross-cultural work.

Following a thorough regional and international search for consultation and training regarding this programmatic challenge, administrators of the clinic determined that appropriate existing external resources were minimal. Consequently, despite best efforts, program response has been diffuse, reactive, and rudimentary. Staff morale and client retention remain significant barriers to effective and safe service provision.

Specific Objectives of Project

      This vignette demonstrates the importance of a readily available, organized, and responsive professional training program that supports clinicians in addressing the needs of Iraqi refugees. The necessary program accommodates clinicians with little to no cross-cultural or cross-linguistic clinical experience, balances didactics with experiential self-development, and includes rigorous evaluation and quality improvement mechanisms.

Chapter 2: Conceptual Framework

Clinical training is a complex endeavor involving the proximal goal of preparing clinicians to meet distal challenges of unique patients. When these patients are Iraqi refugees, the learning and growth required of clinicians before they can meet these challenges may be overwhelming. As such, it has been essential that this training program for clinicians of refugees be well-designed so as to maximize time, attention, and capacities of the clinicians who attend. In order to anchor the proposed program in respected theory and contemporary practices, the projected training program development process was guided by several conceptual frameworks. Providing services to Iraqi refugees poses local community-based challenges that are yet, situated in profoundly complex global dynamics. These frameworks helped to organize priorities in this research and guide decision-making toward effective and meaningful training.

Practice-Based Evidence

Practice-based evidence is a movement, the proponents of which argue that an essential aspect of program improvement is the examination of local data (Barkham, Mellor-Clark, Connell, & Cahill, 2006; Clement, 2013). Localized data is valuable because it accounts for the inherent fluctuation seen in the effects of evidence-based practices between the randomized clinical trial environments and the particularities of a natural clinical environment (Barkham et al., 2006; Clement, 2013; Trierweiler, Stricker, & Peterson, 2010). In the case of refugee services for which there are few evidence-based practices established, practice-based evidence allows programs to avail themselves of valuable information particular to their own victories and growth areas (Birman et al., 2008). This framework informed not only the materials the facilitator provides to the recipients of the training but also informs the development of an internal evaluation process for the training itself.

Cultural Competence

Cultural competence is a framework for providing cross-cultural services that are appropriately adapted to the cultural values, morays, beliefs, traditions, and development of clients. Cultural competence is defined as an ongoing process of developing cross-cultural sensitivity through the exploration and development of one's own knowledge, skills, attitudes, and beliefs regarding people of other cultures and backgrounds (Upvall & Bost, 2007). Cultural competency development is thought to be a life-long aspirational process (Potocky-Tripodi, 2002). The Multicultural Counseling Competencies framework is organized into three domains of clinician development: (a) clinician awareness of his or her own worldview, (b) clinician awareness of clients' worldviews, and (c) clinician use of culturally appropriate interventions (Arredondo, 2003). Within each of these domains are three competency areas that pertain to the relationship between a provider and client: (a) attitudes and beliefs, (b) knowledge, and (c) skills (Arredondo, 2003).

Clinician self-awareness.

Attitudes and beliefs. Clinicians competent in this area not only recognize cultural differences but show sensitivity to the ways in which their own culture has shaped their development and the development of others. Clinicians also acknowledge that the influences of culture on themselves and others can make it difficult to connect with individuals who do not share their developmental influences and monitor the ways their culture-driven worldview limits their connectedness with others. This process of developing self-awareness about one's attitudes renders them theoretically capable of becoming increasingly comfortable with cultural differences (Roysircar, 2003).

Knowledge. Culturally competent clinicians understand that their culture has shaped the way they define normative behavior, are familiar with their own verbal and non-verbal communication styles, and acknowledge that although racism and cultural stereotyping (e.g., Islamophobia) are inappropriate, any racist beliefs they hold themselves are the product of development and a lack of self-examination (D. W. Sue & Sue, 2012). Culturally competent clinicians take steps to introduce flexibility into their ethnocentric perspectives.

Skills. Culturally competent clinicians pursue continuing education in cross-cultural service provision and welcome opportunities to engage with people different than themselves. Eventually, these experiences equip clinicians to develop a non-racist identity and to become active leaders in non-discriminatory practices (Arredondo, 2003).

Clinician awareness of client.

Attitudes and Beliefs. Culturally competent clinicians examine their reactions to clients. They are open to the possibility that they hold unfair culturally-driven biases against clients and take steps to remedy them. These unfair ideas include widely held stereotypes or personal preconceptions and can insidiously influence clinicians (Roysircar, 2003).

Knowledge. Culturally competent clinicians also seek specific information about the culture, socio-political history, worldview, religion, ethnicity, traditions, sexuality, and values of the clients they work with. While simultaneously considering all of these aspects of an individual client's identity, clinicians honor the individuality and unique preferences of the client and are careful not to make generalizing attributional errors (Roysircar et al., 2010; D. W. Sue & Sue, 2012).

Skills. Culturally competent clinicians stay current on clinical research pertaining to the cultures and presenting complaints of each client. They also develop comfort interacting with

different cultures through informal social engagements (Arredondo, 2003; Roysircar et al., 2010; D. W. Sue & Sue, 2012).

Clinician application of culturally appropriate interventions.

Attitudes of Client. Culturally competent clinicians honor the manner in which a client's religious and spiritual beliefs shape their constellations of protective factors and view these beliefs as powerful sources of resilience. Similarly, traditional healing practices indigenous to various cultures are treated with respect and seen as potentially valuable sources of healing. Clinicians value bilingualism and the multiple ways knowledge is constructed through language (Potocky-Tripodi, 2002; Roysircar et al., 2010; D. W. Sue & Sue, 2012).

Knowledge. Culturally competent clinicians are aware that evidence-based interventions are at times inconsistent with a client's cultural values, worldview, family structure, beliefs, and social hierarchies and approach these conflicts with sensitivity (Birman et al., 2008; Roysircar et al., 2010). Clinicians think systemically, identifying institutional and societal barriers to healing for cultural minority clients.

Skills. Culturally competent clinicians value the subtle challenges of communicating cross-culturally, endeavor to provide services in the client's language of choice whenever possible, and appreciate the significance of nonverbal communication (d'Ardenne, Farmer, Ruaro, & Priebe, 2007; O'Hara & Akinsulure-Smith, 2011; Smith, 2013). Lastly, culturally competent clinicians reduce assessment bias and discrimination by discerning culturally-appropriate assessment tools (Potocky-Tripodi, 2002; D. W. Sue & Sue, 2012).

Cultural competence is a lifelong endeavor that is never fully accomplished—it is a professional ideal. For the purposes of the training program, the cultural competence framework suggests that two important goals of an initial cultural competence training program are: (a) to

equip clinicians to do no harm in the process of cross-cultural work and (b) to broaden their

understanding of their own cultural development.

Ecological Systems Theory

The compelling international and historic forces that have and will determine refugees'

lives even as they migrate and acculturate to their resettlement communities renders the

ecological model an appropriate framework for conceptualizing the provision of culturally

competent and humble care (Potocky-Tripodi, 2002).

Ecological systems. Ecological systems theory was developed by Urie Bronfenbrenner in

the latter part of the 20th century (Rosa & Tudge, 2013). First published in 1979, *The Ecology of*

Human Development offered a theoretical explanation of human development as a function of

infinite interactions between the many systems within which an individual is embedded.

Individuals are understood as inherently networked into *microsystems* of face-to-face interactions

each in a given setting with individuals who have unique temperaments, beliefs, and

idiosyncrasies (Bronfenbrenner, 2005; Gardiner & Kosmitzki, 2011; Rosa & Tudge, 2013).

These microsystem settings are themselves networked in a *mesosystem* within which the various

social groups and environments of a person interact. The *exosystem* is made up of various forces

that indirectly influence the development of an individual by directly impacting aspects of the

individual's mesosystem. The broader *macrosystem* is:

> …The overarching pattern of micro-, meso-, and exo-systems characteristics of a given
>
> culture, subculture, or other broader social context, with particular reference to the
>
> developmentally instigative belief systems, resources, hazards, lifestyles, opportunity
>
> structures, life course options, and patterns of social interchange that are embedded in
>
> each of these systems. The macrosystem may be thought of as a societal blueprint for a

particular culture, subculture, or other broader social context. (Bronfenbrenner, 2005, pp.

149–150).

These systems are highly networked social forces that create an individual's sense of reality and

possibility.

Refugees in the ecological field. The challenge of work with refugee clients lies not

simply in forming an alliance with an individual who has developed outside of one's own micro-,

meso-, or exosystems, but outside one's macrosystem and, therefore, outside many of the

developmental forces that form the worldviews of individuals and that pervade the zeitgeist of

clinical work in the Western world. It is within macrosystem structures that conceptualizations of

health and pathology develop and interventions are established and evaluated (Potocky-Tripodi,

2002). The ecological systems model is a valuable framework for conceptualizing the goals of

cross-cultural mental health interventions because it provides a way of understanding human

variability at all levels from idiosyncratic personological differences to broad metaperspectives

about human flourishing. Mental health clinicians are bound to confront differences that span

this entire range when working with refugees; the ecological systems model establishes this

range as a normative manifestation of infinite system interactions and thus, forbids rigid

adherence to the culturally bound Western definitions of pathology (Potocky-Tripodi, 2002;

D. W. Sue & Sue, 2012).

Conceptualizations of pathology. The issue of framing pathology is most relevant to

refugee services in the discussion regarding posttraumatic stress. Traumatic experience is what,

at its simplest, defines the refugee for the sociopolitical task of framing the responsibilities the

international community has for human rights arbitration. In order to be recognized by the

international community, individuals must have incurred severe forms of persecution, what are

known in the Universal Declaration of Human Rights as "barbarous acts which have outraged the conscience of mankind" on the basis of constitutive identity variables: religion, ethnicity, culture (United Nations, 1948; United Nations High Commissioner for Refugees, 1951). The connection between trauma and undesirable symptoms (i.e., depression, panic) is well-founded; when the symptom constellation is such that it impedes psychological, social, and occupational functioning, an individual is said to have "posttraumatic stress disorder". But in the case of refugees, this conceptualization of posttraumatic stress is problematic on several grounds (Nickerson et al., 2011).

The first problem is a two-part pragmatic issue: (a) symptom presentation and (b) diagnosis. Refugees often present a different symptom configuration suggestive of posttraumatic stress than the general population. As such, researchers disagree about whether PTSD is a unitary disorder with diagnostic criteria that adequately capture severe posttraumatic stress (Goździak, 2004; Nickerson et al., 2014; Nieves-Grafals, 2001; Rousseau, Measham, & Nadeau, 2013). This concern joins a broader discussion about the validity of mental disorder conceptualization and diagnosis in the Western world that, while vital, is beyond the scope of this paper. It is possible that a unitary refugee posttraumatic stress disorder exists but manifests in a fundamentally different manner than PTSD in the general population (Nickerson et al., 2011, 2014; Nieves-Grafals, 2001). Refugees often do not meet all criteria as stated in the Diagnostic and Statistical Manual (American Psychiatric Association, 2000). Diagnosis, in general, is problematic because it is difficult to determine whether posttraumatic stress symptoms impede social, psychological, and occupational functioning—establishing a functional baseline in each of these domains is made impossible by virtue of the upheaval in refugees' lives and our poor clinical assessment tools (Gong-Guy et al., 1991).

The second problem is conceptual and involves the pathologization of normal microsystem behavior in abnormal exo- and macrosystems circumstances. Refugees are recognized as such because atrocious acts of violence by others have threatened their inherent humanity. These violent acts are the severest forms of human experience that defy sense and challenge survivors to regain and retain meaningful lives—to find intrapersonal order in interpersonal disorder. As such, some scholars point out the intrinsically disrespectful practice of pathologizing posttraumatic stress by diagnosing refugees as "disordered" (Goździak, 2004; Mollica, 2009). For the purposes of this training program, "posttraumatic stress" is used to describe the signs and symptoms of the natural process of recovery from excruciating circumstances without pathologizing and regardless of whether the symptom constellation maps onto the diagnostic category of PTSD.

The third problem is phenomenological. Western conceptualizations of human experience (i.e., health, well-being, illness, suffering, trauma) are inconsistent with many of the worldviews of refugees (Colucci, Szwarc, Minas, Paxton, & Guerra, 2014; Mollica, 2009; Potocky-Tripodi, 2002). Most academic and professional training undergone by clinicians in the United States is anchored in its own macrosystem zeitgeist. Clinicians rely on their necessarily finite worldview when defining their roles, options, and hopes for clients; but, these definitions may be meaningless or even harmful to refugees. Refugees may not consider themselves to be traumatized, nor may even think of themselves as having had an individual experience (Mollica, 2009). Ecological systems theory offers a framework that assumes the value of plural worldviews and invites individuals to relish rather than rebuff cultural differences.

Epistemology and competence. Ecological systems theory also challenges the notion of clinical cultural competence in important and relevant ways. This model challenges the

foundations of the cultural competence movement by articulating that the very processes of

defining and evaluating competence, as a cognitive entity, are culturally-bound acts

(Potocky-Tripodi, 2002). By extension, striving after a kind of cognitive competence of cross-

cultural work is an epistemological impossibility (Ortega & Faller, 2011). Any conceptualization

of competence—any stance of knowing—is inherently confined by the ecological field available

to a person (Bronfenbrenner, 2005; Guzder & Rousseau, 2013; Ortega & Faller, 2011).

Proponents of the cultural competence movement acknowledge that cultural competence is an

ideal that can never be fully attained; the process of self-development that the cultural

competence movement mandates is a life-long process of ever more nuance and openness to

experience. However, from the standpoint of ecological systems theory, even defining

parameters of a hypothetical ideal of cultural competence is a futile endeavor.

> The emphasis in cultural competence training typically focuses on learning knowledge
>
> and skills that will help a worker engage with or work on behalf of people who share
>
> similarities with others in their cultural group. A cultural competence approach, which
>
> emphasizes similarities, involves assumptions about cultural groups that may or may not
>
> be accurate. It may also convey a misconception that culture can be understood as a set of
>
> observable and predictable traits, thereby instilling a false sense of confidence in workers
>
> about their knowledge of the person or family. Ironically, the concept of cultural
>
> competence originated to promote respect for cultural differences yet may emphasize
>
> similarities at the expense of individual differences. (Ortega & Faller, 2008, p. 2)

Rather, cross-cultural interactions are thought to depend on and shape the culturally-bound

individuals who engage one another. Therefore, healthy intercultural interactions may be more

appropriately defined by stances of curiosity, uncertainty, and infinite possibility rather than a

defined ideal (Chang, Simon, & Dong, 2012; Delgado et al., 2013; Guzder & Rousseau, 2013; Kutob et al., 2013; G. Miller, 1998; Ortega & Faller, 2008; Ortega & Faller, 2011; Piachaud, 2007; Tervalon & Murray-García, 1998).

This is not to say, in the context of cross-cultural clinical work, that professionals ought not consider the ramifications of their behaviors and the ways their behaviors can inadvertently do harm. Clinicians have an ethical responsibility to honor human plurality and to take appropriate steps to offer clients the most compassionate and effective services possible. Ecological systems theory, however, problematizes the epistemological and semantic implications of the cultural competence ideal. More consistent with Bronfenbrenner's model is the related concept of *cultural humility*, sometimes also described as "cultural safety" (Chang et al., 2012; Cleaver, Carvajal, & Sheppard, 2016; Guzder & Rousseau, 2013; Kutob et al., 2013; G. Miller, 1998; Ortega & Faller, 2008, 2011; Reavy et al., 2012; Tervalon & Murray-García, 1998).

Cultural Humility

Because cultural competence is an unattainable and hierarchical ideal that misleads clinicians into complacence, some scholars prefer the use of a more recently articulated "cultural humility" concept that encourages clinicians to approach their work with a generosity of spirit, personal vulnerability, and permanent commitment to self-reflection (Chang et al., 2012; Kutob et al., 2013; G. Miller, 1998; Ortega & Faller, 2011; Tervalon & Murray-García, 1998).

Humility and safety. Cultural humility was originally conceptualized by Tervalon and Murray-Garcia (1998) in an effort to orient multicultural medical education toward growth rather than mastery (Isaacson, 2014; Tervalon & Murray-García, 1998): "…cultural humility incorporates a lifelong commitment to self-evaluation and critique, to redressing power

imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 123). Humility is defined as accurate self-awareness including acknowledgement of personal biases and weaknesses, an "appreciative" interpersonal receptivity, and a respect for meaningfulness in others' lives (Paine, Jankowski, & Sandage, 2016).

Since the coining of this term, other scholars have joined the conceptual development process of this construct (Owen et al., 2014; Paine et al., 2016). Chang, et.al., have proposed four elements of cultural humility: (a) self-reflection and self-critique, (b) learning from patients, (c) building partnerships with individual clients and the broader community with which they identify, and (d) viewing cultural humility as a life-long process (Chang et al., 2012). The tension between the self-evaluation necessary to cultivate humility and the commitment to interpersonal elasticity, curiosity, honoring, and attending to the other is not thought to resolve itself in the work—it is the nature of the work.

In a recent concept analysis, Foronda, Baptiste, Reinholdt, and Ousman (2016) elaborated on prior models of cultural humility. While they reiterated the centrality to the construct of openness, self-awareness, and self-reflectiveness, they have also suggested that self-examination is in itself insufficient; the nature of providers' *relationships with themselves* shapes their capacities to engage humbly (Foronda, Baptiste, Reinholdt, & Ousman, 2016). *Egolessness,* defined as the ability to relinquish attachments to the ego, is a necessary attribute of a culturally humble person because one must be able to absorb the many conflicts of working interculturally without defensiveness (Foronda et al., 2016). In fact, 'differentiation-of-self' was shown to mediate the association between providers' humility and intercultural competence:

…the capacity to resist losing oneself in the relationship while negotiating difference is

closely tied to internally tolerating and regulating the anxiety generated by interpersonal

difference… intrapersonal differentiation of self can foster the interpersonal capacity to

balance separateness and togetherness, particularly when navigating cultural difference.

(Paine et al., 2016, p. 19)

One of the hallmarks of intercultural effectiveness is the capacity to manage one's internal states

and self-referent emotions when faced with anxiety-provoking interpersonal encounters.

Within the cultural humility concept, the most egregious professional error is to be

unwilling or unable to continuously self-examine one's own worldviews, attitudes, and biases—a

process without which clinicians will allow negative racism and other forms of institutionalized

discrimination to interfere with the treatment process. This distinction has profound conceptual

implications about the nature of the power dynamic between the client and the clinician (Ortega

& Faller, 2011). By renouncing ethnocentrism and abandoning the assumption that one person

can ever be "competent" about another culture or, furthermore, that competence ought to be

endeavored in the first place, culturally humble clinicians are encouraged into productive

vulnerability and openness.

In sum, a cultural humility perspective encourages workers to take into account an

individual's multiple identities and the ways in which their social experiences impact

their worldview, particularly as it relates to their expression of their culture.

Demonstrating cultural humility frees workers from having to possess expert knowledge

about an array of cultural differences. This perspective has the benefit of placing the

workers in a learning mode as opposed to maintaining power, control, and authority in

the working relationship especially over cultural experiences about which the client is far

more knowledgeable. (Ortega & Faller, 2011, p. 34)

Within the competence ideal, the clinician strives after a stance of knowing whereas, within the

humility ideal, the clinician cultivates a stance of learning. This is not to say that endeavoring

toward humility requires that the onus is on the client to be a representative, a token, of entire

groups to which they belong, but rather that providers adopt with elasticity any generalized

knowledge about groups different than themselves and avoid imposing assumptions on their

clients. Within its growing representation in the literature, the relationship between cultural

humility and cultural competence has been conceptualized in various ways: (a) as evolutions of

the same construct, (b) as twin constructs, (c) as one subsuming the other, canceling the other, or

operationalizing the other, and (d) as opposing constructs. For the purposes of this discussion,

humility is conceptualized as the standard for multicultural practice and the goal for multicultural

education. However, the history of and tools developed within the cultural competence literature

remain valuable and will be used in pragmatic necessity. Experiential methods, developed in

cultural competence literature, are among these tools.

Experiential education.

Cultural humility and new experiences. Given the conceptual frame of cultural humility,

the questions then are: (a) how is humility cultivated? (b) can people become more humble in a

given domain of functioning? and (c) if indeed they can, what can I offer that cultivates this

humility? Didactic conferring of cultural information is only a small part of preparing providers

for work with refugees; I am neither qualified to act as the expert on Iraqi refugee patients nor is

this helpful (van den Bos & Loseman, 2011). Intercultural learning must give participants not

just new information but *new experiences of themselves* (Foronda et al., 2016; Paine et al., 2016;

Pedersen, 2004; Roysircar, 2004; Roysircar, Gard, Hubbell, & Ortega, 2005; Schuessler, Wilder, & Byrd, 2012; Seelye, 1996; D. W. Sue, Arredondo, & McDavis, 1992; S. Sue, 1998). For this reason, intercultural training for providers must include experiential approaches to education (Pedersen, 2004; Roysircar et al., 2005; Schuessler et al., 2012; Seelye, 1996).

This experiential education can involve guided reflection exercises, group simulations, journaling, interviews, critical incident debriefing, and storytelling (Pedersen, 2004; Prasad et al., 2016; Roysircar, 2004; Schuessler et al., 2012; Seelye, 1996). The goal of experiential education is that participants are confronted in gentle but genuine ways with experiences that challenge implicit assumptions they make about the nature of reality and their roles as selves within it. These subtle confrontations humble providers by at once acquainting them with what they do not know and expanding the boundaries of what they do know.

Zone of proximal development. It makes sense here to briefly discuss Vygotsky's classic concept of the zone of proximal development (ZPD; Cole, John-Steiner, Scribner, & Souberman, 1978). Put simply and leveraging contemporary language, Vygotsky theorized that learning occurs when a child's environment and the adults within it adopt an acceptance-change position. Individuals are thought to have a domain of solid skills that are firmly learned and can be employed successfully significantly more often than unsuccessfully. The zone of proximal development then is understood as those skills that a child is capable of performing if and only if they have 'scaffolding' by learned others. As individuals stretch themselves, their skills grow, and the ZPD grows too (Cole et al., 1978; van der Kolk, 2014). This process allows the potential for human knowledge growth to be conceptualized as infinite. Learning is conceptualized as challenging individuals beyond their existing resources but doing so in the context of support.

This is important for two reasons: (a) learning is understood as expansive and (b) learning—or growth—cannot occur in the absence of others.

Indeed, growth requires discomfort—distance from familiar things—and a reliance on others. It requires an acknowledgement that we are interdependent. Humans are inherently relational beings; so be the independent self-sufficient beings that our Western worldview would have us believe we are would actually be to impede continued growth intellectually and experientially (Pargament & Faigin, 2012; van der Kolk, 2014). Our worldview, in particular, disinclines us toward humility, disinclines us toward the interdependent connectedness vital to our fullest potentiation. If growth of any kind can feel threatening, what then does the learner risk when the task is growth of *self*? Creating a program for developing humility means that I am attempting to alter, for the better, the *selves* of its participants. To throw their relationships with themselves into confusion is bound to feel tectonic. This task is not insignificant.

Personal uncertainty and reactivity. In fact, social psychologists study how humans are particularly sensitive to uncertainty when the uncertainty in any way relates to identity and belonging. These group dynamics operate at all levels of society from the micro levels of families of origin to the macro levels of nation states and multinational psychoideologies. Membership in a group that shares beliefs and therein, values, goals, and behaviors, serves the function of reinforcing, through reification, one's sense of reality (Festinger, 1950). The reality that is shared by a group is not, however, to be understood as absolute truth but rather is an evolving creation of its members (Kruglanski, Pierro, Mannetti, & De Grada, 2006).

Membership—*belonging*—is a basic human need that not only cultivates one's sense of the world but creates and continuously reaffirms who one is (Hogg, 2011; Ramsey, 1996). Cultural groups function this way also (Ramsey, 1996; Staub, 2011). In fact, the influence of

culture can be so profound that in-group members cannot identify or describe the world except in

its terms (Ramsey, 1996). Belonging provides the security of presumed righteousness, identity,

and certainty. Humans go to great lengths to avoid or reduce uncertainty. Indeed there is a vast

literature regarding how people react in uncertain conditions: individuals will demonstrate a

higher need to conform to in-group norms (De Grada, Kruglanski, Mannetti, & Pierro, 1999), are

more likely to reach group consensus (Kruglanski & Orehek, 2011) despite deliberating for less

time before making a group decision (Kelly & McGrath, 1985), show preferences for autocratic

hierarchical social structures such that they show less confidence when led by leaders who are

contemplative about fairness and show more confidence when led by leaders who are theocratic

and decisive (Kruglanski & Orehek, 2011), are less likely to notice socioemotional cues (De

Grada et al., 1999), demonstrate less interpersonal empathy (Nelson, Klein, & Irvin, 2003), show

less attunement in conversation (Richter & Kruglanski, 1999 cited in Kruglanski & Orehek,

2011), communicate in greater abstractions contributing to more miscommunications (Rubini &

Kruglanski, 1997), and are less willing to compromise, agreeing to fewer and smaller

concessions during negotiations (an effect most pronounced when their partners trigger cultural

and racial stereotypes; de Dreu, Koole, & Oldersma, 1999).

     Intercultural interactions trigger a particularly threatening kind of uncertainty known as

"self-uncertainty" or "personal uncertainty" (Hogg, 2011; van den Bos, Euwema, Poortvliet, &

Maas, 2007; van den Bos, van Ameijde, & van Gorp, 2006; van den Bos & Loseman, 2011):

    …a pivotal factor that leads people to strongly engage in cultural worldview defense and

    processes of autonomic radicalization is *personal uncertainty*, which we define as the

    subjective sense of doubt or instability in people's self-views and/or worldviews, and

which involves the implicit and explicit feelings that people experience as a result of

being uncertain about themselves. (van den Bos & Loseman, 2011, p. 72)

Van den Bos (2007) has also found that personal uncertainty, in contrast to informational

uncertainty, functions as a hot-cognitive and affective experience that they argue triggers a

physiological stress reaction along the hypothalamic-pituitary-adrenal axis (Greco & Roger,

2003; van den Bos & Loseman, 2011), the axis that functions as the existential threat response

system of the brain (Eisenberger & Lieberman, 2004; Eisenberger, Lieberman, & Williams,

2003; van den Bos, 2009; van den Bos & Loseman, 2011; van der Kolk, 2014). Physiologically,

we respond to personal uncertainty—to intercultural interactions—as if our lives are at stake

(Ramsey, 1996; van den Bos & Loseman, 2011). The aversive nature of personal uncertainty

fuels efforts to reduce it; unfortunately for refugee patients, and for intercultural exchange

broadly, personal uncertainty is most rapidly reduced by retreating into the security of one's own

cultural group. In fact, this flight response is often followed by, conversely, a fierce rededication

to one's worldview regardless of evidence to refute or challenge it (J. Greenberg et al., 1992;

Major, Kaiser, O'Brien, & McCoy, 2007; Proulx, 2012; Reis, 1990; Tesser, 2000; van der Kolk,

2014). Our impulse is to engage in subtle and irrational self-reinforcing—not to choose humility.

Given that intercultural interactions trigger a particularly potent kind of uncertainty and

that uncertainty is capable of exerting significant negative power over the behavior of

individuals, how can we shift impulses to flee into open-hearted approach behaviors? How could

I design a training that fosters humility? Maas and van den Bos (2009) demonstrated that

personal uncertainty can be simulated and meaningfully engaged with in simulation. In fact,

merely asking participants to remember a time they felt uncertain was sufficient difference in

group conditions for a significant experimental effect; individuals primed for personal

uncertainty received experiences in a more affective-intuitive manner showing strong positive affect for members of their in-group and strong negative affect for members of the out-group (Maas & van den Bos, 2009). Although physiological reactions are understood as evolutionary and as automatic responses in intercultural situations, providers can learn, through practicing self-regulation in safe conditions, how to prevent primary physiological arousal from becoming secondary agentic, emotional, behavioral, and intellectual retreat (Hogg, 2009; Ramsey, 1996; van der Kolk, 2014). The more able we are to recognize how we react physiologically to uncertainty, the more able we will be to recognize that we are having an ethnocentric reaction— that we are bristling to difference—and the more able we will be to negotiate an elastic human response within and between ourselves (Foster, 1998; Hirsh & Inzlicht, 2008; Hogg, 2009; Keller, 2007; Quillman, 2013; Schore, 2012). I have designed this training to stimulate vulnerability by simulating uncertainty via experiential activities and intensive self-reflection even as participants will receive comprehensive content for consideration. Providers will practice inquiring within themselves about their reactions at multiple levels: physiologically, emotionally, and intellectually. This training program is informed by the large body of cultural competence scholarship but application of this scholarship has occurred within the ideals of the cultural humility movement and builds on fundamental clinical skills providers already have (Khoury & Manuel, 2016). As the writer/facilitator, I have incorporated my own reflexive processes to the program development process where possible.

Humility is, in part, a commitment to owning the limitations of our perspective—that is, knowing that we cannot ever account for all that is beyond us. Yet, adopting a firm stance, regardless of the topic, involves a process of discarding alternatives as if all possible perspectives have been accounted for. So to assert that humility is an imperative is paradoxical. Multiple

dimensions of this project have been impacted by this tension: When I rely on scholarship to make informed assertions, when providers use clinical judgments to make differential assessments, when clinic administrators hold providers accountable for their approaches with clients, we leverage our "expertise" over those less "expert". So, the paradox between humility and conviction (with competence being one sort) is most stark in the context of these imbalances of power: Is it possible to humbly hold another person accountable for humility? Power imbalances do not lend themselves well to humble stances; Humility is an aspiration that ought not be an edict. The goal for any leader of a professional development program anchored in the cultural humility aspiration is not to make imposing demands of professionals, but to make inspiring, principled enticements into humble, curious witnessing. Refugees benefit from providers who wish to hear and see.

The way that I have situated myself in this paradox—as a provider, a scholar, an educator—has been to define my stance as one of *curiosity*. It is in the zone of proximal development that curiosity exists; we accept that there is more beyond ourselves and, with enthusiasm and support of others, we expand to greet it. Curiosity is conceptually and behaviorally humble, but does not diminish or deny us the strengths that come from the knowledge and wisdom we already have. Humble receptivity allowed for by stances of curiosity renders encounters with human atrocities a potentially compelling force; if providers truly absorb the experiences of refugees and manage to avoid retreating into the certainty of their privilege, then they are bound to feel profoundly fitful and enraged—the paralysis of an urgency to speak in the context of the unspeakable. As familiarity with refugee issues is developed, providers may feel increasingly compelled to assume unfamiliar roles of advocacy and activism that extend beyond their identities as clinicians:

Safety is an interaction…The tools for the therapist include: love for people who have

had dreadful experiences, who have been sorely tried, who possibly do not completely

toe the line. It includes an open eye for the global situation, which can hardly fail to lead

to unease and rage about inhumanity in the therapist's country and the rest of the world,

rage as a signal that can lead to constructive action. (van der Veer & van Waning, 2004,

p. 212)

Advocacy and activism leverage power toward righteous ends. As activist roles are incorporated

into professional and personal identities, the challenge of navigating this paradox of power and

humility is bound to intensify. Denying the existence of professional power—of American

power—in global ecological systems does not change its existence; our power cannot be

disowned. Van der Veer and van Waning (2004) go on to name "the acceptance of permanent

irresolution" as inherent to refugee work (p. 212); So as long as global inequality persists, we are

unlikely to resolve this paradox. The essential component in the aspirational process of humility

is persistent self-reflection; we need to be able to hear and to see—to listen and to witness—in

order to know how to speak. Being curious about our power, its impact and its potential, enables

us to make difficult choices in acting on convictions about justice.

Social Justice

Historically, social justice questions have dealt with individuals' access to and thus,

representation within nation-based political spheres. Citizenship within a nation state, in theory,

has accorded individuals equal access to the benefits distributed among its members (Fraser,

2009). According to this social justice paradigm, that the arbiter of social justice claims has been

located within the boundaries of each nation was not only sufficient but thought to be the natural

order (Fraser, 2009).

The condition of the refugee, however, provides a poignant counterpoint to the historical frame within which we have located a people's claim to participation in justice. The catastrophic abuses refugees incur within the boundaries of their homelands and the bureaucratic, uncertain "no man's land" they enter upon claiming asylum relegate them to political spaces in between the "framed" communities of the nation-state and thus, leave them politically powerless with few channels through which to make legitimized justice claims (Agier, 2008; Drožđek & Wilson, 2004; Kirmayer, 2007; Lifton, 2006; Mollica, 2009; Pipher, 2002). This misframing leaves the refugee beholden to the generosity of other nations, which enact relativistic forms of justice well-suited to their own national and international interests and their own political values about the legitimate distribution of resources (Fraser, 2009; Lifton, 2003, 2006; Mason, 2011).

The presenting of a refugee at a mental health clinic in the United States, or in any country in the Western world, ought not be understood independent of the complex global context that conspired to place him or her there. Refugees become such when a political global entity defines them as deserving of refuge and by extension the freedoms of residence and recognition within a nation-state that is not their own. Yet, through bureaucracy and procedure, refugees regain little control over their lives and often trade physical violence for political withholding (Agier, 2008; Hölscher & Bozalek, 2012; Ivry, 1992; Mason, 2011; Pipher, 2002).

Consistent with ecological systems theory, Prilleltensky, Dokecki, Frieden, and Wang (2007) argue that wellness of any kind cannot be achieved until justice exists in levels of the personal, the relational, and the collective:

Wellness cannot flourish in the absence of justice, and justice is devoid of meaning in the absence of wellness….By framing wellness in light of justice and by linking personal satisfaction to relational and collective concerns, we open a whole new field of ethical

inquiry. All of a sudden, it is no longer the sanctity of the relationship between counselor

and client that is the sole refractor of ethical concerns, but the very context within which

that relationship is situated. (pp. 19–20)

Furthermore, neither wellness nor justice can be understood to exist when stark power

differentials separate two people or communities (Freire & Macedo, 2000; Prilleltensky et al.,

2007). The traditional dynamic between clinicians and clients is one in which power accrues to

one more than the other (Brown, 2004; Miller, 2008; Miller & Stiver, 1997). If left

unmonitored, this power imbalance is harmful in many therapeutic situations (Brown, 2004). In

the case of resettled refugees, intersecting identities and histories of traumatizing global

invisibility render them some of the most oppressed groups in the world (Crenshaw, 1991;

Sanders & Smith, 2007). The consensus among global medical and mental health specialists is

that the issue of refugee health is monumental and resources are sparse (Aggarwal & Kohrt,

2013; Duncan, Shepherd, & Symons, 2010; Kagan, 2007).

> Prilleltensky urges the helping professions to look at the individual and also beyond the
>
> individual and focus on the larger human community and the political-social structures
>
> that impede human life…The testimony of homeless people, refugee survivors, families,
>
> and children who are excluded from clinical services because of economics and a
>
> disintegrating mental health system is necessary for understanding the community and
>
> our future…when survivors no longer speak, or when there is nobody to hear, when
>
> mental health and social services especially for certain groups are minimized or
>
> eliminated, our awareness and compassion for the needs and concerns of others are
>
> eliminated too. (Prilleltensky et al., 2007, pp. 60–61)

A clinician's culturally humble stance may offer refugees a relational experience defined less by subjugation and more by human recognition (Mollica, 2009; van der Kolk, 2014; Van der Veer & van Waning, 2004). It is vital that clinicians greet the help-seeking refugee with cultural humility and readiness.

I, as the writer, provider, and educator too, must not be considered outside the system within which contact between clinicians and refugees is situated. Yet, I also contend with the conflict between maintaining semantic clarity and the constructionist capacities of language to maintain power differentials. The construct of training itself contains differentials in power: in concept, an expert trainer imparts knowledge on a neophyte audience in a unidirectional and hierarchical manner. The collaborative spirit of this training program is more accurately captured by terming it "professional development" as a specific allusion to the lifelong process of cultural humility and to the developmental nature of the ecological frame. However, the choice to define this program as a "training" is made for two pragmatic reasons: (a) because the concept of training is familiar and has clear parameters in the field of professional psychology, *training* is an obvious keyword and (b) my process of developing this program is semantically difficult to distinguish from clinicians' process of developing professional competence. Thus, using *training* avoids potential semantic confusion in this document.

Having identified this choice, I wish to describe myself as "facilitator" rather than as "trainer" in order to heed Freire's (2000) warning that the dissemination of knowledge itself can create damaging power structures (Freire & Macedo, 2000). I seek to honor the constitutive capacity of language as well as the rights Iraqi people have to be their own experts, and it has been in spirit of these principles that the program was designed. This training program has not been developed from a stance of expertise even as I have engaged in meaningful and evidence-

based processes to produce it but rather from a culturally humble and receptive stance, which I hope to engender in anyone who attends the program.

Program Development Model

I have used of the Comprehensive Program Development Model (CPDM) which has been designed by Calley (2009) for mental health professionals (Calley, 2011). The CPDM accommodates the current climate of program development and evaluation in the mental health sciences: in order to develop credibility and compete for finite funding resources, programs must be anchored in the best practices related to the target goals and must be designed with rigorous evaluation procedures imbedded. Haphazard or unsystematic decisions in program design can lead to expensive and time-consuming programs that do not accomplish stated goals or that are designed in a manner that renders evaluation difficult. Successful program development includes consideration of long-term implementation and evaluation implications of short-term decisions in order to maximize resources and effectiveness. Calley's (2009) model leverages a semi-sequential series of fourteen steps in two parts: (a) *planning and implementation* and (b) *implementation and sustainability.* The Method section includes a thorough discussion of my application of the CPDM to the development of a training program that meets the goals described below.

Training Program

In seeking mental health services, refugees denounce their invisibility by standing up for a more hopeful future, but do so within a system often ill-prepared to meet their needs. Through this conceptualization of refugee service requests, the imperative is clear: clinicians must be prepared to respond. But how?

It is vital that this program respect and attend to the local environment within which the refugee attempts to acculturate: practice-based evidence is necessary to ensure that broad evidence-based interventions, when conducted in the particularities of real service venues, retain effectiveness. Evidence-based practices for cross-cultural mental health care are anchored in the academic cultural competence and humility movements, which conceptualize culturally safe practice as dependent on clinician self-development. The cultural humility enterprise is well-suited to the ecological model which, as a theory of development, accounts for influences that range from local to global including generational and historical impacts. This ecological model is useful here in the conceptualization of Iraqi clients but also useful for myself as I conceptualize the training needs of clinicians inherently situated in their own cultural meaning-making systems. Providing culturally competent and humble care in service of healing and expansive human possibility is understood as a clear matter of social justice: a matter of not only professional ethicality but human responsibility.

Each refugee group presents unique clinical challenges that range from the pragmatic (i.e., interpreter acquisition, billing, treatment plans, attrition) to the socio-historical (i.e., global political zeitgeist, societal familiarity with cultural groups' customs, religions, traditions; Miller & Rasco, 2004; Ortega & Faller, 2011). Within the ecological model of development, refugees, though historically treated as a single political community with a common label, are not expected to be an internally homogenous group—rather, their diverging needs are seen as expectable functions of natural human development. As a matter of social justice, refugees are to be honored and approached with respectful specificity (Potocky-Tripodi, 2002; Roysircar et al., 2010). The cultural competence and humility frameworks are useful in that they provide direction for examining gaps in providers' readiness for working with culturally different others. By tailoring

this training to the treatment of Iraqi refugees, specifically, I honor their cultural, ethnic, and

national identities as precious developmental influences and therefore, valuable protective

factors against posttraumatic stress (Eisenbruch, de Jong, & van de Put, 2004; Potocky-Tripodi,

2002).

This program has four proximal goals and three distal goals. The primary proximal goals

are: (a) to increase clinician knowledge about and skills for working with Iraqi refugees; (b) to

provide clinicians experiential opportunities to apply knowledge, practice skills, and extend

attitudes as an operational definition of broadening cultural competence/humility; (c) to inspire

clinicians to work with Iraqi refugees; and (d) to increase clinicians' comfort with

conceptualization from an ecological model. The three distal goals are: (a) to improve Iraqi

patient engagement, (b) to inspire clinicians to engage in social justice advocacy—to find their

voices—regarding refugee health/mental health in their communities, and (c) to improve the

quality of life for Iraqi refugees in the communities where training is given.

Chapter 3: Method

The *Comprehensive Program Development Model* established by Nancy G. Calley (2009; 2011) leverages an extensive two-part, multi-step, evidence-based approach to program development with attention to designing for future evaluation (Calley, 2009, 2011). The first part of the Comprehensive Program Development Model (CPDM) consists of eight "Planning and Implementation" steps. The second part of this model consists of seven "Implementation and Sustainability" steps. The model's fifteen total program development steps will are discussed as they pertain to the development of a cultural humility training program for clinicians of Iraqi refugees. After describing each step as developed by Calley (2009, 2011), I explain how I have addressed each step including brief descriptions of deliverables that can be reviewed in Appendix A (Calley, 2009, 2011).

Part I: Planning and Implementation

A significant superordinate deliverable of this project is having engaged in a formal and evidence-based process in order to produce a meaningful and intellectually sound product. The CPDM steps leading up to the implementation of the program are most relevant to the training development. As such, I have engaged in the process and have delivered content associated with these steps (Steps 1-10). A description of how Part II steps have been addressed is included in the introduction to Part II.

Step 1: Establish the need for programming—developing the rationale. The process of developing the rationale for a program is a critical first step in program development because it confirms that the proposed program has good chances of being utilized by those it intends to serve (Calley, 2011).

Step 1 plan. Rationale development for this program consists of a thorough literature review (in preceding chapter) of the situation of refugees with attention to the various levels of the social ecosystem from macro to micro. The "plight" of refugees, particularly from Iraq, illuminates additional review of the challenges facing mental health clinicians who treat refugees in the United States. A single-case vignette based on past events at a community mental health center in the region provides a case example of some of the needs facing mental health clinics where Iraqi refugees present for services. Brief quantitative needs assessments with the featured agency staff have been used to provide further specifics about the obstacles to providing safe mental health services to refugees. This quantitative data augments information gleaned from the literature review.

Step 1 deliverable. I have conducted an extensive multidisciplinary topical literature review and offer its summarization. I have developed and conducted a brief quantitative survey of clinicians who have, as of November 2013, provided services to Iraqi refugees at the clinic described in the case vignette. Proper Antioch University New England (AUNE) institutional review procedures were followed so as to maintain ethical soundness in conducting social research (please see Table B1 for informed consent document, Table B2 for needs assessment survey questions, and Tables B3-B7 for needs assessment results). Once approval was received from AUNE's Institutional Review Board (IRB), I submitted this approval and clinician survey to the Clinical Director of the aforementioned community mental health center for formal clinic approval. Once I received approvals from both AUNE and the participating CMHC, clinicians were invited to participate in proposed survey via email. This email contained an embedded link to a confidential digital survey service.

Step 2: Establish a research basis for program design. Establishing a research basis for program design was essential to the effectiveness of the program. Program developers who conduct analyses of similar programs are situated to apply prior learning about effectiveness and outcomes to their program design (Calley, 2011).

Step 2 plan. I reviewed cultural competence and cultural humility development programs nationwide with particular attention paid to programs that focus on refugee services. A selection of these programs are described in terms of structure, content, audience, and method.

Step 2 deliverable. Brief descriptions of these existing programs are provided in the Step 2 section of the results. This review explicitly identifies ways these programs each influence the development of this training.

Step 3: Address cultural identity issues in program design. The third step of Comprehensive Program Development is to consider cultural and human diversity factors that may play a role in program design (Calley, 2011). By considering cultural issues early in the development process, program developers account for variability in the needs-services fit and prevent unanticipated shortcomings that could interfere with program outcomes or impact.

Step 3 plan. The culture of the systems in which the program will be implemented will also shape the tone and receptiveness of the program in ways that vary each time it is offered. Just as the program itself explicitly addresses cultural issues, so too will I consider the role of my own culture as the program developer and facilitator.

Step 3 deliverable. I have built into the model an initial cultural assessment of the organization inviting me to conduct the program. This will help me fully consider the environment I will be entering and how I may be able to best accommodate the program to its needs. Possible program accommodations are elaborated in another section. To monitor my own

cultural issues, I have reflected on these questions throughout the process: (a) *How might my own cultural worldview be impacting my decisions in the development of this training?* and *(*b) *How can I anticipate my cultural worldview informing or interfering with the implementation of the training?* This step is elaborated in the forthcoming section (see Appendix C for organizational cultural competence assessment and the Afterword for my cultural self-reflection).

Step 4: Design the clinical program. The fourth step in Calley's (2009, 2011) CPDM is to design the program. During this step, developers contend with the conceptual aspects of program design including (a) program mission and vision, (b) core program components, (c) outputs, and (d) aspirational short-term and long-term outcomes (Calley, 2009, 2011). This step is often aided by logic modeling processes. Logic models provide mappings of the various stages of program design and implementation such that planners and administrators can identify necessary links between these stages (W.K. Kellogg Foundation, 2004).

Step 4 plan. During this process, I have explicitly addressed these conceptual components of program design including developing a mission statement and vision for training, identifying core components of an effective training of this kind, and identifying outputs and target outcomes.

Step 4 deliverable. An appropriate mission and vision statement for this proposed training accompanies the core program components; these are described in the results section of this document (see also Appendix D). This mission and vision is informed by the literature review and the quantitative needs assessment conducted in Step 1. I have made extensive use of the Kellogg Logic Model Development Guide (2004), which explicates the application of logic modeling to the process of program development and evaluation (W.K. Kellogg Foundation, 2004). The Theory Approach Logic Model and Activities Approach Logic Models (see results

section and Appendix D) were completed so as to clarify the relationships between various

assumptions, needs, goals, plans, and hypothetical outcomes and impacts of this proposed

program. The development of these logic models was informed by the deliverables of Step 1 as

well as the review of existing programs conducted in Step 2.

       Step 5: Develop the infrastructure. Calley's (2009, 2011) CPDM Step 5 explicitly

targets the development of a staffing infrastructure, which was not specifically required by this

program. The proposed training involves a single facilitator and an array of training materials

(Calley, 2009, 2011).

       Step 5 plan. Instead of focusing on staffing the program in this step, I have developed the

complete content infrastructure of the proposed program, which consists of the course

curriculum, training plans, and materials that are necessary to conduct the training.

       Step 5 deliverable. I have leveraged work accomplished through Steps 1-4 of the CPDM

in order to create comprehensive program materials that enable immediate implementation of the

program. The training curriculum is included in its complete form with extensive notes about

materials, content, facilitator and trainee roles, handouts and scripts of training activities. This

curriculum is described in the results section and included in its complete form in Appendix E. I

have addressed Calley's (2009, 2011) staffing emphasis by briefly discussing the attributes

necessary of the facilitator to appropriately conduct this proposed training (Calley, 2011). By

identifying the ideal qualities and demeanor of a facilitator, I make explicit the kind of

       self-presentation I intend and account for the situation in which the training is facilitated

by someone other than myself. For the purposes of this program development process, this

infrastructure development step has been the most significant of the steps requiring an extensive

multidisciplinary review of literature regarding mental health training, cross-cultural services, and Iraqi refugees.

Steps 6-8: Evaluate and Leverage Resources. Calley's (2011) model accommodates the development of comprehensive programs such as multi-system non-profit clinics with large budgets, wide ranging services, and many departments (Calley, 2011). As such, Step 6 (Identify and Engage Community Resources), Step 7 (Identify and Evaluate Potential Funding Sources), and Step 8 (Develop a Financial Management Plan) are individually more extensive than this program warrants. In sum, these steps represent the process of considering the resources necessary for the initial implementation and long-term sustainability of a program.

Steps 6-8 plan. This program is one for which the investment of time and other resources is more significant during the development stage because in order for the program to be initially implemented, the full training curriculum product must be complete.

Steps 6-8 deliverable. Current and projected needs and assets are discussed here. There are few financial costs associated with the development of this curriculum. Much of the development is being conducted by myself, a clinical psychology doctoral candidate, in satisfaction of my dissertation requirement and in conjunction with formal clinical practicum agreements. Additional development and sustainability considerations are addressed.

Step 9: Develop the proposal. The ninth step in the Comprehensive Program Development Model was develop a formal proposal for the purposes of vying for and receiving funding through external grants or loans (Calley, 2011). For large non-profit programs, this process is critical as without such funding, implementation is likely impossible. But, this grant proposal and application process also serves as a form of external review for the necessity, quality, and viability of the program.

Step 9 plan. In the case of this training, which requires external funding neither for its development nor its maintenance, the opportunity for external review is most valuable as a quality improvement mechanism.

Step 9 deliverable. I have contacted mental health professionals specializing in the area of refugee mental health services, inviting them to review the deliverable products for Steps 1-8 and the projected plans for Steps 10-15. Reviewers were provided with a feedback form including both quantitative and qualitative prompts including questions similar to those recommended by Calley (2011): (a) "Does the proposal spell out a plan of action that suits project goals and objectives?" and (b) "Is the program model supported by research and best practices?" (Calley, 2011, p. 299). I have reported the feedback received and discussed how it has been applied. Exposure to this kind of peer review process enriches the quality of the training in a rigorous manner consistent with sound scholarly traditions in the field of professional psychology. I committed to contacting ten professionals who specialize in refugee mental health and cross-cultural services and endeavored to receive as many reviews as possible with three reviews being the minimum. Discussion of this step follows in results section (see also Appendix F for external review questions and results).

PART II: Program Implementation and Sustainability

The Program Implementation and Sustainability steps are addressed through the development of projections; deliverables for these steps took the form of hypothetical plans. It is inherent to the program development task that the requirements of program sustainability are largely dictated by the execution of the program. Nevertheless, it is imperative that the sustainability steps figured actively into the development process; programs that are designed

with implementation, evaluation, growth, and sustainability in consideration are more likely to be successful (Patton, 2012).

Step 10: Implement the program. Implementation of the program not only requires incorporating plans developed in all previous steps but also attention to quality assurance—vigilance to ways in which the process of enacting the program can impact the quality of the program's services (Calley, 2011). One possible process-level interference in training quality is the fit between the program itself and the settings within which the training is offered. I developed a projected implementation plan including steps from the point of first contact with the organization seeking training through the conduction of the training to the post-training follow-up communications. The pre-training and post-training phases of implementation were devised consistent with the practice-based evidence framework by provisioning for quantitative and qualitative information about the needs, improvements, and strengths that the clinic can use for its own program improvement purposes. The plan for pre-training contact between the facilitator and the clinic is designed to equip the facilitator with important context about the culture of the organization and attendees of the training as well as the history of the "problem". Both the pre- and post-training information streams will be designed to inform adaptations and improvements to the training itself. The specifics regarding the evaluation plan are described in the results section (see also Appendix G for brief summary).

Step 11: Evaluate the program. Evaluation is essential for the success of a program (Patton, 2012). This training program was designed to have a culture of evaluation such that evaluation is an ongoing and intrinsic aspect of program execution that seems neither perfunctory nor burdensome. I included an evaluation plan with sample measures and a timeline

for administration. These materials address both process evaluation and outcomes evaluation. (See description in forthcoming results section and, for sample measures, Appendix H).

 Step 12: Build and preserve community resources. Calley (2011) identifies the importance of Building and Preserve Community Resources in the garnering long-term support for the efforts of program leaders. The issues of providing culturally humble and competent care to refugees is so comprehensive that developing a network of professional peers is vital for a professional who facilitates trainings such as the one proposed. Some networking with professional peers has occurred in the aforementioned process of peer review. In addition to these experts, I suggest additional ways the training facilitator can seek formal and informal alliances with similar others. A discussion of direct and indirect benefits of some of these avenues of support is discussed.

 Step 13: Develop an advocacy plan. The issue of advocacy is inherent to the development of this training program (Calley, 2011). The values and demeanor of the facilitator as well as the content of the training will implicitly assert the value of the refugee and the imperative that his or her mental health services be conducted within a cultural safe alliance with culturally sensitive interventions by cultural humble and competent clinicians. This implicit professional-level advocacy is distinguished from public, community, and individual levels of advocacy (Calley, 2011). Avenues for advocacy are suggested.

 Step 14: Develop an information-sharing plan. The 14th step of planning for information dissemination involves sharing the information collected as part of the evaluation process (Calley, 2011). In the case of this training program, there are three possible audiences for information: (a) the facilitator/program itself, (b) the recipients of the training, and (c) the

broader community of refugee mental health providers. I have addressed these audiences and the type of information they will value and offer an information-sharing plan.

      Step 15: Attain program accreditation. The final program development step in the CPDM is the seeking of program certification or accreditation (Calley, 2011). Although there are no known training program certification programs, I researched the steps and regulations associated with registering training programs as a source of continuing education units (CEUs) with the American Psychological Association. This process is discussed as it relates to the training program developed here.

