A Qualitative Study of the Perceived Attitudes Toward Counseling and Effective
Counseling Practices in Working with Clients of Iranian Origin

A DISSERTATION
SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL OF THE
UNIVESRITY OF MINNESOTA
BY

Saba Ghazi-Moghadam

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

Advisor: Michael P. Goh

October 2009

Acknowledgements

I would like to thank my academic advisor, Dr. Michael Goh, for his ongoing support and mentorship, enormous patience, and immeasurable guidance. Without his encouragements, follow-ups, reminders, and genuine care and kindness, I would have not been able to perform and complete this project. Thanks for believing in me and my work, and thank you for not giving up on me when I was ready to resign.

Thanks to many faculty, program directors, support staff, and administrators at the University of Minnesota for years of assistance, care, and concern. To name only a few, Dr. Chris Espin gave me a job, and was the most understanding and caring boss when I was seriously ill for a couple of months. Dr. Kristen McMaster was generous with her time so I could travel to Los Angeles and conduct my research. Dr. Kay Thomas and her staff at the International Student and Scholar Services (ISSS) have repeatedly supported me in dealing with immigration services as an international student and never let me fall into the "illegal" group. In my 17 years as a student at the U, at each road block I faced, there was a helping hand to open a new door to me and in every seemingly impossible circumstance, there was a wise and informed individual to show me the way. Thanks to you all. I made Minnesota my new home and I am proud of being a graduate of the University of Minnesota.

My deepest appreciation goes to the 16 remarkable therapists in Minnesota and California that dedicated their time and knowledge and made this project possible. I became a better practitioner by observing these professionals at work, I admired their passion for helping their fellow Iranians, and I learned immensely about the culture from which I came from and the heritage I will pass on.

Last, but not least, many thanks to my family. To my mother, who left us too soon. She would have loved to see her daughter earn a doctorate degree. To my father, who did not live to see the end of this long process. He was there, with me, every step of the way and gave me strength and courage. To my brother, who is my inspiration, my role model, and the one who has always helped me through the most challenging times. To my husband, for his love and support, for his serenity and calm, and for putting up with my many doubts and indecisions. And to my baby daughter, for bringing such joy to my life, and reminding me every day that life continues on, regardless of struggles, and there is something to cherish in every moment of every day.

Dedication

To the Iranians, all over the world….

Abstract

Since the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fisher & Turner, 1970) was developed more than 30 years ago, the ATSPPHS and other similar instruments have attempted to capture the essence of individuals' help-seeking attitudes across cultures and countries. However, the majority of published studies in this area has focused on college students as subjects and studied mainly Asian and Asian-American populations. With the ever-changing population of the United States and current multicultural social and political environment, there is a definite need for investigation of the willingness to seek professional psychological help in other cultural and demographic groups.

This study explored common attitudes toward counseling, as well as the effective psychological practices among Iranians residing in the United States. The study's goal is to understand the general attitudes of Iranians toward mental health and seeking help, and to provide practitioners with ideas for working with this population. Sixteen Farsi-speaking Iranian therapists, 5 men and 12 women, were interviewed using a semi-structured interview guide. Sixteen interviews were transcribed and analyzed using an inductive qualitative method and consensual qualitative research principals. Six domains and 21 themes emerged. The domains were: 1) Clients' Expectations/Preferences in Therapy; 2) Therapists' Approach to Therapy; 3) Relationship/Rapport Building; 4) Boundary Setting; 5) Gender Roles; and 6) Help-Seeking Barriers. Implications for working with Iranian clients are discussed.

Table of Contents

Chapter One

Introduction

Leong, Wagner, and Tata (1995) noted that Hollingshead and Redlich's (1958) study about social class and mental illness recognized that understanding the help-seeking process was a complicated enterprise. Additionally, Leong, Wagner, and Tata noted that individuals' help-seeking attitudes determined whether they sought professional psychological help when they needed it. Other studies observed that members of certain groups such as some ethnic minorities, lower income or undereducated individuals, and those differentially acculturated to U.S. culture were at equal or greater risk for psychological problems than other members of society (Padilla, Ruiz, & Alvarez, 1975; Ruiz & Padilla, 1973). As such, it was important to try to understand the attitudes these individuals had toward seeking professional help in order to provide better access and more effective delivery of helping services to them.

More than 30 years ago, Fisher and Turner (1970) operationalized the study of help-seeking attitudes when they developed the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS). The ATSPPHS is a 29-item Likert scale with four subscales: Recognition, Tolerance, Interpersonal, and Confidence. In a follow-up study published several years later, Fischer and Farina (1995) developed a shortened, 10-item unidimensional version of the ATSPPHS. The authors concluded that the shorter form could be substituted for the original, though only for use in research and not as a clinical device.

Initial studies on help-seeking attitudes using the ATSPPHS tended to focus on demographic variables such as gender, race, and previous experience with counseling (Terrell & Terrell 1984; Blazina 1996; Leong 1999). More recent analyses concerning attitudes toward seeking help have focused on a variety of psychological and personal characteristics (Cepeda-Benito & Short, 1998). Authors, such as Komiya, Good, and Sherrod (2000) have also reported that lack of emotional openness, greater perception of stigma associated with counseling, and lower psychological symptom severity contribute to individuals' reluctance to seek psychological help. Another major variable explored in studies of general help-seeking attitudes and behaviors is client nationality. A handful of studies have examined groups from a variety of cultural and ethnic backgrounds, and the majority of studies in this area have predominantly focused on the Asian and Asian-American college population.

Statement of the Problem

The ATSPPHS has been used by researchers in a variety of settings to study factors influencing attitudes toward seeking psychological help. Variables such as gender, level of self-disclosure, nationality, and race have been included in such studies. Although each of these studies has contributed to the body of knowledge regarding attitudes toward seeking help, there has been little systematic review of the research findings in this area.

While a handful of studies have examined attitudes toward professional psychological help seeking in groups from a variety of cultural and ethnic backgrounds, the majority of studies in this area have predominantly focused on the Asian and Asian-American college population. In fact, it is notable how few studies have examined the

help-seeking attitudes of other cultures and nationalities residing in the United States. It is also notable how few of the studies to date have examined non-college populations. Accordingly, results should be interpreted and generalized with a high degree of caution, at least until more research about different cultural and ethnic groups is available. With the ever-changing population of the United States and current multicultural issues in present society, there is a definite need for investigation of the willingness to seek professional psychological help in other cultural and demographic groups.

The purpose of this study is to explore the attitudes of Iranian population residing in the United States toward seeking professional psychological help. More specifically, we would like to see what has been working well with the Iranian population as it pertains to mental health, what mental health professionals working with this population have been experiencing, and what should be done to educate and encourage the Iranian population to seek mental health services during times of stress and despair.

Importance of studying the Iranian population in the United States

According to Price (2005), Iranian culture is a traditional, patriarchal, and class-based culture. For most, tradition is rooted in the religion of Islam. Additionally, class and patriarchy have been constant features of Iranian society since ancient times. Class, in its simplest form, is mainly based on socioeconomic status or family genealogy, though modernity (westernization) and traditionalism might also be used to set apart classes. In Iran different classes have different cultures and are bound together through different processes. For example, relationship is a primary source of security and financial support for low-income families; in contrast, connection is a source of emotional and psychological support for the affluent. Division of labor for the poor

and/or uneducated could be a relatively simple division between the public (men's work) and domestic (women's work). Generally the lower and uneducated classes may regard females as inferior or different, and entitled to a lesser position in society. On the other hand, the modern classes normally make every effort to guarantee the equality of sexes and eliminate gender inequity (Price, 2005).

As stated by Jalali (1982), it is important to understand the cultural characteristics of Iranian clients in order to deal with psychological issues associated with this population. The family is considered the most significant element of Iranian culture. Most physical illnesses and mental disorders are usually managed by the family. The family acts as the decision maker and is considered an important source of support for the patient (Langsley et al., 1983). To this date, there have been only two published articles studying the attitudes of Iranian population toward seeking mental health. Both studies, conducted by female Iranian doctoral students in Counseling Psychology (Rahimi, 1989 & Khoie, 2002), have used the ATSPPHS for measuring the attitudes of Iranian population toward help-seeking with relatively small samples, and have either focused on a college population or only one gender (male).

According to an extensive search of the published and unpublished research data-base, there does not exist a recent study conducted on the Iranian population residing in the U.S. regarding their help-seeking attitudes that has attempted to investigate these attitudes in depth, to learn about therapy experiences, or to find out what works and does not work with this group of people.

Research Questions

In the present study, the questions to be explored are: What is the Iranian attitude toward seeking professional psychological help? What is most helpful to Iranians? What are some of the barriers in working with Iranian clientele? What does a therapist need to know when working with this population? What are certain therapist/therapy characteristics that help or hinder the therapeutic process with this population? The goal of this study is to explore the general view of Iranians toward psychological services and to learn what is unique about presenting such services to this community.

Chapter Two

Literature Review

Development of the "Attitudes Toward Seeking Professional Psychological Help"

Scale

Edward Fischer and John Turner were the first researchers to develop and

standardize a scale to measure the attitude toward seeking professional help for

psychological disturbances (Fischer & Turner, 1970). The scale was written in

collaboration with several other psychologists familiar with a variety of mental health

settings such as state hospitals, private clinics, and school counseling centers. Out of a

pool of many suggested items for the scale, 31 items were considered to be highly

relevant by the 14 clinical and counseling psychologists and psychiatrists who acted as

judges on the panel. These 31 items were tested with a variety of subjects such as high

school students and summer college students, along with the Marlowe-Crowne Social

Desirability Scale (Marlowe & Crowne, 1960) to measure the correlation of the attitude

scale with the social desirability scale. The eventual Attitude Toward Seeking

Professional Psychological Help Scale (ATSPPHS) was formed with 29 items, from

which eleven are positively stated and eighteen are negatively stated. The higher score on

the scale indicates a more positive attitude toward help seeking (Fischer & Turner, 1970).

A factor analysis of the attitude scale conducted on 424 college and nursing

students (249 females, 175 males) resulted in four defined and interpretable factors: 1)

Recognition of personal need for professional psychological help; 2) Tolerance of stigma

associated with psychiatric help; 3) Interpersonal openness regarding one's problem; and

4) Confidence in the mental health professional. Furthermore, the authors hypothesized that certain personality variables would have a significant relationship with attitudes toward help seeking such as masculinity, authoritarianism, trust, and social desirability.

By administering the scale to different groups of subjects, along with other scales such as Marlowe-Crowne Social Desirability Scale (Marlowe & Crowne, 1960), Rotter's scale of Interpersonal Trust (Rotter, 1967), and Rotter's Internal-External control scale (Rotter, 1966), Fischer and Turner (1970) concluded that a great variability is evident in the attitudes expressed toward seeking professional psychological help. There was especially a strong sex difference with males holding a less positive attitude than females, though it was unrelated to masculinity.

In a follow up study, Fischer and Farina (1995) developed a 10-item unidimensional version of ATSPPHS, aimed at devising a measure with adequate test characteristics to produce a single score representing the subject's attitude toward seeking help (Fischer & Farina, 1995). By testing their abbreviated scale on university students similar to those studied by Fischer and Turner, the authors concluded that the shorter form can be substituted for the total-scale original version. Fischer and Farina believed that the shorter version of ATSPPHS would be easier to use and less obtrusive. Similar to Fischer and Turner (1970), Fischer and Farina cautioned that the ATSPPHS is intended only for use in research and is not an appropriate clinical device. The ATSPPHS has been the instrument of choice for a range of studies that will be presented in the next sections.

Help-Seeking Attitudes and Demographic Variables

Initial studies on help-seeking attitudes using the ATSPPHS tended to focus on demographic variables such as gender, race, and previous experience with counseling

(Terrell & Terrell 1984; Blazina 1996; Leong 1999). Terrell and Terrell (1984) conducted a hierarchical regression analyses to examine the relation between counselor's race, mistrust level, and clients' sex and the premature termination from counseling. The subjects were selected from a community mental health center. They were originally referred to the clinic because of complaints of mild depression, anxiety attacks, sexual dysfunctions, or marital problems. Mostly lower-class outpatient subjects were assigned to the study. The subjects were native-born blacks, 72 males and 80 females. Counselors consisted of three white men and three black men working at the community health center as a part of their practicum requirements. The counselors held at least the equivalent of a master's degree in clinical or counseling psychology and had a minimum of two years of clinical experience. The clients and counselors were assigned randomly. The clients were asked to complete all standard agency forms as well as the Cultural Mistrust Inventory (CMI; Terrell & Terrell, 1981). Each client was seen for an hour-long intake interview and was scheduled for a return appointment within one week. Premature termination was defined as clients not returning for the second or any subsequent counseling session.

Terrell and Terrell (1984) concluded that there exists a significant relation between termination rates of the clients and the counselor's race. The results of this study indicated that black clients are more likely to terminate from counseling prematurely when seen by a white counselor than when seen by a black counselor. The other significant finding of this study was the relation between the trust level of the clients and the termination rate. A lower level of trust related to a higher rate of premature termination of counseling. This effect might be due to a generalized mistrust of people, or

the clients might have perceived the counseling clinic as a white-oriented context. The results of this study confirmed the major hypothesis which was to examine whether combined variables of counselors' race and cultural mistrust level are related to premature termination from counseling. Black clients with a high level of mistrust who were seen by white counselors had a higher rate of premature termination from counseling than those who were seen by black counselors.

The results of this study failed to produce evidence for differences in termination rates between male and female clients, and male counselors. One possibility is that the clients of this study were solely black people and that gender differences was less important among black women than they were among white women. To enhance the results of this study, one could assign white and black female counselors to black clients and review the premature termination rates in those clients for studying gender differences.

In a comparable study, Blazina and Watkins, Jr. (1996) investigated the effects of gender role conflict (GRC) on college men's scores of psychological well-being, substance usage, and attitude toward psychological help-seeking. Blazina and Watkins, Jr. (1996) conducted a correlational study of 148 male undergraduate students at a southwestern university, ages ranging from 18 to 55 years old. The subjects were 80% white and 20% African-American, Hispanic, and Asian. Subjects were asked to complete six psychological scales: the Gender Role Conflict Scale (GRCS, O'Neil et al., 1986); Beck Depression Inventory (BDI; Beck & Steer, 1987); the State-Trait Anger Expression Inventory (STAEI; Spielberger, 1991); the State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983); the Substance Abuse Subtle

Screening Inventory (SASSI; Substance Abuse Subtle Screening Inventory Manual, 1985); and the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The Gender Role Conflict Scale consisted of four subscales: (a) success, power, and competition; (b) restricted emotionality; (c) restricted affectionate behavior between men; and (d) conflict between work and family relations.

The authors concluded that each of the four sub-scales for Gender Role Conflict was significantly related to at least one of the variables of interest (psychological well-being, substance use, & help-seeking attitude). With regards to psychological well-being, the Success, Power, and Competition variables of GRCS were strongly related to men defined as Angry Reaction type (disposition to express anger when criticized or treated unfairly by other individuals). Moreover, there was a significant relation between the Success, Power, and Competition variable and college men's willingness to admit to increased alcohol usage. Men, who scored higher on GRCS, viewed seeking help more negatively than did men who scored lower. In addition, men who present as more traditional may believe that feelings are unnecessary and time-consuming baggage and view help seeking more negatively.

The results of Balzina and Watkins, Jr. (1996) study have some limitations. The majority of the subjects studied identified as white for their race and the diversity of ethnicity among subjects was limited. Additionally, the results of this study are restricted to a sample of college students and might not generalize to a wider population. It would be beneficial to extend this study to a more diverse group of male subjects and randomize the administration of the self-report measures.

Leong and Zachar (1999), in an attempt to investigate the relationship between students' opinion about mental illness and their attitudes toward seeking professional help, conducted a correlational study of 290 white undergraduate students at a large American university. The subjects were 53% male and 47% female, ages raging from 17 to 20 years old. The subjects were asked to complete two questionnaires: the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); and the Opinions about Mental Illness scale (OMI; Cohen & Struening, 1962). The OMI scale has five orthogonal factors of Authoritarianism, Benevolence, Mental Hygiene Ideology, Social Restrictiveness, and Interpersonal Etiology.

Leong and Zachar (1999) concluded that female college students had more positive attitudes toward seeking psychological help than male students did. In addition, with respect to opinions about mental illness, college men were more socially restrictive and less benevolent than college women. Subjects with a higher social restrictiveness and those who were more authoritarian had a more negative attitude toward seeking help. Finally, subjects that believed in a mental hygiene ideology carried a more positive attitude toward help seeking. These subjects believed that psychological intervention can work.

The results of this study provide helpful information for psychologists and mental health practitioners. Clients' expectations of counseling and willingness to cooperate at sessions are highly related to their opinions about mental illness and consequently their attitudes toward seeking help. The result of the study is limited since it can only indicate that certain opinions about mental illness are correlated with certain help-seeking

11

attitudes. In a future study, one could monitor the subjects' opinions about mental illness and actual psychological services utilization.

