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Pepperdine University
Graduate School of Education and Psychology

COUNSELING WITH IRANIAN-AMERICANS: A CRITICAL REVIEW OF THE
LITERATURE

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of
Doctor of Psychology

by

Crystal Saidi

May, 2014

Miguel Gallardo, Psy.D.-Dissertation Chairperson

This clinical dissertation, written by

Crystal Saidi

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

To my parents and my husband

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This dissertation could not have been completed without the guidance of my chairperson, Dr. Gallardo, and my committee members, Dr. Harrell and Dr. Shekarabi. I would like to express my sincere gratitude to them for all of their assistance throughout this process.

In addition, I would like to express gratitude to my parents, Nick and Susan Saidi, who emigrated to the U.S. from Iran in 1977 and have worked hard and sacrificed so much for me. Without them, none of this would be possible, and I hope I have made them proud. In addition, I would like to acknowledge my grandmother, Akram Ahmadi, who always dreamed of seeing me earn my doctoral degree, but unfortunately, did not live to see this day.

Finally, I would like to express love and gratitude to my dear husband, Ali Komaili, who has always supported and encouraged me. Thank you.

VITA
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- Provide on-call 24 hour emergency services 1 day per week as well as 3 weekends per semester
- Co-leader for Survivors of Sexual Assault support group
- Conduct outreach presentations to the campus community
- Diagnose a wide range of clinical disorders and devise short-term treatment plans using CBT interventions
- Make long-term referrals as well as psychiatry referrals when necessary
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- Participate in weekly intake disposition team meetings as well as group case conferences

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 - Administered psycho diagnostic tests and symptom inventories to clients and made medication evaluation referrals when necessary
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- 09/11-07/12 Clinical Psychology Extern, Otis College of Art and Design, Student Counseling Services
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 - Conducted psycho-educational workshops and outreach presentations
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 - Worked with clients whose diagnoses included brain tumors, leukemia, epilepsy, pervasive developmental disorders, mental retardation, ADHD, mood disorders, communication disorders, and learning disorders
 - Provided assessment feedback sessions to provide treatment planning and appropriate follow-up care for clients
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 - Participated in weekly multidisciplinary team meetings with physicians, nurses, and social workers to provide coordinated services
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 - Administered psychodiagnostic tests and symptom inventories to clients and made medication evaluation referrals when necessary
 - Diagnosed a wide range of clinical disorders and devised treatment plans using predominantly CBT interventions

RESEARCH AND TEACHING EXPERIENCE

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Presented at Titan Fitness Challenge, CSUF, Fullerton, CA
- 11/2012 *Healthy Eating and Positive Body Image*
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ACADEMIC HONORS AND AWARDS

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ABSTRACT

The present study is a critical analysis of literature regarding counseling with Iranian-Americans. This dissertation will provide an overview and critically analyze the existing relevant literature on the common mental health challenges Iranian-Americans face and how they are addressed in mental health settings. Special attention will also be paid to acculturation and cultural considerations that impact treatment. Based on the existing literature, strengths as well as limitations will be discussed, and suggestions will be made for future research in this area. This dissertation will conclude with recommendations based on the existing literature as well as this author's personal and professional experiences in order to improve clinical work with this population.

Chapter I. Introductory Literature Review

Iranian-Americans

Iranian immigrants comprise a growing ethnic group in the United States (Jalali, 2005). Iranians are defined as individuals from the nation of Iran or of Iranian descent (“Iranian,” 2013). Iran, which was known as Persia until 1935, is currently an Islamic Republic located in the Middle East region of Asia (Central Intelligence Agency, 2014). Iran primarily consists of ethnic Persians (61%); however, other groups include Azeris, Kurds, Lurs, and Turkic tribes (Central Intelligence Agency, 2014). The official language spoken in Iran is Farsi, but other languages spoken by non-ethnic Persians include Armenian, Kurdish, and Azeri. The Central Intelligence Agency (CIA; 2014) World Factbook states 99.4% of Iranians are Muslim, while other religious groups include Zoroastrian, Jewish, and Christian. This figure is significantly different, however, for Iranians living in the U.S. Iranian-Americans consist of a more varied mix of secular individuals and religious backgrounds represented include Agnostic, Atheist, Muslim, Christian (Armenian and Assyrian), Jewish, Baha’i, and Zoroastrian (“Iranian American,” 2012).

According to the 2012 American Community Survey of the U.S. Census Bureau, there are 472,114 Iranian-Americans residing in the United States, with 306,209 of those born outside of the U.S. (U.S. Census Bureau, 2012). However, the U.S. Census has undercounted many ethnic minorities, especially Iranian-Americans (“Iranian American,” 2012; Mostashari & Khodamhosseini, 2004). The estimated number of passports held by the Iranian Interest Section in Washington, D.C. was estimated to be 900,000 only a few years earlier. This discrepancy can be attributed to the fact that many Iranians are hesitant to participate actively in the Census due to distrust of the system (Sayyedi, 2011) as well as strained relations between the United States

and Iran (Kaeni, 2006). An additional reason is the fact that there is no specific box labeled “Iranian” which may cause some Iranian-Americans to mark *other* or *Caucasian*. Other estimates have placed the current number of Iranian-Americans close to 691,000 (Kaeni, 2006) and as high as nearly 2 million (Hojat et al., 2000; “Iranian American,” 2012). According to the American Community Survey of 2012, almost half of all Iranians in the U.S. reside in California. Other areas with significant Iranian-American populations include New York, the Washington D.C. metropolitan area (including Virginia and Maryland), and Texas (“Iranian American,” 2012). Iranian-Americans can be defined as Americans who are of Iranian ancestry or people possessing Iranian and American dual citizenship (“Iranian American,” 2012). For purposes of this literature review, the term Iranian-American will be used and refers to any individual now residing in the U.S. who was either born in Iran or has at least one parent born in Iran.

Due to the growing number of Iranian immigrants, mental health professionals are starting to realize the value of exploring the needs of this cultural group. However, there is still a need for continued research in order to better understand the needs of this specific group. In order to understand how to effectively work with Iranian-Americans, it is imperative to understand the community’s cultural characteristics and values.

Family. As is the case with a majority of cultural groups, the family is considered to be the most significant element in Iranian culture and it is central to one’s life (Ghazi-Moghadam, 2009; Jalali, 2005; Kaeni, 2006). Iranians tend to keep close ties with immediate as well as extended family. The father is typically the head of the household and there is particular respect paid to elders (Kaeni, 2006). Iranian families value “the harmony within an established patriarchy, avoidance of open conflict, the unconditional respect and deference to parents, and the indirect and figurative communication to maintain social hierarchy and family harmony”

(Sayyedi, 2011, p. 244). Although the culture is collectivistic in theory, it has been stated in the literature that Iranians tend to be more individualistic when compared to collectivist societies of other Asian groups (Sayyedi, 2011). Perhaps one explanation for this could be that Iranians “are a very competitive and individualistic society to some extent when it comes to pursuing careers and education, but when it comes to family relationships, are very collectivistic” (Monakes, 2011, p. 75).

Collectivism. As stated previously, Iranian culture is fundamentally collectivistic, in which attitudes, behaviors, family structure, and well-being are guided by loyalty to one’s family (Zandi, 2012). This is significantly different than the U.S. culture in which individualistic beliefs and behaviors are the norm (Zandi, 2012). Stated broadly, individualism can be described as viewing the self as an autonomous individual, while collectivism can be described as viewing self as “embedded in a larger collective and in a rubric of complex relationships” (Hadizade, Mohammadipour, & Mesbahi, 2013, p. 71). Iranians typically learn at a young age that cooperation between group members is crucial and that collective goals are achieved by every member of society knowing and understanding their place within the larger group as a whole (Zandi, 2012). Iranians tend to communicate in a “restrained manner” (Zandi, 2012, p. 14) which is meant to maintain coherence within a group, or family. This style of communication tends to be high in context versus direct or literal meaning, which is meant to maintain the value of interpersonal peace and harmony.

While there were no studies found that specifically examined collectivism in the Iranian-American community, a recent study by Hadizade et al. (2013) examined the differences between collectivistic and individualistic tendencies between different age groups in Iran. The researchers classified individualism and collectivism into four distinct categories based on

Triandis's typology of individualism and collectivism: *horizontal individualism* (self is independent and the same as others), *vertical individualism* (self is independent and different from others), *horizontal collectivism* (self is interdependent and the same as others), and *vertical collectivism* (self is interdependent and different than others). In their study of 164 Iranians, ages 15-86, they found that horizontal individualism was highest in the youngest age group (15-20) and horizontal collectivism was highest in all other age groups (21-35; 36-50; 51 and up). The researchers measured individualism-collectivism by using the Individualism-Collectivism Scale by Triandis and Hui, which consists of 66 Likert-scale items used to assess an individual's level of collectivism by measuring attitudes and behaviors toward six relational domains (Hadizade et al., 2013). Although the sample size in this study was small, the results suggest that the younger generation in Iran is slowly moving toward a more individualistic tendency. It would be beneficial to further study this phenomenon in order to fully understand where Iranians and Iranian-Americans stand on the individualism-collectivist spectrum.

Education, achievement, and pride. Iranian-Americans highly value education and achievement, and obtaining higher education is a significant source of pride (Jalali, 2005). Iranian-Americans have been recognized for their high achievements in fields such as medicine, engineering, and science (Sayyedi, 2011) and a study on 67 immigrant groups in the U.S. found that Iranian-Americans are the most highly educated ethnic group, with more than one in four Iranian immigrants over the age of 25 holding an advanced degree (Mostashari & Khodamhosseini, 2004). Iranians have also adopted unique cultural characteristics to ensure their self-preservation and to cope with the political instability and tumult over the years (Jalali, 2005). Iranians both accept authority and indirectly resist it at the same time, and most Iranian leaders have been authoritarian in nature. Often times, Iranians tend to be very proud people

who believe in their uniqueness, while being “nostalgically tied to the past” (Jalali, 2005, p. 453). Their sense of pride may also appear at times as “boastfulness, impatience with learning, and difficulty in admitting mistakes” (Jalali, 2005, p. 453).

History of Iranian-American Immigration to the United States

Iranians are a relatively new immigrant group in the United States, and their immigration history can be categorized into four phases. The first phase (1950-1970) consisted of individuals predominantly from large cities. These individuals tended to have a general understanding of Western culture, were highly educated and wealthy, and belonged to the elite and professional upper –middle class. Many of these individuals were physicians, engineers, or scientists and their skills gave them the opportunity to adapt well to their new culture (Jalali, 2005).

The second phase of immigration (1970-1978) consisted of individuals who came from various social classes. Similar to the first wave, most of these individuals were professionals that were in good standing to gain employment in the United States. Thirty percent of these individuals held advanced degrees, including 10% who were physicians. The predominant reason for migration in this phase was economics, although a minority of these individuals immigrated for political reasons. Second wave immigrants currently reside all across the United States, with the highest numbers in the Northern, Eastern, and West Coast urban hubs (Jalali, 2005).

The third phase (1978-1984) came either immediately before or immediately after the Iranian Revolution. This group was more varied in terms of education and age, although most tended to be affluent. Unlike the first two waves, most individuals in this group did not immigrate by choice. Similar to any group who is forced to flee their homeland for political or economic reasons, this group of Iranians experienced “culture shock, alienation, frustration with their families, and depression in adjusting to life in the United States” (Jalali, 2005, p. 452). The

future appeared uncertain for these individuals and many still maintained thoughts of returning to Iran one day (Hojat et al., 2000). Unfortunately, many lost their social positions and could not practice their previous professions (Jalali, 2005).

The fourth phase of immigration (1984-present) constitutes an even more diverse group of Iranians that continue to immigrate to the United States. These individuals tend to be disenchanted with the current political and economic conditions in Iran, namely lack of religious freedom and lack of educational opportunities for the rapidly growing younger generation (Jalali, 2005). This wave of immigrants is still fairly new, and thus less research has been conducted on this particular group. Jalali indicates that this group tends to be more heterogeneous in terms of socioeconomic status when compared to previous groups of immigrants.

Acculturation

Iranian's adaptation to American culture can range between acculturating and holding onto the old culture (Jalali, 2005). At times, Iranian-Americans preserve aspects of their culture no matter how American they may appear. Iranian immigration to the United States is still relatively new and thus it is currently unclear how these patterns will develop over the years (Jalali, 2005).

Acculturation has been defined in numerous ways. One such definition describes acculturation as the process through which an individual adapts to a culture different from the one in which he or she was born and raised (Ghaffarian, 1987). There are also many different models that explain how acculturation takes place. There are typically two major issues that immigrant groups and individuals struggle within their daily encounters. These issues include *cultural maintenance* and *contact and participation*. Cultural maintenance refers to the extent to which cultural identity and characteristics are considered to be important and thus maintained.

Contact and participation refers to the extent to which immigrants become involved in other cultural groups (Berry, 1997). Considering these two concepts, Berry (1997) developed a conceptual framework that hypothesizes four acculturation strategies. These four strategies include: assimilation, separation, integration, and marginalization. Assimilation is when individuals do not wish to keep their cultural identity and seek out daily interaction with individuals from other cultures. Separation refers to individuals placing a high value on their original cultural identity and avoiding interaction with others. When there is an interest in both maintaining one's original culture and interacting with other groups, this is labeled as integration. The concept of integration also corresponds with the notion of *biculturalism*, which can be defined as an individual being simultaneously involved in two cultures that are in contact (Berry, 1997; LaFromboise, Coleman, & Gerton, 1993). The last strategy, marginalization, is when there is little to no interest in maintaining the original culture (often for reasons of enforced cultural loss) nor adopting the mainstream culture and interacting with other groups (often for reasons of exclusion or discrimination) (Berry, 1997).

The acculturation process is different for each individual, and can occur either quickly or slowly. It can be a stressful experience for individuals and families. Interpersonal conflicts may occur as a result of differential acculturation among individuals or changes in family structure and gender roles. Certain individuals find that they can adapt to their new culture with ease, while others struggle to let go of their old values and ideas. Attitudinal changes are among the inevitable outcomes of acculturation (LaFromboise et al., 1993). Forming new attitudes as a result of acculturation can be normal; however, tension can result if the new beliefs are perceived to be at odds with the old beliefs and intergenerational conflicts ensue (Hojat et al., 2000; Jalali, 2005). In the United States, family relationships remain important to Iranian-Americans;

however, they have undergone drastic changes, including more distant family ties (due to extended family not being physically available). In addition, fathers retain a portion of their traditional authority, while mothers juggle new social freedoms with traditional responsibilities in the home (Jalali, 2005).

The first wave of Iranian immigrants adjusted fairly easily to the new culture, due in part to their previous exposure to the West. In addition, their wealth and education allowed them opportunities to become financially stable in their new environment. Many immigrants in this first wave married Americans; however, it was found that Iranians who married other Iranians tended to “do better” (Jalali, 2005, p. 460), particularly if they were well educated. For second wave immigrants, many were initially excited about immigrating, but later began to miss their home country and extended family and felt isolated in the new culture. The second wave immigrants tend to be especially prone to intergenerational conflicts, with children often attempting to dissociate themselves with Iranian culture, ridiculing their parents, and rejecting Iranian values. Fathers especially are threatened by these behaviors and may blame the new culture for these difficulties. Second wave families are also prone to marital conflicts due to the social freedoms wives are provided with, which may threaten traditional husbands (Jalali, 2005). The third wave Iranian immigrants are highly susceptible to developing psychological difficulties. This is primarily due to the disruption of family unity and integrity by having to flee their homeland. This group’s traumatic arrival into the new culture has often seen disappointment, failure, financial struggle, and hopelessness (Jalali, 2005). The fourth wave of immigrants are a relatively new group and while Jalali did not elaborate on acculturation difficulties they may encounter, one can hypothesize that this group may experience a cross between what the second wave and third wave immigrants experienced. In other words, these

groups of immigrants tended to migrate by choice and are likely to have had more time to prepare (similar to second wave); however, their reasons for leaving Iran are generally not positive (i.e. lack of political and religious freedom) and they may experience ambivalent feelings toward leaving their home country and coming to the U.S. In addition, this group of immigrants has been in the U.S. for the least amount of time, and thus has had less exposure to Western culture and may be less likely to assimilate.

Given the fact that the acculturation process can pose many psychosocial stressors for immigrants, it is critical to further study acculturation and the impact it has on Iranian immigrants. While the literature is currently limited, there have been several studies on acculturation in Iranian-Americans and a few that have found that acculturation, specifically assimilation and/or integration, are positively correlated with better mental health in Iranian-Americans (Ghaffarian, 1987; Ghaffarian, 1998; Kadkhoda, 2001).

Acculturation and mental health. A study conducted by Kadkhoda (2001) investigated the relationship between acculturation, acculturative stress, and levels of depression and anxiety in Iranian-Americans living in Los Angeles. The results revealed a significant positive relationship between cultural resistance and levels of depression, anxiety, and acculturative stress. In other words, it was found that the more an individual resists the acculturation process, the more they experience stress, anxiety, and depression. Consequently, the more an individual adapted to and acquired the customs of American culture, his or her levels of depression and anxiety were decreased (Kadkhoda, 2001). These findings appear to be in contrast to other cultural groups and one hypothesis for this is that Iranian culture is significantly different than U.S. culture. Due to significant cultural differences, adjustment difficulties may arise if immigrants resist assimilation or adoption of the new society's traditions and values. If Iranian-

Americans strive to separate themselves or resist assimilation, they may not “fit in” (Ghaffarian, 1998, p. 650) and therefore experience stress that can lead to emotional and psychological difficulties. Those Iranian-Americans who adopt U.S. cultures, beliefs, and behaviors are likely to have improved mental health since they are more comfortable in the new culture, and thus are likely to not experience as much stress (Ghaffarian, 1998). Another possible hypothesis for this is that due to strained relations between Iran and the U.S., many Iranians may try harder to assimilate and in a way prove themselves to be proud American citizens, in an effort to distance themselves from negative stereotypes (i.e. Hostage Crisis). This phenomenon will be further discussed in chapter 3, as it is an important factor in Iranian-American identity development.

Another study of 238 Iranians living in Los Angeles (Ghaffarian, 1998) found that as cultural resistance (or separation) increased, mental health difficulties (i.e. anxiety and depression) increased as well. More specifically, people who did not acculturate and resisted change, usually experienced adjustment problems and depression. It was also found that men scored lower on the cultural resistance survey, indicating a willingness to incorporate American culture into their lives. Ghaffarian defined acculturation as the process of adjusting to a new culture and an acculturated individual was considered one who assimilated into the host society. The findings of this study support both the melting pot hypothesis and the bicultural hypothesis. The melting pot hypothesis predicts that the more immigrants hold onto their native culture (and thus separate themselves from the host culture), the more they will experience acculturative stress as well as adjustment problems (Ghaffarian, 1998). The bicultural hypothesis indicated that immigrants who can identify with both their native culture as well as the host culture will have the healthiest adjustment. The author in this study hypothesized that individuals who integrate (or become bicultural) will most likely experience the least levels of distress and

adjustment difficulties. By integrating both cultures, they will be able to not feel “alienated from Iranian society” (Ghaffarian, 1998, p. 651) while also being comfortable in mainstream U.S. society.

