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Evenson, LynAnne M. ***The Meaning of Therapy in the Lives of Hmong and Iraqi Refugees***

Abstract

The purpose of this study was to examine the experiences about and perceptions of therapy by Hmong and Iraqi refugees. The objectives of this study were to contribute to the literature on what therapy means to Hmong and Iraqi refugee populations. Hmong and Iraqi refugees living in the metropolitan area of the Twin Cities in Minnesota were requested by their mental health practitioner to participate in the study. Participants responded to seven demographic questions and five questions about the meaning of therapy in their lives. Participant responses were analyzed using grounded theory method. The results demonstrated cultural differences in how Hmong and Iraqi refugees viewed, experienced, and talked about the meaning of therapy.

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Chapter I: Introduction

According to the United Nations High Commissioner for Refugees (UNHCR), there were 121,200 claims of refugees applying for asylum to enter the United States (US) in 2014, which is 36,800 more claims than in 2013 (+44%) (UNHCR, 2015). The Refugee Act of 1980 standardized the admittance procedures for all refugees admitted to the United States. The Refugee Act of 1980 incorporates the definition of "refugee" that is used in the U.N. Protocol (The Office of Refugee Resettlement, 2015). Refugees are defined as “displaced persons” and have been displaced from their country of origin because of persecution or fear of persecution on account of race, religion, nationality, political opinion, or membership of a particular social group.

Not surprisingly, displaced persons arrive in the United States with a range of emotional reactions stemming from difficult memories, lingering losses, and confusion about American culture and how to fit in. They often experience having a transnational identity of “living here” (physically living in the United Sates), but also “living there” (emotionally/spiritually residing in their country of origin) (Falicov, 2007). Their dual identity, memories of the past, and unknown future are chronic stressors which often result in somatic symptoms. Depending on cultural norms, consulting with a physician and/or therapist may be a sign of strength or weakness. Of particular interest to this researcher is the lived experience of Hmong and Iraqi displaced persons and their cultural view of therapy.

Statement of the Problem

The purpose of this research is to find the meaning of therapy and the impact of therapy on the lives of Iraqi and Hmong refugees living in the metropolitan area of Minneapolis and Saint Paul MN.

Definition of Terms

Refugee. A refugee is a displaced person, fleeing their country because of persecution or fear of persecution on account of race, religion, nationality, political opinion, or membership of a particular social group and cannot count on their country or government to protect them from oppression or torture, or is a displaced person facing a humanitarian crisis (Department of Homeland Security, 2015).

Hmong. The Hmong are an ethnic minority from the mountainous regions of Laos, Vietnam, Thailand, and China. Currently the metropolitan area of Minneapolis/St Paul, MN has the largest Hmong population concentration in the United States (Minnesota Department of Health, 2014).

Iraqi. Iraq was under the control of one political party for over 40 years; however, a U.S. lead invasion of Iraq caused over 2 million Iraqis to become displaced. Iraq is now the second most source country for residents applying for asylum and refugee status in the United States in 2014 (UNHCR, 2015).

Somatic symptoms. The appearance of symptoms related to significant distress and impairment of functioning in a client's life without medical cause. This can include symptoms of pain, worry over health, and "feeling sick" as a result of their mental health condition rather than medical problems (American Psychiatric Association, 2013).

Primary refugees. Refugees who arrive directly from their country of origin or, from a refugee camp to their asylum destination (Minnesota Department of Health, 2014).

Secondary refugees. Refugees who have already arrived at their asylum destination and then move within their host country or move to a different country. This can include moving from state to state, province to province, or from one country to another (Minnesota Department

of Health, 2014).

Ambiguous loss. Ambiguous loss is defined as one of two different kinds of loss: when someone or something is psychologically absent but physically present (such as a person with dementia), or when someone or something is physically absent while being psychologically present (such as having to leave one's family behind in another country). Ambiguous loss has been described by many refugees as an additional stressor over which they have little control or relief (Boss, 1998).

Assumptions and Limitations of the Study

A few assumptions and limitations are pertinent to this study. It is assumed that the information and data researched and cited is accurate and valid. Also assumed is that the body of research on refugee populations has been conducted to provide an adequate overview of this topic. While this study makes every attempt at objectivity, one limitation is that some of the research literature cited may not be. It is assumed that the participants were truthful in their responses and not influenced by the nature of their relationship to the researcher, or biased towards or against her cultural identity or gender. Limitations include language and cultural barriers that may have influenced the understanding of the research questions and transcribed responses. A further limitation is that the sample size is small and may not be generalizable to other refugee populations.

Chapter II: Literature Review

Refugees are a separate and distinct demographic group, as compared to other immigrant groups. The very definition of a refugee is a displaced person, removed from their country because of persecution or fear of persecution on account of race, religion, nationality, political opinion, or membership of a particular social group (Department of Homeland Security, 2015). Refugees leave their homeland, because they cannot expect protection from their own country. Often refugees have experienced war, torture, and political oppression (Van der Veer, 1998). The complex trauma background that all refugees have experienced in some shape or form is a burden they bring with them when they arrive in the country that has granted them asylum. Transitioning to a new culture while retaining their original cultural traditions, learning to live in relative safety, and struggling with a knowledge of the brutal violence that humans are capable of, can make the assimilation into their host country's culture difficult.

Entering a western culture where there is an emphasis on medical care to cure all ailments and a medication for every complaint can be disconcerting for refugees. Diagnoses such as post-traumatic stress disorder (PTSD), adjustment disorder, major depressive disorder, and anxiety disorders are often unheard of in other cultures or are viewed with distrust. In some cultures, mental illness can be viewed as a sickness of the soul. In other cultures, somatic symptoms are considered completely acceptable for people to experience, and the expectation is that a medical doctor can fix or treat the somatic complaints (Weaver, 2005).

Refugee Status in the United States of America and Minnesota

During the years 1980 to 2012, there were 2,671,511 refugees who arrived and admitted to the United States of America (Department of Homeland Security, 2013). In 2012, among the 58,179 refugees admitted to the United States of America, 12,163 refugees were admitted from

Iraq alone (Department of Homeland Security, 2013). As conflicts around the world escalate, even more displaced persons have been applying for refugee status. The United States of America recorded approximately 121,200 claims in 2014; 36,800 claims more than in 2013 (UNHCR, 2015). The United States of America is second behind Germany for receiving the highest number of asylum applications (UNHCR, 2015).