Comparable to the previous study, Halgin, Weaver, Edell, and Spencer (1987) conducted a multivariate analysis of variance (MANOVA) to investigate the relation of help-seeking history, sex, and depression to college students' attitudes, beliefs, and intentions about obtaining professional psychological help. The authors conducted a pilot study to assess college students' significant beliefs about advantages and disadvantages of seeking professional psychological help. The results of the pilot study were used to formulate the items of the attitude measure administered in the main study. For the main study, subjects were 429 undergraduate students from a large northeastern university. The sample was 51.7% female and the mean age of the participants was 19.1 years. About 14.8% of the students answered positively to the question whether they have sought professional psychological help in the past. The subjects were asked to complete two measures: Decision Measure, constructed by the authors, and Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). The Decision Measure measured the intention to seek professional psychological help and a global attitude toward psychological help.

The authors concluded that the experience of having sought professional psychological help in the past is significantly related to how one felt about seeking such help again. Among students who had never sought professional psychological help, there was no difference in beliefs between depressed and non-depressed students; therefore the experience of depression did not seem to be significantly related to one's views toward help seeking. Depressed subjects evaluated the experience of seeing a competent mental

12

health professional very positively and predicted that seeking help would more likely lead them to confront painful feelings and issues. Finally, the depressed subjects saw help seeking as likely to involve a commitment of their time.

Halgin, Weaver, Edell, and Spencer (1987) indicated that help-seeking history is positively related to perceived positive outcome of the help-seeking experience. For future studies, it is interesting to determine whether those beliefs are specific to the sample characteristics or are representative of college students' beliefs about the outcome of seeking professional psychological help. Further research could gather information on the relationship between types of personal distress and the decision to seek help and attitudes about professional help.

According to the studies by Terrell and Terrell (1984) and Leong and Zachar (1996), women and people with previous counseling experience tend to have more positive attitudes toward seeking professional help. Additionally, traditional attitudes about the male role, concerns about emotional expression, and concerns about expressing affection toward other men were significantly related to negative attitudes toward seeking professional psychological assistance (Good, Dell, & Mintz, 1989).

In an attempt to study the relation between help-seeking attitudes and behaviors and adherence to traditional male gender role, Good, Dell, and Mintz (1989) conducted a canonical analysis and regression on 401 undergraduate male students with an average age of 19.3 years at a large Midwestern university. Subjects were asked to complete four psychological instruments: the Attitudes Toward Men Scale (AMS; Downs and Engleson, 1982); the Gender Role Conflict Scale-I (GRCS-I; O'Neil, 1986); the Attitudes Toward Seeking Professional Psychological Help scale (ATSPPHS; Fischer and Turner,

1970); and the Help-Seeking Attitude and Behavior Scale (HABS), which was designed by the authors for this study.

Good, Dell, and Mintz (1989) concluded that there is a significant relation between men's attitudes and behaviors of help-seeking and the elements of the male role. Moreover, men with more traditional male roles in society, like having concern about expressing affection toward other men and concerns about expressing emotions, had a more negative attitude toward seeking professional psychological help. It is interesting to note that contrary to theoretical literature, the authors did not find that men's need for success, power, and competition impacts their views on seeking help.

The results of this study might only be generalized to men of a late adolescent age group who attend college. These relations need to be examined within groups of older male subjects and those who do not attend college to be able to draw a clearer conclusion. If the results of such a study are generalized for male clients, the relationship of the therapist and client might be moderated based on the therapist's gender.

Alternatively, Cash, Kehr, and Salzbach (1978) found that help-seeking attitudes provided a significant positive influence on counselors' perceived expertise, trustworthiness, regard, and empathy, and on subjects' willingness to return for a second counseling session and expectation to improve across a variety of personal problems. Cash et al. (1978) conducted an investigative study to examine the attitudes toward help-seeking in relation with clients' perception of counselor's behavior. The subjects were 219 female undergraduate students, ages ranging from 18 to 26 years old. The subjects were asked to indicate if they had any previous experience with counseling, to complete the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS Fischer

14

& Turner, 1970), to listen to a taped counseling session, and to complete an 8-point

Counselor Rating Scale (Barak & LaCrosse, 1975). The Counselor Rating Scale

measured the perceived expertness, attractiveness, trustworthiness of the taped counselor.

Subsequently, the subjects completed the Relationship Inventory (Barrett-Lennard, 1962)

to express their perceived empathy, regard, and genuineness of each counselor. Finally,

subjects completed another 8-point Likert scale, designed by authors to determine the

helpfulness of continuing counseling with the taped counselor.

  The results of this study indicated that subjects with prior counseling experience

expressed a more favorable attitude toward seeking help. Subjects with a positive attitude

toward seeking help described the taped counselors in regards to expertise,

trustworthiness, regards, empathy, and genuineness. They also were more optimistic

about the outcome of counseling and more favorable toward a need for commitment to

future counseling. The authors pointed out that these results must be considered with

caution, as factors such as need recognition, stigma tolerance, interpersonal openness,

and generalized confidence might affect each subject's perceived quality of counseling.

  An apparent limitation of this study is the restriction of the subjects to a non-

clinical sample of female college students who evaluated counselors' behaviors from a

passive role, rather than an active and participant role.

Help-Seeking Attitudes and Personal Characteristics

  More recent analyses concerning attitudes toward seeking help have focused on a

variety of psychological and personal characteristics. For instance, Cepeda-Benito and

Short (1998) indicated that self-concealment (i.e., the tendency to keep intimate

information secret) was positively associated with self-reported distress and avoidance of

needed psychological treatment. Cepeda-Benito and Short (1998) conducted a

correlational study to explore the likelihood of seeking professional help in relation to

level of self-concealment, degree of psychological distress, and fear of psychotherapy.

The subjects consisted of 732 Texas A&M University undergraduate students. The mean

average age of participants was 19.5 years, and 65% were female. The majority of

subjects (73%) identified themselves as European American, and the rest were Hispanic

American, African American, Asian American, and Native American. The subjects were

asked to complete five psychological inventories: The Hopkins Symptom Checklist-21

(HSCL-21; Green, Ealkey, McCormick, & Taylor, 1988); the Attitudes Toward Seeking

Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); the

Thoughts about Psychotherapy Survey (TAPS; Kushner & Sher, 1989); the Wilcox

Social Support Network Survey (WSSNS; Reis, 1988; Wilcox, 1981); the 10-item Self

Concealment Scale (SCS; Larson & Chastain, 1990); and the Intention of Seeking

Counseling Inventory (ISCI; Cash et al., 1975).

The authors concluded that people with high self-concealment (those who are

inclined to keep distressing intimate information secret) were more likely to avoid

counseling. The subjects with high self-concealment reported an elevated level of

psychological distress and need for counseling, but did not seek help. In addition, general

feelings of psychological distress were predictive of the likelihood of seeking

psychological help, but not the somatic symptoms. To the authors' surprise, those with

fear of psychotherapy were positively associated with the likelihood of individuals who

would seek help for academic difficulties.

In an analogous study, Kelly and Achter (1995) also indicated that although self-concealment was associated with less favorable attitudes toward seeking help, it was also associated with greater intentions to seek counseling. Kelly and Achter (1995) conducted a two-part study with 256 undergraduate students. For the first part, 256 students, 186 female and 70 male, with an average age of 21.81 years, and 95% identified as white for race, completed five psychological inventories: The Self-Concealment Scale (SCS; Larson & Chastain, 1990); the Intentions to Seek Counseling Inventory (Cash et al., 1975); the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); Social Provision Scale (SPS; Cutrona & Russell, 1987); and the Beck Depression Inventory (BDI; Beck & Steer, 1987). For the second part of the study, 167 undergraduate students, including 119 female and 48 male, with an average age of 22.54 years, and more than half identified as white for ethnicity, responded to the question: "How much does counseling require the client to disclose highly personal information to counselor?" Subjects rated the question on a 9-point scale ranging from 1 (not at all) to 9 (a great deal).

The authors, from the findings of the first and second study, concluded that high self-concealers had less favorable attitudes toward counseling. Interestingly, high self-concealers reported being more likely to seek counseling and to having seen a counselor previously for family or individual counseling, compared to low self-concealers. In addition, the high self-concealers were less favorable toward counseling if the importance of client disclosure in counseling was emphasized.

The inconsistency in these findings indicates that even though those high in self-concealment are afraid of counseling (e.g., because it requires a high level of personal

self-disclosure), they have a higher probability of requesting counseling because of their greater perceived need for psychological help.

Komiya, Good, and Sherrod (2000) have also reported that lack of emotional openness, greater perception of stigma associated with counseling, and lower psychological symptom severity contribute to individuals' reluctance to seek psychological help. In a correlational study, Komiya et al. (2002) examined the effects of emotional openness as a predictor of attitudes toward seeking psychological help. The subjects consisted of 311 undergraduate students from a large Midwestern university, with an average age of 18.4 years and 60% were female. The majority of participants were identified as white for ethnicity (87%), and the rest were African, Asian, and Hispanic-Americans, and less than 1% were Native-American and international students. The subjects were asked to complete four psychological inventories: Test of Emotional Styles (TES; Allen & Hamsher, 1974); Stigma Scale for Receiving Psychological Help (SSRPH), which was designed by the authors; Hopkins Symptom Checklist-21 (HSC-21; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974); the Attitudes Towards Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-SF; Fischer & Farina, 1995).

Komiya, Good, and Sherrod (2000) concluded that greater emotional openness is a predictor of more favorable attitudes toward seeking psychological help. Additionally, the factors that contributed to predicting reluctance to seek psychological services were: (a) male gender; (b) greater perception of stigma associated with counseling; (c) lack of openness to emotions; and (d) lower psychological symptom severity. Another finding, unrelated to the original hypothesis, was that compared to men, women possessed more

open attitudes to emotions, perceived less stigma associated with counseling, and reported more severe psychological symptoms.

Among some of the limitations associated with this study is that the study relied on self-report measures that might fail to gather a genuine psychological functioning due to potential of subjects being in denial or using other psychological defenses. It is also difficult to generalize the results of this study because the sample consisted of young, predominantly white college students. It is advisable to investigate the hypothesis with a more diverse population. In summary, there is fairly strong evidence that self-concealment and lack of emotional openness are potentially related to psychological maladjustment, and that these same characteristics can inhibit potential clients from seeking the professional help they need.

Other authors such as Vogel and Wester (2003) have also examined the factors associated with a potential client's decreased likelihood of seeking psychological services. The authors hypothesized that the risk of self-disclosure negatively impacts the attitude of clients' toward counseling. The subjects of this study were 209 college students (143 women, 66 men) from a large Midwestern university. About 65% of participants had never been in counseling and 35% had been in counseling before this study. The subjects were asked to complete four psychological inventories: Distress Disclosure Inventory (DDI; Kahn & Hessling, 2001); Emotional Self-Disclosure Scale (ESDS; Snell, Miller. & Belk, 1988); Perceived Risks and Utility of Disclosing Emotions (2 questions developed by authors); and the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970).

The findings of this study confirmed the original hypothesis that those clients who reported being less likely to self-disclose distressing information, who reported being less comfortable with such disclosure, and who less readily accepted the potential benefits of such disclosure tended to have less positive attitude toward seeking counseling services.

Although the results of the above study shows the importance of self-disclosure in predicting one's attitude toward seeking help, Vogel and Wester (2003) believed that it did not adequately assess the importance of avoidance factors in relation to other identified help-seeking factors such as level of psychological distress or perceived social support. To examine the predictive ability of the avoidance of self-disclosure and level of psychological distress on attitudes toward seeking help, Vogel and Wester (2003) organized a second study of 268 new college students (167 women, 101 men) from a large Midwestern university. From the sample, 79% had never been in counseling and 21% had counseling experience. The participants were predominantly European American (88%). The participants were asked to complete five questionnaires: Distress Disclosure Inventory (DDI; Kahn & Hessling, 2001); Anticipated Risks and Utility of Disclosing Emotions (developed by the authors); Hopkins Symptoms Checklist-21 (Green et al., 1988); Social Support (SPS; Curtona & Russell, 1987); the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); and Intention to Seek Counseling Inventory (ISCI; Cash, Begley, McCown, & Weise, 1975).

Vogel and Wester (2003) concluded that participants' tendencies to self-disclose distressing information negatively impacted their help-seeking attitudes. Additionally, the researchers concluded that clients' psychological distress and/or social support are not

unique predictors of the attitude toward seeking help, and that the past counseling experience of each client had a direct link to the present attitude toward seeking psychological help.

While the results of this study have their limitations, including participants being from a college population and the majority were from white ethnic group, it provides clear evidence for the importance of avoidance factor and fear of disclosure in determining one's decision to seek psychological help.

Likewise, Hinson and Swanson (1993) examined the effects of problem severity, amount of self-disclosure, and self-disclosure flexibility on willingness to seek help for a problem. They selected 101 Midwestern university students for this study, who had no previous counseling experience and were not from a cultural group different than United States (excluded international students). The participants were 38 men and 63 women, ages ranging from 17 to 28 years old, and were 79% Caucasian and 21% ethnic minorities. The participants completed three questionnaires: Jourard Self-Disclosure Questionnaire (SDQ; Jourard, 1971); Self-Disclosure Situations Survey (SDCC; Chelune, 1976); and Help-seeking scenarios (developed by the authors).

The results indicated that the willingness to self-disclose to a counselor and the severity of the problem were significantly related to willingness to seek help for the problem. The outcomes suggested that the more severe the problem, the more likely it is to be perceived as appropriate for counseling. The participants indicated that the greatest amount of self-disclosure was directed toward same-sex friends, followed by parents and counselors.

Considering the impact of willingness to disclose personal information on one's attitude toward seeking psychological help, it seems logical to make an effort to raise awareness of what counseling is and provide additional information to clients before they attempt connecting to professional services. In their study, Gonzalez, Tinsley, and Kreuder (2002) examined the effects of psychoeducational interventions on opinion of mental illness and help-seeking attitudes. The study participants were 167 undergraduate college students from University of North Texas, ages ranging from 17 to 36, 58% female and 71% Caucasian. Subjects were asked to indicate their opinions about mental illness by completing the Nunnally Conception of Mental Illness Questionnaire (NCMIQ; Nunnally, 1961); to express their attitudes toward help seeking with Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-SF; Fischer & Farina, 1995); and to measure expectations about therapy by completing the Expectations About Counseling Scale-Brief Form (EAC-B; Tinsley, Workman, & Kass, 1980). Two statements called "The Mental Illness and Psychotherapy Interventions," developed by the authors, were given to the experimental intervention groups of the participants in order to study the opinion of this group on seeking psychological help.

Results from the Gonzalez, Tinsley, and Kreuder (2002) study pointed out that the experimental groups that read the mental illness and psychotherapy interventions seemed to develop an appreciation for the level of personal commitment necessary for a successful mental health treatment, but the interventions did not produce significant improvement of opinions about mental illness. Similar to previous studies, those participants with previous experience with mental health reported a better help-seeking attitude and had a more positive opinion about mental illness.

Those clients who had a better understanding of mental health treatment had a significantly better attitude toward seeking help. Therefore, the optimal approach to improving attitudes toward mental health services may lie in "normalizing" the mental health treatment process. As with medical illnesses, it would be advisable that the actuality of mental health concerns and the need for some people to seek professional help be introduced to general public in educational settings such as high schools and colleges.

In studying help-seeking attitudes among college students, Uffelman and Hardin (2002) conducted an investigation to see whether students are likely to seek counseling when the number of sessions is limited, while also considering the type of problem and help-seeking attitudes. The authors recruited 377 students from a large Midwestern university (187 women, 113 men). The subjects ranged in age from 17 to 43 years, 80% Caucasian and 65% reported no previous counseling experience. The subjects were asked to complete three questionnaires: the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); Urgency rating and Likelihood ratings (developed by the authors); and a demographic questionnaire.

Uffelman and Hardin (2002) indicated that setting a limit to the number of sessions available did not influence the college students' self-report of their likelihood of seeking counseling. Students indicated that they were more likely to seek help for high urgency problems such as abuse, suicidal thoughts, and were least likely to seek counseling for low urgency problems such as sexual activity concerns.

Overall, subjects appeared to be more concerned with the stigma attached to seeking professional psychological help. The fear of disclosing personal information and

being labeled as mentally incompetent are stronger factors in creating negative attitudes in subjects toward seeking psychotherapy (Ey, Henning, & Shaw, 2000). On the other hand, the general public finds personal benefit in having someone to listen to their problems, offer them support and guidance, express empathy, provide resources and referrals, and maintain confidentiality (Sharpley, Bond, & Agnew, 2004). Considering the positive impact of counseling on mental well-being of clients, it is essential to review the cultural interpretations and indications of mental health services in order to be able to work on organizing an ethnic-friendly and culturally centered interventions to improve general attitudes toward seeking psychological help.

Help-Seeking Attitudes and Nationality

In addition to more personal or psychological characteristics, one of the major variables explored in studies of general help-seeking attitudes and behaviors is clients' nationality. A number of these studies focused mainly on attitudinal differences between American students and students from other countries (e.g., Tedeschi & Willis 1993; Mau & Jepsen, 1988; Yoon & Jepsen 2003).

