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Understanding and Addressing Arab-American Mental Health Disparities

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MANUSCRIPT

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ABSTRACT

The landscape of mental healthcare and focus on disparities research in the United States has vastly improved in recent years. However, Arab-Americans continue to be a commonly overlooked group within the scope of research. This trend is especially worrisome given the detrimental factors for Arab-Americans that have arisen as a result of 9/11 and the 2016 United States Presidential Election. This work explores barriers to accessing formal mental health care and offers recommendations to reconcile them for Arab-Americans. The present study completes this through a review of the literature and an interview conducted by the author of a panel of mental health professionals at a community health organization in order to gain a contemporary perspective of the issue. Salient suggestions that arise from this study are reducing stigma in the community by incorporating increased usage of primary care and religious providers as well as family therapies; the allocation of Arabic-speaking translators to clinics or a focus on hiring Arabic-speaking practitioners; supporting safety-net insurance funding; increased education on what psychotherapy and mental illness are within this community; and pushing the necessity of professional training in the culture, religion, and therapeutic preferences of Arab-Americans.

With every passing generation, some barriers to mental healthcare have slowly been removed for the majority of Americans, and the landscape of healthcare as a whole has made vast improvements from the days of old. Mental health is now seen as a prominent issue on a national scale through parity agreements that would have been inconceivable years ago. However, these improvements have not applied to all Americans equally. Like many ethnic minorities, Arab-Americans face distinct barriers in accessing formal mental healthcare. The aim of this paper is to examine why Arab-Americans seem to be so unwilling, or unable, to seek formal mental healthcare services. This question is especially pertinent given the tendency of Arab-Americans to have protective factors, or attributes that reduce the risk of mental illness, of increased wealth and education compared to the average American (Arab-American Institute, 2011; Mrazek & Haggerty, 1994). Once those barriers were identified, the goal was then to synthesize the perspectives of the literature and the author in order to address how to reduce them. To help achieve these goals, an interview was conducted with a panel of mental health practitioners at a local community health organization in a large Northeastern city in order to supplement the views in the literature with a more contemporary perspective. The panel was composed of one supervising licensed social worker, two clinical psychology students on internship, and two social worker students on internship. The interview lasted 35 minutes. Questions were determined a priori by the author, but were expanded based on the interviewees' responses. This interview was approved by the IRB at the author's institution.

Arab-Americans are a less frequently studied ethnic group within the main focus of disparities research. This proves troublesome for the approximately 3.7 million Americans of Arab descent today, which has rapidly grown by 47% within the last decade (Arab American Institute Foundation, 2011; US Census Bureau, 2011). Unfortunately, there are limitations with these estimates as the United States does not federally recognize Arabs as an ethnic group, instead considering them "White" or "Caucasian." These estimates are then drawn from reported countries of origin instead of self-report. Because of this, much of the research drawn from Arab-Americans has been conducted in the state of Michigan, as the category is recognized there. This is an important limitation to consider throughout this report; however, specific efforts were made by the author in order to gain a more holistic view of the Arab-American experience across the United States.

RECENT TRENDS AND DEMOGRAPHICS OF ARAB-AMERICANS

In order to gain a better understanding as to why this group has a unique need for study, a better understanding of Arab-American's recent history is necessary. Arab-Americans generally immigrated to the United States in three waves, though the third wave is the most pertinent to this review. The third wave of immigration occurred after the 1967 Six-Day War between Israel and several Arab nations, leading a large influx of Arab (mainly Palestinian) immigrants to flee to the United States. This wave continues to this day, and has reached a greater influx with recent turmoil in the area including the Arab Springs, the wars in Iraq and Afghanistan, and the Syrian Civil War (Abraham, 1995; Vermette, Shetgiri, Al Zuhieri, & Flores, 2015). It is important to note that although the majority of Arab-Americans are not Muslim (about 23% are), the vast majority of recent Arab immigrants to the US are indeed Muslim, and so this percentage may not be truly representative of the current population of Muslim Arab-Americans in the United States (Bagby, Perl, Froehle, 2001). Moreover, much of the research examining Arab-Americans has used samples that were majority Muslim, sometimes reaching 96 and 97% (Aloud, 2004; Jaber et al., 2015; Vermette et al., 2015). Due to these factors, even though Muslim Arab-Americans are not the main focus of this paper, it seems essential that factors affecting Muslim Americans will also be observed in order to gain a holistic view of the detriments that keep Arab-Americans from seeking formal mental health care.