Many refugees settle in Minnesota. Minnesota is an attractive location for refugees to resettle due to the established refugee resettlement agencies and the long history of social work advocacy in the state. The Minnesota Department of Health has collected statistics on all primary refugee arrivals to Minnesota since 1979. Primary refugees are defined as refugees who arrive directly from their country of origin or from a refugee camp to their asylum destination (Minnesota Department of Health, 2014). A secondary refugee is a refugee who moved within their asylum country to a new state or province (Minnesota Department of Health, 2014). For example a Hmong refugee arriving in California would be considered a "primary refugee;" whereas, if they move to Minnesota, they would be considered a "secondary refugee" in Minnesota. This designation is used for data collection purposes by the Minnesota Department of Health to track the needs of refugees (Minnesota Department of Health, 2014).

As of 2013, the cumulative number of refugees who arrived in Minnesota from Laos who identified as Hmong was 22,033. This does not include secondary Hmong refugees. The cumulative number of refugees who arrived in Minnesota from Iraq, as of 2013, was 930 (Minnesota Department of Health, 2014).

Refugees' Mental Health Needs

Refugees by their very definition are people who have experienced trauma. Most survivors of trauma experience stress responses, ranging from hyper arousal to sleep disturbance

(Van der Veer, 1998). Refugees may have experienced long periods in refugee camps, frequently faced violence, and are constantly reminded of what they have lost (McFarlane, 2004). The loss of community support and the inability to use their native language to be understood compound their experience of stress.

Additionally, loss of traditions and customs from their country and culture increases their stress over having to leave (Falicov, 2003). Refugees may often experience a form of ambiguous loss (Boss, 1998). Ambiguous loss is defined as one of two different kinds of loss: when someone or something is psychologically absent but physically present (such as a person with dementia), or when someone or something is physically absent while being psychologically present (such as having to leave one's family behind in another country). Ambiguous loss has been described by many refugees as an additional stressor over which they have little control or relief.

Because refugees have been in constant survival mode from their first experience with violence or conflict in their home country, when they arrive at their asylum country they have to learn how to feel safe again, while at the same time navigating a foreign country. It is only when they feel safe, that they can attempt to contemplate what they have experienced and lost. Most survivors are able to overcome early posttraumatic stress responses, but some refugees have continued symptoms that become pathological (Silove, 2004). Many refugees have somatic symptom complaints; however, when medical doctors find no physical basis for the symptoms, clients are referred to therapists and psychiatrists. Therapists who work with refugees need to recognize that somatic symptoms are common with a PTSD diagnosis. Additionally, understanding of the culture surrounding mental illness diagnosis and corresponding somatic

complaints is critical for therapists to assist clients in a culturally competent way (McFarlane, 2004).

Mental Health Intervention for Refugees

When refugees arrive in Minnesota they are sponsored by a refugee resettlement agency that assists refugees with obtaining housing, county assistance. This can include cash assistance, medical assistance, and vocational assistance. Medical assistance enables the refugees to see medical and mental health providers. Many refugee resettlement agencies screen for mental health symptoms, and refer refugees to mental health providers to ensure they are able to function adequately in their new lives in their host country (Minnesota Council of Churches, 2014).

Refugees often find themselves struggling to function and navigate their host country's systems. As a result, many refugees exhibit mental health symptoms of distress leading to referrals for mental health services. Their general physicians might refer them to psychiatrists or therapists. If the client continues to struggle and need additional support, medical doctors, psychiatrists, and therapists usually refer the client to a mental health practitioner. The mental health practitioner will meet with the client in their home to continue to provide psycho-education support and to teach additional coping skills.

In Minnesota, low income clients who qualify for Medical Assistance (MA) are eligible for Adult Rehabilitative Mental Health Services (ARMHS), as long as there is an eligible mental health diagnosis. For many refugees, although the mental health diagnosis may carry a stigma, the ARMHS provide much needed relief for their distress (Minnesota Council of Churches, 2014). ARMHS provides in-home services which addresses management of mental health

symptoms, management of mental health services, and teaches a variety of skills to assist clients in learning coping and therapeutic skills for daily functioning.

Many mental health practitioners struggle with working with refugee populations due to lack of training specific to the refugee experience. Many refugees struggle to navigate new medical systems that emphasize labeling of clients, which can carry a stigma in their culture (Minnesota Council of Churches, 2014). Because of the differences in lived experiences of refugees and their cultural backgrounds, the purpose of this research was to better understand the meaning of therapy for refugees.

History of Hmong People

The Hmong are an ethnic minority from the mountainous regions of Laos, Vietnam, Thailand, and China. The Hmong fought for the United States during the so-called "secret war" in Laos against Vietnam from 1959 to 1979 (Fadiman, 1997). When the United States ended their war and withdrew from Vietnam, the Hmong were left to be targeted by their own government and military. As a result, the Hmong fled Laos to Thailand, where they spent many years before gaining refugee status and were admitted to United States, France, and Australia among other countries. Because of their involvement aiding the United States, a majority of Hmong refugees have settled in the United States. The first wave of primary refugee numbers started to arrive in Minnesota in 1980 and continued until 2004 (Minnesota Department of Health, 2014). The Minneapolis-St. Paul area developed the largest Hmong community outside of California due to its immigration services, community networks, and agricultural focus. Hmong primary refugee numbers peaked in Minnesota in 2004, with the closing of the last refugee camp in Thailand. Currently, the Minnesota metropolitan area has the largest Hmong population concentration in the United States. There is also a large number of secondary Hmong

refugees living in Minneapolis/St Paul, MN, their numbers are documented by the Minnesota Department of Health for statistical and data collection purposes (Minnesota Department of Health, 2014).

Hmong Spiritual Beliefs and Health Care Practices

The Hmong have a fiercely independent identity. One of the biggest struggles that Hmong refugees face is navigating how to remain Hmong and how to fit themselves into a different, western society while still keeping their eastern beliefs, practices, and cultural norms (Donnelly, 1994). Although it has been over 40 years since the first Hmong refugees from Laos were resettled in the United States, traditional concepts of illness and traditional approaches to healing remain important to Hmong families. However, the very beliefs which helped the Hmong people resist acculturation as refugees in the past are those which can set them apart in U.S. communities today (Koepke & Hare, 2001).

