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Counseling Refugees of Middle Eastern Descent in the United States

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Counseling Refugees of Middle Eastern Descent in the United States

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FACULTY COMMITTEE:

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Dedication

This research project is dedicated to all refugees of Middle Eastern descent. You are all strong and courageous people who have fought for their freedom. You all deserve to be treated with dignity and kindness wherever you are. I hope that you can all feel safe and find peace in your hearts and minds.

Acknowledgements

I would like to acknowledge my parents and brother for their support throughout these three years. I would especially like to thank my partner, Joe, who has been my rock throughout this rollercoaster journey. I would also like to acknowledge Dr. Lennis Echterling who has believed in me since day one, and has instilled in me a sense of independence and courage. This project is the culmination of my three-year journey in the United States, and I could not have persevered without these people.

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Abstract

Refugees of Middle Eastern descent in the United States face a countless number of challenges throughout their journey. Many of these obstacles are overlooked or unaccounted for. This research paper serves to help mental health counselors identify the unique challenges of each phase during the refugees' migration process, as well as provide information on evidence-based practices that can be useful when working with this population. This project also speaks to the different roles that counselors play in a therapeutic relationship, including direct therapy, advocating on behalf of refugee clients, and educating other counselors and the public on the specific needs of this population.

Personal Experience

I am a Lebanese woman, currently residing in the United States in order to pursue my Masters and Education Specialist degrees in Clinical Mental Health Counseling. I am about to graduate from James Madison University and begin a career in this field. Mental health has been my passion since middle school. I have always believed in counseling as an effective method to treat a wide variety of concerns, ranging from daily life stressors to more severe forms of mental illness.

Being a woman, but more specifically a woman of Middle Eastern descent, I know what it feels like to be marginalized in today's world. I have always empathized with minority groups and people whose voices have been unaccounted for. My background and my experiences are what prompted me to write my Ed.S. Research Project on an often-underestimated population: refugees and asylum-seekers of Middle Eastern descent in the United States.

I do not identify as a refugee because I have been blessed to be raised in an area in Lebanon that was not subject to tragic crises. However, my parents were unfortunately exposed to the atrocities that wars carry, and they hence taught me how to recognize my privilege and put it to good use. My hope is that this minor contribution encourages people, specifically mental health professionals, to look beyond the stereotypes and prejudices that refugees are aggregated into. I would be a hypocrite to claim that I do not have my own biases and stereotypical thought patterns. I recognize that each person's worldview is unique to his or her own experiences. However, my hope is that this research paper provides, at the very least, some awareness and education around the very

current subject matter of refugees. As mental health counselors, we have the duty to educate and advocate on behalf of all our clients.

Introduction

With the significant increase of global crises, the migrant population in the United States is also on the rise. According to the Migration Policy Institute (2015), an approximated 1.02 million refugees from the Middle East are currently residing in the United States, representing 25% of the nation's refugee population (Zong & Batalova, 2015). This population's exposure to trauma suggests the importance of having the adequate mental health resources in order to adequately serve its people.

According to the American Psychological Association (2010), a refugee is defined as a person who is outside his/her country of nationality and has a well-founded fear of persecution because of his/her race, religion, nationality, membership in a particular social group or political opinion, and is unable to avail himself/herself of the protection of that country, or to return there, for fear of persecution.

Trauma exposure is often correlated with a higher occurrence of mental disorders. It is suggested that the most prevalent psychological concerns within the refugee population are posttraumatic stress disorder, depression, and anxiety (Ekblad, Hauff, & Lindencrona, 2007). These struggles may be attributed to the refugees' pre-resettlement trauma, migration, and post-resettlement stress-provoking situations. However, mental health professionals should also capitalize on the refugees' profound strength, resiliency, and adaptability despite the adversity that they face.

This research project aims at reviewing the literature in order to aid mental health professionals in using evidence-based practices to better serve the refugee population in the United States. Counselors should be able to attune to the three stages of the continuum of the relocation process that refugees are on: pre-migration, in transit, and

post-migration (Wessels, 2014). Creating a multicultural, holistic approach bearing witness to refugees' narratives will help them feel better understood and validated.