Tedeschi and Willis (1993) investigated the difference in attitudes toward counseling among Asian international and native Caucasian students. The participants were 114 undergraduate students at a state university in Missouri. Of the 114 subjects, 30 were Asian international women, 36 Asian international men, 26 native Caucasian women, and 22 native Caucasian men. The international sample ranged in age from 20 to 44 years, and the native Caucasian sample ranged from 18 to 35 years. The Asian international sample included students from Malaysia, Taiwan, Thailand, Korea, and China. The participants completed a demographic questionnaire in which they also rank-

24

ordered sources of help they would seek and counselor characteristics. They also

completed the Attitudes Toward Seeking Professional Psychological Help Scale

(ATSPPHS; Fischer & Turner, 1970).

Tedeschi and Willis (1993) concluded that there was no difference between Asian

and Caucasian students in the sources of help they would seek first if they had a personal

problem to discuss. Asian students assigned a higher importance to the counselor's

ethnicity and age and preferred an older counselor from a similar ethnic group.

Regardless of the ethnic group, women were more likely to indicate a need for help and

Caucasian women were more tolerant of the stigma attached to being a client in

counseling. Finally, regarding interpersonal openness, confidence in counselors, and

tolerance of stigma related to counseling, there was no difference between Asian

international and Caucasian students.

An obvious limitation of this study is lumping all of the students from different

countries in a group of Asian international students. Clearly, each Asian country has a

different approach and value judgment in regards to counseling. In addition, the sample

of this study was relatively small and not representative of the national groups residing in

United States. As the authors pointed out, a proper starting place would be to ask each

international community to design an appropriate intervention method suitable to their

unique cultural values.

In a similar study, Mau and Jepsen (1988) compared native-born Chinese and

American graduate students' preferences for counselor characteristics and their attitudes

toward counseling and counseling services. One hundred and two Chinese and 148

American graduate students participated in this study, of which 80 were American men,

68 American women, 62 Chinese men and 40 Chinese women. The age range of

participants was between 22 and 32 years. The subjects were asked to complete a four-

page questionnaire developed by the authors that was divided into two parts for help-

seeking perceptions and attitudes toward counseling and processes.

Mau and Jepsen (1988) found that Chinese and American students had

significantly different preferences for counselors (e.g., Chinese students preferred

counselors with the same racial background while American students were less

concerned about the counselor's background). Mau and Jepsen also reported that Chinese

and American students had significantly different images of counselors and mental health

professionals: Chinese students were more likely to expect counselors to provide direct

and immediate answers and to make decisions for them. In addition, Chinese students

preferred an older counselor to discuss personal problems. The sex of the counselor was

not an issue for either group. Finally, American students perceived a counselor as a

listener and a friend, while Chinese students saw a counselor as an expert.

Mau and Jepsen (1988) call attention to the fact that the differences between

American and Chinese graduate student in their preferences for counselors'

characteristics and attitudes toward seeking help indicate a need for counseling services

to be sensitive to these differences in structuring and planning their services for "non-

white" clients. More importantly, a client should not be "pre-judged" based on his/her

ethnicity, but be recognized as a unique individual for his or her attributes.

In a related study, Yoon and Jepsen (2003) investigated Asian international

graduate students' utilization of, expectation of, and attitude toward counseling. The

participants were from mainland China, Japan, South Korea, and Taiwan which are

geographically and culturally close to each other. The sample was recruited from a large Midwestern public university. One hundred and eighty-nine Asian international students and 186 American students participated in this study, of which 95 were Chinese, 69 Korean, 15 Taiwanese, and 13 Japanese. The Asian international students were 114 men and 75 women with an age range of 22 to 45 years old. The American students were 77 men and 109 women and ages ranging from 22 to 76 years old. The participants completed a two-part questionnaire consisting of demographic questions including previous counseling experience and attitudes toward and expectations of counseling. The questionnaire was partly developed by the authors and in part adapted from Mau and Jepsen (1988).

Yoon and Jepsen (2003) reported that Asian international students indicated less perceived need for counseling, greater shame/discomfort with counseling, less openness to counseling, and greater preference for a directive style of counseling. Additionally, Asian international students expected the counselor to take greater responsibility for improvement and preferred a more flexible counseling format in length and frequency than American students.

Although the findings of this study have some limits in its interpretations, including a small sample size and possible within-group variability, it has implications for counseling services serving diverse clientele. Considering international students and multicultural clients' concerns about language and cultural barriers, counseling staff would benefit from an on-going cross-cultural training in dealing with non-white populations.

At the same time, there appears to be consistencies between clusters of studies that deal with similar topics or subjects. For example, there is a general consensus that Asian or Asian-American students' level of acculturation significantly correlates with their tolerance of stigma associated with psychological help and their willingness to ask for help (e.g., Atkinson & Gim, 1989; Kim & Omizo, 2003; Zhang & Dixon, 2003).

In a 3.2.2 multivariate analysis study, Atkinson and Gim (1989) explored the relationship between Asian-American students' cultural identity and attitudes toward mental health services. The participants were 557 Asian-American students, consisting of Chinese, Japanese, and Korean American students at a major west coast university. The subjects were 274 men and 283 women, with the average age of 20 years old. The subjects completed a survey questionnaire including three parts of demographic data, a modified version of Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA; Suinn, Rickard-Figueroa, lew, & Vigil, 1987), and an adaptation of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970).

The results of this study provided strong evidence that Asian-American students' attitudes toward professional psychological help were directly related to their level of acculturation. The more acculturated subjects in this study recognized the need for professional help, were more tolerant of the stigma associated with psychological help, and were open to discuss their problems with a counselor. This study did not provide a significant difference in attitudes due to gender, which is surprising since in general female student populations tend to have more positive attitudes toward mental health services (Good, Dell, & Mintz, 1989).

In a parallel study, Kim and Omizo (2003) examined the relationship among Asian American adherence to Asian cultural values, attitudes toward seeking professional psychological help, and willingness to see a counselor. Two hundred and forty-two Asian- American college students (140 women, 102 men) ranging in age from 18 to 57 years at a large mid-Atlantic university and a large university in Hawaii participated in this study. The Asian American students were Chinese, Korean, Filipinos, Japanese, Asian Indians, Vietnamese, and multiethnic Asian Americans. About half of the participants were second-generation Asian Americans. The participants completed three psychological inventories: the Asian Values Scale (AVS; Kim et al., 1999); the Attitudes Toward Seeking Professional Psychological Help Scale-Short Form (ATSPPHS-SF; Fischer & Farina, 1995); and Willingness to Seek Counseling (WSC, Gim et al., 1990) to measure one's willingness to see a counselor for a specified list of problems.

The results of this study showed an inverse relationship between adherence to Asian cultural values and attitudes toward seeking professional psychological help. There also existed an inverse relationship between loyalty to Asian cultural values and willingness to see a counselor. These results were both above and beyond the effects of other demographic variables such as age, gender, generation status, and previous counseling experience. Therefore, adherence to Asian cultural values created a negative attitude toward help seeking and reluctance to see a counselor.

In conjunction with the results of the above studies, Zhang and Dixon (2003) explored the correlation between international students' levels of acculturation and attitudes toward seeking psychological help. One hundred and seventy Asian international students from a Midwestern public university were recruited for this study.

29

Fifty-four percent of participants were men and 47% were women, with an average age

of 27 years. The Asian students were from China, Korea, Japan, India, Thailand, Taiwan,

Malaysia, Indonesia, Singapore, the Philippines, and Nepal. The participants completed

three instruments: a demographic data sheet designed for this study; a modified version

of Suinn-Lew Self-Identity Acculturation Scale (Suinn, Rickard-Figueroa, Lew, & Vigil,

1987); and the Attitudes Toward Seeking Professional Help Scale (ATSPPHS; Fischer &

Turner, 1970).

The results of multiple regression analysis showed that the higher the

acculturation levels of the Asian international students, the more positive their attitudes

were toward seeking professional psychological help. There was no significant

relationship between attitudes of help-seeking in Asian international students and their

gender, educational level, and religious beliefs. Lastly, prior exposure to mental health

services and previous counseling experience did not significantly correlate with help-

seeking attitudes in Asian international students.

The collective results of above studies offer evidence that for Asian students' in

the United States attitudes toward seeking psychological help are significantly related to

their level of acculturation. This significant effect necessitates further study of the general

effects of culture on attitudes of people toward seeking help. The implications of

outreach, assessment, and intervention with people of diverse ethnic backgrounds need to

be examined in order to provide appropriate psychological services to these groups.

Furthermore, Fang's (1998) research on the Hmong population in the United

States confirmed this conclusion. The research indicated that attitudes towards seeking

professional help positively correlated with level of acculturation in Hmong immigrants.

30

In a research study for his doctoral dissertation, Fang examined the relationship between demographic variables and levels of acculturation in predicting Hmong refugees' attitudes toward seeking professional psychological help for psychological difficulties (1998). One hundred and twenty-six adult Hmong refugees from five communities in California were selected to participate in this study. Their ages ranged from 18 to 70 years. The subjects were asked to complete two psychological instruments: Acculturation Measure Scale (Berry et al., 1989); and the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS, Fischer & Turner, 1970).

This investigation indicated that over 90% of study participants were highly acculturated. Therefore, the demographic variables such as religion, gender, socioeconomic status, and education in Laos did not turn out to be significant predictors of attitudes toward help-seeking for mental health services. On the other hand, those participants who were educated in the United States were naturally more proficient in English and were more positive about seeking professional psychological help. The older Hmong refugees who were less literate in general, chose to take the Hmong version of ATSPPHS and expressed a positive attitude toward help-seeking when encountering psychological difficulties.

Among the apparent limitations of this study is the fact that the method of data gathering was a very new concept to the majority of the participants. Many of the subjects had never taken a survey before and were concerned about the confidentiality of the recorded items. The other factor is the relatively small sample size compared to the Hmong population residing in the United States; thus, it might not be representative of the population in general. It is also important to consider the diversity within the group of

Hmong participants. In any refugee group in the U.S., some are older and new to the American culture and not fluent in the language, and some are younger, more westernized, and acclimated to the environment and the English language. Therefore, these refugees might hold a very different view of mental health services.

Tata and Leong (1994) attempted a similar study to investigate the cross-cultural issues and their impact on attitudes toward psychotherapy and counseling. The sample comprised of 219 (117 women, 102 men) Chinese-American students at a large Midwestern university. Tata and Leong (1994) found that variables of gender, acculturation, social network orientation, and individualism were significant predictors of attitudes toward seeking professional psychological help. The study sample was asked to complete the Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970), Suinn-Lew Asian Self-Identity Acculturation Scale (Suinn, Rickard-Figueroa, Lew, & Vigil, 1987), Network Orientation Scale (Vaux, 1985), and Measure of individualism-collectivism (Triandis et al., 1988).

In agreement with previous studies, female subjects responded more positively than men toward seeking help for mental health services. Similar to the study by Fang (1998), Chinese-American students who had higher levels of acculturation were more willing to seek psychological services. The subjects who identified as more self-reliant and individualistic did not have a positive attitude toward reaching out to professionals for psychological help. Lastly, the Chinese-American students that expressed a more positive social-network orientation indicated a more positive attitude toward seeking help.

In summary, the attitudes of international students and immigrants to United States toward seeking professional psychological help is notably predicated by their level of acculturation, demographic variables, and previous experience with counseling (Dadfar & Friedlander, 1982). The ethnic barriers such as differences in language, social and cultural values, and confidentiality issues render difficulty in accepting help in regards to psychological problems. One area of growing professional consensus in this area concerns the "ethnocentric" nature of the helping profession, and how individuals from different cultures or ethnic backgrounds avoid professional mental health services altogether or simply fail to consider these services as viable options for help. Several studies (e.g., Fager, 1973; Sue, 1999) have in fact documented ethnic minority groups' long history of underutilizing professional mental health services in favor of dealing with problems individually, through the family system or through some other indigenous healing method. Many in the field have also suggested that potential clients from different cultures or countries avoid or fail to use professional services because of therapists' perceived inability to: a) understand different worldviews; or b) offer culturally sensitive treatment interventions (Webster & Fretz, 1978; Haviland, Horswill, O'Connell, & Dynneson, 1983; Sanchez & King, 1986).

Help-Seeking Attitudes in the Middle-Eastern Population

According to Merriam-Webster encyclopedia, the Middle East is a loosely defined term for the historical and cultural sub-region of Africa-Eurasia traditionally held to be countries or regions in Southwest Asia together with Egypt. In the Western world, the Middle East is generally thought of as a predominantly Islamic Arabic community defined by frequent war. However, the area encompasses many distinct cultural and

33

ethnic groups, including the Arabs, Armenians, Assyrians, Azeris, Berbers, Greeks, Jews, Kurds, Persians and Turks. The main language groups include: Arabic, Armenian, Assyrian (also known as Aramaic and Syriac), Hebrew, Persian, Kurdish and Turkish. The corresponding adjective is Middle-Eastern and the derived noun is Middle-Easterner. The Middle East is the birthplace and spiritual centre of Judaism, Christianity and Islam. The region has experienced both periods of relative tolerance and conflicts. In the 20th century, the Middle East has been at what could be considered the centre of world affairs; it is a strategically, economically, politically, culturally, and religiously sensitive area. It possesses significant stocks of crude oil (Merrian-Wester.com).

While a handful of studies have examined groups from a variety of cultural and ethnic backgrounds in their attitudes toward seeking professional psychological help, the majority of studies in this area have predominantly focused on the Asian and Asian-American college population. In this section, we will present four studies that constitute the small literature base on help-seeking attitudes of a non-American and non-Asian population residing in United States.

Kilinc and Granello (2003) examined the effects of acculturation, beliefs about mental illness, and selected demographic variables on the help-seeking attitudes of 120 Turkish-born students attending college in United States. The 120 subjects were attending a college or university in one of the four Midwestern states of Ohio, Indiana, Michigan, and Pennsylvania. Sixty-two percent were men and average age was 27.5 years. The sample group was asked to complete four questionnaires: Mental Health Information Questionnaire (MHIQ; Nunnally, 1961); the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); the American-

International Relations Scale (AIRS; Sodowsky & Plake, 1991); and Background Data

questionnaire developed by the authors.

The results of this study indicated that the Turkish students reported high

satisfaction with overall life in the U.S. and low satisfaction with their spiritual/religious

lives in the U.S. The primary difficulty reported by Turkish students was homesickness.

The more acculturated they were, the less they presented with academic life, language,

and physical health problems. The Turkish international students reported that their

knowledge about mental illness was primarily based on the media. They also indicated

that they prefer to go to a friend for psychological assistance rather than professional

services. The help-seeking attitudes of Turkish-international students in this study were

significantly related to factors such as age, gender, education level, socioeconomic status,

acculturation level, and beliefs about mental illness. Due to the size of the sample and

method of subject selection, the results of this study need to be interpreted and

generalized to the larger population of Turkish people living abroad with caution.

In another study, Al-Darmaki (2003) focused on examining attitudes toward

seeking professional psychological help in relation to self-esteem, depression, and some

demographic variables in 350 undergraduate students attending the United Arab Emirates

University. The subjects were 273 females and 53 males, ages ranging from 18 to 33

years. The participants were asked to complete three psychological measures: the

Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer &

Turner, 1970); Self-Esteem Scale (SES; Rosenberg, 1965; cited in Blascovich & Tomaka,

1991); and Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977).

The results of factor analysis indicated that factors such as education, family values, and cultural beliefs regarding mental health and illness have significant correlation with attitudes toward seeking professional help in United Arab Emirates college students. Individuals indicated that they would prefer to rely more on traditional methods such as family, friends, and religious persons to help with psychological difficulties. The college students in this study reported to be more accepting and more tolerant of stigma resulting from seeking help for psychological issues, but it was unclear if they would seek help if need arises. Al-Darmaki (2003) found a different factor structure of the ATSPPHS for the United Arab Emirates (UAE) sample than what was reported from research with American samples:

> Subjects in the current investigation revealed slightly positive attitudes toward seeking professional help. With the exception of interpersonal openness, the UAE sample reported more confidence in psychological health practitioners and more tolerance to stigma about seeking professional help. Participants with more education and social sciences majors exhibited favorable attitudes toward professional help-seeking. High self-esteem and low depression were associated with more positive attitudes toward professional help-seeking (Page 506).

The results of this study has its own limitations of only including college students in the sample and using Western/American-developed measures to study a population from an Arabic country.

Help-Seeking Attitudes in the Iranian Population

According to Price (2005), Iranian culture is a traditional, patriarchal, and class-based culture. Tradition for most is rooted in the religion of Islam, and class and

36

patriarchy have been constant features of Iranian society since ancient times. Class in its simplest form is mainly based on socioeconomic status or family genealogy, though modernity (westernization) and traditionalism might also be used to set apart classes. In Iran different classes have different cultures and are bound together through different processes. For example, relationship is a primary source of security and financial support for low-income families; in contrast, connection is a source of emotional and psychological support for the affluent. Division of labor for the poor and/or uneducated could be a relatively simple division between the public (men's work) and domestic (women's work). Generally the lower and uneducated classes may regard females as inferior or different, and entitled to a lesser position in the society. On the other hand, the modern classes normally make every effort to guarantee the equality of sexes and eliminate gender inequity (Price, 2005).