Chapter 4: Results

Part I: Planning and Implementation

The most comprehensive aspects of this program development process have occurred in Part I of

the Comprehensive Program Development Model. In the steps of this section, I conducted a

literature review and needs assessment, established a research basis for the design of the

program, considered cultural identity and issues, designed the structure of the program and

developed the entire infrastructure including the curriculum and lesson plans, described

resources, and consulted with external professionals regarding quality and areas for

improvement.

      Step 1: Justifying the training program. Two sources of information inform the

rationale on which this training program was founded: an extensive literature review and a needs

assessment of the aforementioned example clinic. The literature review that opens this document

(which is elaborated in the training curriculum developed in Step 5) provides record of this step.

In addition, I conducted an anonymous needs assessment of providers at the clinic that was

described previously. This survey was conducted with the support of Antioch University New

England's Institutional Review Board and was approved by senior administrators of the clinic.

      This needs assessment addressed the perspectives of mental health staff about what the

transition to working with Iraqi refugees was like, whether they felt supported, and how they

view their own cultural attitudes, beliefs, knowledge and skills. Participants included mental

health staff who had recently provided direct services to Iraqi refugees as part of their

responsibilities to the aforementioned community mental health center in Northern New

England. These include members of outpatient (OP), home and community treatment (HCT),

multisystemic therapy (MST), and adult targeted case management teams. Respondents qualified

for inclusion if they had worked with Iraqi refugees directly while being employed at the specified agency. The participants are licensed mental health professionals with at least undergraduate training in the mental health field or who had attained appropriate state certification for their respective roles (e.g. case manager). They are literate, computer proficient, and regularly produce professional mental health documentation as a function of their job responsibilities; they are versed in the vocabulary of the mental health professions. Only individuals matching this description were recruited. Respondents were recruited by administrators of the clinic who forwarded my hyperlink for a web-survey platform with a description of the project and informed consent materials.

An alternative form of needs analysis may have been to conduct live focus groups. However, the anonymity and confidentiality of surveys allowed for minimal chance that the identities of individual employees would be discerned through the results. Employees were more likely to provide honest self-assessments when given privacy and anonymity to do so. This survey format, while perhaps less likely to give a primary investigator the textured material possible in a dialogical needs assessment, protected employees from the possible organizational or social repercussions of honest responding. The ultimate goal of the entire project, of which this needs assessment is a small part, was to better support staff. As the principal investigator, I assume that staff have experienced some vulnerability regarding intercultural work; I do not consider these vulnerabilities as indicative of weakness on the part of the mental health professionals but rather of the potent challenges this work provides. This data has been collected in the spirit of supportive, not punitive, program development.

I did not recruit at-risk participants. A primary source of protection embedded in the structure of this survey is that participation was completely voluntary. Neither I, as the principal

investigator, nor the community mental health center required participation. No personal

identifying information was collected. Results from multiple-choice questions were compiled

and used in aggregate. Quotes from the qualitative comments section have been reported with no

identifying information about the respondents.

The survey, consisting of 39 multiple-choice questions and one free-response comments

section, was meant to assess readiness for intercultural work as well as levels of cultural

humility. This survey was administered electronically using SurveyMonkey, the confidential

web-based survey platform. Once collected, results were compiled into descriptive statistics and

used, alongside relevant literature, to guide choices about content and structure of the training

program I have developed. (Results can be reviewed in Appendices A and B). The survey

assesses providers' (a) prior experiences (e.g., "Prior to my first Iraqi refugee patient, I worked

with individuals of a different race/ethnicity than myself."), (b) providers' readiness for working

with Iraqi refugees (e.g., "In the first two months of working with Iraqi refugees, I felt

comfortable conceptualizing my Iraqi patients' situations."), (c) as well as providers' cultural

competence/humility at the level of attitudes and beliefs (e.g., "Sometimes my biases impact my

work with people significantly different from myself."), knowledge (e.g., "In my professional

life, I seek to learn new things about the cultural, socio-political history, worldview, religion,

traditions, and sexuality of patients different from myself."), and skills (e.g., "I endeavor to

reduce bias in my work by using culturally appropriate assessment tools."). These quantitative

questions are designed to assess the range of providers' stances regarding themselves vis-à-vis

their refugee patients and thus the degree to which providers were prepared for and invested in

intercultural work with Iraqi refugees. The final question in the survey ("Please comment about

your experiences in the first two months of working with Iraqi refugees. Consider what you

learned, what was helpful, and what support you wished for") allowed respondents to make any comments or requests they wished. The results from this survey and their relevance to the development of the training program are discussed below.

Quantitative results. Results have been aggregated. There were 17 total participants in the needs assessment.

Prior Experience. Prior to first meeting with Iraqi refugees, more than half of respondents had only rarely (35%) or occasionally (47%) worked with individuals of a race/ethnicity different from themselves, yet more than half of respondents had occasionally (41%) or frequently (35%) worked with individuals they identified as culturally different than themselves. More than half of respondents reported having never (47%) or rarely (23.5%) conducted clinical work through a spoken language interpreter. At the time of the survey, 71% of respondents had never or rarely worked with refugees. This array of responses is consistent with the historically homogenous ethnic make-up of rural New England. The case clinic for which respondents worked embraces a broad definition of culture and, through its formal diversity initiative, encourages its employees to view every interaction as a cross-cultural one. As such, it is unsurprising that providers identify much of their work (which often occurs across boundaries of socioeconomic status) as cross-cultural. Although experiences working with individuals different than ourselves on any dimension can better prepare us to manage these differences on all dimensions, this particular data point may be artificially inflated because the clinic conceptualizes socio-economic diversity as a form of cultural difference (and one of the primary forms of difference represented by this clinic's constituents). That most of the respondents had never or rarely ever conducted work using a spoken language interpreter complicates adjustment

to working with refugees especially given the minimal experience with refugees reported by this sample of providers.

Readiness. Despite the relative lack of experience using spoken language interpreters to conduct therapy work, the sample was nearly evenly divided about their perceived readiness to engage with patients through an Arabic interpreter (53% never/occasionally). During this time more than half of respondents often (47%) or almost always (24.4%) felt supported by their superiors, often (24.4%) or almost always (35.3%) felt supported by their colleagues, and only occasionally (35.3%) or never (35.3%) felt the agency could have done more to support them. Having reported this, 70.6% of respondents reported having never (23.5%) or only occasionally (47%) felt comfortable conceptualizing their refugee patients' situations. Fewer than half of respondents felt they understood the relevant cultural issues and could assess the risks and protective factors associated with their refugee clients' presentations. More than half of respondents reported never (41.2%) or only occasionally (35.3%) being able to develop meaningful working alliances with Iraqi patients. The discrepancy between providers' reports that they felt supported during this adjustment process and their reports of being unable to engage in preliminary clinical activities such as initial assessment and alliance formation suggests that they while respondents may have had some awareness that the professionals around them were doing what they could to be supportive, this support did not translate into a true sense of confidence in doing the work being demanded of them. This dynamic was further reflected in providers' responses regarding their capacity to generally meet the needs of Iraqi refugee patients: most providers reported never (23.5%) or only occasionally (58.8%) feeling able to meet refugee needs.

Knowledge. Across all seven "knowledge" oriented survey questions, at least 70% of respondents endorsed the statements as definitely or usually true. Generally speaking, respondents agreed that culture impacts definitions of well-being, that a provider's language and non-verbal communication impacts work with patients, that how a provider is raised impacts their assumptions about others, and that learning about human difference, being cautious about automatic attributions regarding cultural differences, considering potential conflicts between evidence-based practices and non-Western clients, and utilizing a systemic approach to institutional, political, and societal barriers to well-being for clients are all worthwhile enterprises. The relative lack of variability in these responses suggests that the professional training respondents have received and the organization's endorsement of the cultural competence movement have equipped providers with a foundational knowledge of industry standards regarding cross-cultural work. The degree to which endorsements of these knowledge domain statements reflect true commitments to human diversity instead of socially desirable responding is unclear (Krumpal, 2013).

Skills. With regard to cultural competence/humility skills, more than half of respondents endorsed having sought opportunities for learning about different cultures including through informal settings and in-service trainings. However, respondents ranged in whether they stay current on research pertaining to cultural minority clients. This suggests that although providers are willing to use staff time to enrich their skills through trainings and feel positively about encountering cultural minorities incidentally in daily life, they are either not interested or do not have time to seek additional academic learning regarding their specific client populations.

Self-directed continuing education varies by person. More than half of respondents report using culturally appropriate assessment tools, report valuing using spoken language interpreters in their work, and report having advocated for non-discriminatory practices.

Attitudes/Beliefs. Providers' responses to items exploring attitudes and beliefs varied between items. All respondents asserted being able to easily describe their own ethnic, racial, and cultural identities and asserted that they celebrate human difference. Additionally, all respondents reported that they consider the impact of their own cultural identity on their patients. This is an interesting point when juxtaposed with the fact that fewer than half of respondents in this sample reported discussing cultural differences with patients (definitely: 5.9%; probably/usually: 24.4%). Furthermore, 82% of respondents asserted that they definitely do not or rarely hold unfair attitudes or beliefs about different cultures and 88% denied having biases that sometimes impact their work. The conflict between providers endorsing socially (and professionally) desirable answers and their reluctance to acknowledge their own theoretically inevitable cultural bias (e.g., "Sometimes my biases impact my work with people significantly different from myself") suggests that they may believe that the professional development of cultural competence is both temporary and finite—that mere awareness of the professional standard of multiculturalism is sufficient.

Quantitative results summary. The quantitative portion of this needs assessment reflects a few key points. First, this sample is made up of clinicians who are relatively inexperienced regarding intercultural work, interpreter services, and refugee patients. They identify feeling supported by their colleagues, supervisors, and organization, but have not felt prepared to conduct even basic clinical tasks with refugees. They are aware of cultural competence/humility principles, endorse having the skills necessary of a professional enacting those principles, and

feel confident in their commitment to a life including these values. Having said this, providers may not conceptualize culturally appropriate care as requiring their own ongoing humility and education and are cautious about acknowledging and exploring their own biases—some of them even going so far as to deny that biases exist. Developing a training program that will meet the needs of these providers is likely to require a process of engagement—providers are unlikely to automatically see themselves as needing growth in the areas of cultural humility and service provision and as such may engage in "paying lip service" to multiculturalism if not initially enticed into thorough-going vulnerability. Unexpectedly, in response to the prompt "I notice how my mind and body react to patients whose worldview is significantly different from my own," nearly 75% of respondents reported that they definitely (23.5%) or probably/usually (47%) do have this level of self-awareness. Mental and physiological responses are valuable clinician reactions, the exploring of which may be an effective inroad for the facilitator to develop enough credibility to entice providers into stances of vulnerability.

   Qualitative results. My analysis of qualitative feedback was informed by the consensual qualitative research (CQR) method, which in its pure format, consists of reviewing and mapping qualitative results to arrive at conceptual domains and themes by group consensus (Anderson, Leahy, DelValle, Sherman, & Tansey, 2014; Hill, Thompson, & Williams, 1997; Roysircar et al., 2005). The CQR process is iterative and collaborative which is important for the theory development work that follows much qualitative research. As such, the complete CQR process is more extensive than this needs assessment warrants; however, the CQR identification of relevant themes and conceptual domains is a useful way to organize feedback that can inform this training development.

My review of respondents' qualitative feedback yielded nine themes: system strain, interpreter issues, encounters with uncertainty, refugee discounting, open resentment, pressure for information, compassion for refugee situation, call for support and desire to do the right thing. These themes load easily into the cultural competence KSA framework: (a) knowledge (pressure for information), (b) skills (interpreter issues, call for support), (c) attitudes/beliefs (encounters with uncertainty, refugee discounting, open resentment, compassion for refugee situation, desire to do the right thing).

The most frequently endorsed theme was *pressure for more information* through which providers expressed a wish for additional cultural information (e.g., "I wish I had more information on cultural practices" and "It would have been helpful to understand male/female roles."). That the least frequently endorsed theme was a general *call for support* (e.g., "As far as gaining education into these issues, I have not seen any to take, or I definitely would.") suggested that providers were otherwise able to offer specifics about how and with what they were struggling and what they imagine they needed in order to feel supported. Although *pressure for more information*, which is the only theme within the 'knowledge' domain, was the most frequently endorsed theme, the 'attitudes/beliefs' domain contained more themes and, all told, was more frequently addressed through a wide range of sentiments (e.g., "I learned that compassion and concerns about family are universal," "It's so sad that some Americans think anyone from Iraq is a terrorist," and "More freeloaders who wish to circumvent the rules other immigrants had to endure"). The frequency and range of attitudes/beliefs themes suggests that the vast majority of providers have been struggling to navigate the attitudes/belief domain at some level (all but two respondents included attitude/beliefs themes in their responses) but that the group was internally varied on the manifestation of uncertainty in this domain. Providers are

entering these clinical situations with refugees, and hence would be entering training situations, in both interpersonal and intrapersonal conflict.

Respondents tended to make comments that loaded into the attitudes/belief themes when they were recounting the experiences of providing services to refugee patients; however, when suggesting areas they needed help with, they tended to see *more information* as the solution. This is an expectable demonstration of our propensity to solve cultural service issues with concrete knowledge rather than reevaluating our own attitudes/beliefs (Hogg, 2011). The conceptual distance between what respondents report struggling with and what they imagine the solution to be is one way of understanding the phenomenon that the cultural humility movement is designed to bridge. Providers crave more knowledge as a solution to problems that are better understood as originating in the domain of their own internal value structure. This misattribution has implications for how this curriculum is designed and what is necessary in order to engage participants in the training. Specifically, providers do not necessarily think they need to work on themselves in order to better meet the challenges of working with refugees yet, consistent with cultural humility principles, the results of this needs assessment suggest that they do. The challenge was to develop a training that is sensitive to the resounding call for more knowledge and skills while creating a training environment and curriculum that meets the personal self-in-role needs providers do not realize they have.

This needs assessment also revealed the discouraging but realistic theme of *open resentment:* "At the end of most encounters with this uninvited minority, the final question is what more can we do to help them advance their panhandling agenda." This kind of open resentment is a form of contempt that will impair the therapeutic alliance with refugees. Although these responses are realities, providers unwilling or unable to explore themselves in

service of developing empathy for refugee patients should recuse themselves or be excused from the work. Gate-keeping is a secondary function of this training.

Respondents ranged in their prior experience, their readiness, and their KSAs. Consequently, the training has been developed with an effort to meet the needs or respond to the questions brought up in the full range of responses. When in doubt, however, the training errs on the side of encouraging a cultural humility foundation—the absence of which are conditions ill-suited to the imperative of harmlessness. Approaching refugee patients with cultural humility is conceptually thought to render clinicians more flexible and adaptable to whatever the situations they encounter. Also, perhaps contrary to expectation, striving for cultural humility can make providers more at ease and confident not because anything substantive has shifted except their expectations and self-attunement.

Step 2: Research basis for the design of the training program. After conducting a thorough international online review for related programs, I found no current training programs with the same configuration of target goals, audiences, and conceptual frameworks; however, learning from related programs remains important. I reviewed a selection of programs that together represent the variety of training programs being implemented internationally. At the end of each description, I compare and contrast to the needs of the case clinic and discuss how it might inform development of an appropriate training.

Cultural humility programs.

UC Davis Extension Continuing and Professional Education, Northern California Training Academy Key Concepts Courses. This academic course consists of case examples through which social work students are called upon to examine their own perspectives as well as possible clients' perspectives in service of determining 'how to enter the client's cultural world'

(The Regents of the University of California, Davis campus, 2016). The goals of the course are to equip participants to distinguish between concepts of cultural competence and cultural humility and to recognize a client's intersecting identities (Crenshaw, 1991, 1995). Participants leave with an awareness that these intersecting identities impact therapeutic social work relationships and are able to apply the cultural humility framework to child welfare interventions, noticing and negotiating cultural barriers to positive transformation. Students in this course may be professionals seeking continuing education credit or students of social work seeking graduate course credit. This course ranges from half-day to two full days long. This program is not culturally-specific, does not focus on refugee services, and although it includes applied elements such as extensive case review, does not include structured experiential activities. However, this program is one of the first training programs in a formal education setting that explicitly targets cultural humility.

　　　RAMS, Inc Psychology Internship in Cultural Humility. The RAMS, Inc., cultural humility training program is embedded in the organization's pre-doctoral internship program for psychologist trainees. The program is structured in two parts: a rigorous weekly process group in which trainees choose and deconstruct an aspect of their cultural identity they believe is impacting their clinical work; interns use the group and supervisor to self-evaluate about these issues (Richmond Area Multi-Services, Inc., 2013). Secondly, interns engage with this bias in research throughout the second half of the training year which culminates in a manuscript and lecture shared with clinic staff. Trainees use the heuristic for culture put forth by Weaver (2001), of culture as an iceberg of which only a small portion is exposed to the surface and is in our consciousness. Through self-disclosure, supportive confrontation, and group process, trainees explore deeper aspects of their own culture such as worldview, epistemology, metaphysics, and

logic. The goal is to reveal more and more counter-transferential facets of trainees and their clinical work. This program requires highly trained facilitator and sufficient in-group diversity to provide emotional and cultural counterpoints to the interactions of the group. This process requires that trainees fully engage by deconstructing themselves as cultural beings. This is often emotionally-charged and requires significant trust built between group members as well as sufficient time for the working through (Wooldridge, Dwiwardani, & Prasad, 2014). Evaluation occurs in the context of the broader training program. This program leverages the full-time relationships formed between the intern cohort in order to challenge participants in group process confrontations. RAMs, Inc. training places clinicians' personal reactions and self-development at the center of provider training. Although this internship training is more extensive than the program that is necessary for community mental health, my process has been informed and inspired by the way RAMS, Inc. administrators privilege process over content; deconstructing clinicians' personal reactions is seen vital even as it requires participants to be vulnerable in their professional environments (Holmes, 2012).

De Anza College Office of Equity, Social Justice, and Multicultural Education Cultural Humility Workshop Series. This workshop series for educators and other social service professionals in the academy is a five part multi-day series in which each part is offered over the course of one day. Part I consists of an introduction to the philosophy of cultural humility including its attendance to power structures inherent in social service interactions and the various ways professionals can alter their approaches to self (their own self and the selves of others) to reduce the negative impact of these power differentials. This workshop distinguishes cultural humility from cultural competence. In Part II, power is conceptualized in a matrix of domination, privilege, and oppression and these topics are explored relative to both their internalization and

institutionalization. Part III focuses on transformative dialogue and builds participants' skills for

facilitating effective, culturally humble discussion. Attention is also given to the characteristics

and process of building culturally humble inquiry at the systems level. Part IV revolves around

the imperative of self-reflection as providers negotiate their identities relative to their work with

culturally different others. Emphasis is placed on privilege in identity. The final module

discusses conflict as an inevitable and important process of an evolving multicultural,

intersectional group of people eschewing the popular notion of conflict as dysfunctional. Conflict

is understood as necessary for growth at the individual and organizational level and as such,

ought not be avoided by educational leaders. These modules begin with didactics and close with

group break-out sessions and self-reflection activities. This workshop series is primarily

designed for higher education administrators and members of the De Anza College community.

Its emphasis is not on mental health nor on social service provision specifically but rather on the

administration of social justice within community engagement efforts (De Anza College, 2014).

The value of this program development process is the training's modular structure. I borrowed

and condensed this structure to allow flexibility in the process and content of the training.

Thematic modules also frame for participants the content that is otherwise intricately

interconnected.

Refugee services trainings.

Harvard Program in Refugee Trauma Global Mental Health Trauma and Recovery

Certificate Program. This program utilizes a hybrid structure of training methods in order to

bring together health care professionals, humanitarian aid workers, and global mental health

policy advisors from around the world to exchange knowledge and to develop interdisciplinary

networks, skills, and plans. The program consists of two phases: (a) a two week live summit with

all program administrators and participants in Italy followed by (b) five months of synchronous and asynchronous online learning modules and group consultations (Harvard Program in Refugee Trauma, 2016b). Participants are responsible for applied learning/service work with traumatized communities in their home countries; this culminates in a video project to be shared with the cohort at the end of the five months (Jaffe, 2016, personal communication). This program is designed within the framework of "communities of practice" which are defined as "groups of people who share similar goals and interests. In pursuit of these goals and interests, they employ common practices, work with the same tools, and express themselves in common language. Through such common activity, they come to hold similar beliefs and value systems" (Harvard Program in Refugee Trauma, 2016b). Communities of practice galvanize like-minded mission-oriented possibly geographically-disparate professionals in service of mutual support, learning, and maximal advances to the states of the art of their respective industries (Li et al., 2009). These CoPs continue beyond the training period to become a network of global professionals that serve in an alumni capacity. The social justice orientation and commitment to cultural safety inherent in the HPRT certificate program are so thorough-going, they almost need not be referenced. Cultural competence is discussed in program materials not as aspirational but as the standard of professional behavior.

Unsurprisingly then, this program was designed as an intensive summit of professionals with extensive involvement in global mental health practices. The HPRT program is the standard in refugee provider training. Participants understand that they are members of a global network and that this network of collaborators is necessary to do the work of global justice. I adopt this orientation to provider networks in this program. The way this will manifest will be discussed in a later step. Administrators of the clinics that participate in the training I developed may seek out

HPRT as a next step if they are to become a long-term clinical fixture in the refugee community their clinic serves. HPRT will be recommended as an opportunity for extensive additional work in this area.

The Center for Victims of Torture National Capacity Building Project: Healtorture.org Webinar Series. The Healtorture.org webinar series is a special project of the Center for Victims of Torture as a part of their National Capacity Building initiative which is funded by the U.S. Department of Health and Human Services, the Office of Refugee Resettlement, and the Administration for Children and Families (HealTorture.org, 2016a). Healtorture.org offers 1-hour live webinars on a range topics related to working with torture survivors. These webinars are archived and can be accessed asynchronously at no cost. At the time of writing, the archive of Healtorture.org consisted of more than 100 webinars six of which were designed for professionals treating Iraqi survivors specifically (HealTorture.org, 2016b). Some of these include "Working with Chaldeans," "Approaches and Clinical Experiences in Treating Iraqi Torture Survivors," "Backgrounder on New Iraqi Arrivals," and "Iraqi Torture Survivors: Panel Discussion with Experienced Service Providers". These webinars offer valuable content by both content experts as well as average field providers who have navigated issues similar to those of the clinics receiving the trainings. One of the challenges of meeting the immediate needs of refugees is that providers who have never worked with refugees before have vast literatures through which to sift; webinars provide an orientation to this content area and the issues that colleagues face worldwide. Having said this, these webinars do not allow for bidirectional engagement so providers have no way to get questions answered in the context of the training itself. The didactic format of these web lectures also only address the knowledge domain of cultural competence, leaving skills and attitudes/beliefs relatively unchanged. These seminars

demonstrate how much can be accomplished in short periods; but, webinars alone are insufficient as a foundational training tool because they do not intervene experientially. Webinars provide content-driven training but do not offer the relationships—support in the zone of proximal development—that are necessary for true transformation. I prioritized developing training methods that are challenging in the context of supportive human relationships. Community mental health centers have finite resources. I designed an ambitious training to be delivered over the course of a single day; this structure allows time for experiential exercises in a manner attainable for busy community mental health organizations.

     Experiential Pedagogy. Tara J. Fenwick (2001) identifies five frames within which we can understand what makes experiential learning have its potency as an agent of change: (a) *reflection* within a constructivist frame, (b) *interference* within the psychoanalytic perspective, (c) *participation* within situated cognition perspective, (d) *resistance* within a critical cultural perspective, (e) and *co-emergence* within a bio-ecological 'enactivist' perspective. It is this last frame that is most consistent with ecological systems theory:

> Enactivists explore how cognition and environment become *simultaneously enacted* through experiential learning. The first premise is that the systems represented by person and context are inseparable, and the second is that change occurs from emerging systems affected by the intentional and unintentional tinkering of one with the other….This understanding of co-emergent cognition, identities, and environment begins by stepping aside from notions of knowledge as a substantive 'thing' to be acquired or ingested by learners as isolated cognitive agents, thereafter to exist *within* them. (p. 47)

The approach to "education" I have taken in developing this training program is consistent with this co-emergence stance of group experiences:

The problem lies not in underdeveloped critical abilities that should be educated, but in a

false conceptualization of the learning *figure* as separate from the contextual *ground*.

Enactivism draws attention to the background, the invisible implied by the visible, and

the series of consequences emerging from any single action. All of these we normally

relegate to the backdrop of our focus on whatever we construe to be the significant

'learning' event. The focus of enactivism is not on the components of experience (which

other perspectives might describe in fragmented terms: person, experience, tools,

community, and activity) but on the *relationships* binding them together in complex

systems. Learning is thus cast as continuous invention and exploration, produced through

the relations among consciousness, identity, action and interaction, objects, and structural

dynamics of complex systems. (p. 48)

In addition to data supporting the effectiveness of experiential learning for increasing cultural

competence and humility, this stance on learning is conceptually consistent with the ideals of

cultural humility: the goal is less to impart knowledge as it is to acquaint participants with the

vast expanse of what they do not know. Whenever possible in this training program, the

facilitator will utilize experiential activities, group debriefing, and process comments. Fenwick

offers a broad way of conceptualizing the role of the educator.

The educator's role might be first, a *communicator:* assisting participants in naming what

is unfolding around them and inside them, continually renaming these changing nuances

and unlocking the tenacious grasp of old categories, restrictive or destructive language

that strangles emerging possibilities. Second, the educator as *story-maker* helps trace and

meaningfully record the interactions of the actors and objects in the expanding spaces.

Third, the educator as *interpreter* helps all to make community sense of the patterns

emerging among these complex systems and understand their own involvements in these

patterns of systems. Naturally, educators must be clear about their own entanglement and

interests in the emerging systems of thought and action. (p. 49)

Admittedly, one of the critiques of this enactivist frame for experiential learning is that it is

idealistic to treat all nodes in the system as equally powerful. In reality, demographic categories

and other forms of accrued/awarded power within a system shape not only what is possible to

co-manifest in a group setting but has historically shaped methods, narratives, functional realities

for the individuals within it according to the individual interests of the powerful (Fenwick,

2001).

In other words, people participate together in what becomes an increasingly complex

system. New unpredictable possibilities for thought and action appear continually in the

process of inventing the activity, and old choices gradually become unviable in the

unfolding system dynamics. (Fenwick, 2001 p.49)

This means that it is a fundamentally idealistic goal to imagine that a professional training

program will be free of interpersonal and systemic power dynamics that can leave participants to

question the safety of exhibiting open vulnerability to learning. As such, I designed an

organizational cultural assessment to employ with any organization that seeks to host this

training: the facilitator is able to assess the extent of the safety that is possible and to enter the

training prepared to help the organization expand the boundaries of this vulnerability by an

ambitious but still realistic amount (Cole et al., 1978; Ramsey, 1996).

Another critique of these experiential approaches is the practical challenge of accounting

for infinitely complex system events within which even the facilitator is situated:

> How can an educational project for change be formulated that adequately accounts for the
>
> complexified ongoing systemic perturbations, without being deliberately illusory? That
>
> is, if any action of an educator or other particular element of a system becomes enfolded
>
> in that system's multiple interactions and unpredictable expansions of possibility, what
>
> sort of reference point can be used to guide intention toward some deliberate pedagogical
>
> goal? (Fenwick, 2001, p. 51)

One of the tensions in this training program, and in the science of human connection broadly, is

between the sort of success that is measurable and the sort of success that is not. Within

multicultural, ecological, and social justice frames, we assume there are ways to be successful

that operate in domains that defy measurement. Experiential exercises are well-established in the

fields of human services pedagogy but their impacts beyond the broad circle of the ecological

system and into the non-verbal felt sense of participants (in short, the same thing that makes

them powerful intercultural training tools), is the same thing that makes them difficult to

quantify (Lewis, Amini, & Lannon, 2000; Pedersen, 2004; Schore, 2012; Seelye, 1996; Siegel,

2010). But the task of intercultural training does not need to be understood as convoluted or

elusive:

> Accepting the wide variety of forms that intercultural work can take, it remains the case
>
> that our work, at its core, is directed toward only a few very fundamental themes. These
>
> are developing the abilities and capacities to live and work effectively with
>
> difference/unfamiliarity/ambiguity, live and work effectively with change, access
>
> creativity, and consciously manage one's state of being. These themes are the focus of
>
> current research and serve as the foundation of several developmental models that give
>
> logic to the design of training and consultation efforts. For example, William Gudykunst

posits forty-nine axioms describing the relationship between effective interpersonal and

intergroup communication and the ability to manage uncertainty and its emotional

equivalent, anxiety, when in unfamiliar situations. In a training program, participants

would be encouraged to discover their personal thresholds above which there is so much

apprehension that one wishes to avoid contact with another and below which one is not

motivated to attempt communication. Such discovery and self-management of

interactions influences by that knowledge base Gudykunst anchors in the concept of

"mindfulness". (Ramsey in Seelye, 1996, p. 12)

In this training, providers are meant to feel uncertain; if they feel uncertain and show willingness

to explore it, we will have launched a crucial campaign of self-change and reflective discussion.

Experiential activities are included throughout the training plan. The facilitator is also called

upon to model vulnerability, elasticity, and true involvement in group interactions. Subjective

self-report about these experiences will supplement objective evaluation of provider change.

Referenced earlier, Gudykunst et al. (1996) offers two dimensions within which

multicultural trainings can be classified. The poles of the first dimension are experiential and

didactic. Proponents of didactic models argue that participants need a foundation of knowledge

before personal transformation can occur. The reverse is true of proponents of experiential

education. The poles of the second continuum are culturally general content or culturally specific

content. Although inexact, I do make the assumption, given the uncertainty in attitudes and

beliefs shown in the needs assessment, that providers will benefit from first engaging

experientially with themselves and each other before internalizing specific cultural information.

As such, broadly speaking, I developed the training so that the morning modules are experiential

and general and the afternoon modules are didactic and specific. The training will stay flexible to

the emerging needs of the group; when in doubt, the facilitator will prioritize process-experiential work. *Pressure for more information* will be understood as a defense against uncertainty. "These changes have influenced training methods as well to move away from the goal of 'dissonance reduction' and toward 'tolerance of ambiguity' as the appropriate outcome measure" (Pederson, 2004, p. 5).

Step 3: Cultural issues in the design of the training program. Consistent with the ecological systems model, individual providers cannot be understood to operate independent of the ethos, values, and resources of the organization for which they work. In fact cultural competence and humility are concepts that extend beyond the individual and are relevant to the work of organizations. In fact, we can understand cultural competence and humility at the approximated levels of the ecological systems theory: at the level of the individual (micro), the levels of the program (meso-p) and institution (meso-i), and at the level of the society (macro) (Fung, Lo, Srivastava, & Andermann, 2012).

Organizational Cultural Competence. Fung et. al. (2012) propose eight domains that need to be operationalized when evaluating organizational cultural competence: (a) principles and commitment, (b) leadership, (c) human resources, (d) communication, (e) patient care, (f) family and community involvement, (g) environment and resources, and (h) data collection and evaluation. These domains are thought to interact in different ways with one another to influence organizational outcomes. For example, organization leadership (domain b) influences and is influenced by principles and commitment (domain a) and sets the standards for communication (domain d). Likewise, the environmental and human resources (domains c and g) of an organization necessarily interact to form the foundation of patients' experiences (domain e) of the organization and as such, sets boundaries about the potential of an organization's

programmatic output. The degree to which a service organization itself functions in culturally competent ways impacts the degree to which individuals within the organization can ultimately operate with cultural safety and clinical effectiveness—cultural competence in organizations is understood as comprehensively influential.

Organizational values create the foundation of intervention/support in the treatment of refugees in a community:

> Cultural competence at the organizational level must be embedded in the infrastructure and ethos of any service provider. Culturally competent organizations actively design and implement services that are developed according to the needs of their service users. This involves working with others in the community, for example traditional healers, religious, and spiritual leaders, families, individuals, and community groups. Clearly this located individuals' training and education in a more complex system of values, finances, policies and contracts. (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007, p. 7)

As such, I developed a short organizational interview that operationalizes these eight domains put forth by Fung et al. (2012); this structured interview would be conducted with leaders of an organization before the training is offered. These qualitative interview questions address the history of cultural work within the organization, the history of adopting a commitment to multiculturalism, and stories about the times that multicultural commitment has been tested.

This organizational cultural competence assessment will be used to assist the facilitator in assessing systemic variables in the organization that are supportive to or destructive of culturally humble service provision. Individual providers cannot function in culturally appropriate ways without the support of their institution. (The full organizational culture assessment can be viewed in Table C1). Although it is designed as an information-gathering tool to aid the facilitator in

preparing to engage with the culture of the institution during the training, this assessment serves a gate-keeping function in the rare circumstance that overt systemic hostility to cultural humility efforts is revealed. In this circumstance, the facilitator would have a discussion with administrators at the institution offering consultation services but will decline to offer training until organizational barriers can be addressed. The specifics of this contingency are beyond the scope of this project.

Reflection in the development process. As described in the conceptual framework of this project, programs are founded on value systems with biases and assumptions that help define problems, solutions, and the processes to achieve these solutions. Just as I have worked to design a program that cultivates humility in participants, I intended to approach the design process with a similar commitment to non-defensiveness and self-reflection that is inherent to the humility construct. At times this has required reflection on multiple psychological levels simultaneously—intellectually, interpersonally, and spiritually. These processes undoubtedly shaped the outcome of this work, so I compiled an extended cultural self-reflection. (Please see the Afterword.) This entry is the product of ongoing self-assessments and reflective note-taking throughout this process. At the conclusion of the program design, I tidied these notes into a cohesive piece about the personal nature of the work I have done. The themes in this reflection provide a lens through which to view ways in which this program has been impacted, both intentionally and unintentionally, by the personhood I have brought to it.

Step 4: Design of the training program.

Theory of the Program. The "theory approach" logic model for this program can be viewed in Table D3 but will be briefly described here. When providers are overwhelmed by the demands of service provision to new Iraqi refugee communities, they engage in self-protective

defenses that undermine their professional responsibilities and ultimately disenfranchise the refugees they seek to serve *(problem statement;* van der Veer & van Waning, 2004**).** Any organization seeking the training has identified this issue as a significant area of concern and, as such, is worth investing in (c*ommunity needs/assets)*. This program has four primary proximal goals and three primary distal goals. The primary proximal goals are: (a) to increase clinician knowledge about and skills for working with Iraqi refugees, (b) to provide clinicians experiential opportunities to apply knowledge, practice skills, and extend attitudes as an operational definition of broadening cultural competence/humility, (c) to inspire clinicians to work with Iraqi refugees, and (d) to increase clinicians comfort with conceptualization from an ecological model. The three distal goals are: (a) to improve Iraqi patient engagement, (b) to inspire clinicians to engage in social justice advocacy regarding refugee health/mental health in their communities, and (c) to improve the quality of life for Iraqi refugees in the communities where training is given (*desired results*).

The degree to which providers feel safe to take risks and expose vulnerabilities within their organization will inform their capacity to engage meaningfully in a training as well as in their work with Iraqi refugees broadly (*influential factors*). The program will prepare providers for work with Iraqi refugee clients by employing a training strategy that balances didactic dissemination of pertinent information with meaningful experiential activities. These experiential exercises were designed to target self-development and improve providers' ability to cope with uncertainty and human difference. When didactics and experiential self-development are in conflict, the program will prioritize experiential activities in service of preparing providers to engage in reflective cross-cultural practices (*strategies*). Personal uncertainty and ambiguity are fundamental aspects of cross-cultural work. Self-reflection and self-exploration are necessary

aspects of developing cultural humility. Cultural humility is paramount in work with Iraqi refugees. Discrete bodies of knowledge are important in cross-cultural work to the extent that they indicate to clients a provider's investment in their lives, cultures, and histories (*assumptions*; W.K. Kellogg Foundation, 2004).

    Activities of the program. Developing the "activities approach" logic model has been an iterative process beginning with decisions about the needs for the training itself. The activities approach logic model situates the flow of the program in parallel timelines enabling the development of critical steps that inform and support one another. (See Table D4 for the activity approach logic model). The structure of the training has been informed by theory about effective intercultural education as well as data and pragmatics about what is possible given the needs of most community mental health clinics. The pilot needs assessment and a review of peer programs informed the content of the training program. In the hypothetical future, when an organization seeks training, a similar needs assessment will be administered to them and accommodations to structure and content will be made according to that organization's specific needs.

    Given the interesting gap between provider consensus about feeling *pressure for more information* and the frequency and range of their concerns in the attitudes/beliefs domain, one challenge of the activities approach logic modeling for this program is how to offer what is necessary in a satisfying way—how can providers who think they need more discrete information willingly engage and grow in the domain of attitudes/beliefs? One way I have answered this question is by conceptualizing the *pre-training phase*—the period between initial contact with organization and the actual administration of the training—as a period of education and engagement with participants.

The most significant step in this engagement process is that the facilitator talks with participants each individually for 15 minutes with the intention of discussing the results of their needs assessment, listening to their concerns and self-defined needs and describing facilitator's intentions and plan for meeting those needs including the experiential activities. Although time consuming, this conversation serves multiple functions: (a) the facilitator develops relationship with individual participants that can be leveraged in training discussion (b) the facilitator assesses organizational culture and mood (c) the participants feel that they have been considered in the development of the training program (d) the facilitator addresses resistance to experiential vulnerability by 'coming alongside' [Miller & Rollnick, 2013], (d) the facilitator sets standard for behavior in training, and (e) facilitator prepares participants to enter training with self-reflective mindset. This is just one example of how undergoing the activities approach logic modeling process assists program development. Each step has been reviewed in order to ensure that the steps preceding and following it are complete and do not allow for information or process gaps. The activities approach logic model can be reviewed in the Appendix (Table D4). This logic model also formed the skeleton of the program implementation plan, which is explained further in a later section.

If during these conversations with individual participants, the facilitator encounters a potential participant who expresses overt hostility or contempt toward his or her refugee patients, a targeted assessment of their capacity for self-reflection, flexibility, and vulnerability will be conducted. In this event, the aforementioned goals of this conversation will be redirected toward gatekeeping. Attempts will be made to assess the provider's reactions (and their attitudes/beliefs, knowledge, and skills) regarding themselves, their work, and their refugee patients. Consistent with ecological systems theory, the facilitator will make inquires of the potential participant at

the levels of the microsystem ("When you have walked away from interactions with refugee

patients, what has been your prevailing feeling?"), the mesosystem ("When you heard that your

clinic would be hosting this training, what response did you have to spending a full work day on

these issues?"), the exosystem ("How do you feel about refugees joining your community?"),

and the macrosystem ("How do you suppose who you are impacts your work with refugees?"

(Bronfenbrenner, 2005; Letourneau, 2016). Attempts will be made to engage the provider in a

collaborative decision-making process regarding the fit between the provider's readiness and the

minimum self-reflective non-defensiveness necessary for all participants to have a meaningful

experience; as Letourneau (2016) offered in his ethical gatekeeping decision-making model,

"feeling-intuitive" as well as "rational-evaluative" assessment will inform the ultimate decision

about whether to permit a provider to come to the training. The facilitator will insist that no

penalty be incurred if it is decided that a provider not attend the training.

  Program mission statement. A mission statement should be broad enough to address the

purpose of the program, the guiding philosophy, the target audience and methods, and how it is

situated in its landscape of peers—that is, distinguishing it from other similar programs

(Timmreck, 1995). A strong mission statement identifies the type of program, the needs being

addressed, and the unique services/product being offered; balances specificity with room for

growth; avoids inadvertent alienation of potential stakeholders; and employs catchwords useful

for branding and marketing the program (Calley, 2011). Developing a mission statement is an

iterative process that is broader than any one individual role and broad enough for future

creativity and adaptation (Calley, 2011; Timmreck, 1995). The final version is as follows:

    As Iraqi refugees increasingly resettle in the United States, a mental health professional

    training program is necessary to prepare providers and their agencies to engage Iraqi

refugee patients in culturally responsive therapeutic relationships. This series of training

modules, informed by cultural humility principles, uses didactics, experiential activities,

self-reflection, and discussion to cultivate providers' capacities to offer refugees safe,

effective care.

Drafting the mission statement was an iterative process in which the purpose of the program is

distilled into two sentences. The earlier versions of the mission statement can be reviewed in

Table D1.

     Program vision statement. The function of a vision statement is to offer an idealistic,

expansive view of the context within which the program is situated. It should be brief,

aspirational, and galvanizing. This was not difficult to develop given the ease of imagining a

better world for refugees. The short iterative process is demonstrated in Table D2. The final

vision statement is: "This training program will inspire participants toward productive global

citizenship committed to individual and collective forms of international social justice such that

there is no human being without an appreciative community in which to belong".

     Step 5: Infrastructure of the training program. The fifth step of the CPDM is the most

significant of the steps and consisted of developing the structure and the content for the

program's entirety. This training was organized into eleven modules to be delivered over nine

hours. Its sequence exposes participants to the cultural humility self-in-role functions of

cross-cultural work before providing significant didactics. In particular, the first modules

emphasize clinician self-development, set standards for flexible intercultural care, and confront

participants with challenging experiential learning that establishes an emotional-affective

foundation for later didactic-driven modules. An underlying assumption of this curriculum is that

the capacity to not know—to carry uncertainty both interpersonally and intrapersonally—is a

prerequisite for safe cross-cultural work (Pedersen, 2004; Ramsey, 1996). If unidentified or unmanaged, uncertainty causes people to engage in an array of defenses including shutting down or becoming conversely and artificially *more* certain—that is, more entrenched in previous beliefs and attitudes. The fear triggered by personal uncertainty renders us less flexible, less adaptive, and less receptive to new ideas (Hogg & Blaylock, 2012). With regard to cross-cultural and cross-linguistic services, providers must deliberately suspend their own perceptions, personal histories, and convictions about the human condition to allow for the whole radically different set of perceptions, histories, and convictions brought into their relationship by the client. The most important function of this training is that it may prepare participants to recognize feelings of uncertainty in themselves, value and foster this form of personal reaction, and harness it toward a humble, curious, and receptive interpersonal stance (Holmes, 2012).

This training begins with *Module I: Introduction and Arab Greetings* in which the facilitator sets the agenda and trains participants to greet one another in Arabic. This begins a discussion about the nature of greetings in Iraqi culture and the necessity of using a refugee's language to convey interest and respect at the outset. In *Module II: Interpretation—Language and Behavior,* the facilitator introduces standards of cross-linguistic services including effective use of spoken-language interpreters. An experiential exercise allows participants to practice techniques of interpreted communication as well as exposes them to personal uncertainty—which is drawn out in reflective discussion by the facilitator at the end of the module.

The reflective discussion from Module II acts as a transition to *Module III: Self-Reflexivity, Elasticity, and Receptivity,* in which *personal uncertainty* is defined and its relevance described. The facilitator introduces the ecological-systems model. Though brief, this

module offers a lens through which participants are encouraged to view the remainder of the training. In the fourth module, *Cultural Competence and Humility, cultural competence* is defined and its insufficiencies explored. Cultural humility is subsequently offered as an appropriate framework for cross-cultural work with refugees. *Module V: Personal Reflections* consists of a meal break and a private individual reflection assignment designed to acquaint each participant with themselves as culturally humble beings.

When participants return from their lunch/reflection period, the facilitator leads a discussion about refugees, Iraqi culture, and Islam. *Module VI: Iraqis in Exile—Culture, Religion, and Mental Health* ends with a facilitated discussion about participants' personal reactions to human difference and encourages the group to practice dynamic sizing of cultural information by drawing on the ecological-systems model. This module transitions well to *Module VII: Posttraumatic Stress and Conditions of Resettlement.* In this, the longest of the modules, the facilitator discusses the characteristics of posttraumatic stress in refugees, compares and contrasts these characteristics with the diagnostic criteria for PTSD in the DSM-V, and describes the challenges of diagnosis, conceptualization, and treatment.

In *Module VIII: Patients and Providers—Roles, Responsibilities, and Possibilities,* the facilitator offers treatment options including intake procedures, relationship formation, and evidence-based practices for refugees. Roles and responsibilities of both clinical practitioners and case managers are addressed. *Module IX: Support, Sustainability, and Systems Issues* is future-oriented including discussions about the risks of compassion fatigue, and the important roles of peer and administrative support, as well as logistics of interpreter services, sustaining relationships with refugee communities, utilizing cultural brokers, and making proactive systems decisions. This module is primarily discussion oriented and highly adaptable to the needs of the

participants. *Training Program Evaluations* are distributed in a brief *Module X.* Follow-up

procedures are described as well as ongoing support and contact information of facilitator is

shared. The training ends with *Module XI: Termination and Arab Partings,* in which the

facilitator reflects back on the lunch activity, provides brief psycho-education about the concept

of endings in Iraqi culture, and teaches participants how to offer parting words in Arabic. Each of

these modules is described in detail in the following section. Please see Appendix E for lesson

plans including sample scripts; readers may find it useful to review each module's goals,

materials list, and plan in the appendix prior to reading the specific description of the module

below. Appendix E also includes lengthy sample scripts for each module; readers may wish to

return to reading these at a later time. I drafted these scripts as a true representation of what

might be spoken by the facilitator. Consistent with tenets of effective education, lesson scripts

are iterative in the sense that concepts are introduced, built upon in increasingly nuanced ways,

reviewed, and discussed. This strategy is effective for imparting auditory information and differs

from the linearity that characterizes most writing (Stanford University Office of the Vice Provost

for Teaching and Learning, 2016). These scripts should be understood as one possible way the

facilitator might accomplish the goals of the modules.

     Module I: introduction and Arab greetings. Module I: Introduction and Arab Greetings

is designed to set a frame for the modules that follow. This 60-minute module includes time for

participants to get settled with refreshments. As participants arrive for the training, the facilitator

encourages them to write a brief introduction of themselves on an index card that will be

provided. As the module begins, the facilitator opens with an Iraqi Arabic greeting; this begins

the process of teaching providers the Arabic necessary to greet their patients for the first time.

The facilitator invites participants to practice these Arabic words as, turn-by-turn, they introduce

themselves by reading what they've written on the index card. This greeting circle serves

multiple functions: (a) the providers practice saying the Arabic words out loud in realistic

exchange (b) the providers become acquainted with each other (c) the facilitator sets the standard

of universal participation by requiring speaking at the outset and (d) the facilitator prepares for

later activity of editing introductions for work with Iraqis.

After the greetings, the facilitator describes the plan for the day including how pre-

training evaluations and requests will be incorporated into the training. The facilitator uses this

opportunity to establish ground rules for participation: safety, non-judgment, vulnerability,

curiosity, and passion. That participants will have much misinformation about Iraqi, Arab,

Muslim, and refugee populations is understood as an inevitable reality given the media culture of

the United States. The facilitator approaches this with an acceptance/change dialectic; she will

normalize the existence of stereotypes and misinformation, establish the workshop as a safe

place to expose them, and assert the imperative that they be explored. The facilitator also

identifies several additional thematic tensions that are likely to arise throughout the training: (a)

content versus process, (b) idealism versus realism, (c) severity versus immediacy, (d)

uncertainty versus excellence, and (e) professional standards versus social justice. (Please see

Table E2 for complete Module I lesson plan, goals, and script.)

Module II: interpretation—language and behavior. In this module, the facilitator

describes the tension of what is ideal versus what is realistic when working with spoken

language interpreters. Best practices for spoken language interpretation in mental health are

important for clinicians to know about so that they can strive toward the safest situation for their

patients. When immigrant groups are establishing themselves in new communities, it is unlikely

that there are preexisting interpreter services to meet this need. The facilitator normalizes this

situation and encourages patience and adaptation. This module also includes an extended

experiential activity designed to familiarize providers with the experience of engaging

effectively and rhythmically with their interpreter. (Please see Table E3 for complete Module II

lesson plan, goals, and script.)

Experiential Activity: Spoken language interpreting simulation. The module includes a

simulation of interpreted communication in which participants divide into groups of three. Group

members are assigned to *therapist*, *interpreter*, and *refugee* roles; the facilitator provides ear

plugs for each *therapist* and each *refugee*. Participants are told to engage in interpreted

communication in which the 'therapist' and 'refugee' plug their ears when the opposite person is

talking and unplug their ears when they are listening to the interpreter or when they are

themselves talking. Providers are encouraged to notice nonverbal communication and the rhythm

of receiving nonverbal communication before linguistic content. Debriefing follows this activity.

This activity was piloted in 2015 during a combined piloting of Modules II and VII. Participants

reviewed this activity positively. (Please access these reviews in Table E11).

Module III: self-reflexivity, elasticity, and receiving of the other. Module III mostly

comprises an extended experiential activity in which participants engage in silent gesturing to

introduce themselves to one another in pairs. This activity is designed to challenge participants to

consider what is essential about themselves (e.g., *what makes you, you?*) and to convey this

quintessence without a shared language. Participants also practice conveying care, interest, and

understanding through nonverbal attunement and demeanor. After this activity, the facilitator

discusses ecological systems to encourage personal elasticity in the context of personal

uncertainty.

In this module's experiential activity, participants are given ear plugs for the duration of this activity to simulate the linguistic distance between them. The earplugs are also thought to facilitate individuals' capacity to access inner physiological and mental events by reducing external stimuli. One member of each pair is told to convey what is essential about themselves without using words but the other member does not know that that is their task. The second person is told merely to stay as attuned to their partner as they can—to put them at ease and make them feel seen and cared for. This activity switches role half-way through; after both rounds, everyone, still wearing earplugs, reflects privately about the experience before returning to the large group to discuss it. (Please see Table E4 for complete Module III lesson plan, goals, and script.)

Module IV: cultural competence and humility. In the "cultural competence and humility" module, the facilitator problematizes the notion of competence and introduces the notion of cultural humility. Participants engage in a brainstorm about what they know about cultural competence; facilitator then distinguishes knowing from *not* knowing and asserts the independent value of humility in intercultural interactions. One participant is invited to tell a brief story about preliminary work with a refugee client to discuss with the group. The facilitator will deliberately probe the participant for his/her experience of uncertainty with the patient and will reframe frustrations and struggle as expectable parts of the process. The facilitator completes the review of ecological systems from the previous module by reminding participants that because our macrosystem dictates our worldview, we do not completely know what we do not know. This module was designed to function as a reinforcing or bolstering experience for participants—they ought to go to lunch feeling strong and encouraged about the work. (Please see Table E5 for complete Module IV lesson plan, goals, and script.)

Module V: lunch and personal reflections. The priority during the lunch break is that participants are able to relax and decompress before a content-rich afternoon series. During this time, participants are asked to take ten minutes of solitude to complete two tasks. First, on one side of an index card, they will revise their self-introductions from the morning greetings if they were introducing themselves to refugee clients. They are prompted to reflect on how these introductions might have evolved from the morning session or from actual introductions they have made to refugee patients. This requires them to incorporate Arabic greetings into their introductions and hopefully inspires them to consider the opportunity of setting the frame of their professional role. A conversation about the importance of anticipatory problem-solving through clear boundaries and descriptions of procedure will be elaborated in afternoon modules. Planning their introductions ahead of meeting with patients allows providers to engage patients with open, intentional greetings that create structure and safety.

Second, on the other side of the index card, participants will describe their physiological experience of uncertainty. The facilitator wishes to assert the value of somatic information in maintaining self-awareness particularly regarding clincians' reactions to their refugee clients (Forester, 2007; Hook, Watkins, Davis, Owen, van Tongeren, & Ramos, 2016; Ross, 2000; Siegel, 2010). In an effort to reinforce this point, providers will explicitly identify their own personal physiological indicators of uncertainty and anxiety. These indicators will be discussed as valuable tools of self-assessment and monitoring. Reflection is understood as an essential component of cultural humility (Cleaver et al., 2016; Prasad et al., 2016; Schuessler et al., 2012):

> When a learner writes down a thought, the thought takes shape and form. Journaling
>
> helps students engage in introspection and analyze situations critically…Reflection
>
> fosters thinking that changes practice, and is not merely a rote or routine experience.

When reflective thinking is paired with journaling as a learning activity, students develop self-analysis and an increased awareness of their environment. (Schuessler et al., 2012, p.96)

(Please see Table E6 for complete Module V lesson plan, goals, and script.)

Module VI: Iraqis in exile—culture, religion, and mental health. Module VI was developed with both content and process in mind. A primary goal of this module is that participants learn about Iraqi people—their history, religion, and culture. But, there is always the question of how information learned will be applied later by its learner. Whenever we increase cultural "knowledge," we run the risk of over-estimating its value and applying it with insufficient nuance. As I was developing this module, the imperative for education—for "knowledge"—seemed at conceptual cross-purposes with imperatives for humility. As such, I endeavored to design a module that engages participants in a humble *process* even as the facilitator offers *content*—"facts"—for consideration.