Acculturation in older Iranian-Americans. Ghaffarian’s (1998) study indicated that higher levels of assimilation as well as higher levels of cultural integration (biculturalism) were both correlated with better mental health. Her study also found that older Iranian-Americans were more likely to resist cultural change or engage in the separation process. In other words, as age increased, so did scores on cultural resistance (separation), which in turn signified poorer mental health. She found that older immigrants assimilate at a slower rate than their younger counterparts and rely more on their “past experiences and not as much on new learning experiences and therefore adjust less easily to the ways of the new society” (Ghaffarian, 1998, p. 651). Given that higher rates of separation or cultural resistance were found to be correlated with lower levels of mental health (i.e. more psychological and emotional difficulties), it is particularly important for older Iranian-American immigrants to receive culturally responsive mental health services. However, it is also important to recognize that this group is typically more hesitant to seek services due to feeling a sense of shame (Raofi, 2011).

Acculturation differences between genders. In another study by Ghaffarian (1987), 110 Iranian college students in Los Angeles were surveyed and an interesting paradox was found in regards to acculturation. She defined acculturation as the “process through which an individual adapts to a culture different from the one into which he or she was born” (Ghaffarian, 1987, p. 565). Ghaffarian’s study showed that Iranian men in Los Angeles were more assimilated than Iranian women and thus experienced less depression and anxiety. Iranian men accepted American values more than the women did because they had been accustomed to freedom, self-

determination, and exposure to the Western world even while they were still in Iran. The women, on the other hand, did not previously enjoy these freedoms, and were trying to adapt to a completely new social environment after moving to the United States. In other words, Iranian men did not need to greatly alter their roles after moving to the United States, while Iranian women did (Ghaffarian, 1987). A discrepancy was found when the subjects were asked about traditional values. The study showed that although Iranian men appeared to be more acculturated, they still kept their traditional values regarding the role of women (i.e. females being inferior to males in certain respects). In contrast, the women had acculturated less and held onto traditional behaviors, but had modern values concerning the role of women. For both sexes, their values were found to be contrary to their behavior. This discrepancy between the men and women regarding the role of women often leads to conflict between couples, and is perhaps a significant factor in the increasing divorce rate for Iranian-Americans.

One of the most sensitive areas where there is contrast between “Western” and Iranian values is in the interaction of Iranians with the opposite sex and their attitude towards dating, intimate relationships, and gender roles (Hanassab & Tidwell, 1996). One study in particular was aimed at exploring the acculturation process for Iranian young women in the Los Angeles area and the impact this had on their attitudes toward gender roles and intimate relationships (Hanassab, 1991). In this study, acculturation was defined as “the process through which an individual adapts to a culture different from the one into which he or she was born” (Hanassab, 1991, p. 11). Hanassab studied the extent of Iranian women’s acculturation into the American culture, their attitudes toward the role of women, and their attitudes toward intimate relationships. The main hypothesis of the study was that more acculturated Iranian women would have more liberal attitudes and the less acculturated women would have more

conservative attitudes, which was proven to be true. This could be due the fact that attitudes toward women's roles and intimate relationships are more liberalized in the United States, so the young Iranian woman who is more closely identified with the mainstream culture (highly assimilated) is more likely to have liberal attitudes concerning the roles of women and intimate relationships. In addition, a significant negative relationship was found between the age of the individual when she left Iran and her acculturation level. Thus, the younger the individual was when she left Iran, the higher her acculturation level tended to be (Hanassab, 1991). The reason could be that the younger the individual, the less shaped her identity is, and, therefore, the more flexible she is to change. This finding was also supported by Nourian's (2012) study in which younger age of emigration resulted in higher levels of acculturation (specifically, cultural shift, or assimilation).

Contrary to Ghaffarian's (1987) findings, Nourian (2012) found that Iranian men living in Los Angeles did not report significantly higher levels of acculturation when compared to Iranian women. This can be explained by the fact that these studies were conducted almost 25 years apart. In more recent times, Iranians have had more time to adjust to the U.S. culture and women have had more time to adjust to their new gender roles. In addition, both studies used different measures to study acculturation. Ghaffarian used Mendoza's Cultural Life Style Inventory while Nourian utilized Shahim's Iranian Acculturation Scale, which is the first known acculturation scale designed specifically for Iranians. While the creation of an acculturation scale for Iranians is necessary, this scale was sampled on Iranians living in Toronto, Canada and thus may not be representative of Iranian-Americans. In addition, Nourian states that despite adequate reliability and validity, it is "not a well-established measure and has not been frequently

used” (Nourian, 2012, p. 54). In the future, it would be clinically beneficial for the establishment of a reliable and valid acculturation scale appropriate for use with Iranian-Americans.

Overview of Common Concerns

In general, when any immigrant is adjusting to a new culture, it may lead to psychological and emotional problems (Ghaffarian, 1998). This is precisely why is it imperative to study individuals who come from different cultural or ethnic backgrounds. In mental health counseling settings, Iranian client’s problems predominantly involve acculturation difficulties (discussed in the previous section), intergenerational conflicts, and gender role expectations (Ghazi-Moghadam, 2009; Hanassab & Tidwell, 1996; Kadkhoda, 2001; Kaeni, 2006). Of course, these issues can lead to other mental health concerns as well, such as: depression, anxiety, substance abuse and adjustment disorders.

Gender roles. Iranians who move to the United States often times experience difficulty adjusting to their expected roles as men and women. Traditionally, courtship and marriage rituals in Iran are extremely different than in the United States. The roles of women and men tend to be traditional. In any society there are prescribed roles for men and women, but in Iranian culture, these roles are very distinct. In fact, a study by Sharepour (2005) revealed that there are one-sided and exaggerated images of men and women among Iranian adolescents and that gender role stereotypes prevail among them, especially boys. For example, a majority of the boys surveyed believed that women should enter culturally sex-appropriate jobs (i.e. nurse or social worker) and leave the politics and high-ranking positions to men (Sharepour, 2005). These ideas and stereotypes, in turn impact the quality of relationships between Iranian men and women. Since women who live in the United States often have more liberal and egalitarian values, many Iranian men resort to the traditional arranged marriages and ask their relatives to

find them a partner from Iran (*khastegari*) to be brought here as a domestic spouse (Hojat et al., 2000). These men believe the women in the United States to be “Americanized” or “poisoned by the west” (*gharbzadeh*) (Hojat et al., 2000, p. 429). Many of these men expect a woman to be a *khanoum* (lady) who conforms to Iranian society’s ideals of being *najeeb* (chaste) and *sar-be-zeer* (submissive) (Rashidian, Hussain, & Minichiello, 2013). In turn, many of the women believe these Iranian men are old-fashioned (*ommol*), regressive, and retarded in adjusting (*aghahmondeh*) to the new cultural and social environment (Hojat et al., 2000). For the Iranians who live outside of Iran, more specifically in the United States, relationships and marriages are often strained because of cultural or gender role conflicts. For example, the divorce rate among Iranians living in Iran has been reported as approximately 10% (Hojat et al., 2000). Interestingly enough, the divorce rate for Iranians living in the United States and other Western countries has been approximated to be as high as 66% (Hojat et al., 2000). Clearly, this indicates a need to take an in-depth look at this issue in order to find ways to improve relationships for Iranian-Americans. In addition, it would be beneficial for future research to look into these areas currently, as approximately 14 years have passed and these figures are likely to have changed.

Intergenerational difficulties. Intergenerational conflicts are also of particular concern for Iranian-Americans and children’s ability to cope with their new environment ultimately depends on their parents’ ability to adapt to the new culture. Children of immigrants may often feel shy, avoid peer relationships, or may develop academic problems and language difficulties, which can lead to depression and anxiety (Jalali, 2005). Iranian parents are typically attentive to meeting their child’s needs for “comfort, safety, and success” (Sayyedi, 2011, p. 244). However, in return, parents expect the child to be unwaveringly loyal to them, even after they have married and established a family of their own. Traditionally, Iranian parents are overprotective and often

rely on shaming or emotional control to discipline their children. In addition, families often emphasize interrelatedness and the individuation process is only supported with respect to academic or career endeavors. When children perform poorly in school, this can shame the family and often becomes a significant source of conflict between parent and child. This, of course, can lead to strained relationships between the two generations.

Impact of Iranian Culture on Treatment

In order to work effectively with Iranian-Americans, clinicians must fully understand the concepts of acculturation, intergenerational conflict, and gender role expectations as these are common concerns Iranian-American clients often present with. In addition, it is imperative for clinicians to become familiar with Iranian culture and values as well. When a clinician is not familiar with Iranian's cultural expression of stress and distrust of outside helpers, this often leads to misunderstandings (Jalali, 2005). This can also cause ruptures in the therapeutic relationship, leading to less effective therapeutic work or perhaps early termination.

Iranians tend to believe there is an inner self, which is guarded strongly and only revealed to people that are very close, and an outer self, which is what is presented to the rest of the world (Jalali, 2005). Often times, the outer self may appear well-adjusted and psychologically healthy, while the inner self is not. Non-Iranian mental health professionals should take into account these concepts and anticipate that it may take a longer amount of time to truly get to know their Iranian client.

In addition, problems are often expressed through somatization, such as aching, racing, pain, and discomfort of the heart (Holakouee, 2011; Jalali, 2005). Often times, these heart-related symptoms can be traced to interpersonal problems and stress. Weak nerves, shaking hands, lack of sensation, and numbness may also indicate depression or anxiety. In addition,

Iranian clients may present with general body pain, digestive issues, weak stomach, weak liver, weak limbs, exhaustion, and lack of strength. If one is not familiar with Iranian culture and the tendency to somaticize, a clinician is very likely to misdiagnose. Ghadisha (2004) posits that Iranian clients may present with somatic complaints due to an inability to verbally communicate their distress. In addition, in collectivistic societies, concern for others is often valued over individual autonomy and to express emotional conflict would disrupt group harmony and expose personal weakness. Consequently, psychological problems are often stigmatized while medical or physical complaints are responded to with attentiveness and care. Therefore, individuals from collectivistic cultures, such as Iranians, may suppress emotional distress and find the support they need through physical expression of their pain. Iranian clients may also present with physical symptoms since they believe these are more socially acceptable compared to psychological difficulties (Holakouee, 2011). Holakouee (2011) suggests that clinicians make sure to assess for somatic symptoms in order not to miss potential emotional distress, either through questioning during an intake or by using a standardized instrument. A study by Rouhparvar (2000) found higher levels of somatization were found more often in individuals who resisted acculturation, while lower levels of somatization were found more often in bicultural or assimilated individuals. Ghadisha (2004), however, found that higher levels of perceived stress were associated with more somatic symptomology but contrary to expectations, no correlation was found with acculturation. It is important to note that these differences could be due to the fact that using English only instruments can potentially exclude less assimilated individuals from the study, thus skewing results. Overall, these findings suggest a potential relationship between acculturation and somatization, and clinicians should be mindful of this when assessing for symptoms.

Iranians may also explain their problems by attributing them to outside events, people, or forces, such as grief, academic difficulty, or relationship trouble. Often, a triggering event is seen by the individual as well as the family as the lone cause of their current problems. They often fail to see the larger factors that may have played a role in their current psychological distress (Jalali, 2005). Most Iranians may turn to a trusted family member or friend during these times and only go to an outside helper as a “last resort” (Jalali, 2005, p. 461). Many Iranians tend to be ambivalent or mistrusting of mental health professionals, although in certain instances they may form a special relationship with a doctor and even believe they have special healing powers. According to Jalali, Iranians are known to be doctor shoppers and may go to several different doctors in order to obtain their desired outcome. In addition, Iranian clients may not always be compliant with orders, and this should not be taken as a sign of rejection (Jalali, 2005). Ghazi-Moghadam (2009) also warns clinicians to be aware of potential “skepticism” or “lack of trust” (p. 62). She adds that Iranian clients may lack trust in the helping profession and in sharing their personal problems with a stranger, which Ghazi-Moghadam attributes to the tumultuous socio-political history of Iran. Given the traumatic history that many Iranians have faced, it is important for clinicians to “not pathologize such cultural paranoia” (Nili, 2013, p. 103). Many Iranians have learned to censor topics that might bring threat of legal implications, and thus it is difficult for them to quickly change from the mindset of protecting themselves. Mental health professionals should be aware of and sensitive to this.

Mental health professionals working with this population should also be sensitive to different rates of acculturation that could also contribute to strained relationships in Iranian-American families. Clinicians should be aware of traditional family hierarchy, gender roles, power structure, and roles of each member of the family (Hanassab, 1991). They should also be

mindful of the acculturation rate of an individual so that they do not misdiagnose or label according to mainstream U.S. norms. When working with this population, one should try to understand the impact of immigration and attempt to assist clients in finding their own degree of acculturation, whether that is assimilation, integration, or even separation.

Treatment Modalities

While it is imperative for clinicians working with this population to be mindful of the cultural factors mentioned in the previous section, there has been no one specific mode of treatment that has been deemed “best” for working with Iranian-Americans. A study by Kaeni (2006) found that many therapists believed there were “no limitations of Western psychotherapy and theory for working with children and adults; however, they all stated that it has to be modified to fit the culture” (p. 73). The example Kaeni provided in regard to modifying treatment was for clinicians to emphasize interdependency over independency. In other words, clinicians should try to focus on the client in the context of their family and help them do well in that context. Iranian mental health professionals who worked with Iranian-American clients indicated using CBT, psychodynamic and family systems interventions. One therapist in this study stated that family systems therapy is especially important to use with this population since family is of utmost importance in Iranian culture (Kaeni, 2006). Other studies have found that there are preferred modalities of treatment when working with Iranian-Americans. For example, Ghazi-Moghaddam (2009) found that Iranian therapists working with Iranian-Americans indicated receiving better results when using a Cognitive-Behavioral Therapy (CBT) or Solution-Focused mode of treatment. The reason for this is that Iranian clients in this study were found to be more solution focused versus process-oriented and preferred a “short and quick approach” (Ghazi-Moghaddam, 2009, p. 67). The study also revealed that Iranian-American clients often

times are “less patient” and prefer a model of treatment in which the therapist gives “clear and concrete goals for them to follow in order to resolve problems” (Ghazi-Moghaddam, 2009, p. 68). This study also found that Iranian-American clients are very receptive to the idea of changing their way of thinking in order to reduce psychological distress, which of course aligns with the principles of CBT treatment.

Purpose of Literature Review

Currently, there is limited published psychological research regarding Iranian-Americans. In fact, it has been stated that “Iranians are one of the least studied immigrant groups in the United States, despite possessing significant amounts of psychological distress” (Saedi, 2010, p. 137). As many Iranians now reside in the United States and are faced with various emotional and psychological difficulties, more research needs to be conducted. As previously stated, it is crucial for mental health professionals to be familiar with and understand cultural issues that Iranian-Americans may present with. Counseling and family therapy with Iranians in the United States poses a challenging problem for mental health professionals who are not familiar with Iranian cultural values (Hojat et al., 2000). It is important to understand acculturation, common concerns Iranian-Americans present with, as well as cultural values they hold. It is also important to explore existing data and literature regarding special populations (i.e. families, couples, older adults) and specific treatment modalities that have resulted in successful treatment with this population. Thus, the purpose of the present literature review is to explore and critically analyze the existing literature regarding psychotherapy with Iranian-Americans in order to provide clinical guidelines for mental health professionals working with this population.

Chapter II. Review and Analysis Procedures

Introduction

This chapter presents all aspects of the research methodology, including review procedures such as identification and collection of relevant literature and analysis procedures such as finding strengths and weaknesses, synthesizing general findings, and making clinical recommendations based on the current literature.

Review Procedures

Identification of relevant literature. For purposes of this analysis, the primary search tools that will be utilized include: PsycINFO electronic database, Science Direct electronic database, Sage Publications electronic database, University library catalogue holdings (e.g. Pepperdine University), and ProQuest Dissertation and Theses online database. These sources will be utilized in order to maximize the collection of relevant literature, and this review will utilize quantitative and qualitative journal articles, dissertations, and relevant books.

The following key words will be utilized in the search process in order to maximize the collection of relevant literature: *Iranian-American, Iranian, Counseling Iranian-Americans, Therapy with Iranian-Americans, Acculturation, Collectivism, Gender Role Stereotypes, Depression among Iranian-Americans, Anxiety among Iranian-Americans, CBT with Iranian-Americans, Solution-Focused Therapy with Iranian-Americans, Family Therapy with Iranian-Americans, Marital Satisfaction in Iranian-Americans, Iranian-American Older Adults, Future Directions for Counseling with Iranian-Americans, Iranian-American Immigration.*

Literature published before 2000 was excluded as the focus is on analyzing salient characteristics and values, as well as current trends in counseling with Iranian-Americans.

However, pre-2000 publications may have been cited if they were considered historical or significant pieces in the literature. As this dissertation is specific to Iranian-American mental health and trends in counseling, literature involving Iranian immigrants in other countries was excluded. In addition, although expanding the search to include *Middle Eastern* would have resulted in significantly more literature, this author chose to exclude those studies. This is due to the fact that even though Iran is in the Middle East in terms of geography, it is significantly different than other nations of the region in that the official language is Farsi, rather than Arabic. In addition, Iranians are “proud people who believe deeply in their uniqueness, which is rooted in their history” (Jalali, 2005, p. 453). This uniqueness is due to the fact that Iranians have survived several foreign invasions throughout the course of history and still managed to absorb cultural influences without losing their own identity and continuity (Jalali, 2005). Even when Islam was assimilated into Iranian culture, Iranians opted for a new branch of Islam, called Shiism. This differentiates them from most of the Muslims of the Middle East, who are Sunni Muslim (Jalali, 2005).

Collection of relevant literature. Literature relevant to this analysis will be gathered in several ways: articles and dissertations from electronic databases will be downloaded or printed and books or book chapters will be borrowed from Pepperdine libraries.

Analysis Procedures

All of the literature will be read thoroughly and placed in electronic folders organized in multiple categories relevant to this analysis. An outline will be created to highlight each category, and main ideas from different pieces of literature will be written to develop ideas. These steps will help to integrate and formulate a critique of the literature.

Review and Analysis of Literature

This section will analyze the strengths and weaknesses found in certain individual pieces of literature, as well as in the literature as a whole. For example, with empirical studies, issues related to the study design and methodology will be addressed, as well validity of the study findings and ability to generalize findings to the Iranian-American community. In addition, qualitative studies and literature reviews are analyzed with regard to their comprehensiveness concerning counseling with the Iranian-American population. The author has defined comprehensiveness as how sensitive the studies are in regard to attention paid to acculturation levels, gender roles, and cultural considerations in counseling in Iranian-Americans.

Synthesis of General Findings

This section will outline major themes present in the literature pertaining to counseling with the Iranian-American population. It will highlight any significant commonalities as well as differences found in the literature.

Clinical Recommendations Based on Literature

Recommendations for culturally responsive counseling with Iranian-Americans will be made based on current interventions and relevant findings from literature. In addition, areas of the research that require further study will also be discussed.

Chapter III. Review and Analysis of Literature

Introduction

The goal of this chapter is to provide a comprehensive review of and analyze the existing literature regarding counseling with Iranian-Americans. First, a brief introduction will review Iranian-Americans in general including factors that contribute to their identity. The chapter will then discuss common concerns that Iranian-American clients may present with in therapy. Next, the chapter will focus on specific treatment modalities that have been used with Iranian-Americans. Finally, the chapter will end with a focus on specific populations of Iranian-Americans, as well as special cultural considerations for the population as a whole, including strengths and sources of resilience.

