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Addressing stress and well-being among women of Arab descent living in the United States: development of a training workshop for mental health professionals

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Graduate School of Education and Psychology

ADDRESSING STRESS AND WELL-BEING AMONG WOMEN OF ARAB DESCENT

LIVING IN THE UNITED STATES: DEVELOPMENT OF A TRAINING WORKSHOP FOR

MENTAL HEALTH PROFESSIONALS

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Hoda Abou-Ziab, M.A.

September, 2016

Shelly Harrell, Ph.D.−Dissertation Chair

This clinical dissertation, written by

Hoda Abou-Ziab

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

Doctoral Committee:

Shelly Harrell, Ph.D.

Carrie Castañeda-Sound, Ph.D.

Astrid Reina, Ph.D.

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DEDICATION

I would like to dedicate my dissertation to my parents, Adnan and Nada Abou-Ziab, who have taught me the value of hard work, commitment, discipline, perseverance, love and genuine kindness. And who have provided me with unrelenting love and support through every obstacle and accomplishment over my lifetime. Thank you to my mother who devoted all of her time and energy making sure I was centered and sharing in my struggles, I could not have done this without you. And to my father, who was my biggest fan and never stopped cheering me on. Thank you to both of you for encouraging me to connect to my Arab heritage and teaching me the value of giving back to our community. I would also like to dedicate my work to my sister Rima Abou-Ziab, who has never left my side and continues to be the rock that I lean on, I admire everything about you. Lastly, I would like to also dedicate my dissertation to Khalo Talal Nassereddine, despite our geographical distance; I never stopped hearing you say "it could have been worse." Thank you for all your love and support.

ACKNOWLEDGMENTS

nights of work, providing me a shoulder to cry on (many times), sending me those encouraging

texts, making sure I was fed, and always being there for me. And to the rest of my family and

friends, thank you for believing in me!

VITA

Pepperdine University, Graduate School of Education and Psychology, Los Angeles, CA
Doctor of Psychology in Clinical Psychology   May 2016
APA-accredited Psy.D. Program

Pepperdine University, Graduate School of Education and Psychology, Irvine, CA
Master of Arts in Clinical Psychology with an emphasis in Marriage and   June 2012
Family Therapy

University of California, Santa Barbara Santa Barbara, CA
Bachelor of Science in Biopsychology   June 2009

LANGUAGE SKILLS
- Fluent in English, Arabic and French

SUPERVISED CLINICAL EXPERIENCE
VA Los Angeles Ambulatory Care Center, Los Angeles
Psychology Intern   August 2015-August 2016

Mental Health Outpatient Clinic
- Conduct initial intake assessments and present cases to Mental Health Clinic Team in order to discuss differential diagnosis, treatment planning and referrals each week.
- Administer and interpret psychodiagnositic assessments in order to clarify diagnoses and guide the appropriate psychiatric and psychological treatment for veterans utilizing a variety of assessment measures, such as the MMPI-2, MCMI-III, BDI-II, MMSE, BAI, PCL-C/s, MMPI-2-RF, and the Rorschach
- Cofacilitate CBT for Depression and Anxiety, Anxiety Management, ABC Emotional Regulation, and Depression Process groups
- Conduct psychotherapy utilizing Cognitive Processing Therapy (CPT), Acceptance and Commitment Therapy (ACT) and Time-Limited Dynamic Therapy (TLDP) and attend weekly group supervision/seminars.
- Attend weekly staff/intern interdisciplinary team meetings and seminars (e.g., motivational interviewing, psychopharmacology, high risk conference)

Supervisors: Sharon Jablon, Ph.D., Susan Steinberg, Ph.D., Anna Leshner, Psy.D., Michael Karakashian, Ph.D., Carissa Klevens, Ph.D., Kimberly Newsom, Ph.D., and Carole Goguen, Psy.D.,

Behavioral Medicine/Primary Care Mental Health Integration
- Provide time-limited individual behavioral medicine treatment to veterans utilizing empirically validated interventions (e.g., relaxation techniques, mindfulness, biofeedback, cognitive behavioral therapy interventions) through individual psychotherapy.

- Co-facilitate time-limited, support and skills-based psychotherapy groups such as Women's Chronic Pain and Support Group, Smoking Cessation and Smoking Cessation for female veterans, Anger Management for Women, Topic of the Month (e.g., stress management, sleep management, assertiveness training,)
- Attend weekly Behavioral Medicine Seminar that cover topics such as pain, diabetes, tinnitus, biofeedback, mindfulness and relaxation training.
- Participate in workshops for veterans, such as Target Diabetes and Target Pain.
- Attend weekly staff interdisciplinary team meetings for women's health.

Supervisors: Debra Sobol, Ph.D., Kimberly Newsom, Ph.D., and Michael Karakashian, Ph.D.

East Los Angeles Posttraumatic Stress Disorder Clinic
- Clinically interview and asses veterans for PTSD and other co-occurring disorders utilizing the following measures: Combat Exposure Scale, Los Angeles Symptom Checklist, Modified PTSD Symptom Scale, PTSD Checklist for DSM-5 (PCL-5), Mississippi Scale for Combat Related PTSD, Michigan Alcohol Screening Tests (MAST), Drug Abuse Screening Test (DAST), and Beck Depression Inventory II (BDI-II).
- Conducting individual psychotherapy with veterans with PTSD utilizing Prolonged Exposure and Cognitive Processing Therapy, and also providing psychotherapy to veterans with PTSD and a Substance Use disorder utilizing motivational interviewing and relapse prevention techniques.
- Co-facilitate a psychoeducationalrr PTSD group focusing on anger management
- Collaborate on an interdisciplinary team in order to coordinate and plan treatment for veterans.

Supervisor: Carolyn Feigel, Ph.D.

University of Southern California, Engemann, *University Counseling,*
Doctoral Practicum Trainee   August 2014-May 2015
Supervisor: Elizabeth Reyes, Ph.D.   Los Angeles, CA
- Administered intake evaluations for undergraduate and graduate students with a range of mood disorders, eating disorders, anxiety disorders, ODD, relational problems, and etc.)
- Provided short-term therapy, including Cognitive Behavioral Therapy, Intensive Short-Term Psychodynamic therapy, and Solution-Focused Therapy and case management.
- Worked with staff psychiatrists, licensed social workers and other medical clinicians in the Student Health Center.
- Participated in outreach activities on campus including: presenting and discussing psychological services offered at the counseling center, and presenting on diversity issues.
- Participated in weekly all-staff meetings, professional development trainings, and individual and group supervision.
- Participated in crisis intervention training and sexual trauma training.

University of California, Los Angeles Longevity Center

Doctoral Practicum Trainee   September 2014-July 2015

Supervisor: Karen Miller, Ph.D.   Los Angeles, CA

- Conducted clinical interviews; administer and score weekly neuropsychological test batteries for research patients for various memory and aging studies.
- Wrote integrative reports for research batteries which include: WTAR, Buschke Selective Reminding Test, BVMT-R, COWAT, Trail Making Test, NYU Story Test, Connors Continuous Performance Test (CPT II).
- Participated in weekly individual and group supervision.

University of California, Los Angeles Memory Care

Memory Trainer   September 2014-July 2015

Supervisor: Karen Miller, Ph.D.   Los Angeles, CA

- Participated as a memory trainer in weekly 3-hour group, "Memory Care," which provides cognitive rehabilitation to individuals diagnosed with MCI and dementia using integrative approaches to treatment including: memory training, mind-body exercise, and patient and caregiver support groups.
- Developed and presented lecture material for memory-rehabilitation component of Memory Care (i.e., stress reduction)
- Participated in a patient group with a focus on Reminiscence Therapy and patient support.

Harbor UCLA Medical Center, Behavioral Medicine

Doctoral Practicum Trainee/Psychology Extern   September 2013-August 2014

Supervisor: Astrid Reina, Ph.D.   Los Angeles, CA

- Administered initial evaluations and intakes in HIV Mental Health Services.
- Formulated treatment plans; Brief and long-term psychotherapy using behavioral medicine interventions to medical patients with diverse diagnostic presentations (e.g., mood disorders, anxiety disorders, PTSD, ODD, personality disorders, relational problems, and etc.) and medical illness (e.g., HIV+, diabetes, kidney failure, and etc.).
- Brief psychotherapy, psychological consultations and interventions in Women's Behavioral Health, Family Medicine, Immunology and Pediatric Endocrine Clinic (e.g., Obstetrics and Gynecology referrals, primary care referrals, immunology referrals).
- Conducted behavioral medicine psychodiagnostic assessments and also psychologically screened patients for renal transplantation and breast reconstructive surgery.
- Worked alongside psychiatrists, primary care physicians and case managers; outpatient setting.
- Participated in weekly didactic training with residents, fellows, and doctors.
- Participated in weekly dyadic supervision meetings with a licensed psychologist and individual supervision with a post-doctoral unlicensed psychologist.

Pepperdine University, Graduate School of Education and Psychology, Pepperdine Community Mental Health Center

Doctoral Practicum Trainee   September 2012-July 2015

Supervisors: Aaron Aviera, Ph.D.; Shelly Harrell, Ph.D.   Los Angeles, CA

- Administered initial evaluations and intakes
- Administered, scored and interpreted clinic outcome measures.
- Formulated treatment plans; Brief and long-term psychotherapy to adults, adolescents, and children with diverse diagnostic presentations (e.g., mood disorders, anxiety disorders, ODD, personality disorders, relational problems, and etc.) and backgrounds in an outpatient setting;
- Participated in on-call pager duties.
- Participation in weekly dyadic supervision meetings and case conference meetings.

Pepperdine University, Graduate School of Education and Psychology, Pepperdine Community Mental Health Center

MFT Practicum Trainee   September 2011-June 2012

Supervisors: Duncan Wigg, Ph.D.; David Marsten, LCSW   Irvine, CA

- Administered initial evaluations and intakes.
- Participated in weekly trainings in narrative therapy.
- Formulated treatment plans; Brief and long-term psychotherapy to adults, adolescents, and children with diverse diagnostic presentations (e.g., mood disorders, anxiety disorders, ODD, personality disorders, relational problems, and etc.) and backgrounds in an outpatient setting;
- Participated in weekly individual supervision meetings and group supervision meetings.

The Orange County Rescue Mission, Village of Hope

MFT Practicum Trainee   February 2012-June 2012

Supervisors: Duncan Wigg, Ph.D   Tustin, CA

- Provided mental health treatment services and crisis intervention for the homeless community within a residential treatment facility.
- Conducted individual weekly psychotherapy with clients from diverse cultural and ethnic backgrounds presenting with a broad range of psychiatric disorders
- Formulated treatment plans; Brief and long-term psychotherapy to individuals and families with diverse diagnostic presentations (e.g., mood disorders, anxiety disorders, ODD, personality disorders, relational problems, and etc.) and backgrounds in an inpatient setting.
- Incorporated Narrative Therapy to address presenting issues such as Substance Abuse, Mood Disorders, PTSD.
- Engaged in weekly individual and group supervision.

SUPERVISORY EXPERIENCE:

VA Los Angeles Ambulatory Care Clinic

Supervision of Practicum Student   January 2016-August 2016

Supervisor: Sharon Jablon, Ph.D   Los Angeles, CA
- Provide weekly individual peer supervision for practicum trainees on an individual therapy case from a specific modality fostering the development of clinical skills, such as intake assessments, diagnosis, treatment planning, conceptualization, the application of ethical and legal issues, consultation and referrals
- Participate in weekly supervision-of-supervision trainings.

Pepperdine University, Graduate School of Education and Psychology, Pepperdine Community Mental Health Center
Peer Supervisor   September 2014-July 2015
Supervisor: Aaron Aviera, Ph.D   Los Angeles, CA
- Provided weekly individual peer supervision for first-year and second-year Psy.D. doctoral level therapists fostering the development of clinical skills, such as intake assessments, diagnosis, treatment planning, and the application of ethical and legal issues.
- Participated in weekly supervision-of-supervision trainings.
- Facilitated case conferences and provide feedback to first year Psy.D. doctoral level therapists to increase case conceptualization and diagnostic skills.

RESEARCH EXPERIENCE
Pepperdine University, Graduate School of Education and Psychology, Harrell Research Group
Researcher   October 2012-May 2016
                                                               Los Angeles, CA
- Assist a research study on well-being and diversity using Harrell's well-being scale
- Assist with the development of culturally-syntonic FFIT intervention, emphasizing Behavioral Medicine applications to the prevention and treatment of stress-related problems and disorders.
- Participate in abstract submissions; gather research and assist in writing a manualized treatment for FFIT using health psychology and behavioral medicine concepts.
- Data collecting; Literature reviews.
- Participate in weekly meetings.

Pepperdine University, Graduate School of Education and Psychology, Pepperdine Applied Research Center
Research Assistant   May 2011-June 2012
Supervisor: Susan Hall, Ph.D., J.D.   Irvine, CA
- Assisted a research study on developing and maintaining an infrastructure for research at GSEP community clinics and counseling centers through standardized measures
- Inputted and analyze data from (e.g., Outcome Questionnaire (OQ, YOQ, & YOQ. SR), the Brief Multi-Dimensional Measure of Religion and Spirituality (BMMRS), and the Multidimensional Scale of Perceived Social Support (MSPSS)
- Data coding using SPSS
- Participated in monthly meetings.

University of California, Irvine, Molecular Biology and Biochemistry Lab
Laboratory Assistant   August 2009-Septmeber 2010
Supervisor: Huiying Li, Ph.D., Thomas Polous, Ph.D.   Irvine, CA
- Worked with heme enzyme Nitrate Oxide Synthase (NOS) and E-coli to figure out a new structure for NOS
- Assisted faculty/researchers in a study on diverse biological functions by analyzing protein crystals
- Paper submitted for publishing in Journal of Biological Chemistry

University of California, Santa Barbara, Biopsychology Lab
Research Assistant   April 2007-June 2009
Supervisor: Karen Szumlinski, Ph.D.   Santa Barbara, CA
- Focused on changes in brain and behavior produced by chronic exposure to drugs of abuse, specifically alcohol and cocaine
- Worked with gene knock-out mice and adeno-associated viral vectors to examine consequences of manipulating gene expression on drug-induced behavioral and neurochemical phenotype of rodents
- Paper published in Journal of Neuroscience

University of California, Los Angeles, Ahmanson/UCLA Adult Congenital Heart Disease Center
Research Assistant *Internship*   June 2007-December 2007
Supervisor: Jamil AbolHosn, M.D.   Los Angeles, CA
- Assisted cardiologist with case studies
- Compiled research and learned to read various medical records

University of California, Santa Barbara, Vision and Image Understanding Laboratory
Research Assistant   September 2005-December 2007
                                                           Santa Barbara, CA
- Worked with medical images, placed stents in collapsed arteries for patients from neighboring hospital
- Worked on assisting in creating a program for medical imaging to improve quality of x-rays for placement of stents

JOURNAL PUBLICATIONS
Li, H., Jamal, J., Chreifi, G., Venkatesh, V., **Abou-Ziab,** H., & Poulos, T. L. (2013). Dissecting the kinetics of the NADP+-FADH2 charge transfer complex and flavin semiquinones in neuronal nitric oxide synthase. *Journal of Inorganic Biochemistry, 124, 1-10.*

Cozzoli, D. K., Goulding, S. P., Zhang, P. W., Xiao, B., Hu, J. H., Ary, A. W., Obara, I., Rahn,A., **Abou-Ziab,H**., ... Szumlinski, K. K. (2009). Binge drinking upregulates accumbens mGluR5-Homer2-PI3K signaling: functional implications for alcoholism. *The Journal of Neuroscience: the Official Journal of the Society for Neuroscience*, 29, 27, 8655-68.

Abou-Ziab,H., Pena,C., Park, E., Moshfegh, N., & Harrell, S.P. (2013, August*) Well-Being & the Immigrant Woman: Relational Strengths & Challenges from Three Parts of the World.* Poster presented at Poster presented at the One Hundred Twenty-First Annual Convention of the American Psychological Association, Honolulu, HI.

Kalai,C.,**Abou-Ziab,H.,**&Clark, K. (2013, October) *A Culturally-Syntonic Perspective on Developmental Theories: Implications for Intervention.* Poster presented at the Los Angeles County Psychological Association 25th Annual Convention.

Harrell, S.P., **Abou-Ziab, H.,**Thomas, B., & Pena, C. (2013, June) *Promoting PEaCE: A Culture-and Context-Conscious Model For Individual and Collective Well-Being.* Poster presented at the Society for Community Research and Action Conference.

Harrell, S.P., Moshfegh,N., Anderson, G., Orozco, M., Pena, C., Bellete, N., Underwood, J., Park, E., Chmiel, L., & **Abou-Ziab, H. (**2013, June). *Multidimensional Well-Being Assessment (MWA): Measuring Relational, Psychological, Physical, Collective, and Transcendent Contexts of Wellness.* Poster presented at the International Positive Psychology Association: World Congress on Positive Psychology.

Cozzoli,D., Goulding, S., **Abou-Ziab**, H., & Szumlinski (2009, April). *Binge Drinking Upregulates Accumbens mGluR5–Homer2– PI3K Signaling: Functional Implications for Alcoholism.* Poster presented at the University of California, Santa Barbara, Symposium.

PROFESSIONAL PRESENTATIONS
Abou-Ziab, H. (2016, June). Addressing wellbeing and stress with women of Arab descent living in the United States. *Lecture conducted at the VA Los Angeles Ambulatory Care Center.*

Harrell,S.P., **Abou-Ziab,** H., Adams, T., Bailey, J, Harrison, M.,Rajagopal,S. (2014, March) *Self-care, stress management, and well-being enhancement for psychology graduate students: Content and process of the 'focus and flow' approach.* Workshop presented at the Society for Humanistic Psychology 7th Annual Conference 2014: Human Dignity.

Abou-Ziab, H., & Clark, K. (2013, March). The deleterious effects of stress on well-being: Loving kindness meditation (LKM) and improved health outcomes. *Lecture conducted at the Union Rescue Mission, Los Angeles.*

ASSESSMENT EXPERIENCE
Emotional & Personality Assessment
- MMPI-2; MCMI-III TAT; HTP; RISB; Rorschach;
- Test administration, interpretation and report writing

Cognitive & Neuropsychological Assessment
- WISC; WAIS-IV; WMS-III, WMS-IV, MMSE, COWAT; RAVLT; WTAR; COWAT; BVMT-R; CDRS; CPT; HamD, HVLT-R, FAQ; Rey-Osterrieth Complex Figure (REYO), Stroop Test,Trailmaking Test; Bender Visual-Moto Gestalt; Brief Visuospatial

Memory Test; Buschke Selective Reminding Test, NYU Story Test; Connors' Continuous Performance Test (CPT II).

- Test administration, interpretation and report writing

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ABSTRACT

Due to the increasing number of persons of Arab descent living in the United States, estimated at over 3.5 million in 2012, there has been a recognized need for a deeper understanding of acculturative, gender, and immigration-related stressors that Arab American women face. In response to this need, a one-day workshop for mental health professionals interested in or currently working with women of Arab descent living in the United States was developed. The workshop focuses on increasing knowledge of the various types of stress (e.g., acculturation, discrimination, gender role strain, parent-child relationships, care giver, familial, cultural expectations, work, school, etc.) experienced by Arab American women and providing culturally congruent stress reduction interventions. The development of the curriculum was informed by existing literature on people of Arab descent living in the United States, cultural issues in serving diverse populations, and stress management interventions. Interviews with 3 Arab American women were integrated with the literature and the 1-day workshop curriculum was developed. The curriculum was reviewed by 2 current practicing psychologists who rated the content, strengths, and weaknesses of the curriculum. Their feedback was incorporated into a compilation of suggestions and future directions for the refining and evaluating curriculum.

Chapter I: Introduction and Literature Review

Introduction

According to the empirical and professional literature, stress continues to be a ubiquitous experience in our society (APA [American Psychological Association] 2012, 2013; Lederbogen et al., 2011). It is strongly linked to the following six leading causes of death, including heart disease, cancer, lung ailments, accidents, cirrhosis of the liver, and suicide (APA, 2007). Research suggests (Murphy, Xu, & Kochanek, 2012) that heart disease is the leading cause of death for women in the U.S., one out of every four females in 2009 die from this serious condition.

Not only has stress been shown to negatively impact an individual's physical wellbeing, but literature has also indicated psychological ramifications related to stress, including overall poor health outcomes (Tennant, 2002; Terril, Garofalo, Soliday, & Craft, 2012). More specifically, women of Arab descent tend to express their distress through physical symptoms (e.g., gastrointestinal issues, migraines, physical pain), which are often more "morally" acceptable expressions of pain and stress (Al-Krenawi & Graham, 2000; Mourad & Abdella, 2010; Nassar-McMillan, Ajrouch, & Hakim-Larson, 2013). Additionally, due to the vast number of disabilities globally linked to stress, it can be said that it has become an increasing economic problem that we are facing (Lucassen et al., 2014). The World Health Organization (WHO) projects that by year 2020, mental illness and other stress-related disorders will serve as the second primary cause for disabilities across the world (Lucassen et al., 2014). As a result, taking into consideration the significant impact of culture and gender on the experience of stress particularly for Arab American women living in the United States becomes crucial to addressing overall wellbeing and health for women.