As stated by Jalali (1982), it is important to understand the cultural characteristics of Iranian clients in order to deal with psychological issues associated with this population. The family is considered the most significant element of Iranian culture. Most physical illnesses and mental disorders are usually managed by the family. The family acts as the decision maker and is considered an important source of support for the patient (Langsley et al., 1983). To this date, there have been only two published articles studying the attitudes of Iranian population toward seeking mental health.

In her doctoral dissertation, Rahimi (1989) investigated the attitude of Iranian students residing in United States toward seeking professional psychological help for emotional and psychological problems. The author studied the effects of such variables as age, sex, religion, educational level, acculturation level, and prior contact with mental

health professionals on help-seeking attitudes in this population. Sixty Iranian students (36 female, 24 male) attending universities and colleges in Southern California were recruited for this study. The ages of subjects ranged from 17 to 54 years and they had been in the U.S. between one and thirteen years. The subjects were asked to complete three questionnaires: the Behavioral Acculturation Scale (BAS; Szapocznik et al., 1978); the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970); and the Demographic Data Form designed by the author.

The results of this study indicate less positive attitudes toward seeking professional help for personal problems among the Iranian students, when compared to the norm used in this study by Fischer and Turner (1970). Students who were more acculturated and spent more time in the United States had more positive attitudes than those who were relatively less "westernized." With regards to gender, the help-seeking attitude was more positive among Iranian females than males. The age of the subjects did not show a significant correlation with their attitudes toward seeking professional help.

An apparent limitation of this study is the lack of information regarding how the 60 Iranian students for this study were selected, in addition to the small sample size. It is therefore difficult to generalize the results of this study to the entire Iranian student population studying in the U.S., and likewise, cannot be generalized to Iranians in general.

In a similar study conducted for her doctoral dissertation, Khoie (2002) investigated the predictors of Iranian males' attitudes toward psychological counseling. The participants of this study were 80 adult Iranian males who resided in California. The age range of subjects was from 21 to 68 years. Samples were selected randomly in

regards to educational level, socioeconomic status, and religious affiliations. The participants had to meet three criteria: being an Iranian immigrant, having lived in the United States, and having Iranian parents. The subjects were asked to complete six questionnaires: Demographic Questionnaire; the Attitudes Toward Seeking Professional Psychological Help Scale- Short Form (ATSPPHS-SF, Fischer & Farina, 1995); Iranian Self Identity Scale, adapted from the Suinn-Lew Asian Self-Identity Scale (SL-ASIA; Suinn, Ahuna, & Khoo, 1992); Perceived Social Support (PSS; Procidano & Heller, 1983); the Bem Sex Role Inventory Short Form (BSRI short form; Bem, 1974); and Marlowe-Crowne Social Desirability Scale (M-C SDS; Marlowe-Crowne, 1960).

The results of ANOVA, Multiple Regression, and Zero Order Correlation analyses indicated that there was no significant correlation between age and acculturation and the help-seeking attitudes of Iranian males. Additionally, there was no difference in attitudes toward seeking psychological help between males who had college education and males who did not. There was a significant positive relationship between attitudes of help-seeking and perceived social support; the higher perceived social support in the Iranian males, the more positive their attitudes were toward psychological help-seeking. Finally, the study indicated that there was a significant positive relationship between attitudes toward seeking help and traditional gender roles; males with more non-traditional gender roles were more positive toward seeking professional help.

Among the limitations of this study are the relatively small sample size and the use of a translated version of Suinn-Lew Asian Self-Identity and Acculturation scale with an Iranian population, in which some meaning might be lost.

39

Chapter Three

Methodology

Participants

Sixteen mental health professionals, eleven female and five male, were interviewed. These individuals were limited to licensed psychologists recruited from the states of Minnesota and California because of the medium to large populations of Iranians that reside in these states. These 16 mental health professionals have worked with at least 10 or more Iranian clients both for short and long-term therapy. Participants' age range was from 36 to 65 years old. Two lived in the Twin Cities of Minneapolis/St. Paul, Minnesota and 14 lived in the Los Angeles County, California. Five were men and 12 were women. Three had their master's degree (MA) and 13 were either Doctor of Philosophy (Ph.D.) or Doctor of Psychology (Psy.D.). The master's level therapists were all licensed in Marriage and Family Therapy (LMFT). The Ph.D. or Psy.D. level therapists were Licensed Practitioners in Psychology (LP) or Marriage and Family Therapy (LMFT), except two therapists; one is licensed as a Certified Professional Counselor (CPC) from the state of Arizona, and the other is a Licensed Professional Counselor (LPC) from the state of Texas. Nine participants identified themselves as White/Caucasian; the other seven identified as "Iranian- American." At the time of the study, participants had lived in the United States between 7 and 40 years, and had practiced psychology for an average of 16 years. Eleven therapists were in private practice, five worked for a non-profit agency, and one worked in a residential treatment facility.

Design

This is a qualitative study. Data was collected through interviews with mental health therapists currently working with a mainly Iranian population residing in the United States. The therapists were Iranian and were fluent in Farsi. Interviews were an hour to an hour and half in length and consisted of open-ended questions. Interview data were transcribed and analyzed to identify emerging themes that describe effective mental health services for working with Iranian clients and barriers to seeking mental health services.

Procedures

A search was conducted via the internet to locate therapists working with Iranian clients in the state of California. The principal investigator used Google as the main search engine and found a directory of Farsi-speaking therapists through the Los Angeles County Department of Mental Health. In addition, the principal investigator referred to the Iranian yellow pages, published in the state of California, to locate therapists that might have not been listed in the Los Angeles County directory. The therapists working with Iranian clients in the state of Minnesota were introduced to the researcher through word of mouth and professional associations. A recruitment letter was sent to 97 Iranian and Farsi-speaking mental health professionals who worked at clinics located in these two states. The recruitment letter described the study and invited the mental health professionals for an interview with the principal investigator. Fourteen of the California therapists responded to the researcher, mainly via e-mail, indicating their interest in participating in this study. Of this group, four were not licensed and therefore not considered for the study. The two Minnesota therapists agreed via phone conversations to meet with the researcher and take part in the interviews. While in Los Angeles for the

41

interviews, the researcher was able to recruit three more licensed therapists for the study, and the final number of participants from California was 14. Each mental health professional was invited to a 90-minute interview session. Participants completed a consent form in advance, approval for audio recording. The form indicated future contact for further clarification in future e-mails, phone calls, or an in-person meeting.

Data Collection

The principal investigator conducted a semi-structured interview with each mental health professional for no more than 90 minutes in length. Questions included: Please tell me how you came to be involved in working with Iranian clients? Can you briefly describe the services that you provide through your practice/clinic? Would you say that there is/are anything unique about how you deliver services to Iranians? In your view, what is important for therapists to know when working with the mental health of Iranians? (for a complete list of interview questions please refer to Appendix B).

Data Analysis

Transcription procedures: All of the interviews were audio recorded and later professionally transcribed by a confidential transcriptionist. Notes were taken during the interviews as a back-up measure and for future clarification. After transcribing the interviews, all tapes were destroyed and efforts were made to protect the anonymity of all interview subjects.

Coding: A modified version of the Consensual Qualitative Research (CQR) method was used (Hill, Thompson, & Williams, 1997). The CQR method is the most appropriate method of choice given its emphasis on collaboration and consensus. The research team, comprising the principal researcher and her academic advisor, looked at

interview transcripts individually and then collaboratively to derive a classification system of domains and eventual categories based upon the transcribed data. Following each transcript review, the research team consensually developed themes for each case. Finally, domains were derived from the themes.

In the present study, the research analysis team consisted of the principal investigator and her academic advisor, a counseling psychologist with expertise in multicultural issues and qualitative research. The principal investigator first analyzed the transcripts independently through paragraph-to-paragraph analysis in search of basic concepts that were represented by quotes from participants. Then the team worked through a consensus process to develop the domains and themes reflected in the results. A total of 21 themes were generated from 178 pages of data from sixteen interviews. The themes were identified under six domains.

Chapter 4

Results

Introduction

The domains and themes derived from the interviews are presented in this chapter. Six domains and 21 themes emerged from the semi-structured interviews. Domains are the major areas presented by the participants in regards to their perceptions of Iranian clients and their attitudes toward seeking professional psychological help. The domains are: clients' expectations/preferences in therapy, therapists' approach to therapy, relationship/building rapport, boundary setting, gender roles, and help-seeking barriers. A number of themes are presented within each domain and selected quotes from the interviews are cited as "raw data." As suggested by Hill, Thompson, and Williams (1997), variations within samples are designated as follows: Concepts that apply to all participants (N=16) are denoted as general, concepts that apply to half or more participants (> 8) are denoted as typical, and concepts that apply to less than half of the participants (< 8) are denoted as variant. In addition, general concepts will be discussed as applying to "all participants" to illustrate harmony between themes. Hill et al. (1997) recommend dropping ideas that apply to only one or two cases; their recommendation is observed in this study. Additionally, results of traditional qualitative studies are often presented by most common themes first, narrowing down to more variant themes. However, the results of this study are presented more reflective of the counseling process, such as beginning with clients' expectations and therapists' approach, and ending with help-seeking barriers. In this chapter, the therapists working with Iranian clients are

referred to as "participants" and their Iranian clients are referred to as "clients". The

emergent domains and themes are presented below, as well as in Appendix D.

DOMAIN 1: Clients' Expectations/Preferences in Therapy

Participants emphasized what Iranian clients consider important when receiving mental

health services. According to participants, Iranian clients look for certain traits in their

mental health providers, and want mental heath services to include their Iranian values.

Theme 1: Iranian clients seek out cultural-specific (Iranian) services; knowing client

preferences, therapists therefore advertise their services in Iranian/Persian media

outlets. The participants indicated that the majority of Iranian clients prefer working with

an Iranian therapist. Iranian clients search for a provider through word of mouth or refer

to media such as Iranian Television advertisement or Iranian yellow pages, especially in

state of California. Responses to how participants have come to focus on Iranian clients

were:

> "I didn't do anything. They found me. I recently advertised but most of it has
> been word of mouth and recently since I've advertised in the Yellow Pages, I've
> got a couple clients call from that but the majority of it has either been other
> therapists who refer either family or friends that they couldn't see, or people who
> have come through other referrals. "

> "Iranians have a community in which that when they begin to trust you, they
> begin to refer. They really…word of mouth is really powerful, so if they say, This
> doctor we really like, and then all of a sudden they come out of the woodwork.
> Ironically, I got a call from a gal from Los Angeles and she wanted to interview
> me for Iranian television because at that time I was involved in a men's
> movement and I was traveling around the country doing lectures and had
> interviews with different television shows—ABC—and newspapers and she was
> interested to interview me to come to Iranian television. I wasn't and I said, No,
> thank you. And, looking back, it didn't have to do with Iranian issues, it had to do
> with…I didn't like it…I didn't like to be in the public eyes. I just liked having my
> own little office here. I show up and help people get out. Then they called again
> and they said, "By the way we referred someone to you." Okay. She came in…I
> don't know it was like a mushroom from her, then she started referring people,
> and I would say, who did refer you…and it was so-and-so who knows so-and-

so…it was like a web, and then I decided to put ads in the Persian yellow pages and then people started to call."

Theme 2: Iranian clients expect/prefer therapists who are authority figures with the highest credentials. According to participants, Iranian clients pay attention to the educational background of their therapist. They prefer a therapist who has earned a higher graduate degree such as Ph.D. or a Psy.D., and would like this person to take charge of their treatment. Iranian clients would like to see an assertive clinician who exerts power in the therapeutic relationship.

> "Iranians have,…and I'm not sure if that works very well…they like to look at…they don't always work well especially at the beginning of session with therapeutic allies and therapeutic relationships, coming from the point of view of equal person…partnership…that doesn't…I notice they don't respond well to that…they like to see you as the expert and the one who is in control. So, prestige is really important to them. So, a lot of times although I ask them and I tell, "I'm not a doctor," they feel more comfortable to call me a doctor, you know? So…because that gives them more a sense of security."

> "…sometimes I can see a big difference between American clients and Iranian clients, working with both. American clients feel very comfortable when you level with them. But with Iranians, you have to kick their defense, you have to be the authority, you have to speak in that idealized way, so they can listen to you or respect you or feel that their money didn't go to waste and this has a lot to do with that culture of course and these are the people that know best: authorities who are worthwhile to listen to."

> "Expertise would be the first major, the first major thing because, you know, back in Iran there is a gap between…a different type of gap between professionals, especially doctors in the medical community and, you know, common people, uneducated. So, the doctor is the one who is supposed to know everything and have all the answers and…you know, even,…it's not, it's not acceptable in our culture that the patient hears something like this from the doctor that…you know, you ask the doctor a question and the doctor says, You know, I don't know. It brings down the prestige. So the expertise, of course, it's different here, fortunately…so you can set the limits here and you can say, I'm a professional in this area and I have limits and if you have questions in the medical area or in other things or legal you have to really go to those professionals, because I'm asked a lot of questions, actually—legally, medically, you know…"

Theme 3: Iranian clients prefer a "quick-fix" method in therapy. According to the

participants, Iranian clients would like to find a solution to their problems quickly and

feel better in a short amount of time, rather than a lengthy process of understanding their

issues.

> "And another thing I remember to tell you, in our culture, when they have a problem, they want you to fix it right away. And I say, it's not like you have a cold or infection and you go to doctor to get antibiotics and then you see the results. I cannot fix your problem. "Okay this is my problem: what do you suggest?" It takes time, therapy takes time, you know? So, you have to, you know, walk them through it and explain and, you know, and sometimes they get disappointed and after three or four sessions when they don't get their answers, they quit. Or they bring excuses, A, B, and Z...I cannot come...and I know the reason is they didn't get the answer...."

> "So, a lot of them I don't think they understand what the process is. Some of them need short-term fixes. You know, should we be doing da-da-da-da? And they come and if it works, it's done, and I think that's part of the barriers saying, "Now that I'm here, what else can I get out of this? Okay, we've had difficulty with this; can I avoid other difficulties by understanding things now? Can I change some things to make sure that difficulties later will be decreased?" They don't necessarily see it in that way."

> "....some people don't choose to continue after six to eight sessions—in the Iranian community many of them usually like therapy as a symptom relief, you know..."

Theme 4: Iranian clients prefer a more "direct" style in therapy; however, while this

appears to be a preference, therapists also talked about other approaches. Iranian

clients would like to be told what to do in order to feel better. They respond well to

setting concrete goals for changing behavior in order to see instantaneous results. In

addition, some might be willing to work on their past issues to resolve current difficulties.

> "The beginning of therapy, CBT okay? And, um, then maybe later—like six months later, two years later down the road if you're doing long-term therapy— then psycho-dynamic therapy works. So, this is the approach that I've really seen that works with the Iranian population. Cognitive behavior at the beginning and as many as I've...because many of us culturally, culturally...we have learned to

make decisions not with our emotions so the cognitive-behavior kind of…it creates a great balance in there…"

"—I try to confront them and I try this in a different way and I see this is working, because when you confront, you know, there is something here, they don't want to look at it and you put it in front of their face, this way will work with them. But when you try to, you know, active listening, it's good, good, good, but once…it's like you go with that active listening for one month, two month, three month, four month, five month, six month…after that you need to be in active terms. You know? You cannot just sit there and say, mm-hmm, this is not working you need to sit there and reflect and confront. So, in that way they feel it, they will respond better."

"..that there isn't that much—well there is some, but not as much as with the Americans—the need and desire of the patient to really do self-analysis and depth-exploration, to really go deep inside themselves and to grow in that way. The focus is still more externally focused than internally focused so it's harder to deep the psycho-analytic or psycho-analyzing work that we learn in school, which is really what we were attracted to. It's harder to do that. And you really have to be a little…you have to use as much as you can…cognitive behavioral model with Iranians."

Theme 5: As a matter of cultural practice, Iranian clients are known to bargain for

therapy fees. Iranian clients, especially the older ones who have lived the majority part of

their adult lives in Iran, follow a social tradition of bartering for fees here in United States

as well. In this case, they would like to bargain the therapy fee and bring it down to a

more suitable level for them, rather than accepting the standard fee for service.

"Again, I've run into a couple situations where they'll try to bargain and I stay firm and then done and I don't think it's the money, it's just bartering…like there was one guy, my fee was at $150 and he wanted to give $140, so obviously it wasn't about the money, it was just having to barter."

"..what's interesting about Iranians that I notice is that they always look for bargains and they try to…and it's mind-blowing,… I mean even here, I have people who come here…I don't take insurance anymore, last four years I got out of the insurance business, but…in the past when I was taking insurance and people would say, is there any way we can waive the co-payment? Ten or fifteen dollars."

"The other thing that I know is bargaining for the fee. Okay, now…before I used to get offended. I…yeah, I came here when I was thirteen, so I haven't done business…I have never done business in Iran, so I didn't know what it was. I used to get offended., like this is a professional, this isn't about you…what are you talking about what's true with bargaining. And then I got it, even if you give them $5 or $10, to them that means they're special."

DOMAIN 2: Therapists' Approach to Therapy

One of the main focuses of these interviews was to understand if participants employed a different approach while working with Iranian clients. The majority of participants agreed that the length of time an Iranian client has lived in the United Stated and the level of his or her acculturation play important roles in the process of therapy. Iranian clients benefited from education about the therapeutic process, and younger clients were more open to change than older clients.