ARAB-AMERICANS AS A DISTINCT GROUP OF STUDY

The study of Arab-Americans as a distinct ethnic group from "White" Americans is essential due to heightened risk of media bias and discrimination that can lead to negative ethnic identity (Jackson, 1997). This issue is especially relevant given the rise of hateful speech towards Muslims and Arab-Americans since 9/11 (Persson & Musher-Eizenman, 2006) and the 2016 United States Presidential Election. One of the most shocking pieces of literature to emerge as a result of 9/11 was a survey conducted by Amer and Hovey (2011) that found that across 35 states, 50% of Arab-Americans met symptoms of depression and almost 25% of the surveyed Arab-Americans met symptoms of moderate/severe anxiety. Previous to this, Amer (2011) also found that Arab-Americans had significantly higher rates of anxiety, depression, and acculturative stress post-9/11 as compared to before the event. A study of Arab-American adolescents corroborated these results, finding that 14% of them reported symptoms matching a diagnosis of moderate or severe depression, compared to 8% in the same age group of other ethnicities. Importantly, 35% of the study participants stated they would never consider speaking to a health professional about mental health (Jaber et al., 2015). This story took a turn for the worse when a study of Arab- and Eastern African-immigrants to the United States in San Diego found that 37% of the participants reported an adverse event or discrimination in the United States, with most of them attributing it to 9/11. Risk factors associated with reporting an adverse event included being Arab, Muslim, or wearing traditional clothing. Furthermore, 56% of the immigrants had faced persecution in their home country, and 54% of those reporting an adverse event had symptoms similar to a PTSD diagnosis. However, despite such large numbers reporting experiencing these negative events, many of the study participants described that professional mental health services were not an option for them (Reimann, Rodriguez-Reimann, Ghulan, & Beylouni, 2007). Barriers must be identified in order to understand and address what is keeping Arab-Americans out of mental health treatment even when facing such appalling circumstances.

ARAB- AND MUSLIM- AMERICAN MENTAL ILLNESS CONCEPTUALIZATION

An understanding of how this population conceptualizes mental illness can provide a key insight into what help-seeking pathways they undertake. In one study of Muslim American individuals, the prominent conceptualizations that emerged were based in biological, religious, supernatural, and environmental models (Bagasara & Mackinem, 2014). The most dominant model was the biological one, but on closer examination through open-ended response, it was found that the religious and supernatural models were also pervasive in the population. A frequent theme in the study was a multi-dimensional view that had components of each model

interacting with one another in order to form an understanding of mental illness (Bagasara & Mackinem, 2014). This multi-faceted model was also found in a study of Muslim Arab-Americans, and so has a more applicable nature for the purpose of this paper (Aloud, 2004). In a similar study of Muslim Arab-American illness conceptualization, it was found that the spiritual model was the most commonly reported illness conceptualization, whereas the biological model became the most prevalent when speaking about experiences either the participants, or their friends or family, had (Smith, 2011). Perhaps tied to this biologically dominant view is the frequently reported somatization and conversion disorders of Arab individuals. In other words, it is reported that Arab-Americans frequently display physiological symptoms in response to psychological distress (Al-Krenawi & Graham, 2004).

PREFERRED HELP-SEEKING SOURCES

Family.

It is important to note that the literature on preferred help-seeking sources in the Arab-American community is mixed. Therefore, the most commonly reported sources of help-seeking will be explored here. The most common source of reported help-seeking in Arab-Americans is through the informal source of family (Abudabbeh, 1996; Kulwiki, June, Schwim, 2000; Smith, 2011; Vermette et al., 2015). This is consistent with the theory in the literature stating that Arab values typically align along the family far more than the individual, so much so that even an individual's health can be seen as not as important if it jeopardizes the family in any way (Gorkin et al., 1985; Shalhoub-Kevorkian, 2005). The focus of an extended family in Arab culture is attributed as a large source of social support for individuals and, as such, is typically the main pathway in which treatment is sought out (Abraham, 1995). For example, in one study of Iraqi refugees in Texas, participants noted that the family was the best suited to handling most mental health problems. Many of the participants noted that they would only seek help from other sources if the problem became too severe, in which case they would typically seek a Primary Care Provider (PCP) (Vermette et al., 2015). This finding is corroborated with the results of another study which found that some participants reported it was seen as inappropriate to speak about secrets outside of the family (Smith, 2011). This dependence on family is so prevalent within the Arab help-seeking process that in some cases individuals could even be ostracized for seeking help through formal services as it was seen as attempting to actively circumvent the family structure (Abuddabeh, 1995). However, other studies have conflicted with this finding of family as the most used help-seeking source (e.g. Aloud, 2004).