Many Hmong practice shamanism and believe that the soul and bodily health are intertwined; one cannot be treated without the other. As a result, many Hmong clients may complain of somatic symptoms as a result of the soul or souls being sick, lost, or stolen. Health is perceived by Hmong as a balance of forces in the social, natural, and supernatural realms. Health care treatment is perceived as realigning these forces into harmony; what a western physician calls a medical problem is always a matter of the soul and spirit for the Hmong (Koepke & Hare, 2000). For them a physical symptom may mean that the entire universe is out of balance (Fadiman, 1997). Thao (1986) explained that traditional beliefs concerning sources of illness include soul loss, supernatural or spirit causes, natural causes, magical causes, or the expiration of one's "life visa" (as cited by Helsel, Mochel & Bauer, 2004). The services of a shaman are generally sought to address these problems. Decreasing Hmong refugees' sense of

isolation through familiar, communal shamanic activities may help to achieve the comfort they seek. Such connectedness may serve to ease the sadness of some of the losses they have sustained as individuals and as a group. One Hmong American immigrant noted “Laos still remains, deep inside me” (Helsel et al, 2004, p. 937).

History of Iraqi People

The Iraqi refugee experience is relatively new. During the 1950’s, Iraq was part of a bigger nationalist movement in the Arab world. Under Saddam Hussein, education flourished and there was a creation of state universities where education was available to everyone (Hourani, 1991). While Iraq was under the control and direction of one political party for over 40 years, life was relatively stable. During the 1990s under Saddam's regime, some refugees were permitted asylum in the United States but not in any great numbers. However, after the U.S. led invasion of Iraq, over 2 million Iraqis became displaced. The middle class and educated elite fled for neighboring countries, including Jordan and Syria. When the civil war in Syria ended, many Iraqis returned to Iraq only to find their country in shambles and sectarian violence everywhere. As a result, Iraq has the second highest number of asylum seekers in the world (UNHCR, 2015).

Iraqi Spiritual Beliefs and Health Care Practices

Iraqi culture is intertwined with Arab culture. “Arab” is a term that encompasses all countries that were conquered in the Muslim Arab conquests, which occurred hundreds of years ago. Muslim identity can be part of Arab identity, although there are ethnic and religious subsets that also identify as Arab while not identifying as Muslim (Hourani, 1991).

In the Arab culture, there is an aversion to mental illness. Mental illness is perceived as being linked to the supernatural (Al-Krenawi & Graham, 2000). Affective disorders, such as

depression, are often viewed as somatic in origin. Because of this belief, there can be an expectation that the client will be treated like a medical patient, with the doctor diagnosing and prescribing treatment quickly (Weaver, 2005). However, when the somatic symptoms do not go away with medical treatment, such as prescriptions, problems can arise. Because the problem is believed to be physical and "not in their head", receiving a mental health diagnosis may not be acceptable and may be viewed with suspicion and shame by the client.

Application of a Multicultural Lens in Therapy

Much has been written over the past ten years about the importance of incorporating a multicultural lens by therapists. When therapists work with refugee populations, understanding the different aspects of migration and the different experiences across cultural groups is a critical therapeutic skill (Falicov, 2007). There is a need to view therapy through a multicultural lens that may incorporate or embrace the client's culture and belief system, and offer an active role in the client's own healing.

Refugee clients are victims of trauma, and their treatment plans and goals should reflect this experience. Many times refugees will try to initially solve their own symptoms by themselves or with the help of friends or family (Van der Veer, 1998). When refugees finally seek and receive treatment, it is usually because they are experiencing symptoms that go beyond the somatic. Nightmares, flashbacks, and disassociation are common symptoms experienced by refugee clients. Therapists will be wise to treat these symptoms by incorporating the client's past and present experiences and their expectations of the future (Van der Veer, 1998). Allowing the client to tell their story, asking questions about their experiences in the past, how it is affecting them currently, and how they want it to be changed for the future is a helpful process to use. Interventions will usually be addressed to the individual client, and include the social

environment of the refugee, or institutions that might be able to contribute to the solution of the problem for the refugee, (such as local churches, mosques, or elders that might help them) (Van der Veer, 1998).

In working with Hmong refugee clients, understanding shamanism and asking about their beliefs concerning their soul or souls and its relationship to their health will provide the therapist direction with how to treat their diagnosis. Some Hmong are Christian, but the therapist's curiosity about their beliefs will help shape therapy. It is helpful for therapists to be knowledgeable but not overly directive. Gentle suggestions will be more effective with Hmong clients than assertive instructions.

In working with Iraqi refugee clients, it would be wise for the therapist to ask questions and approach the family as a friend, establishing a rapport first rather than being assertive or directive (Sharifzadeh, 1998). Awareness of family and gender roles is helpful, as well as curiosity into what they have experienced and how they expect the therapist to be helpful to them.

Chapter III: Methodology

The purpose of this research is to examine the meaning of therapy for Iraqi and Hmong refugees in the United States. Currently there is not a body of research on the experiences of refugees related to the therapeutic process. The Hmong and Iraqi refugee populations are growing in the United States, and their experiences are unique. Refugees by their legal definition are "displaced persons who are fleeing oppression, persecution, or torture, as well as humanitarian crisis" (Department of Homeland Security, 2015). This legal status definition translates into a mental health diagnosis that may include depression, anxiety, and post-traumatic stress disorder, as well as a litany of other diagnosable conditions. The primary significance of this research will be to contribute to the literature on what therapy means to this population of refugees, and how future therapists can help refugee populations.

Research participants were recruited from the researcher's current therapeutic practice at Family Support Services, Inc. Five Hmong research participants and five Iraqi research participants were recruited by the researcher as she met with them for in-home therapy.

Participant Selection and Description

The target population was Hmong and Iraqi refugees in Minneapolis/St. Paul, MN. Participants were identified and recruited from the researcher's current therapeutic practice at Family Support Services, Inc. The researcher was the Adult Rehabilitative Mental Health Service (ARMHS) practitioner for each of the potential participants. As a result of the therapeutic work being done with the clients, it became evident that the meaning of therapy was important to explore, so that 1) future refugee clients can be better assisted, and that 2) therapists can be better equipped to help refugee clients. Every three months, clients participated in a functional assessment, in which discussion about the meaning of therapy was one of the required

components; therefore, the dual nature of the client/therapist relationship was not harmed by this research.

Instrumentation

The researcher and thesis advisor developed the instrument to be used based upon the researchers understanding of the unique needs of refugee clientele and needs of therapists. After developing the instrument, the researcher had it translated into Hmong and Arabic, by professional interpreters and then pilot tested the instrument with four different native Hmong and Arabic speakers. Two Hmong native speakers reviewed the Hmong instrument and two Arabic native speakers reviewed the Arabic instrument. The instrument was clear and specific as developed and translated, and there were no changes needed to ensure clarity of the questions in the Hmong and Arabic languages.