According to the American Psychological Association's Mind/Body Health campaign and multitude of surveys exploring the impact of stress on individuals, the results of a recent survey suggest that a complex link between the mind and body exist as evidenced by both physical and emotional effects of stress (APA, 2013). More specifically, the survey suggests that an individual's immune system can become easily compromised when experiencing chronic stress. This can then lead to frequent viral infections and increased inflammation, both of which have been linked to cardiovascular disease (APA, 2013). In addition, chronic stress has also been shown to create sleep difficulties, increase irritability, anger, and sadness, and lead to depression and anxiety (APA, 2013). Furthermore, an individual's lifestyle choices (e.g., eating and physical exercise habits) can be shaped by the experience of stress both physically and emotionally, often times leading to poorer food choices driven by mood changes and significantly decreasing physical activity (APA, 2013). As a result, this pattern can place individuals at risk for a myriad of illnesses, including obesity, type 2 diabetes, depression and hypertension along with collectively impacting one's overall emotional and physical wellbeing (APA, 2013).

Gender appears to play an important role in the experience and effects of stress. Men and women report different reactions to stress both physically and emotionally (APA, 2010). The American Psychological Association conducted a study from 2007 to 2010 on gender and stress. The study consisted of 771 men and 1,077 women in 2007; 789 men and 1,002 women in 2008; 729 men and 839 women in 2009; 530 men and 604 women in 2010. The results suggested that women are more likely (29% versus 20%) to report experiencing a great deal of stress (APA, 2010). More specifically, it has been shown that approximately 33% of married women tend to report higher levels of stress than 20% of single women (APA, 2010). Studies also show that

women have reported an overall increase and rise in their stress levels compared to men and gender differences exist in what events or conditions are perceived as threatening. Women tend to be more reactive than men to emotionally and socially challenging situations and less reactive to performance-based stressors (Kajantie & Phillips, 2006; Kudielka, Buske-Kirschbaum, Hellhammer & Kirschbaum, 2004; Terril et al., 2012). The American Psychological Association's (2010) study on gender and stress suggested that 41% of women (n = 604) are likely to report physical and emotional symptoms of stress as compared with 31% of men (n =530). Balancing work and family life is a particularly challenging source of stress for women. In addition, women are more likely than men to report physical symptoms associated with stress. The study suggests that in general, both men and women choose stationary activities for managing stress, such as reading, listening to music or watching television instead of seeking help from mental health clinicians. However, the study also suggests that that men and women manage stress very differently (APA, 2010).

The research here aims to contribute to the resources relevant to women and stress, more specifically, women of Arab descent currently living in the United States. The vast immigration experiences and sociopolitical history between the Western and Arab world has shaped the development of Arab identities in the United States as well as their experiences of stress (Abboud, Jemmott, & Sommers, 2015; Erickson & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013). The continued interactions between the traditional homeland and new homeland have also shaped the way Arab Americans perceive themselves and how others have portrayed them (Abboud et al., 2015; El-Aswad, 2010; Nassar-McMillan et al., 2013). More specifically, family, religion, ethnicity, sexuality, gender, politics and immigration experiences have greatly influenced their lives and their experience of various stressors (Abboud et al. 2015;

Nassar-McMillan et al., 2013). According to the literature, Arab American women experience a host of potentially stressful factors including acculturation issues, multiple roles, societal and gender pressures as well as physiological changes that may exacerbate existing levels of stress (Ahmed & Reddy, 2007; Amer & Hovey, 2005; Erickson & Al-Timimi, 2001; Jadalla & Lee, 2004; Mourad & Abdella, 2010; Naber, 2000; Nassar-McMillan, & Hakim-Larson, 2003; Padela & Heisler, 2010; Wrobel, Farrag, & Hymes 2009). These potential stress factors, taken together, warrant serious concern for the emotional and physical well-being of Arab American women. Considering the exponential growth in this population, an estimated 72% increase between 2000 and 2010 (Arab American Institute, 2012), it is expected that many mental health professionals will find themselves providing services to Arab Americans (Al-Krenawi & Graham, 2000; Erickson & Al-Timini, 2001; Haboush, 2007; Hall & Breland-Noble, 2011; Kakoti, 2012; Nassar-McMillan et al., 2013; Nassar-McMillan, & Hakim-Larson, 2003).

Based on the significant amount of literature demonstrating the deleterious effects of stress as a psychosocial risk factor and with the shortage of research on Arab American health (Nassar-McMillan et al., 2013), this study aims to illuminate the specific stressors relevant to women of Arab descent living in the United States and hopes to provide resources to assuage the toxic and potentially fatal outcomes associated with stress (Al-Krenawi, & Graham, 2000; Arthur, 1998; Carter, 2007; Collins, David, Handler, Wall & Andes, 2004; Ellis, Gehrman, Espie, Riemann, & Perlis, 2012; Erickson & Al-Timini, 2001; Harrell, 2000; Herman, 2012; Kassel, Stroud, & Paronis, 2003; Kaiser & Miller, 2004; Kakoti, 2012; Klitzman, House, Israwel, & Mero, 1990; MacGeorge, Samter, & Gillihan, 2005; Meyer, 2003; Muhonen & Torkelson, 2004; Murphy et al., 2012; Myers, 2009; Zivotofsky, & Koslowsky, 2005).

Stress defined. Stress, a widely used term, can be defined as a person-environment transaction that an individual appraises as being personally salient and places demands on the individual that tax or exceed his/her resources to efficiently cope (Lazarus & Folkman, 1984; Folkman, 2010). It has also been referenced in literature when discussing an individual's physiological reaction to a response in addition to when an individual's well-being or survival is threatened (Kemeny, 2003; Lucassen et al., 2014). Specific to this dissertation study, the term *stress* will refer to the cumulative "cognitive, emotional, behavioural and physiological responses to a stressor" (Clark, Bond, & Hecker, 2007, p. 18).

Hans Selye (1979), who was responsible for coining the term "stress," postulated that the stress response is "the non-specific response of the body to any demand" (p. 53). Furthermore, he proposed that each organism will respond to stress in a similar reactive process, regardless of what may be causing the stress (Selye, 1950). However, depending on both endogenous (i.e., genetic predispositions, age and sex) and exogenous (i.e., drug/hormone treatments, environment, social influences) factors, individuals may respond differently to the same stressor (Selye, 1979).

The most common reaction to a stressor, the fight-or-flight response, was first identified by Walter Bradford Cannon, an American physiologist (Henze, Leite de Oliveira, & Mazzone, 2012). He described this response to be that of an animal's instinctive reaction when facing a threatening or dangerous encounter (i.e., stress; Henze et al., 2012). Similar to primitive animals, this state of arousal is also a common stress response regulated by the sympathetic nervous system, allowing humans to prepare to take action or escape the dangerous situation (Bracha, 2004; Kolb & Whishaw, 2014). According to recent literature, the fight, flight, freeze, fright and faint response appears to be a more complete depiction of the stress response that humans engage

in (Bracha, 2004). However, more specific to women, Taylor and colleagues (2000) have shown that women tend to adopt a "tend-and-befriend" reaction to stress, which has evolved and become more favorable to protecting the self and the offspring. It is suggested that behaviors that protect offspring and reduce neuroendocrine responses that can jeopardize the health of their offspring are more common for women (Taylor et al., 2000). Further, women seek and use social support systems in an effort to reduce risk/vulnerability and manage the stressful situation which has a biobehavioral protective element for the stressed female who is then able to down- regulate the sympathetic and hypothalamic-pituitary-adrenocortical (HPA) responses to stress via the release of the hormone oxytocin (Taylor et al., 2000). Females are documented to have a higher release of oxytocin than men in response to threat which has a bidirectional effect in that it promotes nurturing behaviors that enhance physical contact with offspring and subsequently enhances the flow of oxytocin - the increased oxytocin has a calming effect and ameliorates the arousal response (Taylor et al., 2000).

Psychoneuroimmunology (PNI) emphasizes the continued interactions between the nervous and immune systems along with the psychosocial factors that may be impacting an individual's health. Furthermore, the field of PNI has provided a significant amount of research that illustrates a strong link between psychological factors (e.g., social support, loneliness, anxiety, and stress) and overall physical wellbeing (Gruenewald & Kemeny, 2007; Loving & Keneski, 2014). Recent research studies have further shown the importance of this association by assessing the varied psychosocial contributors to health and mortality. In a study conducted by Floud and colleagues (2014), the association of marital status and ischemic heart disease (IHD) was assessed with 734,626 women, with a mean age of 60 years, who had no indication of any previous history of heart disease, cancer or stroke and after controlling for possible confounding

variables (e.g., lifestyle, socioeconomic status). The study demonstrated lower levels of IHD present in women who were cohabitating with their partners than those who were living alone and/or unmarried (Floud et al., 2014). These results coincide with Loving & Keneski's (2014) discussions around the significance of assessing social factors that may be serving as stressors that lead to a compromised immune system functioning and overall higher risk of mortality.

Stress can manifest in many different ways, ranging from taxing daily experiences such as length of time sitting in traffic, to chronic conditions including caregiving for a sick family member and/or abuse in a partnership. The term *stressor* is frequently used to describe various experiences, contexts, and incidents in an individual's life that may trigger a stress response and impact their overall functioning (APA, 2013; Boss, 2011; Clark, Anderson, Clark & Williams, 1999; Clark et al., 2007; Harrell, 2000; Lucassen et al., 2014; Mendenhall et al., 2012; Shah, Trivedi, Diwan, Dixit, & Anand, 2009). Stressors can include areas related to finances, occupation, romantic and familial relationships, friendships, academic performance as well as more specific instances such as discrimination, racism, bereavement issues, life transitions and caregiving for a loved one. Further, exposure to traumatic events such as violence, natural disasters, and/or war also serve as stressors that individuals may face through out their life.

Stressors occurring in various contexts, such as family, occupation, and relationships, can exacerbate stress and contribute to negative health outcomes (Au, Chan, Cheung, Yuen, & Lee, 2008; Tausig & Fenwick, 2001; Tennant, 2002). Additionally, excessive demands and/or stress in one context or role can interfere with and affect life in another context or role (Klitzman et al., 1990). More specifically for Arab American women, negotiating between both Arab and American values of family and employment can be a significant source of stress and often results

in an increased need for support (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Read, 2004).

Family stressors have been found to play a significant role in psychological and physiological complaints associated with everyday feelings of stress (Grönlund & Öun, 2010; Hsiao, 2010; Klitzman et al., 1990; Noor, 2002; Scott, 2001). Family stress encompasses stressors from the combination of parenting and partnership roles, as well as incorporating family involvement, caretaking for family members and housework responsibilities. Family, a prominent value and a central aspect of Arab identity development, serves as both a source of stress and protective factor for women of Arab descent living in the U.S. (Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Marshall & Read, 2003; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Read, 2004). Tausig and Fenwick (2001) suggest that parenting is the most stressful role for people, affecting work family balance as well as well-being. Cultural views on appropriate type of work for women influence Arab American women's' decisions to enter the labor force and preference of employment (Nassar-McMillan et al., 2013). This tends to create many challenges for Arab American women seeking employment with low levels of education and for Arab refugees in the U.S., who are required to work for pay to receive benefits for their families as soon as they have arrived (Nassar-McMillan et al., 2013; Read, 2004). Lastly, the presence of children in the home can create barriers or challenges for Arab American women seeking employment opportunities, and the presence of nonspouse adult family members may alleviate that stress through helping with domestic responsibilities and providing care for the children (Nassar-McMillan et al., 2013; Read, 2004). Additionally, in dual income families, unequal allocation of housework responsibilities among parents may increase distress within a relationship, resulting in decreased marital satisfaction and increased family stress (Ehrenberg,

Gearing-Small, Hunter, & Small, 2001). Research shows that family stress increases the likelihood that interference with work will occur for both men and women (Bernas & Major, 2000). Interference at work may lead to occupational stress, which is another important component to consider when discussing stress and well-being with women.

Occupational stressors include events and circumstances that an individual perceives as stressful in the work environment, such as physical working conditions, interpersonal relationships, work pressure, and demands of the job. Occupational stress has been found to be associated with both psychological and physiological distress (Heraclides, Chandola, Witte, & Brunner, 2009; Israel, Schurman, & House, 1989; Klitzman et al., 1990; Levi, 1981; Su et al., 2001; Wadsworth et al., 2007), as well as interference with family role responsibilities (Bernas & Major, 2000).

In addition to work environments, academic environments reportedly also may contribute to increases in stress and decreases in psychological and physiological well-being. Academic environments can be chronically stressful due to the demands and requirements expected of students (Murphy & Archer, 1996). Academic stress is known to contribute to a variety of negative health symptoms, including physical illness (MacGeorge et al., 2005; Torsheim & Wold, 2001) and depression (Arthur, 1998). Conversely, negative health problems, both physical and mental, contribute to a decrease in academic achievements, including grade point average (Haines, Norris & Kashy, 1996).

Types of stress and appraisal. The concepts of eustress and distress were introduced in 1976 by Selye as a means of describing the diverse stress responses and varied stimuli that contributed to the stress (Kupriyanov & Zhdanov, 2014). Lazarus further contrasted the positive

feelings and overall state of physical health (i.e., eustress) with the negative health implications and negative feelings related to stress (i.e.d, distress; Kupriyanov & Zhdanov, 2014).

Since its first presentation in 1966, Lazarus' conceptualization of stress, which includes an individual's cognitive appraisal and meaning making strategies, has continually evolved over the years into a dynamic and relational concept between the person and the environment (Krohne, 2001; C. Park, 2010). According to Lazarus and Folkman's (1986) definition, "psychological stress refers to a relationship with the environment that the person appraises as significant for his or her well-being and in which the demands tax or exceed available coping resources" (p. 63), both cognitive appraisal and coping are emphasized as a part of the person-environment transaction (Krohne, 2001). Furthermore, Lazarus and Folkman's research also suggests that in order to determine whether an event is going to be a threat, a loss or a challenge, early appraisal of the stressor through meaning strategies is necessary (C. Park, 2010). It is this initial appraisal that allows an individual to assess whether he or she has enough adequate resources to address the threat (DeLongis, Folkman, & Lazarus, 1988; Krohne, 2001).

According to Lazarus and Folkman's Stress and Coping Theory, primary and secondary appraisals are essential components of the cognitive appraisal system used to assess stress. In primary appraisal, an individual's values, goals, personal history and belief system influence whether or not he or she appraises the event as salient, while secondary appraisal refers to how an individual feels about his or her resources and coping ability in managing the stressor. Both of these types of appraisals are hypothesized to discern the strength and quality of an individual's emotional response to a possible stressful event. For example, expressing anger or sadness when experiencing a loss of a loved one, fear when feeling threatened, or excitement and anxiety for challenging situations (Folkman, 2010). The theory behind the element of appraisal in examining

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stress can shed light on how each individual's perspective plays an integral role in whether or not an event is deemed to be a challenge or a threat. For example, an upcoming large party (i.e., a stressor) may be considered an exciting opportunity to meet people for one person, yet for another this event may raise fears about rejection and appraised as a threat.

According to the biopsychosocial (BSP) model of challenge and threat, an individual's response to stress is shaped by the interaction of the demands of the situation with the appraisal of the individual's available resources (Jamieson, Nock, & Mendes, 2011). Here, the model is emphasizing the impact that the process of appraisal has on determining the type of response to the threat that is elicited (Blascovich, Mendes, Hunter, & Salomon, 1999). For example, when individuals perceive that they have adequate resources available to cope with the stressor, the response they experience is described as a *challenge* (Jamieson et al., 2011). On the contrary, if individuals perceive inadequate resources to deal with the stressor, their response is related to a *threat*, and are often associated with more damaging physiological reactions (Blascovich et al., 1999; Jamieson et al., 2011; O'Donovan et al., 2012).

Scientific literature has extensively documented the vast effects of stress on the body and brain of both humans and animals (Kemeny, 2003; Lucassen et al., 2014). Some researchers suggest that the physiological impact of the stressor can be comparable regardless of whether the stressor is positive (e.g., receiving a reward or recognition) or negative (e.g., loss of a relationship; Kolb & Whishaw, 2014; Lucassen et al., 2014). More so, an exciting event may trigger a response that results in the same physiological effects as a tragedy or a negative event thus putting an individual at greater risk for negative health consequences (APA, 2007).

Stress not only varies in type, eustress versus distress, but it can also differ in length of time, acute versus chronic stress. Additionally, stress may continue to persist even after the event

or stressor has ended (e.g., sexual trauma). Acute stress has shown to help individuals flee for threatening situations as a way of surviving; however, continued exposure to stress (i.e., chronic stress) or residual effects from a traumatic situation can also be very harmful (APA, 2012). According Cohen and colleagues (2007), psychological stress was identified as a contributing factor in the development and advancement of disease, more specifically, stress was seen as a precursor for negative emotional states like anxiety and depression, which can then impact the physiological response and the types of behaviors individuals engage in thus increasing the risk of disease (Cohen, Janicki-Deverts, & Miller, 2007). Some studies have identified stress levels as a predictor for negative behaviors For example, studies have demonstrated that stress predicts negative health behaviors and risk for relapse in smoking, alcohol abuse, substance use and sleep disturbances (Ellis et al., 2012; Herman, 2012; Kassel et al., 2003). Furthermore, at times of high stress, individuals tend to engage less in healthy behaviors that could potentially aid in the reduction of stress and improve well-being such as getting proper rest, nutrition, and reaching out for social support. An increase in negative health behaviors and decrease in positive health behaviors places an individual at a higher risk of becoming ill by jeopardizing the natural resources necessary to protect his or her well-being. If consistently high stress is left untreated, it could become a chronic condition resulting in serious health problems including anxiety, insomnia, muscle pain, high blood pressure and a weakened immune system (APA, 2012). Current research associating chronic stress with illness and disease is vast and demonstrates that the effects of stress can contribute to serious conditions such as depression, Post Traumatic Stress Disorder (PTSD), cardiovascular disease, (CVD), HIV/AIDS, obesity, diabetes, dementia and cancer (APA, 2012; Carter, 2007; Cawthon, Smith, O'Brien, Sivatchenko & Kerber, 2003;

Cohen, Janicki-Deverts, & Miller, 2007; Doyle, Dunt & Morris, 2014; Kemeny, 2011; Lucassen et al., 2014; Mendenhall et al., 2012; Willeit et al., 2010).

Physiological effects of stress. The fight, flight, freeze or faint response is triggered when the homeostasis of an individual's body is threatened by a stressor (Bracha, 2004; Kolb & Whishaw, 2014). This results in the arousal of two endocrine response systems, the hypothalamic-pituitary-adrenocortical axis (HPA) and the sympathetic-adrenal-medullary (SAM) system. The mediating effects of stress on illness and disease through the engagement of the SAM and HPA systems are well documented in research with both humans and animals. Repeated and chronic activation of the HPA and SAM systems can compromise their ability to govern other physiological systems and ultimately result in an increase in risk for both physical and psychiatric disorders (Cohen et al., 2007).

In order for the body to return to a state of equilibrium, it will engage in physiological reaction through either a fast response or slow response as a way of regulating the body's stress response (Kolb & Whishaw, 2014; Lucassan et al., 2014). In the SAM system (i.e., fast-acting pathway), the hypothalamus activates the sympathetic part of the autonomic nervous system (ANS) triggering an arousal response that reacts to sudden stress (Kolb & Whishaw, 2014). In this system, the hypothalamus activates the sympathetic branch of the autonomic nervous system (ANS) which then triggers the arousal response through activating the adrenal gland, energizing the medulla and thus releasing both epinephrine and norepinephrine into the cardio vascular system in hopes of preparing the body for any sudden movements or actions (Kolb & Whishaw, 2014; Lucassan et al., 2014). The body is then provided with ample amount of energy (e.g., adrenaline surge) through the activation of the body's endocrine glands, brain and cell metabolism processes (Kemeny, 2003; Kolb & Whishaw, 2014). The hormones released increase

the basal metabolic rate (BMR; i.e., the rate of energy outflow by animals at a state of rest), blood pressure, rate of breathing and the movement of blood to the heart and skeletal muscles which are essential for the fight-or-flight response (Lucassan et al., 2014). Consequently, through the release the hormone and neurotransmitter corticotropin-releasing factor (CRF), the HPA axis, which is part of the neuroendocrine system and includes the hypothalamus, the pituitary gland and the adrenal glands, is activated (Lucassan et al., 2014; Marin et al., 2011). Some of the most important functions of the body including digestion, regulating mood, sexual functioning, use and storage of energy, and the immune system are controlled and regulated by the HPA axis. It uses a feedback system between the limbic and hypothalamic brain structures to determine hormonal, behavioral and neural responses to stress (Kolb & Whishaw, 2014; Lucassan et al., 2014).

In the slow-acting pathway, the HPA axis releases the cortisol hormone from the adrenal cortex in response to stress thus activating the glucocorticoid (GC) component of the pathway (Herman, 2012; Kolb & Whishaw, 2014; Marin et al., 2011). This cortisol pathway, which tends to be a slow-acting process in comparison to the fight-or-flight response, is the main system that allows the bodily functions (e.g., digestion, reproduction, immune system) that are not necessary for immediate survival to become suppressed and/or inhibited as a means of protecting the body. During this time, the body's energy supply is increased through the release of cortisol which inhibits insulin production allowing the liver to release glucose in order to ensure that body is able to response solely to the stressor. Generally, the stress response is brief and the perceptions of threat will be improved once the body is able to return to its normal conditions. However, when the stress response is unable to become shut down, the body will continue to use up energy and proteins further exhausting and wasting muscles. In addition, many bodily functions remain

suppressed and/or inhibited including the suppression of the growth hormone, the gastrointestinal system (i.e., decreases the body's ability to replenish necessary nutrients), the reproductive functions and the immune system further increasing the chances of disease and/or infections (Kolb & Whishaw, 2014).