Iranian-Americans. As stated in chapter 1, Iranian-Americans are a growing ethnic group in the United States (Jalali, 2005). However, despite the fact that they are a growing group, the literature regarding Iranian-Americans does not appear to reflect this fact. This could partly be attributed to the fact that there are varying estimates on the exact number of Iranian-Americans, ranging from 472,114 to nearly 2 million (Hojat et al., 2000; U.S. Census Bureau, 2012). As discussed in the introduction, explanations for this discrepancy are the lack of a specific box labeled “Iranian” on the Census, as well as hesitation to identify as Iranian which could be due to strained relations between the U.S. and Iran (Kaeni, 2006).

Ethnic identity development. There have been few studies that have carefully examined Iranian-American ethnic identity development and reasons for why they may identify as Iranian or not. Ethnic identity can be broadly defined as an “individual’s subjective experience of belonging to an ethnic group” (Syed et al., 2013, p. 143). Asayesh (2006) suggests that for most Iranians, race or ethnicity was not an issue in Iran. She describes Iran as a color-blind society

because for the most part, everyone is the same color. She states, “I grew up thinking I was white. When I moved from Iran to America, I discovered otherwise” (p. 12). Mobasher (2006) states that the question of identity is a complex and even problematic issue for Iranians living in the U.S., with some calling themselves Persian, others Iranian, and some Iranian American. He argues that prior to the Hostage Crisis of 1979, “informed Americans considered Iran an ancient civilization with a rich cultural heritage and viewed Iranian immigrants as a professional group that had made great educational and medical contributions to the United States” (p. 111). He suggests that the hostage situation was the start of the first anti-Iranian sentiment which revealed a new image of Iran, Iranians, and Islam. Mobasher described several ways that Iranian immigrants cope with the discrimination and negative images, including withdrawal from mainstream society, or “passing” (p. 112).

Mobasher (2006) describes “passing” (p. 112) as altering physical appearance or adopting Americanized versions of Iranian names, or even calling oneself Persian rather than Iranian. In an exploratory study on Iranians in Southern California, Mostofi (2003) also discusses *passing* and adds that many Iranians now resort to “plastic surgery, fake contact lenses, dyed hair, and various other cosmetic changes to ‘Whiten’ themselves and construct a new identity to facilitate their assimilation and economic success” (p. 694). Mostofi did not provide any statistics on the prevalence of cosmetic surgery, however, she did state that “for Iranian Americans, the ‘whiter’ the body, the more attractive the appearance, the greater the ability for assimilation of the public face, which translate to success” (p. 694).

In regard to identifying oneself as Persian rather than Iranian, Mobasher (2006) adds that adopting the label of Persian helps one avoid discrimination associated with the Islamic regime. By emphasizing the golden age of the Persian Empire and pre-Islamic celebrations such as *Noruz*

(Persian New Year) and *Chahrshanbeh Souri* (traditional bonfire before New Year), Mobasher suggests that Iranians are able to decrease the stigma attached with the Islamic Republic of Iran. By the creation of what Mobasher labels a *Persian ethnic identity*, Iranians in the U.S. have built a strategy to oppose the backlash against Iran and build solidarity. Mobasher emphasizes the fact that Iranian immigrant ethnic identity is far more than just national origin—it involves religious and political factors as well. He suggests that future research on ethnic identity construction among Iranian immigrants be conducted in order to better understand this issue. It would also be beneficial to study different sub-groups of Iranians, such as Jews, Baha'is, Zoroastrians, Kurds, and Christian Armenians.

Another study on Iranian American identity by Daha (2011) aimed to take an in-depth look at contextual factors that lead to ethnic identity development in second generation Iranian-American adolescents. Studies have shown that Iranian immigrants have brought with them a strong sense of cultural identity, family connectedness, and ethnic values (Jalali, 2005; Kaeni, 2006; Ghazi-Moghadam, 2009). However, in addition to these factors, they have also faced racism and prejudice that have stemmed from the Iranian Hostage Crisis as well as the attacks on 9/11; despite no proven Iranian involvement in the 9/11 attacks (Daha, 2011). In addition, Iranian-Americans are prone to being stereotyped as “devout Muslim fundamentalists” (Daha, 2011, p. 545) when in fact, many Iranian-Americans are secular and consist of Muslim, Jewish, Baha'i, and Zoroastrian individuals.

The results of Daha's qualitative study (2011) revealed that 82% of Iranian adolescents labeled themselves as Persian, 2% identified as Iranian, 9% identified as Persian and Iranian interchangeably, 5% identified as Iranian-American, and 2% labeled themselves as American. She found that several factors contributed to the preference of using *Persian* over *Iranian*. These

factors included cultural and historical pride (i.e. Persia being linked to ancient glory and Cyrus the Great), impact of media and politics, lack of information on the part of teachers and peers, and experiences with stereotypical remarks. Daha also found that the non-Muslim (Jewish, Baha'i, Zoroastrian) participants appeared more "proud" of their faith while 97% of the self-identified Muslim participants reported not observing the religion (i.e. secular families). These responses stressed the salience of politics and its connection to religion as well as how perceived discrimination impacted their faith. Several responses included, "Here, people associate Islam with violence" and "Muslim is associated with terrorism" (p. 554). Mostofi (2003) also found that a significant amount of young Iranian-Americans had experienced prejudice at some point in their lives, including name calling, hostility, and discrimination. Garakani (2008) states that such negative experiences, especially at a young age, may result in dissociation from Iranian culture in an attempt to be accepted by mainstream society. This is important for clinicians to be mindful of when working with Iranian immigrants or second generation youth who appear to feel shame toward their primary culture, which may alter their sense of identity (Garakani, 2008).

Despite perceived stigma surrounding ethnic or religious identity, 84% of participants in Daha's (2011) study reported feeling a sense of ethnic or cultural pride. The majority of participants attributed this pride to Iran's rich culture (literature, art, science); the history of the Persian Empire; and the success of Iranian individuals in the U.S. In regard to retention of ethnic identity, factors that contributed to this included: family connectedness, engagement in cultural activities and traditions, community ties, sense of ethnic/cultural pride, mannerisms, and educational aspirations. Overall, results of this study show that ethnic identity is constructed both by social and situational factors, a consequence of a negotiation process between the person and the surrounding environment (Daha, 2011). The fact that the majority of participants expressed

feeling a sense of ethnic pride as well as experiencing prejudice or discrimination is clinically relevant and is an issue that should be further researched. It should also be noted that previous studies have described Iranians as very proud people who believe in their uniqueness, while being “nostalgically tied to the past” (Jalali, 2005, p. 453). Their sense of pride can also appear at times as “boastfulness, impatience with learning, and difficulty in admitting mistakes” (Jalali, 2005, p. 453). Daha posits that this sense of pride and ethnic loyalty participants in her study expressed could be due to the negative stereotypes (re: terrorism and inferiority) they have experienced, thus strengthening their loyalty to Iran and their ethnicity. Although this study only surveyed a small sample (N=55) it is a starting point and provides insight for mental health professionals into the experiences of second generation Iranian-Americans.

In an exploratory study by Mostofi (2003), she found that acculturation and assimilation into American culture have played a significant role in young Iranian’s sense of identity. She argues that Iranian youth experience identity confusion and an important question second generation youth ask is “who are we?” versus “what are we?” (p. 683). She states that Iranians do not need to ask where they come from, because they tend to maintain close ties to Iran either through visits, nostalgia, or memories. Mostofi argues that getting the balance right between the two sets of cultures is the main issue for immigrants, especially 1.5 generation and second generation youth. As Mostofi states, “they are Iranian but they are also American” (p. 683).

It is evident that ethnic identity can impact the mental health status Iranian-Americans, and further research should be conducted in this area. An additional area that is lacking in the literature is ethnic identity development and experiences of bicultural Iranian-Americans, or in other words individuals who identify as Iranian as well as another ethnicity. Mahboubi & Mahboubi (2008), a mother and daughter, briefly discussed their experience as an interracial

family (African-American and Iranian-American) in a short book chapter. They discuss their experiences with discrimination and stress the importance of raising a bicultural child to value all parts of their cultural self. They also discussed the difficulty in how to identify when one is both Iranian and African-American. When it came to their bicultural daughter, the mother indicated that they “settled on telling her she was Black for all practical purposes” (p. 151). The daughter stated that while she identified as Black throughout adolescence, her Iranian identity emerged after the 9/11 attacks. She indicated that at that moment, for the first time she felt she “was not American...enough” (p. 152). This feeling of not fully belonging to either ethnic group is common among immigrants, but appears to be even more common among bicultural or biracial individuals. Thus, it is pertinent that future research focus not only on Iranian ethnic identity, but also on bicultural Iranian identity as well.

Common Presenting Concerns

The following section will focus on common concerns that Iranian-Americans present with in therapy and will begin with a brief summary of factors that influence help-seeking behaviors. This is by no means an exhaustive list of all concerns that this population may present with, but is rather a review of the most salient issues that have come up in the literature.

Help-seeking behaviors. Before the common presenting problems are discussed, it is important to review the factors that influence Iranian-Americans to enter into therapy in the first place. Gorovoy (2013) identified a gap in the literature regarding this topic and conducted a doctoral dissertation to find specific factors that influence Iranians to seek help for mental health difficulties. This study was conducted using a sample of 132 Iranians over the age of 18 living in various states throughout the U.S., using the Inventory of Attitudes towards Seeking Mental Health Services, which is the most well-known instrument in the domain of acculturation and

help-seeking attitudes toward professional psychological help. Gorovoy found that female gender, acculturation into U.S. oriented culture, higher educational attainment, younger age at time of immigration, and longer residency in the U.S. were associated with more positive attitudes toward seeking professional psychological help. These results appear to be consistent with previous research and literature regarding factors that cause individuals to seek help for mental health issues. She also found that stronger perceived social support was correlated with more negative or resistant attitudes toward seeking help. It can be speculated that individuals who reported higher perceived social support may have felt less of a need for professional help, and thus reported more resistant attitudes towards help-seeking. It may be helpful for future researchers to further explore this negative correlation between social support and positive attitudes toward seeking counseling, as this was a small sample size and results cannot be generalized to the entire Iranian-American population.

In a similar study, Khoie (2002) examined the predictors of attitudes toward seeking psychological help in a sample of 80 randomly selected Iranian men ages 21-68 living in Southern California. Results of this study indicate that perceived social support and social desirability had significant positive relationships with attitudes toward seeking psychological help. Specifically, males who reported greater social support had more positive attitudes toward counseling, as did the males who wanted to portray positive images of themselves. The correlation between social support and positive attitudes toward counseling are in contrast to Gorovoy's (2013) findings. This could be due to the fact that males who perceive higher social support could potentially have more open relationships with friends and family, and thus are more accustomed to discussing feelings compared to the general male population. They may find it easier to confide in a therapist since they have done it before with friends and family. In

addition, males may be encouraged by supportive female family members or spouses to seek counseling. It would be beneficial to further explore this area as there are contrasting findings in the literature. With regard to social desirability, Khoie posits that this trait could have influenced those individuals who wanted to please the researcher to participate, thus resulting in the positive relationship between social desirability and openness to counseling. Recruitment for this study was conducted in person, so perhaps those with a greater need for social desirability could potentially have a more difficult time declining to participate. Khoie also found that adhering to traditional male (i.e. masculine) gender roles contributed to negative attitudes toward counseling. This appears to be consistent with traditional gender role expectations for males to be “emotionally restricted, logical, and independent, qualities that may restrict help seeking behavior” (Khoie, 2002, p. 80). Interestingly, there was no significant relationship found between acculturation level and attitude toward counseling. Khoie suggests that this could be due to how the participants were recruited since those who volunteered to participate in a psychological research study may have been more acculturated than individuals who elected not to participate. In addition, Khoie states the scale used to measure acculturation, the Suinn-Lew Asian Self Identity Scale adapted for use with Iranians, has been criticized for detecting more behavioral changes rather than attitudinal or belief changes. Overall, the results of this study indicate that when working with Iranian-American males, clinicians should be mindful of assessing for a support system and to try and involve this support system when necessary and appropriate. In addition, psychoeducation for the community, especially males, may be beneficial in order to dispel myths regarding therapy and what is traditionally masculine or feminine.

Khanideh (2007) also examined attitudes of Iranian immigrants toward seeking psychological help, but her study focused on females. She recruited a sample of 257 females ages 18-30, who were born in Iran and now residing in the U.S., and were college students. Khanideh found that as length of residency in the U.S. increased, so did level of assimilation. She also found that as the age of emigration increases, level of acculturation (i.e. assimilation) decreases, as do negative attitudes toward counseling. Interestingly, no significant relationship was found between acculturation and attitudes toward counseling. One reason for this could be that the scale used, Suinn-Lew Asian Self-Identity Acculturation Scale (SL-ASIA) adapted for Iranian use, assumed that acculturation is a linear process with two ends (Asian identified or Western identified) and it focuses more on behaviors versus attitudes. This issue is similar to the issue found in Khoie's (2002) study as well. In addition, due to the fact that higher age of emigration was inversely related to acculturation and positive attitude toward counseling, one can hypothesize that level of acculturation (whether it be biculturalism, assimilation, or separation) actually does make a difference in attitudes toward counseling. This is an area that should be further explored in order to find more consistent results. Perhaps using an acculturation scale that has been used and found valid and reliable with the Iranian population would provide more accurate findings. Another limitation is that this sample consisted of only college educated females who had to have been able to read and write in English, thus the results can not necessarily be generalized to all Iranian-American females.

Another study by Hill-Lindsay (2007) also explored attitudes toward seeking mental health services in Iranian-Americans. Hill-Lindsay used a sample of 55 Iranian adults, ages 20-71, living in Southern California, who left Iran in 1978 or later. Results of this study found that moderate levels of cultural shift (i.e. assimilation) were associated with more positive attitudes

toward seeking mental health services. Significant results were not found for either cultural resistance or cultural incorporation in relation to attitudes toward seeking services. The author also found that as cultural incorporation scores went up (i.e. integration or biculturalism), mental health scores improved as well. Thus, individuals in this study who embraced both Iranian and U.S. culture simultaneously appear to experience less mental health difficulties. In addition, better mental health was also found to be correlated with more positive attitudes toward seeking mental health services. The author posits that moderate levels of cultural shift perhaps cause Iranians to experience greater feelings of trust in American culture, which leads to more openness to seek services. However, it is difficult to generalize results to the larger Iranian American community due to the small sample size as well as the homogeneity of the sample. In addition, the measures were only provided in English and data was collected through the internet, which potentially leaves out many individuals who do not fit criteria. Leaving out individuals with no internet access and no fluency in English may not give an accurate view of acculturation patterns in this population. Despite its limitations, this study does provide insight into how acculturation patterns may impact attitudes toward seeking mental health services. Future research with larger sample sizes is needed in order to yield statistically significant results.

Garakani (2008) found that the topic of mental health is traditionally taboo in Iranian culture and mental illness can be seen as a sign of weakness. However, this trend is slowly changing in the community due to the increased availability of resources (Garakani, 2008; Shamloo, 2009). The commencement of a Farsi-language interactive radio show on Iranian radio in Southern California (670 AM) in which callers can anonymously discuss their problems with a psychologist, Dr. Farhang Holakouee, has tremendously helped change the view of mental health and seeking help in the community (Garakani, 2008; Shamloo, 2009). Shamloo

(2009) suggests that Dr. Holakouee, an accomplished and respected therapist, is “the primary force that has brought emotional and family relationship problems out from a dark and shameful closet into the fresh air where issues can be discussed openly and professional mental health is an accepted form of care” (p. 29). In fact, the broadcast of his radio program in 2000 has paved the way for other psychologists and MFT’s to have their own programs and segments on Iranian satellite television (Shamloo, 2009). Although his radio show has changed the views of some, there is still more work to be done in terms of psychoeducation and increased culturally competent services for Iranian-Americans. In addition, for Iranians who do not live in Southern California and do not have access to this radio show or for individuals who do not have access to Iranian satellite programming, their views may still be similar to traditional views. Of course, these differing views may also be due to many other variables, such as: socio economic status, education level, sex, acculturation, and length of stay in the United States.

Acculturation. Although there is limited published psychological research on Iranian immigrants in the United States, the majority of the research that does exist focuses on acculturation and adjustment difficulties (Saedi, 2010). A qualitative exploratory study by Kaeni (2006) aimed to study the experience of therapists working with Iranian-American clients. This study interviewed 5 psychologists in California to see what their experience conducting therapy with this population was. The most common issues raised were acculturation difficulties, difficulties between spouses, parents, and children, and gender role expectations. Kaeni interviewed therapists who were born in Iran but trained and educated in the U.S., so that they may be better able to recognize cultural dynamics and how Western therapy practices interact with Iranian culture.

A study by Saghafi, Asamen, Rowe and Tehrani (2012) examined the relationship of religious identification to acculturation style among Iranian immigrants. The aim of this study was to see if religious identification (Jewish or Muslim faith) had an impact on acculturation style and acculturative stress. The authors used a sample of 107 (54 identified as Muslim and 53 identified as Jewish) Iranian immigrants over the age of 18 residing in Southern California. Saghafi et al. chose to focus on intracultural differences in this study in order to provide useful clinical information for understanding Iranian American clients. In order to measure acculturation, the Cultural Life Style Inventory (CLSI) adapted for use with Iranians was used and in order to measure acculturative stress, the Kerendi-Kadkhoda Acculturative Stress Scale (K-KASS) was utilized. The K-KASS measures stress associated with acculturation among nonclinical samples of Iranians in the United States and was standardized with a sample of Iranians residing in Los Angeles. The results of this study revealed that participants who identified as Muslim reported a higher Iranian orientation of acculturation (cultural resistance or separation) and resistance-based acculturative stress. Participants who identified as Jewish reported a higher U.S. orientation of acculturation (cultural shift or assimilation). The authors posit that this could be due to the fact that Iranian Muslims were used to being in the majority when in Iran, and after immigrating to the U.S. this significantly changed as they are now in the religious minority. Alternatively, Jewish Iranians held minority status in both Iran pre-immigration as well as the U.S. after immigration, however, they appear to have more religious freedom in the U.S, which may have strengthened their religious identity (Saghafi et al., 2012). In addition, Jewish Iranians may find it easier to adapt to the U.S. culture by joining existing Jewish communities and organizations, which can provide them with extra support. Some may even argue that the less tense relationship between Israel and the U.S., as opposed to Iran and the

U.S. is also a factor that may ease the immigration and acculturation process for Jewish Iranians. The authors also suggest that the current negative perception of Islam in the media can contribute to the resistance-based acculturative stress. This study illustrates the fact that Muslim Iranians appear to experience higher levels of acculturative stress when compared to their Jewish counterparts. This information is useful for clinicians when working with this population so that they may be mindful of asking about the importance of religion and religious self-identification. Future research on the issue of acculturation and religious differences should aim to include other religious minorities as well, including Zoroastrian, Baha'i and Christian Iranians. It would also be important to include participants from other areas of the U.S. instead of restricting to one location. Perhaps the results of this study may have been different had the Jewish Iranians been recruited from another city in which there was not a substantial Jewish Iranian community.