Data Collection

Data from participants was collected during January of 2015. Data was gathered via individual interviews with participants. Participants were asked to read the cover letter (Appendix A) which explained the purpose of the study, the process of responding to the survey, and a statement about informed consent and confidentiality. The survey included five questions relating to the purpose of the research, in addition to seven demographic questions (Appendix B). A total of 10 participants responded to the survey. Although the survey was translated into both Hmong and Arabic (Appendix C), an interpreter was used to ask the questions to the participants, because some of the participants were not literate. Following survey completion, the researcher transcribed verbatim the participants' answers recorded by the interpreters' translation of participant responses.

Data Analysis

The researcher and thesis advisor independently reviewed the transcriptions of the five-question survey. The qualitative data was analyzed using grounded theory methods as described by Strauss and Corbin (1990). Inter-rater reliability was established through the identification of responses for each question. Open coding was used to identify themes and to categorize the data.

Limitations

One limitation of this study is that the sample size was small (10 total participants). There was also potential for language barriers, lack of clarity in answers, or misunderstanding of answers during the survey, because English was not participants' native language and, in fact, was a second language to all of the participants. Although the survey was translated into both Hmong and Arabic, an interpreter was used to ask the questions to the participants, while the researcher transcribed the answers verbatim from the participants, as transcribed by the interpreter. It is possible that the interpreters used language that may not have asked the questions in the exact style as the survey and that some of the meaning may have been lost. Lastly, there is a possibility that participants may have held back or not answered freely to the survey because of cultural factors, including, but not limited to the cultural identity of the researcher (one Caucasian female), mixed gender and age of participants, and religious differences of the participants.

Chapter IV: Results

The purpose of this study was to examine the meaning of therapy for Iraqi and Hmong refugees. Currently there is not a body of research on the experiences of refugees as it relates to the therapeutic process. The Hmong and Iraqi refugee populations are growing in the United States, and their experiences are unique. Since refugees are considered to be displaced persons who have experienced trauma, depression, anxiety, and/or post-traumatic stress disorder, as well as other diagnosable conditions, therapy may be of critical assistance to their immigration experience and cultural adjustment. The primary significance of this research will be to contribute to the literature on how to help refugee populations and benefit future therapists.

Participants were Hmong and Iraqi immigrants residing in the Minneapolis and Saint Paul metropolitan areas. The sample consisted of 10 total participants. Demographic data were collected, and the qualitative data were analyzed using grounded theory method.

Demographic Results

The specific demographic questions asked of participants prior to completing the survey are included in Appendix B. All participants were asked how old they were. Hmong participants had an "estimated birthday"; whereas, all Iraqi participants had an "established birth record" that was documented by the Iraqi government and hospitals. Hmong participants included four females and one male; Iraqi participants included three females and two males. All Hmong participants were born in Laos, and all Iraqi participants were born in Iraq. Date of entry to the United States is provided in Table 1. The primary language of Hmong participants was Hmong. The primary language of Iraqi participants was Arabic. When asked "if there is a secondary language preferred?" one Hmong and one Iraqi participant responded with "English". Number of years of education in a school setting is provided in Table 2.

Table 1

Date of Entry into the United States of America

	Date of entry into the U.S.
Hmong participant 1	I cannot remember I was around 5 or 6 years old (1976/1977)
Hmong participant 2	December 1993
Hmong participant 3	1992
Hmong participant 4	September 5th 1991
Hmong participant 5	September 5th 1991
Iraqi participant 1	February 24th 2014
Iraqi participant 2	May 22 2012
Iraqi participant 3	July 8th 2014
Iraqi participant 4	July 8th 2014
Iraqi participant 5	February 24 2014

Table 2

Years of Education in a School Setting

	Years of education in a school setting
Hmong respondent 1	9
Hmong respondent 2	6 years plus 3 months
Hmong respondent 3	A few months 2 or 3
Hmong respondent 4	0
Hmong respondent 5	10
Iraqi respondent 1	18
Iraqi respondent 2	12
Iraqi respondent 3	16
Iraqi respondent 4	18
Iraqi respondent 5	16

All of the Hmong participants had an “estimated birthday”, and the estimated age of Hmong participants tended to be between the ages of 41-52. Participants responded with having an "estimated birthday" because all of the Hmong participants were born in small villages in Laos where no birth records were kept. Anecdotally, all Hmong participants mentioned they received their “birthday” when they entered into the refugee camp in Thailand. All entrants were required to have a birthday, so the official making the record assisted the Hmong participants and their family members estimate the year they were born. There was one male Hmong participant in the study, while there were four female Hmong participants. Hmong participants had 10 or fewer years of education, with a mean score of five years of education in a school setting. Hmong participants all entered the United States of America between the years of 1976 and 1993 and had lived in the United States between 22 and 39 years.

All Iraqi participants had an “established birthday”, because the Iraqi government records all births of all Iraqi citizens. In general, the Iraqi participants tended to be between the ages of 32 and 60. There were two male Iraqi participants and three female Iraqi participants in the study. All of the Iraqi participants had more than 12 years of education in a school setting, with a mean score of 16 years of education in a school setting. All Iraqi participants had entered the United States of America between the years of 2012 and 2014 and had lived in the United States for less than 3 years.

Survey Results

The researcher interviewed the ten participants and asked seven demographic questions and five questions about the meaning of therapy. The themes for Hmong participants, the themes for Iraqi participants, and overall participant themes are summarized below. Participant responses, transcribed verbatim, can be found in Appendices D-F. The researcher and thesis

advisor independently reviewed the five-question survey transcriptions for Hmong and Iraqi participants. The qualitative data were analyzed using grounded theory methods as described by Strauss and Corbin (1990). Inter-rater reliability was established through the identification of themes for each question.

Themes from Hmong participants. The researcher interviewed five Hmong clients and the results are as follows. Hmong participant responses, transcribed verbatim, can be found in Appendix D. The researcher and thesis advisor independently reviewed the transcriptions of the five question survey and identified common themes.

For question one: "What is the most important thing you want a therapist to know about you?" the researcher and thesis advisor had 80% inter-rater reliability. Both coded themes of mental health issues and language barriers, while one researcher also coded physical ailments.

For question two: "Do you tell friends and/or family you are in therapy? If yes, how do you describe what therapy is? If no, why not?" all five Hmong participants replied "Yes" to "Do you tell friends and/or family you are in therapy?" To the question asking "describing what therapy is", themes of assistance/help and help in the area of mental health symptom management were coded. The researcher and thesis advisor had 100% inter-rater reliability.