The facilitator begins this module by mapping out the history of Iraq in parallel to the milestones of multiple generations of a hypothetical Iraqi family. As the timeline of modern Iraq is written on a white board, the psychological implications of Iraq's instability become clearer. These parallel timelines provide a structure within which the facilitator provides information about the history, culture, worldview, religion, and social lives of Iraqis. Participants are encouraged to wonder, to be curious, about how our Iraqi "patient" might have experienced a given historical event. This process is vital practice in asking questions that inform our conceptualization of Iraqi patients. By appreciating the immense developmental challenges of a family in wartime, we expand our structures for understanding Iraqis within an ecological systems frame; the more clinicians appreciate the immensity of their stories, the less they

understand refugees as unidimensional or vacant beings but as robust and valuable ones. Within the worldview of Arabs, individuals are bound to their extended family networks—discussing the Iraqi worldview within the structure of an average family of multiple generations is consistent with Arab ecological systems perspectives. Individuals are embedded in complex and large family systems in the Arab world; these family structures shape not only an Iraqi person's development but how and what they stand to lose in war. (Please see Table E7 for complete Module VI lesson plan, goals, and script as well as Table E8 for lecture notes handout.)

Module VII: posttraumatic stress and conditions of resettlement. In module VII, the facilitator begins by framing trauma and the levels of impact trauma has on survivors. This frame introduces the problems associated with applying to refugees the Western conceptualization of PTSD as a unitary disorder. The facilitator then engages participants in mapping out the resettlement process with the intention of conceptually immersing participants in the immense undertaking that is resettlement. This process was designed to be educational as well as to inspire compassion from its participants. Resettlement is overwhelming; participants too will feel overwhelmed. The module closes with an elaboration of the ways conceptualizing posttraumatic stress as a formal disorder in refugees is problematic. (Please see Table E9 for complete Module VII lesson plan, goals, and script.)

This module was piloted in the spring of 2015 with a class of clinical psychology graduate students. The script included in Appendix E for this module is an adaption of the recording from that pilot. Evaluations of this module were also administered, the results of which were included in this document (see Table E11). The most common feedback was a request for more citations; in addition to increasing the amount of cited material in the script itself, I addressed this feedback by committing to including a list of references and additional resources

when delivering the training. The references cited in this document suffice as an example of what participants might receive following the training but a small subset of the most meaningful subsequent sources is included in Table E16.

Module VIII: patients and providers—roles, responsibilities, and possibilities. The eighth module is content laden. Participants receive information about the ways Iraqis' cultural and religious worldviews may interface with clinical service including social values, attitudes about substance use, conceptualizations of the human condition, and the elements of explanatory models for suffering and treatment. This information is shared with a commitment to honoring these worldviews and collaborating with imams and others when a patient's multiple explanatory models require a multidimensional approach to support. The module transitions into weighing the compatibility of major psychological paradigms with Iraqi Muslim worldviews. Psychodynamic, humanistic, cognitive, post-modern/narrative, and mindfulness-based Eastern approaches are discussed. The module closes with a discussion about reactions to and between the client and clinician in the therapy dyad; this discussion acts as a transition to the next module. The script included in the appendix for this module provides one example of how this module may unfold if there is little audience participation. When offered to an active group of participants, the facilitator can respond to participant stories or questions in a more dialogical manner. This decision can be made by the facilitator. (Please see Table E12 for complete Module VIII lesson plan, goals, and script.)

Module IX: sustainability, support, and systems issues. This module serves as a placeholder for debriefing, brainstorming, and discussion. The facilitator frames this module as primarily a time for forward-thinking: how will the participants make use of the training, how will the clinic function in support of refugees, what future steps are necessary, and what

questions remain? Regardless of how the discussion unfolds, the facilitator will emphasize the importance of peer support specific to refugee providers—clinical work with refugees can neither be done in isolation of other professionals nor without significant institutional and community support (Herman, 1997; Pipher, 2002; Van der Veer & van Waning, 2004). Clinicians' personal reactions to refugee issues are acknowledged as inherent to refugee service tasks—the facilitator asserts the imperative of organizational support for staff vulnerability and reports back about the outcome of the organizational cultural assessment that was administered in preparation for the training. These results are discussed in a formative and constructive way (Patton, 2012). The opportunity for providers to engage in a long-term community of practice (CoP) is described. The structure for this module is intentionally loose and can be adapted to the needs of the participants. Furthermore, if participants prefer to ask questions after each module, the facilitator can shift the training timeline by effectively distributing this module, the time and content allocated for it, throughout the training instead. What is vital is that participants have the time necessary to digest and apply material. (Please see Table E13 for complete Module IX lesson plan, goals, and script.)

Module X: evaluation. Module X is a brief period for evaluations. During this time, evaluations are given that are designed both for subjective and objective evaluation of the training process. The two-part survey administered addresses participant change on several variables (knowledge, skills, attitudes/beliefs) that were measured originally in the pre-assessment (i.e., whether the educational intervention has worked—that participants have grown) as well as participants' opinions/evaluations of the training. This evaluation section is a small part of a large and longitudinal evaluation plan for this training program. (Please see Table E14 for complete Module X lesson plan, goals, and script.)

Module XI: termination and Arab partings. Module XI is also brief and acts as a termination for the training session as well as teaching Arabic parting phrases. The prospects for terminations with refugee patients are discussed. The facilitator expresses gratitude for the presence and effort of the participants, reiterates the importance of community in this work, and conveys her joy for having spent the day with participants. The module closes as everyone practices Arabic parting words. (Please see Table E15 for complete Module XI lesson plan, goals, and script.)

Conclusion. The structure of the program progresses from culturally general and heavily experiential morning modules to more Iraqi-specific content oriented afternoon modules. This progression was intentional. Participants will hopefully invest themselves in their own growth and humble reflection before undertaking new content-based learning about Iraqi refugees. This work begins with self. I have attempted to reinforce this in all aspects of the program. Patients may approach providers clamoring for answers and resources just as participants of this workshop may crave solutions or discrete bodies of knowledge that will provide clarity; instead what both need is the capacity to sit with immense bewilderment together without becoming paralyzed.

Steps 6-8: resources of the training program. Access to global digital library resources, the Internet, and a community mental health center willing to allow a doctoral student to access aforementioned clinicians is vital to the successful development of this training program. Very little has been required to sustain the program as an intellectual product. One foreseeable challenge of sustainability involves the issue of visibility in implementation; in order for the program to meet the need for which it was developed, organizations struggling to meet the needs of Iraqi refugees must be able to discover the program's existence. As such, some form of web

marketing could be indicated. My experience managing a small business website will be an asset. Some financial commitment would be necessary in order to maintain this website but that sum is likely to be nominal. The program is designed to meet the needs of clinics confronting this issue regardless of where in the United States the clinic is. As such, if the facilitator were to be invited to offer this training, a formal contract, a consultation fee or honorarium, and travel expenses would be appropriate compensation by the clinic to the facilitator. Sustaining the program also depends on its capacity to meet the needs of those to whom it is offered. Ongoing evaluation of the training is necessary and discussed more fully in another section.

      Step 9: expert reviews of the training program. Following the completion of the first polished draft of the description, curriculum, and materials for this training program, I contacted professionals who have expertise in one or more areas relevant to this project in order to seek their feedback. After contacting eight individuals, six responded with interest in reading and reviewing the project. As the original agreement in the proposed project was to approach ten experts with the hope of yielding three reviewers, I chose not to further contact potential reviewers once I had commitments from six. These individuals included: an Iraqi refugee who is an experienced Arabic-English interpreter in a community near the clinic described in the case example (Reviewer A), a licensed clinical social worker who leads the case conference for outpatient clinicians at the agency of the case example (Reviewer B), a licensed psychologist/director of training and researcher who is an alumnae of the RAMS, Inc. clinical psychology training program (described earlier) and who is published in the topic of cultural humility (Reviewer C), a licensed psychologist employed at the agency featured in the case example (Reviewer D), a doctoral-level professor of languages with a specialty in interpretation for trauma with refugees who is an alumnae of the Harvard Program for Refugee Trauma

(HPRT; described earlier; Reviewer E), and a graduate student in social work who is an Army veteran serving multiple tours in Iraq and Afghanistan as a cultural integration specialist (Reviewer F). I provided them with (a) a condensed description of the conceptual framework and method, (b) the activities approach logic model, (c) the training curricula, lesson plans, and scripts, and (d) the implementation and evaluation plans. These reviewers were asked to respond to specific questions (see Appendix F) that address the broad intentions of this project: relevance to mental health services, specificity to Iraqi refugees, appropriateness for needs of clinicians with little/no cross-cultural experience, consistency with current best practices, and structural alignment with stated goals and objectives. Reviewers were asked to rate the degree to which they agreed with five statements using a 5-point Likert-style scale. Each of the five questions also included space for qualitative responses. (The quantitative and qualitative reviews can also be accessed in Appendix F.) Reviewers B, C, D, E, and F responded to my review questions electronically through a provided survey and track changes. I conducted the review with Reviewer A in two phone conversations, which were recorded and transcribed with permission. Relevant excerpts from these conversations have been included in the appendix for this content.

   Relevance to mental health services. Reviewers were in agreement that the program is relevant to mental health service provision (average score: 5). Reviewer C highlighted the value of balancing content and process without losing practicality: "…a keen attunement to process (which accounts for the majority of safety building, rapport, relationship, and ultimately outcome) in service provision. The module also includes very practical recommendations both for self-monitoring and providing services." Reviewer B reflected that case-management with this population often poses additional challenges for community mental health centers. The emphasis in this program has been on counseling rather than case management but this is an

important future direction. A supplementary training could be offered for case managers; if so, it might be useful for a cultural humility facilitator to offer a few hours of training followed by a local case management specialist who can speak to the resources and barriers pertinent to their state and local communities.

    Specificity to Iraqi refugees. Reviewers are also in agreement that the program addresses issues relevant to Iraqi refugees (average score: 4.7). Reviewer A strongly agreed with this question asserting his appreciation for the extent to which Iraqis are portrayed in a balanced way without inadvertent religious bias. Reiterating this sentiment, Reviewer E commented: "The project is painstaking in providing thorough and current information and insight into Iraqi history, cultural, and religious norms, while also noting the importance of not stereotyping and emphasizing the need to recognize that each individual's experience is unique..." To that point, Reviewer F encouraged more specificity regarding the many interest groups within Iraqi society including the Assyrian, Turkmen, Yazidis, and Arab Christian populations who have all suffered various persecutions under the Ba'ath regime. This theme of balancing macro-, exo-, and meso-system generalities with microsystem individualities raises the helpful concept of intersectionality. In offering support for the timeline activity developed in Module VI, Reviewer C suggested incorporating the concept of intersectionality into the discussion of intragroup diversity among the hypothetical Iraqi family that is discussed as part of that activity. Intersectionality is the relationship and interaction between the multiple aspects of an individual's identity and is a collective force that is understood to contribute independently to the variance in the way a person experiences their identity (Crenshaw, 1991; 1995). Intersectionality theory is exceptionally relevant in the question of identity for Iraqi refugees—not only because refugees are inherently developing among influences outside of their home ecological systems

but also because Iraqis specifically are so internally distinct from one another. The way that an

Iraqi refugee has developed given the many developmental influences acting upon him or her—

many of which may feel to Iraqis as mutually exclusive or at least highly conflictual—is

infinitely determined by intersectionality. During Module VI: Iraqis in Exile—Culture, Religion,

and Mental Health, in which the facilitator encourages participants to build a collaborative

multigenerational timeline of Iraqis' lives, defining and discussing intersectionality may be a

useful conceptual tool for internalizing developmental *processes* in addition to developmental

content.

Although Reviewer D agreed that the program addresses Iraqi refugees, he offered the

feedback that in the program's cultural specificity, broad applicability is lost. He questioned the

value of such specificity and encouraged me to consider whether the work could benefit more

providers nationwide if it did not focus so closely on Iraqis in particular. Reviewer D's

professional position is one in which practicality, efficiency, and cost-effectiveness must be

administrative priority—therefore his feedback represents several tensions. The tension between

generality and specificity/pluralism is an ongoing tension in the human services industries. How

should we allocate finite resources when individual minority groups have urgent and distinct

needs? The challenge of distinct versus common needs is formidable and ongoing. The second

tension inherent in this piece of feedback is between sound scholarship and practical

implementation—a tension closely related to that between idealism and realism. Providers in the

needs assessment, and anecdotally when I worked at the clinic, reported struggling not only with

their patients' refugee status and histories but with their Muslim-*ness,* their Arab-*ness,* their

Iraqi-*ness*. This struggle was also occurring in the context of much ignorance about what these

individual forces mean in reality for the treatment. During this adjustment period, I witnessed the

administration of the clinic pivot to messaging about the universality of the human condition in an effort to normalize and humanize the refugee patients these providers reacted against. This is an understandable, moderately effective strategy but is incomplete. As providers we are always sitting with human universality and human specificity *simultaneously*. The program was designed to empower providers to sit intentionally in this tension. Several ideas informed the decision to devote afternoon modules to Iraqi Muslim refugees specifically: (a) developing a project that is both ideal and realistic is possible when governed by local, practical information; and (b) accommodating this program to meet new needs/populations/problems is made simpler because this program was developed to induce a theory-driven and evidence-based *process* within its participants, even as the curriculum is built using situation- and culture-specific content. This training program is easily adjusted to refugee groups from other regions of the world.

Appropriateness for needs of clinicians with little/no cross-cultural experience. With regard to whether the training is appropriate for providers with little or no cross-cultural experience, reviewers strongly agreed (average score: 5). Reviewer E suggested that one way to reduce participants' anxieties about cross-cultural work is to remind providers that they form relationships with people different from themselves as a regular part of their work: "It might be possible to eliminate the category of 'no' cross-cultural experience, while eliciting in discussion the very different cultural perspectives that patients may bring even when those patients are also from the United States. Suggesting a gamut of cultural difference (from within one's own country to beyond) might lessen some of the anxiety." Reviewer F compared this training to fundamental training courses used in military pre-deployment preparation commenting that after

foundational trainings such as these, the next step in the learning process is to put the skills to the test in real experiences.

       Consistency with best practices. There is constricted agreement among reviewers (average score: 4) that the program has been developed using current research and best practices. Reviewers B, D, and F declined to rate citing limits in their knowledge of the literature. In reference to my Module VIII discussion about Narrative Exposure Therapy (NET) as one of the strongest evidence-based treatments for refugees, Reviewer C suggested citing effect sizes for its use with Iraqi refugees. Indeed, Hijzi, Lumley, Ziadni, Haddad, Rapport, and Arnetz (2014) conducted a study implementing a brief version of Narrative Exposure Therapy (NET) with Iraqi refugees. Groups assigned to the brief-NET condition showed significant posttraumatic growth (Effect size=.83) and well-being (Effect Size=.54) immediately following, at two months and at four months post-treatment while the control condition showed no change (Hijazi et al., 2014). This information has been added to the script for Module VIII. The reviewers who declined to rate did acknowledge being grateful to have been exposed to NET more extensively and asserted that the modules appeared 'face-valid'. Reviewer E verified the quality of the works cited regarding trauma and posttraumatic stress.

       Structural alignment with stated goals and objectives. Reviewers also strongly agree (average score: 5) that the training is structured in a manner conducive to its goals: "The approach is challenging, yet kind, is grounded in important and sound principles, yet practical" (Reviewer C), "Cannot imagine a clinician attending this training and not being profoundly affected/changed/challenged" (Reviewer B), and "Strongly agree. And what's making me say that is because dealing with religion is a very sensitive thing. And so what I read, you deal with it a very right way. You were careful, and you are not picking one side and talk about—like you

didn't go with Shia against Sunni…So you was just in the middle, you know? And that is a very great thing, because this is very real…" (Reviewer A). Reviewers also attributed the future success of the project to the level of detail included in the module scripts: "The way that the program includes potential scripts for the different modules gives the reader a very clear sense of how each module might play out with participants and also illustrates how each of the modules would move toward and reach its goals and objectives" (Reviewer E).

Additional qualitative feedback. Reviewers used the sixth open format question in various ways. As mentioned above, Reviewer C introduced intersectionality theory as a frame for conceptualizing the manifestation of multiple developmental influences and identities (Crenshaw, 1991; 1995). Reviewer E also commented on the value of aligning our social justice responsibilities with conceptualizations of altruism as a healing enterprise. I appreciated these reviewers engaging with this work at this conceptual level and have incorporated these ideas at various points throughout this piece.

Reviewers also used this space to reiterate that the requirement for participants to be vulnerable necessitates an intentional process of engaging them in advance. One reviewer raises the question of participant engagement. Acknowledging that the incentives a clinic's administrators might have for hosting a training can be varied and that the participants' self-assessed need for this training can also vary, I cannot assume that participants will be fully invested in the self-growth that this training is designed to stimulate. Because this training also depends upon participants' willingness to be vulnerable and take intrapersonal and interpersonal risks, it is vital that I enlist their commitment and investment prior to their arrival. I agree with reviewers that engagement is crucial and conceptualize the preliminary 15-minute phone conversations with each participant as serving an engagement function. Reviewers are in support

of this pre-training phase. Broadly speaking, reviewers celebrated the breadth and depth of the project, the attention to process and content, and the efforts to balance the many tensions inherent to work in this field.

PART II: Program Implementation and Sustainability

      Step 10: Implementing the training program. This section is expanded from the activities approach logic model. The program begins when Iraqis first present for services in a clinic ill-equipped to provide them. When the organization first makes contact, the facilitator provides them with information about the program, a contract is negotiated, and the facilitator administers a needs assessment of the providers as well as an assessment of organizational culture. Once these assessments are reviewed, the facilitator tailors the program accordingly. Two weeks prior to the date of face-to-face training, the facilitator administers a pre-test to all participants. This pre-test assesses provider competence/humility, and readiness. The facilitator also conducts phone conversations with the organization's clinical director and all expected participants.

      This training begins with *Module I: Introduction and Arab Greetings* in which the facilitator sets the agenda and trains participants to greet one another in Arabic. The training ends with *Module XI: Termination and Arab Partings,* in which the facilitator reflects back on the lunch activity, provides brief psycho-education about the concept of endings in Iraqi culture, and teaches participants how to offer parting words in Arabic. Participants are given a post-test before they leave the training.

      Four to six months following the training, the facilitator administers a time-delayed

post-test to assess longevity of training effects. Facilitator also schedules a follow-up

conversation with the clinical director about progress on organizational goals derived in the

Support, Sustainability, and Systems Issues module. Facilitator offers a 1-year post-training

support-oriented follow-up conversation with the clinical director as a courtesy. The actual

instrument to be administered is further described in the next step. (Please see Appendix G for

implementation steps and materials.)

      Step 11: Evaluating the training program. As laid out in the implementation plan,

there are multiple feedback streams incorporated into the program execution (see Tables H1,

H2). The first feedback stream is the organizational cultural competence assessment

administered around the time of contracting (see Appendix C). This assessment served less as a

tool for directly evaluating the program and more for adjusting the program to best fit with

organizational needs. Organizational cultural competence assessment, which was discussed in

the third CPDM step, helped insure the program meets stated goals. The second feedback stream

is a needs assessment of providers (see Table B2). This needs assessment would be similar to

that which was administered to the case study clinic but has been enriched in two

ways—providers will be asked to describe their own salient identity variables as well as their

position and responsibilities with the agency. This assessment will inform the facilitator about

the experiences of providers as well as convey what their expectations for the training are.

Participant expectations are also measured through a brief series of questions which can be

accessed in Table H3.

      The third feedback stream begins with a pre-test of participants that assesses readiness

and cultural humility approximately two weeks before the training (see Table H4). This same set

of questions is then administered during the evaluations module at the end of the training and

then again at the 6-to-12 month follow-up. Developing an instrument for measuring cultural

humility is beyond the scope of this project. Evaluating provider cultural humility and

competence is a challenging endeavor as there is currently only one validated measure of cultural

humility (Paparella-Pitzel, Eubanks, & Kaplan, 2016). The measurement of humility, itself, is in

its infancy. Humility researchers acknowledge the challenge of and dearth of measurement of the

humility construct (Davis et al., 2011). As mentioned in the beginning of this section, cultural

humility measurement is currently limited to a single client-report questionnaire. Likewise,

relational humility, a related construct, can be measured using a validated instrument that is also

other-report (Davis et al., 2011; Hook, Davis, Owen, Worthington Jr., & Utsey, 2013). Even

theoretically, the extent to which individuals can be self-aware about their own humility is

unclear and understudied.

The Cultural Humility Scale (CHS) developed by Hook et al, (2013) is a client-report, not

self-report, measure (Hook et al., 2013). While converting CHS items into a self-report format

may be one option for creating a measure, the CHS items (such as: "my counselor is respectful"

and "my counselor is open to seeing things from my perspective") are so face-valid, I am

unconvinced that providers would be able to accurately and honestly self-assess (Hook et al.,

2013, p. 365). A measure that better operationalizes the construct of cultural humility for

self-report is needed.

Regardless, there also remains the conflict between culture-general and culture-specific

measurement. My approach has been to balance general and specific cultural training but to err,

when necessary, on cultural specificity such that providers are equipped to work with the Arab

refugees they are presented with. Although there are numerous culture-general cultural

competence measures, until recently there were no known validated culture-specific measures for

providers working with Arabs or Arab Americans. Dalia Khoury (2016) recently developed and validated a measure of multicultural competence and readiness for clinical work with Arab Americans (Khoury, 2016; Khoury & Manuel, 2016). This measure was developed using the aforementioned tripartite conceptual framework for cultural competence (knowledge, skills, attitudes/beliefs) and leverages the trans-theoretical model in order to assess readiness in providers (Khoury, 2016; Khoury & Manuel, 2016; Prochaska, DiClemente, & Norcross, 1992). They acknowledge, as I have, that while the comprehensiveness of the cultural competence literature is necessary to leverage in training, the sentiment and spirit of the measure and of this project is better accounted for by the cultural humility concept (Khoury & Manuel, 2016). The MCCAA is an 18-item questionnaire developed and validated for measuring (a) knowledge ("All Arabs are Muslim"), (b) skills ("I would feel comfortable engaging the services of a third party certified translator to communicate more effectively with an Arab/Arab-American client"), (c) attitudes/beliefs ("I respect the religious beliefs and practices that clients may have, even if I feel that they are interfering with the therapeutic relationship"), and (d) readiness ("I interact with members of minority groups in community and neighborhood settings") for work with Arab populations specifically. The measure was validated against well-known culture-general measures (Khoury, 2016; Khoury & Manuel, 2016). As I administer this measure to providers in this training in the future, we can collaboratively validate its use with Arab refugees as well as in the context of training evaluations.

During the evaluation module, participants are also surveyed about the training itself as a subjective measure of quality; this becomes the fourth feedback stream (see Table H5 for items). A strong cultural training should touch the affective domain through experiential learning, promote reflection and cooperation, offer a supportive environment within which to take risks,

and address relevant issues (Ramsey, 1996). The workshop is evaluated using 23 questions measuring the extent to which participants find the workshop applicable, clear, safe, engaging, encouraging, and transformative (Ramsey, 1996). Sample items include: "This workshop helped me to increase my awareness of my physiological reactions related to work with refugees" and "The training prompted me to consider my values". This evaluation is administered in Module X.

It is possible but difficult and beyond the scope of the program to measure program outcomes through journals, observations, key informant interviews, community feedback, participatory action research, and other qualitative methods. But this is valuable part of post-training discussions with the clinical director of the host clinic that would occur following the training. It is not necessary for me to be a part of this local level of evaluation, particularly when it involves direct contact with refugee clients, but conveying these methods as possibilities and consulting about them furthers the program's commitment to practice-based evidence and enables organization-level discussion about cultural brokerage. In my follow-up consultative role with the hosting clinic, I will strive to emphasize attention and evaluation of organizational process as much or more than privileging outcomes; progress in the process of an organization is an appropriate way to operationalize success. Has the agency continued to ask vulnerable questions that it may be afraid to answer? Have individuals continued to ask questions of themselves and each other even when they know it may lead to more uncertainty? Sample questions for guiding immediate and time-delayed follow-up discussion with the clinical director of the host clinic are included (see Tables H6 and H7).

Step 12: Bolstering the network of the training program. Refugee service provision cannot occur in the absence of peer support (Herman, 1997; Pipher, 2002; Van der Veer & van Waning, 2004). As discussed in the training modules, this is true at the level of the individual

provider but is also imperative at the level of whole systems (Pipher, 2002). Refugee mental health is a globally complex endeavor requiring the collaboration of globally educated and variously experienced professional minds. As Mary Pipher (2003) has asserted: "The best treatment programs for refugees are user-friendly systems" (p. 298). Providers must lubricate interagency collaborations both for the good of the service users and the service providers. The aforementioned process of external review provided an automatic network of concerned professionals. As such, this program is already networked with community service agencies, academic institutions, and the regional Iraqi community. Additional networking and collaborative thinking could be fostered through presentations at professional conferences as well as reaching out to the additional refugee service organizations in the communities where the training is given. As a part of the implementation plan, the facilitator will research the area of the target clinic in an effort to learn as much as possible about the city system the refugee navigates beyond the clinic that requests the training. This process of research will also serve to further network the facilitator and the training program with agencies committed to refugee resettlement.

  Step 13: Advocating for refugees through the training program. The primary form of advocacy produced by this training program is the facilitator's role as a model; the facilitator endeavors to thoughtfully and humbly approach work with refugee patients and model this to participants of the training. The facilitator must adopt a demeanor of passionate conviction (about the rights refugees have to safety, security, and healing) while balancing sensitivity to the worldviews of the clinicians taking the training (their worldviews and their zone of proximal development; Cole et al., 1978). How much growth can the facilitator reasonably expect from each participant? This question informs the patience with which the facilitator will endeavor to respond if/when participants make particularly ignorant, racist, or judgmental comments or if the

facilitator notices her own critical reactions. (For additional discussion about facilitator reactions, see my self-reflection in Appendix C.) As the facilitator models receptivity and reflection, clinicians are thought to be better able to visualize how they might embody these principles in their own work. Clinician demeanor is understood as contributing to the strength of the vital therapeutic alliance. Hopefully as clinicians develop comfort and passion for work with refugees, they will be more invested in advocating for them as individuals within the complex social service systems to which they are bound.

Second, the facilitator encourages agencies to network with their community's cultural organizations. The more networked mental health agencies are among cultural groups in the refugee community, the better the services and the stronger the troubleshooting, advocacy, and lobbying in local and state government.

Step 14: Sharing learning from the training program. The pre- and post-training assessments of the individual providers as well as the follow-up conversation with clinic leaders provides quality improvement data for the program itself. This is the information that will be used to demonstrate the effectiveness of the training and to make evidence-based improvements.

The receiving clinic of the program is likely to be interested in a few different kinds of information: (a) the readiness of clinic (broadly) and clinicians (specifically) to provide refugee services, (b) the worth of the training relative to its cost and, (c) the assessed growth areas and goals revealed by the process. To address these needs, the facilitator would share the results of the organizational cultural competence assessment and the pre-/post-training assessments as well as be available for additional debriefing and consultation following the training.

Finally, the broader community of refugee mental health professionals has a vested interest in the ongoing results of this training. Over time, with numerous administrations of the

training, the data collected as a part of the internal program evaluation will become robust

enough to be mined for additional learning about provider readiness, receptivity and humility

development. This data set can also serve as ongoing validation of the experiential activities I

have developed. As I mentioned in the evaluation step, collaborating with other researchers, such

as Khoury and Manuel (2016) who have developed an assessment tool for cultural competence in

work with Arab Americans, can broaden and deepen the contributions of this training. In

addition to possible publications, I could create and maintain a website to use as a platform for

marketing as well as disseminating additional information about the experiences of clinicians,

the response of clinicians to various experiential exercises, the longevity of training effects, and

the approach to training in the multiple domains of cultural competence/humility.

Step 15: Validating the training program. As there is no central accrediting body for

training programs of this kind, one way to validate the program is to meet the standards for

American Psychological Association Continuing Education (CE) credits. Continuing Education

is the practice of maintaining a commitment to formal learning made by career psychologists. CE

credits are one aspect of maintaining professional licensure and ensure that professionals stay

current on industry knowledge as well as continue to develop skills and improve services

(American Psychological Association, 2015). Trainings must meet certain qualifications in order

to be approved by the APA as a credit-bearing event; these qualifications are organized into a

hierarchy of "standards" and "criteria" by which the APA Continuing Education program

evaluates applicants.

The training must have goals (Standard A) that are relevant to and consistent with

psychological practice; course materials must include a goal statement that bears this out

(American Psychological Association, 2015). Standard B holds program leaders accountable for

effective program management. Instructional methods are regulated by Standard C which compels program leaders to clearly state educational objectives, which for a 7-8 hour training should total 5-6 objectives, in operationalized terms that describe what participants will be able to do upon completion of the training. In addition to educational objectives, Standard C also requires that program leaders use the most appropriate and effective pedagogical strategies available to them given the structure and content of the training and that these leaders have appropriate levels of expertise in order to justify their leadership. Curriculum within the training must be supported by current and sufficient scientific evidence and must incorporate discussion of legal and regulatory statutes pertaining to professional conduct (standard D). Evaluation of continuing education programs is required by the APA; as such, program leaders must be prepared to document their plan for, at a minimum, conducting satisfaction reviews of their participants. These reviews ought to emphasize the degree to which "the transfer of learning" was "practical and useful" in order to guide quality improvement efforts by the trainer and the host organization (Standard E). Following attendance at an approved program, credits are only awarded if participants have attended all teaching hours of the program; credits are only awarded for actual teaching time, so hosts are encouraged by the APA to attend the event being hosted elsewhere before assigning and publicizing an event's credit amount (Standard F). It is the responsibility of the host to ensure that participants do not receive credit if they have insufficient attendance. Promoting and advertising is regulated by Standard G; potential participants must be fully informed of the cost, time commitment, credit amount, educational objectives, and refund policy in the marketing for the event. The following statement must be used on promotional materials: "[organization name] is approved by the American Psychological Association to

sponsor continuing education for psychologists. [organization name] maintains responsibility for this program and its content"(American Psychological Association, 2015).

Whether this program would immediately qualify as a source of continuing education credits is unclear. Participants will learn much content about Iraqi Muslim refugees, but this will occur in the context of participatory discussions and numerous experiential activities, which are sound pedagogy and build skills even more foundational to refugee work than content knowledge, but will be process-oriented and thus, more difficult to quantify. The APA's Continuing Education program will approve the use of experiential approaches to skill development in accordance with literature on the effectiveness of such methods but these methods must have direct capacity to build professional skills in participants (American Psychological Association, 2015). As such, I would need to develop 5-6 educational objectives that define the target skills as *flexible use of self* in intercultural encounters and articulate ways these will be operationalized for the purposes of evaluation. Although I intend for the facilitator to fully inform participants of the vulnerability the training will require, marketing and evaluation are aspects of the program in which the conflict between the skills providers think they need and the skills the literature and the needs assessment show they need may impact the unfolding of the program: the attendance, investment, and satisfaction of its participants.

Results Conclusion

The fifteen steps of the Comprehensive Program Development Model (CPDM) have been undertaken to create a complete, ready program that prepares participants to convey warmth and safety in relationship with refugee clients. A literature review and needs assessment informed conceptualization of the competing demands and needs of a training program. These competing needs and ways to negotiate them were elaborated via an international review of existing

trainings as well as exploration of cultural competence at organizational levels with consideration of its impact on providers who may participate in the program. I included my own cultural self-reflection in an effort to monitor the impact of my cultural worldview on the process as well as to model reflection and reflexivity.

The mission and vision statements were both developed through an iterative process which has been made transparent in this document. Logic modeling served to elucidate the theory of change embedded in the program's structure—that is, how it will accomplish its mission and vision—as well as the specific activities that are required to do so. These processes informed development of the structure and organization of the program including the degree to which it balances culture-general with culture-specific content as well as experiential learning with interactive didactics. The entire infrastructure of the program was drafted and included here. This infrastructure includes extensive lesson plans with complete scripts for the eleven training modules as well as handouts, lecture notes, and evaluation tools. In final steps, strategy regarding implementation, networking, marketing, and sustainability were considered. Future directions for this work will be address in the forthcoming discussion section.

Chapter 5: Discussion

This program has been designed to operate in that relational space between human difference, which is always uncertain, which is always at least partially risky, and which always reminds us that there is something beyond the edges of our own worldview. In the needs assessment, exasperated providers expressed a desire for more information without realizing or naming intrapersonal and interpersonal conflicts related to their attitudes/beliefs. Even the standards for continuing education credits within the American Psychological Association privilege skill development and knowledge acquisition over exposure and reflection. The burden of proof is on the educator: How can I prove that this is useful? Consequently, this program was designed with evaluation in mind. Multiple feedback streams double back in the program implementation plan as well as inform ongoing quality improvement efforts and could facilitate collaborative research projects with external research teams. Were it to be executed repeatedly, the program would rest on a rich foundation of efficacy data. But what if the question of the burden of proof were instead phrased like this: how can we show that we have grown? It is my hope and my intention that participants grow in the valuable capacity to recognize when they feel uncertainty and notice as they react visibly or invisibly against it.

The Training Program

Consistent with Vygotsky's argument that learning is dependent on supportive others who challenge us to stretch a safe distance beyond our current capacities, all steps in the implementation plan, including all modules and experiential activities, have been intentionally created so as to push participants beyond what is familiar without pushing past the point of panic and retreat (Cole et al., 1978; Holmes, 2012). The needs assessment, organizational cultural competence assessment, and participant pre-test equip the facilitator with information about the

situation as well as about the participants as people. In pre-training phone conversations, the facilitator offers persuasive orientation to the need for self-growth and motivates participants toward productive vulnerability.

In *Module I: Introduction and Arab Greetings,* participants begin by taking the small risk of learning Arabic greetings and practicing them aloud. This serves multiple functions including preparing them to initiate warm relationships with refugee clients and to demonstrate an investment in Iraqi culture. *Module II: Interpretation-Language and Behavior* engages individuals in an experiential interpretation activity that stimulates a higher level of uncertainty. This uncertainty is comprehensively processed in group discussion, which serves as a segue for defining the concept of personal uncertainty in *Module III: Self-Reflexivity, Elasticity, and Receptivity*. Module III complements the second module by involving an extended riskier experiential activity meant to expose participants to significant personal uncertainty while also increasing their self-efficacy for communicating without access to shared language. By this point, participants will hopefully have grown to some extent in their capacity to redefine the problem from "insufficient knowledge" to "personal fear and discomfort". *Module IV: Cultural Competence and Humility* may expose individuals to some uncertainty as the facilitator explores the insufficiencies of the ubiquitous concept of cultural competence in favor of the less familiar cultural humility concept. Much of this module, however, consists of an extended case conference; the facilitator will guide this discussion away from problem-solving and toward the providers' reactions while highlighting markers of a strong therapeutic alliance. This discussion was meant to highlight for participants the dialectic between how much good can be done relationally despite how little we cognitively "know".

The lunch module provides brief space for participants to turn attention inward, reflecting on their own physiological reactions associated with uncertainty as well as on how they might wish to introduce themselves to refugee clients. This module reinforces reflection and self-awareness; one of the most important indicators of this program's efficacy is the degree to which participants are compelled to assess their physiological reactions to uncertain situations going forward. Ideally, participants are ever more able to recognize, observe, and make choices about how uncertainty impacts their behavior. Although Modules VI, VII, and VIII are heavily content-oriented, the pedagogical strategies used to facilitate delivery of this content contribute independently to participant growth. For example, although *Module VI: Iraqis in Exile—Culture, Religion, and Mental Health* conveys much information about Iraqi people, the process of being curious in an historically-informed way about an imaginary multi-generational Iraqi family supersedes the specific cultural content delivered by it. The increased capacity to be thoughtfully and warmly curious is a marker of participant growth. In *Module IX: Sustainability, Support, and Systems Issues,* the facilitator channels what is hopefully increased participant engagement toward local systems issues and collaborative systemic goal-setting. Growth following this module and following the whole training is at least partially indicated by increased investment in quality improvement of local services for refugees. Sound refugee work cannot be accomplished in the absence of supportive others. All post-training activities (including contact with organization administrators, evaluation analyses, and fostering an online community of practice) serve to retain connections between professionals, encourage improvements to the program, and celebrate organizational efforts toward goals.

Limitations and Future Directions

      Commitment. Nine hours of training is admittedly insufficient. This would be true of any training in any length. Cultural humility is an infinite task of ever more expansion of our personal worldviews and ever more assurance that there is much we do not and will never know. A successful training should discomfit providers out of complacence with themselves. Even if difficult, it is possible to find comfort in the unease; my goal is that providers also surprise themselves by finding a passionate compassion for the fate of refugees. The expectation for myself, for participants, and for their organizations is that we all engage in a process of vulnerability.

      Measurement. In the review process, experts asserted the importance of using validated measures when evaluating cultural competence and humility. In developing the evaluation components of this program, I reviewed validated cultural competence measures in search of one that includes non-discriminatory attitudes, self-reflection, comfort with uncertainty, and egolessness in the definition of cultural competence and operationalizes competence using items that reflect these humility constructs (Foronda et al., 2016). As Kumas-Tan, Beagan, Loppie, MacLeod, & Frank (2007) and Lin, Lee, and Huang (2016) have found, the most robustly validated cultural competence measures have emphasized the knowledge and skills domains of the competence enterprise and do not necessarily assess providers' capacity to translate cultural knowledge and skills into meaningful relationships (Kumas-Tan, et al., 2007; Lin, Lee, & Huang, 2016). These existing competence measures are founded on a set of dubious assumptions that relate directly to the problematic nature of the competence construct; among these assumptions are that incompetence is only a function of insufficient contact with the 'other' and that competence is merely a function of confidence and comfort (Kumas-Tan et al., 2007).

Related to this assumption regarding comfort and confidence is the question of how to interpret competence measures once administered. There is emerging evidence suggesting that a true increased capacity to handle intercultural interactions is not associated with an increase in but rather a *reduction* in one's self-rated cultural competence; indeed, learning how much one does not know, and therefore assessing oneself as *less* knowledgeable, may be a better statistical indicator of successful intercultural work (Isaacson, 2014; Kumas-Tan et al., 2007). Confidence, the construct necessary to rate oneself highly, might be aligned with competence but it is conceptually and statistically at odds with humility.

An important future direction for this field is to discern not how to increase competence but whether or not increases in operationalized self-reported competence relate to strong client-rated working alliances and outcomes. Successful therapeutic relationships might actually be associated with a permanent decrease in provider self-reported competence; more likely, however, this relationship is parabolic: providers initially rate themselves with optimistic confidence, confront their lack of knowledge, rate themselves with more critical humility, slowly develop a seasoned appreciation for the work, and later rate themselves highly and realistically on the items whose meanings have deepened for them.

As such, clinic administrators ought to implement thoughtful client-feedback mechanisms that leverage advances in humility measurement such as the Cultural Humility Scale (CHS; Hook et al., 2013); I have included this citation in the additional resources table so that clinic administrators have access to the resources necessary to enact this evaluation mechanism. Nonetheless, evaluating participants' humility remains a critical part of program evaluation for the training itself. Humility researchers recommend that future measures incorporate physiological, behavioral, and cognitive operationalizations of the humility construct

(Davis et al., 2011). This recommendation is well suited to my training approach that emphasizes self-reflection at, particularly, the physiological level. Furthering our understanding of humility—its character and its measurement—is also an important future direction.

Representation. The reviewers also commented that this training can be improved by increasing the number of Iraqi voices that speak through it. Incorporating excerpts from autobiographies, survivor statements, interviews, web videos, and poetry into the module scripts will undeniably enrich the quality and depth of the content. What I noticed as I have reviewed these sources is my own reluctance to choose among them—how does one decide which voices are most valuable? What I hope is that in the hypothetical future, when I am facilitating the training, I am nimble enough in my store of Iraqi sources that I can pull fluidly from them as they are relevant. This program will always be progressing toward a greater degree of cultural sensitivity and depth just as are we as individuals.

Readiness. People do not always want to grow. The success of this training is dependent upon enticing participants into the process; several reviewers noted the importance of participant investment and how critical pre-training conversations are to the trajectory of the training. There are several checks on this probability (i.e., the needs assessment, organization cultural competence assessment). Even still, it is possible that one or more participants will enter the training unwilling to explore the impact they as *selves* have on their patients. This will be managed in a case-by-case manner but it will be made clear to clinic administrators that work with refugees cannot be done by professionals with contempt for them (Pipher, 2002; Van der Veer & van Waning, 2004). Refugee work, more than much work done by mental health professionals, exposes individuals' political and sociological attitudes and beliefs. It is understandable that providers may feel afraid that they will do something wrong or say

something that separates them from their colleagues, but some attitudes and beliefs are incompatible with refugee service provision and must be confronted.

Facilitation. This program requires a facilitator willing to give deeply of herself. Although I have made choices in the program development process to allow for the possibility that someday this training could be offered by a facilitator other than myself, the scripts have been written in my voice. Although scientific writing is traditionally dispassionate, I painstakingly strove to avoid dispassion (Herman, 1997; Pipher, 2002). Providers must be inspired to do this work. In the module scripts, I intended to translate evidence-based methods and content into a warm, transformative, safe, and inspiring experience for participants:

> We give shape to this journey not only with the methodologies we choose and create but also with our presence….we have become facile in speaking about the importance of self-reflection, about becoming comfortable with ambiguity, about the importance of flexibility, or adapting communication styles. However, these capacities can easily remain conceptual or relegated to a 'nice to know but soon forgotten' to-do list unless connected with heart and spirit. In working to bring this connection to life in our counseling sessions or training program, we are continually called on to manage our own state of being, to work with our own responses to difference and change, and to access the heights of our own creative abilities. Our work is grounded in the very essence of what we are trying to help others bring forth. (Ramsey, 1996, p. 22)

These scripts were drafted in service of conveying the "heart and spirit" that is lacking in a mere description of the curriculum. Are the scripts generalizable? While it may be difficult for another facilitator to adopt them wholesale, my hope is that I have modeled levels of vulnerability, transparency, and sensitivity that are prerequisite conditions for change. Beyond that, future

facilitators are encouraged to leverage the process I have designed here and to find their own voices.

Uncertainty, Hope, and the Future

Finding one's voice in world affairs, particularly if it is a voice of temperance and complexity, is not an easy task in the technologically connected world we have created and in an era of significant global upheaval and terrorism. Even when one finds words to speak out, it is hard to predict how what is spoken will be interpreted and who it might reach. In our global media landscape, the incendiary voices are those that get heard—not regardless of but *because of* how extreme they are. The credibility of our global narratives rests on our conflation of decibels with truth. Of what can we be certain?

In describing the tension between hope and despair, Mollica (2006) asserted, "…this fundamental decision to live is made daily" (Mollica, 2009, p. 158). The decision to live—making a commitment to existence—is a decision to hold a stake in the future, the details of which none of us can know. *To exist is to be uncertain*. But the security of certainty renders despair a formidable temptation (Solnit, 2016); Refugees who have made it as far as resettlement have renewed their commitment to living thousands of times just by rising each morning (Pipher, 2002). Without embracing uncertainty we cannot embrace hope:

> Hope locates itself in the premises that we don't know what will happen and that in the spaciousness of that uncertainty is room to act. When you recognize uncertainty, you recognize that you may be able to influence the outcomes—you alone or you in concert with a few dozen or several million others. Hope is an embrace of the unknown and the unknowable…the belief that what we do matters even though how and when it may

matter, who and what it may impact, are not things we can know beforehand. (Solnit,

2016)

Employing intentionality in our uncertainty enables us to have agency in shaping our futures and

allows us to form life-giving relationships. Earlier in this document, I discussed that we cannot

be said to have achieved justice in the absence of wellness. We also know that wellness is

predicated on human relationships—on connectedness (Herman, 1997; Miller & Stiver, 1997;

Mollica, 2009; Schore, 2012; Siegel, 2010, 2012; van der Kolk, 2014). The stronger our

relationships, the more likely we will thrive. Human beings crave being seen and known.

Tariq Alziadi, one of the Iraqi refugees I consulted in this process, was wistful in his

desire to return to Iraq: "I was recently honestly thinking of going back home, like just to stay

over there again, to be close to my friends over there. Home is friends, family. We don't care

about if it's hot, if there's no power. But I would like to see. I would like to smile again from my

heart" (T. Alziadi, 2016, personal communication). Being at home means being surrounded by

the ones who know our stories—and our histories—and being able to 'smile again from our

hearts'. Although the vision of a world in which every person would have a place of belonging is

an aspiration for the macrosystem, this program's entry toward global justice is in the

microsystem—me with you. This work is possible when we know our own idiosyncratic

intrapsychic processes that prevent us from true presence and witnessing.

Himself. The *person* of the therapist is the converting catalyst, not his order or credo, not

his spatial location in the room, not his exquisitely chosen works or denominational

silences. So long as the rules of a therapeutic system do not hinder limbic

transmission—a critical caveat—they remain inconsequential, neocortical distractions.

The dispensable trappings of dogma may determine what a therapist *thinks* he is doing,

what he talks about when he talks about therapy, but the agent of change is who he

is....The person of the therapist will determine the shape of the new world a patient is

bound for…Thus, the urgent necessity for a therapist to get his emotional house in order.

His patients are coming to stay, and they may have to live there for the rest of their lives.

(Lewis et al., 2000, p. 187)

In an ideal world, no provider would do any professional work without an ongoing commitment

to personal work. We must bring ourselves nimbly and open-heartedly to those that sit across

from us, but plenty of therapies move forward with just sufficient momentum that neither the

patient nor provider notice unnecessary fits and starts. Intercultural work, however, illuminates a

provider's limited range. We all bristle to difference—that our first reaction is fight or flight is

acceptable insofar as our second reaction is fellowship (Pipher, 2002).

At the time of writing, the political climate in the United States is volatile. Racism,

sexism, homophobia, Islamophobia, and xenophobia are being expressed openly and without

compunction. These are not humble times. So the quest to facilitate humility is at once timely

and anachronistic. It is difficult to imagine clearer demonstrations of extremism in periods of

uncertainty than these months of this U.S. presidential election. Ironically, yet consistent with the

literature, the collective desire to rescue ourselves from uncertainty propels us not only into

reaffirming extreme and unfounded opinions, but into profound states of willful ignorance, that

actually maintain the *not knowing* we fear.

As Guus Van der Veer and van Waning (2004) explain, the capacity for hope in the lives

of refugees and those who devote their lives to supporting them requires transcendent acts of

imagination:

A change in attitude is not brought about by the provision of still more standardized learning packages or training modules. It is the result of a personal process of development. Working with refugees in essence is not different from working with other people with complex problems, and that applies as well for the attitude described. Still there are a number of caveats. Working with refugees requires that the therapist cooperate with seriously traumatized persons who lost their trusted cultural context and who have to find a new balance in a society in which they are marginalized. The helper will be a more truthful therapist when he or she is aware that there can be little imagination of that which cannot be imagined, what we people afflict on each other, and what we still have to give to the client. A more effective therapist can also allow himself or herself to be surprised by the uncommon ways of coping originating in a different culture. Therapy with refugees is not only about the there and then but certainly also about us here and now as we could have been them. (p. 214)

Assuming the role of a refugee, even for a few minutes, is not fun, is not easy, is not actually even completely possible, and so, leaves us to react with any number of defenses to the thing that feels insurmountable. It is this very incomprehensibleness that to me, with all of my own biases, renders the question of whether we are to support refugees both asked and answered: *my humanity depends on my recognition of the humanity of others*. When those others are quite "other"—when they speak a different language, believe different beliefs, make decisions I would not make, choose words and actions that leave me enraged or despairing—*it is humility* and imagination that enable me to span an otherwise vast expanse between us. If our job as providers is to recognize another—to *see*—then our challenge as providers is to find what it is in us that blinds.

Afterword: Cultural Self-Reflection

It would be antithetical to the concept of cultural humility to conceptualize me as outside the systems that have enabled the development of this training, separate from the processes of a clinic that eventually hosts the training, or disconnected from the global humanitarian cause. I am a person with a history, a perspective, and professional power.

In this process, I have experienced recurrent themes in myself—tensions, fears, frustrations. I began this project as a third-year practicum student who was uncertain of her professional worth and her capacity for making meaningful contributions to her professional team— a team that, unexpectedly that year, faced the challenge of working with refugees for the first time. It is not my default to speak loudly, to act quickly, to advocate readily in groups of people; I am less likely still to do this when surrounded by professional superiors. But, my involvement in this work began when I sat among my colleagues in a staff meeting consumed by clamor about Iraqi clients and, unusually, I felt compelled to speak.

The uncertainty that filled that conference room was palpable. These clinicians, from whom I had learned much, were frustrated and overwhelmed by demands of care. Iraqi refugee families had moved into the community and though providers held multicultural values in theory, these had rarely been tested in practice. We were all lost. As I listened, I recalled experiences I had a few months earlier when sitting with patients at an NGO in Haiti. How easy it is to feel insufficient and bewildered in the context of such despair! In this staff meeting, my colleagues seemed to raise the same question I remembered having: *what good can possibly I do?* Clinicians were frustrated; so too were they afraid. Speaking gently, I said, "I remember feeling so self-conscious when I was in Haiti. What if I said the wrong thing? It sounds to me like we are all afraid to blunder. What if we talked about that for awhile?"

They hesitated, but the tone moved briefly from emerging resentment to compassionate vulnerability. In shifting out of answer-seeking to self-reflection, I think we moved toward cultural humility, though I did not have a name for it then. The gentle invitation to introspect enabled us to explore deeply emotional undercurrents of formidable clinical demands—reflection so essential to accompanying a person in the process of healing. Bustling clinics, though, may not foster space for such professional vulnerability; indeed, clinicians returned to their resentful stances by the time they reached the hallway. How could we cultivate in ourselves the receptivity and reflexivity imperative to cross-cultural work? What good can *I* do? I think I saw enormous potential for all of us in that moment, so there have been some disillusioning events as I have worked on this project since then.

My work has coincided with the worst months of the Syrian refugee crisis and multiple global attacks by ISIS. So, the disdain for refugees I encountered in my neighborhoods and newsfeeds juxtaposed with real-time humanitarian crises merely an ocean away ignited a rage in me that was difficult to negotiate internally. During this time, I also received the results of the needs assessment in which my former colleagues, who by that point had been working with refugees for over a year, reported ongoing feelings of frustration and defeat. I understood our exhaustion—our uncertainty—but my compassion for our professional bewilderment felt at times at odds with my sense of urgency for the issues: patience first requires acceptance, which does not comes easily in the domain of global suffering. How do we accept that which is unacceptable?

This is the question we face regardless of where we stand in the human quagmire that is international resettlement. As I have acquainted my mind and aligned my heart with the

confusing human space between citizenship, I've noticed myself loosening grip on my Americanness. My nationality feels so arbitrary in the human lottery.

But I am also the product of my own childhood world—which, for me means that deciding to be or not to be a patriot is about more than negotiating heady ideas or making choices about how to vote. It requires reorganizing my relationships, both real and internalized, with my beloved family whose ancestors fought in the revolution and in most major American wars since. At some point in the weaving of our family story, the ocean-crossing fell away. Ours hasn't been a narrative about immigration—at least not for the several generations of storytellers I've had the joy of loving—but a narrative of bona fide, unquestioned belonging. We have always been free and brave.

I have had many conversations in the course of this project. Some of them with the real people in front of me. Some of them with the real people who have written things I've read. These conversations have been valuable and inspiring—indeed, there is no writing more stunning than that by scientists impassioned by human rights! But I have also been tentatively—tectonically—conversing with the real people who live inside these family stories I carry. In the quiet under this project, I have been tending what now feel sometimes like tenuous threads to my beloved patriotic grandparents and therein to the generations of patriots preceding them. For me, the deeply emotional undercurrents of these formidable clinical demands are situated in contentions about American righteousness: that which is real, that which is perceived, and that which is required now. I think the name of this fitfulness is shame.

In what was perhaps the most meaningful of the conversations I've had about this project, Tariq Alziadi, an Iraqi refugee, and I were discussing ignorance. I commented about the weaknesses of U.S. education for preparing people to know about the world. I was impatient and

wished things were different. With open-heartedness and attunement to me, Tariq replied,

"Megan, you did a great job. But also you do not need to deal with shame. You know why?

Because you don't have enough time…" (T. Alziadi, August 16th, 2016, personal

communication)

It is a privilege, I know, that some fantastic act of imagination can relinquish me of my

Americanness for a few minutes—and a greater privilege still that a sort of national non-

attachment fantasy would feel good at all. I realize that there are people in the world for whom

the United States remains a beacon. How American it is of me to fantasize about throwing it all

away. And whether or not I like my Americanness is moot. Tariq is right. There is no time for

shame in the global list of work there is left to do. And so I have been watching my heart, and

my emotional undercurrents, and making choices about what particular contributions I'll be

situated to make. At the very least, to this project, I have brought my whole self. And I want to

be able to do that as often as possible going forward.