Medical Doctors.

In a survey of help-seeking preferences and attitudes for mental health disorders, Aloud (2004) found that Muslim Arab-Americans reported that 33% preferred medical doctors, 22% preferred family, 19% preferred approaching an Imam or Sheikh, 11% preferred formal mental health services, and 6% stated they would not seek help at all. This finding runs in contrast to much of the literature noting preferences for familial help-seeking, but it is not completely out of expectations. Aloud (2004) speculated that medical doctors were the most favored in this sample due to the greater emphasis on the biological conceptualization of mental illness among the studied population, the influence of somatization and conversion disorders, and the fact that the sample reported higher levels of education. Smith (2011) reported that individuals that had a stronger belief in the biological model of mental illness tended to prefer medical doctors as the primary source of care.

Religion.

Through focus group discussions of Muslim Arab-Americans, Smith (2011) noted that the most frequently reported source of care reported in her sample was through a religious or faith healer. This was especially true if the individual had stated an illness conceptualization based on a religious or spiritual model (Smith, 2011). Aloud (2004) found that there was a strong inverse relationship between help seeking preferences and attitudes toward formal mental health services among the sample he recruited. This was corroborated by a follow up study conducted by the author in which formal mental health services were less preferred by the questioned sample (Aloud & Rathur, 2009). Therefore, individuals tended to exhaust all informal mental health care sources before attempting to reach for

formal services. The complaint of participants in multiple studies that formal mental health services providers did not have prerequisite knowledge of the Islamic religion displays the importance of this aspect in the preference of help-seeking behaviors, even in cases where it was not the dominant model of the individual (Aloud, 2004; Reimann et al., 2007; Smith, 2011; Vermette et al., 2015).

BARRIERS TO ACCESSING FORMAL MENTAL HEALTH SERVICES

Stigma.

By far, stigma is one of the most prevalent themes within the literature as a barrier for Arab-Americans. Stigma is so prevalent and damaging that one study found that, without regards to socioeconomic status or education level, it was the most reported barrier in Arab-Americans (Aloud, 2004). At the very root of the issue is the fact that the word crazy, or *majnoon* in Arabic, is heavily stigmatized within Arab culture (Gorkin et al., 1985). In focus group discussions, individuals reported fears that others would view them as "weak" or that they "had nothing better to do" if they sought therapy (Smith, 2011, pp. 64-65). This was clarified by participants in that study to not have anything in particular to do with Islam, but was rather a cultural stigma within the Arab community (Smith, 2011). In a separate study, both providers and patients recognized the prevalence of stigma as a barrier (Arfken et al., 2009). The effects of stigma can reach to the help-seeking process. It was noted that when individuals, or members of their families, had personally experienced mental illness, they were more likely to attribute it to the biological model and seek a PCP (Aloud, 2004; Smith, 2011). Some also argue that somatization can serve as defense mechanism against the stigma of a psychiatric diagnosis through the presentation of physical symptomology (Hotopf, Wadsworth, & Wessely, 2001).

The effects of stigma could even reach into the therapy room as there were reports of interpreters shaming the patient for speaking about mental illness both in the literature (Vermette et al., 2015) and in the interview conducted by the author. Stigma seemed to be amplified when Arab-American communities were small (Vermette et al., 2015). This was best summarized in the interview conducted by the author in which the mental health provider noted:

I2: the Middle Eastern community in [city] is so tiny, umm and they all know each other regardless if they knew each other before, but just through health care here and maybe going to the same mosque or maybe going to the same stores, they end up knowing each other so they will maybe see each other in the waiting room and get really uncomfortable.