For question three: "How would you decide if someone else needs therapy?" the researcher and thesis advisor had 100% inter-rater reliability and identified themes of needing help and display of mental health symptoms.

For question four: "What is the role of the therapist?" the researcher and thesis advisor had 80% inter-rater reliability. Expert role and helping role were identified as themes, with one researcher specifying counseling as a subtheme of the helping role.

For question five: “Does therapy help you? If so, how? If no, why not, what would?” all five Hmong respondents responded affirmatively to therapy being helpful. Themes of confidentiality and reduction of mental health symptoms were coded. The researcher and thesis advisor had 100% inter-rater reliability for question five.

Themes from Iraqi participants. The researcher interviewed five Iraqi clients and the results are as follows. Iraqi responses, transcribed verbatim can be found in Appendix E. The researcher and thesis advisor independently reviewed the transcriptions of the five question survey and identified common themes.

For question one: “What is the most important thing you want a therapist to know about you?” the researcher and thesis advisor had 50% inter-rater reliability. Both coded the theme of finding solutions to problems. Additionally, the researcher identified themes of medical, mental health, and social issues; whereas, the research advisor identified discomfort with current life and loss as themes.

Question two was: “Do you tell friends and/or family you are in therapy? If yes, how do you describe what therapy is? If no, why not?” Four of the Iraqi participants responded, “No, they do not tell friends and/or family,” and one respondent responded with a “Yes, they do tell friends and/or family they are in therapy.” To the question, “If yes, how do you describe what therapy is?” the theme was that “therapy helps”. The themes coded for the reasons the Iraqi participants do not tell friends and/or family were culture and privacy. The researcher and thesis advisor had 100% inter-rater reliability for question two.

For question three: “How would you decide if someone else needs therapy?” the researcher and thesis advisor had 100% inter-rater reliability. The three themes that were coded were mental health symptoms, behaviors, and past experiences.

For question four: “What is the role of the therapist?” the researcher and thesis advisor identified themes of problem solving/helping, privacy, and hope, and they had 100% inter-rater reliability for this question.

For Question five, “Does therapy help you? If so, how? If no, why not, what would?” the researcher and thesis advisor had 100% inter-rater reliability. All five Iraqi participants responded affirmatively to therapy being helpful, and the primary themes coded were problem solving, hope, and caring.

Common themes from participants. The results from the Hmong and Iraqi surveys were combined. Common themes between both of these groups are shown in Table 3. Themes were identified by the researcher and research advisor based on independent reviews.

For question one: “What is the most important thing you want a therapist to know about you?” the researcher and thesis advisor had 100% inter-rater reliability. Themes of finding solutions to problems, mental health, and physiological symptoms were consistent from participant responses.

Question two was: “Do you tell friends and/or family you are in therapy? If yes, how do you describe what therapy is. If no, why not?” The researcher and thesis advisor found no consistent response or common theme for the question of “do you tell friends and/or family you are in therapy?” because the participant responses were reflective of their cultural norms. As noted in the above findings, Hmong responses viewed therapy as an area open for discussion with family and friends. The Iraqi responses reflected cultural norms of therapy not being helpful or viewed as positive. The researcher and thesis advisor had 100% inter-rater reliability for question two.

For question three: “How would you decide if someone else needs therapy?” the

researcher and thesis advisor had 100% inter-rater reliability. The two themes consistent from participant responses were mental health symptoms and help/problem solving.

For question four: "What is the role of the therapist?" the researcher and thesis advisor had 100% inter-rater reliability. The two themes consistent for all participant responses were problem solving/helping and counseling.

For question five, "Does therapy help you? If so, how? If no, why not, what would?" the researcher and thesis advisor had 100% inter-rater reliability. The responses were 100% affirmative to the question "does therapy help you?" The themes evident from participant responses were management of mental health symptoms and problem solving/help.

Table 3

Common Themes with both Hmong and Iraqi Responses

	Common Themes
What is the most important thing you want a therapist to know about you?	• Finding solutions to problems, mental health, and physiological symptoms
Do you tell friends and/or family you are in therapy? If yes, how do you describe what therapy is. If no, why not?	• There were no common themes found
How would you decide if someone else needs therapy?	• Mental health symptoms • Help/problem solving
What is the role of the therapist?	• Problem solving/helping • Counseling
Does therapy help you? If so, how? If no, why not, what would?"	• Management of MH symptoms • Problem solving/help

Discussion

This section discusses the qualitative themes identified from the participant responses to the questions about the meaning of therapy and ties their responses to the existing literature on refugee experience. Discussion will focus on the uniqueness of Hmong responses, as compared to the uniqueness of Iraqi responses, and finally the commonalities that exist among the responses. Particular attention to assisting future therapists to better serve immigrant populations will be the primary goal of this section.

Hmong participants' responses. Many of the Hmong responses revolved around the identification of mental health diagnoses and the importance of, and ease about which the

diagnoses were discussed. The researchers coded the theme of mental health symptoms in four out of the five questions. Participants were able to talk openly and candidly about suicidal thoughts, anxiety, and depression. This shows a marked awareness of the language around mental health symptoms and an adaptation to and integration of this language into their lives.

The researchers coded the themes of help, a helping role, and assistance/help in three out of the five questions. This shows that Hmong participants' view therapy as an important need and view therapy as an integral part of their lives. It seems that "help" is a general term used by the Hmong participants to describe what therapy is, when someone else needs it, and why it is important to seek out. The end result of this "help" unanimously lowered mental health symptoms among participants, including experiencing less worry, stress, anger, and sadness.

Hmong participant responses were unique in having a unanimous affirmation of telling others they are in therapy. Therapy seems to be regarded as an essential and necessary component to daily functioning. There seems to be no shame or stigma attached to therapy; instead, it is viewed as a positive vehicle of change, and a way to relieve mental health symptoms. In addition to relieving mental health symptoms, Hmong participant responses also endorsed that therapy is a form of assistance.

Iraqi participants' responses. Iraqi participant responses revolved around the idea of therapy being a "problem solving technique". The researchers coded themes of problem solving and helping in four out of the five questions. Problem-solving and help received from therapy ease the discomfort reported in the day to day lives of the Iraqi participants.

The researchers coded "past experiences" and an "overall discomfort with current life," as well as "loss" in two out of the five responses. The Iraqi responses show they have experienced a disruption in their lives and changes that have not been pleasant experiences. The

current discomfort and past experiences provide the reason why therapy is needed and viewed as necessary.