Bringing my whole self to a place means bringing my Americanness with me—the

smallness and the largeness of it. I've noticed that training frustrated providers or conversing

with contemptuous neighbors requires me to reorient my body, my mind, and my heart away

from the global refugee crisis to the human being in front of me. I plainly have ideals and

convictions about the responsibilities of our nationality but in tough moments, I have worked to

protect my interactions from being consumed by the urgency of the work I think is inherent to

our Americanness. In rage, it is helpful to breathe.

We have a lot of hate in this world. I don't know exactly how to tinker with a person's hate

structures but it feels like the first step at least is to allow them to feel fully witnessed and

warmly loved—even in our profound disagreements. This is the hardest of the hard efforts. To

understand a violent power-hungry despot a few continents away is challenging, but sitting with American disdain is excruciating. If my convictions are what feed my rage in difficult interactions, humility is what allows me to persist through them into compassionate joining. I know that people care more about how much I care than about how much I know.

So this is what I have been doing. Caring a lot. And noticing where in my body my rage lives. And where in my heart and mind my shame lives. I've been getting to know them inviting them to arrive with me at my desk, to be with me in the reading and writing. But it hasn't just been rage and shame that have fueled me. My heart swells for refugees. And I have deeply loved people who have deeply loved this country. So even in complexities, love abounds. I think Tariq captured this all so beautifully:

> I'm not saying to you I'm a perfect guy. Nobody is perfect. This is the truth. We are not like gods or nothing. But thanks God that I don't have that emotion to be on one side against another side. God gives a brain to everyone. So the people, they need to think with their brain, not just taking things that are not true and believing them. You have the tools. You have your brain to learn more, to understand more. I tell my clients, all my clients. And thanks God I have friends that are Sunni, Shia, Christian. I don't have any problem with them. I tell my friends, 'Just don't be sensitive. Don't be placing a judgment on things very quick or just from how they say it in English, like the title of a book. Read the book'. (T. Alziadi, August 16th, 2016, personal communication)

Tariq closed this comment with an apt commitment: "So," he said, "I will keep reading."

I nodded back to him: Indeed, Tariq, so will I.

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Appendices

Appendix A

Table A1

Application of Literature Review to Program Development

Aspects of Program Design	Search Terms	Application to Program Design
Conceptual Framework	Bronfenbrener's Ecological Model, macrosystem, social justice, microsystem, biopsychosocial	Training Structure Training Content
Population	refugee services, Iraqi refugees, asylum-seekers, war trauma, PTSD, resettlement, Islam, Middle East, Iraq, Muslim	Training Content
Target Audience	community mental health, clinical social work, rural mental health, behavioral health centers,	Training Structure Training Content
Goals	cultural competence, cultural humility, cultural safety, cross-cultural therapy, cross-linguistic therapy, acculturation, professional development, knowledge, skills, attitudes, self-awareness, evidence-based practice	Training Structure Training Content
Method	Comprehensive Program Development Model, program evaluation, workshop design, training effectiveness, practice-based evidence, logic model, pre-intervention and post-intervention evaluation	Program Design Process Program Evaluation Plan

-- (Bronfenbrenner, 2005; Calley, 2011)

Table A2

Comprehensive Program Development Model Execution

Steps	Deliverable
PHASE I	
Step 1 Establish need for programming Develop rationale	**Step 1** Extensive literature review with summary in program materials Quantitative/qualitative needs assessment of case example clinic. Results included in appendix
Step 2 Establish research basis for program design	**Step 2** Reviewed existing programs Summarized in manuscript
Step 3 Address cultural identity issues in program design	**Step 3** Developed organizational cultural assessment. Reflected on personal process Summarized in manuscript and appendix
Step 4 Design the clinical program	**Step 4** Developed mission/vision statements Developed logic models Described in manuscript and appendix
Step 5 Develop the infrastructure	**Step 5** Developed curriculum and agenda Drafted all necessary materials Described in manuscript and appendix
Step 6-8 Develop staffing infrastructure Identify and engage community resources Identify and engage potential	**Step 6-8** Discussed resources Summarized in manuscript

funding sources

Step 9
Develop the proposal

Step 9
Consulted experts and make changes
Summarized in manuscript and
appendix

PHASE II

Step 10
Implement the program

Step 10
Developed implementation plan
Described in manuscript and
appendix

Step 11
Evaluate the program

Step 11
Developed evaluation plan with
sample measures, timeline, and
questions
Summarized in manuscripts and
appendix

Step 12
Build and preserve
community resources

Step 12
Discussed local/global community
resources
Identified target networking

Step 13
Develop an advocacy plan

Step 13
Discussed advocacy avenues in
manuscript

Step 14
Develop an information
sharing plan

Step 14
Discussed audiences
Developed information sharing plan
Summarized in manuscript

Step 15
Attain program and
organizational accreditation

Step 15
Discussed professional validation
avenues in manuscript

-- (Calley, 2011)

Appendix B

Table B1

Step 1—Informed Consent for Case Example Clinic Needs Assessment

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A Survey of Experiences With Iraqi Refugee Patients

Principal Investigator: Megan Brunmier Marsh, M.S., Antioch University New England
Faculty Advisor: Roger Peterson, PhD, ABPP, Antioch University New England

Dear Participant,

Megan Brunmier Marsh, M.S., invites you to participate in a brief, online survey about your preliminary experiences working with Iraqi refugee patients. This survey will take approximately 15 minutes to complete. In order to participate, you must be at least 18 years old and an employee of a community mental health center. You also must have encountered Iraqi refugees as part of your work.

Description of Project

This survey is designed to help the principal investigator understand the needs of service providers when they are working with Iraqi refugees for the first time. This survey one part of a research project. Results from this survey will be used to inform the design of a training program for mental health professionals who conduct work with Iraqi refugees.

Description of Participant Involvement

If you agree to complete this survey, you will be asked to consider your first few experiences of working with Iraqi refugees. The survey includes questions about the type/quality of support you received from your organization. You will also be asked about your personal reactions to working with people from a different culture.

Benefits and Risks

There are no direct incentives for completing this survey. This study will contribute to general knowledge about the needs of mental health providers adjusting to Iraqi refugee service provision. The results of this survey may be used to inform employee training and support practices at your agency. There are no foreseeable risks from participation that are greater than one would encounter in daily life.

Confidentiality

Your responses to this survey will be anonymous. The principal investigator will not ask for your name or other information that would reveal your identity. Your responses will also be kept confidential. All results from this survey will be reported in a manner that no person may identify the responses of individual participants.

Voluntary Participation

Participating in this survey is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time by closing your browser window. If you choose to stop taking the survey, your responses will not be recorded. There is no penalty for choosing not to submit your responses.

Contact Information

If you have questions about this research, you may contact Megan Brunmier Marsh, M.S., principal investigator and doctoral candidate in Clinical Psychology [contact information].

If you have questions about your rights as a research participant, or wish to obtain information, ask questions or discuss any concerns about this study with someone other than the researcher(s), please contact [Name], Chair of the Antioch University New England Institutional Review Board, [contact information].

If you complete this survey, it means that you have read (or have had read to you) the information contained in this letter, and would like to be a volunteer in this research study.

Thank you,

Megan Brunmier Marsh, M.S.

_____

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Table B2

Step 1 Materials—Quantitative/Qualitative Retrospective Needs Assessment of Case Example Clinic

Assessment Targets/Prompts	Responses			

Prior Experience
Directions: "*Please answer each question by choosing the response that best completes each sentence. These questions assess your experience prior to your first Iraqi refugee patient.*"

1. Prior to my first Iraqi refugee patient, I _____ worked with individuals of a different race/ethnicity than myself.	*Never*	*Rarely*	*Occasionally*	*Frequently*
2. Prior to my first Iraqi refugee patient, I _____ worked with individuals of a different nationality than myself.	*Never*	*Rarely*	*Occasionally*	*Frequently*
3. Prior to my first Iraqi refugee patient, I _____ worked with individuals culturally different than myself.	*Never*	*Rarely*	*Occasionally*	*Frequently*
4. Prior to my first Iraqi refugee patient, I _____ worked with refugees.	*Never*	*Rarely*	*Occasionally*	*Frequently*
5. Prior to my first Iraqi refugee patient, I _____ conducted my work through a spoken language interpreter (i.e., not an American Sign Language interpreter).	*Never*	*Rarely*	*Occasionally*	*Frequently*

Readiness

Directions: "*Please answer each question by choosing the response that best describes your experience in the first two months working with Iraqi refugee(s).*"

6. In the first two months of working with Iraqi refugees, I felt prepared to meet their needs.	*Never*	*Occasionally*	*Often*	*Almost always*
7. In the first two months of working with Iraqi refugees, I felt prepared to engage with patients through an Arabic interpreter.	*Never*	*Occasionally*	*Often*	*Almost always*
8. In the first two months of working with Iraqi refugees, I felt comfortable conceptualizing my Iraqi patients' situations.	*Never*	*Occasionally*	*Often*	*Almost always*
9. In the first two months of working with Iraqi refugees, I felt supported by my colleagues.	*Never*	*Occasionally*	*Often*	*Almost always*
10. In the first two months of working with Iraqi refugees, I felt supported by my superiors.	*Never*	*Occasionally*	*Often*	*Almost always*
11. In the first two months of working with Iraqi refugees, I felt my agency could have done more to support me.*	*Never*	*Occasionally*	*Often*	*Almost always*
12. In the first two months of working with Iraqi refugees, I understood the cultural issues relevant to my patients.	*Never*	*Occasionally*	*Often*	*Almost always*
13. In the first two months of working with Iraqi refugees, I felt I could easily assess my patients' risk and protective factors.	*Never*	*Occasionally*	*Often*	*Almost always*
14. In the first two months of working with Iraqi refugees, developing meaningful working alliances with my Iraqi patients came easily.	*Never*	*Occasionally*	*Often*	*Almost always*

Cultural Competence and Humility

Directions: "*Please respond to each item by choosing the response that best describes your approach to diversity.*"

<u>*Attitudes and Beliefs*</u>

15. I can easily describe my own ethnic, racial, and cultural identities.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
16. I prize and celebrate human difference.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
17. In my work with cultural minorities/immigrants, I consider how my own cultural identity impacts my patients.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
18. With patients who are significantly different from me, I discuss our cultural differences.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
19. The more I work with cultural minorities/immigrants, the more I enjoy it.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
20. I notice how my mind and body reacts to patients whose worldview is significantly different from my own.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
21. I hold attitudes or beliefs about different cultures or worldviews that are unfair to my patients.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
22. Sometimes my biases impact my work with people significantly different from myself.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
23. I consider how the religious/spiritual beliefs of culturally different patients may be sources of resilience.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*

24. I value the indigenous or culturally-derived healing practices of my patients and strive to understand how shape health and well-being.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
25. I monitor the ways I may use language differently than my patients and value how their language shapes their worldview.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*

Knowledge

26. My culture impacts my definition of well-being.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
27. My language and use of non-verbal communication impacts my work with patients.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
28. Some of the assumptions I make about others come from the way I was raised.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
29. In my professional life, I seek to learn new things about the cultural, socio-political history, worldview, religion, traditions, and sexuality of patients different from myself.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
30. I remember that patients are individuals and avoid automatically attributing their beliefs and behaviors to their culture.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
31. I am open to the ways in which the evidence-based practices I employ may be culturally inconsistent with the worldviews of my patients.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
32. When working with cultural minorities/immigrants, I account for institutional, political, and societal barriers to well-being by thinking systemically.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*

Skills

33. I pursue continuing education related to cross-cultural services.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
34. In my social life, I seek opportunities for learning about cultures different from myself.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
35. I advocate for non-discriminatory practices in my personal and professional communities.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
36. I stay current on research pertaining to my cultural minority patients and their presenting complaints.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
37. In my social life, I feel comfortable engaging with cultural minorities/ immigrants in informal settings.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
38. I value communicating with my clients through spoken language interpreters.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
39. I endeavor to reduce bias in my work by using culturally appropriate assessment tools.	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*

40. Please comment about your experiences in the first two months of working with Iraqi refugees. Consider what you learned, what was helpful, and what support your wished for.

--Questions developed based on the Multicultural Counseling Competencies (Arredondo, 2003).
*Item is reversed scored.

Table B3

Step 1—Needs Assessment Quantitative Results by Question

Assessment Targets/Prompts	Responses *(number of respondents/percentage of sample)*			

Prior Experience
Directions: "*Please answer each question by choosing the response that best completes each sentence. These questions assess your experience prior to your first Iraqi refugee patient.*"

	Never	*Rarely*	*Occasionally*	*Frequently*
1. Prior to my first Iraqi refugee patient, I _____ worked with individuals of a different race/ethnicity than myself.	*0/0*	*6/35.3%*	*8/47%*	*3/17.7%*
2. Prior to my first Iraqi refugee patient, I _____ worked with individuals of a different nationality than myself.	*0/0*	*0/0*	*12/70.6%*	*5/29.4%*
3. Prior to my first Iraqi refugee patient, I _____ worked with individuals culturally different than myself.	*0/0*	*4/23.5%*	*7/4128%*	*6/35.3%*
4. Prior to my first Iraqi refugee patient, I _____ worked with refugees.	*9/52.9%*	*3/17.7%*	*4/23.5%*	*1/5.89%*
5. Prior to my first Iraqi refugee patient, I _____ conducted my work through a spoken language interpreter (i.e., not an American Sign Language interpreter).	*8/47.1%*	*4/23.5%*	*5/29.4%*	*0/0*

Readiness

Directions: "*Please answer each question by choosing the response that best describes your experience in the first two months working with Iraqi refugee(s)."*

	Never	Occasionally	Often	Almost always
6. In the first two months of working with Iraqi refugees, I felt prepared to meet their needs.	4/23.5%	10/58.8%	2/11.8%	1/5.9%
7. In the first two months of working with Iraqi refugees, I felt prepared to engage with patients through an Arabic interpreter.	3/17.7%	6/35.3%	5/29.4%	3/17.7%
8. In the first two months of working with Iraqi refugees, I felt comfortable conceptualizing my Iraqi patients' situations.	4/23.5%	8/47.1%	3/17.7%	2/11.8%
9. In the first two months of working with Iraqi refugees, I felt supported by my colleagues.	0/0	6/35.3%	5/24.4%	6/35.3%
10. In the first two months of working with Iraqi refugees, I felt supported by my superiors.	2/11.8%	2/11.8%	8/47.1%	5/24.4%
11. In the first two months of working with Iraqi refugees, I felt my agency could have done more to support me.*	6/35.3%	6/35.3%	2/11.8%	3/17.7%
12. In the first two months of working with Iraqi refugees, I understood the cultural issues relevant to my patients.	2/11.8%	9/52.9%	6/35.3%	0/0
13. In the first two months of working with Iraqi refugees, I felt I could easily assess my patients' risk and protective factors.	2/11.76%	12/70.59%	1/5.88%	2/11.76%
14. In the first two months of working with Iraqi refugees, developing meaningful working alliances with my Iraqi patients came easily.	7/41.2%	6/35.3%	2/11.8%	2/11.8%

Cultural Competence and Humility

Directions: "*Please respond to each item by choosing the response that best describes your approach to diversity.*"	*Definitely not true*	*Rarely true*	*Probably/Usually true*	*Definitely true*
Attitudes and Beliefs				
15. I can easily describe my own ethnic, racial, and cultural identities.	0/0	0/0	8/47.1%	9/52.9%
16. I prize and celebrate human difference.	0/0	0/0	5/24.4%	12/70.6%
17. In my work with cultural minorities/immigrants, I consider how my own cultural identity impacts my patients.	0/0	0/0	14/82.4%	3/17.7%
18. With patients who are significantly different from me, I discuss our cultural differences.	6/35.3%	5/24.4%	5/24.4%	1/5.9%
19. The more I work with cultural minorities/immigrants, the more I enjoy it.	2/11.8%	3/17.7%	7/41.2%	5/24.4%
20. I notice how my mind and body reacts to patients whose worldview is significantly different from my own.	2/11.8%	3/17.7%	8/47.1%	4/23.5%
21. I hold attitudes or beliefs about different cultures or worldviews that are unfair to my patients.	10/58.8%	4/23.5%	3/17.7%	0/0
22. Sometimes my biases impact my work with people significantly different from myself.	7/41.2%	8/47.1%	2/11.8%	0/0
23. I consider how the religious/spiritual beliefs of culturally different patients may be sources of resilience.	0/0	1/5.9%	9/52.9%	7/41.2%

24. I value the indigenous or culturally-derived healing practices of my patients and strive to understand how shape health and well-being. *1/5.9%* *0/0* *11/64.7%* *5/24.4%*

25. I monitor the ways I may use language differently than my patients and value how their language shapes their worldview. *1/5.9%* *2/11.8%* *9/52.9%* *5/24.4%*

Knowledge

26. My culture impacts my definition of well-being. *0/0* *1/5.9%* *10/58.8%* *6/35.3%*

27. My language and use of non-verbal communication impacts my work with patients. *0/0* *2/11.8%* *7/41.2%* *8/47.1%*

28. Some of the assumptions I make about others come from the way I was raised. *2/11.8%* *3/17.7%* *9/52.9%* *3/17.7%*

29. In my professional life, I seek to learn new things about the cultural, socio-political history, worldview, religion, traditions, and sexuality of patients different from myself. *0/0* *1/5.9%* *6/35.3%* *10/58.8%*

30. I remember that patients are individuals and avoid automatically attributing their beliefs and behaviors to their culture. *2/11.8%* *1/5.9%* *9/52.9%* *5/24.4%*

31. I am open to the ways in which the evidence-based practices I employ may be culturally inconsistent with the worldviews of my patients. *0/0* *2/11.8%* *10/58.8%* *5/24.4%*

32. When working with cultural minorities/immigrants, I account for institutional, political, and societal barriers to well-being by thinking systemically. *0/0* *3/17.7%* *11/64.7%* *3/17.7%*

Skills

33. I pursue continuing education related to cross-cultural services.	3/17.7%	7/41.2%	2/11.8%	5/24.4%
34. In my social life, I seek opportunities for learning about cultures different from myself.	0/0	6/35.3%	4/23.5%	7/41.2%
35. I advocate for non-discriminatory practices in my personal and professional communities.	1/5.9%	2/11.8%	6/35.3%	7/41.2%
36. I stay current on research pertaining to my cultural minority patients and their presenting complaints.	2/11.8%	7/41.2%	3/17.7%	4/23.5%
37. In my social life, I feel comfortable engaging with cultural minorities/ immigrants in informal settings.	1/5.9%	3/17.7%	3/17.7%	9/52.9%
38. I value communicating with my clients through spoken language interpreters.	1/5.9%	1/5.9%	6/35.3%	8/47.1%
39. I endeavor to reduce bias in my work by using culturally appropriate assessment tools.	1/5.9%	3/17.7%	6/35.2%	7/41.2%
40. Please comment about your experiences in the first two months of working with Iraqi refugees. Consider what you learned, what was helpful, and what support your wished for.	For free response results see Table _____.			

--Questions developed based on the Multicultural Counseling Competencies (Arrendondo, 2003).

*Item is reversed scored.

Table B4

Step 1—Needs Assessment Qualitative Results by Respondent

Respondent	Verbatim Response
1	"To begin my work with Iraqi refugees, I wish I had more information on cultural practices. I meet the family in a room with no furniture and the family brings a chair for me to sit in while they sit on the floor. I have also noted that each family member removes their shoes before entering the room. It would be helpful to know if it is the practice of only males, or if females should also remove their shoes. It would be helpful to know the little details before entering a family home, so as to not offend."
2	"I found that the expectations were much more than our systems were designed to provide, limits of what can be offered were not completely understood. I was shock to hear that racism and their own cultural differences caused riffs between separate groups."
3	"It would have been helpful to understand the male/female roles. Also the cultural expectations. I offended my client by refusing food and the interpreter had to explain. A good interpreter can make or break a relationship with non-English speaking clients. First two months were very good, then client became more and more demanding of EXPECTED services and benefits from living in the U.S. (not wanting or willing to work towards)"
4	"At the end of most encounters with this uninvited minority, the final question is what more can we do to help them advance their panhandling agenda."
5	"I have come to believe that complex problems, at times, require complex, or at least well coordinated, solutions. Some of my patients have had their treatment further complicated by seeking additional consultation and by assisting me to establish clear boundaries with the translator in question, and by offering multiple translation service alternatives. With that said, there are numerous resource limitations that require macro-level assessment, funding, and interventions that will enable us to provide adequate care to a highly vulnerable population. I recommend the following: (1) Grant funding and/or immigration funding to support additional clinical and administrative needs related to health care barriers (2) Monthly meetings with Catholic Charities and other agencies that have taken point on serving our refugee population (3) Closer examination of potential peer supports (4) A closer alliance with local institutions of higher learning—to establish sustained educational training and including the development of efficacy evaluation (5) a multidisciplinary [clinic] team to assist with established protocol development."
6	"More information about cultural views specific to psychiatric illness and care would be very useful."

7   "I learned that compassion and concerns about family are universal. Although I have not experienced the trauma they have, I can offer empathy, and this is appreciated. I understand it takes time to adjust to our culture. They have been open answering questions about their culture. We have discussed the Muslim history, 5 pillars, Ramadan, and I have learned so much from my patients. I did my own research to learn more. I did not feel the need to get additional support from my organization."

8   "It's so sad that some Americans think anyone from Iraq is a terrorist. I have worked with two clients from Iraq and have gotten to know them and their families. They are no different then myself or people I have known all my life. They are compassionate, love their families and friends, have a great sense of humor, have fears and dreams like the rest of us. I great appreciate the interpreters I have worked with and the patience and respect my Iraqi clients have received from providers in the community."

9   "The first two months I felt like I was under water sometimes with all I needed to learn and practice. I found significant help from a friend outside the agency to start the self education process and help lead some education process in the clinical group. I know that we are always learning on the job and that the surprise of needing to Learn so quickly was stressful. It would have been more helpful to get some policies in place for Arabic translation services and more learning experiences with training components. By the time we received some training, I was already making gains, which was satisfying, but the wish we could have received it soon will probably be a regret thoughts for some time."

10   "It was and continues to be a struggle given the limitations of the language barrier. Some are NOT interested in learning the culture/language/etc. of where they are now a part of. The agency does it's best to get interpreters, but then they will turn them away and want to use their "own", Or wanting to do it over the phone, which brings to light a whole new barrier for all involved in their care. Now there isn't body language to add to the mix. Care providers can not do and be all when it seems one-sided in that care givers are making adjustments/education/changes, and the recipients are not.This is not all, but a good portion. The problem with serveys, as they are tilted in the Questions. #18 was confusing as is #21. As far as gaining education into these issues. I have not seem any to take, or I definitely would. Maybe company wide, they could get this for us, as in the community and professional sector, I have not run across any."

11   "I enjoy learning new cultures, I have worked with several different cultures, and have been educated by many which has been a huge learning tool. I have researched on my own time to retrieve more info on the tools that have been given to me so I can better provide the quality of care that is needed."

12   "More freeloaders who wish to circumvent the rules other immigrants had to endure."

13   "I wanted and volunteered for this experience. Unfortunately, I found that the agency was not prepared ahead of time to support me in the way that I needed or wanted. I also had a very difficult case and did not feel the experience was successful for my client or myself and felt it was due to systemic barriers, not clinical ones. I think the

interpreter situation was confusing and difficult to arrange as well as confusing regarding confidentiality because I did not have the same person each session. I appreciate you doing this research and helping clinicians and supervisiors to further their understanding of this important work as well as to help agencies prepare AHEAD of time, not having to find themselves or us in a situation of reacting instead which added to the stress of the work. Thank you for this opportunity."

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Table B5

Step 1—Needs Assessment Quantitative Raw Scores and Qualitative Comments by Individual Respondent

Respondent	Results		Total	
#1	Prior Experience	9	Raw Score	93
	Readiness	21		
	Attitudes	30		
	Knowledge	21		
	Skills	12		

Qualitative Response
"To begin my work with Iraqi refugees, I wish I had more information on cultural practices. I meet the family in a room with no furniture and the family brings a chair for me to sit in while they sit on the floor. I have also noted that each family member removes their shoes before entering the room. It would be helpful to know if it is the practice of only males, or if females should also remove their shoes. It would be helpful to know the little details before entering a family home, so as to not offend."

Themes
Pressure for information.
Encounters with uncertainty.
Desire to do the right thing.

Respondent	Results		Total	
#2	Prior Experience	11	Raw Score	114
	Readiness	22		
	Attitudes	32		
	Knowledge	23		
	Skills	26		

Qualitative Response

"I found that the expectations were much more than our systems were designed to provide, limits of what can be offered were not completely understood. I was shock to hear that racism and their own cultural differences caused riffs between separate groups."

Themes

System strain.
Compassion for refugee situation.
Encounters with uncertainty.

Respondent	Results		Total	
#3	Prior Experience	13	Raw Score	114
	Readiness	26		
	Attitudes	32		
	Knowledge	24		
	Skills	19		

Qualitative Response

"It would have been helpful to understand the male/female roles. Also the cultural expectations. I offended my client by refusing food and the interpreter had to explain. A good interpreter can make or break a relationship with non-English speaking clients. First two months were very good, then client became more and more demanding of EXPECTED services and benefits from living in the U.S. (not wanting or willing to work towards)"

Themes

Pressure for information.
Desire to do the right thing.
Refugee discounting.

Respondent   **Results**   **Total**

#4

Prior Experience	9
Readiness	18
Attitudes	28
Knowledge	20
Skills	21

Raw Score   96

Qualitative Response

Participant did not respond to qualitative question.

Themes

N/A

Respondent   **Results**   **Total**

#5

Prior Experience	17
Readiness	22
Attitudes	31
Knowledge	22
Skills	13

Raw Score   105

Qualitative Response

Participant did not respond to qualitative question.

Themes

N/A.

Respondent	Results		Total	
#6	Prior Experience	19	Raw Score	115
	Readiness	27		
	Attitudes	28		
	Knowledge	21		
	Skills	20		

Qualitative Response
"At the end of most encounters with this uninvited minority, the final question is what more can we do to help them advance their panhandling agenda."

Themes
Refugee discounting.
Open resentment.

Respondent	Results		Total	
#7	Prior Experience	15	Raw Score	129
	Readiness	23		
	Attitudes	36		
	Knowledge	27		
	Skills	28		

Qualitative Response
"I have come to believe that complex problems, at times, require complex, or at least well coordinated, solutions. Some of my patients have had their treatment further complicated by seeking additional consultation and by assisting me to establish clear boundaries with the translator in question, and by offering multiple translation service alternatives. With that said, there are numerous resource limitations that require macro-level assessment, funding, and interventions that will enable us to provide adequate care to a highly vulnerable population. I recommend the following: (1) Grant funding and/or immigration funding to support additional clinical and administrative needs related to health care barriers (2) Monthly meetings with Catholic Charities and other agencies that have taken point on serving our refugee population (3) Closer examination of potential peer supports (4)

A closer alliance with local institutions of higher learning—to establish sustained educational training and including the development of efficacy evaluation (5) a multidisciplinary [clinic] team to assist with established protocol development."

Themes
System strain.
Interpreter issues.
Compassion for refugee situation.
Desire to do the right thing.

Respondent	Results		Total	
#8	Prior Experience	13	Raw Score	99
	Readiness	16		
	Attitudes	32		
	Knowledge	21		
	Skills	17		

Qualitative Response
"More information about cultural views specific to psychiatric illness and care would be very useful."

Themes
Pressure for information.

Respondent	Results		Total	
#9	Prior Experience	9	Raw Score	107
	Readiness	22		
	Attitudes	30		
	Knowledge	22		
	Skills	24		

Qualitative Response

"I learned that compassion and concerns about family are universal. Although I have not experienced the trauma they have, I can offer empathy, and this is appreciated. I understand it takes time to adjust to our culture. They have been open answering questions about their culture. We have discussed the Muslim history, 5 pillars, Ramadan, and I have learned so much from my patients. I did my own research to learn more. I did not feel the need to get additional support from my organization."

Themes

Compassion for refugee situation.
Pressure for information.

Respondent	Results		Total	
#10	Prior Experience	10	Raw Score	124
	Readiness	32		
	Attitudes	38		
	Knowledge	24		
	Skills	20		

Qualitative Response

"It's so sad that some Americans think anyone from Iraq is a terrorist. I have worked with two clients from Iraq and have gotten to know them and their families. They are no different then myself or people I have known all my life. They are compassionate, love their families and friends, have a great sense of humor, have fears and dreams like the rest of us. I great appreciate the interpreters I have worked with and the patience and respect my Iraqi clients have received from providers in the community."

Themes

Compassion for refugee situation.
Interpreter issues.

Respondent	**Results**		**Total**	
#11	Prior Experience	14	Raw Score	116
	Readiness	15		
	Attitudes	38		
	Knowledge	22		
	Skills	27		

Qualitative Response

"The first two months I felt like I was under water sometimes with all I needed to learn and practice. I found significant help from a friend outside the agency to start the self education process and help lead some education process in the clinical group. I know that we are always learning on the job and that the surprise of needing to learn so quickly was stressful. It would have been more helpful to get some policies in place for Arabic translation services and more learning experiences with training components. By the time we received some training, I was already making gains, which was satisfying, but the wish we could have received it soon will probably be a regret thoughts for some time."

Themes

Pressure for information.
System strain.
Interpreter issues.
Call for support.

Respondent	**Results**		**Total**	
#12	Prior Experience	15	Raw Score	110
	Readiness	22		
	Attitudes	31		
	Knowledge	24		
	Skills	18		

Qualitative Response
Participant did not respond to qualitative question.

Themes
N/A

Respondent	Results		Total	
#13	Prior Experience	12	Raw Score	113
	Readiness	23		
	Attitudes	29		
	Knowledge	24		
	Skills	25		

Qualitative Response
"It was and continues to be a struggle given the limitations of the language barrier. Some are NOT interested in learning the culture/language/etc. of where they are now a part of. The agency does it's best to get interpreters, but then they will turn them away and want to use their "own", Or wanting to do it over the phone, which brings to light a whole new barrier for all involved in their care. Now there isn't body language to add to the mix. Care providers can not do and be all when it seems one-sided in that care givers are making adjustments/education/changes, and the recipients are not.This is not all, but a good portion. The problem with serveys, as they are tilted in the Questions. #18 was confusing as is #21. As far as gaining education into these issues. I have not seen any to take, or I definitely would. Maybe company wide, they could get this for us, as in the community and professional sector, I have not run across any."

Themes
Interpreter issues.
Refugee discounting.
Encounters with uncertainty.
Open resentment.
Call for support.

Respondent	**Results**		**Total**	
#14	Prior Experience	11	Raw Score	89
	Readiness	21		
	Attitudes	24		
	Knowledge	16		
	Skills	17		

Qualitative Response
Participant did not respond to qualitative question.

Themes
N/A

Respondent	**Results**		**Total**	
#15	Prior Experience	15	Raw Score	111
	Readiness	28		
	Attitudes	34		
	Knowledge	20		
	Skills	28		

Qualitative Response
"I enjoy learning new cultures, I have worked with several different cultures, and have been educated by many which has been a huge learning tool. I have researched on my own time to retrieve more info on the tools that have been given to me so I can better provide the quality of care that is needed."

Themes
Pressure for information.
Compassion for refugee situation.

Respondent	Results			Total	
#16	Prior Experience	16		Raw Score	94
	Readiness	16			
	Attitudes	26			
	Knowledge	19			
	Skills	17			

Qualitative Response
"More freeloaders who wish to circumvent the rules other immigrants had to endure."

Themes
Refugee discounting.
Open resentment.

Respondent	Results			Total	
#17	Prior Experience	12		Raw Score	105
	Readiness	13			
	Attitudes	34			
	Knowledge	26			
	Skills	20			

Qualitative Response
"I wanted and volunteered for this experience. Unfortunately, I found that the agency was not prepared ahead of time to support me in the way that I needed or wanted. I also had a very difficult case and did not feel the experience was successful for my client or myself and felt it was due to systemic barriers, not clinical ones. I think the interpreter situation was confusing and difficult to arrange as well as confusing regarding confidentiality because I did not have the same person each session. I appreciate you doing this research and helping clinicians and supervisors to further their understanding of this important work as well as to help agencies prepare AHEAD of time, not having to find themselves or us in a situation of reacting instead which added to the stress of the work. Thank you for this opportunity."

Themes
System strain.
Interpreter issues.
Encounters with uncertainty.

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Table B6

Step 1—Needs Assessment Qualitative Responses by Refugee Providers and Thematic Analysis

Respondent	Verbatim Response	Themes

Prompt: *Please comment about your experiences in the first two months of working with Iraqi refugees. Consider what you learned, what was helpful, and what support you wished for.*

1	"To begin my work with Iraqi refugees, I wish I had more information on cultural practices. I meet the family in a room with no furniture and the family brings a chair for me to sit in while they sit on the floor. I have also noted that each family member removes their shoes before entering the room. It would be helpful to know if it is the practice of only males, or if females should also remove their shoes. It would be helpful to know the little details before entering a family home, so as to not offend."	Pressure for information. Encounters with uncertainty. Desire to do the right thing.
2	"I found that the expectations were much more than our systems were designed to provide, limits of what can be offered were not completely understood. I was shock to hear that racism and their own cultural differences caused riffs between separate groups."	System strain. Compassion for refugee situation. Encounters with uncertainty.
3	"It would have been helpful to understand the male/female roles. Also the cultural expectations. I offended my client by refusing food and the interpreter had to explain. A good interpreter can make or break a relationship with non-English speaking clients. First two months were very good, then client became more and more demanding of EXPECTED services and benefits from living in the U.S. (not wanting or willing to work towards)"	Pressure for information. Desire to do the right thing. Refugee discounting.
4	*Participant skipped qualitative question.*	

5	*Participant skipped qualitative question.*	
6	"At the end of most encounters with this uninvited minority, the final question is what more can we do to help them advance their panhandling agenda."	Refugee discounting. Open resentment.
7	"I have come to believe that complex problems, at times, require complex, or at least well coordinated, solutions. Some of my patients have had their treatment further complicated by seeking additional consultation and by assisting me to establish clear boundaries with the translator in question, and by offering multiple translation service alternatives. With that said, there are numerous resource limitations that require macro-level assessment, funding, and interventions that will enable us to provide adequate care to a highly vulnerable population. I recommend the following: (1) Grant funding and/or immigration funding to support additional clinical and administrative needs related to health care barriers (2) Monthly meetings with Catholic Charities and other agencies that have taken point on serving our refugee population (3) Closer examination of potential peer supports (4) A closer alliance with local institutions of higher learning—to establish sustained educational training and including the development of efficacy evaluation (5) a multidisciplinary [clinic] team to assist with established protocol development."	System strain. Interpreter issues. Compassion for refugee situation. Desire to do the right thing.
8	"More information about cultural views specific to psychiatric illness and care would be very useful."	Pressure for information.
9	"I learned that compassion and concerns about family are universal. Although I have not experienced the trauma they have, I can offer empathy, and this is appreciated. I understand it takes time to adjust to our culture. They have been open answering questions about their culture. We have discussed the Muslim history, 5 pillars, Ramadan, and I have learned so much from my patients. I did my own research to learn more. I did not feel the need to get additional support from my organization."	Compassion for refugee situation. Pressure for information.

10	"It's so sad that some Americans think anyone from Iraq is a terrorist. I have worked with two clients from Iraq and have gotten to know them and their families. They are no different then myself or people I have known all my life. They are compassionate, love their families and friends, have a great sense of humor, have fears and dreams like the rest of us. I great appreciate the interpreters I have worked with and the patience and respect my Iraqi clients have received from providers in the community."	Compassion for refugee situation. Interpreter issues.
11	"The first two months I felt like I was under water sometimes with all I needed to learn and practice. I found significant help from a friend outside the agency to start the self education process and help lead some education process in the clinical group. I know that we are always learning on the job and that the surprise of needing to learn so quickly was stressful. It would have been more helpful to get some policies in place for Arabic translation services and more learning experiences with training components. By the time we received some training, I was already making gains, which was satisfying, but the wish we could have received it soon will probably be a regret thoughts for some time."	Pressure for information. System strain. Interpreter issues. Call for support.
12	*Participant skipped qualitative question.*	
13	"It was and continues to be a struggle given the limitations of the language barrier. Some are NOT interested in learning the culture/language/etc. of where they are now a part of. The agency does it's best to get interpreters, but then they will turn them away and want to use their "own", Or wanting to do it over the phone, which brings to light a whole new barrier for all involved in their care. Now there isn't body language to add to the mix. Care providers can not do and be all when it seems one-sided in that care givers are making adjustments/education/changes, and the recipients are not.This is not all, but a good portion. The problem with serveys, as they are tilted in the Questions. #18 was confusing as is #21. As far as gaining education into these issues. I have not seen any to take, or I definitely would. Maybe company wide, they could get this for us, as in the community and professional sector, I have not run across any."	Interpreter issues. Refugee discounting. Encounters with uncertainty. Open resentment. Call for support.

14	*Participant skipped qualitative question.*	
15	"I enjoy learning new cultures, I have worked with several different cultures, and have been educated by many which has been a huge learning tool. I have researched on my own time to retrieve more info on the tools that have been given to me so I can better provide the quality of care that is needed."	Pressure for information. Compassion for refugee situation.
16	"More freeloaders who wish to circumvent the rules other immigrants had to endure."	Refugee discounting. Open resentment.
17	"I wanted and volunteered for this experience. Unfortunately, I found that the agency was not prepared ahead of time to support me in the way that I needed or wanted. I also had a very difficult case and did not feel the experience was successful for my client or myself and felt it was due to systemic barriers, not clinical ones. I think the interpreter situation was confusing and difficult to arrange as well as confusing regarding confidentiality because I did not have the same person each session. I appreciate you doing this research and helping clinicians and supervisors to further their understanding of this important work as well as to help agencies prepare AHEAD of time, not having to find themselves or us in a situation of reacting instead which added to the stress of the work. Thank you for this opportunity."	System strain. Interpreter issues. Encounters with uncertainty.

-- RESULTING THEMES: System strain, Interpreter issues, Encounters with uncertainty, Refugee discounting, Open resentment, Pressure for information, Compassion for refugee situation, Call for support, Desire to do the right thing.

Table B7

Step 1—Needs Assessment Qualitative Themes Frequencies

Theme	Frequency of Response
Knowledge	
Pressure for more information	6
Skills	
Interpreter issues	5
Call for support	2
System strain	4
Attitudes/Beliefs	
Encounters with uncertainty	4
Refugee discounting	4
Open resentment	3
Compassion refugee situation	5
Desire to do the right thing	3

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Appendix C

Step 3—Organizational Cultural Competence Assessment for Clinic Receiving Training

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Domain A: Principles and Commitment
"In what ways are staff informed/trained in multiculturalism?" (Tervalon & Murray-García, 1998)
Does the institution have a formal diversity initiative? If yes, for how long, what is the history of it, and what are the specifics of this?

Domain B: Leadership
Who are the agency leaders primarily responsible for multiculturalism standard-bearing and enforcement?
What disagreements exist at the level of senior management about organizational efforts at multiculturalism?

Domain C: Human Resources
"What is the demographic profile of the staff?" (Tervalon & Murray-García, 1998)
What efforts are made to recruit and support underrepresented groups as employees?

Domain D: Communication
"Does the institutional ethos support inclusion and respectful substantive discussions of the clinical implications of difference?" (Tervalon & Murray-García, 1998)
Please characterize the process and content shared in staff meetings, consultations, and case conferences.
In what circumstances are providers empowered to discuss personal reactions to clinical content?

Domain E: Patient Care
What is the demographic profile of your catchment area? Consequently, what is the demographic profile of your patient base?
Compare/contrast these demographics—how does the organization understand any differences that exist between these two profiles?
What is the organizational history regarding providing care to immigrants? What is the timeline of this history and what have been the victories and challenges?

Domain F: Family and Community Involvement
What has been the history of the institution with the community?
What occasions are there for the connected public (interested family, local peer agencies, community leaders) to engage with the agency? (eg. workshops, open houses, social events)

Domain G: Environment and Resources
"What institutional processes contradict or obstruct the lessons taught and learned in a multicultural curriculum?" (ie. if its taught that children and relatives should not be interpreters, are there alternatives provided?)(Tervalon & Murray-García, 1998)
What are the agency efforts to put patients from full range of backgrounds at ease?

Domain H: Data Collection and Evaluation.
What feedback is collected from patients?
How do cultural performance indicators factor into this feedback?
Have you received feedback from refugees using these mechanisms?
If not, have other cultural minorities utilized these feedback forms?
What have you learned about the organization through this feedback?
What is your organizational process for responding to feedback?

-- (Tervalon & Murray-García, 1998)

Appendix D

Table D1

Step 4—Mission Statement Iterations

Iteration #1
This professional training program provides a clinical foundation for new providers to Iraqi refugees. Through introduction to the premise of cultural humility and exercises that stimulate critical thinking and self-examination, participants depart with an appropriate approach to clinical work with Iraqi refugees.

Iteration #2
This training program equips mental health providers to approach Iraqi refugee clients with the contemporary model of cultural humility. Requiring intensive self-examination and critical engagement, this series of modules inspires participants to embark on professional and therapeutic relationships with refugees that are marked by personal elasticity, curiosity, comfort in uncertainty, and relational safety.

Iteration #3
This training program equips mental health providers of Iraqi refugees to approach clients with the contemporary model of cultural humility. In this series of modules, intensive self-examination amid didactics and discussion prepares participants and their agencies to embark on effective therapeutic relationships with Iraqi refugee communities.

Iteration #4
As increasing numbers of Iraqi refugees resettle in the United States, this mental health professional training program prepares providers to engage in culturally responsive and effective relationships with Iraqi refugee patients. In this series of modules, informed by principles of cultural humility, didactics and discussion are enriched by participation in intensive self-reflection.

Final Mission Statement
As Iraqi refugees increasingly resettle in the United States, a mental health professional training program is necessary to prepare providers and their agencies to engage Iraqi refugee patients in culturally responsive therapeutic relationships. This series of training modules, informed by cultural humility principles, uses didactics, experiential activities, self-reflection, and discussion to cultivate providers' capacities to offer refugees safe, effective care.

-- (Calley, 2011)

Table D2

Step 4—Vision Statement Iterations

Iteration #1

This training program will engage professionals in processes of self-awareness in order to prepare them to be effective clinicians and advocates for Iraqi refugees.

Iteration #2

This training program will engage professionals in self-reflection, prepare them for work with Iraqi refugees, and inspire them into advocacy positions.

Iteration #3

This training program will engage professionals in imperative cultural self-reflection and growth, prepare them for therapeutic work with Iraqi refugees, and inspire them into appropriate advocacy positions as responsive global citizens.

Final Vision Statement

This training program will inspire participants toward productive global citizenship committed to individual and collective forms of international social justice such that there is no human being without an appreciative community in which to belong.

-- (Calley, 2011)

Table D3

Step 4—Theory Approach Logic Model

Assumptions	Inputs	Activities	Outputs	Outcomes	Impact
Ecological Systems Theory Iraqi refugee resettlement patterns are unique. Iraqis tend to resettle in areas with almost no infrastructure with which to support them.	Literature review.	Compilation of didactics	8.5-hour training consisting of 11 training modules.	Providers feel more enthusiastic and committed to work with Iraqi refugees.	Iraqi refugees receive better mental health care.
Social Justice The mental health community has an ethical responsibility to provide humble, sensitive care to refugees.	Needs assessment of case example clinic.	Preparation for possible group discussion.	Pre/post training evaluation plan.	Providers have more information about the details of service provision to Iraqi refugees.	Relationships between agency and the Iraqi community improves.
Cultural Competence/Humility Cultural competence is an imperfect aspiration—rather providers ought to approach clients from a learning stance instead of a knowing stance. Well-intentioned providers can inadvertently harm refugees by acting out of uncertainty and fear.	Reflective/reflexive facilitator.	Development of experiential activities.		Providers have new a new frame for understanding personal critical reactions related to their work. They are more able to recognize uncertainty inherent to the work and recognize this as normal.	Iraqi refugees find healing relationships with providers at agency.

Ecological Systems Theory Service provision to refugees is a complex endeavor requiring taxed rural clinics to adapt existing services.	Peer program review.	Creation of evaluation plan/materials.		Providers have increased sense of self-efficacy.	
Cultural Competence/Humility In order for training to be effective, it must be built on sound information, offer experiential challenges to participants, meet perceived and actual needs, and include feedback mechanisms for future quality improvement.	Expert review during program development process.	Anticipatory problem-solving.		Providers have increased self-knowledge.	
				Providers feel interpersonally and organizationally supported.	

-- (W.K. Kellogg Foundation, 2004)

Table D4

Step 4—Activities Approach Logic Model

Refugees request services	Providers attempt to meet demonstrated need and react by requesting organizational support	Organization struggles to provide support and seeks external training.	1st contact: Organization makes first contact with training facilitator. Facilitator provides information about the training.	2nd contact: Agency contracts for training. Facilitator administers needs assessment and org. cultural assessment.

6th contact: 4-6 months after training, facilitator administers time-delayed post-test to assess longevity of training effects. Facilitator also schedules a follow-up conversation with the clinical director about progress on organizational goals.	5th contact: One of the final training modules consists of a post-test for individual participants. Facilitator administers post-test. Facilitator also administers quantitative/qualitative review of the training itself.	4th contact: Facilitator offers training comprising didactics, experiential activities, self-reflection, discussion, anticipatory problem-solving, and organizational goal-setting.	3rd contact: Facilitator administers pre-test to all participants 1-2 weeks prior to date of training. Pre-test assesses confidence, competence, and humility. Facilitator also has phone conversations with organization's clinical director and all expected participants.	Facilitator reviews needs assessment and organizational cultural assessment and tailors training appropriately.

7th contact: Facilitator offers 1 year post-training follow-up conversation with clinical director. Introduces communities of support, etc.	Review of training feeds future training quality improvement efforts.

-- (W.K. Kellogg Foundation, 2004)

Appendix E

Table E1

Step 5—Training Curriculum and Agenda

Time	Module	Title	Training Approach
8am	Module I	Introduction and Arab Greetings	Didactic/Experiential Culture Specific
9am	Module II	Interpretation: Language and Behavior	Didactic/Experiential Culture General
10am	Module III	Self-Reflexivity, Elasticity, and Receptivity	Experiential Culture General
10:25am		Buffer	
10:30am	Module IV	Cultural Competence and Humility	Experiential Culture General/Specific
11:30am	Module V	Lunch: Personal Reflections	Experiential Culture General
12:30pm	Module VI	Iraqis in Exile: Culture, Religion, and Mental Health	Didactic/Experiential Culture Specific
1:30pm	Module VII	Posttraumatic Stress and Conditions of Resettlement	Didactic Culture Specific/General

2:50pm		Buffer	
3pm	Module VIII	Patients and Providers: Roles, Responsibilities, and Possibilities	Didactic Culture Specific
3:30pm	Module IX	Sustainability, Support, and Systems Issues	Didactic Culture General
4:15pm	Module X	Evaluations	
4:30pm	Module XI	Termination and Arab Partings	Didactic/Experiential Culture Specific
5pm		End of Training	

-- (Gudykunst, Ting-Toomey, & Nishida, 1996; Pedersen, 2004)

Table E2

Step 5—Training Lesson Plans: Module I

8-9am: "Introduction and Arab Greetings"

Goals

- Create a frame for participants
- Prepare participants for their own person critical reactions
- Establish safety parameters
- Teach appropriate Iraqi/Arabic greetings

Materials

Iraqi baked goods, coffee, etc.
3x5 cards
pens
handout with assessment results

Plan

1. Get settled, coffee, gather everyone—possible Iraqi baked goods from local family or shop.
2. Facilitator encourages everyone to take 3x5 card, write a how they might introduce themselves.
3. Describe greetings in Iraqi culture and teach Arabic greeting for "good morning" and "welcome".
4. Practice greeting one another using Arabic words and cards.
5. Facilitator handles housekeeping, etc. and sets ground rules for safety, respect, taking risks, and taking breaks.
6. Facilitator shares results of pre-training assessment and how requests will/will not be met; identifies broad themes of ideal vs. possible, advocacy vs. patience, and processes in the clinician, clinic, client and community.
7. Facilitator sets agenda Set the agenda and suggest broad themes that participants should be alert to (a. dialectics between what is ideal vs. what is possible at the outset of working with new refugee communities, b. advocacy and patience, c. process in the clinician, in the clinic, and in the community relationships. (Rousseau and Measham (2007) dialectics are necessary).

Sample Script

[Greet arriving providers with refreshments and instructions to balance mingling with writing a brief two-sentence introduction of themselves that will be shared with the group once the group convenes for start of training.]

/Masa sabah./ Good morning to all! Let's find seats and begin. Whenever I offer these trainings, there is so much thoughtfulness on the part of the organization and all of you in advance of the actual training day that I feel not only excited to share this time with all of you generally because the topic is important, but also with each of you specifically—we've had such lovely

conversations already. This thoughtfulness bodes well for the day. I know a few of you have just come in. Let's take a few minutes to enjoy our refreshments and finish writing a brief few sentences to introduce ourselves…

[Participants write on index cards.]

I'd like to begin by reading a quote from Guus Van Der Veer and Adeline van Waling (2004) that I think frames the journey of the day: "A change in attitude is not brought about by the provision of still more standardized learning packages or training modules. It is the result of a personal process of development. Working with refugees in essence is not different from working with other people with complex problems, and that applies as well for the attitude described. Still there are a number of caveats. Working with refugees requires that the therapist cooperate with seriously traumatized persons, who lost their trusted cultural context and who have to find a new balance in a society in which they are marginalized. Working with refugees therefore makes a personal appeal on the therapist. The helper will be a more truthful therapist when he or she is aware that there can be little imagination of that which cannot be imagined, what we people afflict on each other, and what we still have to give with the client. A more effective therapist can also allow him- or herself to be surprised by uncommon ways of coping, originating in a different culture. Therapy with refugees is not only about them, there and then, but certainly also about us, here and now, as we could have been them" (Van der Veer & van Waning, 2004, p. 214). Today is, in one sense, a day of 'learning packages' and 'training modules' but we cannot think of the learning as beginning now and ending at 5pm this evening. Our goal today is that wherever along the process of self-development we are, that we quicken pace toward a greater capacity to do this work. That is what today is for. If we do not feel energized for ongoing self-expansion, then there is something necessary that we are not doing. Let's greet one another and we'll cover some additional housekeeping.

Now in Iraqi culture, greetings serve a social courtesy as well as a religious function. These greetings vary depending on the region, social hierarchy, religion, and piety of the individuals involved in the greeting. Just as in English, what you say to someone when you first meet them is different from what you say once you have an established relationship(Gorgis & Al-Quran, 2003). There is a difference between "It is nice to meet you." and "Hey! What's up?" We also might say something different if God plays an important role in our lives and is assumed between you and the other person: "Goodbye!" is different than "God bless!" I have studied and consulted about greetings in Arabic and will teach you a simple enough structure that is consistent with our relationships as clinicians. How many of you greet patients in a waiting room? Ok, what do you usually say and do?

[Group responds including possibly identifying "welcoming" patients to the clinic.]

We like to welcome our guests to the clinic. One of the most common greetings for a host to say in Iraqi Arabic is merely "you are very welcome" or /ahlan wusahlan/. [Write on board.]   This is also an appropriate greeting for multiple people at once, which is important because you may be greeting more than the identified patient—Iraqi families often accompany each other to appointments. So you might go to the waiting room, see your patients and say, "Ahlan wusahlan. Ismi Megan Marsh." (Fernea, 1995; Prendergast, 2015).

Your patients might then say something like "greetings to you" or /salam alaykoum/ which is literally "peace be upon you" (Gorgis & Al-Quran, 2003; Prendergast, 2015). [Write on board and say as a group.] "Salam alaykoum." The appropriate reply for this is /alaykoum salam/. It is appropriate in Iraqi culture to use the /salam alaykoum/ /alaykoum salam/ formula for greetings and tends to be easier for Westerners to say because the 'h' is difficult for native English-speakers to pronounce correctly (Alziadi, 2016, personal communication)

So I want to practice greeting each other and introducing ourselves. We will go around the circle introducing ourselves one-by-one as if you were walking to the waiting room for the first time. You'll start with "Salam alaykoum" then introduce yourself using "ismi". We will all reply using "alaykoum salam" and then you'll read the sentences you wrote about yourself. We'll move onto the next person. I'll start:

"Salam alaykoum. Ismi Megan Marsh." [Group: "alaykoum salam".] "I am delighted to be here with you today. I have been working with clinicians just like all of you for awhile but before graduate school, I knew nothing about refugees—I doubt I would have been able to define for you what a refugee was. This work grew out of a training experience in which we all felt we were starting from scratch. But I found a passion for the social justice lacking but necessary in resettlement processes and enjoy working with clinicians immersing themselves in this work for the first time. I spend my days working as _____ and my nights/weekends doing _____."