Kira and colleagues (2014) noted that internalized stigma was also an issue for Arab-Americans, Muslims, and refugees, stating that those groups had significantly higher internalized stigma compared to white Americans. Furthermore, they found that the degree of internalized stigma predicted negative mental health outcomes and modified or amplified other forms of stigma (Kira, Lewandowski, Ashby, Templin, Ramaswamy, & Mohanesh, 2014). Arab-American participants also noted significant "feelings of shame" in regards to the seeking mental health services (Aloud & Rathur, 2009, p. 93).

Arab-American females seemed to face unique stigma specific to their gender. Smith (2011) and Al Krenawi and colleagues (2000) both noted the hesitation of some women to seek mental health services due to the possibility that it could harm their marriage opportunities. This stigma can be seen in an excerpt from the interview conducted by the author in which the mental health provider noted

I2: "we've had phone interpreters who have shamed our clients throughout therapy and…when we ask questions about like sexuality and you know a female Iraqi woman is responding and this interpreter was like you should not be speaking like that."

Stigma in relation to family had multiple dimensions. Individuals feared seeking mental health services in order to not harm the reputation of their family (Smith, 2011). However, individuals also feared stigma within the family due to the aforementioned expectation that they should be the main source of care and, in some cases, how they could be ostracized due to the view they were attempting to circumvent the family structure (Abuddabeh, 1995; Smith, 2011). An extreme of this can be seen in an event reported by the interviewed mental health professionals:

I2: one time we had a parent and a child coming and they didn't

know that the other were coming, and they had the same therapist but because they had different names and they were booked one after the other, so… They didn't return after that.

Structural Barriers.

Language.

The inability to speak or share a language with a therapist can understandably deter individuals from seeking treatment (Aloud, 2004; Arfken et al., 2009; Kulwiki et al., 2000; Smith, 2011; Vermette et al., 2015). However, simply getting an Arabic interpreter does not solve the issue. Arabic dialects are very distinct from one another, and if the client does not speak the same dialect as the interpreter, then not much benefit has been achieved (Vermette et al., 2015). The community health organization from which the interviewed panel of mental health professionals were drawn from had overcome many barriers in this regard, as it had both on-call phone interpreters and three in-house interpreters. However, an analysis of the difficulties that still surfaced at this location can illuminate more nuanced cracks that emerge once main barriers are removed. A major issue with language was when a therapist received a response that did not match the question, they were unsure if the response was mistranslated, misunderstood, or even if it was simply psychosis. Difficulties with the phone interpreters ranged from sound quality, quality of the interpreter themselves, and loud noises in the background. One interviewee noted the dynamic shift in using a phone interpreter:

I1: a lot of our training is to like focus in on the affect, or the way things are coming across, or what else is going on in the room and there is literally a third person in the room, and they may not even be in the room, they may be on the phone. Umm, so it really changes the dynamic, and how things are conveyed.

The same interviewee also noted how difficult it was to describe some types of therapies over the phone and the loss of body language:

I1: I was going through a grounding relaxation technique… and luckily I had a person interpreter and…as he was doing it he was mimicking my movements of tightening all the muscles and you could tell that the patient might not have fully understood the words cause it was something new for her, but she was like, she started tightening too, and it just changes the dynamic.

The availability of live interpreters in this location was low as they were spread out throughout the entire health center. This meant that even though they had interpreters, it was not frequently a reality with one provider noting they had yet to receive a live interpreter regardless of how many times they had requested it. Furthermore, there was the noted issue of the interpreter in some cases shaming the client (Vermette et al., 2015).

Financial.

Like many ethnic groups, finances serve as a barrier for Arab-Americans. In a study of Iraqi refugees, Vermette and colleagues (2015) noted the disdain some of the recent immigrants felt for the healthcare system in the United States. The Iraqi refugees felt that the US healthcare system seemed to function more as a business than as a humanitarian structure. In some cases, these immigrants had arrived from countries where healthcare treatment had cost very little, or nothing at all, to having to pay large amounts of money in the United States. Individuals can also not have insurance or have Medicaid which is not accepted by many healthcare professionals within their travel range, and, as such, cannot afford treatment (Kulwiki et al., 2000; Reimann et al., 2007; Vermette et al., 2015). Even when Medicaid applications were sent for renewal, sometimes the individual would not hear back for months and would be left unaware if they had insurance or not (Vermette et al., 2015). Individuals could even be in a way fined for attempting to get insurance, as an Iraqi woman serviced by one of the interviewed providers was forced to pay $500 a month for insurance for filling out an application for the state health insurance incorrectly.