Darya (2006) examined the relationship between acculturation, ethnic identity, and psychological well-being in second generation Iranian-Americans in her mixed methodology study. Participants were recruited through convenience sampling and included 51 second generation college students in the Washington D.C., Maryland, and Virginia metro area. Through quantitative and qualitative methods, Darya found that the majority of participants reported a bicultural orientation, a high level of Iranian ethnic identity and that this was positively correlated with a positive psychological well-being measured by autonomy, purpose in life, environmental mastery, personal growth and positive relationships with others. Ethnic identity and acculturation were measured by the Abbreviated Multidimensional Acculturation Scale, and psychological well-being was measured by Ryff's Scale of Psychological Well-Being. Darya also utilized a qualitative approach to fully capture the lived experiences of the participants. Overall, the results of this particular study indicate that a bicultural orientation and

high ethnic identity correlate with positive psychological well-being. The results of this study, however, may not be generalized to the larger Iranian community as a whole due to several factors: the sample used was non clinical and consisted of a group of college students who were likely to have healthy coping skills. In addition, the sample in this study consisted of young adults in the Washington, D.C. metro area, in which there is a very large Iranian-American community. Had the study focused on Iranian-Americans elsewhere, there may not have been such a high level of ethnic identity, bicultural orientation, and positive psychological well-being. It would be clinically useful for future studies in this area to also include Iranian-Americans in areas that do not have a high percentage of Iranian residents. It can be hypothesized that Iranians who live in geographical locations with low percentages of Iranian residents may feel disenfranchised and fall into Berry's marginalization category of acculturation. On the other hand, Iranians in areas with low numbers of other Iranians may also be likely to assimilate more and abandon Iranian culture, in an effort to fit in to mainstream culture. As marginalization has been correlated to poorer mental health, it is important to conduct future studies on this sub-population.

Askari (2003) encourages clinicians who work with Iranian immigrants to be mindful of the immigration and acculturation process and provides suggestions for questions that will help build rapport and establish a solid therapeutic relationship:

- 1) How does the immigrant perceive and respond to the transition from a culture of extended families and a large support group to one of nuclear families and a perceived lack of community support?
- 2) How does the immigrant handle the drastic changes in his/her socioeconomic status?

- 3) How does the immigrant deal with the transformation from being a part of the cultural majority in the original culture to being a “minority” in a foreign culture?
- 4) How does he/she deal with family relationships with their daughter/son, siblings, parents, and in-laws during this transition period?

These questions are likely to reveal the difficulties of immigration and acculturation and can begin a dialogue between therapist and client.

Gender roles. Difficulties with ascribed gender roles are just one of the issues that stem from acculturation difficulties. As stated in chapter 1, Kaeni’s (2006) exploratory study found that issues with gender role expectations were one of the most common presenting problems with Iranian clients. These gender role expectations can result in difficulties between the sexes in relationships. Kaeni suggests that although gender roles change during acculturation, men may have an easier time adjusting since they are already used to more freedom. Women, on the other hand, tend to experience somewhat of a culture shock and may have difficulty balancing their new freedom with loyalty to traditional rules. Traditional gender role expectations can also lead to double standards when it comes to premarital sexual relationships (Hojat et al., 1999).

A study by Abdolsalehi (2010) examined factors that contribute to sex guilt among Iranian-American women, as this has been found to be a source of marital distress. The study consisted of 65 Iranian American women, ages 18-59 residing in California. Abdolsalehi used the Sexual Self-Schema Scale-Women’s Version to measure sexual self-schema (cognitive representation of sexual aspects of self), the Revised Mosher Guilt Inventory to measure guilt, and the Acculturation Rating Scale for Mexican Americans-II (adapted for use with Iranian Americans) to measure acculturation, and the Satisfaction with Life Scale to measure global life satisfaction. The results showed that as sexual self-schema became more positive, sex guilt

levels decreased and a significant negative relationship was found between sex guilt and life satisfaction. In addition, religion was found to be significantly correlated to sex guilt, with considerably higher sex guilt reported by Muslim women. Abdolsalehi states that there was an inverse correlation between acculturation and sex guilt before controlling for religion. In other words, once religion was taken into account, the correlation between acculturation and sex guilt was not as strong. This study suggests that Muslim Iranian women are less likely to embrace modern gender roles and become accustomed to Western influences, when compared to Iranians of other religious affiliations, such as Jewish, Zoroastrian, Christian, or Baha'i. In addition, the results suggest that Muslim Iranian women are at a higher risk of decreased life satisfaction as a result of increased levels of sex guilt. This can be detrimental to their relationships or marriages, thus resulting in overall lower life satisfaction. It should be noted that this study was a correlational study and thus, a cause and effect relationship cannot be assumed. Rather, the results may be due to other variables, such as views on gender roles, educational level, or socioeconomic status. In addition, the results may be difficult to generalize to all Iranian American women, as the participants were all from the Southern California area, and individuals in other areas, such as smaller cities, may have different views on sex and sex guilt. Lastly, the study was Internet based and thus excluded individuals who did not have access to a computer, as well as individuals who did not speak English. Overall, the findings strongly suggest that sex guilt is an issue in the Iranian American female community, especially in Muslims, that needs to be addressed (Abdolsalehi, 2010).

One recommendation for clinicians working with this population is to stress to parents the importance of being open to discussing sexuality with their family. Because of the extreme taboo nature of this topic in the Iranian community, it is crucial to be culturally sensitive and

make sure to promote sexual discussion rather than promote or encourage sexual activity.

Clinicians should assist parents in educating their children about sexuality at an appropriate age in order to assist with developing a healthier and more positive self sex-schema. Abdolsalehi (2010) cautions clinicians to be aware of the manner in which they broach this topic in order to not hurt the therapeutic alliance. Future research in this area is needed in order to understand other factors that can lead to sex guilt, such as traditional views on gender roles, education level, or age. It would also be clinically relevant to examine this issue in Iranian American men.

Ghazi-Moghadam (2009) also found in her exploratory study that evolving gender roles tend to be a controversial issue for Iranian clients in counseling. Therapists interviewed in Ghazi-Moghadam's study state that in their experience in working with this population, "the common expectation for the Iranian woman in the U.S. is to work and help with the household income, while still adhering to her traditional roles as wife and mother by taking care of the home and children and attending to all of the household chores" (p. 59). This, of course, adds a significant amount of pressure on women, especially those who grew up in Iran and are not used to this dual role. Essentially, they are going from a culture in which roles were fairly set to a new culture in which roles are more fluid, which can create confusion and stress. The discrepancy between the traditional expectations and the new freedom (and responsibilities) can create tension between a husband and wife and clinicians need to be aware of how gender role expectations can impact marital distress.

Kaeni (2006) warns clinicians to not make assumptions that all Iranians will adhere to traditional gender roles and to assess the level of acculturation in order to understand the gender role dynamics in a particular couple or family. Differences in views on gender roles and sex can

often lead to difficulty in marriages. The next section will review the literature on marital difficulties in Iranian-Americans.

Marital difficulties. Marriage is viewed as an “everlasting commitment that bonds not only two individuals but their two families together” in Iranian culture (Hojat et al., 2000, p. 420). There is a strong cultural stigma attached to divorce, but despite this stigma, there appears to be an increase in the number of divorces in Iranians, especially those living in the U.S. Hojat et al. state the incompatibility of traditional Iranian cultural values and the norms of mainstream U.S. culture regarding sex, relationships, marriage, and family could result in difficulties and tension in relationships and marriages.

In Kaeni’s (2006) exploratory study of therapist’s experiences with Iranian client’s, the issue of difficulties with in-laws involvement in marriage proved to be a common presenting problem. One of the therapists stated that in her experience, many of her female clients had difficulties with their in-laws due to the in-laws constantly trying to interfere in the marriage. The involvement typically tended to be in the form of advice giving and decision making. Kaeni’s study did not elaborate further; however, given that it appears to be a common presenting concern, future research should focus on this issue.

Another common issue therapists in Kaeni’s (2006) study found to be common was the issue of Iranian men living in the U.S. and going back to Iran to find a spouse. The therapists interviewed stated that in their experience, going back to Iran to find a spouse was a very rare occurrence for women, but tended to occur often with men. Kaeni suggests that this can be a problem as “culturally, they are very different, emotionally at different levels of sophistication, and it is more complicated” (p. 56). Given the fact that previous published literature has shown varying acculturation rates between Iranian men and women both residing in the U.S.

(Ghaffarian, 1987; Janan, 2013), one can hypothesize that two individuals from different countries are also likely to hold differing values and beliefs (i.e. gender role expectations) due to acculturation. This variation in acculturation style has been shown to cause strains in a relationship (Hojat et al., 1999; Hojat et al., 2000; Jalali, 2005), and it is an area that should be further explored in future studies.

An added difficult marital situation can be the case of an Iranian husband and a Caucasian wife (Askari, 2003). Askari suggests that conflicts often arise in situations in which the husband's closeness to his extended family may cause discomfort in the wife, who may wish for more distance and independence. In these situations, Askari states that therapists should recognize the cultural differences and encourage the couple to communicate and compromise in a way that both of their cultural identities are not threatened.

It is also important to examine intermarriage in which the wife is Iranian and the husband identifies with another culture. A qualitative study by Ruebelt (2009) explored the cross-cultural experiences of 13 couples in which the wife identified as Iranian and the husband identified as European-American. These couples all resided in Northern California and had been married for at least 5 years. Through individual and joint interviews, Ruebelt found that although cross-cultural differences existed, these differences were not major issues that impacted marital adjustment as all participants reported being either satisfied or very satisfied in their marriage. A few of the cultural differences that couples reported included setting boundaries with extended family, making sense of cultural practices (ex: *tarof*, which will be discussed further in the chapter), and balancing the cultural identity of their children fairly and evenly across both cultures. Couples indicated that working through these cultural differences required awareness and sensitivity to various cultural norms, understanding, acceptance, tolerance, openness,

flexibility, communication, and willingness to make compromises. Through individual interviews, common personality traits observed in the wives included being strong-minded, intelligent, self-aware, and honest. Common personality traits observed in the husbands included acceptance, patience, open-mindedness, and interest in new experiences and cultures. This author chose to utilize a strengths based approach, which is not common in most studies on this topic, and can be of great use to clinicians when working with an intermarried couple. Among the most significant findings from this study are that these multicultural couples possess many strengths which have helped them achieve successful marriages despite cultural differences. Clinicians are encouraged to assess for commonalities and strengths and build on those, rather than focusing solely on cultural differences. Ruebelt suggests assessing for and exploring the following when working with multicultural couples in therapy:

1. The couple's level of multicultural understanding, awareness, and acceptance towards one another as well as their level of open-mindedness, non-ethnocentricity, and willingness to learn new things.
2. The couple's desire and commitment to create unity, and shared meaning through agreements, compromises, and communication about various ideologies.
3. The couple's establishment of a strong interpersonal foundation and bonds through mutual respect, honesty, loyalty, and trust.
4. The couple's level of acculturation, adaptation, and integration into one another's cultural worlds and cultural identities.

Although this study provides clinically useful information, there are several limitations as well. The first limitation is the homogeneity within the group of participants. All couples lived in Northern California and were college-educated and middle to upper class in socioeconomic

status. In addition, different couples were in different life stages (i.e. 5 years of marriage versus 30 years of marriage; children versus no children) and couples married for a shorter amount may have been exposed to less life stages and events. Nonetheless, this study provides useful information on an area of the literature that needs to be further explored. This study is also unique in that it focuses on strengths versus difficulties and differences. Future studies should aim to explore intermarriages between both Iranian women with non-Iranian men and Iranian men with non-Iranian women. In addition, longitudinal studies would be useful to show progression of marriage through different life stages. Expanding sample size and geographical location would also yield results more likely to be applicable to the larger Iranian-American population as a whole as well.

Jalali (2005) states that there has been an increase in cross-cultural marriages for Iranian-Americans in the past 20 years and it appears families are adjusting to them more easily than the past. As the rate of intermarriage continues to increase, further exploration and research is needed in order to better understand their realities and experiences.

One common issue in many failed marriages is infidelity; however, there appears to be a paucity of literature on this topic as it relates to Iranian-Americans (Bakhtiyary, 2012). Bakhtiyary (2012) states that due to increasing divorce rates as a result of infidelity and the psychological problems that arise, it is imperative to explore this phenomenon in the Iranian population as well. In her study of infidelity in Iranian-American men, she examined the relationship between sexual infidelity and narcissism, attitudes about sex-role egalitarianism, and commitment to spouse. Her quantitative study included two groups of Iranian-American men, one group who had admitted to engaging in extra marital sex ($n=22$), and one group who had not ($n=15$). This sample was comprised of Iranian-American men ages 31-62, who had been married

for at least 2 years and were in a first marriage, residing in Southern California, and had been living in the U.S. for at least 5 years. Bakhtiyary used the Narcissistic Personality Inventory, which is the “most widely used instrument for assessing narcissism” (p. 62), the Sex-Role Egalitarianism Scale, and the Commitment Inventory to measure the dependent variables (level of narcissism, attitudes toward sex-roles, and commitment to spouse). The results of this study found that the group of men who had admitted to sexual infidelity scored higher on the Narcissistic Personality Inventory, lower on the Sex-Role Egalitarianism Scale, and lower on the Commitment Inventory when compared to the group of men who had not admitted to sexual infidelity. Bakhtiyary states that these results show that in this study, men who had engaged in sexual infidelity were “more narcissistic, less accepting of sex role egalitarianism, and less committed to their marital relationship” (p. 75). The author posits that these findings are clinically valuable and relevant for any professional working with Iranian-American couples with issues of infidelity. She states that clinicians should be mindful of assessing for these personality and attitudinal characteristics when faced with this presenting problem. It would also be effective for clinicians to work on altering stereotyped sex role views. In order to achieve this, psychoeducation and Cognitive-Behavioral therapy may prove to be effective, in order to explore where these beliefs come from and work on ways to create more balanced thoughts and beliefs which may lead to a healthier marriage.

There were several limitations with this study (Bakhtiyary, 2012), however, that make it difficult to generalize the findings to all Iranian-Americans. The sample size for this study was small and nonrandom. In addition, due to the sensitive and taboo nature of this topic, it is unclear whether or not participants were completely honest in their responses. In addition, this was a causal comparative study, and it is possible that the two groups of men could have differed

on personality and attitude measures, and that had nothing to do with whether or not they engaged in infidelity. These differences could have been due to socioeconomic status, attachment style, family history, religion, or education. Lastly, men under the age of 31 and older than 62 were not included. Future research should include a larger age range to determine if there are any differences with regard to age as well. Nonetheless, even with the small sample and various limitations, this study did show statistically significant results and is a useful starting point in further exploring this sensitive and critical issue.

Due to the increasing divorce rate among Iranian-Americans, it is important to examine how this impacts not only the spouses involved, but their children as well. Sajed (2012) conducted a study in which she explored the relationship between parental divorce and marital satisfaction in Iranian-American female adult children of divorce. Sajed collected data from 59 Iranian-American married women between the ages of 21-61. This group of women was divided into 2 groups (1 group from families in which parents were not divorced and the other from families in which parents were divorced). All participants were from Los Angeles and recruited using a snowball sampling method. Sajed utilized the Marital Satisfaction Inventory, Revised to measure marital satisfaction and the Cultural Life Style Inventory to measure acculturation. Sajed controlled for acculturation due to the fact that this has been shown in the past to be related to global marital distress. After controlling for acculturation, results showed that for a majority of the subscales on the Marital Satisfaction Inventory, parental divorce negatively impacted marital satisfaction in this population. Parental divorce was found to be associated with higher levels of dissatisfaction on subscales of global distress, problem solving communication, history of family distress, affective communication, and disagreement about finances. It is important to note that the subscales that were negatively impacted by parental divorce are all issues that require

communication and involve a high degree of stress. These are also common issues that can cause couples to enter counseling, and clinicians should be aware of how parental divorce may impact these issues. Despite the clinically relevant information found through this study, it is important to point out the limitations as well. This study assumed that divorce would be a risk factor for marital dissatisfaction and did not take into account how high conflict marriages would impact the children (i.e. parents are still living together but in a high conflict environment). It is quite possible that many children would benefit more from a divorce versus living in a home with both parents always in conflict. In addition, the sample size used was relatively small and future studies in this area should aim to include a larger and more random sample size. It would also be beneficial to include Iranian males to see how they are impacted and if there any differences. It may also be beneficial to see how religion plays a role in future studies on this topic.

Hojat et al. (1999) stress the importance of clinicians being aware of the impact of acculturation and difficulties due to gender roles on marital relationships in Iranian-Americans. Although there are many other variables that can lead couples to counseling (i.e. infidelity), it appears that for Iranian-Americans, the increasing marital discord can be at least partially attributed to different modes of acculturation between spouses, at different rates and different degrees. Hojat et al. encourage clinicians to be aware of these dynamics and to be familiar with them and ready to explore them in therapy.

Parent-child difficulties. Different levels of acculturation (i.e. assimilation versus separation) between parent and child can often times lead to conflict, especially on issues regarding family rules, identity, relationships, and sexuality. Thus, when working with parent

and child, it is imperative for therapists to assess the acculturation level of both parties and be mindful that certain conflicts could be due to cultural differences.

Janan (2013) explored the relationship between first generation parents and their second generation daughters to understand the difficulties they may experience, specifically gender role expectations and sexuality. In this cross-sectional correlational study, she used 30 participants from Los Angeles between the ages of 20-31 (daughters), 45-60 (mothers), and 55-70 (fathers). Attitudes toward gender roles were measured by using the Traditional Egalitarian Sex Role (TESR) self-scale as well as a scale for parental perception. The results of the study indicated that second generation Iranian females endorsed more egalitarian attitudes towards sex roles when compared to the normative sample study of the TESR. One possible reason for these results, however, could be that the normative data was collected in 1988 and societal norms and values have evolved since then. The study also found that mothers held slightly more traditional attitudes towards gender roles when compared to their second generation daughters, however the difference was described as marginal. The last hypothesis to be tested was the difference in attitudes toward gender roles between daughters and their fathers. The results indicated a significant difference in attitudes between fathers and daughters, with fathers endorsing more traditional attitudes toward gender roles. Overall, results of this study suggest that Iranian males may hold more traditional gender role expectations, which can cause difficulties between fathers and daughters. It is helpful for clinicians to be mindful that many of the clashes regarding sexuality, dating, and freedom could be due to these differences in gender role expectations. Future studies in this area would be beneficial, as this study used an extremely small sample size and was limited only to the Los Angeles area. Perhaps if a similar study was conducted in smaller cities or areas where there are less Iranians, results may have been different.

Zandi (2012) explored the relationship between intergenerational acculturation gaps, gender, and family functioning within the second-generation Iranian-American population. His study included a sample of 55 second generation Iranian-Americans recruited through convenience sampling. Measures used included the Suinn-Lew Asian Self-Identity Acculturation scale (adapted for use with an Iranian population) and the Family Adaptability and Cohesion scale (FACES-IV). Results from this study implied that families who were more closely matched in terms of acculturation level reported less overall family dysfunction. Participants with acculturation levels similar to their parents consistently reported having more “cohesive families” (p. 71). The author of this study defined cohesion as “the degree of emotional bonding that family members have toward one another. It is also the degree to which family members experience a sense of emotional safety and trust toward one another while simultaneously maintaining appropriate and comfortable interpersonal boundaries” (p. 71). Similarly, participants who were more closely matched to their parents in terms of acculturation level also reported higher levels of flexibility in their families. The author defined flexibility as “how well a family manages structural elements such as leadership, parenting style, discipline strategies, role relationships, and relationship rules” (p. 71). It should be noted that a significant limitation in this study was the small sample size and the fact that this was a non-clinical population. Future researchers who wish to study similar issues may want to use a clinical population to see if that impacts the presence of family conflict.