Three-Stage Continuum

Pre-Migration

According to Bhugra and Jones (2001), the pre-migration stage is when the refugees are still in their home countries, contemplating and preparing to move to a safer location. Normally, their home countries should be in significant political, religious, or economic turmoil that require them to seek asylum elsewhere.

This study focuses on refugees in the United States who come from areas of war, political mayhem and religious oppression in the Middle East. People from this part of the world face traumatic events on a daily basis, including economic deterioration, gender oppression, the death of their loved ones, the collapse of their communities, lack of the most basic living necessities such as food and shelter, and many more horrors that have plagued these countries (Wessels, 2014).

The Washington Post (2013) followed the story of Huda Khalaf, a Syrian woman who is a mother of four young children. She told the Washington Post that she begged her husband, Imad, not to go to war. Despite her many efforts to stop him, he responded by, "I will give my soul to my country, and I will leave my kids to God". He tragically died as a result of a bullet to his heart planted there by Assad supporters. Huda revisited her trauma as she retold her experience to the Washington Post. She said, "No words can express what I was feeling. I lost my husband. My kids lost their father. We were going to an uncertain future and I couldn't stand it." Huda's story is only one of the hundreds of thousands that are out there.

Mental Health professionals who are working with refugees from the Middle East should be educated on the adversities of these people's realities. Their psychological

diagnoses because of trauma exposure might be clinically similar to those of other clients. However, it is important to recognize the uniqueness and severity of the refugees' situation, often resulting in a comorbid diagnosis (Farrag, Hakim-Larson, Jamil, & Jamil, 2002).

In Transit

The "in-transit" stage of the continuum consists of the refugees leaving their home countries, and embarking on a journey of fear involving countless unknown threats, dangers, and hardships. Often times, these displaced people end up living in refugee camps, while waiting for a more permanent living situation in a safer country. People may perceive camps as a refuge and safe haven; however, this may create a re-traumatization effect because the conditions of these camps resemble what the refugees just fled: poverty, sickness, and sexual violence (Wessels, 2014).

Zaatari, a refugee camp located in Jordan, exemplifies some of the struggles that are pertinent during the in-transit stage. Zaatari's area is approximately two square miles and is currently hosting around 80,000 refugees from various countries in the Middle East (UNHCR, 2016). More than half of Zaatari's population is comprised of children under 18 years of age. This camp has gone without electricity for nine months when UNHCR was unable to pay the Jordanian government. Each adult refugee receives a \$30 stipend each month. People in Zaatari are exposed to daily doses of poverty, poor living conditions, inadequate food, and Assad's constant depredations.

In addition to these adversities, refugees undergo a very selective individual status determination, often creating delays in the resettlement process (UNHCR, 2011). They undergo multiple interviews and a very comprehensive background check. Although this

is a very crucial step to ensure the safety of the host countries, it may result in more of the stressful experiences that refugees have been facing throughout this emotionally, mentally, and physically draining process (Duckworth & Follette, 2012).

It is of high importance that mental health professionals be aware of the in-transit stage. It is often underestimated and overlooked because of the comparison made to the significant trauma history. However, clinicians are expected to recognize that the in-transit stage is, in and of itself, another harrowing experience that has shaped the asylum seekers' journey in multiple ways (UNHCR, 2011).

Post Migration

The fact that refugees have been able to make it to this third and final step in the continuum is a testament to their powerful coping skills and resilience, which instill in them a readiness to adapt to all the difficulties in the new, unfamiliar environment (APA, 2010). Despite the fact that refugees are now in a relatively safer environment, they face daily complications that are unique to their population. These difficulties often include, but are not limited to, racism, new gender roles, language barriers, bereavement, culture shock, social isolation, religious differences, poverty, ethnic density, loss of identity, and unemployment (Awad, 2010).

Awad (2010) conducted a study on 177 individuals of Middle Eastern descent to assess the impact of acculturation and perceived discrimination towards them. This experiment yielded the following results: "52% of the study sample reported that it has been implied that they were dangerous or violent as a result of their ethnicity. An

astonishing 77% reported being subjected to offensive comments about their ethnic group” (Awad, 2010, p. 64).