On a micro level, the cortisol receptors in the hippocampus are ordinarily responsible for the detection of cortisol in the blood in order to signal to the adrenal gland (i.e., hypothalamus) to inhibit the production of the hormone as a way of reducing the blood-cortisol levels in the body. When the stress response has not been resolved, these neurons are damaged as a result of the increased levels of cortisol and the compromise of their normal capacity further creating a devastating feedback loop responsible for uncontrolled levels of cortisol and progressive degeneration of the brain and the adrenal gland (Kolb & Whishaw, 2014; Miller & O'Callaghan, 2005). Studies have illustrated the deleterious effects of hippocampal degeneration related to chronic stress in monkeys with similar stress pathways to humans, and further proposed that sustained high levels of cortisol is associated with increased rates of gastric ulcers, swollen adrenal glands and neuronal atrophy (Sapolsky, 2005).

A biomarker is an indicator of some type of larger biological condition, for example, cholesterol, which originates from the blood usually serves as biomarker for cardiovascular health (Jaszczak, Lundeen, & Smith, 2009). Allostatic load (AL), a chronic stress biomarker, illustrates the impact of stress on both health and cognitive functioning through demonstrating the 'wear and tear' of the body as a result of perceived stressful situations (Clark et al., 2007; Juster, McEwen, & Lupien, 2010). Research has also shown that factors such as genetics, coping strategies, health habits, and past experiences of trauma influences an individual's perception of threat and regulates the stimulation of allostatic mechanisms (i.e., the sympathetic-adrenal-

medullary (SAM and the HPA axis). These factors can also contribute to an individual's resiliency to stress. However, the continued over activity of both the SAM and HPA axis can cause allostatic overload and contribute to an individual's susceptibility to stress-related infections and diseases (Juster et al., 2010).

Telomeres are described as DNA-protein complexes positioned near the ends of chromosomes and are responsible for shielding the DNA that is used to encode genetic information from damage that has been done (Harris, Martin-Ruiz, von Zglinicki, Starr, & Deary, 2012; O'Donovan et al., 2012). According to current research, telomeres have been shown to be valid biomarkers illustrating the association of different types of psychological stress with diseases of aging and the overall normal aging process (Fossel, 2012; O'Donovan et al., 2012). The length of telomeres is postulated to be responsible for the mechanisms of cellular aging. More specifically, the shortening of telomeres results from continued experiences of oxidative stress and somatic cell division (O'Donovan et al., 2012). Literature suggests that high risk of cardiovascular disease, autoimmune and neurodegenerative disorders, and cancer has been linked to shorter telomere lengths (Cawthon et al., 2003; Goronzy, Fujii, & Weyand, 2006; Willeit et al., 2010). Additionally, individuals who have been exposed to various types of psychological stress and life stressors have demonstrated shorter telomeres and further support the research on cellular aging (Damjanovic et al., 2007; Epel et al., 2004; O'Donovan et al., 2012). Moreover, when comparing women with high levels of perceived stress to those who have low levels of stress, studies have shown that these women (e.g., high levels of stress) possess shorter telomeres (Epel et al., 2004).

Stress, Culture, and Gender

Stress affects every person differently depending on various factors, including gender and culture. Gender can be thought of as the accumulation of socially constructed roles, relationships, personalities, attitudes, behaviors and values. Additionally, gender plays an important role in the interactions one has with her environment and the perception of a particular stressful situation followed by subsequent coping (Dedovic, Engert, Pruessner, & Wadiwalla, 2009). Culture, an incredibly complex construct, has been historically defined as a dynamic system of shared beliefs, traditions, learned behaviors, and customs, that members of a group use as they interact with the world and make sense of their surroundings, as well as a way to develop a shared sense of community and identity (Bustamante, Nelson, Henriksen, & Monakes, 2011; Cohen, 2009; Falicov 1995, 2007; Harrell, 2015; Harrell & Gallardo, 2008; Kakoti, 2012; Lehman, Chi-Yue, & Schaller, 2004). Furthermore, scholars have also described culture as a multidimensional construct (Cohen, 2009; Falicov, 1995; Harrell, 2015; Sue, 2001), occurring in multiple contexts that are "more varied, fluid, unpredictable and shifting than groups defined by using an ethnic-focused approach" (Falicov, 1995, p. 375). More specifically, Harrell (2015) offers an integrative conceptualization of culture's multifaceted construction to include:

> the multiple historical, sociopolitically-situated, and organizing systems of meaning, knowledge, and daily living that involve patterns of being, believing, bonding, belonging, behaving, and becoming which provide foundational frames for developing worldview, interpreting reality, and acting in the world for a group of people who share common ancestry, social location, group identity, or defining experiential context; but for whom, as individuals or intersectional subgroups, particular elements of a cultural system may be embraced, internalized, and expressed differently. Cultural systems emerge and

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transform over time through cumulative and adaptation-oriented person-environment

transactions, and are maintained and transmitted through collective memory, narrative,

and socialization processes. (p. 18)

The complexities of culture provide an alternative way of understanding the impact of stress on

women, including the inward and outward expression of mental or emotional distress and the

coping mechanisms used (Aldwin, 2004; Kakoti, 2012; Kral et al., 2011; Taylor, Welch, Kim, &

Sherman, 2007; Wong, 1993).

A transactional framework of conceptualizing stress emphasizes the importance of

incorporating culture, as defined above, in order to better understand women's experiences and

expressions of stress (Aldwin, 2004, 2014). Aldwin (2014) further postulates that culture can

affect stress and the coping process by shaping the type of stressors an individual experiences,

the appraisal of the stressful event, and the coping strategies and mechanisms that are used in

response. More specifically, the types and appraisals of stressors can vary based on gender,

socioeconomics status, religious affiliation, ethnicity, geography and sexual orientation (Aldwin,

2014; Wong, 1993). Understanding cognitive appraisal as a more objective process does not

leave much room for the impact of culture. Moreover, culture creates an objective condition in

the way resources or access to resources are distributed in a population (Aldwin, 2014; Hobfoll

& Schroder, 2001). However, the way those resources are appraised or understood is often

filtered through a cultural lens. For example, when working with Arab American women,

virginity is deemed as a "resource", which if lost through premarital sexual activity, would

prevent and complicate the woman's ability to marry, which is then generalized to her female

siblings and the overall reputation of the family (Abboud et al., 2015; Al-Krenawi & Jackson,

2014; Naber, 2006, 2012; Nassar-McMillan et al., 2013). As a result, potential economic

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alliances (Aldwin, 2014) are threatened, where as in American culture, virginity is not considered to be a family resource. Thus, it can be said that appraisals are a combination of cultural beliefs and values, access to resources, individual and collectivist needs and environmental factors (Aldwin, 2014).

Furthermore, culture influences the use of coping mechanisms, more specifically those grounded in social processes (e.g., social support, emotion-focused coping; Ahuvia, 2002; Aldwin, 2014; Chambers, Ryan, & Connor, 2001; Klienke, 1991; Martire, Stephens, & Townsend, 1998). The culture's values may also be placed on the decision of whether the individual places greater reliance on the self (e.g., internal locus of coping) or whether she relies on others around her (e.g., external locus of coping). As a result, the coping process may affect the immediate social environment thus being more prone to cultural influences.

As individuals continue to interact with their environment, culture plays a prominent role in identifying, defining and appraising various stressors which in turn can result in culturally-sanctioned coping mechanisms (Aldwin, 2014; Wong 1993). More specifically, women of Arab descent face a whole host of stressors ranging from familial expectations, negotiations of Arab and American values to acculturative stress. With these stressors, culture can be used to help define the ways Arab American women appraise and express stress (e.g., physical symptoms) and identify appropriate means of treatment.

Arab American culture and mental health issues. Arab Americans include a variety of ethnic origins that span the continents of Asia and Africa. According to the census, *Primary Ethnic Identification* is gathered from responses describing "Arab" ancestry including: Lebanese, Syrian, Egyptian, Iraqi, Jordanian, Palestinian, Moroccan, Arab or Arabic and the following countries collapsed as "Other Arab:" Algeria, Bahrain, Djibouti, Kuwait, Libya, Oman, Qatar,

Saudi-Arabia, Tunisia, the United Arab Emirates, and Yemen. The census estimates 1,967,219 Arab Americans in the United States (U.S. Census Bureau, 2010). According to the Arab American Institute (2012), the adjusted estimate is 3,665,789 Arab Americans in the United States (U.S. Census Bureau, 2010).

Many scholars have cited anywhere between two (Suleiman, 1999) to four (Nassar-McMillan & Hakim-Larson, 2003) waves of immigration to the United States over a period 125 years. The earliest being a group of laborers joining the *Great Migration* seeking better economic opportunities, fleeing the Ottoman Empire and which consisted of poor Christian Arabs (Orfalea, 2006; Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim-Larson, 2003;). Immediately after World War II, many Arab immigrants came to the USA due to political tensions in their regions and consisted primarily of well-educated Muslims (Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim Larson, 2003; Orfalea, 2006). In the following years, more specifically during the 70's and 80's, a great number of Lebanese migrated to the USA after the Civil War and Israeli invasion of Lebanon. Finally, the Persian Gulf War resulted in an influx of Iraqi refugees to immigrate to the USA and later, continued to immigrate for various reasons. Of note, is USA's key role in the political situations that have indirectly or directly impacted the Arab immigration, including the Gulf War (e.g., those who fought on the side of the USA were allowed to immigrate to the USA), and the U.S.-initiated War on Terror. As a result of these waves of immigration and globalization of knowledge, there is a demand for increased understanding of Arab Americans' multidimensional psychological functioning and mental health needs including the variety of acculturation problems they face (e.g., language barriers, adjusting to dominant culture, intergenerational and marital conflict, adjusting to cultural differences in gender roles, occupational shifts, etc.; Al-Krenawi & Graham, 2000; Erickson &

Al-Timini, 2001; Haboush, 2007; Hall & Breland-Noble, 2011; Al Khateeb, Al Hadidi, & Al Khatib, 2014; Nassar-McMillan et al., 2013).

Religion, community culture and family are central to the development and continued association with the Arab ethnic identity (Abboud et al., 2015; Erickson & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013). For first generation Arab Americans, their Arab ethnic identity is influenced through extended family dynamics and socialization as a result of explicit instruction, religious participation, or implicit processes (e.g., patrilineality in their family system; Erickson & Al-Timimi, 2001; Nassar-McMillan et al., 2013). For many immigrants and first generation Arab Americans, living in the United States has created challenges in negotiating their ethnic and American identities in order to promote an overall cohesive sense of self (Nassar-McMillan et al., 2013). Of note, the "invisibility" of Arab Americans as an identified ethnic group in the United States, the experience of racial stigma and discrimination, the heterogeneity in religious affiliation and country of origin, and the levels of acculturation have contributed to the difficulties of Arab Americans developing a positive individual ethnic identity (Erickson & Al-Timimi, 2001; Nassar-McMillan et al., 2013; Wrobel et al., 2009). Being part of the invisibility, more specifically, Arab American's women are often misrepresented and misunderstood by Western culture further increasing the various stressors they face while living in the United States (Abboud et al., 2015; Kakoti, 2012).

Historically, Arab Americans have sought to define their ethnic identity within the United States; however, this has become more challenging with the increase in, anti-Arab attitudes and misrepresentations in the media over the past two decades. More specifically, Arab women are portrayed and understood as oppressed and inferior to American women. Furthermore, on a socio-structural level, Arab Americans are not represented within the U.S. census's racial/ethnic

classification; instead they are rendered invisible (Naber, 2000; Nassar-McMillan et al., 2013). Using an ecological approach which includes the intersectionality of both macro system issues (e.g., historical events, internal and external culture, societal beliefs and stigma) and micro system issues (e.g., family dynamics, community participation) is crucial to understanding the multiple influences and contexts that make up the identity of women of Arab descent living in the Unites States (Naber, 2000).

Furthermore, the most recent wave of Arab immigrants identifies strongly with their religious ties as a means of defining their ethnic identity, further distancing them from the American mainstream. As a result, religion plays an important role in the development of a collectivistic identity within their children (Erickson & Al-Timimi, 2001; Read, 2003). This is crucial to one's work with Arab American women and further understanding the difficulties of balancing, accepting and/or rejecting the Arab identity with that of the mainstream American (Abboud et al., 2015; El-Aswad, 2010; Marshall & Read, 2003). Additionally, increased military U.S. involvement in the Middle East has increased the salience of gender, religious and ethnicity identities among Arab Americans (Haboush, 2007; Marshall & Read 2003; Nassar-McMillan et al., 2013; Read & Bartkowski, 2000). As a result, many Arab American women are prompted to reject or differentiate themselves from the Western idea of gender equality and feminism as a form of solidarity (Marshall & Read, 2003; Read & Bartkowski, 2000). Furthermore, age, class and level of assimilation must be considered when working with women of Arab descent living in the United States.

Often times, second-generation Arab Americans find themselves living between two worlds (i.e., Arab world and American world) and adopting values from both cultures. This bifurcated way of living has and can create difficulties negotiating individualist

American/Western values with more collectivist conservative Arab values. As a result, identity development is multifaceted and a complex process for Arab American women in terms of their sexuality, gender roles, dress, family and religion. Furthermore, understanding the complexities between U.S policy , country of origin politics, cultural stereotypes assumed by Americans, intergenerational differences and intragroup relations will assist clinicians in providing culturally-syntonic treatment to women of Arab descent living in the United States

Mental and physical health issues. Physical and mental health for Arab American women have been linked to level of acculturation including immigrant status, educational attainment, occupation, gender roles, and the individuals place in her family and community (Al-Krenawi & Graham, 2000; Jadalla, Hattar & Schubert, 2015; Kakoti, 2012; Nassar-McMillan et al., 2013). Furthermore, Arab American women's mental health is greatly affected by the conditions under which they immigrated (e.g., planned/unplanned, refugees, choice/no choice, educational, career). Some studies have indicated less depression and acculturation stress and increased life satisfaction with Arab Americans who have integrated into American mainstream culture and have adopted American beliefs (Kakoti, 2012; Nassar-McMillan et al., 2013; Read & Reynolds, 2012). On the contrary, some studies have also indicated that exclusively maintaining an Arab ethnic identity is associated with a positive psycho-social wellbeing, and that high biculturalism may result in lower personal self-esteem and lower emotional adjustment (Nassar-McMillan et al., 2013). Of note, affective experiences may be expressed in physical symptoms (e.g., headaches, stomach aches, difficulties sleeping), as the expression of conflict or negative feelings is not readily accepted in Arab culture (Al-Krenawi & Graham, 2000; Al-Krenawi & Jackson, 2014; Kakoti, 2012). Physical symptoms are seen to be more legitimate and motivate Arab Americans to seek medical treatment (Al-Krenawi & Graham, 2000). Lastly, navigating

between traditional Arab culture and American mainstream has been shown to create

psychological distress for women of Arab descent living in the U.S., including anxiety,

depression, low self-esteem, and internal conflicts (Al-Krenawi & Graham, 2000; Jadalla & Lee,

2012; Kakoti, 2012; Nassar-McMillan et al., 2013).

The combination of family roles, unappreciated work and other competing demands has

created physical and mental health stressors for Arab American women (Al-Krenawi & Graham,

2000; Barnett, 2004). These stressors are commonly expressed through physical symptoms (e.g.,

gastrointestinal issues, migraines, physical pain) and are often more "morally" acceptable

expressions of pain (Al-Krenawi & Graham, 2000; Nassar-McMillan et al., 2013). Multicultural

theorists emphasize the need for mental health professionals to develop an awareness and an

understanding of their biases, to challenge the stereotyped images of their clients, and to better

understand their clients' behaviors in the context of their culture both on a micro and macro level

(Ahmed & Reddy, 2007; Erickson & Al-Timini, 2001; Kim, & Abreu, 2001; Read & Reynolds,

2012; Sue & Sue, 2003). More specifically when working with Arab American women, utilizing

a multidimensional approach through the lens of ecology allows mental health professionals to

understand the impact of multiple systems on the therapeutic and intervention processes (Mourad

& Abdella, 2010)

Gender and its implications on stress. Women's roles have been shaped throughout

time; from a very early age, girls were taught to recognize the role that gender, or the learned

behaviors or attitude associated with being male or female, played in shaping their lives (Jenkins,

2013). Arab American women's multiple roles and cultural expectations have both negatively

and positively impacted women's mental and physical health. For example, due to a woman's

familial and domestic role, they tend to interact with health care providers more frequently and

receive medical care as a result of seeking care for their family members. The multiple roles have also shown to increase feelings of self-worth and increased connection with others, often times leading to overall improved well-being (Black, Murry, Cutrona, & Chen, 2009; Barnett, 2004). Recognition of discrimination within the family sphere regarding the rights of women and girls is also important to understanding gender role equality (Jenkins, 2013). The way a woman (mother) is perceived in a family plays a huge part in how a girl may understand her role as a female. Specifically for Arab American women, motherhood is strongly emphasized in Arab culture and often brings status to women in family and society, particularly in relation to sons (Crabtree, 2007; Haboush, 2007). Women play a pivotal role in the transmission of ethnic beliefs and traditions through child-rearing practices (Crabtree, 2007; Eid, 2003; Nassar-McMillan et al., 2013). Furthermore, mothers are responsible for mediating situations between the children and their father, and are often the ones providing punishment on behalf of their father (Amer & Awad, 2016). Although some women are encouraged to seek out employment outside of the home, the woman's first responsibility is understood to be the family (Mourad & Abdella, 2010). Additionally, the division of labor including who works longer hours, has a more demanding job, earns higher wages, and who is expected to do the domestic duties influences how each family member perceives the role of a female (Jenkins, 2013).

Across all cultures, gender appears to be a variable that has critically influenced individuals throughout the lifespan. More specifically, gender roles have created social expectations, influenced and shaped behaviors, and illuminated gender differences. Familial socialization has been shown to be the most influential in shaping the child's gender learning and perception of gender roles (Casey, Brabeck, & Nuttall, 1995; Jenkins, 2013; Whiting & Edwards, 1998). Several studies postulate that early gender role socialization is essential for determining

stress responsivity differences between females and males (Dedovic et al., 2009; Ruble, Greulich Pomerantz, & Gochberg, 1993). Furthermore, gender socialization at an early age emphasizes the way a boy and girl perceive his or her sense of self and self worth (Casey et al., 1995; Ruble, Greulich Pomerantz, & Gochberg, 1993). Historically in Western cultures, boys' autonomy and independence was encouraged, while with the socialization of girls resulted in conveying messages of dependence and lack of control (Dedovic et al., 2009; Pomerantz & Ruble, 1998). As a result, girls were encouraged to develop a sense of self that was more socially determined and relied on others' acceptance (Casey et al., 1995; Dedovic et al., 2009; Ruble et al., 1993). Socialization experiences embedded in one's culture play a critical role in gender development and shaping the lives of both men and women.

Sexuality and virginity are important categories that influence the identify formation of Arab American women; however, these categories are understudied (Abboud et al., 2015; Naber, 2006). They are also embedded in ideas around modesty, honor, and morality (Abboud et al., 2015). Generally, enacting and upholding honor influences the actions of both Arab American men and women (Abboud et al., 2015; Nassar-McMillan et al., 2013). However, for Arab American women, honor is enacted through the upholding of chastity and sexual virtue (Abboud et al., 2015; Al-Krenawi & Jackson, 2014; Naber, 2006, 2012). Arab American women are socialized at a very young age to behave in ways that portray Arab American women as innocent and pure (Abboud et al., 2015; Al-Krenawi & Jackson, 2014). Women of Arab descent living in the U.S. struggle to negotiate the more liberal Western view of sexuality and virginity with that of the conservative Arab viewpoint (Al-Krenawi & Jackson, 2014; Abboud et al., 2015; Naber, 2006). As a result, Arab American women tend to be socialized to preserve their "good Arab girl" identity through maintaining their virginity and adhering to traditional gender roles

(Abboud et al., 2015; Al-Krenawi & Jackson, 2014). They are often understood by the Arab American community to be different and better from "American girls" by limiting contact with males outside of the family, controlling their sexuality, and dressing modestly in public (Abboud et al., 2015; Nassar-McMillan et al., 2013). However, Arab American women face double standards within Arab society, where men are allowed to engage in premarital sex while women uphold to the traditional values. Violations of gender role expectations (e.g., premarital sex) among women can damage the reputation of the whole family and leave women in a vulnerable position of having few resources to seek support and information from (Abboud et al., 2015; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Fredrickson's and Robert's (1997) objectification theory can be used to further understand how women's socialization and experiences of sexual objectification have manifested into mental health problems such as depression, eating disorders and sexual dysfunction. This theory postulates that a women's life experiences along with gender socialization include sexual objectification, a dimension of daily experiences of sexism (Swim, Hyers, Cohen, & Ferguson, 2001; Moradi & Huang, 2008). Through these sexual objectification experiences, women are thought to be socialized to treat themselves as objects and to be evaluated and accepted based on bodily appearances (Fredrickson & Roberts, 1997; Moradi & Huang, 2008). As a result, self-objectification and body surveillance is further promoted in women thus increasing body shame and anxiety, and reducing awareness of internal bodily states. This then results in higher risks for depression, sexual dysfunction and eating disorders (Fredrickson & Roberts, 1997; Moradi & Huang, 2008).