Theme 6: It is important to understand the level of acculturation among Iranian clients. Iranian clients present with a variety of issues in therapy, but the therapeutic approach might be quite different in each case depending on how acculturated clients are to U.S. culture. Although the therapy is practiced in United States and the practitioners are trained to treat clients by conventional western psychological models, issues from the home county and culture can significantly change the course of therapy.

"they're raising…their kids that they're raising here and are born here, the cultural issues are playing a part because now the new generations are more open and honest and they want to do things the American way. They want to keep that heritage in that ….like you can't go out with your male friends if you're a girl or you can't go to the party. They're all going to cause a fraction between the family members. So, we have a lot of work on bringing the two cultures and pick and choose the traits we like, but we have to definitely mainstream and become part of the melting pot if…for us if we want to have a functional adult as children."

"I would want to know what the culture is in terms of if you're Iranian you're more aware of it and you've grown up in it and you understand it, and if you're not that's when consultation comes in terms of power differentials, authority, and

how authority seems and I think a lot of therapists will talk with clients and think that they've gotten it and the clients sometimes won't do the stuff. And they've said, "yes" but they don't understand that they're saying "Yes" to be polite. It's not appropriate to say to somebody in authority, "No" or "I disagree." I think that's important to realize culturally."

"Adjustment—not being able to adjust here. Most of my clients are in their twenties and thirties and forties, they have immigrated here five, ten years ago and they're lonely, they feel empty, they feel attached to the motherland, they kind of don't know what they are doing here, that idea of going to the promise land—the United States—you know, everything is going to be wonderful, that dream kind of crashed, and losing…not having friends…they've lost friends and lost connection to their family and,…again, I call it extended culture shock. It continues. It never ends that kind of culture shock."

Theme 7: There are disparate views among Iranians about the concept of psychotherapy and these views seem to fall along generational lines. Iranian clients have different views toward therapy. A distinct difference is between the older generation who were raised in Iran and the younger generation born to Iranian families but having never lived any significant time in the home country.

"For parents, a lot of it is education: hey, listen, this is how this society works, this is how things should be, this is how you need to deal with this situation, this is not Iran anymore, especially not Iran forty years ago, so you need to adapt; you can't say, well, it wasn't like this during my time: it's not your time right now. So, a lot of it involves the education of parents, there…a lot of it involves facilitating healthy communication between the two sides. Some of it involves getting children to be more responsible—the younger generation be more responsible— like, hey, if you are living with your parents and expect them to do everything for you and run your errands for you and pay your bills for you, then you need to realize that…"

"Again, I'm going to split it in half: Iranians who were born in Iran and Iranians born here. Iranians born here are very process-oriented. You can work with them for two years in therapy and you have no problem. Iranian who were born there, they don't like long-term therapy, it should be short-term, it has to be goal-oriented and it has to be tangible material that you work with. They like assignments to be given to them, like step one to step two to step three. And literally goal-setting is the most important part of that work. You have to explain to them exactly like an architect, how you're going to build this building. With the other Iranians, no. You go, how was your week? And from there you open up and

you work with different materials, with these ones, no. So, the other communication problems: tell us how you're going to address that? What are you going to teach us? And if you don't show confidence, they don't respect."

"Kind of a difference between the Iranians who are educated here, really get this idea of…the philosophy of this culture, you know, individualism, human rights…you know, how it is important to follow social rules, the aspect of the this culture…the positive aspect of this culture that, you know, that keeps this culture together and keeps it advanced and keeps it kind of progressive in the world and you can…I think you can learn this through getting education, higher education…those Iranians, they…they're different, so when they come, they come on time. They know the time is limited and they know they need to leave on time. …… older people, then they come late. They may never show up and never call you to let you know……..What happened…they may know that, for instance, it's a fifty minute session, it's a counseling session, but they expect to stay longer, as much as they need."

Theme 8: It is important to consider role-assignment in Iranian family systems.

Recognition of the assigned role of each family member is essential in working with

Iranian clients. In more traditional families, father is the head of the household and

carries a great amount of power. In working with Iranian families in therapy, therapists

would benefit from acknowledging each person's role, especially in facilitating

communication between generations.

"Respect the roles of the families and don't go very strongly too quickly against the roles. Like if you see certain atrocities between husband and wife and man is authoritative and in a dictatorship, you cannot go right away and say, "This is a liberated country. This is not proper." I've done that and I've learned from my mistakes and in fact the wife didn't like the way I handled her husband because I was upset the way he was talking to his wife—this was 15 years ago, 12 years ago—and I learned, Okay, this doesn't work. I need to respect the roles and then gently…the first thing I want to tell you, as many other therapists will tell you, join them through the culture, then work with them and then they will hear you. An angry Iranian came to see me. Tall guy, very authoritative, disrespectful to his wife, and he would sit there and he didn't believe in therapy and I joined him…I joined him and this man, he's a different man today. He comes to my meditation classes, he's into spiritual work now and he's much kinder, much…he said, "I can't believe you even accepted me when I saw you that day." But I knew it was wrong for me to come face to face. If you come strong in the face…because I'm like that, I can come very strong in people's face…with Iranians, it backfires."

"It's quite a lack of refinement in parenting talent and you see a lot of favoritism with the kids. They used to give their children often to people who didn't have children so you see a lot of unfortunate way of thinking as a culture. It works backwards in the sense of, um, feelings and expressing of thoughts, giving each other space, being able to tolerate differences and, um, and giving your opinions and making decisions and being able to accept the consequence of that decision-making. They make decisions for you…you wouldn't go through consequences, so the self-confidence and the lack of responsibility then played a role with the next generation."

"Well, I think just like any family that you treat them on first seeing on what's going on. Like a director sitting in the room and seeing everyone play their roles and get a feel for who is the dominating one, who is the male chauvinist one, who is the bitchy one, who is the insecure one, so kind of look at it first and then later on do the treatment plan based on that, so I would do that with any family whether they are Persian or non-Persian. But, yes, usually we do—although it's changing also—but I think it has been changed the last few years, but we still do see the man still being the one making the decisions and the financial decision especially and the work and the house and the female is more of the domestic—the kids, the PTA meetings, the school, you know, the medical problems for the kids—so you know they do have those different roles. So, based on that, I would then do the treatment and draw diagram and work with them. "

Theme 9: Iranian clients are unfamiliar and impatient with counseling protocols.

Iranian clients express frustration with therapeutic guidelines such as filling out informed consent, observing confidentiality, and adhering to a timeline.

"What I have actually found in working with clients who are from Persian origin is that they really don't like to get into the bureaucracy of things and they just want to get into the real thing right away. So, when you talk to them, it seems that it goes up and it goes past their patience to deal with the administration stuff and working on ethics. It's like an alarming sign for them when we talk about laws and the ethics. Some of the…some of the areas that I found it's very hard for our Persian clients to understand is that this is not a friendship. This is just a pro…this is a professional setting with you as a neutral stance and listening to you."

"You have to really be careful and mindful of what you do when working with these clients. Clients…you have to be, you know, like a train station…you know I explain to them about confidentiality. I tell them, if you don't sign a release, if your husband calls, I'm not going to talk to your husband. If your mother calls, I'm not going to talk to your mother. You have to sign a release, you know? To a doctor, to whoever. You know? Number one. Number two, if I work with you and your husband, usually I see you first and then I see your husband one or two

sessions and then I see you together. You cannot ask me, "What did he say?" You cannot ask me, "What did she say?" Some of them they got mad at me, you know? But then they got to know me when they realized this is the role of my job, you know? So, because they treat you…it takes time to learn you are a therapist; you are not a friend."

"I think with time-management, we have an issue and many times they call one hour before a session and say, "Oh, I can't come; I'm going to a party." And they don't understand and respect, so I penalize them. …we set our limit and boundaries. Many times they want me to go to their house and have dinner, which I don't. And, um, I always tell them that if I see you in the street or at a party, I'm not going to say, "Hi," so if you want to say, "Hi," then I'll say, "Hi." …other than that….usually, if they show up and if they're consistent then therapy usually is very helpful to them."

Theme 10: Use of humor is an effective tool for building rapport with Iranian clients.

The participants pointed out repeatedly that use of humor is a great "ice-breaker" in working with Iranian clients. Making light of a difficult situation allows the clients to relax and be able to express their feelings more effectively.

"I notice that sense of humor is really helpful in therapy in general. However, I've noticed with older Iranians, that's not funny, so they need you to carry yourself as an expert. They need you to be very serious. This is a very professional relationship. At the other hand, I've seen at the end of the session, they want to kiss you…and, you know, say, want to see you someplace else….so you have to explain boundaries, confidentiality, things like that more…but sense of humor helps me in many situations in therapy.."

"Nothing I can tell you has helped me more related to Iranians than a sense of humor: great sense of humor. It eases the situation…. And I use the sense of humor a lot. It's very powerful. And the reason for that is because they can take or not take the concept hidden in humor. So they don't get narcissistic injury."

"…it's…Yeah, part of the passive-aggressiveness or the humor that we have, you know…Iranians have a huge amount of humor because that's probably the safest way they have to release their anger is humor and sarcasm…."

Theme 11: Learning to express feelings and working through emotions is an essential

part of therapy. As it is true for any population, the participants emphasized that developing insight and learning to express feelings are central in treating Iranians.

"…with Persian clients, it's very hard. It's really hard because there are times that they don't know how they feel. They really don't know. So even if they cannot put a name on it, I will say, okay, how is this: comfortable? Is this feeling uncomfortable? So, something that is not comfortable? Okay. So, it's very hard—especially male clients—to get what they feel and that's why I do a lot of body work with them…so by noticing their body they will understand, Wow, how much anger they have, just by…"

"So one of the things we can do in therapy consistently is to modify it, so if somebody is being sarcastic then, you know, we just say the word, which is, "It seems like you're really angry." You know. Give them the word. Iranians are really emotionally expressive but they don't really know the words, they don't really know their feelings, that's the interesting part. They don't have distinction about their feelings. They don't know which one is anger, which one is anxiety, which one is sadness, grief…so part of the education with our clients is even their emotions to be named and then managed and then relieved. So, although it appears that everything is emotional and they are, but they do not have an insight into what the emotion is. There's just this huge amount of emotion that keeps pouring out and then we give each other or ourselves, actually, the permission to do that so you get that the passive-aggressive and the hold-hold-hold and then ignite and then hold-hold-hold, ignite. And you see that extremely in almost everybody."

"…and build the rapport so they'll be able to express their feelings and then the expression of feelings is very difficult for us as a culture because…. we've been…we've learned to act aloof and maybe talk to our mom or best friend, but talking to a stranger is…"

Theme 12: It is important to educate about mental health and psychological services to the Iranian community. Participants emphasized the role of education in raising awareness about mental health issues and decreasing the stigma against seeking psychological help.

"We have way more Iranians that say they don't believe…so education. I think more exposure to, um, the message that this is good for you….we are not fortune tellers, we don't…we can't tell you the future…so…usually I spend about the first ten minutes of the session education Iranians and that has been very fruitful, to tell them what psychology is and what is not and what should be their expectations of what I can provide and what I cannot. And, so, I've seen a couple that I've worked with goes and talks to another couple and say, "This is what we have tried, go and see her." Because usually…then they, usually they say, "This is

how it was explained to me what psychology is," and I say, "Oh, okay," and then, "If it's this way, then I'm going to give it a try.""

"Explaining all these things that a lot of Americans know about therapy. Many Persians have no idea. A lot of it is education, the first few sessions is education about what is therapy—I have three sheets that I give to people that I typed up: What is therapy and how does it work? Addressing their concerns, their questions…because a lot of people don't know. They go to a therapist with the same model in their mind as they go to a medical doctor, that, "I tell you my problem and you tell me what to do." So that's the expectation….."

"…it's kind of like teaching in some ways, but if…it's a little bit less direct than that, the indirectness of it sometimes makes it difficult for people to see the value or understand how it works and for that to take place, I think—because I always ask myself that question when I compare my American clients or clients from another culture with my Iranian clients—and I notice this, you know, easiness and flow and being on the same page that sometimes you don't feel with the Iranian client. So, that I think has to do with that…that we still don't have that historical, … It's not established…it's not part of the culture…"

DOMAIN 3: Relationship/Rapport Building

Building a therapeutic relationship is typically the first step in initiating work with

Iranian clients, besides paying attention to a few other culture-specific characters of this

population. A good rapport is probably the main reason Iranian clients remain in therapy.

A "good" rapport with an Iranian client includes speaking their language, understanding

the history of their home country, and respecting their cultural pride.

Theme 13: Cultural empathy is fundamental in working with Iranian clients; language

is an essential/helpful tool for developing rapport. According to participants, Iranian

clients express a preference for discussing their issues in Farsi. Additionally, clients

prefer a therapist who is familiar with Persian culture and customs.

"Being bilingual is one thing. Cross-cultural understanding is very important. Being able to understand the family-oriented culture because we are very family-oriented, is an other thing. And …being able to understand and realize the difficulties and complexities of culture shock for extended culture shock here that the community is going through. The…the conflict within the two generations,

55

the first generation immigrants and their children living here…there's a conflict there. Many of my clients come with that problem. Children growing up here, they are more acculturated to the majority culture. They don't understand the traditional culture…there is this conflict and struggle here with the parents and the children and then I mentioned being bilingual and I meant, the Iranian-Americans, mainly the children, when they come they want to talk in English language, they prefer English language, most of them. The parents on the other hand talk in Persian, so the counseling session with them is actually bilingual."

"But overall, they feel more comforted by the language. I speak Turkish as well. Sometimes I get people from Azerbaijan and when I talk to them, they say, "Oh, it feels so good. It's comforting to hear that you speak the language." It puts them…I can see that it puts them at ease very quickly. The idea that they feel understood a lot quicker, it's like saying, "Do you remember Tehran?" I don't even have to go any further. "Do you?" Oh, that non-verbal connection of images that comes into the mind that speaks volumes that cuts through a lot of explanation."

"Number one that I have to work on to change with everybody is my command of Farsi language…because I learned psychology in English I have a problem explaining what's going on to people in Farsi, and sometimes I notice that's offensive. And so I have to keep apologizing and saying, "I just don't know what we call this in Farsi." So, I ask for their help. So, if I'm working with a couple and the wife just came from Iran and the husband has been here for years, it kind of connects me more with the husband than it connects me with the wife and that's not okay, so I have to work on becoming more comfortable doing therapy in their language as opposed to English and going back and forth between two…."

Theme 14: Iranian clients come across as "proud" people. Iranian clients present themselves as proud people and it is very important for them that therapists recognize and respect this pride.

"Our culture is rooted in pride and vanity. Pride is so big—and I speak for myself—it is so much in me, that it blinds me. I don't find any good merit in pride, despite of what everyone talks about. Pride to me is one of the biggest barriers in mystical work. Humility is the medicine for pride. And Iranians have a tendency to have extra-ordinary pride, just they way they walk, the way they talk about themselves, who they are, who they associate with, and I have to tell you after years of meditating and working on myself, I still see it coming out of me and I have to address it on a daily basis and I told my wife, "Please, if you ever see aggressiveness. If you see it comes across without humility because I can't stand my own pride." So, I would say one of the biggest barriers is the pride that they think they know and success is extremely important to Iranians. And I have

to tell you that most of them are very, very successful people. Most Iranians come here and they are excelling in anything they do."

"…I think the pride the Iranians the have. That's the pride that is something that doesn't go away with anything, no matter where in life we are…we are wandering Iranians all over the world…still the pride that is rich in each person as an Iranian feels inside to be an Iranian. Although there are many conflicts because of what has happened in Iran, but the pride is part of our psyche and it's just to understand that this is not—in terms of diagnosis—it is not something that we can …bring about and …what's the word—I can't think of the word—but to identify this population as narcissistic people or people with the standards of the diagnosis, which is in the medical book, medical literature…the pride that we feel is something that has to be dealt with tolerance and understanding, which is a society with ancient culture, and the really young or old generation, they all think of this pride. They are all brought up with this pride. I mean, the majority…not all…the majority. So, it likes to be understood, not as a symptom, not as a disease, not as any of that, but understanding and respecting us for this pride that we have."

"I believe that people of Persian culture are very proud people. The Italians say they do not wash their dirty clothes in public and we are worse than that. We even do not wash it in our own house, we hide it. And, therefore, for a therapist to be successful and accepted by them, the therapist has to buy their trust, gain their trust…."

Theme 15: Being of Iranian heritage themselves, therapists have to overcome stereotypes about their own culture. The participants indicated that it is essential for therapists working with Iranian clients to know their own cultural identity, to refrain from being judgmental, to acknowledge diversity in their culture, and to focus on building alliances rather than only focusing on common background.

"Now, one thing that I would …I think that works a lot with the Iranians…to hold a non-judgmental stance consistently. And we say that to have that in therapy but we also know we're all human and we have prejudices, we have counter transference…."

"Non-judgmental stance. I think that's a very important fact for…being with all cultures, and try to understand from the empathic point of view, understand people are people, they…it doesn't matter where they come from, what culture they have…you learn about their culture through their lens and with your own pursuing of studying different cultures. But with people…people are people to

me. They don't…they may vary on the surface, as far as their traditions and belief systems because of the culture they come from, but…the main…need of a human being is to be connected and to be understood. To feel that he or she is in a trusting environment and that's what makes the therapy work."