Asylum seekers are faced with a reality in which they have to relearn social norms and values that are completely different from the ones they have known their entire lives. For instance, refugee families need to learn how to utilize foreign resources in order to provide themselves with even the most basic living necessities (APA, 2010). In addition, it is not uncommon for refugee adults who are very highly educated in their home countries to seek menial jobs in the United States because their educational background is not recognized here; this is often described as a humiliating experience.

Another factor presented by the American Psychological Association (2010) is the difference in rates of acculturation among parents and their children. Children often adapt to the new norms and acquire the language faster than their parents do, generally creating familial tensions and challenges across the different generations. All of these factors are bound to affect the psychosocial adjustment of refugees, making them a unique population for mental health professionals.

Psychopathology of Refugees

Recognizing the three-stage continuum of pre-migration, in transit, and post-migration will help refugee clients feel understood and validated by their mental health providers. However, it is essential to recognize that the exclusivity of this population's background does not necessarily result in unique mental health concerns. Asylum seekers' experiences result in common, and often comorbid, psychological conditions that permeate any culture, race, or gender.

In a study conducted by the Centers for Disease Control and Prevention (2015), a high prevalence of posttraumatic stress disorder, major depression, generalized anxiety, adjustment disorder, and somatization was indicated. Other studies have suggested that the prevalence of mental health symptoms among the refugee population is initially lower than in the general population, but over time increases to either match or surpass that of the general population (Kirmayer et al., 2011).

Fanzel, Wheeler, and Danesh's (2005) study on 6743 adults who are on refugee status in the United States yielded the following results: 9% of the sample are diagnosed with PTSD, and 5% of the sample meet a major depressive disorder diagnosis, with substantial evidence for clinical comorbidity. If these percentages were to be translated to individual cases, over 600 people are diagnosed with PTSD and about 335 people are diagnosed with MDD.

To decipher these numbers even further, of the 1.02 million refugees of Middle Eastern descent in the United States, 91,800 people have a PTSD diagnosis and 51,000 people have a major depressive disorder diagnosis. These astonishing numbers reflect only the people who meet the criteria for a diagnosis, but many people who are

significantly distressed by their experiences do not possess concerns that necessarily warrant a clinical diagnosis (Wessels, 2014).

Barriers to Seeking Mental Health Services

The literature shows that refugees from the Middle East are often less likely than their Western counterparts to be referred to, or seek, mental health services, despite their high levels of distress (Kirmayer et al., 2011). One of the most commonly discussed barriers for why refugees refrain from seeking mental health services is stigma. Although stigma is a very powerful repellent, there are other factors that contribute to refugees' perspectives on therapeutic services.

In an ethno-cultural study on 13 focus groups with 111 refugees, these other factors were identified: history of political oppression, the belief that counseling does not help, fear, lack of education on mental health, symptom avoidance, and shame (Shannon, Wieling, Simmelink-McCleary, 2015). Kirmayer et al. (2011) suggested that lack of mobility and language barriers are also factors that affect refugees' willingness to obtain care.

It is helpful for mental health providers to acknowledge the difficulty involved in refugees' willingness and ability to share private information despite the various obstacles (Sue & Sue, 2012). In many settings, mental health professionals are viewed as authority figures, which may contribute to another level of barriers given the refugees' history of oppression by figures of power and authority. Acknowledging these factors and validating a refugee's concerns should help the client feel that various aspects of his or her narrative are being heard, understood, and validated.

Resilience

According to UNHCR, *resilience* is defined as: “the ability of individuals, households, communities, and institutions to anticipate, withstand, recover, and transform from shocks and crises” (UNHCR, 2016, p. 7). This definition exemplifies the strength from within refugees that is often overlooked or forgotten. Mental health professionals should help them recognize their resilience and adaptability in the face of many obstacles.

Therapy with refugees should mostly revolve around resilience because it creates space for empowerment and potential achievement of self-sufficiency. Although it is crucial to acknowledge and validate all the hardships of a refugee’s narrative, equal attention should be paid on refugees’ protective factors. Some of these factors include: their collectivistic roots, social and religious support from their intact extended family, striving for fairness and justice, and survivorship throughout prior adversities (Kira & Tummala-Narra, 2014).

Another study conducted on refugee children in Sweden found that emotional expression, peer relationships, and prosocial relationships were key determinants in the absence of PTSD symptoms in children (APA, 2010). The coping factors described above can be a powerful tool to use in therapy to help refugees promote their views on their own strength and resilience.