[All participants take turns.]

Now how many of you meet with Iraqis in their homes? In this situation, the dynamic shifts as even though you are a provider, it is still them that welcomes you as an honored guest. Here when you are first meeting, you might start with "greetings to you" /salam alaykoum/ and they might reply with "and upon you be peace" /alaykoum salam/ or "you are most welcome here" /ahlan wusalahn/ (T. Alziadi, 2016, personal communication).

So now we know a bit about one another. When we return from lunch, I'll teach you what to say when greeting someone you already know.

Let's do a few housekeeping things and then we'll move forward! From our discussions on the phone, I feel like I have a sense of what your challenges and goals are for the work broadly and for this training day. I think we each had the opportunity to talk about my approach to the work and how my approach and your goals might interact while we're here. I think about this work as requiring that we give parts of ourselves over to the refugees with whom we work and, as we've all talked about, I conceptualize challenges with intercultural work as a function of clinicians' personal reactions that are natural but possibly harmful. The more committed we are to recognizing and exploring these personal reactions, the less harm we will do. But doing this work of exploring our own cultural selves requires vulnerability. So it is very important that our conversations are respectful, thoughtful, and safe. We should assume that we will encounter difficult thoughts, emotions, interactions, and physiological responses. Our job is to sit with these experiences and be curious about them. What reactions do you have to this?

[Discuss reactions.]

Here's my plan: this morning we will discuss culturally general information, language, and do several cultural self-awareness activities. These will require vulnerability and self-reflection. You never need to share reactions aloud if you are uncomfortable doing this but what I would ask that you do is that you wonder quietly what it is that has you desiring to be silent—is it fear? Is it shame? Use the reaction you are having to learn something about yourself and about what conditions you need in order to be more willing to take interpersonal risks. We will break for lunch during which time there will be a short reflection exercise. I'll talk more about that then. When we come back from lunch we will cover a significant amount of clinical information in a highly interactive way. The morning is likely to feel more emotional and physiological and the afternoon to feel a bit more cognitive but we are attempting to operate at all three levels in all modules. How does this sound?

[Group affirms commitment to plan.]

We have refreshments here; please feel welcome to help yourself at any point today. I have ensured that we have water—both because we need it but also because it is very important that you all have at least water to offer your Iraqi patients either in the waiting room or upon arrival in your office. This is a very important part of hospitality in their culture and doing so can soften them to what can feel like a scary experience in a clinic. Arabs do not tend to accept offers of Western coffee—although it is appropriate to offer them coffee as it is part of our culture, they are more likely to really enjoy chai tea (Alziadi, 2016, personal communication). It is easy enough to have on hand.

How many of you remember the scene of Iraqis in Baghdad pulling down the statue of Saddam Hussein shortly after the U.S. invasion in 2003? In addition to pulling down the statue, do you remember what they also did?

[Brainstorm.]

They also removed their shoes and began throwing them and hitting the statue with them. This is because it is a grave insult in Arab culture to sit in a manner that allows the bottom of your shoe to be seen by others. We must avoid sitting with the sole of our shoes exposed. It is a challenge to adapt to a new way of sitting but this is a significant cultural difference that is very important (Alziadi, 2016, personal communication). Notice your seated postures today and practice adjusting yourselves as you would when working with an Arab client.

If at any point, you need to step away, please do so. There will be few built in breaks but I know that we all have significant reasons that we can be pulled away. I don't need to police this. Just do what you need. The same goes for if you find yourselves having strong emotional reactions. These are valuable pieces of information. Take what space you need but be curious about the process occurring in you. This level of self-reflection is how we learn, which is what the task of today is anyway.

We are bound to encounter a few tensions in this work and in our conversation today: a). the dialectic between what is ideal versus what is possible, b). the tension between acceptance of what is, that is having patience, and conversely, a change orientation that leads to advocacy, c). the multiple tensions associated with process at all levels such as in the refugee patient, in the clinician, in the clinic, in the community relationships, and in policy. These dialectics are a necessary part of this work; noticing them and engaging with them serves to propel the work forward (Rousseau & Measham, 2007). When you notice them today, let's point them out and discuss how they impact us and the work. Let's move onto our second module!

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Table E3

Step 5—Training Lesson Plans: Module II

9-10am: "Interpretation: Language and Behavior"

Goals	**Materials**

Goals

- Establish expectations and standards for services through interpretation including roles and responsibilities
- Explore interpreted care through patient, interpreter, and provider perspectives
- Convey vital importance of non-verbals in interpreted care
- Introduce concept of anticipatory problem-solving
- Practice through experiential activity

Materials

Iraqi baked goods, coffee, etc.
3x5 cards
pens
handout with assessment

Plan

1. Facilitate discussion; draw out stories from participants about using interpreter services or international travel. Questions to be derived from information gathered in the pre-training assessment. *(15min)*
2. Brief conversion activity of excerpt written more simply and clearly.
3. Lecture about models of interpretation, skills of speaking through an interpreter, importance of non-verbal communication, and anticipatory problem-solving. *(20min)*
4. Introduce experiential activity: create groupings of 3 people, describe activity parameters including "when the person across from you is speaking, you should plug your ears," assign roles. *(15min)*
   a. Patient instructions-"Your job is to describe symptoms and stressors in English." (possibly introduce a vignette for content here depending on the pre-training assessment.
   b. Interpreter instructions-"Interpreters are expected to convey the exact meaning of the source language in the target language; but because we have only English to work with, your job and intepreters is to translate into your own words what the client has said. Find another way to say in English what they've conveyed but you should strive to maintain the 'fully content and spirit' of what your client has said—speak as the client's mouthpiece" (Jaffe, 2016, personal communication).
   c. Provider instructions- "Your job is to put the client at ease, establish safety and trust, collect details about symptoms and stressors, attend to your own physiology, nonverbal communication, and personal reactions, and engage in anticipatory problem-solving."
5. Debrief experiential activity including what it was like for interpreters, what it was like for providers, and what it was like for patients. Explicitly facilitate discussion about your own personal reactions and use of self. Comment on fear of mistakes. Comment on any

> laughter or absence of laughter: playfulness as a joining tool, anticipatory problem-solving establishes good intentions and assumes fumbling so that a stable flexible relational foundation can be established. *(10min)*
> 6. Transition to next module: self-reflexivity and elasticity and receiving of others.

Sample Script

"How many of you have traveled to a place where you have not been able to speak the majority language?

Let's all take a few minutes now. Close your eyes and remember what it is like. If you have not had this experience imagine approaching a shop stall in a market, wanting something, and considering getting the attention of the shopkeeper—what do you do? Take a few minutes—check in with yourself. What are your thoughts? What do you feel in your body? What is that like? What do you confront inside of yourself? What is that anxiety like? What's the texture of it? How do you know—in your bodies?

[Possible responses include scared, threatened, anxious, frustrated/exasperated, burdensome, apologetic, stressed, embarrassed, humbled, silences, resignation, invisible, dehumanized.]

The impact of interpretation on clinical work cannot be overstated but this is not because language is critical to communication or because language shapes how we think—though both are true—rather because the presence of interpreters in our clinical comfort zone is an unusual and often threatening experience that causes us to clam up and shut down (Deutscher, 2010; Raval, 2003b). Refugees are not best served by clinicians who have, through feeling professionally exposed or unnerved, disengaged from the client. Using an interpreter is the first new and unnerving experience a clinician might encounter when providing refugee services and it is one of the ones most likely to interfere with relationship-building and all that is founded upon relationship (Cushing, 2003; Raval, 2003a). So—it is vital that we engage on this topic right up front. Considering ourselves as linguistic beings—better yet as communicative beings—is a necessary frame for the whole day.

How many of you have worked with spoken-language interpreters before? How'd they get chosen? What were their credentials? How did it come about that that particular interpreter was used?

At its most fundamental, interpretation is founded on relationship—between you and the client, you and the interpreter, and between the interpreter and the client (Engstrom, Roth, & Hollis, 2010; Mudarikiri, 2003; Raval, 2003a). In the same way that you monitor the relationship between you client and track its progress from a meta-perspective, so too must you consider the relationships involving the interpreter. Even though this may feel foreign or novel or awkward, we all know how to form and foster relationships—its what we do in our work all the time and we have most of what we need to do this well already in our wheelhouse.

Now in a perfect world, the interpreter would be a professional too who is also stellar at forming and fostering the relationships your situation demands. The three of you are a team and the more

you are all stewards not only of content but process also, the richer the relationships can be.

But spoken language interpreters range in quality and professionalism in part because the only central licensing body in the United States requires a process that is prohibitively strenuous and expensive for many immigrants, in part because most state laws do not yet require this licensure, and in part because your community may not have an appropriate established interpreter community that meets the needs of newest immigrant groups (J. Jaffe, 2016, personal communication). So on the one hand, ethical accurate professional interpreters are vital in forming successful clinical relationships at the outset (Lee, Sulaiman-Hill, & Thompson, 2014). On the other hand, within new refugee groups, the ethicality, accuracy, and professionalism of available interpreters may be an evolving enterprise that requires advocacy, training, and patience from mental health professionals and established service organizations (Raval, 2003a).

Interpreters are evaluated for their accuracy (or their ability to convey even subtleties accurately), their completeness (or their ability to capture the entire message), and ethicality (or their capacity to manage their roles while maintaining strict impartiality and confidentiality)(Raval, 2003a).

A really great interpreter is not only professional, accurate, complete, and ethical but can also articulate these parameters of their roles including what their responsibilities are, what variations are possible within these parameters, what their boundaries are, and how they approach all these aspects of themselves (Avery, 1995). That is, they have self-knowledge about how they fill their professional role.

So let's paint the picture of the ideal situation and then address the various approximations of this that are more realistic in the earliest stages of refugee resettlement into a new community. [*Begins making list on whiteboard*]
Ideally you would:
a). Meet face-to-face and know who the interpreter is ahead of time
b). Be able to check in with the interpreter to discuss process and approach (and possibly forewarn of reasons this might be distressing for the interpreter) before the appointment begins (Tribe & Raval, 2003),
c). Ideally the interpreter is also seeking you out to chat about ways you can help one another help the client (i.e. "Is there anything I can do to help you?")(Engstrom et al., 2010).
d). At the conclusion of this check-in or live with the client, you let them know what you've spoken about in a manner like this: "We've been talking about how we can each help the other so that you and I can understand one another. We agreed we would work on this process ongoing. I really want to understand you but we won't always and that is okay. I want you to let me and interpreter know if the communication is not going well and we can all decide how to adjust, ok?",
f). You explain that you will sometimes need to check in with the interpreter for clarification but in these moments, you will try to include them in the process
g). Ideally the interpreter otherwise subordinates himself and his own thoughts in a more-or-less 'neutral' or 'impartial' stance in service of elevating the voices of the client and provider
h). You sit so that when you speak you speak not to the interpreter but to the client—this is very important—Nonverbal information is vital (BlueCross BlueShield of New Mexico, 2013; Y.

Chang, 2015; Cushing, 2003; Raval, 2003a; Yang, 2015). You need to aim your nonverbal communications at the client and you need to be able to observe the nonverbal communication of your client as they listen to you. This concept of nonverbal communication is really important and will inform much of our work today

i). Ideally providers would be able to speak with subtleties as they would ordinarily and that the interpreter would effectively translate these subtleties

j). Ideally your triad will get into a rhythm—this rhythm may vary depending on content, the interpreter, and which language in being paired with English

k). Ideally the interpreter rarely or never steps out of his role. The words are spoken not in a "he said" "she said" but rather in the first person as a true proxy

l). Ideally you, your client, and the interpreter negotiate and adjust as the relationships develop over the course of your work with the patient

m). Ideally the interpreter keeps you and the client apprised of ways cultural understandings could create miscommunication or confusion (See A. Cushing in Tribe & Raval, 2003a for extended discussion about the structure and skills associated with interpretation in mental health settings).

At each of these junctures, however, breakdowns can occur and the less established the interpreter and their agency and the less prepared you are, the more likely they are to occur.

So ideally, interpreters meet with you in and the patient face-to-face. For brief or impromptu situations, you can leverage one of the many interpreter hotline services. These are appropriate and reliable services when the tenor of a conversation does not matter. Scheduling or brief medication consults are appropriate arenas to use a telephone interpreter. However, nonverbal communication is vital in clinical work—for the same reasons our industry is slow to endorse teletherapy, we ought to avoid interpreter hotlines if possible.

Ideally, you and the interpreter would be equally proactive in getting to known one another professionally—even if this is not true, it is important to model this professional behavior—the interpreter is meant to make communication seamless but should not be thought of as invisible (Doherty, MacIntyre, & Wyne, 2010). He has his own significant kind of power in the situation. Even if you just take a few minutes to recognize him, ask if there is anything he needs from you and encourage ongoing communication about process, you will set the frame. This can be done in front of the patient but if so, loop them in. Attention to process at the outset allows for exchange of content to be successful and meaningful for the patient (Engstrom et al., 2010).

Ideally the patient and interpreter do not know one another outside of the their professional relationships but in small new immigrant communities, this is unlikely. Iraqi refugee patients often request interpreters who are not only non-Iraqi but non-Arab. Except in some urban centers, non-Arab Arabic speaking professional interpreters are rare and they don't exist in rural communities where Iraqi refugees may resettle—this problem of accessibility occurs across languages throughout the rural areas of the country (Yarger, 2001). In the absence of this "safest" option, Iraqis will choose an interpreter in their families' circle of close associations rather than an unknown Iraqi Arab. This close association between the patient and their interpreter can feel like an egregious dual-relationship in a professional context that eschews such blurred boundaries. Having said this, for the family this can feel like a paramount issue of

security for themselves and safety for their loved ones still in Iraq. When working with Iraqis, clinics should expect to receive requests for interpreters with very specific often conflicting characteristics that cannot be accommodated. If the clinic finds that families are relying on kinship or less professional interpreters who are merely bilingual but otherwise untrained, the best course of action is to work with the agencies—sometimes newly founded from within the new immigrant community itself—to establish standards and training programs so that even if close dual relationships continue, client-interpreter relationships remain professional, safe, and effective.

Ideally, you would all feel comfortable addressing communication issues that arise. However, there are a number of possible reasons that a patient or an interpreter doesn't address these issues. Don't take for granted that things are going well if no one speaks up—attend to this actively and ask what can be improved upon (Cushing, 2003). Acknowledge the interpreter for what they are doing well.

Now, this is important. Ideally the interpreter stays "neutral" but true neutrality is a theoretical proposition—language even between two people who share the same native language is always filtered (Patel, 2003); meaning is construed through the best approximations available to a person at the time based on how their life has taught them to understand others (Bruner, 1995; Young & Saver, 2001). Even with skill and good intentions an interpreter will still shape the therapeutic encounter just by being a third person in the exchange (Papadopoulos, 2003; Patel, 2003). This can play an important role in the negotiation of meaning specifically in this kind of medical or mental health interpreting (Cushing, 2003). Bot & Wadensjö (2004) even have termed this work "three-person psychology" in recognition of the power an interpreter has (Bot & Wadensjö, 2004).

One of the tasks as providers when working cross-culturally is to work out with the patient an explanation for their symptoms and situation. But the way that Western medicine may define a disorder or explain its etiology is not always consistent with how the patient would describe and explain it for themselves (Cushing, 2003). The explanatory models—how I explain the cause and cure of suffering and how the patient explains the cause and cure of suffering [*draws first circle Venn diagram]* may have no commonalities before negotiation through the interpreter, but through deliberate mutual education our job is to arrive at a mutually agreed upon blend of explanatory models (Raval, 2003b). [*Point to overlap in three circles.]* In this process, we assume there is also a third explanatory model operating in the interpreter who is helping you and the client arrive at shared understanding.

In this way, the interpreter serves as a cultural interface as well as a conduit for language (Avery, 1995).When working with refugees it is the interpreters' job to make judgments about how to take the textured nuances of what one said and translate into how they can be best received by the other. This is not one-to-one interpreting but stands to be the most effective and culturally relevant for the patient (Cushing, 2003).

Now, interpreting etiquette calls for us to look at the client not the interpreter as a sign of respect to the person you are communicating with (Cushing, 2003). I also believe, particularly in mental health but really in any human interaction, that we cannot do our work without attunement to

non-linguistic communication—tone, expression, posture, cadence, breathing, gestures, and the intimacy of eye contact—and this etiquette allows us access to a vast source of critical information (Lewis et al., 2000; Siegel, 2010; van der Kolk, 2014). More than half of communication—some argue as much as 80%— is nonlinguistic (BlueCross BlueShield of New Mexico, 2013). So although it can feel awkward at the outset, you want to receive all the information when your client is talking and you hope your client is able to give the same content to you when they speak. When the interpreter is speaking split your attention between them—the non-verbal communication of the interpreter is also important information but you want to aim most of your "comprehension communication" (e.g., 'uh-huh', nodding, and 'oh I see') at your client so they receive the benefits of feeling understood (Bot & Wadensjö, 2004).

Now having insisted on the vital importance of non-verbals, it is also crucial to remember that nonverbal communication varies across cultures (Chang, 2015; Cushing, 2003; Yang, 2015). When I'm working through an interpreter, I have the experience of receiving information in a two-step process in which I receive the nonverbal information—the vital emotional valence—the urgency or potency of the message first while attending to my client's speaking (Cushing, 2003; van der Kolk, 2014). Then, because I've been so closely attuned, when I receive the actual linguistic content from the interpreter a few seconds later, I have the experience of being unsurprised—my emotional attunement prepared me for a tighter range of possible things the interpreter might say. In my experience, this attunement is the part of communication that establishes safety with a refugee and allows them to feel understood (Bot & Wadensjö, 2004; van der Kolk, 2014). Attending in this two-phase manner is also a valuable assessment tool—if you are attuned in this way but repeatedly have the experience of being surprised between the valence and texture of non-verbals from your client and the content of the interpreters words, then you know something is getting lost between how your client speaks and how you understand. It is possible that the disconnect is in the nonverbals—that you and this person use non-verbals differently. This is important process information because not only may you not be understanding your client but you may be unwittingly using nonverbals in a way that causes them to misunderstand you. Self-awareness is valuable here—sometimes I'll say, "in my culture or in my family, eye contact is a sign that I am listening. If this feels uncomfortable for you, let's talk about it. I may not be able to control it—as it is an automatic part of my communication style. But I want to know how I make you feel" (Cushing, 2003).

Another possibility is that the disconnect is with the interpreter who is a human being with a history and emotional triggers and coping mechanisms. Even the most professional interpreters can respond unwittingly to emotional content. In refugee communities, often the interpreters are refugees themselves. Providers have a small but important responsibility for the momentary well-being of the interpreter—the pre-session check-in is an appropriate time to give the interpreter a heads up if you anticipate possibly triggering content in the session (Razban, 2003). Even still, we all know we can't always predict these things and the more self-aware the interpreter, the more able he will be to mitigate unwittingly amplifying, de-escalating, or shifting emotional content. In any case, process is important here. The more you establish process as a viable conversation topic from the outset, the more able you will all be to navigate these confusions (Cushing, 2003).

[Facilitator reads extended quote:]

"Working with language and meaning is a large component of therapeutic work in mental health. The contextual, constructivist, and social constructionist frameworks help clinicians to place the interpreter as an important partner in the co-creation of a web of meanings. They also highlight how much is taken for granted in monolingual communication, and the important role that the interpreter has in rendering meaning and facilitating meaningful communication between the clinician and the service user. Although the ideal process proposed by Kaufert (1990) whereby an agreed consensus is reached is often difficult to attain in this kind of work, it is nonetheless one that clinicians should be aiming for. In the three-way process of communication numerous meanings may well be attributed to what at first seems like a straightforward piece of information sharing or transfer, particularly as the communication is having to take place across several levels of cultural and language systems. Conversations can only be made sense of in the broader context, and the more specific context of the particular relationship within which the two people talking are choosing to define themselves. Much of the initial phase of working with an interpreter involves negotiating the definitions or parameters that each person is willing to participate in within the context of the therapeutic relationship. Unless this phase is negotiated successfully all the other phases of the work cannot take place smoothly. Again, the amount of time that is needed in this early phase of the work in order to clarify such issues cannot be underestimated. Chances of misunderstandings are likely to increase if this basic groundwork has not been done. Acknowledging that meanings and realities are created through conversations thus leads the clinician away from holding onto 'universalist' positions. The meanings and insights into the problem that will have relevance for the service user will be those that are derived from the context of the service user, that make sense and hold a certain level of validity within his or her understanding of the world. This does not mean that the interpreter's or clinician's knowledge and ideas will have little use, but in order to be useful they have to make sense within the service user's life experiences and understandings of the world" (Raval, 2003b, pp. 131–132).
[Facilitator opens brief discussion about this quote.]

What reactions do you have to this?

[Brief group discussion.]

Interpreters who are truly native in English as well as the language of the refugee client is rare. So while it would be great if your highly nuanced and textured English could be just as beautifully and comprehensively translated, it is unlikely. Speaking English with more specificity will help reduce opportunities for lost meaning or confusion.

 [English translation activity for 5 minutes.]

I'm going to pass out a set of sentences. I want you to read them appreciating the impact of their words but then rewrite them for clarity in interpretation. As you do this, attempt to retain as much of the subtlety and significance as you can.

[Discuss responses; debrief activity.]

In addition to this two-part comprehension process I mentioned, the whole communication

should feel rhythmic.

Trained and certified interpreters are professionals (Raval, 2003a). Providers should expect to have the experience of uncertainty and fear that miscommunication is occurring and it is easy for the full responsibility for this to fall on the shoulders of the interpreter—but that impulse to blame the interpreters is just as likely a function of our own discomfort with a new person in the room—a new witness to our work on whom we must depend—as it is about their professionalism. But in society, we often rely on people who have an expertise that we don't have (doctors, attorneys) and these relationships require trust and surrendering some control. Let me say again: interpreters are professionals. Having said that, it is possible the life circumstances of an interpreter facilitate unprofessional interpretation. In these situations, particularly among refugee communities it is the responsibility of the clinic to address the issue on a systems level with the interpreting agency in the spirit of formative evaluation and collaborative investment in the refugee community in question (Raval, 2003a).

Any questions?

Interpreting Activity
Let's work with this some—let's count off by 3s. Now form triads of those 123s next to you. We are going to simulate spoken language interpreting in session but because we only have English to work with, I brought these earplugs to substitute not hearing what the person opposite you says [pass out earplugs] instead of hearing a different language. "Please take earplugs if you are a #1 or #3."
If you are a #1, you are going to be a refugee patient. Your job is to describe symptoms and convey stressors.
If you are #3, your job is to put the client at ease, establish safety trust, collect details about symptoms and stressors, attend to your own physiology, nonverbal communication, and internal reactions, and engage in anticipatory problem solving.
I want both patients and providers to really get the sense of the two-phase rhythm as well as the close attunement to nonverbals. That's where the ear plugs come in—patients: please plug your ears when the provider is speaking so that while you watch the provider talking, you are not hearing the meaning of their words. Providers, the opposite. Plug your ears when the patient is speaking so that you can practice close non-verbal attunement.
If you are a #2, you will be interpreting; because we have only English to work with, your job as intepreters is to translate into your own words what the client has said. Find another way to say in English what they've conveyed but you should strive to maintain the 'fully content and spirit' of what your client has said—speak as the client's mouthpiece" (Jaffe, 2016).

Any questions? We'll do this for 10 minutes.

[Debrief.]

What was this experience like?
What did you notice in your bodies?
For those who struggled, tell us about the struggle.
What makes this difficult?

[This discussion is likely to evolve into self-reflection about being observed, fear of doing something wrong, and the anxiety that can block openness to receiving the patient fully. These themes act as transition to the next module. As transition away from discussion, read quote.]

"Most communication is not the transmission of packets of completely new information, but the evocation of the already known to build new configurations. Both the form and context of narratives influence this process of evocation, which is regulated not only by the semantic fields activated by familiar words and phrases, but also by the social context of speech and the affectively charged and socially scripted relationship between speaker and listener as conversational partners" (Kirmayer, 2007, p. 367).

Being able to communicate in our native language provides us with tools to be convincing, inspiring, evocative—to communicate intricate meanings—that communicating in second languages or through interpreters does not allow for.

[Show quote and read aloud.]

"River in my language was a vital sound, energized with the essence of riverhood, of my rivers of being immersed in rivers. 'Rivers' in English is cold—a word without an aura, it has no accumulated associations for me, and it does not give off the radiating heat of connotation" (Hoffman, 1989, in Tribe & Morrissey, 2003, p.47).

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Table E4

Step 5—Training Lesson Plans: Module III

10-10:25am: "Self-Reflexivity, Elasticity, and Receiving the Other"

Goals   **Materials**

- Describe current social psychology thinking about 'personal   Signs
  uncertainty' and ideological entrenchment/extremism/defensiveness.   Earplugs
- Explore relevance of hot/cold cognitions to cross-cultural/cross-   3x5 cards
  linguistic work with refugees and the importance of emotional   envelopes
  information.   sheets with
- Discuss ecological-systems and practice locating ourselves within   prompts
  ecological systems structures.
- Practice sitting with uncertainty through experiential activity.

Plan

1. Discuss laughter as a joining tool.
2. Share anecdote about humorous miscommunication.
3. Facilitate discussion about the role of uncertainty in intercultural interactions.
4. Lead experiential activity in which profoundly intimate concepts about oneself are
   conveyed without shared language.
5. Debrief activity and discuss personal reactivity and its relevance to refugee services.

Sample Script

We've just been talking about what its like to communicate without a shared language. One of
the things I heard (or did not hear) during the group activity was laughter—where did that
laughter come from? (or what do you make of there being no laughter?). Laughter is a really rich
joining tool. Cross-linguistic relationships are challenging and humorous misunderstandings
occur all the time—even in the context of much suffering. We know this: one of the most
beautiful moments with patients happen when we find a reason to laugh through grief—laughter
closes the distance between two people (Pipher, 2002; Ramsey, 1996).

[Facilitator shares personal anecdote.]
"I remember I was once doing co-therapy with a fellow outpatient clinician. We had been
struggling to find a rhythm of working together and with the interpreter and refugee patient.
Though plainly our patient was in much emotional pain in session, our work felt aimless. At this
point, we hadn't discerned what to make of this aimlessness—was she expecting something
different from us that what we were giving? Was she feeling scared into silence? Was someone

forcing her to come? Was her interpreter making her uncomfortable? Were we? Was she interested in change? or were we witnessing despondency? What was happening? My co-clinician was a proponent of acceptance and commitment therapy (ACT) and wished to offer a mindfulness meditation at the start and finish of each session (Hayes, Strosahl, & Wilson, 2011). I agreed we could try it. So in our next session, we decided we would suggest this to our patient but the session flew by, and by the time we looked at the clock, we had very few minutes left. We glanced at each other wordlessly agreeing to extend our session a few minutes in order to offer this breathing activity. So as our client began collecting her things, also having noticed the clock, my co-therapist said, "I know its time to go but before we finish, we have a few exercises that we think might be helpful. Would you like to do one or two now and maybe we can open and close each session this way?" The interpreter began interpreting and toward the end of his comments, the patient looked confused and bashful and shaking her head, pulling back and sheepishly raising her hand, declined our offer.

This was strange; she hadn't always been forthcoming and motivated toward therapy but she had always been amenable to our suggestions. Now I almost felt like she thought we were crazy for making the suggestion but wished to be as gracious as possible. My co-therapist was a little deflated; I think this was the one tool she felt she had that might be worth something to our patient. I could feel myself ducking into respecting the client's disengagement. The easiest thing in this moment, which was just barely not a 'doorknob moment', would have been to take the path of least resistance and just walk her out. This is what I felt the pull to do—but the awkwardness and waywardness of this relationship with this patient gave me the sense that if we walked her out then, we would be saying 'goodbye' for good. "We have a few exercises we think might be helpful." "We have a few *exercises…exercises…..EXERCISES!"* I think the realization of what misunderstanding occurred was coming across my face because everyone stopped shuffling their things waiting for me to share. I motioned "exercises" by jogging my arms. She nodded and as I shook "no" and began motioning differently, and said "activity" "in here" "no fitness"—we all died laughing! She feared we were asking her to go to some other room and run on a treadmill! How confused she must have been! How gracious she was! What a window into how bewildering her world is! And we needed this laughter—it was the fulcrum of our relationship, enough to keep her returning. We've got to be able to laugh at ourselves and with one another in this process. Had this gone differently, we all may have retreated into the safety of our own linguistic camps avoiding the risk of additional confusion; but thereby denying us all the dedication and vulnerability necessary for working through. These feel like risky moments and filled with hot cognitions and we've got to watch ourselves closely so that our work isn't governed by our own reactivity or the temptation of the comfort that comes from affective distance and cold cognitions (Lepper, 1994; van den Bos et al., 2007).

Any thoughts or reactions to this?

[Brief reflective discussion from group.]

I love this quote about professional learning:
"A most appropriate brand of in-service education may be to regularly find ways to place ourselves in the unknown situations, where differences abound, in which we can not only learn about people of a different culture, but also learn again and again about our own learning style and observation skills and renew our talent for laughing at ourselves. We bring all that we learn

in this process of self-renewal to assessing a client's situation, to developing objectives, to choosing content to creating and using methodologies, and to aligning the entire learning experience with a larger purpose" (Ramsey, 1996, p. 22).

Let's talk about uncertainty.

Language is a platform for self (Bruner, 1995; Patel, 2003; Young & Saver, 2001). And we rely heavily on language for giving us a sense of security and certainty about who we are. Generally speaking, human beings do not like uncertainty. We avoid it and do all that we can to diminish uncertainty even acting against our self-interest if it means coping with less ambiguity. Worse still if this ambiguity is what social psychologists call *personal uncertainty*, or "the subjective sense of doubt or instability in people's self-views and/or worldviews, and which involves the implicit and explicit feelings that people experience as a result of being uncertain about themselves" (van den Bos & Loseman, 2011, p. 72). This personal uncertainty causes us to become *more certain* across a range of domains (de Dreu et al., 1999; De Grada et al., 1999; Kelly & McGrath, 1985; Kruglanski & Orehek, 2011; Nelson et al., 2003; Rubini & Kruglanski, 1997). Fear or perceived threat by uncertainty is so distressing to us that our coping mechanism is often to fall back harder and with more conviction on our previously held beliefs regardless of whether those beliefs are in the domain of the original uncertainty (Cushing, 2003). We dig in our heels; this happens with politics, with international relations, and with one another: individually and collectively, divisions get wider and more hostile. As responsible global citizens, as connoisseurs of the media, as voters and advocates, but also within ourselves, we should keep an eye on this dynamic. When we confront difference, this reaffirmation process operates in us and we need to ensure that there are forces of leaning in, being vulnerable, and extending ourselves that are stronger than our reflexes to retreat.

I mentioned before that language is a platform for self. Let's engage in an activity that strips that away so that we might acquaint ourselves with what it feels like to expose who we are when we have no language to use—okay?

I want you to pair up with one other person. You will need a pen. I am going to pass out envelopes. Everyone will get two. One envelope will be labeled "1ˢᵗ round" and the 2ⁿᵈ will be labeled "2ⁿᵈ round". I am also going to give you each two sheets of paper. One sheet is for the activity, one sheet is for the reflection questions afterward which I will lead. Now we are going to do this whole activity with earplugs, so from the time I instruct you to put in your earplugs, leave them in even through the reflection period. We are going to start with the 1ˢᵗ round envelopes in which you will each receive a different instruction about your roles. When I tell you, put in your earplugs, open your envelopes, and begin. I will get your attention when it is time to move to round 2 and again for a reflection period which I will guide using these signs. [Facilitator points to stack of signs with reflection prompts.] Use your paper to make notes to yourself. After the solitary reflection, we will debrief as a group. Any questions?

Okay, earplugs in!

Participant A reads card: "Consider your life. Please find a way using no words (spoken or mouthed) and no writing, only non-verbal body language and drawings, to introduce yourself.

Do not shake hands. *What makes you, you?* Please convey that to the person across from you. When drawing, use your non-dominant hand.

Participant B reads: "Without using speech or paper, please find a way to understand your partner and make them feel seen and known. Do not mouth words—practice attunement."

After 7-8 minutes, facilitator indicates that the group should move onto the second round in which Participant B is given the same task as Participant A but in which the prompt has been changed to: *how do you know that you are important*? *How is your story special?* Participant A takes the role of participant B.

After 7-8 minutes, instructor leads a private reflection using prompts cards. Participants will stay ear-plugged until they finish jotting notes on their index cards.

Reflection questions:
a). How did it feel to introduce yourself in this way?
b). What did you notice about your thoughts, emotions, physical sensations?
c). How did you feel as your witness responded to your drawings?
d). What was it like to be the witness?
e). In both roles, what was your sense of relational distance and/or proximity between you and the other?

Ok, let's remove the earplugs.

Bessel van der Kolk writes: "Human beings are astoundingly attuned to subtle emotional shifts in the people (and animals) around them. Slight changes in the tensions of the brow, wrinkles around the eyes, curvature of the lips, and angle of the neck quickly signal to us how comfortable, suspicious, relaxed, or frightened someone is. Our mirror neurons register their inner experience, and our own bodies make internal adjustments to whatever we notice. Just so, the muscles of our own faces give others clues about how calm or excited we feel, whether our heart is racing or quiet, and whether we're ready to pounce on them or run away. When the message we receive from another person is 'you're safe with me,' we relax. If we're lucky in our relationships, we also feel nourished, supported, and restored as we look into the face and eyes of the other" (van der Kolk, 2014, p. 80).

[Allow silence.]

Let's talk about our experiences of the activity. What can be known and what is hard to convey without words? What gets lost? What remains? What is richer? Why might I have required us to leave our earplugs in during our quiet reflection?

This activity draws on vulnerability, invisibility, intimacy, and incompleteness.

Are any of you familiar with Bronfenbrenner's *ecological systems theory*? Tell me about it.

[Draw concentric circles on the board and locate the group's reflections about the experiential

activity among the ecological systems diagram.]

Individuals are understood as inherently networked into *microsystems* of face-to-face interactions each in a given setting with individuals who have unique temperaments, beliefs, and idiosyncrasies . These microsystem settings are themselves networked in a *mesosystem* within which the various social groups and environments of a person interact. The *exosystem* is made up of various forces that indirectly influence the development of an individual by directly impacting aspects of the individual's mesosystem. The broader *macrosystem* is:

> …The overarching pattern of micro-, meso-, and exo-systems characteristics of a given culture, subculture, or other broader social context, with particular reference to the developmentally instigative belief systems, resources, hazards, lifestyles, opportunity structures, life course options, and patterns of social interchange that are embedded in each of these systems. The macrosystem may be thought of as a societal blueprint for a particular culture, subculture, or other broader social context. (Bronfenbrenner, 2005, pp. 149–150).

These systems are highly networked social forces that create an individual's sense of reality and possibility. What makes us who we are—what gives our stories their shape and therein their power—is our location within these systems.

Our histories confine our worldview and limit our sense of possibility. We rely heavily on shared language to navigate confusions and to form connections, but connection with someone with whom you have no shared language and no shared macro-system requires some personal elasticity. We must be curious in a perpetual and gentle way about how we bristle or absorb uncertainty, which parts of our own ecological system are most prone to "defendedness" or entrenched reaffirmation and what it might feel like to make the solid lines around our ecological systems and what we believe we know [point to diagram] more perforated.

[Facilitator creates spaces in the macrosystem circle by erasing parts of the dry erase marker].

Let's take a brief break and we will move on to our last module before lunch.

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Table E5

Step 5—Training Lesson Plans: Module IV

10:30-11:30am: "Cultural Competence and Humility"

Goals   **Materials**

- Distinguish between concepts of cultural competence   White board
  and humility   Dry erase markers
- Explore clinical practices associated with stances of   Possible vignettes or stories
  competence vs. humility   Possible handout with
- Incorporate examples of work with Iraqi refugees   ecological systems diagram
  where appropriate   designed for
- Encourage participants to engage in culturally humble   filling in conceptual
  ways and hearten them to their own ability to be   information.
  humble.

Plan

1. Generate participant responses to question: "What is competence?" Create word cloud of associations through group brainstorm. Expand brainstorm to question: What is *cultural* competence? Deepen this discussion through more specific questioning so that the word cloud includes the knowledge, skills, and attitudes/beliefs aspects of cultural competence concept.
2. Discuss the history and value of cultural competence concept and then discuss its limitations: namely, competence is a cognitive endeavor and leaves out emotional information and visceral sensations that are invaluable and the real source of interpersonal vulnerability and warmth.
3. Describe the tenets of cultural humility.
4. Engage participants in an activity of not-knowing: invite a participant to present a case and what has gone well and not gone well. As the group has not yet covered information about Islam, Iraqis, etc., this activity will demonstrate that we have been elastic and warm—and useful—without having all the answers; knowing allows us to be less surprised by material but does not really direct the way forward. We are not looking for answers.
5. Use the case material to give participant presenter a reinforcing experience; facilitator highlights how much has been accomplished with little and processes the desire in him/her to know more. This reflection transitions into the lunch activity.

Sample Script

What is competence? Let's define the word "competence". ["Competence" written on board—brainstorm.]

Now I'm sure you're all familiar with the concept of cultural competence right? So let's brainstorm specifically about what cultural competence is.

[Brainstorm and write on the board. Expectable responses: understanding others are different, accepting differences, being aware of being offensive, keeping an open mind, never done, open to talking to people from somewhere else, stereotypes may not be true.] Deepen this discussion through additional facilitation so that the board contains sufficient word cloud addressing knowledge, skills, attitudes/beliefs]

We've done a good job defining cultural competence. Cultural competence tenets are vital to good work with refugees but if we briefly return to the definition of competence, which Webster's Dictionary defines as: "the physical or mental power to do something" (Merriam-Webster, 2016. http://www.merriam-webster.com/thesaurus/competence, accessed: June 10th, 2016), we notice that what we are aspiring to—what competence is—is "*knowing*" the right stuff, having the *right* skills and attitudes. But this orientation toward knowing eclipses the importance of the process of *learning*. We've been talking about this concept this morning in a variety of ways. 'Physical or mental power' is not what is called for in intercultural communication. What is called for, conversely and counterintuitively, is *not knowing*—sitting in a learning and humble stance receptive to the world of the client not as though she, and all Iraqis or all Muslims or all Middle Eastern women are interchangeable—though these are vital aspects of her identity development—but as though you have no way of imagining how her life course has allowed her to traverse being an Iraqi Muslim woman—she is infinitely particular to herself and her experiences (Bronfenbrenner, 2005; Elder, 1998). This is another of those tensions we mentioned earlier—we are always infinitely particular and yet universally human.

This shift from competence—from seeking competence—to acknowledging *not knowing* is called 'cultural humility' (E. Chang et al., 2012).

Let's talk about the needs assessment I conducted with all of you awhile back. The thing almost all of you mentioned explicitly was a desire for more information—more knowledge about Iraqis. Tell me about that.

[Group discusses the pull to feel unknowledgeable, inadequate, and unprepared.]

You are not alone in craving more and more concrete facts about refugees, about Iraqi culture, about Islam and about political factions. This is usually the response I receive from groups I do this training with. Providers make the assumption that having ever more *information* will be helpful. But general information—knowledge—fails to account for how this one person—this life—has embodied their demographics. If "facts" are pursued at the cost of reflexivity, receptivity, humility, curiosity, and flexibility, we will not only not help but we will do harm (Van der Veer & van Waning, 2004). I want to read a few quotes that say this better than I can:

"Safety is an interaction. What can a therapist do to facilitate the co-creation of a good-enough safe therapeutic sanctuary? The tools for the therapist include: love for people who have had dreadful experiences, who have been sorely tried, who possibly do not completely toe the line. It includes an open eye for the global situation, which can hardly fail to lead to unease and rage about inhumanity in the therapists' country and the rest of the world, rage is a signal that can lead to constructive action. The tools include the acceptance of permanent irresolution with regard to the meaning of life, in the sense of tolerance of doubts and not-knowing and being able to entrust, to accept. If one has contact with the refugee from this viewpoint and begins to understand what everyday life is like for him or her, the rest is usually self-evident at least for the professional therapist. Technical knowledge covers only a fraction of what occurs during a therapeutic session, the application of particular therapeutic techniques is certainly not the most important part. A systematic approach whether or not formalized in a protocol can be a start, but in the end every treatment is a unique interpersonal endeavor. Knowledge and technique could just as well be seen as the 'carrier wave' that makes it possible for a message of love and hope to be transmitted by the therapist and received by the client" (Van der Veer & van Waning, 2004, p. 212).

"Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic and to developing mutually beneficial and non-paternalistic clinical advocacy partnerships with communities on behalf of individuals and defined populations" (Tervalon & Murray-García, 1998, p. 117).

[Invite person to present an Iraqi refugee case they are struggling with and we'll dissect it in terms of the provider's reactions: uncertainty, inadequacy, other internal reactions—but also in terms of the connection formed with their client. This work is about relationships. Lead debrief of this presentation in a structured manner according to model put forth by Lansen & Haans (2004) in which there is a). an opportunity for clarifying questions without problem solving b). 3-7 members of the group are invited to participate in discussion in which they are asked to identify with the client then c). 3-7 members of the group are invited to participate in a discussion in which they are asked to identify with the provider's position as therapist (Lansen & Haans, 2004). This guided discussion of the case does not proceed in a "what would you do?" manner.]

[Group completes case discussion.]

One last thing: we don't know what we don't know—right? All of our reactions are informed by our own ecological worlds and our professional training in Western medicine. Even the questions and standards we privilege are themselves culture bound (Raval, 2003b). But this does not leave us with nothing. In our activity earlier, we experienced how even if it was unnerving, extending ourselves affectively while being curious made some foundation of understanding possible— and, more importantly, established safety within the connection. All of this was accomplished without 'information'.

"In intercultural communication, not only is difference our domain but it is our avenue into

understanding. We make the assumption that we can best find our shared humanness by examining, allowing, and respecting differences. Indeed, in intercultural situations we know that people must be allowed to be different from each another. To the degree that focus is placed on similarity, there is a good chance that the other can only be seen in comparison with and likeness to ourselves" (Seelye, 1996, p. 11).

So here's another one of those tensions—being blinded by our own worldviews is not acceptable. But it is inevitable. How do we exist in that tension? I think one of the answers is that we should avoid complacency. This tension should leave us feeling fitful and we should harness this fitful energy toward vigilance and advocacy.

Notes

Discussing this case provides the group with a segue to the post-lunch module by framing the issues that providers face. This module should leave providers feeling positive and realistic about what they have to offer refugees. With this tone, participants leave for lunch.

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Table E6

Step 5—Training Lesson Plans: Module V

11:30am-12:30pm: "Lunch: Personal Reflections"

Goals	**Materials**

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- Give participants opportunity to decompress from morning experiences
- Facilitate opportunity for participants to digest and internalize learning on an individual/private level before returning to the group for afternoon didactics
- Provide opportunity to practice iterative self-introduction process as well as increase sense of efficacy in greetings and introductions with refugee clients
- Increase self-knowledge regarding the personal physiological sensations of uncertainty

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Index card
Pens
Food

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Plan

1. Facilitator will distribute materials and explain.
2. Participants will depart for lunch spending 10 minutes engaging in solitary reflection about how they can make use of their initial introductions to set a frame of safety and about how they personally experience uncertainty physiologically.

Sample Script

[Pass out flashcards: 1/person]

Now we've come a long way this morning and we're about to break for lunch. I want you to really enjoy lunch and take a break. While you do this, I want you to use ten minutes by yourself to contemplate and do two things:

Take one of the flashcards and on one side revisit and revise the introduction of yourself you worked on this morning. When you imagine introducing yourself to a refugee client now, what would you say? Notice how it may or may not have evolved since this morning.

On the other side of the card, I want you to write a little journal entry about how you experience uncertainty in your body. Do not use too much of your break for this—just 10 minutes or so but be thoughtful and solitary. *How does your body tell you that you feel uncertain?*

Enjoy yourselves and we'll see everyone back here in one hour.

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Table E7

Step 5—Training Lesson Plans: Module VI

12:30-1:30pm: "Iraqi Exilees: Culture, Religion, History, and Health"

Goals	**Materials**

- Apply details about Iraqi worldview to vignette or cases
- Expose participants to intricacies of Iraqi worldview
- Model and practice engaging with "facts" about Iraqi worldview in temperate, curious way allowing for individual differences.
- Teach Arabic return greetings

Materials: White board, Dry erase markers, Handout?

Plan

1. Develop timeline of imaginary Iraqi family and the history of Iraq.
2. Discuss Iraqi worldview including Arab zeitgeist, Iraqi politics and history, Islam and its influence on the culture(s) of the Middle East.
3. Practice raising questions (and hence practicing *uncertainty*) within ecological systems frame.

Sample Script

[Facilitator begins by teaching return greetings.]

/Masa innur/ or "good evening of the light" or "good afternoon" or /marhaba/ "hello! I rejoice in seeing you" and you all might reply /hala/ which is "hello" (Gorgis & Al-Quran, 2003).

We have been sitting with uncertainty and practicing *not* knowing all morning—this is important in any cross-cultural interaction. We are going to spend the next two hours discussing Iraqi refugees specifically. This is where the uncertainty 'rubber meets the road'.

We've discussed that one source of uncertainty is interpretation—not having a shared system for communicating can make us all feel uncertain. This is true in any cross-cultural or cross-linguistic encounter. Foreignness is another source of uncertainty—understanding issues regarding people who have developed outside of our own worldview does not come automatically. The quest for this understanding can include a journey of much uncertainty.

But one of the things that makes Iraqi refugee resettlement a fascinating global issue and a dire and vital professional challenge is its complexity. Sitting with complex issues also involves much uncertainty. Profoundly complex global issues cannot be wholly understood by one person—and so well-meaning culturally 'competent' providers run the risk of oversimplifying that which is far from simple and in so doing disenfranchising the refugee through well-

intentioned assumptions. There may be no more complex a refugee group than Iraqis who are themselves not inherently bound to one another along lines of nationality and who demonstrate a high rate of secondary migration once 'resettled' in the United States (Ott, 2011)

I am going to share some information about Iraqi culture, religion, and history that I believe will be helpful in your work. But this information should raise more questions than it answers.

There are as many ways to be an Iraqi as there are ways to be an American. As we talk about Iraqi, Arab, and Muslim groups using generalities, incorporate this information into your store of "knowledge" with elasticity. There is almost no generality that would be true 100% of the time. Just as you do with all your patients, use broad knowledge to help you generate dozens of informal loose hypotheses designed to guide assessments—as you test these hypotheses with the patient, you have an increasingly fine-tuned understanding of the individuality of the person you sit with (Eells, 2010; Ridley, Kelly, & Eells, 2010).

When I began to build this module, I struggled with how to do it. Here's why: I am cautious about portraying myself as an expert for a few reasons—I am not an expert. What I have to offer is my hours spent working with Iraqis and with providers and digging around in the literature. Second, I want to avoid confirming stereotypes; Westerners tend to misunderstand and judge Arabs—I'm invested in building our tools for challenging our assumptions and navigating these complexities.

My original approach to this module was to find the entire life story of an Iraqi refugee to share and explore as an anchor to the discussion of the Iraqi worldview and how that shapes who sits before you. I could not find that. Interestingly, I found only snippets about the process of traumatization and fleeing. These small stories humanize the trauma faced by many Iraqis and are used by humanitarian organizations for consciousness-raising and support. Understandably, brevity is called for in these materials because space is at a premium in publications. But it is *only* humanitarian organizations that are publishing Iraqi biographies in English. So deeper, longer, more personalized narratives are not available in English. Why might this be? [Perhaps because Americans don't buy them—there is no demand (Morgan, 2015)]. But having only snippets about their trauma has the effect of portraying individual Iraqis in a flat manner as witless and vacant recipients of actions done *to* them. That this is insufficient, at best, is obvious. Iraqis are human beings with rich textured lives and minds.

So in the relative absence of Iraqi biographies available online in English, I set about the process of trying to build one. I figured that with fragments inspired from here and there, this would not be difficult. I spent weeks reading whatever little was available about Iraqis' lives and the history of Iraq, reading hundreds of snippets to get immersed in all the experiences of Iraqis. And then I sat down to write a story that could convey complexity of identity across generations over time—I became paralyzed. How could *I possibly* write the story of an Iraqi's family's lived experience? Every time I tried to put a stake in the ground somewhere, all the other possible stories splintered my early narrative and I was back to the beginning. I sat for 7 hours mapping out who a family might be and I learned something—perhaps something predictable but at the time, unexpected. I'm going to share my process with you and cover some important information about Iraq and Iraqis.

The median age of refugees entering the U.S. in 2011 was 24 years. There were approximately 18,000 Iraqi refugees that entered the U.S. in 2009, and another in 2010, then 9000 in 2011. Of these Iraqis, approximately 38% were between the ages of 18-34 (and they are parents to the 34% of all refugees that are under 18 years old). (Martin & Yankay, 2012).

So let's say we have Zeinab; it is 2015 and for the ease of math, she is 30 years old.

If you are a 30 year old Iraqi in 2015, what are some of the things that means?

[Begin creating a reverse timeline for 20th century Iraq and a multigenerational imaginary Iraqi family. This reverse timeline begins with the year 2015 and grows in reverse chronological order while facilitator incorporates increasingly nuanced historical and cultural considerations. The module from here consists of guided discussion and much writing on white board. The complete skeleton of this timeline can be found following this module.]

So let's say we have Zeinab, and she's 30 years old. What might we notice or wonder about? So this makes Zeinab 18-years-old in the year of Operation Iraqi Freedom—her adulthood began with OIF. Was she in Baghdad? If so, does that mean she has lived an urban lifestyle? Or was she in another province at the time of the invasion and occupation? What has been the backdrop of her life?

If she is 30 years old now, she was 20 in 2005, 10 in 1995, and 5 in 1990. What was happening in Iraq in 1990? The invasion of Kuwait, right? Followed by Operation Desert Storm and fierce trade sanctions.

So if Zeinab was 5 in 1990, then she was born in 1985. 1985 was right in the middle of the notoriously bloody Iran-Iraq War, which spanned from 1980-1988 (Tripp, 2007). Now when I look at this board, I have many questions. What are you wondering about?

[Allow discussion to be guided by participants' curiosities. The following is a sample of how this could unfold including historical information I believe is important in understanding modern Iraqis and the refugee crisis.]

How about Zeinab's birth? Right in the middle of a fierce war! What is this story? So let's say her parents were also 30 when they had her—we'll call them Marion and Mahmoud. If Marion and Mahmoud were 30 in 1985, they were 20 in 1975. Saddam Hussein takes power of the Ba'ath Party and Iraq here in 1979. Marion and Mahmoud were 10 years old in 1965, right after the rise of the Ba'ath party in 1963, and they were born in 1955. 1958 was the revolution and aftermath before the rise of the Ba'ath party. The Ba'ath party came into power in 1963 when they would have been 8 years old. Which makes Zeinab's mom and dad born before the revolution. So, I want to read this quote from Dwairy (2006): "An encounter with a traditional Arab/Muslim individual is an encounter with a group of people that live inside her and still play a major role in directing her behavior" (quoted in Amer & Jalal, 2012, p. 93)

So let's really build this out. Perhaps Marion or Mahmoud have parents named Fatima and

Feisal. Let's say they are 25 years old in 1955, and 15 years old in 1945, age 5 in 1935 and born in 1930. Iraq joins the League of Nations in 1932 but Britain retains power. In 1920, a treaty following WWI 'mandates' Iraq to Great Britain and Britain rules the Kingdom of Iraq through 1920s, the monarchy and dwindling support for Britain's involvement throughout 1930s, 1940s, and 1950s. But there is growing revolutionary upheaval among youth—were Fatima and Feisal revolutionaries? Importantly, Saddam Hussein was born in 1938—right, so it was in this context of unrest and dissatisfaction that Saddam Hussein developed into who he was (Fandrich, 2012). So if we just build this all the way out, Fatima and Feisal would have turned 40 in 1970, 50 in 1980, 60 in 1990, and 70 in the year 2000, Marion and Mahmoud would be 40 in 1995, 50 in 2005, and 60 now in 2015.

Stepping back, what do we wonder? What do you notice?

Participant: Well I notice how many decades of war Iraqis have undergone—even Zeinab at only 30 years old has hardly ever known peace.