"Privacy, and hope" were coded as themes in two out of the five Iraqi responses. The Iraqi responses were unanimous in indicating that privacy was a necessary and integral part of therapy. Trusting that therapy is private and confidential allows the respondents to grapple with their needs, whether it is mental health symptoms, financial issues, or struggling with their past experiences. The theme of "hope" seems to be essential to participants believing that their situations are going to get better. Receiving therapy they trust is private, leads to feeling hope after the sessions are completed.

The Iraqi responses are unique in their almost unanimous answer that they do not tell friends or family they are in therapy. Four out of the five Iraqi participants cited therapy is a private matter, and that therapy is not perceived as good in their culture as reasons why they do not tell anyone they are in therapy. There seems to be a culture of silence surrounding mental health symptoms and diagnosis. It is noteworthy that although all five Iraqi participants identified therapy as not valued by their culture, they all still assured they receive therapy and all identified that therapy helped them significantly. Although each of the Iraqi participants is actively participating in therapy, they are continuing the culture of silence surrounding receiving mental health assistance.

Common themes. Both Hmong and Iraqi participants unanimously identified therapy as being helpful. The two common themes identified as to how therapy helps the participants were: management of mental health symptoms and problem solving/help. Both participant groups identified therapy as a venue to manage stress, worry, anxiety, and depression. This shows that

therapy is having a positive effect on them. Therapy is a way for the participants to manage their mental health symptoms and is also a way to obtain help to manage their daily lives.

Both Hmong and Iraqi participants repeatedly cited that therapy is a form of problem-solving/helping. Three out of the five questions were coded for using the theme of help/problem solving. A person who "needs help" fits the definition of someone who needs therapy, according to the Hmong and Iraqi participants. The role of the therapist is to "help and/or problem solve", and therapy helps all of the participants by "problem solving". For both participant groups, therapy seems to be a necessary component for daily functioning and to improve daily functioning.

However, Hmong and Iraqi participants differed greatly on being able to tell others, such as friends and/or family, that they are in therapy. The Hmong participants were universal in saying that they talk openly about attending therapy and receiving therapy services. In contrast, four out of the five Iraqi participants replied that they do not speak about therapy or receiving therapy services to friends and/or family at all. This highlights the cultural differences in the views of mental health services between the Hmong and Iraqi participants. Four out of the five Hmong participants identified mental health and medical symptoms as important things that a therapist should know about them; whereas, the Iraqi participants were vaguer in responses about important things a therapist should know about them. It is possible that the openness that the Hmong participants have for identifying and naming mental health and medical symptoms is reflective of the Hmong culture views toward therapy. Likewise the Iraqi participants reflected and continued their cultural norm of silence related to mental health assistance.

From this qualitative study, it seems that Hmong clients are open to therapy, are able to identify their own mental health and medical symptoms, and seem open to discussing them with

mental health practitioners. These results mirror what we know from the literature on Hmong families which is the ability to openly speak to others about their mental health and medical symptoms (Donnelly, 1994). Hmong participants all viewed therapy as a fundamental part of their lives to ensure that their needs are met. They all reported improvement in their daily lives with the help of therapy, as well as a reduction of mental health symptoms such as stress, anxiety, and worry. In general, Hmong are accepting of mental health services, the western view of mental health practices, and mental health diagnoses. They identify with somatic symptoms as a result of their soul or souls being sick, lost or stolen and used western medication to treat their pain and talk therapy to soothe their difficulties while finding solutions to their needs.

Because the Iraqi population is such a new refugee population in the United States, the literature on the meaning of therapy for them is slim. However, what we know about refugees shows that people who have experienced extreme violence have increased concerns about confidentiality and privacy (Al-Krenawi & Graham, 2000). Additionally, anecdotal evidence suggests that privacy is so important that clients will refuse to see a medical provider if the interpreter they know and trust is not present. Other interpreters may be members of their community, but if they do not personally know them, the interpreters are viewed with distrust. Therefore, from this qualitative study, it seems that Iraqi clients are open and receptive to therapy; however, privacy and confidentiality concerns are critical and should be recognized by therapists and discussed with clients. The therapist should ensure that the client knows their privacy will be protected. From this study, it appears that Iraqi clients have embraced a western style of mental health services and utilize therapists, psychiatrists, and mental health case managers as ways to manage their mental health symptoms and to get the “help” they need, even while not telling friends they are receiving help. Iraqi clients have identified that in their home

country they would never attempt to receive mental health services, because mental health assistance has a stigma that is reserved for those in hospitals or jail. In the United States, Iraqi clients viewed therapy as a necessary and integral part of their lives. They reported improvement from receiving therapy, including reduction of mental health symptoms, such as worry, and an increase in hope and feeling comfortable.

Finally, although the age range of the two participant populations was similar, in comparing the length of time residing in the United States, there was a substantial difference. Hmong participants reported living in the United States between 22 and 39 years; whereas, Iraqi participants had lived in the United States for less than three years. The researcher wonders how the Iraqi participants' views on mental health might change after they have resided in the United States for over 20 years. The researcher wonders if, through assimilation, some of the stigma over mental health diagnosis and treatment might diminish.

Chapter V: Summary, Conclusions, and Recommendations

The purpose of this study was to examine the meaning of therapy in the lives of Hmong and Iraqi refugees. Refugees are a special population who likely has experienced trauma and have resulting mental health diagnoses, while contending with cultural assimilation in their asylum country. Participants were five Hmong and five Iraqi refugees residing in the Minneapolis and Saint Paul metropolitan areas. The sample consisted of 10 total participants. Demographic data were collected, and the qualitative data for the five questions on the meaning of therapy were analyzed using grounded theory method. Studying the meaning of therapy in these client's lives through this qualitative study allowed the researcher to obtain a small window to view how cultural background might influence the meaning and success of therapy.

Conclusions

Because this study is one of few that examined the meaning of therapy in the lives of refugees, continued research on refugee populations is needed. This study documents how Hmong and Iraqi refugees view therapy and the effectiveness of therapy through their cultural norms and lived experience.

Health is perceived by Hmong as a balance of forces in the social, natural and supernatural realms. Health care treatment is perceived as realigning these forces into harmony; a “medical problem” in the western world is always a matter of the soul and spirit for the Hmong. Therefore a physical symptom may mean that the entire universe is out of balance and assistance is required to bring the body and soul back into alignment.

In contrast, there is an aversion to mental illness in the Arab culture and a culture of silence exists around receiving support for mental health issues. Mental illness is perceived as being linked to the supernatural, and therefore, receiving a mental health diagnosis may be

viewed with suspicion and shame by the client. This study is unique in that it documents cultural norms about how therapy is beneficial, talked about, and viewed by two refugee populations.