Informational.

An inherent issue as to why some Arab-Americans do not seek formal mental health services is that they do not have a good understanding of what psychotherapy even is (Erickson & Al-Timimi, 2001; Smith, 2011). Even if they do know of the existence of psychotherapy, there can be confusion about the distinct roles of each profession in the mental health field (Vermette et al., 2015). These findings were mirrored in the interview conducted by the author and displays the lack of awareness of what the role of therapy and

the role of the therapist is to some Arab-Americans:

I1: I remember one particular client telling me her kids and they almost described to her what a therapist would do. And she wouldn't have had as good as a definition. So I guess that if they were seeing a therapist they would have a better idea what they are here for.

I3: that mental health treatment… it doesn't exist, it exists for people that have very significant chronic like schizophrenia, so this concept of coming to talk to somebody is completely foreign and they think that you know they can just come and oh give me my pill and I'll sleep better without understanding that we don't prescribe medicine, or they'll be asking people to take on the role of more of a case manager… and then we push back saying that is somebody else's responsibility, they get very frustrated…and don't come back, or come back with the same expectation and then the same answer…it's not a sexy dance.

This is likely due to the dearth of mental health services within the Arab world, partially due to the tendency for psychologists to work in academia instead of as clinicians (Okasha, Karam, & Okasha, 2012). On top of this, a noted issue in this community is a lack of recognition of psychological symptoms, so help may not be sought out as it is not even known what the problem is (Erickson & Al-Timimi, 2001; Aloud, 2004; Vermette et al., 2015). Part of this issue is the lack of distribution of health information within the Arabic language (Vermette et al., 2015). Furthermore, even in some cases when members of the Arab-American community wish to seek specialists, they are unsure to go about how to do so (Smith, 2011; Vermette et al., 2015).

Provider factors.

The most pervasive category of issues reported within the literature revolves around the disconnect between providers and Arab-American patients. At the very root of this issue lies three things: discrimination/bias, difference in expectation of therapy, and lack of training in cultural and religious competence specific to the community.

In a qualitative study conducted by Kulwiki and colleagues (2000), it was noted that Arab-Americans expressed dislike at their perception of disrespect towards their people and their culture by healthcare providers. This occurrence was not a baseless phenomenon, as a review of medical records of Arab-American patients concluded that health professionals had significantly negative attitudes towards them (Lipson, Reizian, & Meleis, 1987). Both patients and providers noted prejudice towards Arab-Americans as a salient barrier in a study conducted in Texas, not only directly from the providers, but also from other staff (Vermette et al., 2015).

Arab-Americans tend to have a high level of respect towards Western medicine and health practitioners, often leading to a deference of judgment to the practitioner who is expected to assume an "expert role" (Cross Cultural Health Care Program, 1996; Gorkin et al., 1985). This clashes with modern recommendations of more humanistic-influenced therapies which have a stronger client-focused nature. One of the clinicians the author interviewed noted that this clash of expectations between client and therapist styles had led to "…frustration [that] has led a couple of clients to sort off stop coming back" as the Arab-American clients "really want the clinicians to lead it." Gender is one therapist characteristic that can form a barrier in some cases. Due to the traditional value of women's modesty in some Arab cultures some may find it difficult to reveal information to their provider in general, and this can be amplified further if the provider is male (Yosef, 2008). One male therapist interviewed by the author noted that this had been reflected by his experience in therapy, and that female therapists seemed to have more "permission" in regards to sensitive topics such as love. However, in rebuttal to this point, one female therapist during the same interview noted that she had a client that shared more personal details than she had expected a male Arab to do. This is an especially important reminder that these cultural revelations should be taken cautiously, and adapted to the individual, or else therapists run the risk of offending the patient and forming another barrier.