Studies have also suggested that women's multiple roles impact their health and result in higher awareness of their health problems compared to men (Read & Reynolds, 2012). Coming

from dual career households, women demonstrate a continued responsibility for housework and child care (Terrill, Garofalo, Soliday, & Craft, 2012). More specifically, a combination of pressures from family roles, unappreciated work and various competing demands results in decreased health outcomes for women (Dedovic et al., 2009; Terrill et al., 2012). This can be attributed to increased time pressure and inability to meet demands of various roles thus increasing risk for depression, anxiety, and poorer physical health (Brezinka & Kittel, 1995; Terrill et al., 2012). A review of literature suggests that multiple roles often place conflicting demands on women, which increase negative health outcomes and increase overall stress (Berntsson, Lundberg, & Krantz, 2006; Berzinka & Kittel, 1995; Chida & Hammer, 2008; Terrill et al., 2012).

As women have taken on less traditional gender roles and have entered the labor force in greater numbers, stress appears to be on the rise for women. Multiple role stressors may be a particularly important consideration for women. Census data suggests that in the US, approximately 70% of women who are married and have a child under the age of 18 years old living at home are also members of the labor force (U.S. Census Bureau, 2010). Additionally, married women who assume multiple roles, both in and out of the home, experience inter-role conflict around the demands of these various roles (Bardwick, 1971; Beutell & Greenhaus, 1983; Black et al., 2009; Nordenmark, 2004). For Arab American women, ethnic identity, religiosity, family structure and social class play a role in their participation in the labor force (Nassar-McMillan et al., 2013; Read, 2004). Arab American women from more traditional families are less likely to be employed and adhere to cultural traditions, such as domesticity and childrearing (Nassar-McMillan et al., 2013; Read, 2004). Second generation Arab American women demonstrate a higher overall labor force participation, which may be attributed to increased

interaction with mainstream American values and separation from traditional gender ideologies (Nassar-McMillan et al., 2013; Read, 2004). Cultural views on appropriate type of work for women influence Arab American women's' decisions to enter the labor force and preference of employment (Nassar-McMillan et al., 2013). This tends to create many challenges for Arab American women seeking employment with low levels of education and for Arab refugees in the U.S. who are required to work for pay to receive benefits for their families as soon as they have arrived (Nassar-McMillan et al., 2013; Read, 2004). Lastly, the presence of children in the home can create barriers or challenges for Arab American women seeking employment opportunities, and the presence of nonspouse adult family members may alleviate that stress through helping with domestic responsibilities and providing care for the children (Nassar-McMillan et al., 2013; Read, 2004). As Arab American women assimilate into American mainstream, their traditional gender ideologies and other factors start to change (Nassar-McMillan et al., 2013; Read, 2004). Furthermore, women's multiple roles have shown to create stressors for women (i.e., physical and mental health outcomes) as well as provide benefits, including increased social connection and feelings of self-worth (Barnett, 2004; Black et al., 2009; Haboush, 2007; Nassar-McMillan et al., 2013).

Many American women work outside of the home due to financial obligations (Dubeck, 2002). When the demands of family and work roles become unbalanced and difficult to coexist, inter-role conflict, frequently described as work family conflict, can result (Bernas & Major, 2000; Hill, Hawkins, Ferris, & Weitzman, 2001; Marks, Huston, Johnson, & MacDermid, 2001; Tausig & Fenwick, 2001). Research has shown that work family conflict affects both men and women, but women are more likely to experience stress from occupying multiple roles (Barnett, 2004; Gyamfi, Brooks-Gunn, & Jackson, 2001; Hattar-Pollara, Meleis, & Nagib, 2003; Simon,

1992). Although an Arab American woman may pursue higher education and develop a career, she is still expected to be responsible for the family (Mourad & Abdella, 2010). As a result, Arab American women may face increased stress and difficulties fulfilling multiple roles expectations (Al-Krenawi & Graham, 2000; Barnett, 2004). Additionally, as females, they are expected to continue to care for their siblings and parents well-after marriage and having their own children (Al-Krenawi & Graham, 2000; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). This can often create increased pressure to maintain cohesion for both nuclear and extended families while also relinquishing her own needs and desires.

Traditional conceptualizations of work-family stress consist of the conflict that arises from two domains of life that are not functionally compatible with each other and result in increased stressed, and often times, feelings of guilt, regret and worry (Andrade & Mikula, 2014; Greenhaus & Beutell, 1985). For example, long work hours can have a negative impact on family and those who struggle with balancing roles and may have limited time dealing with familial or marital conflicts (Andrade & Mikula, 2014; Black et al., 2009; Nordenmark, 2004). Cultural views on appropriate type of work for women influence Arab American women's' decisions to enter the labor force and preference of employment (Nassar-McMillan et al., 2013). This tends to create many challenges for Arab American women seeking employment with low levels of education and for Arab refugees in the U.S. who are required to work for pay to receive benefits for their families as soon as they have arrived (Nassar-McMillan et al., 2013; Read, 2004). Reconciling the multiple roles of family work and occupational work has shown to cause social issues and increased stress in today's society (Andrade & Mikula, 2014; Barnett, 2004). The literature has also shown some inconsistencies when discussing the impact of gender on work family outcomes. In early research on gender differences, it was suggested that women

experience more family stress and occupational stress than men (E. Anderson & Leslie, 1991; Clarke, Koch, & Hill, 2004; Hughes & Galinsky, 1994). However, some literature suggests that there may be no significant differences in work family outcomes based on gender status (Frone, 2003; Hill, Hawkins, Martinson, & Ferris, 2003).

The balance of work and family can be difficult, especially since the more one participates in multiple roles, the more likely one is to become overloaded and experience inter-role conflict (Marks, 1977). Paradoxically, in a study by Clarke, Koch, and Hill (2004), increased involvement in family activities was positively associated with stronger work family balance. This is likely due to the increased levels of family support, as a benefit of family involvement, which are correlated with an increased overall well being (Adams, King & King, 1996; Tausig & Fenwick, 2001). For example, the presence of children in the home can create barriers or challenges for Arab American women seeking employment opportunities, and the presence of nonspouse adult family members may alleviate that stress through helping with domestic responsibilities and providing care for the children (Nassar-McMillan et al., 2013; Read, 2004). As the literature suggests, work family balance is affected by various factors, as evidenced above. Clarke, Koch, and Hill (2004) found that occupational satisfaction and marital satisfaction are both significant predictors of work family balance. In fact, according to Marks et al. (2001), satisfaction with marriage positively affects the balance of multiple roles for both partners.

Studies also suggest that work family balance and marital satisfaction are negatively impacted when a partner feels dissatisfaction or unfairness with the division of housework responsibilities (Erdwins, Buffardi, Casper, & O'Brien, 2001; Hochschild, 1989; Stevens, Kiger, & Riley, 2001; Voydanoff & Donnelly, 1999). However, supportive spouses who equally share housework responsibilities and support one another socially and occupationally experience

increased marital satisfaction, less stress, and have a stronger work family balance (Barnett, 1994; Burley, 1995; Stevens et al., 2001). Additionally, being a supportive spouse, as well as having a supportive spouse can both contribute significantly to positive work-family outcomes (Clarke, Koch, & Hill, 2004). However, it is important to note that Arab Americans' values of love and marriage differ greatly than those of Western society (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). Marriage is highly valued in Arab culture and women are discouraged from leaving the marriage and expected to stay despite conflict and domestic violence issues (Nassar-McMillan et al., 2013). The decision to marry is not based on the couple's romantic love, but instead, on gaining approval from extended family members. Therefore, family involvement is highly common in marriages and in overall decision-making. Divorce is generally looked at as a last result, and the mother/wife is expected to endure marital conflict to avoid the stigma of divorce and creating a divide for the children (Al-Krenawi & Graham, 2000). Divorce also has a strong stigma for women of Arab descent living in the United States. For example, a divorced woman will experience social and emotional turmoil within her Arab community and face difficulties remarrying (Al-Krenawi & Graham, 2000). However, family members and/or religious leaders will play a vital role in intervening, providing support, and encouraging the woman to maintain the marital cohesion (Al-Krenawi & Graham, 2000; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). As social and legal reforms of women's roles and rights continue to develop and women are more educated, young adults are starting to resist family involvement (Nassar-McMillan et al., 2013; Raz & Atar, 2005). These differences can create obstacles for Arab American women that look to their partners for support, especially when there is marital conflict.

Many women today are taking on multiple roles throughout their lives. Research suggests that women are not only caregivers, but are simultaneously occupying other social roles such as employee, mother, and wife (Doress-Worters, 1994; Moen, Robison, & Fields, 1994; Norton, Stephens, Martire, Townsend, & Gupta, 2002). A family caregiver is often referred to as an informal caregiver who provides essential care to a family member experiencing physical and/or mental challenges and who is most commonly unpaid for the services. This may include caring for a physically-disabled child, an elderly parent, or an adult child with challenges such as substance abuse or mental illness. The National Alliance for Caregiving and American Association of Retired Persons (2004) estimate that 44.4 million Americans are unpaid caregivers for a family member over the age of 17. Additional research has shown that caregivers experience numerous negative effects, such as physical illness, psychiatric morbidity, and stress (Cochrane, Goering, & Rogers, 1997; Haley, 2003). Caregivers can also experience other physical symptoms such as high blood pressure, increased risk of coronary artery disease (King, Oka, & Young, 1994; Vitaliano, Russo, & Niaura, 1995), as well as impairment of the immune system (Kiecolt-Glaser, Marucha, Malarkey, Mercado, & Glaser, 1995). Caregiving commonly causes increased financial strain, interference with work, and family strain, which all contribute to increased stress (Covinsky et al., 2001).

Feminist perspectives on gender and stress. Gender is embedded in everyday life, including stereotypes related to emotional expression, relational style, temperament, cognitive abilities, and roles within the family and in society. Gender is a construction of personal experiences and social expectations associated with being male or female in any group or culture (Cosgrove, 2003; Deaux & Major, 1987; Stewart & Dottolo, 2006). Stereotypic male-female imbalances result from power asymmetries which are seen across age, class, color, ethnicity,

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religion and sexual orientation (Worell & Goodheart, 2005). Women at a young age are culturally expected to assume the role of caretaker for the feelings and welfare of others, oftentimes resulting in difficulties expressing their own feelings, thoughts or preferences (Dedovic et al., 2009; Pomerantz & Ruble, 1998; Worell & Goodheart, 2005). This can lead to gender intensification, resulting in increased role strain in interpersonal relationships, stress, chronic low self-esteem, and body-image disorders (Dedovic et al., 2009; Pomerantz & Ruble, 1998; Worell & Goodheart, 2005). Socioeconomic status, in addition to ethnicity and gender, has contributed to increased risk for physical and mental health conditions for women (Fredrickson & Roberts, 1997; Moradi & Huang, 2008; Worell & Goodheart, 2005). Women continue to make less money than men in the workplace and have a higher likelihood of living in poverty.

From 1970 to 1995, egalitarian gender role beliefs increased, with researchers attributing this increase to the feminist movement as more women began entering the workforce (Fine, 1985; Landrine & Russo, 2010). Approximately four decades of research conducted on women's psychological health allowed for the integration of diverse social and economic groups in further promoting awareness of women's psychology (Worell & Goodheart, 2005). Increased establishment in career fields that males used to dominate including, business, science, law, medicine and military is providing opportunities for achievement, higher levels of education and training, increased income and overall increased empowerment (Betz, 2002). Feminists have aimed to promote empowerment and women's well-being across diverse populations.

Kane (2000) found that endorsement of traditional gender roles greatly varied amongst ethnic groups and noted that African Americans were more egalitarian; however, African American men seemed to be more supportive in traditional gender roles specifically in family and leadership positions (Landrine & Russo, 2010). Additionally, S. Anderson and Johnson

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(2003) found that Asian Americans adhered more strictly to traditional gender roles in social areas when compared to White Americans.

Modern sexism, analogous to racism, can be defined as a denial of continued discrimination of women and opposition to women's demands and needs (Landrine & Russo, 2010). This can be seen in the opinion that "women are no longer discriminated against in the United States" (p. 149). Neosesxism is discrimination towards women based on their competency compared to men (Glick & Fiske, 2011; Landrine & Russo, 2010). Additionally, ambivalent sexism includes both hostile and benevolent sexism. Hostile sexism is negative and direct whereas benevolent sexism conveys the same beliefs but in a positive tone (Glick & Fiske, 2011; Landrine & Russo, 2010). With benevolent sexism, common themes found include: paternalism (e.g., women need men to feel protected), complementary gender differentiation (e.g., women's domestic abilities work well with the lack of men's domestic abilities) and heterosexual intimacy (e.g., women fulfill men's romantic needs). Benevolent sexism has been claimed to decrease women's resistance to gender discrimination and increase the dependence on traditional gender roles further encouraging women to achieve subservient positions in society. Women of color experience varying consequences of sexism, including double jeopardy. Double jeopardy can either be treating racism and sexism as separate experiences of discrimination (i.e., additive double jeopardy) or as a simultaneous occurrence of racism and sexism as forms of oppression (i.e., , multiplicative double jeopardy). Continual experiences of sexism can result in increased stress levels for women and lead to increased stigmatization (Landrine & Russo, 2010; Link & Phelan, 2001; Mays, Caldwell, & Jackson, 1996; Padgett, Patrick, Burns, & Schlesinger, 1994; Rieker & Jankowski, 1995; Rollock & Gordon, 2000). Furthermore, stigmatization-- hidden or visible--can result in loss of power, status and discrimination creating self-presentation

and disclosure issues (Landrine & Russo, 2010; Link & Phelan, 2001; Rieker & Jankowski, 1995). Put simply, stigma can cause an individual to protect aspects of their identity in fear of being rejected and/or discriminated against.

Perceived discrimination, including sexism has been found to be linked with increased gender differences in symptoms of depression, anxiety, and somatization (Fischer & Holz, 2007; Klonoff, Landarine, & Campbell 2000; Landrine & Russo, 2010). Women's mental health is significantly impacted through activation of stereotypes, social exclusion, negative treatment and institutional discrimination through interpersonal, psychological and structural mechanisms (Landrine & Russo, 2010). Furthermore, gender-based violence has significant and long lasting effects psychologically. Feminist perspectives of violence and trauma have intentionally included social, emotional and political environments when assessing for traumatic events (L. Brown, 2004; Landrine & Russo, 2010). This intersectionality across social structures and multiple identities further promotes a multifaceted construct of gender that gradually developed as the feminist movement took place. Black feminist scholarship introduced the idea of intersectionality (Crenshaw, 1989), a concept fundamental to addressing concerns of women and emphasized multiple oppressions that emerge from the different dimensions of their social life and identity (Brah & Phoenix, 2004; Macleod, Marecek, & Capdevila 2014; Shields, 2008). Subsequently, increasing numbers of ethnic minority women began to develop spaces and social support systems in professional organizations (Landrine & Russo, 2010).

Immigration, ethnicity, and stress. With an increase in emigration from diverse political, economic and social backgrounds, immigrant health has motivated a new inquiry to examine the health disparities between the new immigrant groups and Americans (Read & Reynolds, 2012). Current studies suggest that these ethnic health disparities resulting from

exposure to different psychosocial stressors are contributing to group differences in the likelihood of negative health-outcomes in adults (Meyer, 2003; Myers, 2009; Myers & Hwang, 2004). The cognitive and emotional processes involved in immigration contribute to a journey and transition that can be both strenuous and stressful. According to Tsihisekedi (2008), immigration whether by choice or constraint, is an undeniable influence to psychological mental states that range from stress, anxiety and excitement, to trauma and despair. Over time, the study of immigration has expanded from its focus on "male laborers" to include female migrants who make up approximately 49% of the immigrant population in the United States (American Immigration Center, 2010). There are important gender differences in the experience of immigration and subsequent acculturation processes that are related to gender roles in one's country of origin and how those may be similar or different to gender roles in the host culture. More specifically, studies suggest that due to an immigrant woman's familial and domestic duties, women are placed in contact with health care systems more frequently than men in order to seek care for their children and elderly family members which result in more access to healthcare (O'Brien, Hunt, and Hart 2005; Reynolds & Reynold, 2012). Women of Arab descent living in the U.S. play a significant role in the family's upbringing and maintenance of gendered norms, and ethnic and social expectations. This, in turn, can heighten a female's sensitivity to the gender differences present in the United States (Abboud et al., 2015; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). Therefore, gender differences can be a strong part of Arab culture and are manifested in social, educational and occupational structures (Al-Krenawi & Graham, 2000). However, gender attitudes vary depending on social class, generational status and level of education. Less educated individuals tend to have stronger attachments to traditional values and gender roles. Religion and level of religiosity also impacts gender dynamics within a

family structure (Read, 2003, 2004). Arab American women's multiple roles and cultural expectations have both negatively and positively impacted women's mental and physical health.

Research indicates that immigration and the acculturation process result in psychological distress among members of immigrant groups (Liebkind & Jasinskaja-lahti, 2000; Stillman, McKenzie, & Gibson, 2009; Bhugra & Jones, 2001). Acculturation is conceptualized as a multidimensional process that occurs as a result of contact with a new or host culture and involves changes in many aspects of immigrants' lives. These changes can include language competence and use, cultural identity, attitudes and values, types of food and music preferred, media use, ethnic pride, ethnic social relations, cultural familiarity, and social custom (Schwartz, Unger, Zamboanga, & Szapocznik, 2010; Yoon, Langrehr & Ong, 2010; Yoon, Lee, & Goh, 2008). It allows for a bidirectional impact, where two cultures of contact are interacting through giving and receiving to and from each other (Kim & Abreu, 2001; Schwartz et al., 2010; Yoon et al., 2010). In other words, there can be a reciprocal process occurring between two different cultures. Changes that arise from the intercultural interactions can include both positive and negative effects. Positive effects include individuals developing a broader range of cultural skills and a stronger "world-mindedness;" while negative effects can include intergroup anxiety or identity conflict due to "culture shock" (Yoon et al., 2008, 2010). Berry (1994) posits four possible outcomes of the acculturation process: assimilation (i.e., movement towards the dominant culture), integration (i.e., synthesis of both cultures), rejection (i.e., reclaiming of the traditional culture) or marginalization (i.e., isolation/alienation from host culture; Berry, 1994, 1997, 1998). It has been suggested that the level of the immigrant's psychological distress can be attributed to stressors that emerge from their acculturation process, such as obtaining employment and housing, accessing health care, language barriers, and interpersonal social

support (Berry, 1997; Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006). Immigrants are faced with a myriad of psychosocial stressors such as adjusting to their new host country, negotiating between their native culture's expectations and their host culture's, reidentifying their value system and redefining their roles in the family and at work. As a result, many immigrants experience acculturative stress associated with a perceived imbalance of cultural expectations and actual resources available (Berry, 2005; Torres, 2010). Although individuals or families migrate to improve their well-being, the World Health Organization (2001), claims that "migration does not bring improved social well-being, rather...it often results in...exposing migrants to social stress and increased risk of mental disorders" (p. 13). Pressures to assimilate into the host culture may be felt differently across various individuals, and the qualitative nature of the acculturation process may also vary across contexts (Negy, Hammons, Reig-Ferrer & Carper, 2010). Acculturative stress can be understood broadly as the "psychological impact of adapting to a new culture" (Smart & Smart, 1995). Working with immigrants illuminates the need to understand transnational lifestyles including family relationships, gender roles, and cultural and sociopolitical issues (Falicov, 2007). Furthermore, understanding how people connect and change within a context such as new definitions of family life, various forms of relational stress and acculturative stress manifested in gender and generational relationships is essential to monitoring stress levels for female immigrants (Falicov, 2007). Exposure to discrimination and racism may be daily experiences for many immigrants. These experiences not only influence an individual's mental and physical health, but also can change relationships within a family or institutional context thus transforming identities for female immigrants (Falicov, 2007; Suarez-Orozco & Suarez-Orozco, 2001).

Acculturation also plays a significant role in how Arab American families adjust to living in the United States and further influences their values, traditions and relationships (Nassar-McMillan et al., 2013). Often times, the expectations that are associated with acculturation can create high levels of stress for families (Nassar-McMillan et al., 2013). Arab Americans who demonstrate difficulties with English, lower education levels, shorter length of residence in the U.S., and involuntary immigration have an increased likelihood of experiencing acculturative stress (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). More specifically, women of Arab descent who have immigrated to the United States are considered to be at risk for developing mental and physical health symptoms as a result of the pressures of adjusting to American mainstream behaviors and influences on their children and family in addition to experiencing their own social discomfort (Wrobel et al., 2009).