Recommendations

Recommendations for further research include obtaining a larger sample, numerically and geographically, and by recruiting additional refugees with diverse nationality and/or ethnicity. As noted in the discussion section, on-going conversation with Iraqi clients may shed light on the impact of length of time in the United States and assimilation experiences upon their views of therapy. It may be beneficial for mental health practitioners to seek out additional trainings that educate and train therapeutic skills tailored for refugees and refugee trauma. It may be beneficial for practitioners to investigate and incorporate culturally informed methods to assist their work with refugees. Identification of effective mental health practices for refugees from various nationalities and ethnicities would add to the refugee trauma literature.

It is the researcher's opinion that additional research into the meaning of therapy for Hmong and Iraqi refugees, as well as other refugee populations is important. According to the United Nations High Commissioner for Refugees the number of asylum requests has been rising due to increased instability and war in various regions of the world (UNHCR, 2015). The men, women, and children who receive refugee status designation will require trained practitioners who not only know how to heal trauma victims, but who also know how to tailor interventions and receive constructive feedback on how therapy is perceived by their refugee clients.

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Appendix A: Cover Letter and Consent Form

Consent to participate in UW-Stout Approved Research

Title: The Meaning of Therapy for Hmong and Iraqi Refugees

Research Sponsor:
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Description: This is a qualitative study of Hmong and Iraqi refugee clients which attempts to define the meaning of therapy in their lives. The purpose of my study is to understand different cultural meanings of therapy. I will ask five questions about the meaning of therapy.

Risks and benefits: Every situation comes with risks, however the benefit in participating in the research means that you get to define what therapy means to you. It will help future therapists in understanding how to better work with Hmong and Iraqi clients in therapy.

Time commitment and payment: Completion of this survey will take approximately ten minutes. You will not receive any monetary compensation or any reward for participating in this survey.

Confidentiality: Your responses to this survey are completely confidential. Your name and any identifying information will not be included on any documents. We do not believe that you can be identified from any of this information.

The right to withdraw: Your participation in this study is entirely voluntary. You may choose not to participate without any adverse consequences to you. Should you choose to participate and later wish to withdraw from the study, you may discontinue your participation at this time without incurring adverse consequences.

IRB Approval: This study has been reviewed and approved by the University of Wisconsin-Stout's Institutional Review Board (IRB). The IRB has determined that this study meets the ethical obligations required by federal law and university polices. If you have question s or concerns regarding this study please contact the investigator or advisor. If you have any

questions, concerns, or reports regarding your rights as a research subject, please contact the IRB administrator.

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Statement of Consent:
By signing this consent form you agree to participate in the project entitled “The Meaning of Therapy for Hmong and Iraqi Refugees.”

____
Signature date

Appendix B: Demographic and Survey Questions

The Meaning of Therapy for Hmong and Iraqi Refugees

Researcher will ask the following questions and record the answers the interpreter provides verbatim.

The following are demographic questions:

1. Date of Birth: (circle estimated/established) ______
2. Gender: M or F
3. What is your Region/country of origin? ________________________
4. What is your date of entry into the United States? ___________________
5. What is the primary language you prefer? ____________
6. Is there a secondary language you prefer? ______ If yes, what is it? ____________
7. How many years of education have you had in a school setting? ___________

The following are five research questions pertaining to your thoughts on what therapy means to you.

1. What is the most important thing you want a therapist to know about you?

2. Do you tell friends and/or family you are in therapy?

   If no, why not?

   If yes, how do you describe what therapy is?

3. How would you decide if someone else needs therapy?

4. What is the role of the therapist?

5. Does therapy help you?

   If yes, how?

   If no, why not, what would?

Appendix C: Hmong Survey Translation

The Meaning of Therapy for Hmong and Iraqi Refugees
Txhai tau li cas yog muaj tug tuaj nrog koj tham rau cov neeg hmoob thiab iraqi yog neeg tawg rog

Researcher will ask the following questions and record the answers the interpreter provides verbatim.
Kuv yuav txhais jan tas cov lus thiab teb koj cov lus.

The following are demographic questions:
Cov lus nug no yog yuav nug tias koj nyob qhov twg tuaj

1. Date of Birth (circle estimated/established) ______

   Hnub yug (khij seb koj lub hnub nyoog puas thwj los tsis thwj)

2. Gender: M or F

   Poj niam los txiv neej

3. What is your Region/country of origin? ______________________

   Koj nyob qhov twg tuaj?

4. What is your date of entry into the United States? _________________

   Koj tuaj teb chaws no thaum twg lub sij hawm twg?

5. What is the primary language you prefer? ____________

   Koj hais hom lus dab tsis?

6. Is there a secondary language you prefer? ______ If yes, what is it? ____________

   Koj puas hais tau lwm hom lus thiab? Yog tias hais tau, hais hom lus twg?

7. How many years of education have you had in a school setting? ___________

   Koj twb kawm ntawv tau tsawg xyoo lawm?

The following are five research questions pertaining to your thoughts on what therapy means to you.

6. What is the most important thing you want a therapist to know about you?
   Puas muaj tej yam tseem ceeb uas koj xav ghia rau tus neeg tuaj pab koj?

7. Do you tell friends and/or family you are in therapy?
   Koj puas qhia rau koj tsev neeg los yog phooj ywg hais tias muaj neeg tuaj ntsib koj?

If no, why not?
Yog tsis qhia no vim li cas?

If yes, how do you describe what therapy is?
Yog qhia no piav seb tus tuaj pab koj yog leej twg?

8. How would you decide if someone else needs therapy?
   Piav seb yog vim li cas nws yuav tsum muaj ib tug tuaj pab koj?

9. What is the role of the therapist?
   Tus tuaj pab ntawd nws tes dej num yog dab tsi?

10. Does therapy help you?
    Tus tuaj pab koj ntawd puas pab tau?

    If yes, how?
    Tsis tau yog vim li cas thiab yog dab tsi?

    If no, why not, what would?
    Thiab yuav ua li cas thiaj pab tau?

Thank you for participating in this survey!
Ua tsaug rau txhua lo lub teb ntawm no!

Appendix D: Arabic Survey Translation

The Meaning of Therapy for Hmong and Iraqi Refugees

معنى العلاج النفسي للهمونغ واللاجئين العراقيين

Researcher will ask the following questions and record the answers the interpreter provides verbatim.