Facilitator: Indeed, in the years between 1985 and 2015 there have been as many or more years of war as there has been peace. And peace is only a technical term we use to describe a nationstate that is not under outright declared war or active fighting—right? But a nation that has experienced this much violent unrest does not recover structurally, economically, or psychologically at the point the wars end. We cannot understand brief peacetime periods as periods of health but of tentative repair and healing or of gearing up for future unrest (Silove, 2007).

If we look here, at this treaty in 1920, Iraq proper is a very young country, the boundaries of which cannot be understood as fixed (Fandrich, 2012; Nydell, 2012; Tripp, 2007). But Iraq fits into the broader complex system that is the Middle East and broader Arab world. So I want to distinguish between some important terms. Much of the Western world's ignorance and inflammatory reporting and behavior in/about Iraq is a function of loose use of terms.

Culture is broad and includes religion, gender, profession, race, ethnicity, nationality, generation, political affiliation, roles and sexual orientation (Rahiem & Hamid, 2012). *Ethnicity* is an individual's subjective sense of group membership based on shared ancestry, kinship, or language (Rahiem & Hamid, 2012). *Arab* is a cultural and political group used to distinguish the population who speaks the many dialects of Arabic spanning from Europe through the Middle East to Africa and Asia. *Arabian* is an ethnicity. "Arab" is a general term a bit like "European". Arabs see themselves, despite differences, as a clearly defined cultural group that are members of the Arab League. Arabs and Muslims are not the same thing. There are 22 member countries of the Arab League that contain 360 million Arabs, 5% of whom practice other religions like Christianity and Judaism. In contrast and barely overlapping, Muslims are the majority in 56 countries all over the world for a worldwide total of 1.8 billion Muslims. Islam is the second largest religion in the US and Europe (Nydell, 2012).

Generally speaking, Iraqis are both Arab and Arabian meaning that they speak an Iraqi dialect of Arabic and are among the ethically semitic groups that originated on the Arabian peninsula. Even though most Iraqis have descended from Bedouins of the Arabian Peninsula, Iraq itself,

like Jordan, is in the Levant region—this is a geographic distinction and does not relate to the ethnic make-up of modern day Iraqis. Other semitic Arab groups include those in Lebanon, Syria, Palestine, Jordan, and today's Arabian peninsula (Nydell, 2012). Iraq has an extremely complex society made up of competing groups at virtually all levels of society including cultural (Arabs, Chaldeans, Kurds, Turkomans, Armenians), religious (Sunni Muslims, Shia Muslims, Christians, Jews, indigenous Mandeans, Yazidis), socio-economic classes (royalty in the upper class, professionals, soldiers, and landowners in the middle class, and peasants in the lower class; Bedoiuns are nomadic outsiders that make up 10% of the population and are admired for their maintenance of traditional living), and many conflictual political parties and associated armed forces (Iraqi Communist Party (ICP), Islamic Dawa Party (IDP), YPG, YBS, HBS, PYD, PKK, Patriotic Union of Kurdistan (PUK), Kurdistan Democratic Party (KDP), Yazidi brigades, KRG and associated peshmerga, Kata'ib Hizbollah, Ansar al-Islam (Supporters of Islam), Jaish al-Mujadiheen (al-Mujhaideen Army), Kata'ib Thawarat al-Ishreen (1920 Revolution Brigades), Islamic State of Iraq and the Levant (ISIL), Asaib Ahl al-Haq, Al-Mahdi, al-Qaeda, Islamic Army of Iraq, Army of the Men of the Naqshbandi Order, General Military Council for Iraqi Revolutionaries, and others (Bayoumi & Harding, 2014; Education for Peace in Iraq Center (EPIC), 2013, 2015a, 2015c). Command structures and intergroup loyalties shift constantly as the stakes associated with historical tensions and various interest groups shift in an unstable social landscape (Education for Peace in Iraq Center (EPIC), 2013, 2015b, 2015c; Nydell, 2012).

Despite social upheaval, historically, social classes in the Arab world have had little tension. Arabs have been generally accepting of their socio-economic status but social mingling of classes has been rare and understood as improper unless done so casually in public business transactions. Generally speaking, there are 30 million Iraqis, 97% of whom are Muslims(Nydell, 2012).

What questions are there so far?

[Respond to questions of participants.]

When Western reporters make assertions such as "Muslims think X" or "Arabs want Y," with this level of societal complexity, do we think these statements can possibly be true? We must see more complexity in what American media presents as simple.

So what we don't know about this hypothetical Iraqi woman is when she arrived in the United States. The first wave of refugees after the OIF invasion in 2003 were fleeing Ba'ath party members who had apparent Saddam loyalties (Fandrich, 2012). After that a huge number of refugees fled in the unrest leading up to and following the consequential bombing of the Al-Askari mosque in 2006. The bombing of this mosque, one of the holiest sites in the world for Shi'i muslims, was a catastrophic transgression and loss as it is the burial place of members of the prophet Muhammad's family. Although no entity claimed responsibility for this attack, general discussion in Iraq about this include debate about the likelihood that attacks were carried out by Saudi Arabia or Iran in an effort to stimulate civil war in Iraq (T. Alziadi, personal communication, August 16th, 2016).

What Westerners do not consider is that Islam is actually one of the only religions in the world

that explicitly honors the sacredness in other religions. By extension, Arabs respect all religions and will hold in high regard any genuinely devout religious person regardless of the particulars of their faith. Religions and their practices and houses of worship are sacred to Arabs (Nydell, 2012). For this reason, bombings of houses of worship are a brutalization of Islam itself. The bombing of the Al-askari mosque in 2006 indeed plunged Iraq into a complex civil war of widespread ethnic and sectarian cleansing and geographical redistribution and segregation of competing factions. Through 2006 and 2007, an estimated 100 Iraqi people were killed each day (Tripp, 2007). By the 2010 Arab spring, 100K Iraqi refugees had submitted requests for resettlement (Fandrich, 2012). Hundreds of thousands more were internally displaced from their previously interreligious, interethnic, multipolitical communities to regional havens and 4.5 million orphans were left to wander unaccounted for (Nydell, 2012; Tripp, 2007). The "Arab Spring" was a period of social unrest and protest by younger generations in and around Arab countries—they sought less oppression and more political rights. Broadly speaking, this Arab Spring has or had been a hopeful time. Although we in the West recycle the narrative that Arabs do not like our way of life, this is inaccurate and misunderstood (Lifton, 2003; Nydell, 2012). In fact, younger generations of Arabs, just as their American counterparts, embrace things like technology, education, and progressive values regarding equity between sexes. Smart phones and social media in younger generations is what facilitated the Arab Spring. The world over, social media is serving an organizing function (Nydell, 2012).

What is true is that Arabs disapprove of European and American social and moral standards but do not wish to proselytize or change the society—they merely wish to protect their own. This does not mean that technological advances are to be rejected—Arabs do not reject science but merely wish to be discerning about what Western "advances" they incorporate into their societies (Nydell, 2012).

As we absorb this political and social history, we should remember that it is an Arab cultural value to maintain conservative standards of morality. This is surely a motivation that we are familiar with—for Arabs, laws have historically been understood as an appropriate way to ensure traditional values if other means fail (Nydell, 2012). This is akin to American political conservatism but is more thoroughgoing—more people agree that this is not only how society is but is the natural order.

[Returning to timeline on board.]

So if we're sitting with Zeinab in 2015, what are the places in this whole array where there might be valuable stories to unpack?

Participant: Well Zeinab would have been quite young during the invasion of Kuwait and Operation Desert Storm.

Facilitator: Indeed, she might have been 5 years old. Perhaps she remembers this? How might a five-year-old remember something as significant as this? What are her stories about this?

It is also significant then that Zeinab would have been born in 1985 right? I mentioned earlier that this was right in the middle of the Iran-Iraq war, which is known for being the most

gruesome of the 20th century. It spanned the 1980s in Iraq. The Ayatollah Khomeini took power of Iran shortly after Saddam Hussein's rise in Iraq. When Shia rebels attempted the assassination of the Iraqi deputy prime minister, Saddam declared war on Iran. This eight year war ended in a draw but was devastating to Iraqi infrastructure, financial stability, credibility in the region, and resulted in approximately 200,000 Iraqi deaths, 400,000 injuries, and 70,000 prisoners. The al-Anfal campaign by Saddam Hussein in the final two years of the war consisted of a widespread chemical weapons attack on Iraqi Kurdish populations who supported Iran, resulting in 5000 deaths by chemical warfare and 80% of Kurdish villages destroyed (Fandrich, 2012; Tripp, 2007). After this expensive and embarrassing war with Iran, Saddam consolidated power and attempted to bully neighbors Saudi Arabia and Kuwait. When neither acquiesced, he invaded Kuwait in 1990 resulting in immediate UN trade embargo, the passing of Resolution 678 by the UN Security Council authorizing military force if Saddam Hussein refused to withdraw forces from Kuwait, and ultimately the comprehensive air bombardment that was Operation Desert Storm in first few weeks of 1991 (Tripp, 2007). These bombings completely devastated Iraq, more than had the Iran-Iraq war: living conditions, infrastructure, and the Iraqi economy were decimated (Fandrich, 2012).

The invasion of Kuwait led to the unprecedentedly strict UN trade embargo. This embargo of the 1990s caused consequent and consequential suffering as Iraqis had access to no oil proceeds, no fertilizer, pesticides, agricultural technology (neither electrical nor water purification) and nearly no food. Citizens suffered hunger, malnutrition, and poor access to medical care (Fandrich, 2012; Tripp, 2007).It is estimated that 5000 children died per month and there were over 1 million total deaths during this period. Many prior professional middle class Iraqis resorted to crime and black market trade in order to keep their families alive (Fandrich, 2012). In this context, what might we wonder about Zeinab's early life?

First, we might wonder about the story of her birth—right? That is a significant event in the lives of parents. It was also a difficult time in Iraq. What might we wonder about Marion and Mahmoud?

[Brainstorm these questions.]

Interestingly, family planning is permissible and promoted in Arab world. Many Arabs use birth control and limit their family sizes as an economic choice. Arab society is fundamentally structured on the extended family unit; Arabs feel close affiliation with all aunts, uncles, cousins, etc.. For most Arabs, 'close family' constitutes over 100 people in total. Family planning is common and births are chosen—making families enormous networks of beloved dear ones (Nydell, 2012).

[Add sibling dots to the timeline board using more colors in each generation for effect.]

So Arabs are raised among large families of adoring adults who they also perceive as authorities. Respect for adults is the paramount mark of good behavior. In these extended families, attachment patterns are more diversified wherein a baby may have many similar attachment to five or six female relatives (Rahiem & Hamid, 2012). How might this have shaped Zeinab's life? Or Marion and Mahmoud's lives?

[Brainstorm.]

What are the odds that an extended family of more than 100 people escapes the violence, suffering, and fear that consumed their nation for this many decades? The odds are that Zeinab's close relatives have suffered variously and acutely at any/all of these junctures. What are these stories? How might this shape our conceptualization of Zeinab: how she has come to be here and what being here means?

[Pointing to board.] Here in 1979 Saddam Hussein took power of the Ba'ath party and consequently of Iraq proper. The Ba'ath party had been in power for many years by this point having taken control in 1963. Marion and Mahmoud would have been 10 in 1965, shortly after the Ba'ath party took power. Saddam Hussein's rule did not lesson upheaval but involved a bloody cleansing of opponents through a fierce accrual of power. His 'republic of fear' created an insidious duality between the intense fear for life and family and the intense necessity of outward enthusiastic devotion to Saddam (Fandrich, 2012).

Okay, so during this whole time, Marion and Mahmoud as well as Feisal and Fatima are family members, with family responsibilities, that we can assume they take extremely seriously. Let's talk about parenting. Authoritarian parenting is likely to be an aspect of Muslim family networks wherein corporal punishment is acceptable—child abuse is never to be condoned but cultural and environmental contexts must be considered. If you encounter corporal punishment in your clinical work, use this is an opportunity for education about American standards of discipline and behaviors that are specifically never understood as acceptable in the United States. Muslim children often experience authoritarian parenting as demonstrative of parental love, which is in conflict at times with American parenting values that favor authoritativeness (Rahiem & Hamid, 2012). This can have inter-family and intra-family implications. This is one of the tensions of this work. It is possible for us to respect that some parenting behaviors that our society deems abusive may not constitute abuse in their culture, while still educating and holding immigrants accountable to our society's laws.

Arabs believe one should behave so as to make a good impression because honor is a collective enterprise that extends from an individual in a momentary interaction to a permanent representation of the whole family or community to which one belongs. Therefore dignity and reputation are vital and much effort and social monitoring goes into such maintenance. In contrast to the independence encouraged by Western parents, Arab parents prefer their children to remain socially, financially, and especially, emotionally dependent (Nydell, 2012). This can be very difficult to navigate when acculturating.

Maternal respect is taught as a part of Islam and is reflected in the Hadith; "Heaven lies at the feet of one's mother" (Ali & Aboul-Fotouh, 2012, p. 38). In the Middle East, children are very close to their mothers. Mothers wish for this and it is culturally endorsed—this closeness is not the Western notion of enmeshment or the pejorative 'helicopter parenting' but a culturally distinct model for maternal parenting dynamics (Ali & Aboul-Fotouh, 2012). An Arab man is the public head of household and although a woman may defer to her husband as a public show of respect, their process in private may be more collaborative and egalitarian. Arabs do not see

traditional gender roles, by and large, as oppressive but rather as accurate accountings of the innate differences between the sexes. What we see as restriction, they see as protection. This is not blindness or ignorance but a disagreement (Nydell, 2012).

In fact, in the 50s and 60s, Iraqi women were some of the most liberated in the Middle East. Women accessed higher education to become advanced professionals. The following is a quote by a woman known as "Salwa N." who was a medical student in Baghdad during the "intifada" or "uprisings" of the early 1950s. She went on to become a pediatrician and fled Iraq for the U.K. in the 1990s. In this quote she reflects about the revolution and the energy among young adult student populations during these revolutionary years:

"I was not a member of any political party, but I remember that my friends and I were always demonstrating against this or that. Some of my friends were communists and others were Arab nationalists. In the mid-1950s, we were protesting against the Baghdad Pact, an alliance with Britain and the USA. We demonstrated in support of Nassar, especially in '56 when he was attacked for nationalizing the Suez Canal. Sometimes we just shouted anti-government slogans. The police were violent at times. One several occasions, people got shot at. But we would still continue. Lots of girls and women took part in these demonstrations. There was never a sense that women should not be part of these actions. On the contrary" (Al-Ali, 2007, pp. 74–75).

Saddam Hussein reversed much of this liberation when re-embracing traditionalist Islamic interpretations to consolidate power. Regarding today, it is worth noting that feminism, though a variant of that in the West, has been and is currently alive and flourishing in the Arab world beyond Iraq. Arab feminists cite the Qur'an's clear messages of social justice for women and seek to make gains within—not beyond—their Muslim context (Nydell, 2012). In the Middle East, feminism is not understood as a subversion of traditional family values, responsibilities, opportunities, but as a fair welcome to and respect for the contributions of women in higher education and in the professions. This occurs within their distinctly Arab, distinctly Muslim, worldview. As one female Iraqi National Assembly member comments: "To tell you the truth, I am not a feminist, I don't want to commit the same mistakes Western women have committed. I like that family should be the major principle for women here" (Nydell, 2012, p. 45). As of March of 2011, Iraq had more women in parliament, 82 total, than any other Arab nation. Muslim women tend to scoff at the degree to which Westerners preoccupy themselves with the way they dress—including the hejab. Arab women often choose the hejab and other aspects of traditional dress out of an anti-imperialist, nationalistic, and self-protective impulse that is not understood as simple-minded—rather a nuanced, political, well-considered commitment to traditional religious and cultural values. Women see gender-based traditions as designed to *protect* them from violence, objectification, and suspicion of impropriety (Nydell, 2012).

[Show video: "Watch Muslim women explain what their hijab means to them" by the LA Times (Biagiotti & Khan, 2016).]

Nowhere in the Arab world are men and women as free to interact with one another as in the West. Any cultural rules have been established to protect women (and by extension their families) from appearance of dishonor. Women interact freely with their female networks and with close male relatives. The appearance of impropriety matters more than factual events—

women avoid situations involving social intimacy of any kind with non-family males not as a personal or family policy but as a total social rhythm. This is how it is—women are not being "duped" which is a common interpretation by the West but are making agentic decisions to renew their commitment to tradition (Nydell, 2012).

So how does this information add texture to what might be Zeinab's story?

[Brainstorm with participants.]

How might these gender-based values shape how we would interact with clients?

[Brainstorm with participants.]

One important thing to remember is that physical touch with strangers is cautioned against and is outrightly prohibited between unacquainted men and women. Although a woman wearing a hejab is usually an indicator of some level of conservatism, during an initial interaction in the waiting room, there is no sure way of knowing the degree of conservatism and the extent to which a family has acculturated to American customs of greeting. It is most likely an outright impropriety for a male provider to shake the hand of a female patient. Same-sex hand shakes may not be seen as improper but depending on acculturation levels may still be seen as embarrassing or uncomfortable. The situation between a female provider and a male patient (or the husband of a female patient) is a more nuanced encounter involving several variables (conservatism, acculturation, and the intersection of a gender/profession power balance). This does not need to be a stressful negotiation. You can replace handshakes with a non-touch greeting or shake readily when one is offered to you.

Okay, looking at this timeline again, what else do you notice about this family's story?

Participant: Well if extended families are so important, I guess I wonder about these marriages—what was going on when these couples were married and how did the joining of families play out?

Facilitator: Sure! Marriage is a major developmental milestone right? And in each of these cases, they occurred during significant national events. Iraqis once by and large favored secularization of government and many entered into Sunni-Shia marriages. Although xenophobia regarding Iraqi Jews, Kurds and other minorities grew toward the end of the 1950s, it was not until the 1963 Ba'ath coup d'etat that a previously absent sectarianism consumed national politics and became institutionalized and violent (Al-Ali, 2007; Tripp, 2007). Today intersect marriages are socially impossible and dangerous for those currently married (Nydell, 2012). The marriages from the 1940s-50s didn't dissolve once it became dangerous. Families struggled and became targets because their very family structure functioned as a public confession of political sympathies. If Fatima and Feisal were married across social boundaries, how might that have played out for Zeinab?

[Brainstorm with participants.]

Let's talk a little more about family life. For Arabs, family takes precedence over one's job, friends, and other responsibilities. These family arrangements create the assurance that one will never be destitute—and all are expected to contribute to the pooling of resources. One of the aspects of Iraqi culture that complicates current conflicts are the competing interests of large family clans/tribes within which loyalties are strong. Marrying within the family has historically been a way families can ensure a match in which honor, finances and loyalties are familiar. This has enabled the kinship and clan orientations that supercede loyalty to nationality. Westerners have an understanding of Arab marriages as polygamous. In reality, polygamy is very rare in the Middle East (1-2% of men). The practice developed following 7th century warfare that left many widows and children. It is a controversial issue in the Middle East and is only practiced when all wives can be provided for equally. Iraq only provisionally allows polygamy although the practice is very common among less educated populations that live in the countryside (Nydell, 2012; T. Alziadi, personal communication, August 16th, 2016).

Islam forbids premarital sexual relations. For many Muslims, their first romantic experiences take place with their spouse. Premarital relationships can damage the credibility of the person and the honor of the family if they become public (Rahiem & Hamid, 2012). We can also anticipate that sexual activity and dating culture among adolescents may present formidable inter-generational problems as teens acculturate at a rate that outpaces their parents. In the West, we think of adolescence as a developmental period in which we experiment with new forms of love—right? Romance and strong extra-familial social bonds are ways young adults learn about themselves in the context of mature and nuanced forms of social closeness (Siegel, 2015). With adolescence for Westerners, comes secret-keeping, trouble-making, and boundary-testing behaviors. These are not understood in the Arab worldview as appropriate regardless of the developmental stage. "Privacy" does not have a direct translation in Arabic—the closest word means "loneliness." This is a good example of how linguistic realities relate to conceptual ones: Arab families are very close. They don't understand the Western desire to be alone. Loyalty to family is paramount to individual desires (Nydell, 2012).

Men are the assumed heads of households in public but this does not usually extend to how the couple functions privately. No abuse is allowed by Islam. Islam assumes that the sexes have different roles in society but neither an imbalance of power nor a victimization or exploitation of one over the other (Ali & Aboul-Fotouh, 2012). Parents receive credit and blame for their child's notable actions. Children, particularly sons, are expected to provide for their parents and unmarried sisters (Nydell, 2012). So if Arab society is structured around family, how might this level of war and loss impact Zeinab's family?

[Brainstorm with participants.]

Ok, so what else stands out to you about this timeline—what other stories might we wonder about?

Participant: "Well I guess I am just wondering about Britain's involvement and the importance of Islam for the people over which they ruled."

Facilitator: Indeed, as we've talk about, not all Iraqis are Muslim but throughout the Arab world,

Islam undeniably influences society at all levels. We must understand even Arab religious minorities as having a distinct worldview that includes the inevitable influences of being raised among Muslims and in countries whose governments and citizens have centuries-long histories of battling over secularization. The psychology of modern Muslims cannot be understood as separate from religious cosmology and Muslim spirituality (Haque & Kamil, 2012). These are mesosystem, exosystem, and macrosystem realities in the Arab world.

So, understanding Islam and its role in the Arab world is essential. Religious competence requires basic information about Islam but accurate information is very difficult in today's Western media (Amer & Jalal, 2012; Haque, 2004a, 2004b).

For Arab families, piety is one of the utmost virtues (Nydell, 2012) This is not all to say that individuals do not vary within a family—right? Just as in the U.S., patriarchal and matriarchal values influence a family but, individuals in all the generations evolve and react within and against these familial traditions. The ongoing impetus for religious devotion varies from person to person and may vary within a family—intrinsic commitment and extrinsic motivation are both always at work in determining religious devotion (Haque & Kamil, 2012; Rahiem & Hamid, 2012).

There are five pillars of Islam. The first pillar is reciting the declaration of faith, which is "there is no God but God and Muhammad is the Messenger of God". Praying five times daily is the second pillar. Prayer occurs at dawn, noon, afternoon, sunset, and night. Because the prayer times change slightly everyday, mosques in the Middle East broadcast the call to prayer as a reminder. The call to prayer starts with /Allahu Akbar/ or "God is great" which you might hear as a form of congratulatory greeting or statement of gratitude in casual conversation. The third pillar is giving alms at a rate of 2.5% of net family income. Muslims understand Islam as *the* model religion of social justice. The fourth pillar is fasting during the month of Ramadan, which serves to rededicate a person to humble and faithful lives of self-discipline. Ramadan is the ninth month of the Islamic lunar calendar and shifts several days every year. The traveling or ailing need not fast until their period of upheaval is complete. The fifth pillar of Islam is making the Hajj—the pilgrimage to Mecca at least once if health and resources allow. Following this pilgrimage, the title "Hajj" may be added to a person's name (Haque & Kamil, 2012; Nydell, 2012).

Integral to the beliefs of Muslims is the mandate to recognize and honor the truth inherent in other religions (Nydell). *Islam* is derived from the Arabic word for "peace" or "submission"(Haque & Kamil, 2012; Nydell, 2012). *Muslim* means "one who submits" to the will of God. *Allah* is simply the Arabic word for "God". So Arab Christians also pray to Allah (Nydell, 2012).

Muslims evaluate historical and daily events by considering whether spiritual needs and ideologies have been honored and furthered and not by any political standard or interest (Nydell, 2012). Muslims assume responsibility for their actions by acknowledging their own free will while also believing that Allah has determined their fate—this duality is known as the "Middle Path" and presents Muslims with complex interpretations of their own human condition, about which there is much theoretical debate among Islamic scholars (Amer & Jalal, 2012).

The Islamic legal code is the subject of wide ranging interpretations among scholars even within the same family. This code is made up of three texts: the Qur'an, the Hadith or "Shariah", and the Sunnah.

There are a few notable differences between the Bible and the Qur'an: the intercession of man to God on behalf of another's sin is not in the Qur'an, prayers in Islam are made directly to God, Jesus was not believed to have been crucified as God would not do this to his prophet, thus, Muslims do not believe Jesus resurrected nor that he is divine—all facts which lead to the Muslim rejection of the Christian concept of the holy trinity (Nydell, 2012).

The Hadith and Sunnah are additional collections of texts with variable interpretations that variously account for the Prophets actions, words, decisions and practices. The Hadith are quotes of the Prophet Muhammad. The Sunnah, which are second source accountings of the life and attitudes of the prophet, are interpreted using consensus among scholars and analogy to other similar issues. For example—wine is explicitly disallowed, therefore other substances are prohibited as well even though they are not mentioned. Islamic law also addresses mental health issues and care (Haque & Kamil, 2012). The Sunni and Shii have different sets of Hadith and attend to different aspects of the Sunnah. The Sunni-Shii divide is originated from disagreement about the succession of authority after prophet Muhammad's death (Nydell, 2012).

"Sharia law" or Islamic law is 70% made up of the Hadith—making it up for debate and modification. Sharia law is not adopted wholesale—rather in most countries including Iraq, there are some combinations of secular and Islamic jurisdiction. Islamic law is understood as fluid and malleable; because it is broadly accepted that societies change, only a small minority of fundamentalists interpret the Sharia, in its totality, as mandating a return to lifestyles of centuries past (Nydell, 2012).

Saddam ruled for the majority of the lives of current Iraqis; however, the people of this region have been at war for decades. Britain overtook the distinct Ottoman provinces of Baghdad, Basra, Mosul, and unified them in one nation state of Iraq in 1920. Subsequent unrest among Shia Muslims and Kurds compelled Britain to establish a ruling structure of a Hashemite (Sunni) king who was to be supervised by Great Britain (Fandrich, 2012). Power changed hands in Iraq multiple times since then, through internal coups, and assisted intervention by the British. During and following this period, political instability caused increases in repressive leadership used to retain control. In response to these strict state boundaries, the historical mistrust of British interference, and the newly discovered but rapidly draining oil resources, Iraqis began developing a strong anti-foreign sentiment (Al-Ali, 2007). Throughout these decades, Yazidis, Kurds, Turks, Assyrians, and Christians have all been very concerned that their rights would not be honored in government turnover .(Fandrich, 2012)

Sunni and Shii are followers of different sects of Islam (Rahiem & Hamid, 2012). The term "Shiite" is an English creation used for the convenience of making Shiite plural by adding an "s". The proper use is "Shii" for singular and "Shia" for plural (Nydell, 2012). The Sunni and Shia divide originates from the period following the Prophet Muhammad's death. The Shia asserted that the caliphate should have remained in the Prophet's family line. The Sunni felt this

successor should be determined electorally. The substance of the conflict between two factions today remains rooted in Islamic jurisprudence (Haque & Kamil, 2012).

What else might we wonder about?

Participant:
Well, I guess I'm surprised that women seem to have as many rights as they do.

Facilitator:
Yes, and as of 2011, there were 82 women in Iraqi parliament—more than anywhere else in the Arab world (Nydell, 2012). The Qur'an makes plain the equivalent rights of men and women—women and men are of the "same soul" and thus are to be honored in such accord. Examples of gender inequity in the Muslim world are functions of the interaction between culture, politics, and individual personalities and are perversions of Islamic law (Haque & Kamil, 2012). We run the risk in the West of making attribution errors—of using single cases as confirmatory evidence of what we ignorantly imagine to be the norm.

In Iraq and elsewhere in the Middle East, many women have their own financial assets, accounts, holdings, and properties that remain solely theirs even in marriage (Nydell, 2012). Women in Iraq are professionally active in all levels of leadership. Having said this, in wartime, women are often targets of violence, kidnappings, and rape. In the years between 2003 and 2006, public movement of women was restricted in large part due to the fact that they became the primary targets of an 'epidemic of kidnappings'. As of 2010, although only 14% of women were in the workforce; this low employment rate is more a function of parenting values, poor economic conditions, and violence than widespread commentary on the capacities of women to contribute politically and socially (Nydell, 2012).

What other questions might we have about Zeinab's family history given Iraq's complex history? What about education? Marion and Mahmoud would have been school-aged around the time of the rise of the Ba'ath party and Zeinab would have been in school during the strict UN trade embargo of the 1990s. What might we want to know?

[Brainstorm with participants.]

Islam conceptualizes children as pure, innocent, and with an inborn proclivity toward righteousness (Amer & Jalal, 2012). Generally speaking, Arabs adore children and have invested in their education. The average youth literacy rate in Arab countries is 90%. Iraq once had one of the highest literacy rates in the world, but is now the only country in the Arab world whose literacy rate has declined since 1970 (Nydell, 2012). The traditional Islamic view is that church and state need not be separated and that governments ought to promote religions and provide resources that it may be furthered in schools. This is less true for Arab Christians (Nydell, 2012). There is much conflict over the degree to which governments, and education therein, ought to be secular or Islamic.

In the way that Europeans are different, Arabs are internally distinct; however, the Arabic language, which is written from right to left, is a formidable unifying force that contributes to the

general favor of a unified Arab identity. Arabs feel passionately about their language believing it to be superior to all others for its beauty. Communication in Arabic is understood as an aesthetic experience. Arabic is very complex, difficult to learn and harder still to master, and allows for easy rhythm and rhyme. It is also thought to be a purer language than most because coining new words occurs easily—requiring less incorporation of other languages for to keep pace with social evolution. Arabs feel that Arabic is their paramount cultural achievement—one that binds them and because it is so difficult, excludes outsiders. Arabs also have an affinity for poetry, which is understood as the finest use of Arabic. The Arabic cultural heritage, rich in the full range of the arts and sciences, go woefully underappreciated, or even unknown, by the West (Nydell, 2012).

"…most of the chapters of the Qur'an are in cadenced, rhymed verse while some (particularly the later legalistic ones) are in prose. The sustained rhythm of the recited Qur'an, combined with the beauty of the content, account for its great aesthetic and poetic effect when heard in Arabic. The Qur'an is considered the epitome of Arabic writing style and when it is recited aloud, it can move listeners to tears. The elegance and beauty of the Qur'an are taken as proof of its divine origin—no human being could expect to produce anything so magnificent" (Nydell, 2012, p. 82). Eloquence is admired in Arab culture and the use of metaphor is frequent. This leads to problems when Westerners translate Arabic in an insufficiently nuanced manner and then hold Arabs accountable for the literal translation—this is insulting to Arabs who are educated and use Arabic for higher order communication (Nydell, 2012).

Arabs see the world in a personalized way—they care about people's feelings and feel Westerners regard things with abstraction and cold detachment. Arabs perceive their distinguishing traits to be generosity, humanitarianism, politeness, and loyalty (Nydell, 2012). Children's kind-heartedness, loyalty, good-behavior, and empathy are important educational values. "'Seek knowledge' and 'kindness is a mark of faith' are Arab sayings that encourage openmindedness and warmth" (Nydell, 2012, p.xxi). Family honor is paramount and individual reputations impact the whole family. Children are raised into these expectations and receive regular reminders of their duty to uphold family honor (Nydell, 2012).

We haven't said much yet about Iraqis' social lives. Arabs and Westerners differ on their conceptualizations of friendship. For Arabs, in addition to pleasant companionship, friendship implies a duty to assist with any favors that are requested or they at least a committment to trying. Not out-rightly refusing a request of an Iraqi may prevent embarrassing them or damaging your relationship. While, because of our professional boundaries, we do not consider our clients' as friends, an appropriate response is to doubt the outcome and circle around later and explain it didn't work out. In the West, actions speak louder than words, but for Arabs, a verbal commitment is a valued response regardless of the outcome and committing to making an attempt does not portend of outcome. Although Arab etiquette around requests may seem frustrating, indicate a lack of reliability, or churn up indignation in us, in the Arab worldview, seeking favors is not a lack of propriety but the presence of it (Nydell, 2012). When we are setting clinical boundaries, it is best to anticipate that special requests will be made and set preliminary boundaries for your role explicitly in advance.

When most Americans imagine Middle Easterners, they imagine an outdated Bedoiun ethos that is not an adequate representation of the average Arab. Arabs are more likely to be a "computer

programmer who lives in a high-rise building" than an exotic desert-dwelling nomad (Nydell, 2012, p.xxiii). Conversation over extended meals is the most popular form of entertainment for Arabs, who eat dinner late and slowly. In most Arab countries, midday meal is served around 2:30 and a large dinner with guests is served around 10pm after 2hrs of pre-dinner conversation. Anyone eating, drinking or smoking anything must be able to share with everyone (Nydell, 2012).

Mixing social classes in the Arab world does not occur informally except in the case of household help or casual market chatter. Social engagement between social classes will incur quizzical impressions by others. Arabs will avoid exposing family disputes to others (Nydell, 2012). This may shape what clinical material we have access to, at least until trust is gained and the family feels accustomed to the tasks of therapy. When socializing out of the home, Arabs spend time in all female or all male groups in effort not to appear improper. Beyond family, the center of social life for most Arabs is the neighborhood mosque; Muslims use their mosques as community sources of psychological support as well as for socializing (Rahiem & Hamid, 2012). However, Iraqis have the same rate of internet media access as the United States (50%); this has shifted the activities in which Iraqis engage both in and out of the home. Arabs travel for school, work, and recreation. Social media has increased political awareness and aspirations; the Arab Spring was in part facilitated by the vast digital networks allowed for by smart phones (Nydell, 2012).

Muslims like to discuss religion and may be compelled to share information about Islam with you. They may offer this information as a favor to you because they feel confident in Islam being the third, most complete, most refined version of the three Abrahamic religions. Any response on your part that indicates a strong commitment to your religion will likely impress them. They respect other religions and see all places of worship as sacred (Nydell, 2012).

Okay, what else?

Participant: I guess I can imagine in addition to all of this, Zeinab might have conflicting feelings about coming to the United States at all, depending on what her politics are and how she has felt about the U.S. through all of this.

Facilitator:
Yes, what a sensitive point—how complicated must be Iraqis' relationships with the United States, right?

As a group, Arabs all over the Middle East understand themselves as having been victims of exploitation by the U.S. and its European allies. Recent Iraqi suffering is just the most current example of this. The situation of Palestinians is a longstanding excruciating example and leaves Iraqis to reject social use of the "refugee" label, which too closely aligns them with the fate of Palestinian refugees. As such, Iraqis usually prefer to term themselves 'exilees' (Fandrich, 2012; Mason, 2011; Nydell, 2012; Sassoon, 2011).

Iraq's relationship with the United States is a difficult one. In the two months following Desert Storm, rebels (both Kurdish and Shia) took the opportunity to rebel against Saddam expecting

U.S. support because of a speech made by President George H.W.Bush. These "intifada" or uprisings, were crushed; an additional 100K lives were lost and 2 million people fled to Iran or Saudi Arabia. The failure of the U.S. to support these rebellions in some ways left deeper emotional scars of disillusionment than those created by a decade of war under Saddam Hussein (Fandrich, 2012).

Jihad is often referred to as a holy war. A true jihad, however, must be in *retribution* for an overt attack by an attacker and is thought to *restore* justice, not promote injustice—the 9/11 terrorists thought of the acts as justified reactions to perceived injustices incurred as a result of U.S. foreign policy. The emphasis in the American media on rewards in paradise for death by jihad are overblown and insulting to educated Muslims. "A good example is a verse often quoted in the Western press, 'Kill them [infidels] wherever you find them.' The context of this revelation was the twelve-year persecution of the nascent Muslim community by enemies intent on eradicating it, and it was directed toward the Arabian pagans. This verse in no way refers to non-combatant non-Muslims today. The prophet Muhammad himself sent a letter to the monks in St. Catherine's Monastery in Sinai, which is still preserved, assuring them that they would be protected by Muslims" (Nydell, 2012, p.105). The Qur'an prohibits Muslims from being the aggressor (Haque & Kamil, 2012). Violent acts by devout Muslims are a) intended justified responses to the acts of an opponent aggressor, b) are the accidental behavior of imperfect human beings, or c) are the willful violation of Islamic law.

In the months preceding and following Operation Iraqi Freedom in 2003, tens of thousands of criminals escaped from prison due to fewer security resources (T. Alziadi, personal communication, August 16, 2016; Fandrich, 2012). Sunni extremists, intent on defeating the U.S. rushed into Iraq and murdered Shia, Kurds, and any Sunni sympathizers of the U.S.. By 2005, 40-50 extremist groups were newly operating in Iraq. Sunni and Shia militias formed to protect against various perceived threats; as these threats and goals differed even within the sects, infighting occurred causing further fracturing of groups (Fandrich, 2012).

Let's discuss language and terms. Extremist terrorists pervert the tenets of Islam. As such, they cannot be understood to be Muslims even as they proclaim to be the bona fide leaders of Islamic faith. The complexities of perceptions and the power of language to shape reality poses challenges for Western media particularly on the issue of terrorism originating in the Middle East. Language evolves. It was once that 'Islamic fundamentalism' was a phrase used to indicate extremists; this was always an unfair term and would have been more accurately termed "Islamism" or "militant Islam" which were meant as descriptors of the extremist political and social movement—not mainstream Islamic religion. Islamism is to extremist as fundamentalism is to strict, *nonviolent* traditionalist. In modern usage, an "Islamic fundamentalist" is misunderstood as a militant radical but is actually an average, conservative, proponent of old values (as in any other religion). Militant "Islamists" do not make up even 1% of Muslims, which would total 50,000 people in the US and 18 million worldwide. Rather, *extremists amount to less than 1/10th of 1% of Muslims*. Islamists not only condemn the West, *but mainstream Islam also* (Lifton, 2003; Nydell, 2012). The unintended or intended consequences of using any version of the word Islam when describing these violent fringe individuals is that we credit, mistakenly, the terrorists with indeed being pious Muslims. They are not. Today, President Obama reminds us that we must be thoughtful about the language we choose to use that we avoid

reifying the false claims by terrorists.

[Show clip of President Barack Obama's June 14th, 2016 speech "Remarks by the President After the Counter-ISIL meeting" from The White House given at the Treasury Department. (http://www.c-span.org/video/?411147-1/president-obama-delivers-statement-us-operations-isis Cue video for 12:45, play until 18:10): Text of the clip to be played:

"And let me make a final point. For a while now, the main contribution of some of my friends on the other side of the aisle have made in the fight against ISIL is to criticize this administration and me for not using the phrase 'radical Islam'. That's the key, they tell us -- we can't beat ISIL unless we call them 'radical Islamists'. What exactly would using this label accomplish? What exactly would it change? Would it make ISIL less committed to trying to kill Americans? Would it bring in more allies? Is there a military strategy that is served by this? The answer is none of the above. Calling a threat by a different name does not make it go away. This is a political distraction. Since before I was President, I've been clear about how extremist groups have perverted Islam to justify terrorism. As President, I have repeatedly called on our Muslim friends and allies at home and around the world to work with us to reject this twisted interpretation of one of the world's great religions.

There has not been a moment in my seven and a half years as President where we have not been able to pursue a strategy because we didn't use the label 'radical Islam'. Not once has an advisor of mine said, 'man, if we really use that phrase, we're going to turn this whole thing around'. Not once. So if someone seriously thinks that we don't know who we're fighting, if there's anyone out there who thinks we're confused about who our enemies are, that would come as a surprise to the thousands of terrorists who we've taken off the battlefield.

If the implication is that those of us up here and the thousands of people around the country and around the world who are working to defeat ISIL aren't taking the fight seriously, that would come as a surprise to those who have spent these last seven and a half years dismantling al Qaeda in the FATA, for example -- including the men and women in uniform who put their lives at risk and the Special Forces that I ordered to get bin Laden and are now on the ground in Iraq and in Syria. They know full well who the enemy is. So do the intelligence and law enforcement officers who spend countless hours disrupting plots and protecting all Americans, including politicians who tweet and appear on cable news shows. They know who the nature of the enemy is.

So there's no magic to the phrase "radical Islam." It's a political talking point; it's not a strategy. And the reason I am careful about how I describe this threat has nothing to do with political correctness and everything to do with actually defeating extremism. Groups like ISIL and al Qaeda want to make this war a war between Islam and America, or between Islam and the West. They want to claim that they are the true leaders of over a billion Muslims around the world who reject their crazy notions. They want us to validate them by implying that they speak for those billion-plus people; that they speak for Islam. That's their propagZQA?1]

Having said that, *over half the people in the entire world* agree with Osama bin Laden's grievances against U.S. foreign policy (Lifton, 2003; Nydell, 2012). Members of Al Qaeda and other terrorists are radical outliers who have no mainstream support, yet their grievances originate from a political zeitgeist that is consistent with mainstream anger at U.S. policies (Lifton, 2003; Nydell, 2012): "…apocalyptic terrorists can connect with mainstream emotions, in this case fear and anger, and thereby influence a society's rhetoric and policies, including that which it comes to consider possible, even if not proper" (Lifton, 2003, p. 99). The propagation of radical Islam is facilitated by two factors: a). these grievances against the U.S. are nearly universal and are reinforced in nearly all U.S. foreign policy actions abroad and b). there are many aimless and disillusioned young Muslims who feel disenfranchised when imagining their futures—such disconnection renders extremist groups both attractive and serve as a powerful in-group maintaining force (Lifton, 2003; Nydell, 2012).

Arabs throughout the Middle East have debated the merits of secular governing structures (separating government from Islamic religion) and the merits of an outrightly Islamic state (unifying government with Islamic religion). Many have feared that an Islamic state would become oppressive. The now Islamic State of Iraq and Syria (ISIS) is not a confirmation of this fear (because they are non-representative radicals) but is a complicating factor. More than 70% of Arabs believe democracy is the best form of government (Nydell, 2012). But "…for any democracy to work, it requires an informed citizenry (a reasonable form of literacy), trust in the opposition (they will give up power if voted out), and a national identity that transcends allegiance based on kin, tribe, religion, or ethnic origin. This is difficult in some parts of the Middle East because many national borders were drawn arbitrarily and incorrectly by England and France…making nations out of people who would not have willingly been united and cutting off others who belong. Middle Easterners found themselves defined for the first time by geography. Even now, we cannot consider the borders of the Middle East as fixed" (Nydell, 2012, p.123).

In the region, the tension between tradition and modernity is felt across all societal levels. Most Arabs wish for societies that balance the technological modernity of the West with traditional family values in distinctly Islamic societies—neither completely theocratic nor democratic. "The goal is a universally *moral and materially advanced* global world order" in which morality is about a balance of interests, not merely (American) self-interest (Nydell, 2012, pp.xxxvi-xxxvii).

By and large, it is *only foreign policy* that the average Arab wishes to change about the United States. Average Arabs find many things to admire about the U.S.—education systems, economic opportunity, representative political systems, and orderly societies. It is just that Arabs do not adopt Western inventions wholesale but seek to incorporate into their lives those that will be beneficial to their families and communities (e.g. medicine, education, agricultural technologies) while rejecting harmful influences that will interfere with family cohesion (e.g. loose social patterns, individual spiritualism, Western popular culture)(Nydell, 2012).

But [Read quote.] "…many people in the Middle East are profoundly angry at how they *perceive* America using its wealth and power when dealing with other nations. Perceptions become realities to people who hold them and people who lack cross-cultural experience can easily misunderstand the attitudes and behaviors they confront" (Nydell, 2012, p. xvi). This occurs in a bidirectional way. It does not help that Americans are known the world over to be poorly informed about international affairs, particularly regarding U.S. actions in the Middle East and so have little understanding and appreciation of the true roots of Arab resentment (Nydell, 2012).

"If the Arabs are angry then there is hope. If we understand the reasons for their anger, we can address those reasons and not misdirect our efforts to bring about change. If they truly hated Americans and American's values, we would have a permanent breach, a real clash of civilizations, and that would be a hopeless situation, one side trying to eradicate the other. It's not that bad. On both sides…sentiments are as much about perceptions as they are about reality—who and what people listen to and the conclusions they reach" (Nydell, 2012, p. 112).

"Muslims all over the world—like most people everywhere—just want to get on with their lives, get an education, find a job, raise their children, and participate in family and community life.

They are not inscrutable. They are not mysterious or exotic. They are ordinary people with no interest in harming non-Muslims or interfering with their way of life. That Muslims have normal human priorities is so obvious that it should not need to be stated" (Nydell, 2012, p.102).

What we have been doing together is being curious about and hopefully overawed by the immense complexity of a life of an Iraqi person. What must these stories be? What do they mean to the people who tell them? What impact must they each have had on the person you sit with? Zeinab would be infinitely particular to her life and experiences. Close your eyes for just a moment and imagine opening conversation with her about some of these curiosities. How might you begin a conversation with her about her history?

Participants close eyes for 30 seconds.

We don't have time now to discuss these ways together but write them down so that you can return to them.

We will not ever know all the stories that could be told yet that we will never know them all does not make them less there.

Notes
This discussion of this module will meander differently each time it is offered. The content included here are the highlights and is information I have chosen as vital to correcting American misunderstandings about Iraqi Muslims.

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Table E8

Step 5—Module Vi: Lecture Notes

			Fatima + Feisal		Marion + Mahmoud	Zeinab
1920	*1920	Treaty 'mandates' Iraq to Great Britain				
1925						
1930			*1930	Fatima + Feisal born		
	*1932	Iraq joins League of Nations but Britain retains power				
1935			*1935	Fatima + Feisal turn 5 years old		
	*1938	Saddam Hussein is born				
1940						
1945			*1945	Fatima + Feisal turn 15 years old		
1950						
1955			*1955	Fatima + Feisal turn 25 years old	*1955	Marion + Mahmoud born
	*1958	Revolution and aftermath				

1960							
	*1963	Ba'ath party takes power					
1965			*1965	Fatima + Feisal turn 35 years old	*1965	Marion + Mahmoud turn 10 years old	
1970							
1975			*1975	Fatima + Feisal turn 45 years old	*1975	Marion + Mahmoud turn 20 years old	
	*1979	Saddam Hussein takes power of Ba'ath party and consequently of Iraq					
1980	*1980-1988	Iran-Iraq war					
1985			*1985	Fatima + Feisal turn 55 years old	*1985	Marion + Mahmoud turn 30 years old	***1985** **Zeinab born**
1990	*1990	Saddam Hussein invades Kuwait; immediately receives UN trade embargo					***1990** **Zeinab turns 5 years old**
	*1991	Operation Desert Storm					
1995			*1995	Fatima + Feisal turn 65 years old	*1995	Marion + Mahmoud turn 40 years old	
2000							***2000** **Zeinab turns 15 years old**
	*2001	U.S. World					

		Trade Center attacks; September 11th					
	*2003	Operation Iraqi Freedom + U.S. occupation					
2005			*2005	Fatima + Feisal turn 75 years old	*2005	Marion + Mahmoud turn 50 years old	
	*2006	Bombing of al-Askari mosque (February); Saddam Hussein dies (December)					
2010	*2010	Beginning of the Arab Spring				***2010**	**Zeinab turns 25 years old**
2015			*2015	Marion + Mahmoud turn 60 years old		***2015**	**Zeinab turns 30 years old**
2020							

-- (Fandrich, 2012; Nydell, 2012; Sassoon, 2011; Tripp, 2007)
This timeline serves as a mapping of a hypothetical multigenerational family alongside a timeline of Iraq's history.

Table E9

Step 5—Training Lesson Plans: Module VII

1:30-2:50pm: "Posttraumatic Stress and Conditions of Resettlement"

Goals	**Materials**

Goals

- Immerse providers in the immensity of the resettlement process in order to increase knowledge and shift attitudes/beliefs
- Introduce providers to the "triple trauma paradigm" and problematize Western conceptualizations of posttraumatic stress and posttraumatic stress disorder
- Situate U.S. resettlement realities in the resettlement timeline
- Balance discussion with sufficiently persuasive data/research

Materials

Several white boards
Dry erase pens

Plan

1. Immerse participants in the realities of pre-migration, migration, and post-migration stages by leading collaborative brainstorm about the process. Facilitator will provide data and explanations in a responsive rather than didactic manner. "Triple trauma paradigm" will be discussed.
2. Once the resettlement process has been mapped out visually, facilitator will deconstruct the conceptualization of posttraumatic stress disorder and offer explanatory modeling as a culturally sensitive approach to PTSD conceptualization.
3. Facilitator will introduce several major paradigms of mental health treatment and discuss within Arab worldview.

Sample Script

So we've just done a rapid overview about the Iraqi Arab worldview. Anytime we try to consolidate information about a population of people, we offer a woefully inadequate summation of historical nuance and social intricacies. Not only do we risk consuming this information in an overly simplistic manner but also ignoring the vast range of individual differences within it and ascribing a complete understanding to ourselves—an understanding that is not possible. In developing these afternoon modules in fact, I really struggled to make choices about what to include and what not include—so much so that at times I wondered whether it was worth doing at all and if so, whether I was the right person to be doing it. Ultimately, I decided that learning some information allows all of us a better sense of the vast horizon of things we don't know—learning some things that are completely outside our reality better situates us to feel fitful and aware that there remains much to learn.

So we are going to move on to the conceptualization of posttraumatic stress and the process of

resettlement. I will share some about my own experiences providing services and support at a rural New England clinic. This began during my graduate training; so, I had an unusual opportunity to start this work.

Posttraumatic stress in the refugee experience is a very specific phenomenon. That refugees request services from a community mental health center is a very low base rate event (Pipher, 2002). In one sense this explains how we've all come to feel underprepared and overwhelmed to be now trying to meet this need but we will also frame this low base rate in terms of social justice and I hope you'll share my enthusiasm for providing the safest and most responsive services we can.

A Vietnamese refugee recently published an op-ed in the New York Times entitled, "The Hidden Scars All Refugees Carry". In it he describes the global refugee population in a manner that I think can help us size this issue appropriately: "An estimated 60 million such stateless people exist, 1 in every 122 people alive today. If they formed their own country, it would be the world's 24th largest—bigger than South Africa, Spain, Iraq, or Canada" (Nguyen, 2016). It is easy for us to view refugees as two-dimensional or as rare; while it is relatively uncommon that refugees seek mental health services in the United States, refugees themselves as a dispersed global community in today's world, are not rare.

We are going to use these three white boards to build out the life of a refugee together and use this to distinguish refugee traumatic stress from much of our research and understanding about posttraumatic stress disorder proper. Sound okay?

What is that moment like when you first sit down with a refugee? That very first moment? [Target response: Uncertainty of having nothing in common. Expand out on this discussion.]

That first moment can feel like there is so little common ground between myself and the refugee patient that I feel helpless or useless. We've been discussing this all morning. What we have in common is merely that we are both human which feels small and inadequate; but my experience is that common humanity is immensely powerful if leveraged sensitively. If you can establish a meaningful relationship with someone with this history, and this amount of difference between you, your clinical work will strengthen with anyone disinclined to trust and who daily lives in fear.

As we discuss this resettlement process, I want you to stay mindful of your roles from the morning interpreting activity; that is, consider this process from the stance of the refugee, the interpreter, and the clinician. Notice when you are using one lens more than another and switch. It is our responsibility to frame shift here.

Ok, so most of the research and consequently the ways we conceptualize PTSD is rooted in western history and culture (Herman, 1997; Levenson, 1995). Classic PTSD occurs when a person lives an average life, experiences a traumatic event, exhibits PTSD symptoms, and seeks counseling, right? [Draws diagram on board.] So let's discuss all the psychological levels that are impacted by trauma. [Writes on the board.] Trauma might impact the brain, the mind or consciousness of a person, the body, the heart or spirit or soul of a person, and since we are

social beings, possibly our social identities or intersubjectivity, right?

So trauma and the brain: How is the brain impacted by trauma? [Gather responses.]

Great, and so if we make a bit of a mind/brain distinction, how is our mind or our consciousness impacted by trauma? [Collect responses.]

And how is the body impacted by trauma? [Collect responses.]

What about the heart, or spirit, and/or soul of a person? [Elicit responses.]

And if we think of ourselves as social beings—how is our intersubjectivity impacted by trauma? [Collect responses.]

Now I would also argue that there is a sixth level here: trauma impacts the human social collective. We are global citizens. This concept of global citizenship frames our entire process with refugees (Pipher, 2002).

So, trauma causes our world to change. All of a sudden the world around us changes. There is an enormous relational component to the way we think about recovering and healing from a traumatic event, right?

So the reason I think about this at the level of each of these categories is that they each provide independent texture to the traumatic stress frame—what is the task of healing? It is complicated and thorough-going is it not?

So if we frame classic PTSD in this way, resulting from a single excruciating event, a person is more likely to be resilient if they have had lifetime stability or normalcy up to the point of the traumatic event (van der Kolk, 2014). The trajectory becomes something akin to 'normalcy, then trauma, then some new but familiar version of normalcy again'. This dynamic differs from combat trauma in which there might be repeated traumatic events in close succession. The PTSD diagnosis is borne out of trying to treat combat veterans—so there is much research about posttraumatic stress when there is a tightly clustered traumatic era, or in the case of multiple tours of duty, multiple traumatic eras (Herman, 1997; Levenson, 1995; van der Kolk, 2014). These factors make the clinical picture more complicated even if fundamentally the hypothetical equation remains the same: a person who had a stable childhood with few adverse childhood events encounters significant trauma and seeks to regain some approximation of normalcy (van der Kolk, 2014). People are very resilient.