Furthermore, evidence suggests that there is a correlation between racial discrimination and both physical and psychological distress (Contrada et al., 2000; Harrell, 2000; Wadswroth, Dhillon, Shaw, Bhui, Stansfeld, & Smith, 2007). Health-related and physiological outcomes such as hypertension, cardiovascular reactivity, cigarette smoking, and physiological arousal have been shown to be associated with racism-related stress (Harrell, 2000; Kaiser & Miller, 2004). Many African-Americans, Latinos, Native Americans, South Pacific Asians, South East Asians and Middle Easterners have been shown to have high morbidity and mortality rates due to suffering from many social disadvantages due to language barriers, inadequate access to health care, discrimination, and/or lack of resources (Keppel, Pearchy, Wagener, & U.S. National Center for Health Statistics, 2002; Myers, 2009). Additionally, the confluence of psychosocial, behavioral, and physiological factors such as reactivity to stress and access to quality health care has heavily influenced the trajectory of disorders for many of these cultural groups. Studies have

also indicated that race/ethnicity, social class, and environment significantly contribute to chronic stress including ethnicity-related stress (i.e., discrimination, racism) and daily-life stressors (Harrell, 2000; Keppel et al., 2002; Myers, 2009; Myers & Hwang, 2004). The frequent experience of discrimination has been shown to be linked to increased angry outbursts, overall stress burden and can exacerbate the impact of other life stresses such as job loss, legal difficulties, relationship and familial issues (Myers, 2009; Clark, Clark, & Williams, 1999; Harrell, Halls, & Taliaferro, 2003). Racism has also been shown to affect self-esteem and self-efficacy (Harrell, 2000) and has been associated with depression (Brondolo et al., 2011). Clark et al. (1999) also argue that the role of micro insults, also known as *microaggressions* (Sue & Sue, 2003), can result in greater psychological and physiological reactivity due to the exposure to both objectively and subjectively measured chronic and episodic stressors (Harrell, Halls, & Taliaferro, 2003; Myers, 2009). In addition, studies show that people from disadvantaged backgrounds are exposed to more chronic stressors and will experience higher rates of hostility, anxiety, depression and hopelessness (Hatch & Dohrenwend, 2007; Meyer, 2003; Myers, 2009). Taking this one step further, studies have suggested that people with dual burdens of disadvantaged backgrounds and race/ethnicity stressors are at a greater risk for limited access to resources (i.e., interpersonal, intrapersonal, socio-cultural, and health care) for coping. As a result, the demands from chronic exposure to stress require the utilization of the limited resources available and increase the likelihood of physical and psychological health risks (Myers, 2009). Recent studies have also linked exposure to chronic social adversities to increased disease and dysfunction in racial and ethnic groups (Mays, Cochran, & Barnes, 2007; Myers, 2009). Overall, research is increasingly showing that physical health outcomes can be determined by ethnicity-related stressors (Contrada et al., 2000; Meyer, 2003; Myers, 2009).

The relationship between racism and health-related outcomes continues to be a focus of study in empirical research (Pieterse, Carter & Ray, 2011). More specifically, Guyll, Matthews and Bromberger (2001) examined cardiovascular reactivity to both mistreatment and discrimination on a group of women and concluded that discrimination is a chronic stressor which negatively impacts Black women. These findings also suggested a positive relation between subtle mistreatment and cardiovascular reactivity for women (Guyll et al., 2001). More recently, Todorova, Falcón, Lincoln, and Price (2010) found that perceived racism and discrimination have negatively affected health resulting in serious immediate and long term physical and mental health consequences (Ryan, Gee, & Laflamme, 2006) . Furthermore, discrimination was shown to be stressor that contributes to increased health-risk behaviors (i.e., smoking, alcohol consumption, eating and sleeping behaviors; Todorova et al., 2010). Some findings have shown an association for decreased physical health and discrimination amongst African Americans, African immigrants and Latino immigrants (Ryan et al., 2006; Todorova et al., 2010). Racism-related life events, continuous microstressors, and chronic discrimination can also result in depression, anxiety, hypertension, and preterm and low birth weight deliveries for women (Harrell, 2000; Mustillo, Krieger, Gunderson, Sidney, McCreath & Kiefe, 2004). Mustillo et., al (2004) further found that racial discrimination was associated with preterm and low weight birth deliveries. It can be concluded that a lifetime exposure of discrimination can be characterized as a "chronic stressor" and cause significant physiological and psychological distress for women (Carter, 2007; Collins, David, Handler, Wall & Andes, 2004). Women, not only face gender-related expressions of racism, but also silently experience stressors associated with sexism within their own ethnic communities thus contributing to differences across disorder

prevalence and treatment outcomes (Mays, Caldwell, & Jackson, 1996; Padgett et al., 1994; Rieker & Jankowski, 1995; Rollock & Gordon, 2000).

Historically, Arab culture has been shaped by many political, religious, and territorial disputes, which play a significant role in assimilation patterns for Arabs (Abboud et al., 2015; Erickson & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013). The early waves of Arab immigrants to the United States who were mostly Christians assimilated more readily to the predominantly white American middle class due their similar Christian religion, identifying as white/Caucasian, Anglicizing their Arabic names, readily accepting American ideals and engaging in peddling activities (Naber, 2006; Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim-Larson, 2003; Orfalea, 2006; Read, 2003). This is in contrast to the post-1965 and more recent wave of immigrants who are mostly Muslims and demonstrate strong transnational linkages to their homelands (Erickson & Al-Timimi, 2001). More specifically, after the 9/11 attacks, there were increased instances of racial profiling and stigmatization of Arab Americans leading to increased interest in establishing "ethnic communities" in order to protect themselves using their own resources. In order to develop a contextualized understanding of Arab Americans and their mobilization, it is imperative that one becomes aware of the significant role American Foreign Policy has played in the political situations that have indirectly or directly impacted Arab immigration, including the Gulf War (e.g., those who fought on the side of the USA were allowed to immigrate to the USA), and the U.S.-initiated War on Terror (Erickson & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013).

The terror attacks on September 11, 2001 and the resulting Global War on Terror further contributed to the widespread negative perceptions of Arab Americans and Arab culture (Nassar-McMillan et al., 2013; Haboush, 2007). Arab Americans demonstrated an increased awareness of

discrimination, exclusion and anger towards their community. Furthermore, the anti-Arab violence and increased racial profiling motivated many Arab Americans to reestablish their roles in American society and motivated mobilization towards transnational and global issues pertaining to Arabs. Many Arab American families faced continued discriminatory attacks, grieved the loss of family and friends and had to cope with the directed anger of many Americans during this time (Beitin & Allen, 2005).

In 2001, the relationship between Muslim women wearing a hijab, or headscarf, and the idea of oppression that many Americans constructed became a central theme in mainstream media and gender discourse (Abu-Lughod, 2002). Often times, this resulted in viewing the use of hijab as prescribing to male domination as opposed to an expression of faith or a cultural choice (Abu-Lughod, 2002). As a result, women were subjected to violent acts including assault, road rage, and hostile comments and were perceived as threats to American culture (Nassar-McMillan et al., 2013; Abu-Lughod, 2002). Furthermore, the resulting effects of the Global War on Terror, including the Patriot Act signed into law in 2001, increased experiences of rejection, isolation and distrust from Arab Americans and American Muslims towards the government and the Federal Bureau of Investigation (Ahmed & Reddy, 2007; Fine & Aziz, 2013; Nassar-McMillan et al., 2013). As a result, Arab Americans and Muslim Americans became the targets of discrimination and racial profiling which increased psychological distress, decreased general happiness levels and contributed to an increase in health problems (Ahmed & Reddy, 2007; Al-Krenawi & Graham, 2000; Nassar-McMillan et al., 2013; Read & Reynolds, 2012).

Coping and Social Support

Research on the stress process frequently includes attention to mediators of the relationship between stressors and health outcomes (Benson, 2008; Carlson, Speca, Faris, &

Patel, 2007; Ghoncheh & Smith, 2004; Hall & Long, 2009; Harrell, 2000; Ludwig & Kabat-Zinn, 2008). Coping and social support are among the most frequently studied mediator variables. Taylor and colleagues (2000) postulate that there are significant physiological effects of social support which includes increased nurturing behaviors that enhance hormonal factors (i.e.oxytocin) which alleviate the negative effects of stress (Taylor et al., 2000). Coping can be defined as a way of changing the experience of psychological stress within a disadvantageous environment through managing external and/or internal demands that are perceived to be dangerous to one's well-being (Bauman, Haaga, & Dutton, 2008; Lazaraus, 1993; Lazaraus & Folkman, 1984). According to Lazaraus and Folkman (1984), coping is understood as a shifting process that includes continuous appraisal and reappraisal of stressful situations in the environment or directed inward to change the meaning of an event or the way an individual understands the event. Lazarus and Folkman initially divided coping into two types: emotion-focused and problem-focused forms of coping (Carver, Scheier, & Weintraub, 1989; Chao, 2011; Lazarus & Folkman, 1984).

Emotion-focused coping. Emotion-focused forms of coping emphasize modifying the way one interacts with the environment to manage the experience of stress, or the relational meaning of a stressful situation, without changing the actual situation (Bauman et al., 2008; Lazarus & Folkman, 1984). Some research suggests that emotion-focused coping is more common among women than men (Bagheri-Nesami, Rafii, & Oskouie, 2010; Bellman, Forster, Still, & Cooper, 2003; Long, 1989; Martire et al., 1998; Matisse, 2002). These strategies include "avoidance, minimization, distancing, selective attention, positive comparisons, and wresting positive value from negative events" (Lazarus & Folkman, 1984, p. 150). Some individuals can also engage in self-blame or other forms of self-punishment to relieve their distress (Lazarus &

Folkman, 1993). Lazarus & Folkman (1984) further incorporate cognitive reappraisals, instances where an individual changes the meaning of a situation without changing it objectively, as part of the coping process and is thus targeted to regulate emotions (Chao, 2011; Lazaraus & Folkman, 1984). Varied literature suggests that although emotion-focused coping, specifically social support, is correlated with decreased levels of stress, some studies have indicated that stress outcomes may be exacerbated due to unhealthy social relationships (Bellman et al., 2003; Sabina & Tindale, 2008; Turner-Cobb et al., 2002). Securely attached individuals tend to perceive and seek higher levels of emotional support whereas insecurely attached individuals avoid interpersonal interactions and social connections. Furthermore, positive social interactions may enhance mood; however, negative social relations form insecure attachments can result in decreases in mood and increased stress (Bellman et al, 2003; Sabina & Tindale, 2008; Turner-Cobb et al., 2002). However, Folkman and Lazarus (1988) suggest that individuals generally use both types of coping, and the predominant coping style is determined by the individual's personal style and the stressful situation.

Folkman and Lazarus (1988) identified four subtypes of emotion-focused: positive reappraisal, distancing, self-control, and accepting responsibility. Through positive reappraisal, an individual decreases the stressful threat by changing the meaning of the situation, for example, "'I decided I didn't need him nearly as much as I thought'" (Lazarus & Folkman, 1984, p. 150). Distancing and emotional suppression (i.e., 'self-control'), or non-expression, has been found in numerous studies to be negatively associated with physical and psychological well-being across various medical conditions. For instance, when anger or hostility is not expressed, it has been shown to lead to increased coronary heart disease and has been found to be related to overall mortality (Graves, Mead, Wang, Liang, & Klag, 1994; Karademas, Tsalikou, & Tallarou,

2011; Nyklicek, Vingerhoets & Denollet, 2002; Panagopoulou, Kersbergen & Maes, 2002).

Another coping strategy that is widely used amongst men and women is accepting responsibility, such as, "I realized I brought the problem onto myself" (Folkman & Lazarus, 1988; APA, 2010). More recent studies have found that reappraisals occur more frequently than suppression or other means of coping strategies for individuals in their daily lives (Karademas et al., 2011; Nezlek & Kuppens, 2008).

      Problem-focused coping. Problem-focused coping strategies focus on eliminating or reducing stress through identifying and defining a problem, as well as creating alternative solutions through problem-oriented strategies (Lazarus & Folkman, 1984). Two types of problem-coping strategies include confrontive coping and planful problem-solving (Folkman & Lazarus, 1988). Confrontive coping entails directly dealing with the problem or issue using aggressive efforts or risk-taking, such as, "I stood my ground and fought for what I believe in" (Chao, 2011; Folkman & Lazarus, 1988; Kaiser & Miller, 2004). On the other hand, planful problem-solving incorporates deliberate problem-focused strategies to alter the situation, such as "I doubled my work and efforts because I knew I had to get it done" (Folkman & Lazarus, 1988; Mahat, 1997). Studies have shown that problem-focused coping increases self-efficacy and self-esteem across individuals (Chao, 2011; Holahan & Moos, 1987). Furthermore, it has been associated with decreased hopelessness amongst women in abusive relationships (Clements & Sawhney, 2000; Sabina & Tindale, 2008). Additionally, social support has been seen to result from problem-focused coping strategies and promotes adaptive coping strategies that increase self-confidence and promote health (Chao, 2011; Holahan & Moos, 1987; Lazarus & Folkman, 1984; Sabina & Tindale, 2008).

Meaning-focused coping. Coping has been shown to be an important mediator between stressful events and improved quality of life experiences (Lazarus & Folkman, 1984; Manning-Walsh, 2005a; C. Park, 2005). The role of meaning-making as a coping strategy has been examined most commonly in association with trauma or extreme stress. Approximately 51% of women and 61% of men in the United States have experienced at least one traumatic event in their lives (Kashdan & Kane, 2010; Kessler, Sonnega, Bromet, Hughes & Nelson, 1995). Literature suggests meaning-making has impacted trauma survivors by influencing personal growth through cognitive adaptations (Ching, Martinson, & Wong, 2012; Kashdan & Kane, 2010; C. Park, 2005). According to C. Park and Folkman (1997), there are two levels of meaning-making, systems of global meaning and the appraised meaning of specific events (C. Park, 2005, 2010). Global meaning comprises of broad beliefs regarding justice, control, goals (i.e., relationships, work, religion, and achievement), subjective feelings and self-views (Emmons, 2005; Koltko-Rivera, 2004; C. Park 2010). Subsequently, global meaning coping strategies influence an individual's thoughts, emotions and behaviors (C. Park, 2005, 2010). Situational meaning is developed in the context of a particular environmental occurrence, usually a stressful encounter (C. Park, 2005). This includes, appraised meaning assignment (i.e., determination of threat and attributions), discrepancies between appraised and global meaning (i.e., one's sense of controllability), and meaning making (i.e., cognitive and emotional processing; C. Park, 2005, 2010; Watkins, 2008). For example, "working through an event" can include reappraising a situation to find more acceptable reasons for the occurrence (i.e., religion; C. Park, 2005; Manning-Walsh, 2005a). Meaning-making coping strategies serve as a mediator between increased experiences of stress and physical health outcomes (Koltko-Rivera, 2004; Manning-Walsh, 2005a; C. Park, 2005, 2010).

More specifically, post-traumatic growth, which results from a positive adjustment to an individual's experience, helps rebuild the life changing event that was experienced (Kashdan & Kane, 2010; Tedeschi & Calhoun, 1996). Individuals will then often develop a greater appreciation for life, increased close relationships, recognition of personal strengths, increased sense of self, and at times, spiritual development (Kashdan & Kane, 2010). However, there are mixed findings regarding the relationship between the intensity of post-traumatic distress and post-traumatic growth. C. Park and colleagues (1996) have suggested an inverse relationship, while others have found that greater posttraumatic distress yielded a greater outcome for post-traumatic growth (Aldwin, Levenson, & Spiro, 1994; Frazier, Conlon, & Glaser, 2001). Studies have also shown that recovery from trauma can be facilitated through behaviors directed towards meaning-making aims instead of solely on the regulation of emotions (Batten, Orsillo, & Walser, 2005; Kashdan & Kane, 2010). Frazier and colleagues (2004) demonstrated that women who reported positive changes after a sexual assault had less depressive symptoms than those who did not report any positive changes. It appears that meaning-making and post-traumatic growth develops through cognitive appraisals of an event and may further improve the overall well-being of individuals who have experienced stress or trauma (Sawyer & Ayers, 2009).

Intimate partner violence is a dynamic stressor for individuals where coping responses may be particularly complicated (Bauman et al., 2008; Sabina & Tindale, 2008). Direct (or problem-focused) coping may not always be physically safe and can exacerbate violence, while the use of emotion-focused coping when survival is at stake may not be sufficient (Bauman et al., 2008; Sabina & Tindale, 2008). For example, an individual will develop and attach a meaning to the abuse that is occurring in intimate relationships because the abuse contradicts the beliefs that an individual can trust and feel safe with their significant other (Bauman et al., 2008).

Additionally, women may exercise their problem-coping strategies as they experience continued increases in violence as a way to modify the abuse.

Although men and women may manage stress in very different ways, research suggests that both groups tend to use particular emotion-focused coping strategies, such as reading, watching television and/or listening to music (APA, 2010). Taylor and colleagues (2000) suggest that women may be programmed towards emotional coping for survival. According to their research, while the traditional fight-flight response may be normative for men, women appear more likely to respond to stress in ways that "tend" to their offspring and "befriend" members of their community (Taylor et al., 2000, p. 139). This is in contrast to the literature which suggests that problem-focused coping is more effective, and instead proposes that women incorporate a relational component to coping during stressful times. Emotion-focused coping, specifically social support and meaning-making coping, seems to play a prominent role in alleviating stress for women with high-risk pregnancies (Geerink-Vercammen & Kanhai, 2003; Peñacoba-Puente, Carmona-Monge, Marín-Morales, & Naber, 2012). Furthermore, religious coping appeared to have positive effects on health outcomes and also alleviated stressors within high-risk pregnancies (Hamilton & Lobel, 2008; Peñacoba-Puente et al., 2012). Lastly, social support seeking and reappraisals have been shown to have positive effects on health (Koltko-Rivera, 2004; Manning-Walsh, 2005a; C. Park, 2005, 2010; Peñacoba-Puente et al., 2012; Rudnicki, Graham, Habbouse, & Ross, 2001).

Shared experiences, another type of social support and emotion-focused coping strategy, have been seen to improve physical health outcomes and decrease feelings of isolation for breast-cancer patients (Kim, Valdimarsdottir, & Bovbjerg, 2002; Manning-Walsh, 2005a). Furthermore, through relational interactions, patients have demonstrated an alleviation of physical symptoms

(i.e., decreased blood pressure, decreased heart rate, etc.; Abdou et. al., 2010; Manning-Walsh, 2005a). More specifically, higher communalism was associated with lower prenatal blood pressure for African American women and amongst women from socioeconomically disadvantaged backgrounds (Abdou et al., 2010). Social support and communal approaches to interpersonal relationships appear to increase health benefits and ameliorate physical distress for women (Abdou et al., 2010; Berkman, 1995; Manning-Walsh, 2005a).

      Coping with socioculturally-based stressors. Societal demands such as gender role expectations, familial expectations, employment issues, immigration, and adhering to cultural norms can contribute to an individual's appraisal of stress and overall well-being (Aldwin, 2004; 2014; Bustamante et al., 2011; Cohen, 2009). Furthermore, for women of Arab descent living in the U.S., the continual navigation between American mainstream and Arab culture can create pressure and difficulties negotiating individualist American/Western values with more collectivist conservative Arab values. When dealing with sociocultural stressors and chronic illness, problem-focused coping strategies have been shown to improve emotional regulation processes by modifying the situation, which then alters the emotional impact (Karademas et al., 2011). The literature suggests that coping styles vary depending on the problems encountered such as financial stress versus oppression (Folkman & Lazarus, 1988; Shorter-Gooden, 2004). More specifically, internalized racism and sexism has been linked with *defeated* or *passive* styles of coping and increased dysregulation of cortisol (Tull, Sheu, Butler & Cornelious, 2005; Kaiser & Miller, 2004; Major, Quinton & McCoy, 2002). Historically, literature has shown that women who are faced with discrimination have remained passive and often do not confront the perpetrators (Kaiser & Miller, 2004; Swim & Hyers, 1999; Woodzicka & LaFrance, 2001). However, there has been an increase in research studies that examine the effects of confronting

discrimination and its positive impact in emotional regulation. For example, Miller and Kaiser (2001) emphasize that confrontation is one type of coping strategy that can be used with prejudiced acts against an individual that are directed at changing the situation of being the target of these unjust events (Miller & Kaiser, 2001). Some of the most common barriers to confronting discrimination are *interpersonal costs* which include being perceived as a "troublemaker" (Bergman, Langhout, Palmeri, Cortina & Fitzgerald, 2002; Kaiser & Miller, 2004), "risky" (Swim & Hyers, 1999), "hypersensitive" (Czopp & Monteith, 2003; Kaiser & Miller, 2004), and/or experiencing retaliation from the perpetrator(s; Bergman et al., 2002). Expectation of these negative reactions may lead women to avoid or engage less in confrontation when faced with sexism and discrimination.