الباحث سوف يسأل الاسئلة التالية وسوف تسجل الاجابات حرفيا

The following are demographic questions:

الاسئلة التالية اجتماعية

1. Date of birth (circle estimated/established) ______
   تاريخ الميلاد (ضع دائرة تقريبا \ او اذا تم تحديده من جهة رسمية)
2. Gender: M or F
   الجنس انثى او ذكر
3. What is your Region/country of origin? ________________________
   من اي اقليم او قطر اقليم؟
4. What is your date of entry into the United States? ___________________
   ماهو تاريخ دخولك للولايات المتحدة الامريكية؟
5. What is the primary language you prefer? ____________
   ماهي لغتك التي تفضل التحدث بها؟
6. Is there a secondary language you prefer? ______ If yes, what is it? ____________
   هل لديك لغة ثانية تفضل التحدث بها؟ اذا نعم فما هي؟
7. How many years of education have you had in a school setting? ___________
   كم هي سنوات الدراسة التي حصلت عليها؟

The following are five research questions pertaining to your thoughts on what therapy means to you.

الاسئلة الخمسة التالية للباحث تتعلق بتفكيرك حول معنى العلاج النفسي بالنسبة لك

11. What is the most important thing you want a therapist to know about you?
    ما هو اهم امر تريد الباحث ان يعرفه عنك؟
12. Do you tell friends and/or family you are in therapy?
    هل تخبر اصدقائك او عائلتك انك تتلقى العلاج النفسي؟

    If no, why not?

    اذا كان الجواب لا لماذا؟

    If yes, how do you describe what therapy is?

    اذا كان الجواب نعم كيف تصف العلاج النفسي؟
13. How would you decide if someone else needs therapy?
    كيف ممكن ان تقرر اذا كان شخص اخر يحتاج الى علاج نفسي؟
14. What is the role of the therapist?
    ما هو دور المعالج النفسي؟
15. Does therapy help you?

هل العلاج النفسي ساعدك؟

If yes, how?

اذا كان الجواب نعم كيف؟

If no, why not, what would?

اذا كان الجواب لا اذن كيف ممكن ان يكون؟

Thank you for your time and participation in this survey!

شكرا لوقتك ومشاركتك في هذه الدراسة

Appendix E: Hmong Responses

	1. What is the most important thing you want a therapist to know about you?	2. Do you tell friends and/or family you are in therapy? If no, why not? If yes, how do you describe what therapy is?	3. How would you decide if someone else needs therapy?	4. What is the role of the therapist?	5. Does therapy help you? If yes, how? If no, why not, what would?
Hmong respondent 1	Because I don't know English, communication is a barrier. I want the therapist to know I have lots of health problems and I am a person who cannot read and I need help understanding	Yes, every person in my family knows that I have a therapist. She is someone who helps me understand what I need and helps get it done.	If someone needs help and doesn't speak English, they should get a therapist	To teach me and help me and show me how to help myself. To remind me about my medication and provide resources.	Yes, you help me think through a situation when I am stuck. You help me analyze and make a decision about my problem.
Hmong respondent 2	If I have depression or anxiety, the therapist needs to know	Yes, when I am depressed or stressed or have anger I can talk to someone about it.	If I see a person who is really depressed or need help, they probably need a therapist.	To counsel with the person to release the stress.	Yes, I know that everything is confidential, I can cry and I know you will help me and not tell anyone. I know when I see you that I have a chance to release my stress.

Hmong respondent 3	That I need help.	Yes, I only tell family. (the therapist) She talks to me and helps me with things I don't know how, or cannot do.	If someone needs extra help they need therapy.	The person to call if I need help. I would like to call directly, but I need to go through an interpreter.	Yes, but it is hard with always needing an interpreter. (Therapy) it helps when you help me help myself, I have to learn how to help myself.
Hmong respondent 4	Something I want the therapist to know about me is my depression, anxiety, and physical pain, and how it affects my body.	Yes I do. The therapist helps me and helps me with things I don't know.	If I see someone talking to themselves or yelling for no reason, or if they are pretending. They need a therapist.	The therapist is there for counseling and for helping.	Yes, a lot. Helping to counsel, to read and to help with mail, everything reduces my stress.
Hmong respondent 5	My anxiety and about my suicidal attempts and thoughts.	Yes. Therapy is helping. It helps my anxiety and it is counseling for everything.	If they talk to themselves, if they talk loud, if they pretend they are a leader or something.	Therapist role is to be there to help the person, to counsel with the person.	Yes. (You are) helping a lot, the medicine helps too. (Therapy) it helps make my anxiety and worry lower.

Appendix F: Iraqi Responses

	1. What is the most important thing you want a therapist to know about you?	2. Do you tell friends and/or family you are in therapy? If no, why not? If yes, how do you describe what therapy is?	3. How would you decide if someone else needs therapy?	4. What is the role of the therapist?	5. Does therapy help you? If yes, how? If no, why not, what would?
Iraqi respondent 1	My psychological problems and my life in USA. How can I be happy here in USA because I am not living comfortable, I have anxiety and feeling sad over my income. My income is beyond low, when my husband doesn't pay rent I feel scared and worried. The financial situation is bad. I am very ill.	No. It is personal.	When I see people with depression, I encourage them to see a therapist. Therapy solves a lot of problems.	To help my problems.	Yes. It helps with finding ways to solve my problems, recommendation and help and you show you care. It makes me feel better, I see you care I am human.
Iraqi respondent 2	The social things and problems I have, you have to know it to help me.	No. The problem is the culture. They think mental issues is crazy, but they don't understand the stress and behavioral things in life need therapy.	When most people talk I can tell if they need therapy or not. I read body language, if someone seems uneasy, I know they need a therapist	To keep secrets.	Yes. You do all the things I need to take care of my life. I am blind and you are my eyes in seeing how to fix my life. And therapists listen and care about you.
Iraqi	I want to see my	No. It is private and	Everyone has an	To solve my	Yes. It makes me

respondent 3	mom, I miss her.	confidential.	issue and everyone has problems, so therapy is for everyone.	problems.	feel comfortable.
Iraqi respondent 4	That I am not comfortable right now.	Yes. I'll use myself as an example for therapy. I would tell someone therapy will help them like it has helped me.	Anyone from Iraq should go to therapy because of what we have experienced.	You give hope to people.	Yes. You give me hope that I am going to move forward with my life.
Iraqi respondent 5	Our problems. Help me to find solutions.	No, my culture does not view therapy as good.	I would recommend therapy to persons who does not want to interact with others.	To give ideas and recommendations to people.	Yes. It helps me and helps solve the problems that worry me. If you would have been here six months ago, I am sure things would be much better.