"It depends on the age range. If you are working with older, more traditional ones it is different than if you are working with younger ones. It's also different depending on within Iranian ethnic group what sub-culture you are dealing with; there is a big difference between Jewish community and non-Jewish community in the way spouses relate to each other."

DOMAIN 4: Boundary Setting

The most common issue raised by participants was a lack of boundaries. In their view, Iranian clients have poor boundaries in their interpersonal relationships and this affects their progress in therapy as well. According to participants, older and more traditional Iranians do not respect the independence and privacy of their children and friends and would prefer an "enmeshed" relationship with them. As it pertains to therapy, Iranian clients do not recognize the limitations of this relationship and would like to become "friends" with the therapist and develop a bond outside of the therapeutic setting.

Theme 16: Managing boundaries is a prevalent topic presented in therapy as well as in the therapeutic relationship. The participants often teach boundary setting, and work on protecting the therapeutic boundary between their clients and them.

> "If I can give you one word: boundary. Iranians have no clue what boundary is. Okay? So when it comes to informed consent, it's like, "Yeah, yeah, whatever…whatever you want me to sign. Okay…." And then I'm trying to explain, and they're like, "Yeah, yeah, I don't need to know." And then, you know, when I'm telling them, "I need to report." "What do you mean you need to report? You can't tell anybody?" Or like, "You know, I'd really like to have a coffee for…a coffee with you." "Well, I can't…." "Well, you've got to come to my wedding…." "I'm sorry, I can't…." "Nobody will find out….I won't tell any authority, don't worry about it." So, there's that kind…that piece I've really got…."

58

"We are coming from a culture that is totally enmeshed with relationships. Separation, individuation means disloyalty. What we are coming from as a collective society, yet practicing in a very individualistic society, and many concepts contradict at many levels…. anybody from Iran comes and they can ask a personal question: how much money do you make? How much tax do you pay? And how much did you buy this house? How much do you owe? It's amazing— what year is this car? And I get a little shock even though I know it's tradition. In our culture you can ask any question and it's not from any bad intention…"

"So, for instance, you need to be aware that those parents who have marrying age children are never going to let go of their children and children are never going to let go of their parents but maybe the relationship now has to become, um, more limited, or take a different shape and form. That notion of independence and individualism that you see in an individualistic society doesn't work for Iranians. Now of course if they immigrated to America and some of that is beginning to change for some; some have a hard time with it and expectations are inflexible and they cannot change really. But some are beginning to understand that, hey, you can't just drop by without calling in advance."

DOMAIN 5: Gender Roles

There is a distinct difference between male and female Iranian clients in their approach to therapy. At the same time, there is difference among immigrant Iranian females and their counterparts in Iran in the role they play in their family and society in general.

Theme 17: The evolving nature of gender roles for Iranian community. Female Iranians living in United States have assumed a different role from the traditional one in their families and community. The common expectation for the Iranian woman in the U.S. is to work and help with the household's income, while still adhering to her traditional role as "mother" and "wife" by taking care of the home and children and attending to all of the household chores. The discrepancy between the western and conventional Iranian values creates problems in marriages and the therapist's needs to recognize the tensions between traditional expectations and a yearning for individual rights.

"Other problems are the traditional roles that play out. And a lot of these families need to have dual income but you still see the traditional roles being desired, like the husband would want the wife to work because it's necessary but she's also got to take care of the kids, and cook, and take care of the house as well, you know, why can't you do both? And vice-versa. Women look to the husband to be the main provider and it's your responsibility but how come you're not bringing the kids to school and coming to the PTA? So, I think that will cause a lot of problems because they're coming from a culture where there was really set roles, which made things easy and then coming into a culture where the roles are a little more fuzzy and then they have this conflict."

"Then I think there is a lot of…there is a lot of frustration among females because on the one hand, they need to—and this is all unconscious, obviously—because they need to work. Let's see how I can explain this…on the one had they need to be modern, and on the other hand there is a lot of pressure for them to remain traditional—stay at home moms or…"

"…actually, the marital problems and the relationships, the marital relationships with husband and wife…the problem was more on the male side. If you look at it like me, I have made some observations in the small communities that I have with Iranians. Woman, Iranian woman, Persian woman…started standing up on their own feet very quickly after they came over here. They started—regardless of who they were before—they started working in bakeries and taking care of sewing and tailoring and becoming salesman in department store…they helped the structure of the family together as opposed to men who were somebody, they were doing something in Iran, they lived in a past dream: "I was general manager of this, I was a general, I was colonel in the army" and they want to go back and they got more depressed, more depressed. And at the same time they wanted the woman to go out and earn a living and come home, do the cooking, cleaning and they are sitting over there and being depressed…"

DOMAIN 6: Help-Seeking Barriers

There are barriers in working effectively with the Iranian clients residing in the U.S. Poor

boundaries create complexity in maintaining confidentiality. In addition, the relatively

small size of the Iranian community makes it difficult to maintain anonymity for clients

in the mental health services. The topic of seeking help for psychological services

remains taboo and clients have a hard time accepting their need to seek professional help,

especially about sensitive topics such as sexuality or abuse. The past history of social and

political turmoil in Iran is another reason this community does not easily trust or open up about personal issues.

Theme 18: Discussion of mental health issues is a "taboo" subject among Iranians.

Admitting to having mental health issues and accepting a psychological diagnosis such as depression or anxiety remain unfavorable among Iranian people. The fear of being labeled as unfit or "crazy" keeps them from seeking help for their issues.

> "I think it's something that came from Iran in terms that people who are in the field of psychology are working with quote-unquote crazy people. Even myself when I decided to go into this field, you know, I had concerns from extended family of like, "Are you sure you want to do this? Are you going to be able to get married?" So it's very taboo and it's not something that's overcome…."

> "The Iranian population still holds a huge taboo about psychology and going to therapy.…and that has to do with in Iran the format was that if you would go to a psychiatrist and you would go to a psych hospital then you had extreme mental health disorders, such as schizophrenia and…or any kind of psychosis that's when that would happen… for other reasons, such as depression or anxiety, most of the Iranians would go to the internal physicians and get psychotropic medication or anti-anxiety medications or, you know, anti-depressant medications and those would come from an internist…."

> "At the beginning of my practice…psychotherapy was not very common among Iranians. It was taboo, you know? So, as I said the first couple I had was court-ordered for child custody, you know. And then,…then I started getting women first, like women reaching me and talking about marital problems and when I wanted to reach husband, they were like, "Oh, no. He's not going to come to you. He's not going to come. He said, 'I'm not sick. You are sick.'" You know? All these Iranian men: "I'm not sick." You know? And then, so…I reached them. Called them. You know, I said, I would like to see you one session because if I want to work on your marriage or even work on your wife's depression, because if your wife is the sick, as you say, is suffering from depression or missing her family or not doing well, functioning well…I need your help. So sometimes when you're reaching them, that, Okay, you are not the identified patient, I need your help to help your wife."

Theme 19: The size and close affinity of Iranian community demands that therapists pay special attention towards ensuring confidentiality. As an immigrant group, Iranians live in small and concentrated groups around the United States. Although there is a larger

61

Iranian population in California, there is still much interconnectedness among this

population. In a smaller community like the one in Minnesota, most Iranians know of

each other; therefore it is even more critical to observe confidentiality.

> "..first I focus on the issue of confidentiality because they are very concerned.
> Let's not forget we are coming from culture of "*Aberoo*" [saving face]...so, we
> have…what I need to do to ensure that I keep the confidentiality and
> unfortunately they do have in the Iranian community, they do have bad
> experience. So, you have to keep them assured that you keep confidentiality and
> somehow they do trust and it is getting much better now. It used to be very
> important not to see anybody in the office. They are so happy that I don't have
> secretary. They are so happy that I make appointments myself. But anyhow the
> confidentiality is very important.."

> "I have to keep telling them, whatever you're telling me is confidential, so even
> though when they were coming in they would start asking me, for example,
> because, you know, we Iranians…we see each other in community, so I will tell
> them, you know what? I will not come to you to say, "Hi." I just want you to
> know this is your choice, you can say, "Hi," if you don't want to say, "Hi," it's
> okay, I understand. So I do not want the client to feel they have to do, like, … or
> any other ceremony that we see each other so they don't feel uncomfortable. So,
> usually, I bring this up, we might see each other outside, how do you feel about
> that? Does that bother you? So, this is the way it is, I'm not coming to you, this is
> your choice and again, sometimes they start to talk about their girlfriends, da-ra-
> da-ra, and they want to bring the girlfriend in or the wife in, and again I will tell
> them again, you are my client, so if you are inviting this person into the session
> because you want to…so I will keep telling them so that they don't think I am
> going to tell something to that person that they don't want me to tell them. So, it's
> a process of confidentiality, to explain the whole thing."

> "Yes, it is a…especially with confidentiality, they are very…I think one of the
> biggest things we have to educate Iranian community is the importance of
> confidentiality. How I really convince them, I say, I lose my license—it's not
> about you—if I ever share anything about you, then I will lose my license, so it's
> more important for me to continue with my professional work then to talk behind
> your back or tell anybody about what's going on with you."

Theme 20: The sociopolitical history in Iran engenders suspicion about others'

motives. This deep skepticism translates to a lack of trust in the helping profession and

helping professionals. The country of Iran has had a tumultuous political history for the

past century. As a result, people of Iran have learned to self-censor topics that might

bring threat of prosecution and incarceration. Therefore, the concept of trusting a stranger

and opening up about private issues contradicts this life-long strategy of self-preservation

by silence and suspicion.

> "…as a culture, because we're coming from kingship, we've been told to do things and we never made decisions, so as a person we don't…we lack that teamwork and that trust to the team and since we become a team, they need to be able to say as much as they want before getting any feedback and they need to be able to process the information because it's coming with a lot of fear. This is not a culture that is open and it's been contaminated with all the wars and all the anxiety. We are a very schizophrenic kind of a culture and we suspect everything is wrong and everyone is trying to, you know, do something wrong. So, building that trust and sometimes you just have to go over your qualifications for them and to explain what you can do for the family, which, you know, for the Americans, they come for help and you don't have to prove yourself or your certificates to them."

> "…you know, when we look at a country that's consistently been under some level of pressure and turmoil, um, they have…I don't know who said it but it was one of the enlightened Buddhists who said that "Life isn't funny if you really don't have a sense of humor." So, this is what I get about us, Iranians, when you look at the history life isn't funny if you really don't have a sense of humor. So, I do get that we do have a sense of humor, but the other side of the sense of humor is also that…the anger that is internal and it doesn't, you know that a lot of us hold…powerless I think is one of the key feelings that we have, so when we are powerless the anger that's inside cannot be lashing out all the time, so then it lashes out into sarcasm, okay?"

> "And again it depends. There are clients that you have a relationship and they trust your work and I feel very comfortable answering those questions because I know it is not going to affect our work, so for the new ones, you know, I mean they ask me sometimes, "Why don't you wear the hijab?" And I say, well sometimes I make jokes, a sense of irony, I do a lot, you know? I say, you know, "My hijab is in my car.""

Theme 21: Iranian clients are not comfortable discussing issues related to sexuality

and domestic abuse. Iranian clients are protective of their families' privacy. When it

pertains to the topics of domestic abuse or sexual problems, they are very reluctant to

discuss such issues as it would be a violation of what is sacred to them; that is, family.

"And, you know, we're coming from a very dysfunctional family, in general. It's …you know, you see a lot of abuse, emotional specifically. You see a lot of physical abuse. You see a lot of sexual issues and contact….. At times you have to report them and they don't take that very well. They see that as a betrayal…you know, they refuse to talk about sex, they don't educate the kids. I had a sister and a brother that they slept together and then when we brought them to the office, they said that no one said anything to us about not touching…"

"Also with the older generation and domestic violence, which, it's very difficult for women to set boundaries with their husband and calling the police, it's really a bad thing. And they remain in a hostile relationship for a long time and, abusers that's not just Iranians, I think that's across the world, that the abusers are also in denial and don't want to get help and they think that they're right with whatever they do and that it's the other person's fault that they do."

"…in terms of being able to communicate what they like or don't like or both people being satisfied… Some are hesitant. But I bring it up like, "How's that department?" Others are open to bringing it up. No one is completely comfortable, maybe just like "This is this…"

<center>**Chapter Five**</center>

<center>**Summary, Discussion, Conclusion, Implications, and Limitations**</center>

Summary

      The general attitude of Iranian clients in the United States toward seeking professional psychological help was explored in this study to answer the following questions: What are Iranians attitudes toward seeking professional psychological help? What is most helpful to Iranians? What are some of the barriers in working with Iranian cliens? What does a therapist need to know when working with this population? What are certain therapist/therapy characteristics that help or hinder the therapeutic process with this population? Additionally, the study provided the opportunity for participants to discuss their opinions about what is most helpful in working with Iranian clients and what are some of the barriers in helping this population. From 16 interviews, six domains and 21 themes emerged that addressed the research questions and suggested recommendations for working with Iranians and for future research with this population.

      The first domain explained what Iranian clients prefer to receive in a therapeutic setting. Iranians typically seek out a therapist from the same cultural background; additionally, Iranian clients like to work with an authoritative therapist with the highest educational credentials. Iranian clients look for a direct style and a quick fix in therapy and would like to negotiate over paying for such services. The second domain addressed the approaches employed by therapists when working with Iranian clients. Therapists need to be aware of the level of acculturation of their clients in the United States and pay attention to the age and family dynamics of each individual. Having a sense of humor is a useful tool in working with Iranian clients, as the clients are typically impatient with the

logistics of a therapeutic relationship and have a difficult time expressing their feelings.

The third domain explained the essential elements in building rapport between therapists

and Iranian clients. One fundamental aspect is having cultural empathy and recognizing

the cultural pride that these clients express, while exercising caution in not generalizing

their own cultural values to the whole population. The fourth domain described the

concept of boundaries, or lack of, among Iranian clients. Therapists working with Iranian

clients need to work on teaching and setting boundaries for both the therapeutic

relationship and for the clients and their families. The fifth domain explored the role of

gender among Iranian clients and the discrepancies in values and rules while living in

western society. The final domain explained the barriers in helping Iranian clients with

their mental health needs. The issues of confidentiality and stigma against counseling

were discussed, in addition to exploring the effects of the home country's sociopolitical

turmoil on perception of psychotherapy within Iranian clients.

Discussion

DOMAIN 1: Clients' Expectations/Preferences in Therapy

What are Iranian attitudes toward seeking professional psychological help?

According to participants in this study, the majority of Iranians prefer counselors of

similar cultural background. In a study by Tedeschi and Willis (1993), Asian college

students assigned a higher importance to the therapists' ethnicity and preferred to see

someone from a similar ethnic background. Similarly, Iranian clients seek a therapist who

is fluent in their language and understands their cultural background. Iranian clients

typically find a counselor through media advertisement or the Iranian Yellow Pages. In

smaller Iranian communities, such as the one in Minnesota, clients are introduced to

therapists through word of mouth or a referral process. The abundance of advertisements

for Iranian businesses in California through television and radio programs has simplified

the search for a therapist for Iranians of that state. Thus, they have easier access to Iranian

therapists and are able to select the best fit for their needs. On the other hand, in smaller

communities, Iranian therapists can be difficult to find and clients do not necessarily have

the freedom to choose the person who better meets their needs.

Mau and Jepsen (1998), in their study of help-seeking attitude, reported that

Chinese college students preferred older therapists from a similar cultural background

that provides direct and immediate answers and makes decisions for them. In the same

way, Iranian clients appear to choose a mental health professional with the highest

possible educational credential such as a Ph.D. or a Psy.D. They also perceive the

therapist as an authority figure who has all the power in the therapeutic relationship.

Iranian clients are less receptive to a "passive" therapist and prefer a practitioner who

controls the process and leads them toward a set goal. The resultant emotion is a mix of

tremendous respect but also apprehension. Therefore, clients may revere their therapists

but may be cautious about their own presentation in the presence of a highly educated

professional. A common sense of individuality in Iranians for self-protection results in

less inclination for the team work required in a therapist-client relationship.

According to participants in this study, Iranians lack the patience for a long-term

and intuitive style of therapy. They prefer a short and quick approach for fixing their

problems. Iranian clients are more solution-focused rather than process-oriented and

prefer a medical model for dealing with their mental health issues. In their approach, the

goal is to treat the symptoms and find immediate relief for the discomfort. Therefore,

these clients are less patient with a long-term developmental or preventative model towards psychotherapy. They prefer a direct style of therapy in which the therapist gives clear and concrete goals for them to follow in order to resolve problems. The process of self-actualization and understanding the connection between events of the past and problems of the present is not what Iranian clients are looking for in therapy. The participants in this study believed that a Cognitive Behavioral approach to therapy is what best fits the needs of this population. Iranian clients are receptive to the idea of changing how they think and consequently changing the way they behave in order to reduce conflict and hurt.