The needs for culturally and religiously appropriate therapies have been brought into the mainstream focus after the Surgeon General's Supplement on Culture, Race, and Ethnicity formally acknowledged the existence of mental health disparities, but these needs still form a barrier to this day (Satcher, 2001). When the interviewed panel of mental health professionals were questioned about their training in reli-

gious and cultural sensitivity, they noted that it was mainly learned through their own motivation to study the topic. They clarified that religious and cultural sensitivity was not taught in their classes, especially in the case of religion. Most of the knowledge they gathered about the culture and religion of Arab-Americans was mainly through trial-and-error with patients and conversing with their interpreters, who formed a link to the community. This is troublesome as studies have repeatedly shown that a main barrier for Arab-Americans in seeking treatment is this lack of a common understanding of their culture (Aloud, 2004; Kulwiki et al., 2000; Reimann et al., 2007; Smith, 2011; Vermette et al., 2015). At the very root of this issue may be a mismatch of definition of "culturally competency" between caregivers and clients. Kulwiki and colleagues (2000) found that non-Arab health professionals defined "cultural competency" as treating everyone with the same degree of care, whereas Arab patients wished to be specifically treated with their culture in mind. Alongside this, religion can be a particularly important facilitator in gaining access to this population as some feel distanced from therapy due to its secular nature. This may be due to the spiritually affected illness conceptualizations of this population (Aloud, 2004; Bagasara & Mackinem, 2014; Smith, 2011).

ADDRESSING BARRIERS FOR FORMAL MENTAL HEALTH SERVICES

It is relatively simple to merely note barriers, but the work must not end there. These variables must be understood and dealt with in order to reduce disparities in this community. However, it must be stressed once again that judgment calls must be made when considering these implementations in some cases in order to avoid seeing patients as "just an Arab-American," when their presenting problems and goals could be unrelated.

Stigma.

Tying into the usage of the biological illness conceptualization as a mechanism to decrease stigmatization, this illness conceptualization could be emphasized when promoting educational materials in order to decrease stigma within the community as a whole (Aloud, 2004; Smith, 2011). This implementation could also target the tendency of Arab-Americans to prefer the medical model. Therapy settings within hospitals or medical settings could be recommended, or referred to by other organizations, in order to work within preferences of the patients and to increase the association with the biological illness conceptualization, therefore hopefully decreasing stigmatization (Gearing et al., 2012). Since Arab-Americans tend to prefer PCPs, and working within the model of somatization as a way to avoid stigma, perhaps PCPs can utilize a more comprehensive mental health battery or be made more aware of the somatization in Arab-American clients to direct them towards therapy (Aloud, 2004; Al-Krenawi & Graham, 2004; Hotopf et al., 2001; Vermette et al., 2015). If one was able to bring Arab-Americans into therapy, including more notions of family or family therapy may also be more useful due to the value system placed around family in Arab culture. This could decrease family stigma from attempting to circumvent the family structure (Abdubbah, 1996; Smith 2011). It is also essential that once they are in therapy, extra care should be taken when screening for interpreters to prevent the client from being stigmatized within the therapy room (Vermette et al., 2015). Due attention should be paid when it is known there is a small Arab community in the area, as it opens up the very real possibility the client and interpreter may know one another. It should also be noted that some have tried experimentally testing stigma reduction activities within the Arab-American community. Jaber and colleagues (2015) reported that a five minute stigma reduction exercise was not useful in decreasing stigma in a study of Muslim Arab-American adolescents, and so future research could be focused on if different types or lengths of exercises could be effective.

Structural.

Language.

Language is a central barrier to address. Language is a substantial component of culture, and psychotherapy is especially dependent on this exchange more so than perhaps any other healing field (Bernal & Saez-Santiago, 2006). Therefore, it is recommended that mental health treatment centers are allocated their own Arabic interpreters that speak the relevant dialect (Aloud, 2004; Reimann et al., 2008; Vermette et al., 2015). Due to the noted importance of affect and emotional connection by the mental health providers inter-

viewed, it is important to make all efforts to have this interpreter be present in therapy. However, it would be naïve to expect this without taking financial considerations into account. If hiring translators is not a viable option, or if efforts are being made to circumvent issues in affect during therapy, an emphasis on training and hiring Arabic-speaking professionals could be a useful intervention. Furthermore, although some authors have argued ethnic and linguistic matching is necessary, it seems realistic to expect therapists to at least have cultural and religious knowledge of the population in order to correctly serve them (Aloud, 2004).

Financial.