Zandi (2012) also explored the correlation between gender and acculturation and the impact on family functioning. Results of this study showed that less acculturated females reported higher levels of enmeshed behaviors when their level of acculturation matched their parents, while males reported more enmeshed behaviors as the acculturation gap between them

and their parents widened. Zandi described enmeshment as diffuse interpersonal boundaries between family members. He further added that in enmeshed families, “loyalty is demanded and individuals tend to be very dependent on and reactive to one another” (p. 74). The author speculated that this difference could be due to the fact that Iranian females who identify with Iranian values may view their roles in the family as more inflexible and feel more pressure toward conforming. Females may feel pressure to conform to traditional gender roles in order to maintain balance and congruence in the family. The author stressed the importance of clinicians being aware of these dynamics and being mindful that enmeshed or overly rigid behaviors may actually create balance in traditional Iranian families. It is important to note that the small sample size may have impacted the results of this study. Participants were all college-educated young adults, and family conflict may have been more evident in a younger adolescent population. In addition, the method in which family functioning was assessed could have also negatively impacted the validity, as the acculturation level for parents were actually collected from participants using their parents’ perspective. Finally, the FACES-IV may have over-pathologized behaviors typical of collectivist cultures (i.e. rigidity and enmeshment). Future research that differentiates between adaptive collectivist behaviors and maladaptive behaviors would be especially clinically relevant.

A study by Frank, Plunkett, & Otten (2010) studied the impact of perceived parental support on Iranian-American youth self-esteem and general self-efficacy. The sample for this study consisted of 158 Iranian-Americans ages 13-20 who resided in the Los Angeles area. The researchers specifically wanted to examine the impact of parental support, parental knowledge, and parental psychological control on the adolescents’ general self-efficacy, self-esteem, and self-deprecation. The authors defined parental support as “warmth and nurturance” (p. 739) or

behaviors that convey “acceptance, warmth, nurturance, and affection” (p. 739). Parental knowledge was defined as “the extent to which parents know of their child’s friends, locations, and activities” and parental psychological control was defined as a parent’s “attempt to assert authority over the child through manipulative techniques such as love withdrawal and guilt induction” (p. 739). The authors used the Self-efficacy Scale, the 10-item Rosenberg Self-Esteem Scale, and the Parental Behavior Measure. The results of this study indicated that perceived parental support and knowledge were significantly and positively correlated with general self-efficacy and positive self-esteem, but negatively correlated with self-deprecation. Perceived parental psychological control was significantly and negatively correlated with general self-efficacy and positive self-esteem, and positively related to self-deprecation. The results of this study are important and clinically relevant in that they show a correlation between parental support and adolescent self-efficacy. The results of this study imply that when an individual experiences psychological control from either their mother or father, they may experience more self-deprecating thoughts and thus be more likely to give up easier and not be as academically successful. It is also important to note that given the importance Iranian parents generally place on academics and achievement, this type of behavior may likely turn into a cycle in which the control causes adolescents to not achieve (due to negative self -views) which in turn may upset parents even further. In addition, the study showed that parental support and knowledge can positively impact adolescents and increase their self-esteem, likely causing them to have increased confidence in all areas of life. As stated by Jalali (2005), Iranian youth heavily depend on parents to provide love and affection and their supportive behaviors are likely to reflect positive images about their self and capabilities. Parental knowledge is also positive in that

adolescents may feel supported and validated when their parents have knowledge about their activities and whereabouts (Frank et al., 2010).

This study (Frank et al., 2010) provides a tremendous amount of insight into the relationship between perceived parenting and adolescent general self-efficacy in Iranian-Americans. The results of this study may be helpful for clinicians when working with parent-child dyads or families, especially in cases where the adolescent is experiencing low self-esteem. It would be helpful to explore the family dynamics and parenting style to see if that is impacting the adolescent's general self-efficacy. Clinicians should be mindful of using psychoeducation to teach parents ways to increase support and knowledge, while decreasing shaming and control-like techniques. In cases in which it may be difficult to change parental behaviors, it may also prove beneficial to use cognitive interventions to teach adolescents how to minimize self-deprecating feelings and negative thoughts. As with any study, there are a few limitations that should be noted. First, this study only utilized a sample from Los Angeles so it would be helpful for future studies on this topic to widen the sample to include other geographic locations. In addition, it would be helpful to examine any gender differences between daughter and sons, as it has been shown in previous literature that Iranian parents sometimes tend to treat sons and daughters differently (Frank et al., 2010; Hojat et al., 1999; Jalali, 2005). In addition, the authors in this study (Frank et al., 2010) only used adolescents in the sample and thus future studies may want to include parents, as their own self-reports of their behavior can provide additional insight.

Trauma. Trauma and Post Traumatic Stress Disorder (PTSD) are common presenting problems in individuals who have lived through war, and given the fact that a significant majority of third wave immigrants were directly impacted by the Iranian Revolution as well as the Iran-Iraq War, it would be beneficial for clinicians to be more familiar with these issues.

A study by Mohadjer (2009) aimed to explore the prevalence of PTSD in a sample of Iranian Americans who immigrated to the United States either prior to or following the Iran-Iraq War. The participants in this study included 60 participants (30 in the pre-war group who immigrated before 1977 and 30 in the post-war group who immigrated between 1978 and 1988). Participants were located through cultural centers in Southern California. The author measured PTSD by creating an online survey that assessed for PTSD symptoms by using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) criteria. In order to assess prevalence of PTSD in pre-war and post-war groups, Mohadjer utilized a chi square analysis to measure symptom differences between the two groups. The results of this study showed that 10% of the pre-war group met criteria for PTSD based on the survey provided while 60% of the post-war group met criteria. The high prevalence of PTSD in this group suggests a need for more research on this topic as well as more culturally sensitive interventions for clinicians to use with this population. The results also found that more post-war individuals were single or never married when compared to their similar aged pre-war counterparts. In addition, pre-war individuals were found to have higher levels of graduate education. These demographic findings suggest that untreated PTSD can potentially lead to difficulty sustaining relationships or marriages as well as hindering academic achievement. However, it is important to note that these differences in demographics could potentially be due to other factors, namely lower socioeconomic status, as many of the third phase immigrants had to leave Iran unexpectedly versus the first and second phase immigrants who typically came from a higher SES and came for purposes of higher education (Jalali, 2005). Another limitation in this study is the fact that a self-report survey was utilized, meaning participants could have responded in exaggeration or even denial. In addition, those who only spoke Farsi were

excluded from the study as the survey was in English. If any participants did not speak English fluently, information gathered could be inaccurate. Future studies should try to incorporate empirically valid and reliable assessment scales and/or use structured interviews to gain more accurate information. Despite all of the limitations, this study is clinically relevant in that it shows how post war immigrants may be at an increased risk for developing PTSD. It would be beneficial to the community to educate them about the effects of trauma exposure through psychoeducation.

A study by Shamtoub (2013) aimed to examine the relationship between trauma experienced by Iranian immigrants in Iran and its relationship with attachment styles of their adult children. For this study, Shamtoub recruited a non-random sample of 92 Iranian-Americans over the age of 18 who had at least one parent who emigrated from Iran between 1979 and 1988. Participants of this study completed the Experience in Close Relationships questionnaire in order to measure attachment styles as well as the Trauma Assessment Scale to measure experienced trauma by their parents. The study revealed that increased maternal trauma was significantly related to anxious, avoidant, and overall insecure attachment styles. Increased paternal trauma was also related to anxious and overall insecure attachment styles. Shamtoub found that trauma can result in the mother becoming emotionally absent, which can cause distress in children and result in an insecure attachment style. Shamtoub posits that the lack of an avoidant attachment style in this the paternal trauma category could be due to the fact those particular children were likely to still have other caregivers available even if the fathers were emotionally absent, such as their mothers. The results of this study indicate that trauma can be passed down intergenerationally and negatively impact children's attachment styles, and thus future relationships and overall mental health. Shamtoub also found that fathers who have

experienced trauma may be more likely to be “controlling, overprotective, and demanding of relationships with their children” and that these types of behaviors are likely to lead to anxiety disorders later in life (Shamtoub, 2013, p. 54). This study is beneficial for clinicians in that it helps them become aware of intergenerational transmission of trauma. While this study appears to be the first of its kind to specifically examine this issue, it does contain a few limitations. First, the sample size used is relatively small and is non-random, as all participants are from Southern California and were recruited mainly through social media. In addition, mothers and fathers did not complete trauma assessment scales, rather their adult children did. This factor could imply that results are not as accurate as they could have been had the mothers and fathers filled out the scales themselves. It may be helpful in the future to study this issue further, but to use a larger randomized sample size. It would be beneficial to widen the time period from 1979-1988 to include later years, as many immigrants who lived through the Revolution and War did not emigrate until after 1988.

Body image and disordered eating. Very little published literature exists on the topics of negative body image and eating disorders in the Iranian-American community. Eshtiaghpour (2011) suggests that this is an important issue to study due to the amount of pressure young Iranian women face regarding “perfection” (p. 13). Eshtiaghpour posits that for many Iranian women, “image is everything” (p. 15). She adds that due to the emphasis on education, achievement, and upward mobility, women may also feel increased pressure to keep up a perfect physical appearance as well. In her quantitative study, Eshtiaghpour examined the relationship between perfectionism, socioeconomic status, disordered eating, and negative body image. For this study, she included 119 Iranian women between ages 18-30 living in Southern California. Participants were recruited through universities, beauty salons, and medical clinics.

Socioeconomic status was measured through the self-report demographic questionnaire, perfectionism was measured by the Multidimensional Perfectionism Scale, disordered eating attitudes were measured by the Eating Attitudes Test-26, and negative body image attitudes were measured by the Multidimensional Body-Self Relations Questionnaire. The results showed that in this particular sample of Iranian American women, a significant positive relationship was found between perfectionism and disordered eating attitudes and negative body image as well as high socioeconomic status and disordered eating attitudes. Higher socioeconomic status was not, however, positively correlated with negative body image as Eshtiaghpour expected. One possible explanation the author provides for this is the fact that with higher socioeconomic status, one has the means to “fix” (p. 43) the parts of their face or body they are not satisfied with.

It can be hypothesized that the women with a higher socioeconomic status focused more on their physical appearance because of the desire to keep their status or to maintain an even higher level. These women may place more emphasis on their physical appearance in order to attract a high SES partner (Eshtiaghpour, 2011). Women with a lower SES may not have the time and resources to maintain their physical appearance as much as they may be busy with work or household responsibilities. The author states that perfectionism may be due to the internalized Iranian cultural value of achievement and success and though beneficial in some ways, this can be a dangerous risk factor in the development of an eating disorder. The results of this study are clinically relevant and show clinicians they need to be more culturally aware of within group differences when working with Iranian women. It is crucial to understand how perfectionism plays a role in the client’s life. Eshtiaghpour suggests that Iranian-American women’s preoccupation with perfectionism should be looked at as a cultural expectation that impacts them

rather than solely an individual pathology. Although this study is clinically relevant and sheds light on a lesser studied but important topic, there are limitations that make it difficult to generalize the results to the larger Iranian population. First, only young women in Southern California were part of the sample and it would be beneficial to include women from other regions in the U.S. as well where preoccupation with physical appearance and cosmetic surgery are not as prevalent. In addition, the author recruited women from universities, medical clinics, and beauty salons and offered a raffle prize of a 200 dollar beauty spa certificate for participating. It is possible that the type of woman recruited for this study is one who places significant value on physical appearance and is not representative of all Iranian American women. It would be helpful for future studies to include a more varied sample and to assess for other variables that impact body image and disordered eating as well (i.e. Western media influence).

Gambling. A lesser studied presenting problem for Iranian-Americans is the issue of problem gambling and pathological gambling. Parhami, Siani, Campos, Rosenthal, & Fong (2012) state that although games of chance have been a significant part of Iranian history and culture, there is no published psychological literature on this topic. In their innovative study, Parhami et al. aimed to explore gambling pathology, behavior, and motives in a sample of Iranian-Americans in Southern California. Participants were recruited from an Iranian-American cultural festival in Orange County, California and included 182 individuals over the age of 18. Participants filled out a questionnaire written by the authors that correlated with DSM-IV criteria for pathological gambling, as well as the Gambling Motives Questionnaire. Of the 182 participants, 77% reported gambling at least once per year, 20% met criteria for problem gambling, and 7% met criteria for pathological gambling. According to the Gambling Motives

Questionnaire, the most common motive was enhancement (versus social and coping).

Enhancement was described as an internal positive reinforcement that increases positive emotions, such as feeling empowered or accomplished. Enhancement is indirectly experienced through the ability to purchase goods through their monetary winnings. The most common types of gambling reported in this study were lottery, slot machines, and table games.

The authors of this study (Parhami et al., 2012) suggest that this population may be at an increased risk for developing problematic gambling due to cultural acceptance of gambling as a past time, as many participants reported “social gambling” (p. 717) such as playing poker or backgammon for money in friends’ homes and outside of traditional casinos. The authors also suggest psychological reasons that increase risk for problematic gambling. They stated that many Iranians are “conscious of their culture’s aggregate financial, educational, and professional success” and “they may feel nostalgia about previous success or envy of the success of their peers” (p. 717). They also posit that because of their emphasis on success and accomplishment, Iranian-Americans may be more prone than individuals from other cultures to desire this “success fantasy” (p. 717) and use gambling as a way to reach it. This can likely increase their chances of developing a gambling disorder (Parhami et al., 2012.). In addition, since enhancement was the main motivator over coping mechanisms or social purposes, the authors posit that those who are motivated by enhancement may be at an even higher risk of developing problematic behaviors. This study has several limitations, including the nonrandom sample (all participants were recruited from a cultural festival in Orange County, California) used as well as potential bias produced by self-reports. The authors state that due to potential stigma regarding addictions and gambling, participants may have under-reported or may have been hesitant to disclose their true behaviors. In addition, the authors state that the small sample size may have

contributed to the non-significance in demographic characteristics, such as religion, education, socioeconomic status, and gender. It would be clinically relevant to examine how these variables impact gambling motives and behaviors. Nonetheless, this study is the first of its kind to study this particular topic and it is clinically relevant as it raises awareness in the Iranian population about gambling disorders. Future research into this area would be helpful as would culturally geared psychoeducation and preventative programs for the community.

Anxiety and depression. Anxiety and depression are two of the most common presenting problems that Iranian-Americans tend to present with in therapy (Ghazi-Moghadam, 2009; Kadkhoda, 2001; Kaeni, 2006; Saedi, 2009). Often times, depressed Iranian clients may present as withdrawn or alienated, and somatic complaints such as headaches and stomachaches can be common (Bayani-Rad, 2012). In addition, depressed Iranian males may present with externalized behaviors such as anger, violence, and substance abuse, while females may exhibit internalized behaviors such as alienation, distrust, and relational issues (Bayani-Rad, 2012). It is also important to note that anxiety may be presented as heart symptoms such as aching, pounding, fluttering, rapid beating, pain, or discomfort (Askari, 2003).

A study by Saedi (2009) examined the relationship between acculturation, depression, and anxiety in a nonrandom sample of 72 Jewish Iranian-Americans residing in Southern California. Participants of this study completed Mendoza's Cultural Life Style Inventory (CLSI) adapted for use with Iranians to measure acculturation, the Beck Anxiety Inventory (BAI), and the Beck Depression Inventory Second Edition (BDI-II). Saedi found that as cultural resistance increased (comparable to *separation* acculturation style), higher levels of anxiety and depression were endorsed. Conversely, Saedi found that as cultural shift (comparable to *assimilation* acculturation style), lower levels of anxiety and depression were endorsed. In addition, as

cultural incorporation increased (comparable to *integration* acculturation style), lower levels of anxiety and depression were endorsed. Thus, the results of this study imply that the more the participants either assimilated into U.S. culture or incorporated U.S. culture and Iranian culture, the less they experienced depression and anxiety. This would suggest that adopting aspects and values of the U.S. culture may be beneficial to Iranians in order to experience fewer mental health problems. These results may help clinicians become more mindful of how acculturation impacts mental health when working with Iranian immigrants who present with depression or anxiety. Saedi posits that it is not necessary for Iranians to completely give up Iranian values and identity, but rather form a combination of Iranian and American values (or in this case, Jewish as well) in order to “fit into the society” (p. 84) and experience less mental health concerns.

Saedi’s (2009) study has several limitations that need to be addressed in future studies on this topic. First, the sample was nonrandom and since many of the participants were friends of the author, results may be biased and cannot be generalized to the larger Iranian Jewish community as a whole. In addition, all participants were from Southern California, where there is a large Iranian Jewish community. Had the participants been recruited from other areas in the U.S., results may have been different. For example, in areas with a small Iranian population, higher rates of cultural shift may have been reported or higher rates of depression and anxiety may have been endorsed due to individuals feeling isolated and as though they are different. In fact, one area that would be beneficial for future researchers to study would be the impact geographical location and community has on Iranian-American mental health.

In a similar study, Kadkhoda (2001) examined the role of acculturation as related to level of depression and anxiety in Iranian immigrants in the U.S. Kadkhoda’s sample consisted of 115 Iranian immigrants residing in Los Angeles, ranging in age from 18-81. Using the CLSI to

measure acculturation, and the BDI-II and BAI to measure depression and anxiety, Kadkhoda's results were similar to Saedi's in that higher levels of cultural resistance were correlated with higher levels of depression and anxiety. In addition, higher levels of cultural shift were correlated with lower levels of depression and anxiety. Interestingly, higher levels of cultural incorporation was correlated with higher levels of anxiety and depression, which is in contrast to Saedi's study as well as previous research that has linked cultural incorporation (or biculturalism) with lower levels of mental health concerns. Kadkhoda suggests that this could be due to the fact that the individuals in this study may have experienced difficulty navigating through both U.S. culture and Iranian culture, which are markedly different. In addition, this could have been due to the fact that many of the participants were older and grew up in Iran, thus making it more difficult to incorporate Iranian and American culture fully. Cultural incorporation may prove easier for younger immigrants or second generation Iranians who have spent most of their lives in the U.S. and are exposed to American culture in school on a daily basis.

Limitations of this study include the way in which data was collected (nonrandom sampling of researcher's network of friends and colleagues), geographic restrictions (only recruiting participants from Los Angeles), and lack of longitudinal data collection. Kadkhoda posits that future research on this topic be collected longitudinally in order to see if there is any difference in how Iranians acculturate over a period of time and whether or not their mental health will improve as a result.