Women Refugees

Cultural factors may affect how each gender responds and copes with displacement. Women refugees face atrocities that are specifically pertaining to their gender group. Culturally, the Middle East has a patriarchal view on society, which often leads to women being the marginalized gender group in society. It is important for mental health providers to be attuned to these differences because displacement can affect women differently from men.

Women face a decreased level of access to healthcare during war-related conflicts. Their access to family planning, safe motherhood, and gender-based violence support, becomes limited (Samari, 2014). Restricted access to these resources may result in increased levels of violence targeting women, including sexual, physical, and emotional abuse.

Some of the horrors that women face include: mass rape, military sexual slavery, forced prostitution, forced marriage, trafficking, forced pregnancy, gang rape, sexual assault, physical assault, resurgence of female genital mutilation, and forced sex for survival, food, shelter, and protection.” (Samari, 2014, p. 2).

One study that was conducted on 24,403 refugees, 48.5% of which were women, yielded results that female refugees had significantly higher likelihood of purchasing psychotropic medication (Hollander, Bruce, Burstrom, & Ekblad, 2011). This suggests that mental health clinicians should be trained in assessing and treating mental illnesses pertaining to women refugees.

Implications for Counselors

Trauma-Informed Care

Mental health professionals who are trauma-informed are able to understand the impact of victimization as a result of violence on their clients. Accommodating the vulnerabilities and needs of refugees must be the priority of the provider in order to form effective therapeutic interventions (Butler, Critelli, & Rinfrette, 2011). These vulnerabilities include, but are not limited to, extreme poverty, disabilities, severe medical conditions, elderly without family support, and unaccompanied minors (UNHCR, 2011).

Trauma-informed services include identifying recovery from trauma as a primary goal; employing an empowerment model; maximizing client's control in the process of his/her recovery; striving to minimize re-traumatization effects; creating an atmosphere in the office space that is considerate of the survivors' need for safety (Elliot, Bjelajac, Fallot, Markoff, & Reed, 2005).

The counselor and the client set therapeutic goals mutually. However, it is a therapist's duty to educate his or her clients on the importance of recovery from traumatic events. Moreover, therapists need to work from an empowerment perspective, which focuses on client rehabilitation and reintegration into their new, host society (McWhirter, 1998). By working from an empowerment framework, a therapist can therefore instill a sense of control that was once lost in refugee clients.

Mental health counselors are almost always aware of the words they utter and their nonverbal cues; however, trauma-informed care expands beyond these aspects. For example, the office setting of the provider may contain items that act as triggers to

refugee clients. One example of such items is a picture of an airplane, which may remind refugee clients of the very reason that brought them to this office in the first place. When all of these aspects are taken into consideration, they are bound to help minimize re-traumatization effects for this population.

A trauma-informed care model that is specifically designed for trauma related to refugees and asylum-seekers is the “H5 Model of Refugee Trauma and Recovery” (Mollica, Brooks, Ekblad, & McDonald, 2014). This model scrutinizes five elements that pertain to the narratives of refugees: (1) Human Rights; (2) Humiliation; (3) Healing and self-care; (4) Health promotion; (5) Habitat and Housing.

“Human Rights” is the first factor of the H5 model, and it characterizes the loss of the basic human rights when asylum-seekers are in the “in-transit” phase, usually in refugee camps. The basic necessities for survival are violated, and they are seldom able to report their traumatic experiences to the responsible authorities. According to UNHCR (2011), refugees and asylum-seekers are entitled to the same human rights that are expanded internationally. These include the right to live, protection from torture, protection from bad treatment, and the right to leave and/or return to one’s country without the element of force.

The second dimension of the H5 model is “Humiliation.” This factor is often overlooked when treating refugees because people rarely think about the actual goal of violent acts— to create the emotional state of humiliation. Humiliation can be the result of the various losses, such as their homes and belongings, to end up living in refugee camps where their fate is unknown (Mollica, Brooks, Ekblad, & McDonald, 2014). Al Jazeera (2015) followed the story of Mohammad Hammou, a Syrian refugee who

currently resides in the Zaatari refugee camp. His devastating words were, “In Syria, we chanted ‘death rather than humiliation’, but when we arrived in Zaatari we realized that we escaped death only to be humiliated” (2015, p. 1). This is one of the many narratives along the lines of humiliation that counselors are likely to hear.