Perceived stress can be heavily impacted by socialization and/or organizational structure (Long, 1989). From a socialization perspective, appraisals (i.e., internal responses) to stressful situations are reconciled through learned sex-role orientation (Bern, 1981; Long, 1989). As parents use less sex-stereotyped ways of interacting with their children, their internal processes are continually being altered (Long, 1989). However, from a structural point of view, there is increased distress and less effective coping when faced with a structural disadvantage (i.e., work issue; Long, 1989). However, Patton and Goddard (2006) indicate that women tend to use emotion-focused coping strategies to mediate occupational stress and tend to seek out support from other employees more than males. Moreover, females have been shown to use social support as a mediator with work-related stressors to decrease physical symptoms and improve their state of mind (i.e., level of well-being; Bellman et al., 2003; Muhonen & Torkelson, 2004; Zivotofsky & Koslowsky, 2005). Additionally, women who seem to demonstrate a decreased locus of control in work-related environments showed an increase in negative health outcomes

(Muhonen & Torkelson, 2004; Zivotofsky & Koslowsky, 2005). With more women entering the workforce and developing multiple roles, coping with these new stressful demands is essential to maintaining a healthy well-being. Furthermore, chronic macro stressors such as safety in a neighborhood, poor housing, discrimination, violence, crime and financial difficulties are more difficult to mediate through social support. This is due to what Everett, Camille, and Hamilton-Mason (2010) refer to as "contagion of stress" (p. 31), which occurs within their social support networks who are experiencing similar stressors.

Traditionally, Arab Americans have sought out healers or look to religion for dealing with mental health issues and various psychosocial stressors (Al-Krenawi et al., 2004; Al-Krenawi & Jackson, 2014; Nassar-McMillan et al., 2013). However, depending on an individual's socioeconomic status, country of origin, religious beliefs and/or level of acculturation, other resources such as social support or seeking medical advice may be used to assist in managing psychosocial stressors (Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). Increased religious practices can be seen as a way of coping with psychosocial stressors and medical illnesses (Al-Krenawi et al., 2004; Al-Krenawi & Jackson, 2014). Additionally, religion can be a source of resilience, providing them with additional coping strategies and support (Al-Krenawi et al., 2004; Dalky, 2012; Nassar-McMillan et al., 2013). Greater psychological wellbeing is shown to be related to higher degrees of religious affiliation or no religious affiliation among Arab Americans. However, religious affiliation may also be a source of stress due to increased religion-based discrimination in the U.S. More specifically, Muslim women are at higher risk for experiences religion-based discrimination and/or violence due to their visible traditional clothing (e.g., hijab). Also, religious practices can often provide soothing effects in place of drugs, alcohol, sex, and

other behaviors (Al-Krenawi et al., 2004; Al-Krenawi & Jackson, 2014). Furthermore, due to the tendency for psychological distress to manifest in physical symptoms (e.g., migraines, gastrointestinal difficulties, headaches, sleeping difficulties, etc.,), Arab American women are more likely to seek out medical treatment as a way of coping with their stressors (Al-Krenawi & Graham, 2000).

Lastly, individuals and families that have immigrated to the United States have successfully utilized active coping in the face of acculturative stress (Torres, 2010). Active coping involves individuals relying and accessing their knowledge and strengths in managing cultural tasks and various negative circumstances successfully (Torres, 2010). In more recent studies, active coping has been shown to decrease depression among Latinos and help individuals manage low family stress simultaneously (Crocket et al., 2007; Torres & Rollock, 2007). More importantly, active coping seems to be a catalyst for individuals experiencing acculturative stress, especially women, including seeking social support, developing relationships, solving problems and engaging in social interactions (Hobfoll & Schroder, 2001; Torres, 2010). Specific to the United States' demanding mainstream environment, active coping appears to mediate some of those above-mentioned stressors as well as increase positive adaptation to problematic situations (Holahan & Moos, 1987; Kosic, 2004; Torres, 2010). Both immigrant and first generation Arab Americans engage in selective acculturation, where they maintain a strong ethnic identity but have a desire in interacting socially with American mainstream culture (Ajrouch, 2000). A strong immigrant community and networks can help mitigate challenges of acculturation due to the Arab collectivist value of emphasizing the receipt of emotional support from others.

Social support. Social support has received a great deal of attention in the research literature related to stress. Social support can be defined by social interactions which provide individuals with assistance or relationships that can be perceived as supportive, loving, and caring (Dunn & O'Brien, 2009). Social support is also seen as satisfying attachment needs, increasing a sense of self-worth, increasing psychological well-being and providing direction for individuals (Chambers et al., 2001; Klienke, 1991; Martire et al., 1998). More specifically, the literature suggests that social and emotional support increases overall emotional well-being for caregivers, including decreasing feelings of loneliness and isolation (Chambers et al., 2001; Greenberg, Seltzer, Kraus & Kim, 1997). Additionally, emotional support has been shown to help decrease the stress burden for women who have multiple family and work roles and experience increased demands on time and energy from these roles (Martire et al., 1998). As a result, a decrease in depressive symptomatology, anxiety and role strain has been linked to increased social and emotional support for women (Bagheri-Nesami et al., 2010; Martire et al., 1998).

Another area of importance for social support is within the realm of multicultural psychology. Studies have shown that higher communalism resulted in decreased prenatal blood pressure for African American women, and for those who may have suffered from socioeconomic disadvantages (Abdou et al., 2010). Additionally, women with higher communalism appear to have better emotional health than those who have lower communalism (Abdou et al., 2010). Literature also suggests that collectivist cultures tend to develop more stable social relationships which have been shown to contribute to overall higher subjective well-being (Ahuvia, 2002; Chamber et al., 2001; Klienke, 1991; Martire et al., 1998). This is highlighted with immigrant cultural groups facing acculturative stressors such as, participating

with the mainstream culture, separation versus assimilation, language barriers, gender-role reversals, occupational changes, and loss of family ties (Berry, 2005; Torres, 2010; Wrobel et al., 2009). Furthermore, Arab American women tend to use their social support networks (e.g., family support, friends in the community) as their primary source for problem solving (Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). Social support as a form of active coping has effectively helped individuals across all cultures manage stressful situations and improve overall well-being.

Approaches to Stress Management

According to Mercer (2009), the biopsychosocial model of stress (i.e., understanding stress as developing via commingling biological, psychological and social-environmental factors), offers a comprehensive outlook on the phenomenon of stress itself as well as the factors pertinent in its assessment and treatment. Consequently, stress management interventions frequently use a variety of techniques, including cognitive-behavioral skills training (e.g., facilitating improved appraisal/reappraisal and coping strategies), arousal reduction, social support, and focusing on improvement of pertinent lifestyle and systemic issues in the mediation of stress on health and well-being (Blom et al., 2009; Groarke et al., 2013; Lazarus & Folkman, 1984; Meichenbaum, 2009; Mercer, 2009; Mok, Chau, Chan, & Ip, 2014; Taylor et al., 2000; Walsh, 2011) and often include meditation, relaxation techniques and/or lifestyle changes (Benson, 2008; Ghoncheh & Smith, 2004; Hall & Long, 2009; Ludwig & Kabat-Zinn, 2008; Mercer, 2009; Mok et al., 2014; Walsh, 2011). As each individual's experience of stress is unique - the approaches that are successful in alleviating stress differs equally from person-to person (Mercer, 2009).

According to Davis, Thwaites, Freeston, and Bennett-Levy (2015), Cognitive Behavioral Therapy (CBT) is considered one of the most common and successful forms of treatment in addressing psychosocial issues, which includes stress. Cognitive Behavioral stress management interventions have demonstrated positive results in treating stress related to an array of populations of women, including women of Arab descent living in the United States, women with breast cancer, post traumatic stress disorder following childbirth, infertility, low-income minority women living with HIV, caregiver specific stress in Non-Hispanic white and Hispanic/Latino Women, battered women, and chronic job-related stress in nurses (Echeburúa, Sarasua & Zubizarreta, 2014; Erickson & Al-Timimi, 2001; Faramarzi et al., 2013; Kakoti, 2012; Gallagher-Thompson, Gray, Dupart, Jimenez & Thompson, 2008; Groarke et al., 2013; Lapp, Agbokou, Peretti & Ferreri, 2010; Lechner, Carver, Antoni, Weaver, & Phillips, 2006; Lopez, 2014; Mourad & Abdella, 2010; Sarid, Berger & Segal-Engelchin, 2010).

CBT based stress management interventions aim to prevent or reduce stress by focusing on the key aspects of the stress process, namely appraisal and reappraisal, thereby addressing the manner in which individuals can cope more effectively with stressful events (de Vente, Kamphuis, Emmelkamp & Blonk, 2008). A key element of CBT is teaching individuals to learn to reappraise their cognitions and modify common distorted cognitions and irrational beliefs that can be potentially exacerbating their experience of stress (Beck, 2011; Granath, Igvarsson, von Thiele, & Lundberg, 2006; Mercer, 2009). CBT techniques aim to restructure maladaptive belief systems and provide clarity while interpreting stressful situations, thereby eliciting change in appraisals of threat and/or one's ability to handle stress more effectively (Beck, 2011; Mercer, 2009; Mok et al., 2014).

In addition to cognitive restructuring in stress management, CBT also employs the use of behavioral skills such as teaching coping strategies to help clients more effectively eliminate, prevent, or avoid stressors, as well as lessen the emotional impact of a stressor (Mercer, 2009). Behavioral interventions related to CBT include coping strategies such as: problem-focused coping which includes: time management, assertiveness training and self-monitoring (i.e., visceral cues). Further, clients can utilize emotion-focused coping skills, including diaphragmatic breathing, distraction, taking a timeout, and systematic desensitization that has been taught by a therapist (Mercer, 2009).

Furthermore, in addressing biological factors associated with stress, arousal reduction strategies are important to address (Benson, 2008; Mercer, 2009). Specifically, arousal reduction strategies include: using passive relaxation (i.e., verbal images or pleasant imagery), progressive muscle relaxation (i.e., sequentially tightening and relaxing muscle groups), meditation (i.e., focused attention and/or expansion of attention), mindfulness meditation (i.e., focus of attention, non judgmentally), biofeedback (i.e., attention and control of peripheral temperature or muscle tension) and guided imagery (i.e., walking on a beach; Mercer, 2009).

With regard to social-environmental stressors, attempting to lessen and/or ameliorate stress related to family, work and/or the community can be a valuable component to address in stress management programs (Mercer, 2009). While some stressors cannot be eliminated, helping an individual lessen its emotional impact can serve as a valuable buffer to protecting one's overall well-being. Lastly, addressing lifestyle choices can be a valuable in addressing issues such as smoking, alcohol consumption, poor nutrition and/or sleep hygiene that may be worsening stress responses (Mattison & Nemec, 2014; Ogden, 2012; Walsh, 2011).

Psychologically-based interventions.

Stress Inoculation Training. In the 1980s, Stress Inoculation Training (SIT), a type of cognitive behavioral intervention, was developed for the prevention and treatment of stress by aiding individuals in coping with a variety of stressors (Meichenbaum, 2009). In line with Lazarus and Folkman, (1984), Meichenbaum's SIT views stress as an interaction between the person and the environment (i.e., person-environment transaction) that is dynamic and bidirectional and where stress ensues when the demands impinging on the individual are perceived by the individual to outweigh his/her ability to cope with those demands (Meichenbaum, 2007). According to Meichenbaum, over 200 studies suggest that SIT has been utilized in treating stress related to a variety of populations, including patients facing surgeries, occupational stress, childbirth, parenting - as well as in medical populations (i.e., pain, hypertension, cancer, ulcers, AIDS, traumatic brain injury) and psychiatric patients (i.e., anger, anxiety, PTSD, rape victims, sexual abuse victims, addiction and chronic psychopathology; Meichenbaum, 2009; Meichenbaum, 2007; Salmela-Aro et al., 2011).

The stressors addressed in SIT range from acute time-limited stressors (i.e., dental exam/surgeries), sequences of stressful events related to life adjustments and/or following exposure to a trauma (i.e., job loss/sexual assault), chronic intermittent stressors (i.e., repeated musical or athletic competitions/ongoing academic evaluation), chronic stressors that are continuous (i.e., chronic pain) and psychiatric issues (i.e., anger/anxiety; Meichenbaum, 2009; Meichenbaum, 2007).

 SIT treatments have been delivered in a variety of modalities, including with individuals, couples, and in group formats and consist of approximately 8-15 sessions with subsequent follow-up sessions that occur over a 3-12 month time frame (Meichenbaum, 2009). Although the SIT treatment is flexible in that it must be altered to address the idiographic stressors of each

individual, there are three core elements to the treatment: a conceptual/educational phase, a skills acquisition phase, and an application phase (Meichenbaum, 2009).

The overarching goal of SIT is to increase an individuals' capacity to cope with milder stressors so that he/she can cultivate the psychological preparedness (i.e., resilience and confidence) to tolerate more demanding stressors (Meichenbaum, 2009; Meichenbaum, 2007). Other goals of SIT include helping individuals to reconceptualize their distress and emotional pain as something meaningful that has contributed to adding purpose to their lives (Meichenbaum, 2009).

With regard to SIT and women specifically, some studies suggest that SIT is beneficial in the treatment of stress related to intense fear of childbirth and suicidal ideation in black female college students (Wang, Lightsey, Jr., Tran & Bonaparte, 2014; Salmela-Aro et al., 2011); however, a study examining women assault victims with PSTD suggests that Prolonged Exposure (PE) therapy was superior to SIT on select measures of post treatment anxiety and global social adjustment (Foa et al., 1999). It was noted, however, that superiority of PE on select measures may have been due to lower drop rate in the PE group (Foa et al., 1999).

Problem-Solving Therapy. Problem Solving Therapy (PST) is an evidence-based CBT intervention, originally developed in the early 1970s by D'Zurilla and Goldfried, that focuses on training people to effectively apply constructive problem-solving attitudes and skills to problematic situations (D'Zurilla & Nezu, 2010; Nezu, Nezu, & McMurran, 2009). Subsequent to its initial development, D'Zurilla, Nezu and associates have continued to modify and refine PST and evaluate its efficacy for various disorders across clinical and non-clinical settings (D'Zurilla & Nezu, 2010; Nezu et al., 2009). According to Nezu and colleagues (2009), based on several decades of randomly controlled trials conducted around the world, PST has demonstrated

to be efficacious as a treatment for diverse populations of adolescents and adults, presenting with a wide array of psychological, behavioral and health disorders.

PST is intended to serve as a preventative program or maintenance strategy, used alone or with other treatments, with the aim to reduce and/or prevent psychopathology, improve psychological/behavioral functioning and increase overall well-being by helping people cope more effectively with stressful life issues (D'Zurilla & Nezu, 2010; Nezu et al., 2009). PST seeks to improve situations (i.e., allowing an individual to achieve a goal or resolve a conflict) and/or reduce emotional distress related to situations (i.e., foster acceptance, derive a positive outcome from the problem, reduce physical discomfort; D'Zurilla & Nezu, 2010). PST has been delivered across settings in a variety of modalities, including individual, group, couples and family therapy (D'Zurilla & Nezu, 2010).

PST is firmly rooted in research correlating social problem-solving (SPS), a psychosocial construct, to psychopathology and positive psychology (Nezu et al., 2009). SPS is defined by Nezu et al. (2009) as the "cognitive-behavioral process by which individuals attempt to identify or discover adaptive means of coping with the wide variety and range of stressful problems, both acute and chronic, encountered during the course of everyday living" (p. 402). According to modern SPS theory, problem-solving outcomes are determined in large part by (a) problem orientations (i.e., relatively stable cognitive/affective schemas that represent generalized beliefs, attitudes about one's problems and ability to cope) which can be either positive or negative; and (b) problem solving styles (i.e., core cognitive-behavioral styles people use to cope with problems) which can be either adaptive or maladaptive (Nezu et al., 2009). For example, if a person has an upcoming speech to present to a room full of co-workers - one person can perceive this as a threat and avoid the speech by calling in sick to work, whereas another person may

perceive this situation as an opportunity and engage in speech writing preparation and thrive in the situation.

PST therapy is delivered through attunement of therapist to the client, skillful assessment and intervention strategies and three core elements of training, including: (a) training in problem orientation; (b) training in four rational problem-solving skills (i.e., define problem, generate alternative solutions, decision making, and implementing and evaluating solution plan); and (c) practice of these skills across a variety of real-world problems (Nezu et al., 2009). According to this approach, effective coping entails being able to challenge stressful situations for the better (i.e., problem-focused coping) and adapting to negative conditions that are unable to be changed or controlled (i.e., emotion-focused coping; D'Zurilla & Nezu, 2010). According to D'Zurilla and Nezu (2010), based on 3 decades of research exploring the efficacy of PST, "it can be concluded that PST is a potentially useful and effective intervention for any disorder in which stress and coping deficits play an important role as maintaining conditions" (p. 220).

With regard to the utility of PST specifically with women, one study examined the problem-solving strategies of 16 women (mean age of 54 years) undergoing chemotherapy for breast cancer and found that PST was helpful in aiding women with problem-solving and increased self-management skills; thereby promoting lifestyle adjustments during chemotherapy (Lyons, Erickson & Hegel, 2012). Further, a pilot study of PST with 14, low-income, expectant mothers at risk for postpartum depression revealed statistically significant improvements on depression measures (Sampson, Villarreal, & Rubin, 2014). According to Sampson and colleagues (2014), PST may be an effective intervention for low-income women at risk for postpartum depression.

Social support and stress management. Social support has been an integral part in stress reduction and stress management for women across both physical and mental health domains (Bellman et al., 2003; Goodwin, Costa, & Adonu, 2004; Ogden, 2012; Sabina & Tindale, 2008; Turner-Cobb et al., 2002). More specifically, women diagnosed with breast cancer or who are currently receiving medical treatment demonstrated positive psychosocial adjustment after sharing their experiences and problems with other women with breast cancer (Manning-Walsh, 2005a; Pålsson & Norberg, 1995). Women reported feeling less isolated and improved adaptation to disease and treatment while they participated in breast cancer support groups (Manning-Walsh, 2005a). Furthermore, Latinas from disadvantaged backgrounds (i.e., low socioeconomic status), demonstrated decreased levels of stress post surgery distress after experiencing support from friends, family and spouses (Alferi, Carver, Antoni, Weiss, & Durán, 2001; Manning-Walsh, 2005a) It is important to note that when there is a need for continued support for breast cancer patients, family members and friends may have difficulties providing adequate support due to the effects of the illness on them and their well-being. As a result, women turn to their religious congregations, or formal social support groups to fill the gap of the reduced support from friends and family (Chan, Molassiotis, Yam, Chan & Lam, 2001; Manning-Walsh, 2005b).

Group therapy studies have suggested that all-female group therapies have been effective in helping women reduce symptoms of stress, increase social support, and improve quality of life when dealing with chronic and medical illnesses (i.e., cardiovascular disease, HIV, substance abuse, hypertension, etc.; Lennon-Dearing, 2008; Holmes, 2002; Walker, 2002). Furthermore, all female groups provide an opportunity for women to relate to each other, develop role models and gender homogeneity (Lennon-Dearing, 2008).

Mind-body and lifestyle medicine. Mind-body medicine, a popular element of complementary and alternative medicine (CAM), has become a widespread treatment option to improve physical and psychological health as well as overall quality of life (Woods-Giscombé & Black, 2010). This includes practices such as yoga and relaxation training that are aimed at decreasing sympathetic arousal, promoting present-moment awareness, relaxation, awareness of the body, and compassion towards others and the self (Woods-Giscombé & Black, 2010).

Lifestyle medicine emphasizes interventions that are non-pharmaceutical such as physical exercise, stress management, and diet. It is part of a growing field of healthcare that promotes lifestyle-type interventions as ameans of treatment and management of disease and illness (Mattison & Nemec, 2014). Research from Hyman, Ornish, and Roizen (2009) shows that chronic disease has impacted approximately 160 million individuals in the United States and has been shown to be linked to both environment and lifestyle factors (e.g., diet, stress, pollution, substance use). As a result, increasing healthy behaviors is essential to managing chronic disease in an affordable manner and can be more effective than utilizing medication and/or surgery. Furthermore, Walsh (2011) postulates that therapeutic lifestyle changes (TLCs) such as exercise, building relationships, religious affiliation, etc., has potential to be as effective as other treatment interventions including pharmacological treatment and/or therapy.

As mind-body and lifestyle medicine continue to grow, mindfulness meditation, various relaxation techniques including diaphragmatic breathing, physical exercise and nutritional interventions are some of the more commonly studied stress-management strategies.

Mindfulness meditation. Mindfulness, a state of present moment awareness without judgment, originated in Buddhist practices as way of promoting clarity and openness. Originally, from a Buddhist perspective, mindfulness was used to improve suffering and develop

compassion for others and for the self (Ludwig & Kabat-Zinn, 2008). In health research, mindfulness meditation has been studied as a means of improving both psychological and physical wellbeing (K. Brown, Ryan, & Creswell, 2007; Ludwig & Kabat-Zinn, 2008). More specifically, mindfulness has been investigated as a treatment approach to reducing depression, anxiety and/or stress for a variety of patient populations including those with HIV, type 2 diabetes and chronic inflammation (Carlson et al., 2007; Cohen et al., 2007; Ludwig & Kabat-Zinn, 2008; Ramel, Goldin, Carmona & McQuaid, 2004; Rosenzweig et al., 2007).