As a country, much must be done in order to make the landscape for mental healthcare more affordable. Greater care must be taken to return Medicaid applications within a specific time frame for individuals to know if they are insured or not. This is especially relevant to Arab-American populations, such as refugees or recent immigrants, who may be unfamiliar with the medical system in the United States due to sharp contrasts in comparison to the medical systems of their home countries (Vermette et al., 2015). Community health centers, such as the one where the author conducted an interview, can be very useful resources for those that do not have insurance. Efforts must be taken to better publicize and fund these resources as a safety net for those that are under-insured or not insured at all. Ease of transportation to these centers is also essential to circumvent the barrier of travel (Kulwiki et al., 2000; Reimann et al., 2007; Vermette et al., 2015). This may take the form of need-based prepaid bus passes, or reimbursal if there are no buses within reasonable range of the patient.

Informational.

Psychoeducation is key for this population as it is a noted issue that many do not have a good understanding of mental illness, of what roles the different mental health professions play, or of what therapy is (Erickson & Al-Timimi, 2001; Goforth, Pham, Chun, Castro-Olivo, & Yosai, 2016; Reimann et al., 2007; Smith, 2011). Another key informational barrier in this population is how the medical system works and how to apply for funding such as Medicaid or other sources of insurance (Erickson & Al-Timimi, 2001; Vermette et al. 2015). One possible intervention to explore is allocating more funding for the assistance of case workers or community outreach initiatives. This is supported by the fact that Stein and colleagues (2014) reported that community outreach centers noticed greater rates of engagement when there was dedicated staff to outreach. In order to mitigate stigma and increase psychoeducation in the community, a local mental health provider proposed that there should be:

I2: more group activities that are not necessarily direct therapy, but more socializing and provide more psychoeducation, so that our clients who don't understand what therapy is, what psychology is what mental health is, can get a better understanding

Language is essential even outside of therapy due to the possibility of language gaps in informational pamphlets. Therefore, care should be taken in offering information for mental illness as well as for the healthcare system. Providing information in the relevant dialects of the community applying to Medicaid ensures Arab-Americans have a working knowledge of these things. Refugee and immigrant populations should be offered the possibility to take a course on the healthcare system, roles of professionals, and applying to Medicaid to address this gap (Vermette et al., 2015).

Provider factors.

In order to address the perception, and reality, that some healthcare providers are prejudiced against Arab-Americans, the general public and physicians should learn more about the realities of Arab culture and religion to decrease stereotypes, misconceptions, and discrimination (Erickson & Al-Timimi, 2001; Goforth, Pham, Chun, Castro-Olivo, & Yosai, 2016; Kulwiki et al., 2000; Lipson et al., 1987). This also extends to staff in general, such as receptionists, as all are associated with the healthcare system (Smith, 2011; Vermette et al., 2015). Another approach is if therapy is not directly accessible to some is to bring the therapy to them. Since some patients do not recognize mental illness symptoms or simply prefer religious healing, perhaps religious leaders can be used as a resource by teaching them basic mental health awareness techniques and asking them if they would be open to referring clients to therapy (Aloud, 2004). The integration of mental health services with local religious centers could be useful in teaching

clients what therapy is and clearing misconceptions about it from within the community.

Due to the lack of enforced current education, as noted in the interview conducted by the author, it would be wise to begin integrating more in-depth learning about the culture and religions of the ethnic groups therapists are working with. Part of cultural competency training will need to place an emphasis on the definition of being treated differently because of the inclusion of their culture, and not just receiving the same therapy as everyone else (Kulwiki et al., 2000). In some cases, part of this cultural adaptation can even be the therapist simply adopting more of an "expert role" than a client-centered approach (Erickson & Al-Timimi, 2001). Modern efforts on tailoring therapies to include functions of religion and culture should be continued in order to assist breaching the barriers noted in this review (for an example of an adapted therapy, see Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). Flexibility may also need to be advocated on the side of the therapist if the client does not recognize or understand the differences in roles of mental health professionals. Furthermore, in some cases with this community, therapists must become more comfortable with some roles of a case worker in order to adequately address some very real needs of the community (Kim & Cardemil, 2011). Hopefully, if these efforts are met, current mental health disparities in the Arab-American population will decrease and more research will be conducted on this underserved group in the Western world.

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