Elia (2001) aimed to explore the relationship between depression and perceived social support (peer and family), family conflict, and acculturation in a group of 94 Iranian-American young adults ages 20-30. Elia used the Cultural Life Style Inventory by Mendoza (CLSI) to measure acculturation (self-report and perceived parental), the Beck Depression Inventory to

measure depression, the Family Conflict Scale to measure family conflict, and the Perceived Social Support Scale to measure peer support and family support. The purpose of this study was to establish a more clear understanding of depression and the factors that may impact the occurrence and severity of it in Iranian-American young adults. The sample included 94 Iranian-American young adults, ages 20-30 (36 male and 58 female) from Southern California recruited through snow-ball sampling. Results of this study indicated that approximately one quarter of the participants endorsed depressive symptoms, with 1.1% of the sample obtaining a score of 30 or higher on the BDI, indicative of severe depression. With regard to the relationship between depression and the independent variables, the only statistically significant relationship was found between depression and perceived family support. As the author had predicted, a significant negative relationship was found between depression and perceived family support, meaning that higher rates of depression correlated with lower degrees of perceived family support and inversely, lower rates of depression were related to higher rates of perceived family support. Perceived family support contributed to 5% of the variance in rate of depression. No significant relationships were found between depression and perceived peer support, family conflict, and difference in parental and self -acculturation level. The results also indicated that Iranian females reported higher levels of depression than their male counterparts. Elia states that this is similar to previous findings which report greater rates of depression in women. One possible reason for the Iranian females experiencing higher rates of depression could be the stress and tension placed upon them in their expected gender roles. It is interesting to note that difference in acculturation level between self and parent did not have a significant impact on depression levels, since previous research has shown that differences in acculturation levels between parent and child can cause strained relationships and mental health issues (Janan, 2013; Zandi, 2012).

One possibility for these results could be that the post hoc analysis revealed a significant relationship between self and perceived parental acculturation level, which may suggest that the young adults and their families are actually similar in their level of acculturation (i.e. both high on cultural shift or both high on cultural resistance). In addition, the results indicating that family conflict had no significant relationship with depression were unexpected. However, this may be explained by the fact that the scale used (Family Conflict Scale) may not have been the most accurate or effective scale for this age group. Some of the items in this scale (i.e. items reflecting curfew or responsibilities at home) appear to be irrelevant with this age group. It is also possible that as young adults grow out of adolescence and into adulthood, they may begin to adopt more of a balance between Iranian and U.S. culture and this may also result in less conflict. In addition, the longer the parents live in the U.S.; they may also engage in cultural shift and begin to adopt more U.S. values and beliefs, which make the young adults and their parents more similar in acculturation level.

This study (Elia, 2001) is clinically relevant as depression appears to be one of the most common presenting problems Iranian clients present with in therapy. The finding that family support can impact depression is important in that clinicians should explore family dynamics and try to include family in the treatment, whether directly or indirectly if possible. If possible, future research in this area should include parents as well in order to more accurately measure acculturation level (versus the young adults responding to the perceived parental CLSI). In addition, the sample used in this study was nonrandom and a non-clinical population. It may be useful for future research to focus on a larger, clinical sample.

Treatment Modalities

The following section will highlight and review various theoretical orientations and treatment modalities that have been used with Iranian-American clients. While there are numerous theoretical orientations and approaches that can be used with Iranian-Americans, this section will review and analyze the most common treatment modalities and interventions that have been shown to be beneficial with this population, as indicated in the literature.

Cognitive-Behavioral Therapy (CBT). A survey of the available literature regarding treatment modalities that work with Iranian-Americans reveals that Cognitive-Behavioral therapy has been found to be quite effective (Bayani-Rad, 2012; Forghany, 2013; Ghazi-Moghadam, 2009; Kaeni, 2006; Raoofi, 2011). The therapists interviewed in Kaeni's (2006) exploratory study stated that "CBT techniques work very well" (p. 74) but did not elaborate further on this. Another therapist in Kaeni's study suggested that homework, progressive muscle relaxation, and cognitive restructuring are effective interventions. One reason CBT was found to be so effective could be the short-term nature and goal-oriented nature of this theoretical orientation. In Kaeni's study, several of the therapists interviewed stated that Iranian clients often times expect solutions to their problems in the first session and it is up to the clinician to educate them on how therapy works. Another therapist in the same study found that in his experience, Iranian clients wanted to see results and make sure their money was not being wasted. He also added that he finds this population comes in to take care of a particular problem at that moment, and thus long-term or more process-oriented work is not usually beneficial (Kaeni, 2006).

In a study examining depression in Iranian-Americans, Forghany (2013) posits that due to the significant positive relationship she found between guilt and depression in Iranian-

Americans, CBT is an effective treatment modality for this population. She suggests that CBT can be used to work through guilt, because maladaptive guilt usually arises from maladaptive thinking. By changing the way one thinks, the goal is to change the maladaptive beliefs into more adaptive ones, thus improving mood and behavior.

Khodayafarid and McClenon (2011) suggest that family CBT may be useful for this population and posit three recommendations for therapists regarding treating Iranian clients from a collectivistic culture: (a) family CBT may be more useful than individual CBT; (b) family CBT should have an integrative approach that focuses on symptoms, schemas, and relationships between family members; and (c) family CBT should be adapted to fit the client's religious beliefs.

Ghazi-Moghaddam (2009) found in her qualitative study that Iranian therapists working with Iranian-Americans indicated receiving better results when using a Cognitive-Behavioral (CBT) or Solution-Focused mode of treatment. The therapists in Ghazi-Moghaddam's study stated their reason for this was that in their experiences, Iranian clients are more solution focused versus process-oriented and prefer a "short and quick approach" (p. 67). They also stated that Iranian-American clients often times are less patient and prefer a model of treatment in which the therapist gives "clear and concrete goals for them to follow in order to resolve problems" (p. 68). Ghazi-Moghaddam also found that Iranian-American clients are very receptive to the idea of changing their way of thinking in order to reduce psychological distress, which of course aligns with the principles of CBT treatment. It is important to note that while CBT is indeed an effective treatment method, it also is one of the most widely researched treatment modalities. It is this author's belief that other treatment modalities such as Narrative, Humanistic, and

Psychodynamic may also be quite effective with this population; however, the existing body of literature appears to lack empirical data for this population in these areas.

Solution-Focused Therapy (SFT). As previously indicated in the literature review, it has been found that often times, Iranian-American clients prefer a quicker or solution-focused approach to therapy (Azary, 2006; Bayani-Rad, 2012; Ghazi-Moghadam, 2009; Kaeni, 2006). In fact, Azary (2006) conducted a doctoral dissertation on this topic to see how applicable Solution-Focused Brief Therapy (SFBT) was in working with the Iranian population in Southern California. She used three case studies with a heterogeneous group of Iranian immigrants. The results of her study indicated that the non-confrontational approach of SFBT, the emphasis on strength and resources, the problem-solving approach, as well as techniques such as “saving face” and “the miracle question” (p. 95) create a strong therapeutic relationship in which solutions and possibilities are formulated. Azary also found that SFBT is consistent with the collectivistic orientation that is a part of Iranian-American’s lives. She posits that SFBT takes into account the client’s world view and encourages clients to identify and use their sources of strength and support, which is often the family. Azary also states that Iranian clients may benefit from SFBT as it takes into account social and historical context. It should be noted that this study used a very small sample and cannot simply be generalized to the larger Iranian immigrant population. However, it would be beneficial to further explore this topic, as it was found effective in this study and it has previously been found in the literature that Iranian clients often times prefer quick, solution-oriented approaches in therapy.

Family Therapy. Iranians come from a highly collectivistic society where family is of utmost importance, which is why many researchers state that family therapy is an effective treatment modality with this population (Askari, 2003; Bayani-Rad, 2012; Jalali, 2005; Kaeni,

2006; Khodayafarid & McClenon, 2011; Monakes, 2011; Raoofi, 2011; Shokouhi-Behnam, 1997). Jalali (2005) suggests the use of Structural Family Therapy due to the hierarchical emphasis, which is congruent with Iranian family structure. Askari (2003) also suggests the utilization of Structural Family Therapy as well as a strategic problem-oriented approach, due to the power-hierarchical orientation matching the cultural values. Askari posits that Iranian families tend to respond positively to directives and may sometimes request them. She also suggests that family therapy may be helpful in breaking certain cultural family patterns, such as a mother's closeness to her sons causing a permissive attitude toward them. She added that the therapist should not confront directly, but rather focus on strengthening the child's sibling and father-child relationships, rather than weakening the mother-child bond (Askari, 2003).

A study by Shokouhi-Behnam (1997) examined the applicability of family therapy in a sample of 100 Iranian and American college students in Washington D.C. The results of this study showed that Iranian students rely more on familial relationships than the American students who rely more on friend or peer relationships, which is indicative of the usefulness of family therapy. However, given the small sample size, it would be difficult to generalize the applicability to all Iranian clients. It would be helpful for future studies on this topic to include a larger sample size and include Iranians living all over the U.S. versus being geographically confined to one region.

In a study examining trends in therapy with Iranian-American children, Monakes (2011) found that a family systems model tends to be most effective. In her exploratory study interviewing 6 Iranian therapists in the U.S. who work with Iranian-American children and families, Monakes found that all therapists agreed that understanding family roles and dynamics are essential in working with children because of the collectivist aspect of the culture. The

therapists interviewed also stressed the importance of filial play therapy, or incorporating the parents into the process of play therapy. The study also revealed that psychoeducation is a helpful tool in working with Iranian families due to the importance of education in the culture. One of the therapists in this study stated, “Iranians respond really well to education, to anything that has to do with learning, for them to just understand that this is all a part of learning a skill set, that they are learning and there is no judgment associated with it” (p. 79).

Monakes (2011) also suggests that in addition to Structural Family Therapy, Narrative Family Therapy is also a technique that may work well with Iranian-Americans. A common technique in narrative therapy is to externalize the problem by using metaphors. The therapists interviewed in this study suggest that by using metaphors, individuals and families may feel less threatened and can become open to new solutions. A qualitative study by Nili (2013) also found through interviews with 3 non-Iranian clinicians that the use of metaphors in therapy helps to establish a strong alliance. Since metaphors are indirect and less threatening than speaking overtly about painful topics, they may help bypass any resistance that may be present initially (Nili, 2013). The clinicians interviewed in this study also stated that although culturally bound metaphors are preferred, they need not be culturally bound to be effective, but rather need to hold meaning for the client. This receptiveness to metaphors and story-telling may be due to the Iranian cultural value placed on poetry, proverbs, and literature (Monakes, 2011; Nili, 2013).

Alternative interventions. In recent times, alternative forms of psychotherapy which incorporate the arts have started to become utilized. While there is limited published research on the effectiveness of these alternative forms of therapy with Iranian clients, one study was found that explored the effectiveness of poetry on depression, anxiety, and stress in Iranian females. In this unique study by Mohammadian, Shahidi, Mahaki, Mohammadi, Baghban, and Zayeri

(2011), a group of 28 Iranian females were studied in order to see the effect of the use of poetry in the reduction of symptoms of depression, anxiety, and stress. Many of the participants noted that poetry enabled them to express what they may have otherwise been unable to say in another way. Mohammadian et al. noted that “until the words are expressed, the feelings remain repressed and this may result in depression, frustration, and tension” (p. 62). The results of this study suggest that the use of poetry to treat depression, anxiety, and stress in a group of 28 female college students was indeed effective as measured by the Depression Anxiety Stress Scale (DASS-21). It should be noted that this study took place in Iran, and not in the U.S. with Iranian-Americans. However, it is included because mental health professionals in the U.S. may be able to apply these techniques with clients here as well. It is well-known that poetry and literature in general play a significant role in Iranian society (Mohammadian et al., 2011). In addition, poetry and story-telling date back to the middle ages in Iran where they were used to treat psychosomatic as well as psychological disorders by famous Iranians such as Avicenna, the world renowned physician (Mohammadian et al., 2011). Although this study was performed in Iran and used a small sample size, very strong effects were found and the authors suggest the use of poetry or literature in general may be a very beneficial part of any treatment package used with clients from Iranian backgrounds.

Throughout the literature, it was found that “western theory and techniques” (Kaeni, 2006, p. 2) can be used successfully with Iranian-Americans, but researchers recommended several modifications in order to fit better with the culture. These modifications include: greeting of the client, using an interdependent model of relationships (versus independent), and a more active role in therapy, including psychoeducation and “cultural brokerage” (Kaeni, 2006, p. 2).

Special Populations

Older adults. Psychological studies regarding Iranian-Americans have consistently found that older Iranians are at high risk for mental health difficulties (Ghaffarian, 1998; Ghazi-Moghadam, 2009; Kaeni, 2006; Raofi, 2011). Azary (2006) stated that older Iranian immigrants are among the most susceptible to mental health issues due to significant cultural differences as well as having to be dependent on their children socially and economically. Often times, older adults immigrate as a result of their children's wishes and they have extreme difficulty adjusting to life in the United States. They may view immigration as a loss versus as personal growth, and a disruption of their life (Raofi, 2011). Older adults are typically highly respected in Iran and often times, moving to a new culture in which respect for elders is not as prevalent can be extremely difficult for them. In Iran, elders are usually seen as being at the top of the family and social hierarchy and are treated with the utmost respect (Kaeni, 2006). As individuals in Iran age, they often go to live with their children or other family members and there are "very few, if any" (Kaeni, 2006, p. 15) nursing homes in Iran.

Ghaffarian's (1998) study indicated that higher levels of assimilation or cultural integration (biculturalism) were correlated with better mental health. Her study also found that older Iranian-Americans were more likely to resist cultural change or engage in the separation process. In other words, as age increased, so did scores on cultural resistance (separation), which in turn signified a decreased level of mental health. Ghaffarian found that older immigrants assimilate at a slower rate than their younger counterparts and rely more on their "past experiences and not as much on new learning experiences and therefore adjust less easily to the ways of the new society" (p. 651). Given that higher rates of separation or cultural resistance were found to be correlated with lower levels of mental health (i.e. more psychological and

emotional difficulties), it is particularly important for older Iranian-American immigrants to receive culturally responsive mental health services.

In his doctoral dissertation examining older Iranian immigrants and mental health vulnerabilities, Raoofi (2011) interviewed three Iranian-American clinicians in the Los Angeles area who had significant experience working with older Iranian immigrants in order to find more effective ways of treating this population. He found that due to the language barrier, culture clash, and the nature of immigration of older adults, they were particularly vulnerable to mental difficulties such as depression and anxiety. Through his interviews, Raoofi found that it is often times more difficult for older Iranians to adapt or assimilate into this society, which is consistent with previous studies that have found positive correlations between acculturation and younger age of immigration (Hanassab, 1991). Raoofi (2011) also found that the most common stressors for this population are financial difficulties, language difficulties, gender role differences compared to Iran, difficulty adjusting to new customs, prejudice and stereotyping, as well as a loss of adulation and respect that they enjoyed back home as “wiser members of society” (p. 48). Loss of status also appeared to be a significant issue for this population, as it is more challenging to rebuild and start over in a foreign land at an older age (Raoofi, 2011).

In regards to which treatment modalities work effectively with this population, all three therapists surveyed reported that using a here-and-now approach and CBT interventions have worked well in reducing depressive and anxious symptoms (Raoofi, 2011). It was also found in Raoofi’s (2011) study that this population is open to psychiatry, as medication would help provide a medical explanation for and treatment of their symptoms. Raoofi also found that using family therapy and treating the family (versus only the individual) is also effective. This could be due to the fact that many older adults live with their children and are thus a part of their everyday

lives. Raofi posits that clinicians working with this population need to be culturally aware of the hardships and realities older immigrants face. In addition, cultural brokerage and psychoeducation (which is crucial for all immigrant clients) are especially important to utilize with this population. Raofi also stated that seeking consultation from other clinicians experienced in working with this population could be beneficial.

Adolescents. It is well known that adolescence is a time of many changes, developments, transitions, and adjustments. Social identity is developed during this time and there are many theories and published research devoted to this issue. However, it is crucial to also explore ethnic identity development in adolescents, as this an important aspect of development (Sayyedi, 2011). In the case of Iranian-American adolescents, they may experience a greater amount of stress due to cultural issues and may have to negotiate their social identity as well (Sayyedi, 2011). The stress associated with this can make this population especially vulnerable to mental health difficulties and adjustment problems. Thus, it is especially crucial for clinicians to be aware of the unique issues this population is faced with and to be mindful of them when conceptualizing and treating them as clients. Based on her clinical experience with Iranian-American youth, Sayyedi states that often times Iranian immigrant parents utilize shaming techniques or control in order to discipline their children. Sayyedi adds that this type of parenting may lead to problems such as maladjustment, addiction issues, conduct disorders, and academic failure. She also states that on the other end of the spectrum, Iranian immigrant parents may be overly lax and overindulgent, which she feels may lead to youth who present as self-absorbed, entitled, antisocial, and engage in self-destructive behaviors.

In an exploratory study by Bayani-Rad (2012), experiences, challenges, and psychological distress in second-generation Iranian adolescents were studied by interviews with

5 field consultants in the Los Angeles area. Bayani-Rad defined second-generation as “U.S. born children with Iranian-born parents” or “Iranian children born abroad who came to the U.S. before the age of 12” (p. 11). Through interviews with the 5 psychologists, Bayani-Rad found that the most common presenting problems they experiences were self-esteem issues, relational difficulties, and depression. Results of this study also indicated that many adolescents struggled with issues related to parental expectations, identity issues, and acculturation (i.e. parents resisting acculturating while adolescents become highly assimilated). It was found in this study that often times, adolescents can experience depression when they feel unable to fulfill their family expectations regarding marriage, career choice, and higher education. Many of the identity issues the psychologists in this study encountered were issues surrounding feelings of guilt for wanting to break away from family, or family expectations of specific educational attainment or career choice. Another common topic brought up was the issue of marriage and feeling pressed to marry someone “professional, educated, and wealthy” (p. 56). Specifically, the issue of marriage tended to be more problematic for Jewish youth in this study, as they reported feeling significant pressure to date and marry within their own ethnicity and religion. Bayani-Rad also sought to explore unique experiences that Iranian-American adolescent’s experience that may not necessarily be problematic for youth of other ethnicities. Responses among the field consultants included issues such as “having to live with parents until marriage, dealing with parents’ feelings regarding premarital sex, and expectations of seeking higher education” (p. 57).

Bayani-Rad’s (2012) study implied that the most beneficial treatment approaches for Iranian-American second generation adolescents included Cognitive-Behavioral Therapy, Solution-Focused Therapy, Time Limited Dynamic Therapy, and Family Systems interventions.

It was also suggested that focusing on relationships and interpersonal communication were helpful modes of treatment, since relationships tend to be a salient theme in this population. In regard to Time Limited Dynamic Therapy, all of the psychologists interviewed agreed that this could be an effective treatment only if the individual is ready to fully engage in the process. Results of Bayani-Rad's study also suggest that clinicians have knowledge regarding the difference between individualistic and collectivistic cultures and how that may impact Iranian adolescents in the U.S. They should also be ready to address how this impacts parents and be able to work through making changes within the family system as a whole.

A quantitative study by Partiali (2011) explored the relationship between family conflict and depression and somatization, while also examining the potential mediating roles of sociotropy (excessive investment in interpersonal relationships) and coping among Iranian-American adolescents. The sample for this study consisted of 85 Iranian-American adolescents from Los Angeles, ages 14-17, with at least one parent born in Iran. Partiali measured family conflict by using the Family Environment Scale (FES), depression and somatization were measured by the Brief Symptoms Inventory (BSI 18), and coping and sociotropy were measured by the Responses to Stress Questionnaire-Family Conflict Version (RSQ) and Personal Style Inventory (PSI II). Results of this study showed that depression (but not somatization) was positively correlated with family conflict and sociotropy. In regard to coping style, involuntary engagement (i.e. rumination, intrusive thoughts, emotional arousal, physiological arousal, and impulsive action) was positively correlated with somatization, while involuntary disengagement (emotional numbing, cognitive interference escape, and inaction) was found to be the best predictor of depression. Given the highly collectivistic nature of Iranian culture, it is not surprising that sociotropy would be a personality trait that indicates a vulnerability to depression.