“Healing and Self-care” summarizes the effectiveness of resilience in the therapeutic process. It is the third element of the H5 model and it encompasses both, the strength of the individual refugee and the strength of the refugees’ support system and networks (Mollica, Brooks, Ekblad, & McDonald, 2014). Although refugee camps have adverse effects on the wellbeing of the individuals, they can sometimes create an unbreakable bond among people in times of need and desperation. The most prominent friendships are enacted in children refugees who are healthy enough to form some of those bonds. Adults, too, can sometimes become inseparable because no one else in the world is able to comprehend the atrocities of their unfortunate and unique experiences.

The fourth factor in the H5 model is “Health Promotion.” In trauma-informed care settings, mental health providers should also be educated on and aware of the physiological effects that trauma can have on people. There is substantial evidence that refugees face long-term and chronic health concerns that are directly correlated with their trauma histories. Some of these chronic health concerns include amputations, malnutrition, infectious diseases such as Hepatitis (A, B, C, and D), HIV/AIDS, malaria, syphilis, typhoid, and tuberculosis (Burgess, 2004). Mental health professionals need to be educated on the adverse effects that these diseases have on the human body in order to make appropriate referrals to medical providers in the community.

The fifth and final dimension of the H5 model is “Housing and Habitat.” Refugee camps can be extremely crowded, leaving very little room for privacy. There are currently sixty registered camps in the Middle East that are presently hosting 5.1 million refugees (UNHCR, 2015). In other words, each camp holds around 85,000 refugees, and this number is increasing every day. When mental health professionals are able to address this issue, and support their clients to find better living conditions in the new host country, it is bound to create a better therapeutic relationship (Mollica, Brooks, Ekblad, & McDonald, 2014).

It is important to note that the H5 model is not the only standard for trauma-informed care with refugees. However, because of its overarching dimensions, it can be modified to fit the presenting concerns of each refugee. In other words, each of its elements can be explored in-depth with a refugee client, therefore creating a holistic approach to therapy. The H5 model provides mental health therapists with helpful guidelines for the effective treatment of refugees.

Advocacy and Education

The role of a counselor exceeds direct therapy, and it often includes other avenues; namely, advocacy and education (Meyers, 2014). Advocacy, in its simplest of terms, means to help or assist, which is the premise that counseling is built on. One-on-one counseling has been proven to be extremely effective in creating long-lasting positive effects on people’s lives. However, it is important to recognize that the counselor is the more privileged party in the one-on-one therapeutic alliance, and he or she is the one who can make the difference outside the four walls of the counseling office.

This understanding of advocacy is especially relevant when working with refugees of Middle Eastern descent. Unfortunately, their voices have been unaccounted for, and sometimes even silenced. These people are seen through tainted lenses, therefore subjecting them to a daily dose of racism, hatred, and prejudice. Hence, advocacy is an accessible and effective way to stand for this marginalized population.

According to UNHCR (2011), advocating for refugees can include activities such as information dissemination, monitoring, and negotiation. As counselors, we are in a privileged position to make a difference in our clients' lives. By recognizing this ability, we can subsequently create a change in the lives of our refugee clients, whether this change is on a community, national, regional, or global level. In other words, we can make a difference in the systemic approach to this matter.

Another role that mental health professionals play, both inside and outside their office setting, is that of educators. Not only can counselors educate the public on the needs of refugees, but they can also educate other mental health professionals about this population's unique needs. This can create a wide collaboration among multiple resources in one community. It can pave a path for new referral options, as well as provide support for various disciplines (Meyers, 2014).

Education around the needs of refugees can be provided in multiple ways. For instance, education can be as simple as turning a stereotypical comment into a teachable moment during a casual conversation. In a more formal setting, however, education can be provided through psychoeducational groups around the needs and skills of refugees. Presenting at conferences, talking in classroom settings, writing columns for the local

newspaper, appearing on the local television news program, or being a guest on a local radio call-in show can all be effective ways in raising awareness on this important matter.

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