As a matter of cultural practice, Iranian clients are accustomed to finding a bargain for the services they receive; therefore, they would like to barter the fees for mental health services and bring them down to an amount that is more acceptable to them. According to study done by Kaeni (2006), Iranian clients are used to asking for a discount. The therapist working with this population should either be very firm in regards to fee for service or should offer a sliding scale to respect the cultural practice (Kaeni, 2006). Although such practice is not common in current western society, Iranian clients seeking psychological help view psychotherapy and counseling as a service offered by a professional and therefore, like other products they purchase, would like to negotiate the fee for such services.

DOMAIN 2: Therapists' Approach to Therapy

What does a therapist need to know in working with this population? According to study done by Fang (1998), the attitudes towards seeking psychological professional help positively correlated with level of acculturation in Hmong immigrants. The more

acculturated and educated the Hmong immigrants, the more positive their attitudes were toward seeking psychological help. The same concept applies to the Iranian clients in this study. Iranians living in the United States are a diverse and heterogeneous group. Older Iranian clients who have spent the majority of their lives in Iran and immigrated to United States in middle age are unfamiliar and more resistant to counseling for dealing with their issues. The more "westernized" Iranian clients are, the more they appear to be open to seeking counseling. Additionally, as a common cultural practice, Iranian clients are used to paying verbal compliments and being very considerate (*Taarof*) to avoid embarrassment or hurting someone's feelings. According to Kaeni (2006), this is a formality that is used out of respect towards other people and does not have a direct translation into English or American culture. Thus, they might concur with the therapist and not express their personal opinions for the sake of being polite and agreeable. The therapists working with more traditional Iranian clients need to be mindful of the clients' amicability and examine their receptivity towards the counseling process.

The issues of newly immigrated and older Iranian clients' are more related to cultural shock and adjustment problems. In contrast, the issues of younger Iranian clients who are raised in the United States are more interpersonal and related to their family of origin. According to the participants, the differences between immigrant and older Iranian parents and their American-born children and their differing views of the American society create the majority of the problems for Iranians who seek counseling. In the Iranian family system, each person is assigned a role and typically men are the head of the household and control the majority of decision making. As stated by Jalali (1982), the family is considered the most significant element of Iranian culture, and most

of the physical and mental illnesses are managed within the family. In addition, Langsley et al. (1983) study confirmed that among Iranians, family acts as the decision maker and is considered an important source of support. For a therapist working with Iranian clients and families, it is essential to pay attention to and respect these roles and traditions. In the participants' view, the children are more process-oriented and receptive of the values of western society, and parents are more protective of the privacy of the family and would like to raise their children according to their home country's cultural values.

According to participants, Iranian clients do not like to make long-term plans and are not pursuing counseling for a long-term effect. Rather, they are looking for quick symptom management. Uffelman and Hardin (2002), in their study of U.S. college students, indicated that students were more likely to seek help for high urgency problems, such as abuse or suicidal thoughts. Similarly, Iranian clients in this study view seeking help as a form of "crisis-management." They are also frustrated with common therapeutic guidelines such as observing confidentiality, limited time for each session, and filling out multiple forms. Relationships among Iranians, even in professional settings, are less formal and less structured; therefore, concepts of punctuality and scheduling are less restricted. Adhering to a weekly schedule, starting and ending the sessions on time, keeping the counseling conversation private, and learning about mandated reporting guidelines make the process of therapy even more complicated for these clients. To assist Iranian clients through the process and prevent their premature termination, therapists would benefit from simplifying the counseling protocol (access, intake, paperwork, scheduling), spending time discussing and educating about the counseling process, and being more flexible with their time management.

According to participants, humor is a highly effective tool used to create a comfortable situation in which Iranian clients are able to open up and talk about their issues. Making light of the situation provides the clients with ease to express feelings. Although Iranian clients are emotionally expressive, they are less intuitive about understanding their feelings, and therapy should focus on developing insight. The use of humor in therapy helps to lessen the resistance in clients.

Iranians clients unfamiliar with psychotherapy equate seeking counseling with being mentally ill. In their study of help-seeking attitudes, Gonzalez, Tinsley, and Kreuder (2002) pointed out that clients who had a better understanding of mental health treatment had a significantly better attitude toward seeking help. The authors indicated that improving utilization of mental health services lies in "normalizing" the mental health treatment process. In a similar fashion, in order to help Iranian clients differentiate between mental illness and family relations problems, raising awareness about mental health and psycho-education are highly recommended by the participants. The more the topic of mental health is discussed, the less is the stigma attached to such problems. By normalizing common mental health concerns such as anxiety and depression, explaining the prevalence of such issues in the society, and introducing solutions, Iranian clients feel less apprehensive about seeking professional psychological help. Ey, Henning, and Shaw (2000) concluded in their study that fear of disclosing personal information and being labeled as mentally incompetent are factors in creating negative attitudes toward seeking psychotherapy. For Iranian clients in this study, psycho-education explains to clients how counseling is a helping tool that enables them to overcome difficulties without being labeled as unfit or "crazy".

DOMAIN 3: Relationship/ Rapport Building

What therapist/therapy characteristics help or hinder the therapeutic process with this population? Building a therapeutic relationship is the cornerstone in initiating work with clients**.** Similarly, an effective rapport is perhaps the reason Iranian clients continue counseling, according to our participants. When creating such a bond, it is fundamental for therapists to maintain empathy for clients' original culture. According to Price (2005), Iranian culture is a traditional, patriarchal, and class-based culture. Class is mainly based on socioeconomic status or family genealogy (Price, 2005). The majority of Iranian clients seek to work with a counselor who can speak their language (Farsi) and who is familiar with Iranian social structure. This way, they do not have to explain the idiosyncrasies common to their culture and would know that the therapist is able to conceptualize their ideas and thoughts accurately. A therapist familiar with such elements would not require clarification and would be able to conceptualize clients' issues while discussing cultural topics. Similarly, Iranian clients' maintain a cultural pride. In Kaeni's (2006) study exploring common issues for Iranians in therapy, one participant commented that pride and class is a common cultural dynamic among Iranian families. This dynamic is a way to prove a person is successful, regardless of his or her job or social status in the United States. It is very important for Iranian clients to have therapists who acknowledge and respect this pride. In order to work with Iranian clients successfully and gain their trust and respect, a therapist should be mindful and considerate of Iranian pride.

Since a majority of Iranians seek counselors of similar cultural background, therapists need to increase their cross-cultural knowledge concerning Iranians. To refrain

from being judgmental or jumping to conclusions, Iranian therapists working with Iranian

clients need to be aware of their own cultural values and beliefs and work on building

alliances, rather than focusing on the common cultural background with the clients. A

great level of cultural and social diversity exists among Iranians, as indicated by Price

(2005). For low-income families, relationship is a primary source of security and

financial support; in contrast, connection is a source of emotional and psychological

support for the affluent. The lower and uneducated classes may regard females as inferior

or different and the modern classes normally make the effort to provide equality of

genders (Price, 2005). If therapists are not aware of these differences, there is potential to

harm the therapeutic relationship. While making recommendations for treatment and

encouraging Iranian clients to seek support, therapists need to be mindful of clients'

socioeconomic status and their values toward gender roles. For example, making the

suggestion to an Iranian female client that she seek employment and gain financial

independence might not be understood and accepted in certain Iranian families, and

therefore would not be considered an effective strategy.

DOMAIN 4: Boundary Setting

According to Backlar (1996), recognizing and responding to boundaries in

relationships is basic to the development of socialization skills. However, many mental

health providers in community mental health services find that guidelines regarding

therapeutic relationship boundaries may be hard to pin down (Backlar, 1996). According

to participants in this study, Iranian clients are less considerate of procedures for a

therapeutic relationship and may want to treat therapists as their friends. In addition,

Iranians are less structured in their relationships; therefore, punctuality and confirming

appointments are less common. Educating clients about professional relationships and teaching how to set personal boundaries are common issues discussed in counseling.

On the other hand, Iranian children, teenagers, and adults have a strong bond with their parents; therefore, separation from the family is difficult. Parents do not respect the boundaries of their single or married children and relationships are more "enmeshed" compared to western society. One of the common goals in therapy with Iranians is for older and less acculturated Iranians to learn to respect their children's privacy and for younger and more "westernized" Iranians to learn how to set boundaries. According to Kaeni (2006), Iranian parents contact their adult children's therapists expecting to receive information about their children's mental health. These parents may not understand that therapists—bound to rules of confidentiality—cannot disclose information about their clients (Kaeni, 2006). Similarly, in smaller Iranian communities, there is a dilemma with setting boundaries for everyday, ordinary, and common relationships. Backlar (1996) indicated that a tension exists between providers' generalized ideas about their professional role and their particular and personal values. Iranian therapists need to abide by the professional guidelines of their mental health practice, while observing common and important cultural values such as acknowledging acquaintances in public and expressing respect.

DOMAIN 5: Gender Roles

According to participants in our study, there is a distinct difference between Iranian men and women's perceptions and treatment of psychological help. In their study of help-seeking attitudes, Leong and Zachar (1999) concluded that college men had a more negative attitude toward seeking psychological help than female students. They

stated that the more authoritarian the male subjects, the more negative their attitudes were toward seeking help. For many Iranians, men are the undisputed head of the family, and women take care of the home and children. Similar to Leong and Zachar's study, introducing psychological help can be a threat to the authority of the head of the patriarchal Iranian family. Furthermore, in traditional Iranian families, women are typically responsible for children and taking care of the house. As Iranian immigrants settled in the United States, women joined the workforce to help with family finances. The expectation of simultaneously making a living and taking care of the household is one of the common issues among female Iranian clients. According to Gaffarian (1998), Iranian immigrant women seem to have more psychological dysfunction, possibly due to the conflict between the sexes regarding roles. While settling in the United States, Iranian women are exposed to new gender roles and have to make large changes in order to adapt (Gaffarian, 1998). While it is essential for therapists to recognize the pressures of traditional gender roles, they often must help clients realize and negotiate the tensions between gender roles, expectations, and possible contradictory individual aspirations.

DOMAIN 6: Help-Seeking Barriers

What are some of the barriers when working with Iranian clients? According to participants, because of the small size of the Iranian community residing in the U.S., it is difficult for clients to maintain anonymity while visiting therapists from the same cultural background. In addition, the close affinity of Iranians creates a problem with confidentiality and privacy of clients.

Iranian clients often associate mental illness with being "crazy." The stigma for seeking psychological help is strong, and clients are anxious about raising issues that

discriminate against them or their families. More specifically, topics of sex and sexual abuse are not open to discussion. Sex education is not typically part of family discussions and children are not encouraged to learn about the topic. In particular, revealing sexual issues and domestic abuse would create a rift between families; the complainer might be disowned for exposing the family to the rest of society and legal authorities.

Lastly, the tumultuous sociopolitical history of Iran has created a deep fear for expressing personal issues. According to Jalali (1996), the 1979 Iranian revolution changed the landscape of Iranian life by changing the government to Islamic rules. This change forced some to flee the country to escape political and religious prosecution (Jalali, 1996). Immigrant Iranian clients may feel anxious about trusting a stranger with their issues and may practice caution while discussing personal issues outside of the privacy of their homes.

Conclusion

Before completing this study, the investigators had an impression that there might be characteristics unique to performing therapy with Iranian clients in the United States. In fact, the results indicated that there are more similarities between Iranians and other cultural/ethnic groups. Similar to some of the Asian ethnic groups, Iranian clients demonstrated a strong preference to work with therapists from similar background, with higher education, and with a direct and "quick fix" style of therapy. In accordance with Hmong immigrants, the level of acculturation significantly influenced whether Iranian immigrants sought psychological help. Acculturation determined clients' willingness to seek help outside of their family and friends and to engage in a therapeutic relationship.

76

Older and less acculturated clients were most resistant to and apprehensive about receiving help. Iranian clients demonstrated preference toward some of the common relationship building pieces of therapy such as therapists' expression of empathy, understanding, and unconditional regard.

A unique aspect of working with Iranian clients seemed to be the cultural practice of bargaining for the fee for service. Similarly, the common cultural pride of Iranians was a factor exclusive to this population and one that demanded special attention from therapists. In addition, participants demonstrated a respect for gender roles and paid special consideration to the role of each client in his or her family of origin. Lastly, participants noted the relative complexity of establishing psychological help for this population because of the Iranian community's small size, close affinity, and lack of boundaries.

Implications

The goal of this study was to explore the general views of Iranians toward psychological services and to learn what is unique about presenting such services to this community. The goal was to answer following questions: What are Iranian attitudes toward seeking professional psychological help? What is most helpful to Iranians? What are some of the barriers in working with Iranian clientele? What does a therapist need to know when working with this population? What are certain therapist/therapy characteristics that help or hinder the therapeutic process with this population?

To date, there has been only one study similar to this study. The similar study was conducted by Kaeni (2006) as a doctoral dissertation, and was not available when the principal investigator conducted a literature review for this study. Kaeni's (2006) study is

titled "Therapy with Iranian Americans: The perspective of Iranian therapists." In Kaeni's qualitative and exploratory study, five therapists who were born in Iran and had graduate education and training in the United States were interviewed. The therapists were asked about doing therapy with Iranian Americans. Several themes that Iranian clients present in therapy emerged. The main therapeutic issues raised were acculturation difficulties and differences between spouses, parents, and children. Another main issue raised was difficulties with gender role expectations. Additionally, culture-specific phenomenon emerged such as "verbal compliment" [*Taroaf*], "grudge" [*Lage-Bazee*], and "barter" [*Chooneh*], and the importance of pride and class as factors in the treatment of Iranian clients. Other important issues discussed were effects of immigration, therapy with older adults, transference and counter-transference dynamics and suggestions for interventions. The therapists interviewed suggested that western theory and technique can be used with the Iranian population if it is modified to fit the culture. The main modifications have to do with greeting of the client; using an interdependent model of relationships and a more active role in therapy, specifically; increased psycho-education; and cultural "brokerage" on the part of the therapist. Psychodynamic therapy, Cognitive Behavioral Therapy and other therapeutic techniques can be integrated to meet the needs of the Iranian client.

The difference between Kaeni's (2006) work and present research is primarily in the approach of the investigators toward a similar topic. Kaeni (2006) conducted five interviews with Iranian therapists in northern California, seeking to demonstrate the common issues raised by Iranian clients while in therapy. The investigator for the present study interviewed 16 Iranian therapists in Minnesota and southern California, seeking to

explore the attitudes of Iranian clients toward seeking professional psychological help. There are many commonalities in the findings of both researchers, such as describing common cultural practices, values, and belief. The main difference is that Kaeni (2006) examined <u>what</u> is commonly discussed in therapy with Iranian clients while this researcher studied <u>how</u> to attract and maintain Iranians clients to seek therapeutic services. Based on the exploratory nature of these studies, there are several suggestions for future research opportunities with Iranian clients.

Interviewing other Iranian therapists residing in states other than California and Minnesota might render different results. Iranian clients who reside in the other 48 states might have different socioeconomic status, education, and acculturation level, and therefore, therapists working with them would present different information about Iranian clients. In addition, the role of religious beliefs and how Iranian clients practice a certain religion could be studied in depth. The present study did not approach the topic of religion while interviewing participants. Similarly, Kaeni's (2006) study did not present evidence about the influence of clients' religion in seeking psychological help and their willingness in discussing their personal and spiritual issues with a trained professional.

The other areas of research with Iranian clients and/or therapists could focus on mental health related topics such as substance abuse, homosexuality, and physical, sexual, and emotional abuse. These topics are among some of the more difficult issues that persons from any community and cultural background have to face. Due to the sensitive nature of such topics and the relative "taboo" attached to such matters, a future study could explore how Iranian communities in general deal with them. Possible questions could be: What are the resources available to a less-acculturated client? How

do families deal with the "coming out" process of a homosexual member of their family? What are the views surrounding sexual abuse or corporal punishment among Iranian clients? In short, there are many research opportunities available in order to strengthen the cultural competency and the mental health literature about Iranian clients. As a growing cultural/ethnic group, both American and Iranian therapists would benefit from studying this group and understanding what is the most helpful approach in offering psychological help to this population.

Based on the findings of this study, the following are some recommendations on how to better prepare the Iranian community to seek professional psychological help and how therapists can work with Iranian clients in order to create a better working alliance and reach desirable outcomes.

1) Iranians might resist counseling for fear of being labeled as "crazy": Alongside educating the public on the concept of mental health and psychotherapeutic services, Iranian clients would benefit from learning about confidentiality and data privacy. Educating about boundaries, the "therapeutic relationship", and its distinction from friendships would enlighten Iranian clients about the privacy of the content of their treatment. Therefore, Iranian clients would not hesitate to seek counseling for fear of "losing face" in their communities.

2) Iranians equate seeking counseling with being mentally ill: Education through public media, especially those that target Iranian communities, such as community newspaper, yellow pages, and radio/television, and one-on-one discussions about seeking psychological help would help Iranian clients to differentiate between mental illness and family relations problems. Normalizing common mental health issues, such as depression

and anxiety, and demonstrating their relevance to daily and relational stressors would allow Iranian clients to view psychotherapy as a useful tool for managing their everyday lives.