In addition, the author posits that disengagement coping styles stop individuals from addressing their concerns directly, which can result in unhealthy stress responses that can ultimately lead to depression. The limitations of this study include the small non-clinical sample size, which makes it difficult to generalize results to other Iranian-American adolescents. In addition, a large percentage of the sample identified as Jewish, which is also not representative of the larger Iranian-American population as a whole. Finally, this study was a cross-sectional study and thus results show correlation rather than causality. Nonetheless, these results highlight the importance of family conflict, sociotropy and coping styles on depression and somatization and show how family support can buffer the effects of stress in Iranian-American adolescents. These findings advance the understanding of the relationship between family conflict, psychological maladjustment (depression and somatization), and sociotropy and coping, which is currently an area of research with little published literature. Given the fact that Iranian culture is highly collectivistic, future studies that examine sociotropy and family conflict and their impact on mental health would be beneficial. It would also be helpful to determine which variables impact sociotropy, such as gender or acculturation level.

In regard to treatment, Sayyedi (2011) has found that although one should be sensitive to culture, clinicians should also be careful to not solely rely on the adolescents to educate them on their parents' acculturation level. In other words, adolescents may try to manipulate the therapist to focus on cultural differences to the extent that their own problems may go unnoticed (Sayyedi, 2011). Sayyedi also suggests that therapists should help adolescents develop an understanding of the cultural expectations of their parents. Iranian culture is collectivistic in nature, and thus often times a child's maturity is defined by how they can care for others versus being responsible only for oneself. Sayyedi posits that therapists can help adolescents understand and respect this value

and attain their own autonomy by proving to their parents they are mature individuals who also care for the well-being of their family. She adds that parents should express what they perceive as responsible acts of caring for the family, so that it is clearly defined for the adolescent. Once both parties understand what is expected of the other, the therapist can then help negotiate a compromise in which both parents and adolescents may benefit.

Jewish Iranian-Americans. There is a paucity of literature regarding Jewish Iranian-Americans as most published research focuses on the Muslim majority. It is important, however, that further research be conducted on all religious groups to better inform clinicians of any unique characteristics they may possess. In a study by Malakuti (2012), depression and anxiety were identified as the two most common psychological concerns of this population. Obsessive Compulsive Disorder (OCD) symptoms, relationship difficulties, identity issues, and low self-esteem were also found to be common issues. Malakuti explored depression and anxiety as well as implications for treatment in the Iranian Jewish population in her doctoral dissertation. By conducting in-depth interviews with several clinicians in the Los Angeles area who had significant experience working with Iranian Jewish immigrants, Malakuti's study revealed four points to be aware of when working with this population:

- 1) Clinicians should be sensitive to the individuals' immigration process and experiences and how this may impact their depression or anxiety.
- 2) Clinicians should have a basic understanding of the Iranian Jewish population, including their beliefs, traditions, and double-minority status. Malakuti described the "double minority" (p. 139) status as being both a minority in the U.S. (due to being Iranian) and a minority within the Iranian community (due to being Jewish). She posits that this status

can have a significant negative impact on anxiety and depression due to how they may be perceived and whether or not they feel as if they belong to a community.

- 3) Clinicians should take a more directive approach when needed, and to be mindful of not imposing one's own values onto the client. Several of the clinicians interviewed in this study mentioned this population not responding well to the "blank slate" (p. 139) approach which makes them feel as though they are wasting their money. Malakuti suggests that this preference for a direct approach and a quick fix could also be due to the history of mental health in Iran, in which clients were used to being diagnosed quickly.
- 4) Clinicians should be familiar with challenges that may prove to be barriers, and how to work around them. The barriers identified through this study were cultural concepts specific to Iranians and will be discussed in depth in the next section.

Cultural Considerations

As stated previously, it is imperative that clinicians understand the culture of the client in order to better work with them in therapy. This section will focus on what the existing literature has found regarding Iranian culture and how culture specific phenomenon can impact the therapeutic relationship as well as therapy in general. It is important to note that not all Iranian-American clients may present with these characteristics, therefore clinicians should not stereotype or generalize. However, it is beneficial for clinicians to at least be familiar with and consider these cultural aspects when working with this population in order to not mistake the behaviors for resistance to therapy.

Family. As stated previously, when working with Iranian clients it is important to take into consideration the family as a whole as well their role within the family. Kaeni (2006) found that it is crucial to make sure one does not mistakenly label a family as "enmeshed" (p. 57) due

to Western standards. She stated that it is very important to understand that what may be viewed as enmeshed in the United States could be considered culturally congruent in Iranian families. One example she used was with a child who wants to have a particular career, however, does not pursue that if the parents do not approve of it. Kaeni also stated that in Iran, when one marries they are expanding their existing family, versus creating their own separate family. Kaeni's study also revealed the importance of interdependency versus independency, which clinicians should be mindful of when working with this population. Kaeni stated that the goal for clients often is "not so much to move on and do your own thing" (p. 58) but rather to function more effectively within the context of family while carrying on their social and family roles and meeting obligations.

Cultural dynamics. It is also important for clinicians to be aware of culture specific phenomenon that may impact the therapeutic relationship. One culture specific norm in particular clinicians should understand is *tarof*, which does not have a direct English translation (Kaeni, 2006) but can best be described as a "formality that you use out of respect toward other people" or "a balance between being gracious and not greedy" (Kaeni, 2006, p. 59). In Kaeni's study, one therapist illustrated how this can play out in therapy with an example of a client paying the full fee on the first session and then in later sessions saying that it was too much. The therapist believed that the client may have thought the fee was too high in the first session as well, but was *tarofing*. Gorovoy (2013) described *tarof* as "something of an implicit test of wills" and added that "guests are supposed to act as if they have no need while their host attempt to figure out precisely what their needs are" (p. 47). Malakuti (2012) defined *tarof* as continual consideration or thoughtfulness towards the needs of others. An example Malakuti used that can apply to the therapeutic relationship is a clinician allowing the client to walk into the room ahead

of them. Mahdavi (2012) defined *tarof* as the cultural practice of using compliments, polite language, and courteous actions in familial, social, political, and business settings. Mahdavi stated that to an outsider, *tarof* can be seen as unnecessary, excessive or even disingenuous, but to Iranians or individuals familiar with Iranian culture, it is an “essential part of daily life” (p. 12). Mahdavi conducted a quantitative study on a sample of 98 Iranian-Americans in Los Angeles in order to examine the relationship of *tarof* to gender and acculturation and results indicated that there were no significant differences between first and second generation Iranians as well as between males and females. These results appear to suggest that *tarof* is an especially strong cultural practice that is utilized by a majority of Iranians. Another culture specific dynamic found in the literature was the form of greeting the client. Therapists stated that they do not greet Iranian clients the same way as American clients, but rather treat them as if they are guests in their home (Ghazi-Moghadam, 2009; Kaeni, 2006). The therapists in these studies expressed modifying their greetings and the use of *tarof* in order to make clients feel comfortable.

Other culture specific issues that may impact treatment are *aberu* and *mehrtalabee* (Malakuti, 2012). *Aberu* refers to the constant fear or worry about how other people will judge, or in other words, fear of losing face. Malakuti found in her study that this tended to be a very common concern with Iranian-American Jewish clients. Malakuti defined *mehrtalabee* as “people-pleasing behavior” (p. 139) or engaging in certain behaviors only for the sake of image or what other people will think. Malakuti also found this concept to be a significant concern with Jewish Iranians, as well as Iranians in general. Being familiar with these concepts is important for clinicians so that they may understand other problems that may be an indirect result of these behaviors (i.e. low self-esteem).

Bargaining for fees. The issue of bargaining, known as *chooneh*, was brought up in the literature as a culture specific dynamic that may often occur with Iranian-American clients (Bayani-Rad, 2012; Ghazi-Moghadam, 2009; Kaeni, 2006; Nili, 2013). This practice of bargaining or bartering for fees has its roots in social tradition and may be observed more often in older Iranians, who have spent most of their lives in Iran (Ghazi-Moghadam, 2009). The therapists surveyed in these studies stated that this is a matter of cultural habit and warned clinicians who may be unfamiliar with this practice to avoid taking offense. One therapist stated that they look at it as part of the culture and use a sliding scale when they can, however, they do not treat them any differently than other clients (Kaeni, 2006).

Time. The fluidity of time is another issue that was brought up in the literature as a potential culture specific dynamic that may occur in therapy (Askari, 2003; Bayani-Rad, 2012; Ghazi-Moghadam, 2009; Sayyedi, 2011). Askari (2003) stated, “generally, punctuality is not a high priority for Iranians” (p. 119). She suggests clinicians initially be prepared for a potential late arrival to an appointment, and to “kindly mention the importance of being punctual” (p. 119). Sayyedi (2011) found that often times, Iranian-American clients will measure the therapist’s degree of care or interest by how much time they spend with them. Often times, clients may be late for appointments or cancel with short notice (Ghazi-Moghadam, 2009). Sayyedi (2011) suggests discussing these issues in a warm and friendly manner, with the therapist even using an apologetic tone but setting boundaries nonetheless.

Boundaries. Ghazi-Moghadam’s (2009) exploratory study found that one of the most common issues brought up by Iranian therapists working with Iranian clients was a lack of boundaries. The therapists interviewed in this study indicated that in their experience, Iranian clients tended to have poor boundaries both in the therapeutic relationship as well as their own

interpersonal relationships. The therapists in Ghazi-Moghadam's study stated that they found older and more traditional Iranians to "not respect the independence and privacy of their children and friends" (p. 58). In regard to therapy, the study found that Iranian clients often times did not recognize the limitations of a therapeutic relationship and wanted to become "friends" with the therapist or develop a relationship outside of therapy. The results of Ghazi-Moghadam's study indicated that boundary setting was a topic that therapists could teach clients and work with them on, both in therapy as well as for their outside relationships. Sayyedi (2011) also found that less acculturated or more traditional Iranians prefer the therapist to share more about their own lives, which normalizes their expectation of a close relationship with the therapist. In some cases, Sayyedi even suggests that Iranian-Americans may think of the therapist as an "adopted member of the family" (p. 270). Sayyedi suggests therapists be open to disclosing their own cultural experiences in order to put clients at ease with regard to not being perceived as "maladjusted or deviant" (p. 270). Disclosure also helps maintain a perception of friendliness, which can be beneficial for the therapeutic relationship. Askari (2003) also encouraged therapists to be prepared for personal questions from the client and to share some of their experiences in order to establish trust and rapport. Askari also explored the issue of gifts in therapy. She found that Iranians usually like to offer gifts as gestures of appreciation and it would be prudent for the clinician to be upfront about their policies regarding gifts, while expressing gratitude and appreciation for the gesture. It is this author's recommendation that therapists accept gifts from their Iranian clients, as not accepting a gift (especially from an elder) can be taken as a sign of disrespect. Of course, therapists should use their clinical judgment when accepting gifts, but in the majority of cases, Iranian clients offering gifts should be taken as sign of respect and appreciation, and not as a way to cross boundaries.

Kaeni's (2006) study also showed that boundaries and confidentiality were issues that the interviewed therapists often experienced in working with Iranian-American clients. Kaeni stated that boundaries and confidentiality need to be thoroughly explained to clients, since rules and laws in the United States may be significantly different than what clients are used to in Iran. In addition, Iranian parents may not realize that due to confidentiality, their child's therapist cannot disclose information about their therapy, thus therapists must be "direct and verbal" (Kaeni, 2006, p. 75) regarding confidentiality and boundaries. Kaeni also found that these issues of boundaries and confidentiality tend to be more of an issue when the therapist is also Iranian. This could be due to client feeling as though the therapist would "bend the rules" (Kaeni, 2006, p. 75) for them due to shared ethnicity and perceived closeness.

Psychoeducation. Due to all of the culture specific factors discussed above, it is imperative for clinicians to educate Iranian clients about therapy and how it works (i.e. what therapy entails, how long it may take and why, how payments are arranged, how medications work, explaining of boundaries, adhering to timelines, ethical guidelines, and confidentiality). Kaeni (2006) suggests clinicians act as "cultural brokers" (p. 87) for their clients to assist them in assimilating to their new environments and relationships. She also suggests that clinicians take a more active stance in order to help their clients make any cultural adjustments necessary for improved mental health. This role as a cultural broker is especially important when working with a less acculturated client (i.e. older adult or a newly arrived immigrant) and clinicians should try their best to assist them with general information, such as knowing they can take a driver's license exam in Farsi, or any other basic information that a non-Iranian may overlook (Kaeni, 2006). It also appears that there seems to still be a stigma related to mental health services, especially in the older population (Shamtoub, 2013). Since Iranians place a high value

on education, psychoeducational interventions, courses, and workshops may be a helpful tool in reaching out to the community and dispelling myths surrounding mental health services.

Clinicians should also be mindful of providing resources and referrals when necessary and being aware that they may need to be more active and explicit with directions.

Strengths. When working with any population, it is imperative to focus not only on clinical issues and difficulties, but on strengths and sources of resilience as well. A literature review on counseling with Iranian-Americans would not be complete without addressing the many strengths inherent in Iranian culture.

As stated previously, Iranian-Americans strongly value education and achievement (Jalali, 2005) and are among the most highly educated ethnic group in the United States, with almost 30% of individuals over the age of 25 obtaining an advanced graduate degree (U.S. Census Bureau, 2012). Ever since the first phase of immigration to the U.S., Iranian-Americans have engaged in highly respected occupations in U.S. society, including: medicine, academia, science and engineering, and more recently the business and technology field as well (“Iranian American,” 2012). It is important for clinicians to use this strength as an asset when working with Iranian clients, and to utilize psychoeducation and homework whenever possible, as Iranian clients are likely to respond well when treatment incorporates educational components. The drive for higher educational attainment has likely helped Iranian-Americans achieve higher socioeconomic status as well. According to Mostashari and Khodamhosseini (2004), the per capita income for Iranian-Americans is 50% higher than that of the nation’s average and the percentage of Iranian-Americans living in homes valued more than \$1 million is nearly 10 times that of the national average (Mostashari & Khodamhosseini, 2004). Der-Martirosian (2008) posits that one reason Iranian-Americans are so successful is the fact that they are “professionals

and high skilled entrepreneurs” (p. 13). Another strength this community possesses is the desire and means to learn the English language in order to be competitive in the U.S. job market.

Mostashari and Khodamhosseini found that only 7% of Iranian-American households do not speak English in the home at all. Given that Iranian-Americans are a relatively new immigrant group, these figures are a testament to how hard-working and resilient this community is.

In addition to professional strengths, Iranian-Americans possess many personal strengths and values that should be noted. It is this author’s observation that Iranians are naturally a collectivistic culture and hold family in high regard, with parents often times doing whatever they can (financially as well as emotionally) for their children, even as adults. Iranian families tend to hold the utmost respect for the elders of the family (Jalali, 2005; Raoofi, 2011), thus clinicians should be aware of these dynamics when working with older Iranians. Iranian culture also has a strong appreciation for the arts (i.e. poetry) and Iranians are proud of their prolific history. Clinicians who are unfamiliar with ancient Iranian history are strongly encouraged to become familiar with it when working with Iranian clients. It is also in this author’s experience that Iranians do not like to go anywhere empty-handed and enjoy offering gifts to friends and family when visiting their homes. These gifts are often in the form of food, flowers, or other small goods. Iranian clients may try to show their affection and respect with gestures such as gift-giving, and as stated previously, clinicians should be aware that this is culturally appropriate and not a means of breaking boundaries. Iranians also tend to appreciate humor (Ghazi-Moghadam, 2009) and when possible, clinicians should try to incorporate this into the therapeutic relationship. Finally, it is this author’s observation that Iranians tend to be very warm, compassionate, and hospitable individuals. Iranians are generally generous individuals

who place the comfort of others above their own. It should be noted that Iranians tend to be affectionate and are likely to respond well to an empathic, attentive, and warm therapy style.

Chapter IV. Discussion

Introduction

The following chapter will provide a summary and overview of the previous chapter as well as note general themes found within the literature regarding counseling with Iranian-Americans. In addition, general limitations will be discussed, as well as suggested directions for future research. The chapter will close with a brief set of guidelines for clinicians when working with the Iranian-American population in a mental health setting.

Synthesis of General Findings

The previous literature review provided information from the currently existing database of published psychological research regarding counseling with Iranian-Americans. After a thorough analysis of relevant literature, general themes or key points were found and the following is a brief overview.

Ethnic identity. Throughout the review of the literature, it was found that Iranian ethnic identity is one of complexity (Mobasher, 2006). It was found that for many Iranian immigrants and second generation individuals, there is a struggle between balancing their Iranian identity along with their new found American identity. The development of this new identity can be problematic or confusing due to the fact that for many, race or ethnicity were never an issue in Iran and the first time they were not in the majority was after arrival in the U.S. (Asayesh, 2006). In addition, discrimination and negative associations due to the Hostage Situation as well as 9/11 has caused increased identity struggles and negative self-perceptions for many Iranians, causing them to label themselves as *Persian* rather than Iranian (Daha, 2011; Garakani, 2008; Mobasher, 2006; Mostofi, 2003). This author has personally witnessed a significant amount of Iranian-Americans label themselves as *Persian*, due to the negative stigma often times attached to the

Islamic Republic of Iran. Clinicians should always ask how individuals identify themselves before making any assumptions. In addition, it may be helpful to start a discussion around why one identifies the way they do (i.e. Persian or Iranian or Iranian-American, etc.) as this may provide valuable clinical information. Malakuti (2012) also suggests clinicians be aware of the “double minority” status that Jewish Iranian-Americans hold and to explore what this means to them and how it relates to identity and mental health in general. One area of ethnic identity that has been overlooked is the identity development, experiences, and difficulties of bicultural or biracial Iranian-Americans. As the rate of intermarriage in the Iranian population is increasing, one can hypothesize that the number of individuals who identify as both Iranian as well as another race is increasing as well. It is also important to keep in mind that Iranians are a diverse and heterogeneous group and to generalize their experiences or to label them with any collective profile is highly discouraged. Clinicians should be aware of similarities and differences, but always ask their clients about their own unique experience in regard to ethnic identity.

Help-seeking behaviors. A review of the literature found that despite the traditional stigma attached to mental health, the Iranian-American population is slowly starting to change this trend, due in part to the contributions of well-known and respected therapist, Dr. Farhang Holakouee (Garakani, 2008; Shamloo, 2009). In addition, it was found that females typically tend to be more open to seeking counseling, as do individuals who have lived in the U.S. longer, as well as individuals with high levels of education (Gorovoy, 2013). In regard to acculturation playing a role in openness to seeking mental health services, results appear to be inconsistent. While Gorovoy (2013) and Hill-Lindsay (2007) found that more assimilated individuals in their studies were more open to seeking services, Khanideh (2007) did not find a significant relationship between these two variables. It appears that further research with larger sample

sizes is needed in order to better determine the impact acculturation has on openness to seeking services. In addition, when different studies utilize different scales to measure acculturation, it is difficult to compare results. It is this author's personal and professional observation that females tend to be more open than males in this community seeking mental health services, perhaps due to the traditional expectation for males to be strong and not need help from outsiders. In addition, as it has been found that longer residency in the U.S. positively impacts openness to seek services (and longer residency has been correlated with higher assimilation rates), this author hypothesizes that assimilation into U.S. culture may positively impact openness to seek services. According to Ghaffarian (1998), older Iranians are also more likely to be resistant to seeking services. This author has also observed this in the community and believes that outreach, psychoeducation, and preventative programs targeted toward older Iranians are necessary. There are various adult day centers and communities for older Iranians in the Los Angeles and Orange County areas and these would be excellent places to conduct these programs in order to reach an underserved portion of the Iranian-American population.