   Mindfulness-based stress reduction (MBSR). MBSR is a mind-body intervention targeting to address many types of illnesses including anxiety and chronic stress (Davidson et al., 2003; Martín-Asuero & García-Banda, 2010). It was developed by Jon Kabat-Zinn and colleagues in 1979 and is typically taught through an ongoing eight-week (Davidson et al., 2003; Martín-Asuero & García-Banda, 2010). MBSR has been deemed to be an efficacious intervention used to improve overall wellbeing by reducing distress through its integration of effective strategies such as mindfulness meditation, yoga, and body awareness (Creswell et al., 2012; Davidson et al., 2010; Hölzel et al., 2011; Martín-Asuero & García-Banda, 2010). In addition, Davidson and colleagues (2003) documented the first findings that show increased activation in the left anterior regions of the brain, which is typically associated with positive affective states, as a result of the use of MBSR. This further illustrates that MBSR has significant effects on improving both brain and immune functioning. Additionally, a research study by Hölzel and colleagues (2011) documented findings that showed increases in gray matter in the brain which are usually related to emotion regulation, decision making, and learning and memory processes through the use of MBSR. As result, these findings further suggest that

through the use of MSBR, individuals may increase their ability to regulate their perceptions of threat thus interfering with the negative stress responses that typically occur.

A quasi-experimental study conducted by Martín-Asuero and García-Banda (2010), showed that there was a reduction in rumination, negative affect and perceived stress following an eight-week course of MBSR with a group of health care professionals. This further illustrates MBSR's association with decreased overall distress in individuals. The authors also emphasized that through the use of MBSR, individuals were able to increase their present moment awareness further increasing their psychological flexibility, feelings of control, and general emotional regulation as a way of better dealing with daily stressors **(**Martín-Asuero & García-Banda, 2010**).** Another study, by Carlson and colleagues (2007), assessed the impact of MBSR specifically on 49 breast cancer and 10 prostate cancer patients (in early stages of their diseases) in regards to their stress levels, mood fluctuations, quality of life, and both immune and autonomic functioning. The results demonstrated decreases in stress, mood symptoms, and blood pressure, and improvement in quality of life and cortisol levels and patterns of immune functioning following the eight-week course of MBSR. Of note, there is a deficit in the mind-body research in regards to the efficacy with specific populations including: Arab Americans, Blacks/African Americans, Hispanics/Latinos, Native Americans, Alaskan Natives, Asian Americans, Native Hawaiians, Pacific Islanders, and medically disadvantaged (Woods-Giscombé & Black, 2010). With respect to African American women who have been exposed to a wide range of stressors (e.g., cultural and/or socio-political experiences), Woods-Giscombé and Black (2010) found three specific components of mind-body interventions to be the most effective, including: mindfulness-based stress reduction (MBSR), loving-kindness meditation (LKM), and NTU psychotherapy. Given that there is a need to further explore the use of these interventions with

African-American women, Woods-Giscombé and Black (2010) state that "MBSR, LKM, and NTU could potentially represent an integrative and culturally responsive intervention that promotes mind-body awareness, equanimity, inter- and intrapersonal harmony, and comprehensive wellness among African American women embodying the role of strength" (Woods-Giscombé & Black, 2010, p. 12). In conclusion, MBSR has been identified and referenced as a very commonly used mindfulness training program in addition to producing significant positive changes to psychological well-being and overall improvement of symptoms related to illness and disorders (Hölzel et al., 2011).

Relaxation techniques. As mentioned previously, serious psychological and physiological consequences that jeopardize an individual's overall well-being can result from continued experiences of stress. Although the physiological response of stress can also help heighten awareness and improve abilities quickly to assist in survival, the prolonged activation of stress creates a metabolic wear and tear that can be very damaging for overall functioning (APA, 2007; Benson, 2008; Kolb & Whishaw, 2014; Murphy et al., 2012; E. Park et al., 2013). Esch, Stefano, Fricchione, and Benson (2002) further explored this phenomenon by investigating the impact and role of stress on cardiovascular disease after taking into account subjective and/or individual differences (e.g., genetic makeup, personal history, experience of stress) and noted the significant impact stress has in the progression and maintenance of cardiovascular diseases.

In order to reduce negative health risks and return to homeostasis, the body must reach a state of reduced physiological arousal, which can be achieved through engaging in a state of relaxation (Benson, 2008; Esch et al., 2002; E. Park et al., 2013). Relaxation Response (RR), Progressive Muscle Relaxation (PMR), Diaphragmatic Breathing (DB) and Therapeutic Lifestyle Changes (TLC) have been identified as approaches used to elicit a state of relaxation and

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decrease arousal as well as encourage improvement in areas of nutrition, exercise and stress management (Benson, 2008; Ghoncheh & Smith, 2004; Hall & Long, 2009; Walsh, 2011).

The relaxation response. According to Benson (2008), there exists a physiological state (i.e., relaxation response [RR]) that counters the fight-or-flight response and instead, activates the parasympathetic nervous system. This process allows the body to reach a state of calmness and relaxation (Benson, 2008; E. Park et al., 2013). During this state of relaxation, an individual's heart rate and rate of breath decreases as the body requires less oxygen and as a result, blood lactate levels that are associated with anxiety also significantly decrease (Benson, 2008). Through engagement of various exercises such as mindfulness, deep breathing, yoga, tai chi/qi gong, ongoing prayer, guided imagery and a body scan, Benson (2008), proposes that the RR can be produced.

Progressive muscle relaxation (PMR). Progressive muscle relaxation, a technique developed by Edmund Jacobson in the 1920's, has been shown to assist individuals achieve a state of relaxation through learning how to control and monitor muscular tension (Hall & Long, 2009; Janke, 1999; McCallie, Blum, & Hood, 2006). Furthermore, PMR has been shown to be the most common type of relaxation approach used by clinical psychologists when compared to the six major relaxation approaches including autogenic training, breathing exercises, yoga, stretching, imagery, and meditation (Ghoncheh & Smith, 2004). Over the years, PMR has evolved to include standardized abbreviations of the training exercises (Hall & Long, 2009) which as been effectively used in various cognitive behavioral stress management programs (McCallie et al., 2006). Through PMR, an individual learns how to notice tense muscles in comparison to relaxed muscles in the body further allowing them to achieve a state of relaxation during stressful instances. PMR also helps control various physiological states through the

progressive relaxation of different muscles in the body and further reduces heart rate, sweating, and startle response (Davis, Eshelman, & McKay, 2008). In addition, calmness and overall wellbeing has been correlated to alpha and theta waves in the brain, which have been shown to increase through the use of PMR (Hall & Long, 2009; Benson, 2008).

Literature has deemed PRM to be efficacious in managing and treating symptoms related to anxiety, depression, insomnia, cancer, chronic pain, stress, trauma, tension head aches, arthritis, irritable bowel syndrome, high blood pressure, stuttering, minor phobias, anger and acute schizophrenia in addition to improving sleep, energy and overall relaxation (Chen et al., 2009; Davis et al., 2008; Hall & Long, 2009; McCallie et al., 2006; Parlow & Jones, 2002).

According to literature, PMR has been shown to be efficacious with a limited population of women including moderate security inpatient females with mental illness, pregnant women, women undergoing chemotherapy for breast cancer and overweight/obese women (Akmeşe & Oran, 2014; Christaki et al., 2013; Demiralp, Oflaz & Komurcu, 2009; Gawande, Vaidya, Tadke, Kirpekar & Bhave, 2011; Hall & Long, 2009). Additionally, some clinicians have noted early dropout within participants due to PMR's tendency to be less intrinsically rewarding than other relaxation exercises (Smith, 1999).

Diaphragmatic breathing. Diaphragmatic breathing (DB), a relaxation technique promoting deep-breathing and described as an essential component in Pranayama, Yoga, Zen and transcendental meditation, is one of the most highly endorsed relaxation approaches (Donovan & Kleiner, 1994; Martarelli, Cocchioni, Scuri & Pompei, 2011). Through DB, an individual is encouraged to deeply breathe into the lungs and contract the diaphragm allowing the belly to expand as air enters the lungs (Martarelli et al., 2011). Moreover, the individual's goal is to change their way of breathing and move away from shallow and rapid anxious breaths to a more

relaxed and deep style of breathing (Marcus & Deodhar, 2012). Generally, it is recommended

that the individual inhale and exhale for five counts as a means of regulating the rate of breathing

(Donovan & Kleiner, 1994). Meditations that tend to use this type of breathing practice have

shown to increase melatonin levels and decrease levels of cortisol and oxidative stress

(Martarelli et al., 2011). Furthermore, DB interrupts the fight-or-flight response activated during

stressful situation as a result of the increase of oxygen in the blood stream and further stimulates

the natural relaxation response of the body (Donovan & Kleiner, 1994). However, the peer

reviewed literature on the use of DB with women is limited, and instead, tends to suggest the use

of DB for women suffering form fibromyalgia as a way of reducing pain related to stress

(Marcus & Deodhar, 2012) and women at risk for preterm labor (Janke, 1999).

   Exercise and physical activity. Physical activity has been associated with a vast number

of positive health benefits ranging from reducing chronic disease to decreasing morbidity and

mortality rates (U.S. Department of Health and Human Services, 1996; Walsh, 2011; Wilson,

Zarrett & Kitzman-Ulrich, 2011). More specifically, moderate physical activity was linked to

positive improvements to the cardiovascular, musculoskeletal, metabolic, and endocrine systems

(U.S. Department of Health and Human Services, 1996). Additionally, psychological well-being

including reduction in stress, tension, chronic pain, eating disorders, cognitive decline, and

depression along with the overall quality of life improve significantly with increased physical

activity (U.S. Department of Health and Human Services; Walsh, 2011). More specifically,

Walsh (2011) identified the benefits of physical exercise to include improved sleep, enhanced

self-esteem and self efficacy, increases in brain volume, and a decrease in rumination. The above

mentioned benefits, as a result of moderate physical activity, were equivalent across diverse

populations including groups defined by age, sex, socioeconomic status, income, ethnicity and

geography (U.S. Department of Health and Human Services; Warms, 2006). According to the U.S. Surgeon General's Report (U.S. Department of Health and Human Services, 1996), it is recommended that individuals engage in 30 minutes per day of moderate aerobic exercise such as walking, biking, playing a sport, and stretching (Warms, 2006).

Research studies have shown positive results in decreasing perceived stress and improving overall health and well-being through the use of movement-based mind-body techniques such as Qigong, yoga, and Tai Chi (Tsai , Chen, Lin & Yeh, 2014; Yoshihara, Hiramoto, Oka, Kubo, & Sudo, 2014). The techniques mentioned above include low impact exercises emphasizing the integration of both psychological and physical movements. More specifically, Tai Chi has been identified as successful type of mind-body exercise used to improve psychological well-being in addition to changing an individual's perceptions of health and social support more positively (Posadzki & Jacques, 2009).

The studies on the impact of physical activity on stress in women are limited; however some studies have shown a reduction of stress after engaging in ongoing physical activity. More specifically, Karolkiewicz and colleagues (2008) studied the impact of an eight-week aerobic exercise program on oxidative stress markers in postmenopausal women with an average age of 65 years. The study revealed a reduction in oxidative stress after completing the program further illustrating that engaging in 40 minutes of exercise per day, three days per week, for a total of eight weeks decreased stress in women (Karolkiewicz et al., 2008). Furthermore, this study noted the improved quality of life, healthy aging and prevention of chronic disease that resulted from decreased stress levels (Karolkiewicz et al., 2008).

Nutrition and diet. Nutrition and diet have been linked to a number of health outcomes and overall well-being based on a large amount of existing research (Fardet & Rock, 2014;

Hibbeln, 2009; Meyer-Abich, 2005; Niemoller, Stark, & Bazan, 2009; Walsh, 2011). More specifically, the type of food provides the body with essential nutrients that contribute to the overall functioning of the brain including preventing damage and some aspects of aging, and increasing cognitive energy (Fardet & Rock, 2014; Gómez-Pinilla, 2008).

Psychosocial factors, such as ethnic background, and religious affiliation influence an individual's choice of food and reinforces the importance of nutrition on a global level impacting health overall (Gómez-Pinilla, 2008). Furthermore, Gómez-Pinilla (2008), suggests the use of epigenetics to further assess the impact of diet and nutrition on mental health that is passed down to future generations (Walsh, 2011). Walsh (2011) also suggests to include food selection and supplements when improving an individual's nutrition. More specifically, he noted that diets low in calories that include a wide variety of fruits and vegetables and fish that have high omega-3 fish oils are essential in decreasing the risk for cognitive disorders (e.g., Alzeimers's Disease and Parkinson's Disease) and enhancing overall cognitive functioning (Walsh, 2011).

Supplements have been suggested as an effective addition to an individual's diet in regards to prevention of disease and overall promotion of mental health (Fardet & Rock, 2014; Walsh, 2011). For example, omega-3 fish oils have demonstrated several anti-inflammatory effects and are encouraged as an addition to an individual's diet due to its counter effects of pro-inflammation from omega-6 fatty acids and furthermore protecting the body from increased risk for negative cardiovascular conditions (Lands, 2009; Niemoller et al., 2009; Walsh, 2011). According to literature, diets deficient in omega-3 fatty acids, a widely studied topic, have been associated to clinical studies on affective disorders (e.g., depression, bipolar disorder, and schizophrenia) with individuals living in countries with less fish consumption (Hibbeln, 2009; Walsh, 2011). As a result, supplementing an individual's diet with omega-3s can dramatically

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improve his or her overall well-being and further promote good health (Hibbeln, 2009; Niemoller et al., 2009).

Stress Management Interventions, Women, and Diversity: Integration and Summary

According to Mercer (2009), stress management programs that are successful tend to use a comprehensive approach including addressing biopsychosocial aspects that are promoting a stress response in individuals. Effective coping responses that tend to remove and/or decrease the sense of purpose and meaning from stressful situations include learning to re-appraise these situations with a reduction of cognitive distortions (Beck, 2011; Granath et al., 2006; Lazarus & Folkman, 1984; Manning-Walsh, 2005a; Mercer, 2009; C. Park, 2005). Furthermore, implementing relaxation exercises, meditation and lifestyle changes into an individual's life can help decrease stress and the risk for developing psychopathology or physical disease as well as promoting overall well-being (Benson, 2008; Carlson et al., 2007; Cohen et al., 2007; Hibbeln, 2009; Ludwig & Kabat-Zinn, 2008; Mattison & Nemec, 2014; Niemoller et al., 2009; Ramel et al., 2004; Rosenzweig et al., 2007).

In regards to women and diversity, stress management programs specifically assessing the reduction of stress with African American women showed that interventions targeting mind and body (e.g., MBSR, LKM & NTU) can address issues related to cultural and sociopolitical backgrounds (e.g., race, gender) and be a culturally responsive intervention for targeting stress with this population (Woods-Giscombé & Black, 2010). Similarly, contrary to Western therapeutic approaches that focus on the individual and her needs, approaching treatment with women of Arab descent living in the United States in the context of family, community, and religious affiliation is crucial (Al-Krenawi & Graham, 2000; Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Additionally, it is important to recognize that seeking mental health treatment and/or disclosing family problems can be a shameful experience for many Arab American women and may create some barriers for treatment (Erickson & Al-Timimi, 2001; Mourad & Abdella, 2010). As a result, providing psychoeducation around mental health treatment, openly discussing the client's expectations of treatment, explaining the client-clinician relationship and thoroughly and continually discussing their rights to confidentiality are culturally syntonic approaches to treatment with Arab American women (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013).

Metaphors are readily used in Arab culture to describe experiences and emotions. The use of metaphors in session, a culturally syntonic approach to treatment, allows clients to process unconscious content that may be contributing to their distress without direct confrontation creating increased discomfort (Al-Krenawi & Graham, 2000; Dwairy, 2009; Nassar-McMillan et al., 2013).

Furthermore, incorporating a *multi-systemic approach* to the presenting problems allows Arab American women to reach out for support from family and friends while addressing any system challenges versus individual conflict (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013). Exploring and thoroughly understanding an Arab American woman's family and religious life will help guide the therapeutic interventions and acknowledge the important cultural values that are integral parts of an Arab American woman's identity (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013). Additionally, explicitly discussing discrimination, stresses of acculturation including the immigration process and biculturalism will give the clinician insight into the particular stage and developmental tasks

that are prominent for the individual (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013).

Congruent with their hierarchical and patriarchal society, many Arab American women may also expect a hierarchical setting in therapy, often times, viewing the clinician as an "expert" who will provide knowledge and teach them how to solve a problem (Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010). Some authors have suggested approaching treatment with Arab American women from a more directive or advisory role as it may strengthen the alliance and trust (Nassar-McMillan et al., 2013; Mourad & Abdella, 2010). Due to the inconsistent literature on treatment approaches with Arab American women, there does not seem to be one theoretical orientation that seamlessly fits with this particular population. Instead, it is important that the clinician use her/his clinical judgment and cultural understanding of the individual's presenting issues. This may include utilizing an integrative approach and additional self-disclosure from the therapist to facilitate an open discussion around cultural differences as additional ways of strengthening the client-therapist relationship (Erickson & Al-Timimi, 2001; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Further, as common themes in stress management interventions discussed above suggest, social support is a mechanism through which women can connect, create meaning out of stressors, regulate their biochemistry via the release of oxytocin and endure the benefits of improved health and well-being (Bellman et al., 2003; Goodwin et al., 2004; Ogden, 2012; Sabina & Tindale, 2008; Taylor et al., 2000; Turner-Cobb et al., 2002). From the literature reviewed, women, more than men, appear to seek out more social support during adverse situations and benefit more from the physiological side effects which are advantageous from a health perspective (Taylor et al., 2000). More specifically for Arab American women, family

support for social needs, economic support and cultural and religious maintenance, can buffer against effects of acculturative stress (Cohen & Savaya, 2003; Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Nobles & Sciarra, 2000). Furthermore, family has been used for coping with the impact of war and violence (Ahmed & Reddy, 2007). This is due to Arab Americans characterizing the struggles as collectivist and utilizing meaning making coping strategies. A more positive physical and mental health outcome was linked to increased satisfaction with their social support system and lower levels of depression and anxiety (Beitin & Allen, 2005). For first generation Arab Americans, strong family support has been identified as a significant factor in their development and maintenance of their ethnic identity (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013; Nobles & Sciarra, 2000). Spousal support/marital relationships are highly valued and can be protective factors during the acculturation process (Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Nobles & Sciarra, 2000; Wrobel et al., 2009). Fostering cultural identity and self-esteem enhances individuals' motivation and drive to work hard. A strong immigrant community and network can help mitigate challenges of acculturation due to the Arab collectivist value of emphasizing the receipt of emotional support from others (Al-Krenawi & Graham, 2000; Kakoti, 2012; Nassar-McMillan et al., 2013).

While literature exists addressing select populations of women experiencing stress related to breast cancer, childbirth, pregnancy, caregiver roles, domestic violence and job-related stress (Echeburúa, Sarasua, & Zubizarreta, 2014; Faramarzi et al., 2013; Gallagher-Thompson et al., 2008; Groarke et al., 2013; Lapp et al., 2010; Lechner et al., 2006; Lopez, 2014; Sarid et al., 2010), there appears to be a significant shortage of research focused specifically on the collective

effects of stressors (i.e., multiple roles, acculturation, sexism, racism, and physiological factors) faced by women of Arab descent living in the U.S. on health and well-being (Aroian, Templin, & Ramaswamy, 2010; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Norris, Aroian, & Nickerson, 2011).

Additionally, the popular stress management interventions that conceptualize stress according to biopsychosocial model and are mentioned above, are useful in addressing some of the stressors unique to ethnic minority women and middle-adulthood; however, none of the programs mentioned above (i.e., CBT, SIT, PST, MSBR et al.) specifically target the combination of specific stressors faced by Arab American women and address how they affect their health. There is a great need for research studies aimed at developing a more comprehensive conceptualization of stress in varied populations of women, more specifically, Arab American women, and further help to inform clinicians of the impact that these population-specific stressors have on the well-being of women.

Overview and Rationale for the Project

Women comprise up to 49.5% of the world's total population ($N = 7.347$ billion) and experience diverse sources of stress (The World Bank, 2016). Consequently, it is imperative that clinicians continue to widen and deepen their understanding of the needs of women, including the different stressors they face (e.g., multiple roles, gender socialization, occupational, acculturation, discrimination, and aging). More importantly, there is a need to continue to expand stress management interventions that target both mental and physical health effects of stress and the needs of specific populations of women. With much literature suggesting the need to include Arab American women in stress research, with specific attention to acculturative stress (Ahmed & Reddy, 2007; Erickson & Al-Timimi, 2001; Nassar-McMillan & Hakim-Larson, 2003;

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Wroble et al., 2009), this project focuses on educating and providing resources to mental health clinicians working with Arab American women in a one-day workshop format through the development of a curriculum. Furthermore, literature (Abu-Ras, 2007; Kakoti, 2012; Nassar-McMillan & Hakim-Larson, 2003; Nobles & Sciarra, 2000; Youssef & Deane 2006) has identified a deficit in culturally competent mental health services provided to Arab American women, noting that majority of the treatment is developed form Western scholars resulting in inappropriate interventions (Ahmed & Reddy, 2007; Al-Krenawi & Graham, 2000; Dwairy, 2009; Kakoti, 2012). This curriculum serves as a guide for mental health professionals in providing more insight into the common struggles, stressors, coping mechanisms and barriers relevant to Arab American women.