3) A low level of acculturation increases resistance to counseling: Historically, persons from middle-eastern backgrounds prefer to rely more on traditional methods such as family, friends, and religious persons to help with psychological difficulties (Al-Darmaki, 2003). The concept of psychotherapy is viewed as a "western" method and incongruent with traditional beliefs. Introducing psychotherapy as a tool for enabling clients to adjust to the new culture and decreasing their clashes with the new society is an effective method of attracting Iranian clients to counseling. Knowledge about professional help and how to access such resources in the absence of friends and family is a fundamental and necessary step for less acculturated clients.

4) Therapists in the United States do not have sufficient access to education regarding Iranian culture to treat them effectively: The implications of outreach, assessment, and intervention with people of diverse ethnic backgrounds have been demonstrated by a variety of researchers studying the attitudes toward seeking psychological help (Zhang and Dixon, 2003). An appropriate starting place according to Tedeschi and Willis (1993) is to ask the international communities to design an appropriate intervention method suitable to their unique cultural values. Yoon and Jepsen (2003) agreed that the counseling professionals in general would benefit from an on-going cross-cultural training in dealing with non-white populations. Therapists working with Iranian community would benefit from training regarding Iranian-Americans as an emerging ethnic group in America.

Limitations

Among a number of limitations for this study, one is the natural limitation of phenomenological research that is choosing depth over breadth. The phenomenology method provides richness in understanding the subjective experiences of the participants, but these findings cannot be generalized to the greater population. In addition, with a small sample size, the focus was to gather a wealth of information rather than representing the greater population (Patton, 1990).

The participants were interviewed in two states of California and Minnesota. The experiences of therapists working with Iranian clients in the other 48 states might be exceedingly different from the sample for this study. Additionally, there is potential risk in learning about Iranian clients from therapists of the same cultural background. There is a strong possibility that participants carried certain biases and judgments toward their clients, depending on their social, political, religious, and familial backgrounds.

Meanwhile, this study could be used as a tool for therapists of non-Iranian background in working with Iranian clients in understanding their common issues. Understanding the cultural pride and the role of each family member when working with an Iranian client would better prepare therapists in approaching inter and intra-personal issues raised by Iranian clients.

Lastly, as a female Iranian therapist, my perceptions, biases, and judgments played a role in conducting this study. My feelings, values, and beliefs, as well as my own adjustment and acculturation journey, may have had an effect on the conceptualization of this study. It is possible that an Iranian man or a non-Iranian therapist would have conceptualized this research in a different way, focused on different

details, and interpreted the results with a different mind set, and consequently drawn

different results.

References

Atkinson, D. R., & Gim, R. H. (1989). Asian-American cultural identity and attitudes toward mental health services. *Journal of Counseling Psychology, 42,* 663-668.

Backlar, Patricia. (1996). The Three Rs: Roles, Relationships, and Rules. *Community Mental Health Journal*, 32, 505-509.

Blazina, C. & Watkins Jr., C. E. (1996). Masculine gender role conflict: Effect on college men's psychological well-being, chemical substance usage, and attitudes toward help-seeking. *Journal of Counseling Psychology, 43,* 461-465.

Cash, T. F., Begley, P. J., McCown, D. A., & Weise, B. C. (1975). When counselors are heard but not seen: Initial impact of physical attractiveness. *Journal of Counseling Psychology, 22,* 273-279.

Cash, T. F., Kehr, J., & Salzbach, R. F. (1978). Help-seeking attitudes and perceptions of counselor behavior. *Journal of Counseling Psychology, 22,* 264-269.

Cepeda-Benito, A., & Short, P. (1998). Self-concealment, avoidance of psychological services, and perceived likelihood of seeking professional help. *Journal of Counseling Psychology, 45,* 58-64.

Fang, K. B. (1998). *Acculturation as a predictor of attitudes toward seeking professional psychological help in the Hmong community*. Unpublished Ph.D. thesis, California School of Professional Psychology.

Fischer E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development, 36,* 368-373.

Fischer, E. H., & Turner, J. (1970). Orientation to seeking professional psychological

help: Development and research utility of an attitude scale. J*ournal of Consulting and Clinical Psychology, 35,* 79-90.

Gaffarian, S. (1998). The acculturation of Iranian immigrants in the United States and the implications for mental health. *The Journal of Social Psychology*, 138, 645-654.

Gim, R.H., Atkinson, D. R., & Whiteley, S. (1990). Asian-American acculturation, severity of concerns, and willingness to see a counselor. *Journal of Counseling Psychology*, 37, 281-285.

Good, G. E., Dell, D. M., & Mintz, L. B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology, 36,* 295-300.

Hill, C.E., Thompson, B.J., & Williams, E.N. (1997). A guide to conduction consensual qualitative research. *The Counseling Psychologist, 25*, 517-572.

Hollingshead, A.B., & Redlich, F.C. (1958). *Social class and mental illness*. New York: John Wiley.

Jalali, b. (1996). Iranian Families. In McGoldrick, M., Pearce, J., & Giordano, J. (Eds.). 2nd Ed. *Ethnicity and Family Therapy (pp. 347-363)*. New York: Publishing Company.

Kaeni, Katayoun S. (2006). *Therapy with Iranian Americans: The perspective of Iranian therapists*. Ph.D. dissertation, Alliant International University, San Francisco.

Kelly, A. E., & Achter, J. A. (1995). Self-concealment and attitudes toward counseling in university students. *Journal of Counseling Psychology, 42, 4*0-46.

Khoie, Kathy (2002). *Predictors of attitudes of Iranian males toward seeking psychological help*. Ph.D. dissertation, Alliant International University, Los

Angeles.

Kim, B. S. K., Atkinson, D. R., & Yang, P. H. (1999). The Asian values scale:

    Development, factor analysis, validation, and reliability. *Journal of Counseling*

    Psychology, 46, 342-352.

Kim, B. S. K., & Omizo, M.M. (2003). Asian cultural values, attitudes toward seeking

    professional psychological help, and willingness to see a counselor. *The*

    Counseling Psychologist, *31,* 343-361.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of

    college students' attitudes toward seeking psychological help. *Journal of*

    *Counseling Psychology, 47,*138-143.

Langsley, D.G., Barter, J.T., & Moshiri, A.A. (1983). Psychiatry in Iran and China.

    International Journal of Social Psychiatry, 29, 39-47.

Leong, F. T. L., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help-

    seeking attitudes. In J.G. Ponterotto, J.M. Casas, L.A. Suzuki, & C.M. Alexander

    (Eds.), *Handbook of multicultural counseling* (pp. 415-438). Thousand Oaks, CA:

    Sage.

Leong, F. T. L. & Zachar, P. (1999). Gender and opinions about mental illness as

    predictors of attitudes toward seeking professional psychological help. *British*

    Journal of Guidance and Counseling, 27, 123-132.

Mau, W. & Jepsen, D.A. (1988). Attitudes toward counselors and counseling processes:

    A comparison of Chinese and American graduate students. *Journal of Counseling*

    and Development, 67, 189-192.

Patton, M.Q. (1990). *Qualitative research and evaluation methods (2ⁿᵈ Edition).*

Newbury Park, CA: Sage.

Patton, M.Q. (2002). Qualitative research and evaluation methods (3rd Edition). Thousand Oaks, CA: Sage.

Price, Massoume (2005). *Iran's Diverse Peoples: A reference source book*. Santa Barbara, CA: ABC-CLIO.

Rahimi, Azadeh (1989). *Attitudes of selected Iranian students toward seeking professional psychological help*. Ph.D. dissertation, University of Southern California.

Sue, S. (1999). Science, ethnicity, and bias: Where did we go wrong? *American Psychologist*, *54,* 1070-1077.

Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43,* 301-308.

Tata, S. P., & Leong, F. T. L. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counseling Psychology, 41,* 280-287.

Tedeschi, G. J. & Willis, F. N. (1993). Attitudes toward counseling among Asian international and native Caucasian students. *Journal of College Student Psychotherapy, 7,* 43-54.

Terrell, F., & Terrell, S. L. (1981). An inventory to measure cultural mistrust among blacks. *Western Journal of Black Studies, 5,* 180-184.

Terrell, F. & Terrell, S. L. (1984). Race of counselor, client Sex, cultural mistrust level, and premature termination from counseling among black clients. *Journal of*

Counseling Psychology, 31, 371-375.

Uffelman, R. A. & Hardin, S. I. (2002). Session limits at university counseling centers: Effects on help-seeking attitudes. *Journal of Counseling Psychology, 49,* 127-132.

Webster, D.W., & Fretz, B.R. (1978). Asian–American, Black and White college students' preferences for helping sources. *Journal of Counseling Psychology, 25*, 124-130.

Yeh, C.J. (2002). Taiwanese students' gender, age, interdependent and independent self-construal, and collective self-esteem as predictors of professional psychological help-seeking attitudes. *Cultural Diversity and Ethnic Minority Psychology, 8,* 19-29.

Yoon, E. & Jepsen, D.A. (2003). *Expectations of and attitudes toward counseling: A comparison of Asian international and U.S. graduate students*. Unpublished manuscript.

Zhang, N., & Dixon, D. N. (2003). Acculturation and attitudes of Asian international students toward seeking psychological help. *Journal of Multicultural Counseling and Development, 31,* 205-222.

APPENDIX A

Demographic Information of Participants

Therapist	State	Gender	Age	Education/ Licensing	Ethnicity	Yrs of Practice	Years in the U.S.	Agency
1	MN	F	46-55	Ph.D./LMFT	White	13	23	Private Ptc
2	CA	F	46-55	Psy.D./LP	White	17	33	Non-Profit Private Ptc
3	CA	M	56-65	Ph.D./CPC	White	12	32	Res. Tx.
4	CA	M	36-45	MA/LMFT	Other	9	21	Non-Profit Private Ptc
5	CA	F	46-55	MA/LMFT	White	7	26	Non-Profit
5	CA	F	46-55	Ph.D./LP	Other	23	30	Private Ptc
7	CA	F	36-45	MA/LMFT	Other	5	7	Private Ptc
8	CA	M	36-45	Ph.D./LP	White	7	28	Private Ptc
9	CA	F	56-65	Ph.D./LP	White	28	30	Non-Profit
10	CA	F	36-45	Ph.D./LP	White	17	31	Private Ptc
11	CA	M	36-45	Ph.D./LPC	Other	5	15	Private Ptc
12	CA	M	46-55	Ph.D./LP	Other	25	31	Private Ptc
13	CA	F	46-55	Ph.D./LP	White	13	30	Private Ptc
14	CA	F	36-45	Ph.D./LP	White	12	32	Private Ptc
15	CA	F	46-55	Psy.D./LP	White	14	40	Private Ptc
16	MN	F	36-45	Ph.D./LMFT	Other	12	24	Private Ptc

Interview Questions

1) Please tell me how you became part of the helping profession
      Probe: Why counseling psychology?

2) Specifically how did you come to focus on clients of Iranian origin?

3) In general, how do you define cultural competence in psychological practice?

      Specifically, can you describe what constitutes culturally competent practice
      when working with clients of Iranian origin?
      Probes: How does one reach out to this population?
            Is there anything about location, office setup, décor, that helps?
            Any language/mental health terminology concerns?

4) Please describe the characteristics that a therapist working with the Iranian population must have?

5) Can you explain any special/unique things you do in therapy that work well with Iranian clients?
      Probes: Explaining informed consent
            Explaining the therapeutic process
            Explaining roles, tasks, time
            Treatment planning and goal-setting

Based on your own experience, can you describe potential barriers to working with clients of Iranian origin?

6) How would you describe your own cultural identity?For example, Iranian, Iranian-American, American-Iranian?
      Probe: Can you please explain/elaborate?

How does your cultural identity influence your work with Iranian Clients?
      Probe: How does being from an "Iranian" origin effect the establishing of a
            therapeutic relationship with the Iranian clients?
            How do your cultural values, beliefs, and understanding influence your
            work with the Iranian clients?

7) How does being from an "Iranian" origin effect the establishing of a therapeutic relationship with the Iranian clients?

8) How much of your cultural values, beliefs, and understanding is influencing your work with the Iranian clients?

9) Is there a few distinguishing aspects of your approach to the Iranian culture when you work with the Iranian population?

10) When you consider all that you have said today, can you summarize what are the most critical factors to consider when working with Iranian clients?

11) Is there anything else you would like to add?

CONSENT FORM

A Qualitative Study of Perceived Attitudes toward Counseling and Effective Counseling
Practices in Working with Clients of Iranian Origin

You are invited to participate in a research study of perceived attitudes toward counseling
and effective counseling practices in working with clients' of Iranian origin. You were
selected as a possible participant because of your expertise in working with clients' of
Iranian origin. We ask you to read this form and ask any questions you may have before
agreeing to be in the study.

This study is being conducted by Saba Ghazi-Moghadam, Ph.D. candidate, and Dr.
Michael Goh, an associate professor. The abovementioned individuals are part of the
Counseling and Student Personnel Psychology program, Department of Educational
Psychology, College of Education and Human Development at the University of
Minnesota, Minneapolis.

Background Information

The purpose of this study is to better understand the attitudes of clients' of Iranian origin
toward counseling and seeking professional psychological help. The sample includes
therapists and mental health practitioners that are experienced in working with Iranian
clients. The data collection will be conducted using a semi-structured interview. We are
exploring these attitudes to improve our understanding and knowledge of the concept of
mental health and psychological help among Iranian population residing in United States.

Procedures:

If you agree to be in this study, we will invite you to be interviewed by the principal
researcher, Saba Ghazi-Moghadam, and for the interview to be audio-taped. Your audio-
taped interview will then be transcribed by a professional transcriber with no identifiable
name attached to the taped interview. The interview will be kept confidential. Further, we
are asking your permission to use the obtained data to perform qualitative analyses. In
data analyses, there will be no identifiable information on your transcribed interview.

Risks and Benefits of being in the Study

The study has no known risks. You may choose to not answer any question or withdraw
from the study at any time, even after you have begun the interview. There are no direct
benefits to you.

Confidentiality:

The records of this will be kept confidential. In any sort of report we might publish, we will not include any information that will make it possible to identify a subject. Research records will be stored securely in the principal investigator's advisor's private office and only the research team will have access to the records.

Voluntary Nature of the Study

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with the University of Minnesota. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

You may ask any questions you have now. The principal investigator for this study is Saba Ghazi-Moghadam. If you have questions later, you may contact Saba at (612) 308-3623, or by e-mail at ghaz0002@umn.edu

If you have any questions or concerns regarding this study and would like to talk to someone other that the researcher(s), contact the Research Subjects' Advocate Line, D528 Mayo, 420 Delaware St. Southeast, Minneapolis, Minnesota 55455; (612) 625-1650, or e-mail irb@umn.edu.

You will be given a copy of this information for your records.

Statement of Consent

I have read the above information and asked any questions I had and received appropriate answers. I consent to participate in this study.

Signature: ---   Date: --------------

Signature of Investigator: -----------------------   Date: --------------

APPENDIX D

SUMMARY OF DOMAINS AND THEMES

DOMAIN 1: Clients' Expectations/Preferences in Therapy

Theme 1: Iranian clients seek out cultural-specific (Iranian) services; knowing client preferences, therapists therefore advertise their services in Iranian/Persian media outlets.

Theme 2: Iranian clients expect/prefer therapists who are authority figures with the highest credentials.

Theme 3: Iranian clients prefer a "quick-fix" method in therapy.

Theme 4: Iranian clients prefer a more "direct" style in therapy; however, while this appears to be a preference, therapists also talk about other approaches.

Theme 5: As a matter of cultural practice, Iranian clients are known to bargain for therapy fees.

DOMAIN 2: Therapists' Approach to Therapy

Theme 6: It is important to understand the level of acculturation among Iranian clients.

Theme 7: There are disparate views among Iranians about the concept of psychotherapy and these views seem to fall along generational lines.

Theme 8: It is important to consider role-assignments in Iranian family systems.

Theme 9: Iranian clients are unfamiliar and impatient with counseling protocols.

Theme 10: Use of humor is an effective tool for building rapport with Iranian clients.

Theme 11: Learning to express feelings and working through emotions is an essential part of therapy.

Theme 12: It is important to educate about mental health and psychological services to the Iranian community.

DOMAIN 3: Relationship/Rapport Building

Theme 13: Cultural empathy is fundamental in working with Iranian clients; language is an essential/helpful tool for developing rapport.

Theme 14: Iranian clients come across as "proud" people.

Theme 15: Being of an Iranian heritage themselves, therapists have to overcome

stereotypes about their own culture.

DOMAIN 4: Boundary Setting

Theme 16: Managing boundaries is a prevalent topic presented in therapy as well as in

the therapeutic relationship.

DOMAIN 5: Gender Roles

Theme 17: The evolving nature of gender roles for Iranian community.

DOMAIN 6: Help-seeking Barriers

Theme 18: Discussion of mental health issues is a "taboo" subject among Iranians.

Theme 19: The size and close affinity of Iranian community demands that therapists pay

special attention towards ensuring confidentiality.

Theme 20: The sociopolitical history in Iran engenders suspicion about others' motives.

This deep skepticism translates to a lack of trust in the helping profession and helping

professionals.

Theme 21: Iranian clients are not comfortable discussing issues related to sexuality and

domestic abuse.