But when we're talking about refugees, we are not talking about this equation at all (Kinzie, 2007). Now I'm going to use all three white boards because I want us to become really immersed in the refugee experience. So what do we know about refugees' lives?

[Facilitator uses three separate white boards—one each for audience responses about pre-migration, migration, and post-migration experiences. As participants share their knowledge about possible experiences of refugees in three stages of resettlement, facilitator writes this

information in each of these spaces duplicating where necessary (e.g. food insecurity belongs in all three stages whereas witnessing murder of family member is usually confined to pre-migration). As these lists are built, audience members are confronted with the immensity inherent to the refugee existence. The following dialogue is a mock script inspired by this discussion held during the piloting of this module in the Spring of 2015. It provides one version of how this discussion could unfold. Where specific data is cited, it was not in the original pilot. I have included additional statistics in response to feedback from the pilot evaluations. Facilitator also distributes note-taking sheet with three columns on it. Participants use these columns to build out the resettlement process for themselves—this later becomes useful in discussion about intake assessment.]

Facilitator: What do you all know about the refugee process?

Female voice: It's incredibly intensive, both before and after.

Facilitator: Intensive, yes absolutely. How is it intensive?

Female voice: I don't know about the official part of that.

Facilitator: That's ok. We'll cover it.

Female voice: I know that some refugees do not come with their families. They leave their families behind.

Facilitator: Yeah. I'm going to use the word 'abandonment' because that's often what it feels like to both the abandoned and the abandoner.

Female voice: I don't know what the word would be but kind of along those lines just feeling lost in general. You leave everything you've ever had behind.

Male voice: Yeah, they feel totally isolated and don't know how to connect with this completely new culture.

Facilitator: Yes, I'm going to write isolation on this middle board and on this board over here. What else?

Female voice: I think refugees don't know anything about this new country but also not whether they can ever return to their homelands.

Facilitator: Yes, perhaps I'll write 'unknown' in giant letters here in all three spaces—the future is very uncertain for refugees.

Male voice: Well the housing they live in is really confusing and they don't get a choice—like government housing. There are complicated logistical realities. They arrive here, don't have skills necessary for the jobs that are available to them, but they are desperate to earn an income to support their families.

Facilitator: So you've said many very important things: homelessness, shelter and probably also food insecurity, right? There are government subsidies but these have complex regulations as I'm sure you've all been learning. And we have very poor professional re-credentialing programs in the U.S.. So not only do they not know how they'll provide for their families, part of them is also grieving their professional identities and what could have been. This is particularly true to Iraqis, many of whom were highly educated middle-class professionals prior to migration (Fandrich, 2012). Their lack of opportunity to re-credential or use their expertise is a massive loss not only to them but to us.

Female voice: Well and I'm just thinking that this whole thing is made complicated by language barriers.

Facilitator: Yes—remember from this morning how difficult it was to communicate without a common language? When asylees are being interviewed by the UNHCR, they are not always

interviewed by people who speak their language natively—but the asylees' lives depend on their capacity to tell a linear and convincing story of their persecution in order to be awarded refugee designation. Not only do traumatized people struggle to tell a linear story, much of the texture that it takes to be convincing is lost in translation (Herman, 1997; Pipher, 2002; van der Kolk, 2014). This reliance on linear factual storytelling with corroborative evidence is a high standard and terrifying for refugees. This is a nice quote that illustrates the incompatibility between expectations and what is possible in this process:

"In June 2010, I applied for a refugee visa from the International Organization for Migration (IOM), which works with the UN resttlement system. The application first seemed simple: it requested basic information about me, my family, and the names of my brother and sisters. But then the application delved into the most minute details: the date my parents married, if I had received military training, if I had ever shot anyone, and if I or my family had joined the Baath Party" (Latif, 2016). But, these facts were sometimes hard to retrieve and/or represented coerced behaviors (e.g., families would join the Baath party but would not be doing so as real representation of their personal politics but out of fear).

The reliance on traumatic storytelling as a part of the refugee resettlement process may be a necessity but it is an imperfect indicator of truth and of the merits of an asylees application. Van der Kolk puts it this way: "All trauma is preverbal....Even years later traumatized people often have enormous difficulty telling other people what has happened to them. Their bodies re-experience terror, rage, and helpflessness, as well as the impulse to fight or flee, but these feelings are almost impossible to articulate. Trauma by nature drives us to the edge of comprehension, cutting us off from language based on common experience or an imaginable past" (van der Kolk, 2015, pg. 43).

Female voice: I once lived in a place where there were refugee groups of different nationalities and there were many conflicts—like the government had put them in the same apartment complex thinking that because they're all refugees, they would help each other but that wasn't true.

Facilitator: This is a vital point about Iraqis in particular. Because as we just discussed, Iraq is internally fractious. There is not much that unifies modern Iraqis; there are fault lines in Iraqi society that divide religions, religious sects, political parties, loyalists to different political leaders, tribes and clans, and various militia groups. When Iraqis are relocated to communities with other Arabs there is significant fear that events in their neighborhoods in the United States can get back to loved ones in Iraq. We've also discussed the Arab cultural value about propriety, right? Refugees managing the demands of resettlement can sometimes make choices that do not necessary follow the rules—these actions are nearly always pragmatic negotiations of priorities (Fandrich, 2012; Van der Veer & van Waning, 2004).

[Quote lines from qualitative feedback (these quotes would come from a prior administration of the training—not from any providers participating in that training): "At the end of most encounters with this uninvited minority, the final question is what more can we do to help them advance their panhandling agenda." "More freeloaders who wish to circumvent the rules other immigrants had to endure."] I want to say a few things about the perspectives given here. These are expectable reactions. Different parts of my heart and mind react differently to these

comments. I am unequivocally in support of refugees and so there is a part of me that despairs and rages when I read comments that feel so unseeing as these. But when I have those rage-filled despairing reactions, I must take a deep breath and accept where the provider is. And I expect these reactions to happen and for them to show up every time I conduct a needs assessment with providers who will take this training. The individuals endorsing these perspectives are not other—they are us—members of our professional community. So I strive to turn on my most empathic self. Here's what I hear when I am my best version of myself: I hear providers feeling exhausted and uncertain and distant from the realities of their patients.

The reaction to accuse refugees of criminality or of 'using the system' is inherently embedded in the assertion that the system has it right or that following the rules at the expense one's survival is the choice we would have them make. The vast majority of Iraqis are average people who do not wish to commit fraud or other crimes but will do so when faced with homelessness and starvation just like any of us (Fandrich, 2012; Suárez, Newman, & Reed, 2008; Van der Veer & van Waning, 2004). But resorting to these behaviors comes with significant family shame and can lead to exclusion from the community of Iraqis they are finally able to find for themselves. It is not safe to assume that Iraqis have an extended family support network beyond their own nuclear unit. Can you imagine making it all this way and still not find a community? Breaking the law or being 'conniving' (as we would interpret it) may make refugees less 'likeable' but no less deserving of fierce human love. What business are we in if not the business of loving people who others dislike (Lewis et al., 2000)?

Okay, so maybe you have already figured this out: the reason I have been walking all over the room writing our brainstorms across multiple boards is that each board represents a different stage of the refugee timeline: pre-migration (when they are in their country of origin), migration, during which time they had fled their country of origin to seek asylum in usually what is a neighboring country, live in refugee camps, and enter a holding pattern until they receive formal recognition as refugees and are resettled to a permanent country of resettlement where they enter post-migration, which is this board here.

Does anyone know the official definition of a refugee by heart?

In 1951, the United Nations hosted the Geneva Convention, which is the convention that established a universal definition of a refugee. The signatories to this convention, which include the United States, most of the European Union, Australia, and, importantly in the case of Iraqis do not include Jordan, have committed not only to recognize the people who meet this definition as formal refugees, but also agree to honor certain rights and privileges that come with the refugee designation. The most significant of rights awarded refugees is called non-refoulement, which means that once their nuclear family has been labeled "refugees", they will never be deported out of their assigned resettlement country and will never be forced to return to their country of origin.

This official UN definition is: "An individual who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality or membership of a particular social group or political opinion is outside the country of his nationality and is unable, or, owing to such a fear, is unwilling to avail himself of the protection of that country" (United Nations High

Commissioner for Refugees, 1951).

So in their country of origin on this board, are all the events that cause one to be able to receive the designation; these are severe human rights violations—the list is overwhelming: rape, pillaging/plundering, theft, home invasion, shootings, bombings, stalking, sex trafficking, kidnapping, surveillance—help me out here.

Male voice: Genocide? Torture?
Facilitator: Indeed, 20% of refugees around the world have been tortured (Gray, 1998).
Male voice: Extreme poverty?
Facilitator: Yes, while poverty is not sufficient injustice to receive refugee status, it is often both a precursor to and a result of whatever the unrest is in the country. With extreme poverty comes food insecurity and starvation.
Female voice: Yeah, what about blackmail?
Facilitator: Yep, blackmail, coercion, and death threats. So I've been working with Iraqi refugees that are about my age. If you are a 30-year-old Iraqi refugee, you have never lived in a nation that is not at war (Fandrich, 2012; Tripp, 2007).

[Pointing to earlier diagram about formula for PTSD…] So if this is birth, then what we're talking about with refugees is a lifetime of this level of uncertainty. But escaping is very dangerous—families are only willing to split up or risk the profound danger of fleeing when the existing danger in their homes far exceeds the risks of uprooting. Uprooting an entire family from one's home, history, extended network, and culture is a massive undertaking. The decision to do this is excruciating; this stage is not understood as hopeful but one marked by resignation to certain death if they stay—fleeing is the lesser of the two most profound evils on earth.

Refugees flee, beginning the migration phase, usually first, to a stable neighboring country where they claim asylum. Though they may be stable, receiving countries are often not friendly to exilees. Most Iraqis fled either to Jordan, which is not a signatory to the Geneva convention and therefore provides for exilees as a function of unguaranteed culturally prescribed generosity, or to Syria, which as we know has now had its own devastating instability (S. Anderson, 2016; Mason, 2011). There is little currently known about the fate of Iraqi exilees in Syria, how many of the Syrian refugees currently flooding into Europe are in fact Iraqis, and what additional abuses they have suffered.

Assuming that refugees claim asylum in a stable enough country like Jordan, they enter a formal refugee screening process by registering with the United Nations High Commission on Refugees. This process can take many years, during which time the fate of their family is profoundly uncertain; countries of asylum usually do not have programs in place to subsidize the living expenses of asylees nor do refugees receive certifications to find legal employment to provide for their families nor spaces for their children in schools. Children are born, grow-up, and become adults in these intermediate environments. Conditions are unstable and unsafe.

As families await their application processing, they do not know whether they will be forced to return to their home country or will be given a country of permanent resettlement. Their great hope usually is that in this interim time, conditions in their home country improve enough that

they are able to return to a stable, politically intact nation. For Iraqi refugees, whose country of origin remains in turmoil, being deported back to Iraq would likely mean death. If after this period, they receive the refugee designation, they are assigned to a third and permanent country of resettlement. Resettlement does not mean that abuses stop. They continue even once on American soil. "In a *New Yorker article,* Margaret Talbot (2008) reported on refugee families detained by the US Department of Homeland Security (DHS) in the T Don Hutto Residential Center, a former medium-security prison. Talbot drew attention to practices there such as prohibiting children from having stuffed animals, crayons, or pencils in their cells, restricting parents' access to their children at night, and conversely requiring parents to keep their children with them throughout the day—even , for example, as they disclosed their often traumatic stories to lawyers (Talbot 2008)" (Henderson, Baily, & Weine, 2010, p. 110)

What Iraqi families hope they will greet upon arrival in the United States is a country where they will not only find health and stability but one where they can form communities, work in their professions, educate their children, worship Allah, and contribute to American society. What they often greet upon arrival however, is more bureaucracy, few resources, poor services, isolation and in the case of Iraqis, a political environment that is hostile to them in particular; in fact, Kira and colleagues (2008; 2010) have shown that discrimination, oppression, and ongoing media exposure contribute the highest variance to Iraqi refugee symptoms of psychoemotional disruption and that these social forces are also related to medical conditions in neurological, cardiovascular, respiratory, and digestive systems after controlling for traumas in pre-migration and migration stages (Kira et al., 2008, 2010).

By this point, by the time Iraqis have come this far, would they not also be exhausted? Mentally, physically, spiritually, interpersonally, and in that grand and vital sense of connectedness to humanity—would they not also be exhausted? (Mollica, 2014).

Trauma exists at each stage—right? This is known as the 'triple trauma paradigm': The cumulative effects of all traumas (including personal, interpersonal, intergroup, and others) have been found to explain unique variance in these mental health outcomes beyond that which is accounted for by the aggregate sum of all trauma and victimization types (Kira et al., 2008, 2010; Kira, Amer, & Wrobel, 2014; Patel, 2003). For these reasons, Arab refugees show significantly higher physical and mental health symptoms compared to the general population (Jamil et al., 2007; Kira et al., 2008).

Now I know we all differ in our approaches to conceptualization. I'd like to take a few moments to engage with this material inside the range of major psychological paradigms. From an existential standpoint, how might we conceptualize this series of traumatic events?

Female voice: Losing themselves—like a loss of self?
Male voice: Yeah, like existential anxiety.
Female voice: Well, and there's also the literal threat of death.
Facilitator: Yes, and often they have lost loved ones—often having witnessed their deaths. What else?
Male voice: Well, they've been so violated—maybe they even question what it means to be human.

Facilitator: Yeah, so maybe they are confronted with questions about how to live a meaningful life (Harvard Program in Refugee Trauma, 2016d). And I think we as clinicians also confront these challenging questions about what meaningfulness can bloom out of this darkness. Sometimes, a refugee's religious or spiritual beliefs can moderate this existential questioning. Religion is an enormous protective factor for refugees (Ali & Aboul-Fotouh, 2012; Boehnlein, 2007; Haque, 2004b; Utz, 2012). Ok, so what about from a behavioral or learning perspective? Female voice: Well, I know that there were Iraqi translators that helped the American military during the war in exchange for promises we made that we would protect their families. They risked their lives for us but it took us years to honor our promises, we only actually relocated a few people relative to the huge number who helped us, and in that time many of their relatives were killed and resources drained. If that were me, I'd be so fed up and so distrusting of bureaucracy—the very system I risked my life and the lives of my family for (Johnson, 2013).

Facilitator: Yes, this is an excruciating example but an appropriate one and a vital piece of American history that we should know when we're thinking about our roles/responsibilities as global citizens. We made promises that we did not deliver on. Iraqi translators for the U.S. military have learned that when Americans make promises, we do not honor them. Right? What does that teach them about the kinds of systemic relationships that are possible within American bureaucracy? Zooming out a bit from the interpreters—have refugees not also learned that the unknown is terrifying?
Female voice: Yeah, like learned helplessness (Gray, 1998). It is just like they have no control over anything—they have learned that there is little on which they can rely.
Facilitator: Yeah, so relationally, they've learned that loved ones die. People they have attachments to do not survive, right? So from a psychodynamic perspective, how might we consider this?
Female voice: Well maybe they're reluctant to get close to people in the future.
Facilitator: Sure, so perhaps closeness begins to feel risky—perhaps these losses also impact their relationship with themselves: through survivors guilt or internalized ideas that somehow their love is what caused the deaths.

Female voice: Well, I don't know if this is psychodynamic but if loyalties are fluid and there are many competing sides, people you've known and trusted your whole life could suddenly become dangerous to you.
Facilitator: Yes, and that's particularly true with Iraqis. We've discussed the many fault lines that divide Iraqis, right? Well, let's say they have been placed in the US.. Each state goes through a kind of bidding process in which a state commits to resettling a certain number of refugee families. With this number comes a certain number of federal dollars that get allocated to that state. Each state then makes choices about the ways to use those dollars in order to provide for the resettlement needs of the refugees. Iraqis might be resettled in an area with significant ethnic diversity—this might be experienced as terrifying because they cannot band together in their own community. They do not automatically trust members of their own refugee group such that engaging with a multi-ethnic refugee community becomes overwhelming. So, we're seeing a high rate of Iraqi 'secondary migration' which is when families uproot once again to another state or community where they think they'll be safer, have access to better services, or find communities they can trust (Ott, 2011). For Iraqis this might be to a more ethnically homogenous rural region that has not received the federal allocation of dollars to support them. This presents

yet another transition, another set of unknowns, and fewer financial resources. They're trying to create a community of just the people they trust which is slow to grow because they are understandably slow to trust.

Okay, so here's the thing about PTSD: *post-traumatic stress disorder*. [Write "post traumatic stress disorder" on the board.] Conceptualization and diagnosis is complicated and problematic on a number of levels. So let's deconstruct this together a bit (Henderson et al., 2010).

First, we aren't talking about the simple PTSD treatment formula or a simple definition of "trauma'—right? Most refugees, and specifically Iraqis, never have a stable early life. Conflicts that escalate to severe systemic human rights violations usually occur over a period of years that can consume the development of a generation or more. So, at the very least, we're talking about something more akin to our Western conceptualization of complex trauma.

So talking about the "stress" in PTSD: refugees' symptom presentation will often vary. There is conflicting research about this, but refugees tend to report more somatic symptoms and are less likely to endorse mood disturbance (Briggs & Macleod, 2006). There are a number of possible explanations for this. It is possible that there is a unitary refugee stress disorder made up of a fundamentally different configuration of symptoms than our current conceptualization of PTSD.

Now, this comprehensive array of life experiences is overwhelming, painful, and depleting—this life timeline feels like a clear story of survival—right? Any one of these experiences independent of the others can leave a person feeling hopeless, helpless, despondent, and suicidal. And the fact that a refugee has made it here and possibly made it to your office is a very big deal and is a remarkable story of resilience and survival.

Even as I am politically and morally enraged that these events occur in the world, I also feel that the refugee story is a testament to awe-inspiring willpower in human beings. This in and of itself is humbling; despite all of these experiences and the expectable learned helplessness that results, that refugees might still enter the bureaucracy of your offices and ask for help is an enormous achievement. The refugee's traumatic stress response that we call "disordered" is better understood as human flourishing in pathological circumstances (Goździak, 2004; Silove, 2007).

Even as we choose to use the PTSD diagnosis pragmatically, it is difficult to establish a functional baseline because of the upheaval in refugees' lives (Herman, 1997). It is difficult to discern when symptoms belong to a traumatic stress reaction or are part of a different disorder constellation. Collecting information about the history of symptoms can be difficult.

Refugees may also have different attitudes about their symptoms by virtue of differences in our worldviews (Goździak, 2004). One example is nightmares. In the Western world, we tend to think of nightmares as a sign of inner torment or emotional imbalance. Some cultures see nightmares as a kind of visitation of the spirits or as a positive working through that allows them to recover from stress (de Jong, 2004). In fact, dreams in the Islamic tradition are a conduit for direct communication by Allah—a Muslim's understanding of truth may deviate from our strictly scientific definition to include a blend of science and spirituality. A Muslim client's dreams may be experienced as receiving messages from God, which is not the same thing as a

delusion or as emotional imbalance (Rahiem & Hamid, 2012). So it is very important for us to be receptive to the ways our clients might conceptualize their own symptoms and whether they see them as troublesome at all (Mollica, 2009, 2014; Raval, 2003b).

Some cultures would not define genocide or similar as a trauma inflicted on themselves as individuals but rather as an experience inflicted and received as a collective, which shifts the nature of the transgression and its meaning (Turković, Hovens, & Gregurek, 2004). So their cognitions about it would be less about individuality than about community, the world at large, citizenship, or followers of their religion. (E. Chang et al., 2012; Mollica, 2009). One's relationship to unthinkable experiences may not be about trauma having been done *to* them but as having been an experience in which they engaged mutually with an opponent aggressor; this subtle distinction shifts the refugee from victim/survivor to agentic fighter (Goździak, 2004). This perspective can vary between and within refugee groups.

The concept of a posttraumatic stress disorder may not feel relevant from their perspective for these reasons. The terrorism that happens pre-migration is the reason that they have migrated and resettled, but the reality is that terror is not confined to pre-migration. We cannot really describe refugees as being *post*-trauma. We do not greet refugees with systems that are healing and respectful but actually with systems that offer familiar traumas and a whole range of novel betrayals (Van der Veer & van Waning, 2004).

Female voice: How do you navigate this? We need to diagnose in order for them to receive services. What should we do?

Facilitator: Yes, I handle this in a pragmatic way and will say something like 'in this country, in my profession, "*posttraumatic stress disorder"* is the way I describe all the things you are struggling with. This allows you to receive X,Y, and Z services which I think will be really helpful. It does not mean that you are ill, or that you cannot heal or that things will never get better. I believe we can do good work together and we'll do a little at a time'. Then I solicit feedback from them about that. This conversation does not happen until I have already asked them what meaning they have made of their own symptoms and what has allowed them to survive.

Female voice: Yeah, I mean I guess it would be good if this could generalize to any clinical situation—really getting inside the other person's worldview without making 'expert assumptions'.

Facilitator: Yeah, what you're talking about is explanatory models for experiences, right? Our job in clinical intercultural encounters is to negotiate with our client, and with their interpreter, a collaborative explanatory model in which all three parties understand where commonalities begin and end (Raval, 2003b). [Draw Venn diagram on the board with a circle representing each the explanatory models of the clinician, the refugee, and the interpreter.] This is a difficult and time-consuming process that can feel burdensome if we're already feeling overworked and underpaid.

We have been mapping out the realities of traumatic experience inherent in the refugee

resettlement process. You have been completing your grid as well—this can become the skeleton of an initial assessment tool. We'll talk about the details of assessment and treatment in the next module. What questions do you have now?

[Group asks questions.]

Each item in these columns could be unpacked. You'll never get to all of it—that's okay. But you do need to know that it might exist. Appreciate that for as many stories as you hear there are hundreds of thousands more you won't ever know.

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Table E10

Step 5—Module VII Refugee Resettlement Handout & Intake tool

	Pre-Migration	*Migration*	*Resettlement*
Traumatic Events	Uncertainty Loss Feeling unwanted Hopelessness Grief Anger Poor health Rape Death threats Genocide Starvation Drought War Torture Shootings Witness violence Maiming Branding Sex trafficking Kidnapping Coercion/Blackmail False promises Fleeing Violence Fear	Loss of status Alienation Loss of culture/food Uncertainty Feeling displaced Relief Hope Guilt Feeling insular Terror Poor health Feeling silenced Seeking refuge Violence Loss Economic strain Despair Separation	Loss of culture/identity Uncertainty Displaced Violence Defeat Hope Joy Relief Safety/Lack of safety Bureacracy Few economic resources Grief Exhaustion Anger Despair Fear

	Feeling Silenced Escape/No escape Stress		
Points of Inquiry *This section can be used to by participants to build an intake interview guide consisting of possible questions they may wish to ask refugee patients.*			

-- The options filled in are from the piloting of this module in 2015. The version I would distribute during the workshop would be a blank grid that participants can use for note taking and then to build questions regarding their assessment curiosities.

Table E11

Step 5—Module VII Pilot Evaluations

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1 This workshop addresses issues related to refugee mental health service provision.

	Definitely not true	*Rarely true*	*Somewhat true*	*Definitely true*
Number of student responses	0	0	1	16

Comments

"This allowed me to think critically about how it would feel to work with refugees."
"Information."
"This workshop has allowed me to think critically about trauma and refugees, which is something that I have never been exposed to before."
"Maybe add a handout to accompany lecture."
"Very unique (and important!) subject area. Thank you for the learning opportunity."
"Some more time for that great exercise—do first!"
"This was an excellent introduction to some of the issues faced by refugees in their process of migration and help-seeking."
"Great integration of fundamental clinical skills—very important for 1st years!"

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2 This workshop identifies issues relevant to trauma and traumatic stress in refugees.

	Definitely not true	*Rarely true*	*Somewhat true*	*Definitely true*
Number of student responses	0	0	0	17

Comments

"Interesting was the comment about refugees experiencing trauma in a collective way."
"Also enjoy emphasis on body language/non-verbals."
"Very thorough."
"Excellent overview and compare/contrast to traditionally conceptualized PTSD."
"Well covered trauma experiences, enough to a get a good overview."
"Yes! In a very well-articulated manner."
"I would have like to more about the prodromal stage of PTSD relevant to refugees."

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3 This workshop addresses material on a level appropriate for clinician with little/no cross-cultural experience.

	Definitely not true	Rarely true	Somewhat true	Definitely true
Number of student responses	0	0	2	15

Comments

"Excellent overview and activity to experience work with interpreter."
"Very interested in this topic, emphasis on common humanity a plus."
"The end activity was very helpful and eye-opening."
"Yes! See above!"
"We were at the adequate pre-requisite level for this. People with less training may not understand."
"Even though I don't have much experience, I feel I really benefitted from this discussion."
"The information about the resettlement process was presented in a very clear manner and was very enlightening."
"I have no experience with refugees and found this workshop very useful."

4 This workshop is supported by current research and best practices in refugee mental health.

	Definitely not true	Rarely true	Somewhat true	Definitely true
Number of student responses	0	0	10	5

Comments

"I would imagine."
"Clear best practices—the nerd in me wants more research/lit but this was entirely appropriate for the class."
"I assume that this workshop *absolutely was* informed by best practices in refugee mental health but hanving no background knowledge myself, I can't rate."
"Meg, you did a very good job tying in the background information to the presentation."
"Although no specific research was stated, I thin it was based off relevant data."
"Would have been great to have references to work."

5   **Cultural competence/humility requires a combination of attitudes/beliefs, knowledge, and skills. This workshop addresses the attitudes/beliefs competency within cultural competence/humility.**

	Definitely not true	*Rarely true*	*Somewhat true*	*Definitely true*
Number of student responses	0	0	0	16

Comments

"I can relate to the concept that competency implies expertise in another's life, which may not be helpful."
"I absolutely loved the point about it's ok to come from a place of not knowing and allowing the client to be the expert and how sometimes competency is damaging."
"She provided a brief explanation on this topic that allowed me to understand the difficulty in even using the word 'competence'."

6   **This workshop addresses the knowledge competency within cultural competence/humility.**

	Definitely not true	*Rarely true*	*Somewhat true*	*Definitely true*
Number of student responses	0	0	2	14

Comments

"Good qualifier about top down vs. bottom up 'expertise' as a clinician."

7   **This workshop addresses the skills competency within cultural competence/humility.**

	Definitely not true	*Rarely true*	*Somewhat true*	*Definitely true*
Number of student responses	0	0	2	14

Comments

[No comments submitted.]

8 **The interpreter services activity was a valuable introduction to working through interpretation.**

	Definitely not true	*Rarely true*	*Somewhat true*	*Definitely true*
Number of student responses	0	0	3	13

Comments

"Excellent session—great information and good to know what to be aware of and really experience what they're feeling on all levels."
"I felt a little silly being the interpreter when they were speaking English but I can see the clinical utility in it."
"It was interesting to experience the dynamics of therapy with the interpreter."
"It might be helpful to suggest that groups cover their mouths when speaking because with common language it is fairly automatic to accidentally lip-read."
"Really awesome class. Thank you so much!"
""Thank you!"
"Great! As you noted, they won't get it elsewhere! Megan, you have natural teaching skills and a calm yet engaged and inspiring style. It was a pleasure to watch you in action!"
"Very worthwhile, only suggestion (barring extra time) would be to rotate so each student can take each of the 3 perspectives/experiences."

-- n=17

Table E12

Step 5—Training Lesson Plans: Module VIII

3-3:30pm: "Patients and Providers: Roles, Responsibilities, Possibilities"

Goals	**Materials**
• Model the process of thinking through cultural adaptations to treatments by discussing the consistencies and inconsistencies with Islam of broad psychological paradigms (e.g., psychodynamic, humanistic, cognitive, postmodern, mindfulness-based/Eastern philosophies)	Possible white board
• Mention several specific treatments that might be valuable avenues for future study given specific needs of patients	
• Engage clinicians in anticipatory problem solving regarding the logistics of service provision given the Arab worldview and the realities of resettled families	

Plan

1. Guide discussion about the ways various treatment paradigms might dovetail or conflict with Arab worldview incorporating information about appropriate adaptations.
2. Prepare clinicians to conduct intake assessments.
3. Make strong assertion about attitude and open resentments

Sample Script

In the Arab worldview, suffering is understood as a function of God's will and mercy (Ali & Aboul-Fotouh, 2012). Muslims believe in a balance between free will and the ultimate power and omniscience of God (Haque & Kamil, 2012). This fatalism is a part of Arab culture although it runs the risk of being overemphasized—Muslims do not deny that humans have the ability to manifest events; human agency is understood as a proximal impetus divinely inspired and guided for distal ends that are determined by God. The legacy of fatalism is /Inshallah/ or "If God wills it" which you may hear Iraqi patients say (Nydell, 2012). "Inshallah" may appear to indicate a surrender or submission to defeat and sometimes it may indeed indicate a lack of intention to strive; however, more often Inshallah represents the acknowledgement of the complex middle path between God's will and the options of the individual (Amer & Jalal, 2012). As such, Inshallah can be leveraged in therapy to emphasize the proximal necessity of the client in engaging and taking steps to heal (Haque & Kamil, 2012). Inshallah is one tenet of Arab explanatory models for mental illness.

Although mindfulness meditation is not used as an extra-religious concept as it is in the West, "salah" is the soothing prayer ritual involving ablution (cleansing) of the body, bowing and

prostrating, and recitation of Qur'anic verses. Eastern traditions of the psychotherapy may be well-suited and practitioners with such experience in these models may be particularly effective in avoiding whatever disenfranchisement comes from Westerners' over-emphasis on individuality (Amer & Jalal, 2012).

Let's discuss case formulation. How do you all conceptualize your work?

[Brainstorm with group.]

But psychotherapy, and therefore case formulation, is value laden (Amer & Jalal, 2012). We know this right? How does this process shift when we are producing an intercultural case formulation?

[Brainstorm with group.]

Put simply, case formulation is made up of the causes, precipitants, and maintaining influences of symptoms; when shifting to intercultural work, we are more intentional about expanding this formulation to include things like cultural identity, cultural explanations of illness, cultural factors of psychosocial environment, cultural elements of the relationship between the individual and the clinician, and the cultural elements of disease manifestation (Rahiem & Hamid, 2012; Ridley et al., 2010). So we've talked a bit about explanatory models—they are an important part of conceptualizing the situation of a refugee client.

Can anyone think of a time you have negotiated to arrive at an explanatory model with a patient? Or a time you client had a different set of ideas than you about their condition?

[Brainstorm with group.]

The Harvard Program for Refugee Trauma (HPRT) offers a frame they call categories of emotional distress (CEDs), which are locally-derived definitions or conceptualizations of suffering, stigma, symptoms, and services. These may or may not be similar to DSM descriptions. HPRT recommends assessing and fully formulating this with the client before attempting to explain or incorporate your own explanations. Bicultural diagnosis does not attempt to meld these explanations but as you work together, this is likely to occur because you will be making choices together about treatment based on your skills and ethical responsibilities and their worldview (Harvard Program in Refugee Trauma, 2016a).

What are some of the kinds of explanations people utilize to make sense of illness?

[Brainstorm with group. Explanatory models consist of several categories (medical, psychological, social, moral, magical/supernatural, and spiritual/divine); Muslims often have multiple explanatory domains functioning simultaneously (Rahiem & Hamid, 2012, p. 56). Facilitator assumes that the group will not generate 'magical' explanations in the brainstorm and will be sure to address its relevance to Arab meaning making. Facilitator will also remind participants that individuals will also have idiosyncratic explanations that are independent of

Islam.]

Indeed, Iraqis will utilize medical and psychological explanations. In fact, Islam has made often disregarded yet significant contributions to the field of psychology (child development, cognition and treatment)—this fact is valuable in enticing a Muslim patient to consider how Western psychology might have relevance to him or her (Haque & Kamil, 2012).

Science is welcomed by Islam. Muslims seek plausible scientific explanations for disease and wish to consider treatment options but will interpret all information within Islamic views of health before making choices. Within Islam, mental illness is not distinguished from physical illness—both call for a process of turning toward Allah. But culturally, mental illness is stigmatized as having derived more in spiritual weakness of the individual rather than an organized etiology guided by the divine hand, which is how physical ailments are understood (Utz, 2012). Muslims approach illness with a great deal of hope and faith in Allah's will. The Prophet Muhammad said, "There is no disease that Allah has sent down except that He also has sent down its treatment…" and "…every illness has a cure, and when the proper cure is applied to the disease, it ends it, Allah willing…" (Utz, 2012, p. 17). Mental illness prevention, within the Muslim worldview, consists of abstinence from substances and other addicting or irresponsible behaviors, seeking education so as to make informed life choice to the best of ability, and living moderately (Utz, 2012).

Stigma may or may not inform a Muslims attitude about psychiatric medication (Ali & Aboul-Fotouh, 2012). Medications containing alcohol, gelatin, or other pork products cannot be taken by Muslims. There is conflicting information about the freedom to take medications during Ramadan—the regulation of this are case-by-case and varies based on the situation and piety of individual (Rahiem & Hamid, 2012). Severely ill individuals are cleared to avoid fasting for the duration of their illness but may shift the fast to a time when their health better enables it (J. Jaffe, personal communication, August 9th, 2016; T. Alziadi, personal communication, August 16th, 2016).

Immigration status and fear of being identified or deported are real and should not be misinterpreted as paranoia (Ali & Aboul-Fotouh, 2012). But when it has been determined through significant differential assessment that a diagnosis of a severe and persistent disorder (SPMI) is warranted, it will be as devastating as it is to American families with the added complexity of cultural guilt and shame. It is also possible that the family will deny the diagnosis as a defense or because the conceptualization offered neither fits what they have known nor what they believe (Ali & Aboul-Fotouh, 2012). When SPMI is diagnosed, referrals should be made to community organizations with materials in Iraqi Arabic (there are plenty of information sheets about this and other mental health issues available in various languages on the web—just be sure to have an interpreter look them over before using). Clinicians should offer to work closely with not only case workers but also the family's Imam. Clinicians might need to counter false information about SPMI that patients might find on the internet which is difficult to do when providers don't speak Arabic. We should anticipate though, that the internet is full of false hope. Even with best laid plans and good intentions, it is also possible the family will disengage from treatment. In order to prevent attrition, we must walk the fine line between supporting the family's belief in the unseen, while also acknowledging that distal and divine causal factors are

not mutually exclusive with proximal biochemical explanations. The scope of our work is on proximal factors while supporting their process of trying to access Allah and divine explanations with Islam (Ali & Aboul-Fotouh, 2012)

Iraqis may also leverage moral and social explanations for illness. Muslims are not naturally inclined to seek services for substance abuse due to the prohibition of all mood-altering substances in Islam and the conceptualization of social substance use as sinful and weak (Ali & Aboul-Fotouh, 2012). Although water-pipe smoking ("hooka" or "sheesha") is widely available in public in the Middle East, recreational substance use of any kind is scorned as a failure to honor Muslim codes of behavior. As such, acknowledging substance abuse is even less likely among a devout Muslim or for a person from a devout family. This issue may take more time for the relationship to develop before substance abuse can be productively addressed (Rahiem & Hamid, 2012). Substance abuse services that are culturally sensible to Muslims are very scarce— fewer still are those that take place in Arabic (Ali & Aboul-Fotouh, 2012).

Suicide is strictly against Islam and is understood as a profoundly weak shunning of Allah (Rahiem & Hamid, 2012). Muslims, particularly first generation immigrants, may be insulted by the clinician inquiring about whether they have contemplated suicide; obviously, this remains a necessary professional act (Sommers-Flanagan & Sommers-Flanagan, 2009). We can protect our relationships with clients by qualifying that these are questions that must be asked of all patients and by finding sensitive ways to conduct the inquiry (Ali & Aboul-Fotouh, 2012; Rahiem & Hamid, 2012).

The process of bicultural and intercultural diagnosis is particularly important because there is one category of explanatory models that we haven't yet discussed. Can anyone think of what that might be?

[Participants brainstorm.]

The last kind of explanation is magical or supernatural. Muslims may also explain mental illness etiology as supernatural through 'whispering, magic, the evil eye, and possession. These supernatural forces responsible are known an "jinn" and are like invisible beings that are mentioned in the Qur'an as having been created our of fire. Evil Jinn—those that do not submit to Allah—are thought to cause problems for people. Jinn may whisper into our thoughts, engage in magic manipulation through hexes, and curse others through the Evil Eye of envy and possession (Utz, 2012). Also related to magic, swearing is offensive to Arabs because words are believed to possess their own power to invoke God unwittingly—swears are avoided in order to prevent inadvertently cursing an ill-fated event into occurrence (Nydell, 2012). Supernatural beliefs do not appear to vary as a function of education (Utz, 2012). Muslims who utilize supernatural explanations may not be forthcoming about these with a non-Muslim but they are crucial aspects of an explanatory model and must be considered. Psychotherapy is less likely to be experienced as helpful when the client attributes symptoms to supernatural causes. Once supernatural beliefs are uncovered, it is important to understand what they imagine the clinician's role to be (Utz, 2012).

Objectivity is highly regarded in the Western world. In fact, objectivism is *the* route to

epistemological legitimacy in Western science (Rousseau & Measham, 2007). In the Arab world however, emotions and personal subjectivity are privileged; sensitivity is valued and used to inform perspectives, opinions, and judgments. Arabs are more likely to use subjective perceptions to inform their sense of reality and truth; this does not come entirely at the expense of "objectivity" but in combination with it (Nydell, 2012).

Arabs are able to allow for multiple coexisting explanations for phenomena—these explanations, including the supernatural, are not experienced with cognitive dissonance in the way that they might be for Americans. It helps to assess all these categories of explanatory models. Involving or collaborating with the Imam of your clients choosing can be particularly helpful in maximizing interventions toward healing and giving your client the sense that the care they receive will unfold in a holistic process (Utz, 2012).

Evidence suggests that Imams would leverage a mental health referral network if they had relationships within the professional community. The clinic will lubricate the process of collaborative care and patient engagement if it starts outreach with Imams in the area (Ali & Aboul-Fotouh, 2012). Imams may suggest *Rugyah*, which the practice of reciting portions of the Qur'an as an antidote for suffering. Muslims often recite the Qur'an verse 2: 156: "Verily unto God do we belong and verily unto him we shall return" (Ali & Aboul-Fotouh, 2012, p. 36). This recitation brings hope and soothing.

Generally speaking, Muslims wish for therapeutic interventions to exist in the context of religious beliefs (Amer & Jalal, 2012). "Religious coping includes active, passive, and interactive methods,. They encompass problem-focused and emotion-focused activities. They include cognitive, behavioral, and spiritual approaches (Pargament, Koenig, Tarakeshwar, & Hahn, 2004, p. 714). It may provide meaning to the tribulation and provide explanations for such concepts as suffering, good vs. evil and guilt (Utz, 2012). We must be genuine in our convictions that the equation most likely to be helpful is clinical intervention and religious coping (Ali & Aboul-Fotouh, 2012). We also know that, just as we understand religiosity as a protective factor for Americans, closeness to Allah is associated with lower depression and a generally more positive experience of living (Utz, 2012).

Intake must include an assessment of religiosity (Haque & Kamil, 2012). Assessment questions such as these can be helpful in allowing clients to tell us what matters to them: Tell me what I should know about your religion—what is important for me to understand so that you feel understood? Do you describe yourself as religious? Do you share the same religion and level of devotion/identification as your parents? How is your daily life shaped by religion? Is your religious community a source of comfort, joy, and stress? Is there any part of your faith life that impacted your decision to come to work with me? Do your parents share the same beliefs and degree of commitment as one another? (Amer & Jalal, 2012; Haque & Kamil, 2012; Rahiem & Hamid, 2012). Encouraging patients to share what parts of the history of Islam are particularly interesting or compelling is a relationship building activity and provides valuable information about their worldview vis-à-vis Islamic law (Haque & Kamil, 2012).

You can say: "What do you believe has caused these symptoms? Many Muslims believe in the evil eye or jinn—did that play a role in your current situation?" If a magical explanatory model is

endorsed, exploring this narrative is necessary to assess the value of collaborating with their imam (Rahiem & Hamid, 2012).

Familiarity with conceptual terminology that feels relevant will help endear patients to the process of therapeutic engagement: *galb* means heart (can be used in the metaphorical or spiritual manner western psychology often uses it), *irada* means "will" (can be used when discussing client engagement and stages of change) (Haque & Kamil, 2012).

Confidentiality should be comprehensively explained in the form of an orientation to such practices in the U.S.. Middle Eastern refugees have significant reasons to be concerned about their privacy (Rahiem & Hamid, 2012; Walter & Bala, 2004).

"Highly traumatized refugee patients initially can only tolerate limited discussions of their lives. Scarce resources limit the ability of most staff to provide each patient with a standard one-hour therapy session. Using a brief contact model, therapy must provide continuous weekly support of the patient through which even the most symptomatic refugee patient or trauma survivors can be safely managed as these patients develop less symptoms and a more hopeful attitude toward their lives. Most important, HPRTs slogan, 'a little a lot over a long period of time' underscore the need for the staff to maintain a long-term commitment to the trauma survivor. These patients need to be told by the staff that they can be seen indefinitely until their situation improves. This verbal commitment of long-term treatment support by staff to the patient is especially helpful to those survivors who are socially isolated and feel hopeless about their ability to recover from the atrocities they have experiences" (Harvard Program in Refugee Trauma, 2016c).

This promise is the standard for refugee treatment. However, that it is the best practice does not mean payers agree to support it. Surely it will not come as a surprise that what is best for our patients is at times inconsistent with what managed care systems will compensate clinics for (Broskowski & Marks, 1992; Ridley et al., 2010; Van der Veer & van Waning, 2004). Providers will likely feel caught between the understandable tests of trust that refugee patients demand and the expectations of the, at times dysfunctional, systems around them. As Mary Pipher (2002) put it: "The best treatment programs for refugees are user-friendly systems" (p.298).

"The therapist must closely attend to all aspects of the therapist-patient relationship. Clear and simple communication between therapist and patient is essential for good compliance; it also promotes improved clinical outcomes. Medical interpreters must be properly used. Trained bicultural workers are the preferred choice of therapeutic partnership. Treatment is an ongoing process. Survivors often need follow up phone calls and reminders for their next visit. Remember, they do not trust the system, and are often testing the therapists' commitment to their care" (Harvard Program in Refugee Trauma, 2016d).

Muslim females should be offered female providers when possible. Mothers (and spouses) are protective of their families and may expect to accompany family to appointments. Allowing this at least initially will help build rapport. This may interfere with the provider's comfort having forthright conversations about sensitive topics but…over time as the whole family trusts you, you'll have more capital to be able to request a private conversation. It may even happen naturally (Ali & Aboul-Fotouh, 2012). Arabs tend to involve their extended families when they

are suffering— this can complicate mental health services. All hospitals in the Arab world have facilities for extended families. Iraqis are likely to be confused by and scared by Western facilities and medical practices that emphasize privacy and seclusion (Nydell, 2012).

It is valuable to remember not to take behavior at face value but it can be easy to glaze over important potentially fruitful points of inquiry when you're overwhelmed. In the same way that you fully explore changes in behavior with your non-refugee clients, do not fear asking these questions. For example, a patient increasingly going to his mosque to "contemplate" may be experiencing a negative state such as despair and suicidality or a positive state such as the exquisite warmth of closeness to Allah (Ali & Aboul-Fotouh, 2012). Among Muslims, reticence in your client can be interpreted many ways. Among them is cultural practices regarding eye contact particularly across genders. As refugees adjust to life in the U.S. they will encounter social practices that make them uncomfortable, and they will adjust, but in the early stages of resettlement and then acculturation, they may not be used to interacting freely with opposite sexes (Ali & Aboul-Fotouh, 2012). What appears to Westerners as intense anger in Arabs can be intense sincerity with regard to any degree of frustration. Yelling and banging suggest commitment to the content of the discussion and not necessarily rage itself (Nydell, 2012). "Inshallah" will sometimes be used in response to requests or suggestions—this is likely a passive decline. Arabs may ask of their acquaintances questions that to their Western counterparts may seem intrusive or too personal (e.g., one's salary or mental status). You can appropriately respond in generalities or with "Inshallah". Conversely, Westerners can inadvertently ask invasive questions about an Iraqi's opposite sex family members. Man-to-man or man-to-women should discuss female relatives only in generalities. Women-to-women can be more revealing (Nydell, 2012).

Okay, so let's talk about the paradigms we all use for formulation.

Psychoanalyis has been ignored if not out-rightly rejected by Muslims. Its foundational conceptualization of human beings as driven by sexual and primitive urges is not consistent with beliefs about the divinity of Allah and the role of the divine to guide events. Muslims believe in the sacredness of people. Traditional psychoanalysis conceptualizes living as a battle against base instincts, whereas Islam sees life as a path toward infinite closeness with Allah through rationality and spiritual choices (Amer & Jalal, 2012). Despite incongruence between classic psychoanalysis and Islam, Muslims may find that loose conceptualization of id, ego, and superego, resonate in that competing forces act on and inform our behavior. Muslims also acknowledge that people seek pleasure and avoid pain (Amer & Jalal, 2012). For Arab Muslims, intrapsychic/introspective approaches that encourage differentiation from one's family-of-origin may be counterproductive—clinicians will find that interventions aimed at increasing familial harmony will be more effective than those that implicitly value self-determination. This should not be seen as entrenching or enabling them toward dysfunctional dynamic but rather an adaptive reconciling of collective needs (Amer & Jalal, 2012). Introspection is consistent with Islam and the worldview of most Muslims to the extent that it is used for spiritual, communal actualization (Amer & Jalal, 2012).

Where psychodynamic psychology has emphasized self-actualization by surmounting primitive nature, humanistic psychology has emphasized self-actualization toward innate human potential

for goodness and dovetails well with the Islamic quest for spiritual oneness with the divine (Amer & Jalal, 2012; Dhiman, 2007). Both humanistic psychology and Islam are future oriented and potential seeking; both conceptualize the developmental task as negotiating between connection and disconnection (although most Muslims would reject that disconnection is fundamental to living (Amer & Jalal, 2012; Yalom, 1980). The concept of unconditional positive regard is not consistent with Islam because Allah is clearly understood to value certain behaviors over others. Interpersonally however, forgiveness and non-judgment are desirable qualities (Amer & Jalal, 2012).

Beyond Islam, the attention in humanism and existentialism to the human condition is inherent to the definition and struggle of a refugee. "At least four basic psychological states have a powerful impact on the emotional status of the patient. These psychological states include humiliation, anger, revenge/hatred, and hopelessness/despair. ..it is essential that the therapist work with the patient to reveal these feelings as well as their effects on the daily life and health of the patient. ..Often spiritual and existential distress related to unresolved desired for justice, retribution and punishment of the perpetrators remain a daily concern for the patient. An essential and sometimes neglected emotion associated with trauma events is humiliation. The humiliation of the survivor, his/her family and community is often the goal of violence. Public degradation can be internalized as shame and fear. Anger, hatred, and a desire for revenge can grow within the hearts and minds of survivors. Humiliation, combined with feelings of unimportance and powerlessness, heightens the depression and despair of the survivor. All of these emotions can become very intense in a real life situation where many losses, such as the murder of family and friends and the loss of one's home, have occurred. Each and every survivor is concerned in his/her therapy with the ongoing issue of social justice" (Harvard Program in Refugee Trauma, 2016d).

Emotion-focused work may be congruent with Arab Muslims who are comfortable incorporating emotion into a kind of rationality—who do not view rationality as in opposition to emotionality but as a part of a complete whole (Amer & Jalal, 2012). Process-experiential therapy offers patients the attunement of an empathic emotionally-focused clinician while also offering direction toward meaning in session (Amer & Jalal, 2012; Elliott, Watson, Goldman, & Greenberg, 2004; L. S. Greenberg, Rice, & Elliott, 1996). Experiential techniques are powerful—this can be intimidating for Muslims for whom they are unfamiliar. Psychoeducation is important to prevent distress and confusion (Amer & Jalal, 2012). Effective use of experiential approaches requires a rhythm and strong working relationship with the interpreter. Metaphors, similies, and parables are regularly leveraged in Islam and will feel consistent if used in therapy (Amer & Jalal, 2012). Arabs may expect clinicians to share their own emotional reactions. If this kind of self-involving disclosure is not a part of your normal practice you may find that this is experienced by Arab clients as withholding (Amer & Jalal, 2012). Muslims may also hesitate to share negative emotions with you as doing so may reflect weakness within their worldview. This may shift as trust increases or may suggest that a cognitive-behavioral (CBT) approach may be more appropriate (Amer & Jalal, 2012).

Religion-informed therapy is effective particularly when employed as variant of cognitive therapy where unhelpful beliefs are replaced by helpful ones from within Islam (Utz, 2012). Religious adaptations to CBT should also include religious cognitions such as the temporality of

pain in this life, surrendering that which we have no control over to Allah, and recognizing blessings rather than afflictions (Amer & Jalal, 2012; Hamdan, 2008). Within religious adaptations to CBT, ablution prayer, community service and progressive muscle relaxation can be assigned to help patients manage stress or anxiety in religiously congruent ways. Metaphor should be leveraged in treatment with Muslims but these should be derived from the client (from the Qur'an and the Sunnah)—asking the client to generate metaphors from Islamic texts that can challenge maladaptive cognitions in an appropriate and useful intervention (Amer & Jalal, 2012).

The cognitive-behavioral emphasis on rationality, education, and consultation are consistent with Islamic discourse (Amer & Jalal, 2012; Husain & Hodge, 2016). The directive role of a CBT therapist is well-suited to the Arab traditions of professional authority and conceptualization of therapist as serving a guiding or parental role (Amer & Jalal, 2012)). The behavioral notions of rewards and punishments will easily fit into a Muslim's worldview. Muslims may not see the punishments as direct consequences of the behavior but as dispensed through Allah as the arbiter. If clinicians can incorporate this role of Allah, CBT may be an appropriate treatment method (Amer & Jalal, 2012). Solution-focused models may be particularly appropriate for Muslims when the presenting complaint is limited to resettlement related adjustment. The miracle question is easily adapted to include Allah. Religious metaphor in Islamic texts can be applied to creative problem-solving. Where CBT diverges from Islam is its emphasis on internal locus of control. Muslims believe in a dual will—their own will as subordinate to the will of Allah (Amer & Jalal, 2012).

I'm going to give an expanded introduction to Narrative Exposure Therapy (NET) because it is a very specific treatment with evidence of its effectiveness with survivors of torture. This description will still be a brief one and I would recommend that you access the NET manual (Schauer, Neuner, & Elbert, 2011). Narrative Exposure Therapy (NET) is one of the only exposure treatments that has been tested on low-income high trauma populations including refugees and actually has preliminary evidentiary support for effectiveness in Iraqi refugees specifically (Hijazi et al., 2014; Schauer et al., 2011). NET researchers feel strongly that the program is culturally universal in part because of the value of oral history and story-telling around the world. NET has been developed out of the tradition of exposure therapy with the goal of generating a complete autobiography. NET restructures implicit non-declarative traumatic memories by intervening on:

  a). psychobiological neural pathways associated with traumatic experience
  b). maladaptive cognitions related to traumatic experience
  c). sensory-perceptual events related to traumatic experience.

The fear structures in refugees tend to be a cohesive neural feedback loop that is preverbal and therefore is resistant to change (Schauer et al., 2011; van der Kolk, 2014). NET therapists seek to make these pre-verbal traumatic memories more connected and diffuse in the brain by attaching linguistic connections to them. The more connected and less unitary they are, the more room there is for changing the autonomic responses to triggers and enabling affect regulation (Herman, 1997; Schore, 2012; Siegel, 2010, 2012; Silove, 2007; van der Kolk, 2014).

NET was developed with the same social justice lens as Testimony Therapy—namely that the

clinician, patient, and interpreter create a formal testimony that is signed. The history of our profession includes a tradition of clinician neutrality; the manifestation of that today is a kind of clinician temperance or non-attachment to an outcome. But with refugees, mental health professionals must take a firm and non-negotiable moral stance (Herman, 1997; Pipher, 2002; Prilleltensky et al., 2007).

NET is designed to be a short term (10-session) but intensive trauma treatment. However, work with refugees often involves significant case management demands that serve as distractions from trauma work. These are realities of refugee services and is one of those tensions we will inevitably sit with—negotiating immediate needs with the severity of long-term needs in systems with finite resources. These negotiations will always be imperfect but the best case scenario is one in which local systems make choices about local strategy based on local practice-based evidence. I will describe the NET process so that you know the ideal execution of it. Then, it makes sense to discuss how to locally make accommodations given logistical demands of responsive refugee services. If you like, we can begin this discussion in the next module. I will describe the sessions, steps, and goals of each step (Schauer et al., 2011).