Acculturation. Acculturation is a complex process and appears to be either directly or indirectly involved in Iranian-American mental health. The literature suggests that resisting U.S. oriented culture (*cultural resistance* or *separation* acculturation style) is correlated with mental health difficulties such as acculturative stress, anxiety and depression (Darya, 2006; Ghaffarian, 1987; Ghaffarian 1998; Kadkhoda, 2001; Saedi, 2009; Saghafi et al., 2012). Similarly, assimilating into U.S. oriented culture or integrating both Iranian and U.S. cultures (i.e. biculturalism) has been linked with decreased acculturative stress and mental health difficulties. Thus, the existing literature appears to suggest that for a significant amount of the Iranian-American population, integrating or assimilating to U.S. culture has proven to be beneficial for

their mental health. However, conflicting results were found in Kadkhoda's study in which biculturalism or integration was actually found to be correlated with higher levels of anxiety and depression. These results could be due to the particular sample in this study having difficulty balancing both Iranian and U.S. culture, resulting in higher levels of stress. A majority of the participants in this study were older and born and raised in Iran, thus it can be hypothesized that for older immigrants, trying to balance two significantly different cultures may be distressing. Kadkhoda posits that incorporating both cultures may be easier for second generation Iranian-Americans or first generation immigrants who emigrate at a younger age. However, for the majority of Iranian-Americans, the literature appears to consistently find that assimilation and integration are correlated positively with better mental health due to the fact that resisting U.S. culture isolates individuals since the two cultures are so different, and integrating allows one to in a sense, have the best of both worlds. One acculturation style which was not mentioned in the literature was marginalization. This author feels that marginalized individuals are highly likely to experience acculturative stress as well as increased levels of anxiety, depression, and other mental health difficulties. It would be useful for future studies to utilize larger and more geographically random samples. Perhaps if participants were surveyed from areas in which there are not large Iranian communities, one may find different acculturation styles, such as marginalization. It would be important to determine this and to try and reach out to those populations with preventative or psychoeducational programs. It appears longer length of residency in the U.S. and/or younger ages of emigration were found to be strong predictors of assimilating at a higher rate (Hanassab, 1991). Furthermore, older Iranians were found to have higher rates of *cultural resistance* or *separation* throughout the available literature (Ghaffarian, 1998; Raoofi, 2011), as well as through this author's personal and professional experiences,

placing them at an increased risk of experiencing acculturative stress. One suggestion this author has for future studies is to create a valid and reliable acculturation scale for Iranian-Americans (sampled on Iranians living in the U.S.), in both Farsi and English. Although there is currently one acculturation scale designed for Iranians, Shahim's Iranian Acculturation Scale, it is sampled on only 119 Iranians living in Canada (Shahim, 2007). Nourian (2012) described this scale as "not well-established" and "not frequently used" (p. 54). The creation of an Iranian-American acculturation scale in English and Farsi would assist in creating consistency between studies and in addition would not leave out individuals who are not fluent in English. The fact that many of these studies utilized English-only scales potentially skews results and leaves out individuals who are likely to be less assimilated. Another recommendation this author has for future research is to study not only acculturation patterns, but *reasons* for acculturation style as well. In other words, it would be beneficial to know what factors influence one's decision to assimilate, separate, or integrate. This author hypothesizes that the high drive for financial success and academic achievement may be motivating factors for learning English quickly and assimilating into U.S. culture; however, it is difficult to determine without the relevant research and literature.

Common presenting problems. Although there are countless issues and presenting concerns that may cause this population to seek professional psychological help, there are specific issues that were found in the literature to be the most salient among Iranian-Americans. It is important to note that acculturative stress and differences in acculturation patterns between families and spouses are often times directly or indirectly involved in many of these issues. These include conflict over evolving gender roles (Abdolsalehi, 2010; Hanassab, 1991; Hanassab & Tidwell, 1996; Hojat et al., 1999; Hojat et al., 2000; Ghazi-Moghadam, 2009; Janan, 2013; Kaeni, 2006), marital difficulties (Askari, 2003; Bakhtiyary, 2012; Hojat et al., 2000; Kaeni,

2006;) parent-child difficulties (Frank et al., 2010; Jalali, 2005; Janan, 2013; Sayyedi, 2011; Zandi, 2012), high divorce rates (Hojat et al, 2000; Sajed, 2012), trauma (Mohadjer, 2009; Shamtoub, 2013), anxiety and depression (Bayani-Rad, 2012; Elia, 2001; Kadkhoda, 2001; Malakuti, 2012; Saedi, 2009) . Other issues brought up in the literature include gambling, perfectionism, and eating disorders. Clinicians should also be aware that as a collectivistic culture, Iranians place high emphasis on family and interpersonal relationships and family support can influence mental health significantly. Thus, clinicians should always inquire about family and interpersonal relationships and assist in increasing their client's social support if possible. An analysis of the literature also suggests that this population may present with somatic complaints when experiencing emotional distress due to less stigma being attached to medical issues (Ghadisha, 2004; Holakouee, 2011; Jalali, 2005; Rouhparvar, 2000). It is recommended that clinicians keep in mind that somatization is more culturally acceptable and to make sure to ask about any adjustment difficulties or distress in their lives that may be contributing to the physical symptoms. Often times, the client may not even realize the connection between their emotional state and their physical symptoms, thus the clinician should be patient and aid them in better understanding what their physical symptoms represent. Clinicians should also be mindful of the negative stigma surrounding mental illness, especially diagnoses and labels. This author suggests that when possible, clinicians try to avoid the use of labels and diagnoses and to treat the client from a strength-based approach.

Treatment modalities. Overall, the literature suggests that various treatment modalities and theoretical orientations can be utilized with Iranian-Americans. As with any client, it is crucial to assess contextual factors to determine which mode of treatment will work best. An

analysis of the existing literature regarding therapy with Iranian-Americans reveals several types of therapy that appear to be quite commonly used and effective: Family Therapy (Askari, 2003; Bayani-Rad, 2012; Jalali, 2005; Kaeni, 2006; Khodayafarid & McClenon, 2011; Monakes, 2011; Raofi, 2011; Shokouhi-Behnam, 1997), Cognitive-Behavioral Therapy (Bayani-Rad, 2012; Forghany, 2013; Ghazi-Moghadam, 2009; Kaeni, 2006; Raofi, 2011;), and Solution Focused Therapy (Azary, 2006; Bayani-Rad, 2012; Ghazi-Moghadam, 2009; Kaeni, 2006). Nili (2013) also highlights the importance of using metaphor in therapy. The use of metaphor may appear to be less threatening to this population, as it is less direct, and thus less stigmatizing. Externalizing the problem, a technique used in Narrative Therapy, is also recommended when working with this population, as is avoiding labels and diagnoses, as stated previously.

Cultural considerations. In order to better serve the Iranian-American community, or any ethnic group for that matter, clinicians need to be familiar with cultural dynamics that may play a role in therapy and the therapeutic alliance. It is important to note that not all Iranian-Americans may present with these culture specific attitudes or behaviors, but it is important to be familiar with them in the case that they do. This author recommends that non-Iranian clinicians engage in conversation with Iranian clients and inquire about their experiences in the U.S. in order to show genuine interest and concern. It has been this author's experience that Iranians often enjoy talking about their culture or their experiences with non-Iranians, thus engaging in these types of conversations will likely strengthen the therapeutic bond. Common cultural dynamics found within the literature include the use of *tarof*, *aberu*, and *mehrtalabee* (Ghazi-Moghadam, 2009; Gorovoy, 2013; Kaeni, 2006; Mahdavi, 2012; Malakuti, 2012). In addition, clinicians should be aware of the cultural tradition of bargaining for fees (*chooneh*), the fluidity of time, and lack of strict boundaries (Askari, 2003; Ghazi-Moghadam, 2009; Kaeni, 2006;

Malakuti, 2012). The importance of family and collectivism was also brought up in the literature, as was the importance of emphasizing interdependence versus independence (Hadizade, et al., 2013; Kaeni, 2006; Zandi, 2012). It is crucial for clinicians to make sure they do not mistake interdependence for enmeshment, based on Western standards. Doing so can potentially rupture the therapeutic relationship, thus resulting in resistance, termination or unsuccessful work. This author also recommends incorporating strengths into therapeutic work versus solely focusing on difficulties. For example, a majority of this population has proven to be successful academically, and places high value on education. Clinicians should be aware of this and utilize educational approaches, such as incorporating homework or bibliotherapy into their work. In addition, reaching this population through educational and preventative workshops and programs may be a useful way of reframing therapy into a positive and growth enhancing experience.

Limitations

One significant limitation throughout this process was the lack of available published peer- reviewed journal articles. A vast majority of the literature was found in the form of doctoral dissertations. Although this may prove useful for a student completing a dissertation, the average mental health clinician who would like to learn more about Iranians and about clinically relevant techniques or issues will not have the time to read through such a long document. It is crucial for more literature to be conducted in the form of journal articles or book chapters, which are more easily accessible and readable to clinicians.

Another limitation found throughout the literature is the use of scales and measures that have not been normed on an Iranian sample population, and/or do not take into account cultural factors (Khanideh, 2007; Khoie, 2002; Zandi, 2012). This proves the need for culturally appropriate scales to be created in order to provide more reliable and valid quantitative results.

Although Nourian's (2012) study included the use of the first acculturation scale created for Iranians, this scale still has not been utilized enough to provide clinically useful results. In addition, when measuring acculturation, it is imperative that scales be available in both English and Farsi. It can be hypothesized that if one does not have a strong command of the English language, they may be less likely to have assimilated. If scales are only available in English, many individuals who are less assimilated may not have the chance to participate in these studies, thus potentially skewing results as well as missing valuable information on this population. In addition, it is this author's belief that current acculturation scales fail to capture the complexity of the acculturation process and/or describe it in linear terms. For example, an individual may score high on assimilation in domains of language and cultural identity, yet score high on separation in domains of family values and relationships. Future research in developing an acculturation scale or profile that can capture the differences in each domain would help to describe this process more accurately.

In addition, several of the studies that measured issues relating to parents and children did not actually obtain data from the parents, but rather through the children's perception (Frank et al., 2010; Zandi, 2012). This may result in data that may not be fully accurate and future studies should be mindful of surveying each person individually rather than having someone fill in data for others based on perception.

Future Directions for Research

Based on the current literature review and on the author's knowledge of issues within the Iranian-American community, it is imperative that further research be conducted on this population in order to better serve their mental health needs. It is imperative that issues

concerning psychoeducation and preventative education be further explored, as this population tends to respond well to education and learning (Monakes, 2011). Specifically, it would be helpful to conduct this research on older adults and newly arrived immigrants, as they have been shown to report higher levels of cultural resistance, increasing their risk of mental health issues (Ghaffarian, 1998; Raoofi, 2011). It would also be beneficial to target males, as they appear to be more resistant to seeking mental health (Gorovoy, 2013). Dr. Farhang Holakouee, a well-known and respected figure in the field of Iranian-American mental health, emphasized the importance of prevention and early intervention (Shamloo, 2009). Thus, programs such as pre-marital counseling and parenting skills courses would be beneficial to the community. Research should try to focus on ways to change the view of mental health counseling from “illness-curing” to normal and “growth-enhancing” (Shamloo, 2009, p. 64).

In terms of treatment modalities, it is crucial for quantitative and qualitative research to be conducted on this population in order to better understand which interventions are most effective. It would be helpful to conduct experiments that include a control group in order to better see the effect of each specific treatment (i.e. a study comparing CBT for depression versus SFT for depression). Longitudinal studies would also be helpful to see how treatment impacts individuals over time. In addition, it has been shown that using alternative forms of therapy such as poetry and the arts has been efficacious in Iranian populations (Mohammadian et al., 2011). Therefore, it would be helpful to study Iranian-Americans to see if this type of treatment is effective for them as well.

Moreover, although there has been research conducted on gender roles and marriage in this community, it would be clinically beneficial to conduct further studies. Specifically, studies that focus on bicultural marriages would be of use as modern times have seen the rise in inter-

ethnic and inter-religious marriages (Askari, 2003; Ruebelt, 2009). It may also be of use to obtain more knowledge on factors that lead to stability and satisfaction in marriage, as these findings would be constructive to counselors working with couples from a strength-based approach.

In addition, although a search of the literature reveals many articles regarding substance abuse in Iran, there was no published literature found on issues of substance abuse in the Iranian-American community. Since this appears to be a significant issue in Iran, as well as in the general population in the U.S., it may be clinically relevant to further examine this issue with Iranian-Americans. Issues that are traditionally known as taboo should also be studied, such as homosexuality, domestic abuse, and sexual abuse. A search of the relevant literature only provided one study regarding Iranian-Americans and homosexuality. This study essentially found that when compared with their American counterparts, Iranian individuals who identified as LGB (lesbian, gay, or bisexual) reported perceiving their culture as more homophobic, which was also correlated with increased levels of perceived stress (Miresghhi & Matsumoto, 2008). This is an area that researchers need to explore further in order to better understand the mental health needs of this population.

The issue of perfectionism and risk for disordered eating is also a topic that should be further studied, as Eshtiaghpour's (2011) study showed a strong correlation between the internalized cultural value perfectionism leading to increased risk for eating disorders or negative body image. Trauma and PTSD symptoms should also be further researched, especially in relation to 3rd and 4th wave Iranian immigrants. Shamtoub (2013) and Mohadjer's (2009) studies provide a basis for the need for increased knowledge and psychoeducation on trauma in this population due to pain experienced during the Revolution as well as the Iran-Iraq War. With the

more recent trauma related to the Green Movement of 2009, it is more important than ever to further study this topic.

Additional research is necessary in the field of ethnic identity and how discrimination plays a role in mental health, as evidenced by findings in Daha (2011), Garakani (2008), Mostofi (2003), and Mobasher (2006). It would also be clinically useful to study Iranian ethnic groups who may identify as a *double minority*, such as Jews, Baha'is, Zoroastrians, Kurds, and Christian Armenians. In addition, as intermarriage is increasing, the number of bicultural Iranians is also increasing. Thus, research on ethnic identity development in individuals who identify as both Iranian and another ethnicity (i.e. White, Black, Asian, etc.) is necessary.

Future research should also be mindful of using larger and more random samples in order to better generalize findings to the larger population. In addition, future studies should be conducted with Iranians all over the U.S., versus being confined to areas with high Iranian populations such as Los Angeles or Washington, D.C. as acculturation rates and ethnic identity development may significantly differ from one region to another. In conclusion, there are still many areas that need to be studied in order to better understand Iranian-Americans and provide more culturally competent mental health services. The suggestions listed in this section are a starting point and are based on gaps found in the existing literature; however, there are numerous other areas that can be clinically relevant to study as well.

Clinical Implications and Guidelines

The following are guidelines for culturally competent mental health services with Iranian-Americans based on the review and analysis of the existing literature as well as the author's personal and professional experiences. It is the author's hope that this literature review

will provide valuable information and insight for both Iranian and non-Iranian clinicians working with this population.

- 1) Increased emphasis on psychoeducation, prevention, and early intervention (i.e. parenting skills courses, pre-marital counseling, general mental health outreach presentations and seminars) is crucial. Rather than focus on illness and pathology, prevention and early intervention may help alleviate a portion of the stigma attached to counseling and reframe it as education, self-awareness, and growth.
- 2) Mental health professionals should be aware of diversity within the Iranian community (i.e. religion or socioeconomic status) and realize that not all Iranian-American individuals are alike. There are often multicultural layers in each individual and these layers should not be ignored.
- 3) Mental health professionals should act as cultural brokers and assist clients with psychoeducation regarding not only counseling, but with community resources as well. This will help clinicians serve as advocates for the clients and strengthen the therapeutic relationship as well. Building and maintaining a strong therapeutic alliance is critical in allowing for successful counseling with this population.
- 4) Mental health professionals should be mindful of immigration status, generational status, and ask (versus assume) about each individual's experiences. It is important to ask about any experiences with discrimination as well as how one feels in their particular environment (i.e. asking a college student how it feels to be an Iranian at their particular college campus).
- 5) Mental health professionals should educate themselves about Iranian culture and history; yet be mindful of not generalizing this information to the entire population. Being aware

of the tumultuous socio-political history, clinicians should also be prepared for potential skepticism or mistrust in the initial stages of therapy and be patient and meet the client where they are at.

- 6) While it is important to be familiar with culture specific dynamics (i.e. *tarof*, *aberu*, *mehrtalabee*, *chooneh*), clinicians should be mindful not to generalize characteristics to the entire population. Every individual has their own unique characteristics and as such they should be treated as individuals.
 - a. *Tarof*, or continual courteousness, may be taken as a sign of excessive, unnecessary, or even insincere politeness to a clinician unfamiliar with the culture. Clinicians should be mindful of this cultural dynamic and avoid pathologizing such behaviors.
 - b. *Aberu*, or fear of losing face, may be taken as unhealthy or excessive investment in other's opinions to a clinician unfamiliar with the culture. Clinicians should be mindful that this is culturally congruent, and to only work on changing these beliefs if the client reports it to be a problem in their life.
 - c. *Mehrtalabee*, or people-pleasing behavior, may be taken as a sign of low self-esteem or co-dependence to a clinician unfamiliar with the culture. Clinicians should be aware that engaging in these types of behaviors are culturally congruent and should only work on reducing or changing them if the client reports them to be a problem.
 - d. *Chooneh*, or bargaining for fees, may be taken as a sign of resistance to therapy or crossing of boundaries to a clinician unfamiliar with the culture. It would be

beneficial to establish a sliding scale one feels comfortable with in anticipation of bargaining, or to simply be firm yet gentle regarding fees.

- 7) Mental health professionals should be aware of the hospitable nature of Iranians and upon initial contact, adjust their greeting and engage in small-talk in order to establish rapport. In addition, counseling is a new concept for many Iranian-Americans, and as such, clinicians should be patient in explaining the process to them (i.e. confidentiality, boundaries, ethics, payments, timelines, what to expect during the course of treatment, etc.).
- 8) As boundaries may be more fluid with this population, mental health professionals should be open to a healthy degree of self-disclosure (especially surrounding questions about clinician's educational or cultural background), which may help strengthen the relationship and establish credibility.
- 9) Mental health professionals should not over pathologize views that are in contrast with their own (i.e. interdependent model of families or traditional views on gender roles) and assess for degree of distress these views cause their clients. Although it is beneficial to provide psychoeducation to adjust maladaptive views, this is only necessary if the client views it as a problem or it is causing problems in their relationships.
- 10) Mental health professionals should assess for social and family support, and if clinically appropriate, incorporate the utilization of that support system as part of the therapeutic work.
- 11) Mental health professionals should be mindful of their own biases and counter transference towards Iranians and be able to work through these issues in order to maintain a strong therapeutic alliance.

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