In the first session, the goals are:
Greeting in culturally relevant manner
Assessment through diagnostic interview
Psychoeducation about symptoms and therapist role
Assertive statement about the universality of human rights (neutrality unacceptable)
Psychoeducation about the treatment goal/plan of developing a comprehensive and linear narrative of the entire life of the client:
1. Personal background and history prior to the 1ˢᵗ trauma
2. Experiences from beginning of threat to 1ˢᵗ event
3. Span of terrifying events with individual attention to each
4. History of escape from or ending of violent conditions
5. Life thereafter
6. Plan, hopes, dreams, and fears for the future.
Psychoeducation about what they can expect from the process of treatment and discussion of potential barriers to treatment: anticipation, anticipation, anticipation!
Explicit acknowledgement that traumatic memories are fragmented and when contradictions in retelling occur, while the clinician will attempt to clarify, there are no consequences.

Session length: 90min-2hrs.

In the second session our goal is:
Construction of the NET Lifeline

Materials: Rope with 1' for each deacde of life + enough length to extend into future decades, flowers of varied shapes/colors, stones of varied shapes, textures, and camera.

The clinician invites clients to construct a "Lifeline" on the floor or table by laying the rope (meant to symbolize the 'flow' of one's life) in a shape that feels resonant with the client's life flow. Then, the clinician encourages the client to place symbols along the line that represent

memorable or transformative events. The client chooses a symbol of his/her birth and starts at the end of the line, chronologically choosing flowers for events that serve as resources for life and stones that mark life-threatening events or sad, difficult moments. The clinician encourages the client to assign names, dates, and places to these important events. It is critical the patient anchors these events in time and space to begin the process of creating mental boundaries about traumatic experiences and differentiating the here/now from the there/then (van der Kolk, 2014). At the end, the therapist summarizes this content from notes taken during the construction of the lifeline. This is not a period of confronting the event in therapy but rather a time to chart the course through the future sessions. Then together, the lifeline is collected and stored in a box to be revisited in the last session.

Session length: 90min-2hrs.

Providers encourage clients to begin their narration in session three

Client is encouraged to begin telling the story of his history from birth to the first traumatic event. The narrative is likely to proceed with varying levels of detail that approximate this progression: childhood, pre-trauma (brief), 1st incident (detailed), posttrauma (brief), life flow between events including highlighting joys (condensed), 2nd and subsequent traumas (detailed), outlook for the future (brief).

The therapist's job is to attend to the material, take notes, and notice subtle signs that the patient is approaching or avoiding traumatic material. Patients may be approaching traumatic material when their speaking becomes fragmented, when they appear nervous or emotional, or when they brush over monumental events. In these moments, the clinician must confirm that there is at least 40-60 minutes remaining the session.

When approaching traumatic material, the clinician clarifies preceding material to anchor context, collects contextual/biographical details (ie. where were you living, what was the season, who were your friends) in an effort to make connections between non-declarative memory and declarative self-knowledge. As the client tells the story of the specific traumatic event, the clinician asks for specifiers such as the year, season, time of day, concurrent events and establishes with the client a sense of what marks the beginning and end of the event (Schauer et al., 2011; Shalev, 2007).

This part of the session moves in slow motion and both the therapist and client will feel activated. Within NET, this hot-cognitive activation is appropriate. Slowing down requires bravery. The patient imagines the beginning, takes the retelling step by step in chronological order, while sharing information about sensations, perceptions, reactions, cognitions, and emotions. The clinician keeps the patient grounded in the here/now even through the retelling.

When the client arrives at a "hot" memory, the clinician addresses the fear structure at all levels and insists on putting all levels into words with thick description. This portion is drawn out with direct questions that connect the past to the past. Clinician observes non-verbals and identifies those that relate to the fear structure encouraging the client to notice their nonverbals in nonjudgment. The clinician should be able to replay the scene in "film-worthy" detail from the

notes he/she has transcribed. If this isn't possible, the client is not giving enough detail. Therapist notes are in the client's words.

When a client becomes somatically overwhelmed, clinician encourages them to stay in the sensation, exploring it, finding its origin, perceiving and describing it so that it becomes anchored semantically.

The dyad (triad) continue with the session until some habituation has occurred. There must be a clear ending to the event being described. This ending is handled by the therapist collecting information in a directive manner about the "denouement" of the posttrauma period. The patient does not leave until their emotional state has improved, their attention shifts away from internal mental/physical activity to external/social activity, and there is evidence of a cognitive shift (that is, greater connectedness between their experience and their autobiography).

Clinician encourages journaling between sessions to manage aroused affect/memories.

Session: 90 min 1-2x/week

The fourth through ninth sessions continue this way:

Clinician encourages client to label their emotional state at the start of subsequent sessions. Then the dyad (triad) attend to the lifeline. The clinician reads the testimony from the previous session and client is instructed to re-experience the content. Therapist leads discussion about the experience of hearing the transcript aloud. Then, the narration picks up where it was left with attempts to avoid going back in time.

Session: 90 min 1-2x/week

Termination occurs in the tenth session.

Clinician reads the final transcript to the patient and all corrections are made. Then the client, therapist, and interpreter sign it in formal recognition of the achievement and documentation of the human rights abuses recounted therein. The clinician and client may choose to reconstruct the physical lifeline and reflect.

Patients may choose to submit this testimony as part of the global historical record of crimes against humanity. This model is extensive—both broad and deep—and demands profound humility from the providers who endeavor it.

I want to share this quote from the Harvard Refugee Trauma program materials: "Extreme violence creates a new historical space, where all ordinary experiences and daily activities become transformed into something radically new. Old attitudes and behaviors are re-defined. Up becomes down. Neighbors and friends becomes enemies; cowards become heroes. This new historical light casts long shadows onto old patterns, changing reality into illusion. Unfortunately, the rational scientific mind, with all of its modern technology, cannot successfully explain the hidden mysteries of trauma's aftermath. The scientist says, in effect, 'What a horrible

unclean human mess. I'll clean it up with my logical and precise analysis in order to make perfect sense of it.' But this scientific analysis almost always falls flat. A social earthquake has transformed the lives of thousands. This earthquake can never be properly understood through numbers and statistics. The artist is essential for describing the inner experience of the survivor. Only the artist's methods can penetrate to the deepest levels of the human spirit to discover these invisible wounds caused by violence and to reveal the healing processes that characterize our essential humanity…The telling of traumatic life experiences may well have become associated with empirical truths in our neural limbic systems. They deal with basic questions of truth: who is the teller of the truth? Where can we find the truth? When does the truth emerge? Finally, what is the truth? But merely knowing the truth is not enough. The essential question is this: how do we live with the truth? Every survivor lives in a culture of great traditional and artistic beauty capable of teaching the survivor and healer deep insights into courage and resiliency. Often, however, this beauty has been destroyed purposely by the perpetrator…The embrace of beauty by the survivor and healer restores a sense of interconnectedness, well-being, and meaning. The artist…tells the story, we listen closely and our violated humanity is healed" (Harvard Program in Refugee Trauma, 2016e).

What reactions do we have to this?

[Discuss.]

Let's discuss transference: what are some of the ways transference might show up for clients?

[Brainstorm with participants.]

Interethnic transference can manifest in reactions to perceived authority or distrust stemming from previous encounters with resettlement system. Clients may also deny that ethnic/cultural difference play a role in the clinical relationship. Inter-religious transference may also occur if the client, fearing being stereotyped, judge, tokenized, or misunderstood, withholds pertinent info about their religious life (Rahiem & Hamid, 2012).

Clients may inquire about the personal backgrounds of their clinicians and within their worldview this quest would not only be appropriate but so would a forthcoming response (Amer & Jalal, 2012). The best way to proceed with this is to expect this to happen, know and honor your own boundaries, but respond with honesty.

Let's talk about our own internal reactions. What are some of the ways we might react internally to this?

[Brainstorm with participants.]

That providers will have strong, impactful reactions to cultural difference is an assumed aspect of work with refugees (Rahiem & Hamid, 2012; Van der Veer & van Waning, 2004). Guilt and consequent mis-distancing is a common manifestation of this kind of reaction. Also fear of embarrassment or doing something wrong can cause clinicians to be more reticent than otherwise. Tokenizing or relying on clients as one's own source of information about the culture

beyond that which is necessary for understanding the client himself is a subtle form of exploitation and is inappropriate (Rahiem & Hamid, 2012; Van der Veer & van Waning, 2004).

The uncertainty clinicians feel when working with Muslims exist at many levels from how and what to say, what interventions are appropriate and how to define the success of them. There is so little information even Muslim clinicians may feel unsupported (Ahmed & Amer, 2012).

Misattributing domestic abuse to culturally sanctioned norms is another form of harmful provider reaction and is closely related to the reluctance to make a cultural misstep (Rahiem & Hamid, 2012). Our role is to provide education about non-negotiable norms of this country. Knowing in advance of your work what these non-negotiables are will help prevent us from retreating into harmful and professionally unethical cultural relativity.

Muslim patients may not be willing to make treatment choices without consulting extended family. This can be frustrating because it delays and complicates services but this frustration is culturally bound on our part (Amer & Jalal, 2012). Resenting our clients is its own form of critical reaction and is particularly insidious because refugees often present a heavier workload (Rahiem and Hamid, 2012). What can we do if we find ourselves feeling resentful?

[Brainstorm with group.]

I want to offer a compassionate but firm assertion. Entrenched open resentment toward refugee clients is not acceptable but its entrenchment is what makes it unacceptable. Resenting our refugee clients makes us human—imperfectly developmentally human. So let us recognize this resentment as the particularly harmful provider reaction. Most importantly, let us be unsatisfied with this resentful reaction in ourselves. That we are *open* about our resentment is also a triumph—an act of cultural humility—we all need to approach ourselves and each other with a supportive acceptance-change dialectic.

"It's natural to feel shy and anxious around newcomers. We are all a little fearful of strangers. That first reaction is nothing to be ashamed of as long as our second reaction is to learn more about the other's humanity" (Pipher, 2002, p. 333).

This open resentment should be something that we do not like about ourselves and that we are galvanized to evaluate and evolve. Safe clinical work cannot be undertaken in the context of political contempt. If you hold dear your resentment and the values you have that account for this resentment, and you do not wish to examine either, you must recuse yourself and leave this work to be done by individuals who can do it with open-heartedness. In this situation, it would be my hope that you would be able to evolve into a more permeable place on this issue. My work with refugees has enriched my life. The journey of a refugee to arrive at the threshold of a clinic is an immense one. It is our responsibility as a professionally ethical and personally moral act to leave refugee work to individuals who can find the humanity in the person they sit with (Lifton, 2007).

If we do find ourselves in the position in which one of our colleagues does recuse him- or herself from this work, it is our responsibility as culturally humble professionals to give space but also to allow for the possibility that they are able to progress in their racial identity development and

rejoin the efforts down the road. This experience with refugee services now can be an unanticipated (and initially unwelcome) catalyst for racial identity growth on the part of white providers (Helms, 1984; Holmes, 2012; Raval, 2003b; D.W. Sue et al., 1992). We are in the business of human change. We must not only encourage that in our patients but strive after it in ourselves and support it in one other.

Let's take a brief break; stretch, get something to drink and we'll return and talk about next steps.

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Table E13

Step 5—Training Lesson Plans: Module IX

3:30-4:15pm: "Sustainability, Support, Systems Issues"

Goals

- Answer participant questions
- Advocate for staff peer support and provide options
- Advocate for practice-based evidence and provide options

Materials

- List of resources for continuing education.

Plan

1. Facilitator opens time for questions and discussion.
2. Facilitator defines community of practice (CoP) and introduces the web-based CoP consisting of prior participants in the training who wish to connect to network about this work.
3. Facilitator asserts the importance of peer support, sets the standard for safety in this support structure, engages in brief anticipatory problem solving regarding the division of time in future peer support meetings, and alludes to various peer support models, the specifics of which surpass the scope of the current project.
4. Facilitator recommends resources for continuing education.

Sample Script

Let's all return to our seats.

I would like to spend the next 45 minutes situating all of our experiences from this morning and the information we have just covered into your work here with this community. I have a few comments I want to be sure I make before we end today, but usually those will get covered naturally if we have a conversation about what you are all most wondering or wanting to process.

[Participants encouraged to ask questions. Group has forwarding-thinking conversation about applying/implementing what was covered in the modules. Facilitator finds opportunity to mention the necessity of peer support and leads brainstorm about signs of vicarious traumatization and compassion fatigue, the importance of the mental health organization networking with other refugee community organizations, and the long-term development of an online community of practice (CoP) with other participants of this training.]

This work with refugees cannot be done in isolation.

Bearing the stories of refugees is not done easily. How might we recognize that we are struggling with vicarious traumatization or compassion fatigue?

[Group brainstorms; facilitator leads anticipatory problem-solving discussion.]

Judith Herman (1997) described the challenges of the trauma treatment provider as founded on the necessity for the provider to rediscover history—to be pulled out of complacence or ignorance about the past and confront their own culpability as citizen bystanders (Herman, 1997). Once confronted with the realities of atrocity, providers' roads are long: they are faced with the question, "what do I do now?"

One of the critical steps going forward is that you establish a local support structure such as supervision or peer consultation groups specifically for providers who are working with refugee patients. Logistical problem-solving can easily consume this support time but it will be imperative that members utilize a structure or appoint a leader that will allow time for personal processing of reactions to cultural difference. This consultation group must have a support function and therefore, must be experienced by group members as safe to challenge themselves and their own worldview (Lansen & Haans, 2004; Van der Veer & van Waning, 2004). This kind of vulnerability is a challenge in professional settings in which expertise is highly valued. We cannot continue to grow if professional vulnerability and humility are not organizational values. [Report what the outcome of the organizational cultural assessment was; group will celebrate cultural victories for the organization as well as discuss steps in developing systems-level cultural competence/humility.]

One of the benefits of all of us getting together for such specific work, is that as I have offered this training to more and more community mental health centers, I have connected with providers around the country who are struggling with these issues. After today, you will all have access to the community of practice (CoP) web forum that I have established (Cassidy, 2011; Li et al., 2009). Your administrators will receive the information about accessing that web-community at the end of the day. You will be able to connect with providers around the country who have taken this training and are navigating these complex issues with Iraqis.

It is also vital that the organization begin building strong connections with other area organizations providing services or cultural events for Iraqis. As these alliances strengthen overtime, patients will fall through the cracks more rarely, needs will be met in more comprehensive, creative, and collaborative ways, and the entire exosystem surrounding the refugee can function in a manner greater than the sum of its parts.

Notes

This module serves as a buffer—I have allowed minimal time in between modules for questions. If the rhythm of the day is such that it feels more appropriate to answer questions ongoing throughout the day, this module will be subsumed by lengthened versions of all the modules before it. In the event that this module does not occur in its original design here, practice-based

evidence principles and communities of practice recommendations will be mentioned and included in organization follow-up.

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Table E14

Step 5—Training Lesson Plans: Module X

4:15-4:30pm: "Evaluations"

Goals	**Materials**
• Assess the effectiveness of training intervention • Gather feedback/suggestions for improving the training • Solicit participants suggestions for what organizational goals should be set (?)	• Evaluation documents • Pens

Plan

1. Facilitator will distribute evaluations to participants. This includes forms that evaluate changes in their knowledge, skills, and attitudes/beliefs regarding this work and forms that assesses their opinion about the quality of the training with opportunity to provide suggestions for improvement.
2. While participants are providing feedback, facilitator will photograph the boards used in modules; these photographs will be included in program records as well as be distributed to the organization leadership for record-keeping. Facilitator will also distribute module summaries, module references list, and suggested reading to participants.
3. After approximately 20 minutes, facilitator will collect feedback forms.

Sample Script

I have offered this training X many times and have received exceptionally valuable feedback about how to strengthen it every time. I take these evaluations to heart; this training is an evolving entity that is built to meet the evolving needs of the people who take it. I have evaluation forms here; I'd like to use the next 15 minutes completing these. While you're doing that I will also photograph all of the notes on these boards and email them to all of you. I will also pass out my own summaries of these modules, references for them, and recommended sources for continuing education. Once we do that, we'll talk about endings and then we will end.

Sound okay?

[Group begins evaluations. Facilitator photographs, distributes, waits until group evaluations are complete.]

Notes

Depending on what platform I use for these evaluations, it would be ideal to be able to pair their post-test with their pre-test responses to be able to make true causal assertions about the quality of the training. Exploration of the technological requirements for this is beyond the scope of this project.

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Table E15

Step 5—Training Lesson Plans: Module XI

4:30-5pm: "Termination and Arab Partings"

Goals   **Materials**

- Prepare clinicians to end their   - Possible handout with greetings and
  sessions with clients in a manner   partings information or other Arabic
  consistent with Iraqi culture   words that might be useful
- Answer remaining questions
- Explain next steps
- Close the training

Plan

1. Facilitator will teach casual parting phrases in Iraqi Arabic.
2. Facilitator will recall the concept of *inshallah* to discuss termination with refugees.
3. Facilitator will express appreciate and joy for having been invited to join the organization for this process.
4. Training ends.

Sample Script

Let's talk about partings.

When saying goodbye to your patients after a regular session, you might hear them use /bay bay/ which is a borrowed "bye bye" (Gorgis & Al-Quran, 2003). This is fine to use in a casual way with someone you expect to see again soon. You might also hear: /maassalaama/ "go in safety" used as "farewell".

But, the journey toward healing with refugee patients is a long one. It is unusual that you would have a true termination with your patients; plenty of refugees terminate prematurely for a variety of reasons but even if you do a lot of work over a long period of time and choose to terminate regular meetings with a patient, in community mental health, they are likely to return someday especially if your organization becomes well-embedded in the Iraqi community. Nevertheless, termination is likely to, once again, involve the concept of *inshallah:* we go separate ways into the future with safety and strength if God wills it.

Perhaps you might say,
/fiimaanila/ "go with God's blessing" or /alla wyak/ "may God be with you" (Fernea, 1995; Gorgis & Al-Quran, 2003; Nydell, 2012).

Poetry in Arab culture is very highly regarded as the finest use of Arabic (Nydell, 2012) There is a saying in Iraq that if one were to through a stone in Iraq, they would be bound to hit a poet—poets are numerous and poems are widely shared and appreciated (Mikhail, 2013). Prominent Iraqi poets were once offered significant stipends and large homes by the dictatorship if they produced poetic propaganda. But with these arrangements always came the surrendering of artistic freedom for pragmatic ends. Poems that outrightly denounce the rule of Iraq's dictators are understandably rare (Mikhail, 2013). I also personally find poetry to be one of the richest inroads for sitting inside the experiences of another person—feeling at once what feels in their poetry to be universal and what feels in their words to be idiosyncratic to them or to their lived experience. These are always attainable adventures. The world of medical education is also catching on and there is some movement toward incorporating more of the autobiographical or narrative humanities into training because unlike lectures and textbooks, they reach us deeply (Prasad et al., 2016). I hope you will indulge me as I would like to close with this poem:

[Close with poem from this list: a). *Ants* by Iraqi poet Yusuf al-Sa'igh (Nye, 1996) b). *Dialogue of the Night Roses* or c). *Season of Beginning and End both* by Iraqi poet Zuhur Dixon (Jayyusi, 1987) d). *Of Freedom* by Iraqi poet Mahmud al-Braikan (Mikhail, 2013) e). *Tomorrow the War Will Have a Picnic* by Iraqi poet Abdul Razaq al-Rubaiee (Mohammad, Najm, Al-Kabi, & Veach, 2008) or f). *Gate A-4* by Palestinian American poet Naomi Shihab Nye].

We are all going to part ways now. I want to say that this has been a joy and an honor to join you today and in the weeks leading up to the day. You have plainly been so thoughtful, committed, and brave about this work. Thank you for showing up to the task, for asking great questions, for challenging yourselves. I look forward to connecting with all of you in the online community of practice and I wish you great luck!

/nawwartu wsarraftu/ "It has been my honor" (Fernea, 1995; Gorgis & Al-Quran, 2003; Nydell, 2012).

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Table E16

Step 5—Suggested Continuing Education Resources List

Anderson, S. (2016, August). Fractured lands: How the Arab world came apart. *The New York Times Magazine*. Retrieved from http://www.nytimes.com/interactive/2016/08/11/magazine/isis-middle-east-arab-spring-fractured-lands.html?_r=0

Biagiotti, L., & Khan, I. (2016). *Watch Muslim women explain what their hijab means to them*. Los Angeles, CA: Los Angeles Times. Retrieved from http://www.latimes.com/visuals/video/la-me-american-women-in-hijabs-video-story.html

Cleaver, S. R., Carvajal, J. K., & Sheppard, P. S. (2016). Cultural Humility: A Way of Thinking to Inform Practice Globally. *Physiotherapy Canada*, *68*(1), 1–2. http://doi.org/10.3138/ptc.68.1.GEE

Herman, J. (1997). *Trauma and recovery: The aftermath of violence--from domestic abuse to political terror*. New York, NY: Basic Books.

Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology*, *60*(3), 353–366. http://doi.org/10.1037/a0032595

Mikhail, D. (2005). *The War Works Hard*. New York, NY: New Directions

Mollica, R. F. (2009). *Healing invisible wounds: Paths to hope and recovery in a violent world*. Nashville, TN: Vanderbilt University Press.

Rahiem, F. T., & Hamid, H. (2012). Mental health interview and cultural formulation. In S. Ahmed, & M. M. Amer (Eds.), *Counseling Muslims: Handbook of mental health issues and interventions*. (pp. 51–69). New York, NY: Routledge/Taylor & Francis Group.

Raval, H. (2003b). Applying theoretical frameworks to the work with interpreters. In R. Tribe & H. Raval (Eds.), *Working with Interpreters in Mental Health* (pp. 122–134). New York, NY: Brunner-Routledge

Schauer, M., Neuner, F., & Elbert, T. (2011). *Narrative exposure therapy: A short-term treatment for traumatic stress disorders, (2nd rev. and expanded edition.)* Cambridge, MA: Hogrefe Publishing.

Silove, D. (2007). Adaptation, ecosocial safety signals, and the trajectory of PTSD. In L. J. Kirmayer, R. Lemelson, & M. Barad (Eds.), *Understanding trauma: Integrating biological, clinical, and cultural perspectives*. (pp. 242–258). New York, NY: Cambridge University Press.

United Nations. (1948). *The Universal Declaration of Human Rights*. Retrieved from http://www.un.org/en/universal-declaration-human-rights/

Van der Veer, G., & van Waning, A. (2004). Creating a safe therapeutic sanctuary. In J. P. Wilson & B. Drožðek (Eds.), *Broken spirits: The treatment of traumatized asylum seekers, refugees, war and torture victims.* (pp. 187–219). New York, NY: Brunner-Routledge.

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Appendix F

Step 9—External Review Questions/Results

Question #1: This program addresses issues relevant to refugee mental health provision.

Strongly Disagree   1   2   3   4   5   Strongly Agree

	Quantitative score	*Qualitative feedback*
Reviewer A	5	"Describe the Arabic culture exactly in the right words. Giving a great description for the Arabic culture…No, its true, because you have all the details exactly, and you start with Iraq from in the '20s, and you talk about the Arabic Spring. So it's a great thing."
Reviewer B	5	"Very well-done. Could be a bit stronger in the practicalities of separating 'therapy' from 'case management' concerns as we must. This has been a point of stressful confustion and, I think, a source of disappointment and frustration for our clients."
Reviewer C	5	"This module is very well thought through, addressing domains of attitudes, beliefs and knowledge, and with a keen attunement to process (which accounts for the majority of safety building, rapport, relationship, and ultimately outcome) in service provision. The module also includes very practical recommendations for both self-monitoring and providing services. It also includes an overview of a therapeutic modality recommended for this population (NET)."
Reviewer D	5	*Reviewer did not comment.*
Reviewer E	5	"The emphases on cultural humility, culturally-informed care, working appropriately with interpreters, navigating carefully between satisfying mental health professionals' desire for factual information about refugee populations they may serve and encouraging comfort with uncertainty that fosters collaborative and open relationship with clients, creating a more nuanced view of PTSD and trauma that acknowledges Iraqis' culture and experiences as different, and discussing a variety of possible treatment modalities, all presented with great sensitivity, are all relevant to refugee mental health service."
Reviewer F	5	I think the program identifies the challenges faced by providers delivering MH services to the refugee population. The need for better MH programs for this particular population has been identified within the context of this program proposal.

Average Score	5	

Question #2: This program addresses issues relevant to Iraqi refugees.

Strongly Disagree   1   2   3   4   5   Strongly Agree

	Quantitative score	*Qualitative feedback*
Reviewer A	5	"You've given a lot of details about the Iraqi culture and have given a lot of ideas how to deal with the Iraqi refugees and how it's very complex to deal with people that have different backgrounds in one country."
Reviewer B	5	"The historic context is very well-done: using a fictional Iraqi family to link to the political time-line is a wonderful tool."
Reviewer C	4	"I have not personally worked much with this population, but I was very impressed by the comprehensiveness of the module in highlighting the history of Iraq. The exercise of taking the perspective of a hypothetical Iraqi woman and generational influences going back three generations was excellent, and a great tool to encourage cultural humility. The module also includes an overview of the rich diversity of the Iraqi refugee population. One content/perspective I may suggest adding is the inclusion of the perspective of intersectionality. one approach is to consider Pamela Hays' ADDRESSING model and the corresponding privilege/oppression associated with the client's identity at any given moment in Iraq's history, and how this may have changed through seeking refuge in the US. For example, what is the main and current cultural worldview on disability among this population? How might this interact with a person's gender, sexual orientation, religion, etc? Another topic to consider along this line is how might a person who experienced religious persecution (either by being a religious minority, or belonging to an Islamic sect that is considered a minority/is disenfranchised) may impact their trauma, anxiety, sense of safety in the host culture, and ability to build rapport with the provider?"
Reviewer D	5	"(Did you address efforts needed to insure that timeline and historical perspective stays current as the years go by? While your overall training is not focused on giving clinicians "facts", Module VI uses historical events to help clinicians think about possible influences. Events in the next 5-10 years (and obviously ongoing) will also have potential impact on this population)."

Reviewer E	5	"The project is painstaking in providing thorough and current information and insight into Iraqi history, cultural and religious norms, while also noting the importance of not stereotyping and emphasizing the need to recognize that each individual's experience is unique. It would be helpful to include the voices of individual Iraqis in addition to academic voices."
Reviewer F	4	"The program defiantly addresses specific issues that relate to the Iraqi refugee population. I think it can be strengthened if more information about different minority ethnic populations (e.g. Kurds, Assyrian, Turkmen, Yazidis, Arab Christian) is included. Especially since these ethnic minorities have faced persecution in Iraq since the Ba'ath party was in power (almost 50 + years)."
Average Score	4.7	

Question #3: This program appropriately targets the needs of clinicians with little/no cross-cultural experience.

Strongly Disagree   1   2   3   4   5   Strongly Agree

	Quantitative score	*Qualitative feedback*
Reviewer A	5	"The details, the right details, and the right information, talking about Great Britain, how they'd taken over the Middle East and what's going on in the Middle East, and also talking about religion. When you have a provider and you explain to him the religion and how everything works, that's a great thing. He will not get lost. Like, 'Okay, how I deal with this person and how I want to talk to him, how I respect him."
Reviewer B	5	"Ample room/prediction of the many feelings/beliefs that can surface and change the therapeutic alliance."
Reviewer C	5	"The author has done an extraordinary job in utilizing practical exercises to foster reflection, discussion, perspective-taking and honest engagement with the material. I believe the exercises are well chosen and content areas presented are comprehensive and pertinent. I also appreciate the author's approach to highlighting biases, negative feelings and tension that may occur in working with the Iraqi refugee population. The approach is normalizing, yet encourages growth."
Reviewer D	5	"(This would seem to be the core of the training)"

		"(May need to have discussion with participants on this topic [responding to requests for favors from patients], as it is likely to feel disingenuous to staff who will not want to make "false promises" or not want to appear as someone who does not keep their word – would go against participants culture)"
Reviewer E	5	"The proposed training is particularly sensitive in its approach, and excellent at recognizing the fear and uncertainty that someone with little/no cross-cultural clinical experience may face in treating refugees. It might be possible to eliminate the category of 'no' cross-cultural experience, while eliciting in discussion the very diffierent cultural perspectives that patients may bring even when those patients are also from the United States. Suggesting a gamut of cultural difference (from within one's own country to beyond) might lessen some of the anxiety."
Reviewer F	5	"This program reminds me of the training I was involved in before my first deployment to Iraq in 2004. It's a fundamental training course in Iraqi culture that allows the practitioner to develop a small understanding of what is involved in being an Iraqi and the traumatic experiences of becoming a refugee. I don't think anything else can be learned about this without the experiences of providing services to this target population."
Average Score	5	

Question #4: This program is consistent with current research and best practices in refugee mental health.

Strongly Disagree   1   2   3   4   5   Strongly Agree

	Quantitative score	*Qualitative feedback*
Reviewer A	4	"Agree because it has a lot of sections and it's talking about how the Americans—especially the providers, they are American—how their image about the Arabic countries and how in the media they are trying not to give a clear image about the Arabic people. So here you're describing everything. So that will help the providers to have some background….When you're talking about they are coming to places and they're trying to get a lot of services. When there's not enough service so they can have it, that makes them disappointed a little bit. And taking so long to have these services while they need it."
Reviewer B	---	"Hard for me to comment on this, as I really have no context for comparison. I appreciated learning about NET."

Reviewer C	4	"The inclusion of Narrative Exposure Therapy (NET) is a reflection of a research-based training on refugee mental health. Given my limited familiarity with refugee mental health, I am unable to comment on whether NET is the current, most recent and strongest Evidence-Based Treatment available. This may have already been done, but in making a case for this in the main dissertation body, I would recommend citing effect sizes compared to other EBPs, if possible when specifically applied to the Iraqi refugee population."
Reviewer D	---	"Unsure – As I am not familiar with the current research and identified best practices. It appears face-valid and from a clinical perspective and from one who supervises clinicians, it presents the information and emphasizes the need for the clinician to be a learner (as contrasted to clinician as expert) in a way that is needed."
Reviewer E	5	"The discussion of trauma and PTSD and different treatment modalities relies on the latest and most respected sources."
Reviewer F	3	The only reason I reviewed this question a 3 is because I don't know what current research states about best practices for this particular population. Based on the organization and detail of this proposed program, I can only assume you have taken into account the detail involved in including appropriate research that reflects evidence based practices for this target population.
Average Score	4	

Question #5: This program is designed in a manner appropriate for its state goals and objectives.

Strongly Disagree   1   2   3   4   5   Strongly Agree

	Quantitative score	*Qualitative feedback*
Reviewer A	5	"Strongly agree. And what's making me say that is because dealing with religion is a very sensitive thing. And so what I read, you deal with it a very right way. You were very careful, and you are not picking one side and talk about—like you didn't go with Shia against Sunni. You didn't talk about Sunnis against Shia. So you was in the middle you know. And that is a very great thing, because this is very real. Not a lot of people they do that….It's true. You're doing a great job. I know it's not easy to collect all this information, to study all this stuff, but

		you're doing a great job….It was an interesting thing for me because I was reading 'til 2:00 in the morning. I didn't stop until my laptop died. So then I just stopped reading. It's a good thing when you have somebody in the middle. You'r enot going with this side. You're not going with Western culture against Eastern culture. It's a great thing….And this is the truth. I am not exaggerating. I'm not saying this just because I want to say it. Because as I've told you, I'm a detail guy. I like to go in details like saying …all this stuff. And the Arabic Revolution back in the '20s, the British in the '30s and '40s. It's a great thing. It's a wonderful thing for us also when somebody who's not from our culture really know a lot about us, while we are not lazy and don't like to read about ourselves. So it's truly a great job. And I hope the best for you, my friend."
Reviewer B	5	"Strongly agree with this—this is a well-done piece of work. Cannot imagine a clinician attending this training and not being profoundly affected/changed/challenged."
Reviewer C	5	"Absolutely excellent. The approach is challenging, yet kind, is grounded in important and sound principles, yet practical."
Reviewer D	5	"I like the way you have this structured. You might think of adding/discussing an additional goal (if it isn't already in your full write-up) of providing a working template that may be useful for any unique/unfamiliar population that presents for service. "d" above may address this, depending on how you cover it." "(Getting the participants to buy in to this approach is going to be key – That's one of the reasons I like the pre-meeting with participants)" "(I especially liked this pre-assessment and individual meetings with training participants – helps with both "buy-in" and allows you to adjust the training content to individual needs)" "(This is a lot of social, political, historical information that may be hard to digest in one hour)"
Reviewer E	5	"The way that the program includes potential scripts for the different modules gives the reader a very clear sense of how each module might play out with participants and also illustrates how each of the modules would move toward and reach its goals and objectives."
Reviewer F	5	This program proposal is extremely well organized and planned out accordingly. It reminds me of an OPORD (operation order) with the attention to detail.
Average Score	5	

Question #6: Please provide any additional comments or suggestions you deem valuable.

	Qualitative feedback
Reviewer A	"I'm glad to help, because this is awesome, very nice, and you have like 97% correct. I'm saying 97 because like Al Jazeera Channel, sometimes when you're taking things from them, Al Jazeera Channel, sometimes they're just trying to be to the Sunni side, not Shiite side, so you need to find somebody [that's] between, not going with this side on this side or this side on this side. I don't recommend anything. You know why? Because everyone has their own channel, and they're just broadcasting what they want to say. But you have people, like [unintelligible], and you can tell they support a certain side or they are balanced, like they don't go [Shiites] or Sunnis."
	"And another thing, if the provider is a male and there is a female patient, he needs to be careful before he is trying to shake her hand, just saying hi, if she's wearing hijab. Maybe she will not shake his hand. She will just put her hand on her chest, on the left side, [Arabic spoken]. They don't prefer to shake hands. Some of them, not everyone. Only the women with hijab. And my suggestion to the provider, if he sees a woman with hijab or without hijab—actually, with hijab most of the time, he will just wait for two seconds to see if she is moving her hand. Then he will just move his hand."
	"And also you didn't talk about the sitting position, like when the provider needs to take the foot of the patient….Because in Arabic culture, the bottom of the foot or the bottom of the shoes is a bit insult, and people don't like when they are sitting down—especially from Middle East—to see somebody pointing his shoes or the bottom of his pointing to his face, because they will consider that like a big insult. Do you remember what happened when George Bush and the Iraqi? ….When they throw the shoes? Because the shoes are a big thing in Iraq."
	"After asking the patient about his feelings or everything, they just need to avoid if there is any sexual assault on them in the first session, because that's very sensitive in the Arabic culture. A lot of people, they just like to hide it. They don't want to talk about it. But maybe in the second session or the third session they will have enough confidence to talk about it. Yeah. I won't go into detail then, especially because my job, I'm working with some caseworkers and some therapists. So I start to notice some stuff, and I hear the people maybe actually—between him and me, how she's sitting or how she's talking or the clothes, coat. They don't want anything obvious, especially where they're female. It's like with the privacy, but I'm not mentioning any names. Like I worked when somebody today and she was wearing a short skirt. So the way she was sitting, the guy he was saying, 'Oh, this is not right. This is not right.' So I was trying to explain to her, like a cultural advisor, without hurt feelings. This job is not an easy job. I don't want like—you need to be careful about these things."

"One other thing I noticed through my experience here—the welcoming process when you have a process. Most of the offices, they don't even have water to offer to the clients. Other Arabic people maybe you met, it's in our culture, when somebody's showing up, you provide them first with water. I'm not saying the providers need to do the same thing exactly, but at least to have some water. It's very important. And napkins also, because people, they will cry a lot. And about the cards, like flashcards, 3 x 5s, "How are you feeling today?" That's when the provider is asking the client, "How are you feeling today?" and he needs to choose one of these [lines] saying if he's feeling good, sad, or something like that. If you can just recommend it—my recommendation is to have three pictures, like they have it on the cell phone. What do you they call it? Like the small figures?….That's like if you have a sad face or happy face or a normal face. So he can just point to it, and the provider, he can easily understand if he's not in a good mood, if the client is not in a good mood….Just an idea….I'm that kind of person looking for details a lot. And I notice my point when I'm taking them to the therapist, and they are thirsty, especially if they are old a little bit. And there is no water in the office. That's a huge thing. So what I started doing, I have a case of water in my car. Before I'm going upstairs, I grab two or three with me and hand it to the patient. And they just start saying, 'What's wrong with those people? They don't have any hospitality? They don't know how to offer stuff?' I said, 'No, it's a cultural thing. They don't know.' So water is very important. And the Iraqis, they don't like coffee. They like chai tea. There is one of the therapists, one time I went to visit her, and I just got surprised. In her office, she had like the tea. She put the hot water with—it's an electric one. And she has two cups and teabags with some sugar. I thought, well, she knows what she's doing. Because it was from the interpreter that was working with her. He just talked to her about this. And he drinks a lot of chai, so he drinks the chai also with her."

"Exactly what I expected. You're doing a great job, because you go into detail. You talked about alcohol and [children]. It's not allowed in Islam to [beat] them. And also you mentioned that people will deny to say they have a mental health issue because of their culture. They will deny it, and this is like a defense. They don't want to show it. This is true. Killing themselves or suicide is forbidden in the culture, and this is true. And what's funny about people, I think—you mentioned the evil eye and how the people, they believe in supernature [sic] stuff, like stuff that does not exist. And they say it's related to God, and this is very, very true. So they don't want to act as negative persons, because that will make them look like they are weak persons. That's also very true. But sometimes this stuff that does not exist, it's like the genies and— because I saw you mention if somebody suffers from something and they feel there is a genie or a bad, evil spirit touching him, so he will get cured by God. You know that these things in Iraq are truly happening. A person believes all this stuff. But I was a witness on several things, and somehow I couldn't find anything to tell me that, okay, why this thing is happening. I'm trying to

remember which year. I believe it was 1996. I saw one of the girls—1997—she was acting weird, like she had a spirit or something. She said, "Okay," I was sitting there and I was looking at her. She requested a candle. They light it up for her, and then she put her finger on the candle for three minutes. And then she started talking. "Okay, ask me questions, guys. What do you want to ask? I'm here now." So the people, they started asking her, and she was answering them correctly, like a lot of details about houses, how—For example, "What's the color of my cousin's house, the door, the front door?" And she was answering this stuff correctly.....Yeah, we have a lot of this stuff, and we have it especially in the south of Iraq. And these things, they are related to the ancient villages…They have their magic there. So it's a weird thing. But you mentioned it, so you just mention everything about the Iraqi culture, and that's good. That's great. I go over everything and see you didn't miss anything."

"Sometimes I just feel—as an interpreter, I'm just giving my opinion. I feel very sad, because when I see a client that there's nothing wrong with it him, he's acting totally different in the community, and when he's seeing the therapist, he's a completely different person, because he wants to have the SSI benefits. So they're just faking everything and making stuff up. That's making me sad, but I cannot do anything, because it's not my job and I sign to be confidential, so I cannot give that opinion. I'm just interpreting what he's saying. There are a lot of people that truly they need it. And I see a lot of people, they truly need it. They can't sleep. They have a lot of issues."

"I was recently honestly thinking of going back home, like just to stay over there again, to be close to my friends over there. Home is friends, family. We don't care about if it's hot, if there's no power. But I would like to see. I would like to smile again from my heart."

"And if you need anything—I'm not saying to you I'm a perfect guy. Nobody is perfect. This is the truth. We are not like gods or nothing. But thanks God that I don't have that emotion to be on one side against another side. God gives a brain to everyone. So the people, they need to think with their brain, not just taking things that are not true and believing them. You have the tools. You have your brain to learn more, to understand more. I tell my clients, all my clients. And thanks God I have friends that are Sunni, Shia, Christian. I don't have any problem with them. I tell my friends, "Just don't be sensitive. Don't be placing a judgment on things very quick or just from how they say it in English, like the title of the book. Read the book." So I will keep reading. It's interesting."

Reviewer B	"Megan, this is fantastic work: I wish we'd been able to have you offer this to [clinic name] staff. You have articulated the difficulties faced by each member of the treatment [triangle]: client, clinician, and interpreter with sensitivity, compassion, and practical solutions. I loved your emphasis on social justice and that our therapeutic practice may need to be less impartial and may need more

	self-disclosure in order to be genuine and impactful. I imagine this training would be invaluable to clinical staff, and would help us to be less scared and rigid than I think we were here. I would suggest more about roles and client expectations: felt we were never able to successfully communicate what 'therapy' could accomplish. Loved your clinical example about 'exercises' (I vividly remember when that occurred in your work here!)."
Reviewer C	"I believe this project not only addresses a large need in mental health service provision, it also engages in a very important research question: "how can providers who think they need more discrete information willingly engage and grow in the domain of attitudes/beliefs?" (copied). I think this project is valuable as a starting point to address a larger issue among mental health service providers. To this end, I believe the data gathered will be crucial to understanding the role of training such as proposed on this module in addressing what Dorothy Holmes calls "deep change." In order to accomplish this, however, the measures used have to be conceptually and psychometrically strong—I was not able to find information about the measures and their psychometric properties here. So my suggestion is to ensure that these measures are valid, reliable and addresses content areas of interest. As the module is continually revised, the researched would have the opportunity to examine the trend in the outcome differences vis-à-vis changes made on the module. Another question I had is that the module assumes that both the organization and the staff members are motivated and recognize a need to receive more training. Sometimes there is a gap between the organization leadership's and the staff members' perceived need for training. Taken to the next level, sometimes organizations are mandated by the governing bodies (the city that provides the contract for service provision, for example). This project takes quite a bit of time commitment over a period of time. One issue that may be helpful to think through is how might the author obtain a buy-in from the organization and the individual staff members? Overall, this is a very impressive project, and I am grateful for the author's commitment and sacrifices in taking on this project. I believe the module was very thoughtfully written, with careful considerations of both process, content and sound pedagogical methods."
Reviewer D	"Comments were made through the body of the program. However, based on our recent communication, I did a more focused reading of Module VI. I find myself agreeing with you that although there is much factual historical/social/cultural content, it is presented in a way for the participants to question possible influences. I do wonder (and maybe it can only be determined in front of a live audience) if the amount of information in this section would be overwhelming to a participant. Especially presented in a one hour block of time. Overall, nice work and very comprehensive. ;)" (I would suggest being careful about adding multiple phrasings for greetings [again in Module VI and for partings in Module XI]. I like the

	exposure/practice to Iraqi language, but I'm not sure how realistic it is to expect that participants would remember the nuances of different greetings based on relationships/settings/piety/etc., as described in highlighted section above. Teaching a general greeting/response and awareness that there are multiple phrases that are influenced by various factors, may be easier for participants to hang on to, especially when they may not have opportunities to use this learning with an Iraqi population until some time after the training has been presented.)
Reviewer E	"Thank you so much for giving me the opportunity to read your dissertation project. I learned so much from it, and it's such important work you're doing. I also can see even more clearly what a fabulous psychologist you are. I've tried to make helpful comments, and used the "Review" function for that. I also couldn't help noting the occasional typo (it's the language professor in me that can't let go of proofreading)—I hope that's helpful too. As I mentioned the other day, what you're doing is incredibly sensitive and thorough. I wish everyone who comes into contact with refugees could experience this kind of training. The one module that I feel could use some editing is Module VIII: Patients and Providers—Roles, Responsibilities, and Possibilities. Of course, I'm not a clinician, but as I read through it, I hoped for clearer delineations between the different modalities (if that's the right word) for treatment, perhaps with a 2-sentence summary at the end of each form of treatment. Then, and perhaps you do this already and I'm just not remembering correctly, say something about how these approaches might or might not be combined. The one other lesson from the HPRT GMH program that I think might be worth including is the notion of altruism as a force for healing, and that, ultimately, with the clinician's assistance, patients heal themselves. Lastly, I don't know if this is available anywhere, but if there were a way to include quotes from Iraqi refugees' stories of healing with the support of American clinicians, that would be fabulous. Failing that, at least some Iraqi voices about their individual beliefs would be helpful as a complement to the information you cite from more academic or anthropological sources. I just love the work you're doing, and I really hope that, even if you're working with college students, you'll be able to continue to offer trainings for working with refugees." "I would love to participate in the training program described here! I am confident it would make a positive difference in mental health service providers' approaches not only to treating refugee clients, but all their clients, while also providing strong support for the providers themselves." "Your dissertation is beautiful—so thorough and so sensitive. It's extremely helpful to me in my work as well."
Reviewer F	"It was a pleasure to read this program proposal and provide my insight to your

dissertation :). I wrote a paper on spirituality, religion and mental health last semester. I am going to include some of the references I used for that paper/presentation that covers providing services for the Arab/Muslim population. Hopefully it will help you with this dissertation."

--(Calley, 2011)

Appendix G

Step 10—Program Implementation Plan

Steps	Materials
Phase I:	
Consultation	Mixed-methods needs assessment survey
Evaluation	Organization cultural competence assessment interview
Preparation	Pre-training phone conversations with participants
	Pre-training humility, competence, and readiness survey
Phase II:	
Implementation	Training plan, scripts, materials
Phase III:	
Reflection	Post-training humility, competence, and readiness survey
Evaluation	Post-training satisfaction survey
Quality Improvement	Post-training follow-up conversation with administrators
	Post-training invitation into digital community of practice
	Time-delayed post-training humility, competence, and readiness survey
	Time-delayed consultation conversation with administrators

-- See 'activities approach' logic model for implementation map

Appendix H

Table H1

Step 11—Plan for the Evaluation of Program Goals

Goal	Plan for Addressing Goal	Plan for Evaluating Goal
Increase clinician knowledge about Iraqi refugees	Didactic training material	Pre-/post-training objective assessment survey Time-delayed post-training objective assessment survey
Increase clinician skills in culturally safe treatment with Iraqi refugees	Didactic training material Experiential activities	Pre-/post-training objective assessment survey Post-training participant satisfaction survey
Broaden clinician cultural identity self-awareness and attitudes	Experiential activities	Post-training satisfaction survey Time-delayed consultation follow-up with clinic administrators
Improve clinician capacities to conceptualize Iraqi refugee clients in using the Ecological Model	Didactic training material Experiential activities	Pre-/post-training objective assessment survey Post-training participant satisfaction survey
Galvanize clinicians to feel passionate about working with Iraqi refugees	Didactic training material Experiential activities Trainer modeling	Post-training satisfaction survey Time-delayed post-training objective assessment survey

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Table H2

Step 11—Evaluation Plan

Level of Training Intervention	Plan for Evaluation
Training of Individual Providers	Individual needs assessment
	Pre-/Post-Training assessment
	Time-delayed post-training longevity assessment
Organization receiving the training	Organizational culture assessment
	Aggregate of individual needs assessment
	Implementation of training including discussion of systemic issues and goals
	Longevity follow-up for systems-level goals
Quality Improvement for Training	Needs assessment of case clinics
	Ongoing literature review
	Review of existing programs
	Development of training using evidence-based program development model

Practice-based evidence collection including organization cultural competence assessment

Pre-training assessment of participants

Delivery of training

Immediate post-training assessment of participants

Time-delayed post-training assessment of participants

Time-delayed post-training organizational check-in

-- (W.K. Kellogg Foundation, 2004)

Table H3

Step 11—Pre-Training Participant Discussion Questions and Template

Question	Responses
What are the characteristics of your ideal training for supporting your work with Iraqi refugees? That is, how will you know that this workshop was worth attending?	
In what ways has working with refugees challenged you personally? I'm sure there are professional complications and we'll have much time to discuss those but I'm wondering how this work has impacted you as a person.	
Usually providers working with refugees for the first time feel a bit unnerved or "freaked out". How is that response showing up for you?	
Have you ever had any multicultural training? If so, what was that like?	

--These questions will used during the brief phone conversations with each participant in service of participant engagement.

Table H4

Step 11: Evaluation—Objective Pre-/Post-Training Participant Survey

Assessment Targets/Prompts	Responses

Competence/Readiness for work with Arabs/Arab-Americans
The MCCAA (Khoury, 2016; Khoury & Manuel, 2016) will be administered as a form of objective assessment. This 18-item measure evaluates providers' attitudes/beliefs, knowledge, and skills as well as readiness for work with Arabs/Arab-Americans.

Sample Attitudes/Beliefs item:

"I respect the religious beliefs and pracrices that clients may have, even if I feel that they are interfering with the therapeutic relationship."

Strongly Disagree   *Disagree*   *Neither Agree nor disagree*   *Agree*   *Strongly Agree*

Sample Knowledge item:

"I would encourage my Arab/Arab American clients to differentiate their individual identities from that of their families."*

Strongly Disagree   *Disagree*   *Neither Agree nor disagree*   *Agree*   *Strongly Agree*

Sample Skills item:

"I would be comfortable engaging the services of a third party certified translator to communicate more effectively with an Arab/Arab American client."

Strongly Disagree   *Disagree*   *Neither Agree nor disagree*   *Agree*   *Strongly Agree*

Sample Readiness items:

	Strongly Disagree	Disagree	Neither Agree nor disagree	Agree	Strongly Agree
"I am ready to explore and clarify the origins of any biases and/or stereotypes I may hold about individuals of minority groups."	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
"I will endeavor to approach new situations with humility."	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
"Please list here your most salient identity variables."	*[Free response space.]*				

-- *denotes reverse scored item; survey to be administered prior to, immediately following, and 6-12 months after training. (Khoury, 2016; Khoury & Manuel, 2016)

Table H5

Step 11: Evaluation—Post-Training Workshop Evaluation Items

Assessment Targets/Prompts	Responses

Workshop Evaluation
Participants will also be given this 23-item satisfaction questionnaire as a form of subjective assessment for quality improvement for the workshop. These items were developed based on standards offered by Ramsey (1996).

1. I can easily imagine applying what I have learned in this workshop to my clinical work with refugees.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
2. I believe this workshop offered material consistent with my needs.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
3. The facilitator made the goals and objectives of the workshop clear.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
4. The facilitator established a learning environment that felt safe.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
5. The facilitator was engaging.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
6. I felt comfortable participating in large group discussion.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*

7. The facilitator was able to respond to questions that arose spontaneously.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
8. The facilitator leveraged the participants as sources of independent wisdom.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
9. The facilitator encouraged participants to express thoughts and feelings associated with clinical work with refugees.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
10. I felt comfortable sharing my thoughts and emotions during the workshop.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
11. The workshop prompted me to consider my values.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
12. The workshop structure allowed me to learn from and with my fellow participants.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
13. The workshop had a good balance of lecture, discussion, and experiential activities.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
14. The facilitator seemed prepared.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
15. The facilitator guided discussions about group process.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*

16. I enjoyed this workshop.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
17. Instructions for experiential activities were clear.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
18. Experiential activities contributed to my preparedness to work with refugees.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
19. This workshop helped me to increase my awareness of my thoughts related to work with refugees.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
20. This workshop helped me to increase my awareness of my physiological reactions related to work with refugees.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
21. This workshop helped me to increase my awareness of my behaviors related to work with refugees.	*Strongly Disagree*	*Disagree*	*Neither Agree nor disagree*	*Agree*	*Strongly Agree*
22. Please discuss the specific ways this workshop contributed positively to your preparation for working with Iraqi refugees.	*(Free response.)*				
23. Please discuss the specific ways this workshop could be improved upon or expanded in order to meet your remaining needs in terms of working with Iraqi refugees.	*(Free response.)*				

-- *denotes reverse scored item (Ramsey, 1996). Survey to be administered in evaluations module at the end of the training.

Table H6

Step 11—Post-Training Clinical Director Discussion Questions and Template

Question	Responses
What do you notice has changed as a result of the training? What do you notice has not changed? How can we address organizational barriers to provider vulnerability? During the training, we identified some organizational goals: _____, _____, _____. How have administrative conversations gone since last week? How can I be supportive in helping you operationalize these goals and follow through with them? How might the organization improve support structures like supervision and consultation for refugee providers? How can providers showing vulnerability, elasticity, and enthusiasm be both rewarded and further incentivized?	

-- Discussion to occur with clinical director one week post-training.

Table H7

Step 11—Time-Delayed Post-Training Clinical Director Discussion Questions and Template

Question	Responses
How is current provider morale regarding work with refugees? How has it evolved since the training?	
In what ways have you noticed providers engaging in more self-reflection?	
In what ways has self-reflection been difficult for providers?	
What are the current organizational barriers to provider vulnerability?	
How is progress on pre-determined organizational goals unfolding?	
What support mechanisms are now in place for provider supervision/consultation?	
How can providers showing vulnerability, elasticity, and enthusiasm be both rewarded and further incentivized?	

-- Consultation to occur 6-12 months following training.