The general goals of the curriculum are (a) to provide psychoeducation and training that incorporates culturally-syntonic methods for working with women of Arab descent living in the United States and (b) to provide information regarding the cultural appropriateness of various stress management strategies that are currently available along with other interventions utilized to target stress in women of Arab descent living in the United States. The specific objectives of this project include: (a) an extensive review of the existing literature and research studies to inform the content of the resource manual, (b) a collection of information from women of Arab descent living in the United States of either first generation or immigrant status in order to incorporate in the development of the curriculum for a one-day workshop for mental health professionals, (c) an integration of data and the development of the curriculum, (d) the development, implementation, and analysis of two brief assessments of the curriculum by two mental health professionals, who are experienced in either working with stress, women, Arab American population, acculturation and/or immigration issues in order to obtain information

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regarding the perceived efficacy of the curriculum and relevance toward the target population, and (e) an integration of the feedback and critiques derived from the assessments into a list of directions for future development.

Chapter II: Methodology

This chapter presents the research methodology that was used for the development of the workshop curriculum for mental health professionals on approaches to addressing stress among women of Arab descent living in the United States. The initial stage of this project involved an extensive review of existing literature and research studies to inform the content of the curriculum. Three women of Arab decent were then interviewed about stress and well-being to further integrate the specific experiences of the target population into the workshop content. The next stage involved the development of the content of the curriculum specifically tailored to the target population. Next, the curriculum was reviewed by two current mental health professionals for feedback regarding the curriculum's utility, organization, and culturally appropriate content for a one-day workshop informing mental health professionals currently working or interested in working with women of Arab descent living in the U.S., in regards to stress reduction. Finally, specific recommendations for modification were informed by the evaluation of the curriculum by two mental health professionals.

Specific Aims

The literature suggests that there is a need for targeting specific stressors that women of Arab descent living in the United States face (Aroian et al., 2010; Erickson & Al-Timimi, 2001; Norris et al., 2011). According to the Arab American Institute (2012), the estimated population size of individuals who identify with Arab Ancestry is approximately three times the number of the estimated population cited in the U.S. Census (2010). This discrepancy between the number of Arab Americans, 82% of which are native born (Arab American Institute, 2012), may be linked to the limitations of ancestry-type questions (e.g., one question regarding ancestry), lack of distinction between race and ethnicity in the census, increased levels of out-of-marriage

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identifications in third and fourth generations, distrust of government-related studies on immigrants, misunderstandings of surveys leading to increased non-responses, and the exclusion of some Arabic speaking countries (e.g., Somalia, Sudan) under the Arab category (Arab American Institute, 2012).

After review of the literature, it is apparent that there is a greater need to deepen the understanding of stressors, primarily acculturative stress and immigration stress, that women of Arab descent living in the United States are facing (Ahmed & Reddy, 2007; Amer & Hovey, 2005; Erickson & Al-Timimi, 2001; Jadalla & Lee, 2004; Mourad & Abdella, 2010; Naber, 2000; Nassar-McMillan & Hakim-Larson, 2003; Padela & Heisler, 2010; Wrobel et al., 2009). Thus, this dissertation study aimed to develop a curriculum for a one-day workshop training for mental health clinicians that focused on interventions with women of Arab descent living in the United States experiencing various stressors. The one-day workshop includes psychoeducation and training that incorporates culturally-syntonic methods for working specifically with women of Arab descent living in the United States . In addition, this workshop provides information regarding the cultural appropriateness of various stress management strategies that are currently available along with other interventions utilized to target stress in women of Arab descent living in the United States. More specifically, this workshop includes psychoeducation on stress and its implications, how stress is experienced in women of Arab descent living in the United States, the limitations to stress-reduction interventions given the cultural context of women of Arab descent living in the United States, identification of commonly experienced stressors among women of Arab descent living in the United States, recommended skill building techniques, and additional resources for mental health professionals to consider when working with this population.

The study was conducted utilizing a program development methodology with the main purpose being to identify content of a training workshop that is culturally-congruent with the needs of women of Arab descent (e.g., attention to acculturation, discrimination, gender role strain, parent-child relationships, care giver, familial, cultural expectations, etc.), as well as develop an organized structure for presenting this content to mental health professionals. The target audience of this workshop are mental health professionals that work with women of Arab descent living in the United States and/or wish to expand their knowledge of cultural and contextual factors within the Arab American population.

Workshop Development: Review of Literature and Existing Resources

The development of this one-day workshop training focused on utilizing an extensive literature review. Data were gathered from a variety of sources including Internet databases such as Psych INFO, Worldcat, Article first, Wiley Online Library, EBSCOHOST databases, PsychARTICLES and other Internet resources and various books. Furthermore, additional information was gathered from national organizations such as Arab Community Center for Economic and Social Services (ACCESS), Arab American Institute (AAI), Arab American Action Network (AAAN), American Psychological Association (APA) Division 35 - Society for the Psychology of Women, and the National Organization for Women (NOW). Lastly, online preliminary interviews were conducted with three women of Arab descent living in the United States to receive feedback on current needs and stressors specific to that population.

The extensive literature review was completed in order to support the creation of this one-day workshop. Specifically, keyword searches included the combination of the following terms: stress reduction, stress, women of Arab descent living in the United States, Arab Americans, mental health, well-being, stress management, health, acculturation, acculturative,

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immigration, health concerns, women, culture, mental health clinicians, and psychotherapy. The literature review incorporated research and information regarding Arab Americans, women of Arab descent living in the United States and their well-being, and current mental health approaches and interventions for stress. The search was initiated by a review of the impact of stress on mental health and well-being among women of Arab descent living in the United States. In particular, descriptive information pertaining to the stressors related directly to women of Arab descent living in the United States, the current stress-reduction practices that are being used with women of Arab descent living in the United States, ways in which mental health professionals currently work with women of Arab descent living in the United States, as well as the obstacles these professionals face in their work with women of Arab descent living in the United States was gathered. Literature related to acculturative and immigration stressors was also gathered to help develop a broad understanding of various stressors related to women of Arab descent living in the United States and further inform culturally-syntonic stress reduction/management resources. Additionally, there was a focus on the difficulties that women of Arab descent living in the United States experience upon seeking treatment or help coping with their stress, and on the need for culturally-syntonic interventions that target stress levels for women of Arab descent living in the United States.

Workshop Development: Interviews with Women of Arab Descent

Three women of Arab descent living in the United States of either first generation or immigrant status were recruited to provide information that could inform the content of the curriculum. Potential participants were contacted initially through email to complete a semi-structured online interview (see Appendix A- Preliminary Brief Questionnaire Interview, Immigrant Status Woman; and Appendix B - Preliminary Brief Questionnaire Interview, First

Generation Status Woman) for the purpose of developing the workshop curriculum. Using a snowball sampling method (Denscombe, 2014), recruitment efforts were made through investigator's personal and professional contacts with women of Arab descent living in the United States. Through some of these personal and professional networks, identified contacts were asked if they could refer the researcher to an organization and/or provide potential participants with the researcher's contact information (see Appendix C- Preliminary Participant Email Script). The researcher also reached out to Arab organizations (i.e., cultural centers, religious centers, groups, etc.) by sending an e-mail (Appendix D-Agency Email Script) to request that the agency provide its members with investigator's contact information. The three women who participated in the initial online interview were acquired via non-probability sampling (i.e., convenience sampling). Inclusion criteria included women who are first generation or immigrant status, experiencing stress, between the ages of 25 to 65 years old, residents in the United States, speak Arabic, and identify with Arab ancestry from Lebanon, Syria, Egypt, Iraq, Jordan, Palestine, Morocco, Algeria, Bahrain, Djibouti, Kuwait, Libya, Oman, Qatar, Saudi Arabia, Tunisia, United Arab Emirates, and Yemen. Research suggested that women immigrating from the Arabic speaking countries listed above experience discordance between their traditional cultural values and the more modern values of their host culture in the United States, and may likely experience some common stressors (e.g., loss, not feeling at home, novelty, occupation, language, and discrimination) identified for people who are from Arab countries (Ajrouch, 2007; Douk, Zineb, Nacef, & Halbreich, 2007; Henry, Stiles, Biran, & Hinkle, 2008; Norris et al., 2011). In regards to selecting the age range, literature suggested that the recent generations are embarking on a longer path to adulthood (Arnett, 2004; Syed & Seiffge-Krenke, 2013). This historically unprecedented period has been referred to as emerging

adulthood (Arnett, 2004). Arnett (2004) suggests that there are five main features of the emerging adulthood phase that include: identity explorations, instability, self-focused, feeling in-between, and it is the age of possibilities. As a result, focusing on post emerging adulthood (25+) minimized the chances of encountering the above-mentioned features, which may insert confounding variables into the needs-assessment questionnaire conducted with the three women. Furthermore, extending through middle age is important to consider when thinking about stress. Specifically for women, middle age adulthood or midlife is a period of transitions (e.g., biological, physical and emotional) that can often result in increased stress and changes in women's health (Borzumato-Gainey, Kennedy, McCabe & Degges-White, 2009; Cosgrove, Franco, Granger, Murray & Mayes, 2007; Doress-Worters, 1994; Miller & O'Callaghan, 2005; Moen, Robison & Fields, 1994; Norton et al., 2002; O'Donovan et al., 2012; Otte et al., 2005). Focusing on post emerging adulthood (age 25) to the beginning of older adulthood (before age 65 when cognitive decline has a greater likelihood of impacting responses and when the specific stressors of aging are more apparent) helped to control for potential age-related confounding variables.

Exclusion criteria included third generation women and women not currently living in the United States. There were no sampling criteria for religion, women representing Islam, Druze and/or Christianity were possibly included among the women interviewed. Purposeful sampling was used in order to ensure the above criteria was met and that the participants helped the researcher better understand the stressors that women of Arab descent living in the United States faced (Creswell, 2014; Merriam, 2009). The chosen methodology did not require a large number of participants and more specifically, according to Creswell (2014), there is an emphasis on a smaller number of participants (e.g., three to five) when conducting interviews in order to focus

on collecting data that is rich in content. The women were recruited through a flyer that explained the purpose of the semi-structured online interview and a brief description of the development of the workshop (see Appendix E- Recruitment Flyer). An Arab American agency, Lebanese Ladies, was contacted via e-mail (see Appendix D- Agency Email Script) and asked to distribute investigator's contact information to female members. However, the agency did not respond to investigator's attempts to contact them via email. All three women who participated in the study were thus those who responded to inquiries from the researcher's individual networks.

To assess participants' eligibility based on the inclusion and exclusion criteria, an eligibility assessment was sent out electronically (see Appendix F- Assessing Eligibility for Women of Arab Descent Participants). The participants who agreed to the task were sent an informed consent via e-mail outlining the purpose of the interview, a brief description of the workshop, the author's affiliation, the associated risks and benefits of partaking in this process, and privacy and confidentiality issues (see Appendix G – Participant Consent Form). The participants digitally, or by pen, signed and return the consent form electronically by scanning and emailing the signed consent form to the investigator. The consent documents were stored separately from the other research materials, in order to protect confidentiality. In regards to confidentiality, email addresses or names of participants on the responses were not stored. Instead, each participant received a research subject number to match the interview responses. Interview questions were sent out via e-mail (Appendix A and Appendix B). Through the semi-structured online interviews, the interviewees were asked about resources available to women of Arab descent living in the United States for stress reduction, resources they would like to see implemented in mental health services, stressors Arab American women face, values pertinent to

Arab culture, strengths of identifying as a woman of Arab descent, and other information relevant to the development of one-day workshop for mental health clinicians working with women of Arab descent living in the United States. More specifically, the questions included asked participants to describe how they identify themselves (e.g., age, ethnic-cultural identity, religion, sexual orientation, relationship status and children), what country their parents were from, their most important values, any conflict they have experienced negotiating between Arab and American cultural values, their understanding of stress (e.g., how is distress expressed), to identify unique stressors that Arab women face, how they cope with stress, the advantages and disadvantages of residing in the U.S, the challenges and strengths as identifying as a woman of Arab descent, mental health resources that they believe Arab American women need, and any suggestions they have to mental health professionals. For the immigrant status participants, in addition to the above mentioned questions, participants were also asked to identify where they immigrated from, duration of their residence in the U.S., any particular difficulties they faced while immigrating to the U.S., to describe their adjustment to the American culture and living in the U.S., and identify any challenges of adjusting to American lifestyle. The researcher requested to receive an email with the filled out questionnaire in two weeks. To address the discomfort or stress that may arise, participants were encouraged to take breaks as needed during the data collection process, discuss the discomfort with the interviewer, and could be provided with referrals for centers where culturally appropriate support or mental health services may be available, if needed.

Development of the Curriculum for a 1-Day Workshop

Following the completion of a comprehensive literature search and review of existing resources, integrating content from the interviews with women of Arab descent, a curriculum

was developed for a one-day workshop with mental health clinicians. The format and structure of this workshop guide consists of text as well as visual aids, and any handouts that mental health clinicians might utilize as resources while working with women of Arab descent living in the United States. The length of one-day was determined based on what was judged to be necessary and useful for providing sufficient guidance to mental health clinicians.

The curriculum was organized into the following sections:

1. Introductions and Purpose of Workshop,

2. Understanding Stress and Women of Arab Descent Living in the United States,

3. Discussion of Historical Events and Current Issues Relevant to Women of Arab Descent Living in the United States,

4. Identifying Stressors experienced by Women of Arab Descent Living in the United States,

5. Examples of Culturally-Syntonic Stress Management Activities and Coping Skills Building,

6. Provide Additional Resources, and

7. Networking.

A detailed description of the curriculum is presented in the Results chapter.

Curriculum Evaluation: Experts in Stress, Women and/or Arab Americans

An evaluation of the curriculum was completed in order to further guide the development of the workshop. Specifically, this curriculum was reviewed by two mental health professionals, who are experts in either working with stress, women or the Arab American population, and focused on providing feedback and information regarding the curriculum in all areas of effectiveness.

Recruitment strategies and procedures. The full one-day workshop curriculum was emailed to the evaluators for review. The evaluators included one mental health professional who had experience (i.e., a minimum of 5 years post-graduate experience) working with individuals of Arab descent, ideally with women of Arab descent living in the United States (i.e., Evaluator 1). The second evaluator was a mental health professional who is an expert and has a minimum of 10 years of clinical or counseling experience working with women and/or immigrant or first generation populations (i.e., Evaluator 2). Evaluator 1 was referred to researcher through her professional and personal network. Additionally, Evaluator 1's contact information was also found on Psychology Today's online database. Evaluator 2 was identified through the researcher's professional network. Both evaluators were contacted via e-mail and asked if they would be willing to evaluate a curriculum for a one-day workshop for mental health clinicians working with women of Arab descent living in the United States. The e-mail described the workshop and the rationale for developing it (see Appendix H- Evaluator E-mail Script). The mental health professionals were asked to complete a brief questionnaire to assess their eligibility based on the inclusion and exclusion criteria mentioned (see Appendix J-Evaluator Eligibility Form and Appendix K- General Mental Health Evaluator Eligibility Form). The evaluators were then sent an informed consent via e-mail, which explained its purpose, the author's affiliation, the associated risks and benefits of partaking in this process, and privacy and confidentiality issues (see Appendix I – Evaluator Consent Form).

The evaluators digitally signed or hand signed and returned the consent form electronically by scanning and emailing the signed consent form to the investigator. Upon receipt of the signed informed consent, the curriculum and the assessment of the curriculum (Appendix L- Assessment of Curriculum) were sent out to the evaluators through email. The researcher's

chairperson reviewed and approved the workshop content before it was sent out to evaluators. The curriculum was designed in manual format to include the designated seven sections and instruction for facilitation of the one-day workshop. Each evaluator was given two weeks to review the curriculum and was instructed to review the curriculum in detail and gather thoughts and comments accordingly. They were each advised to contact the author once the curriculum has been reviewed.

Evaluation Questionnaire

The author created a brief online questionnaire for the aforementioned purpose of seeking input from mental health professional experts in the areas of stress, women, and Arab Americans (See Appendix L-Assessment of Curriculum). Using a 5-point Likert scale, the evaluators rated how much they strongly disagreed or strongly agreed with the quality and content of the curriculum (i.e., does it appropriately depict women of Arab descent living in the United States in regards to stress and stress management), content appropriateness, cultural responsiveness, and the organization and ease of use (i.e., format, style, applicability; see Appendix L-Assessment of Curriculum). It also included open-ended questions in order to allow the mental health professionals to provide narrative feedback (see Appendix L-Assessment of Curriculum). The curriculum evaluation was sent out electronically (based on the preference of the evaluators) upon receipt of their signed consent forms.

The information provided from the evaluations was analyzed and the author explored themes, suggestions and feedback directly related to the improvement of this workshop curriculum. The information collected from this evaluation was used to identify future directions to take in regards to developing workshops for mental health professionals that work or plan to work with women of Arab descent living in the United States who are experiencing significant

stress. Lastly, all of the data collected was appropriately stored and locked to ensure the

evaluators' privacy and confidentiality are protected.

Chapter III: Results

This chapter will provide an overview of the data utilized to develop and evaluate the curriculum for a workshop on stress and well-being in women of Arab descent living in the United States. First, a brief overview of the process of collecting data via a review of past and current literature will be presented. Second, the data collected from participants via preliminary interviews will be presented. Third, the structure and content of the curriculum (see Appendix M) will be discussed. Finally, feedback on the curriculum from two evaluators will be reviewed and examined.

Brief Overview of the Development of the Curriculum

The initial phase of the study involved an extensive review of literature pertaining to issues of acculturation, stress, and need for mental health services for women of Arab descent living in the United States. This review resulted in several primary issues being identified that were important to include in the content of the curriculum and to make choices regarding culturally-syntonic approaches to stress management. These issues included acculturative stress, changes in gender roles, marital discomfort, discrimination, negative stereotyping, familial expectations (Arab versus American values), religious confusion, immigration stress, barriers to seeking mental health treatment, variability in religious affiliation and nationality, and a deficit in culturally congruent stress management interventions (Abboud et al., 2015; Al-Krenawi & Jackson, 2014; Erickson & Al-Timimi, 2001; Ghafari, 2002; Haboush, 2007; Ilkkaracan, 2002 ; Jaber, 2003; Kakoti, 2012; Mourad & Abdella, 2010; Naber, 2000; Nassar-McMillan et al., 2013, Nobles & Sciarra, 2000). This core content from the literature was supplemented with findings from the interview questionnaires completed by three women of Arab descent.

Results of Interviews to Inform Curriculum Development

Participant A identified herself as a single, first-generation Lebanese-American, Christian female living in the United States. She noted that both of her parents immigrated to the U.S in their early twenties and at age 13, her family decided to move back to Lebanon. As a result, she spent her adolescent and young adult years living in Lebanon. At age 24, participant A moved back to the U.S. to complete graduate school. Participant A emphasized a continued conflict that she has experienced with her Lebanese values and American values, suggesting some acculturation stress. Participant A identified gender role expectations, perceived misconceptions and/or discrimination (e.g., ethnic and religious), language differences including physical gestures, dating expectations (e.g., including premarital sex), maintaining familial closeness and expectations, and a desire to be socially and financially independent as stressors that Arab American women face. Additionally, she identified family as a source of support and a way to cope with stress. Some of the challenges that Participant A indicated that she faced as an Arab American women included being judged and discriminated against for being Arab, increased stress and worry about how others will perceived her, feeling like she does not belong in Lebanon nor U.S, and an inability to be completely honest with her parents due to the fear of disapproval of her behaviors. Lastly, when asked about additional mental health resources that are needed for women of Arab descent living in the U.S., participant A identified access to educational resources for women, access to culturally competent therapists (e.g., "familiar and understand differences between Arab and American culture), and support groups specifically for Arab American women to teach coping skills and address stressors.

Participant B identified herself as a married, first generation Lebanese-American, and Druze female living in the United States. She reported that both of her parents immigrated to the

U.S. in their early twenties fifty years ago. Participant B noted frequent visits to Lebanon while she was growing up in the U.S. and currently visits with her children and husband. She also noted that meeting Arab gender role expectations of having a "perfect" family, marriage, house, and children has been a significant source of stress for her as well as other Arab American women. Furthermore, Participant B identified depression as a problem within the Arab community as a result of not understanding one's identity. She further noted struggling with understanding her own American and Lebanese identity while trying to please everyone else in her family. She noted familial expectations, the "competitive nature" of Arabs (e.g., "superficial and money"), and trying to navigate between living in a free country but having strict rules imposed on her by her parents. She also noted challenges with meeting Arab expectations and having difficulties developing trusting relationships. Lastly, when asked about additional mental health resources that are needed for women of Arab descent living in the U.S., Participant B recommended that Arab American women seek out therapy with a culturally competent therapist that understands the Arab culture and the nuances within it.

Participant C identified herself as a 46 year old married, Arab-American, atheist female who has two boys, ages 17 and 13 years old. She initially immigrated to Canada from Iraq during her teen years and then immigrated to the U.S. from Canada at age 25. She reported that she has separated herself from the religion of Islam. She noted an "easier" transition into the U.S. from Canada; however, explained that immigrating to Canada from Iraq was difficult. Since her departure from Iraq, Participant C has reported a decreased desire to return to the Middle East due to feeling isolated from the religious culture (e.g., Islam) in Iraq. Furthermore, she identified stressors upon her arrival, including feeling misunderstood by American women and a need to "prove herself" to feel accepted by American society. She also identified increased

discrimination and marginalization that many Arab women face living in the U.S., especially in more conservative cities. As an Arab female, Participant C, identifies living in the U.S. as a strength and an opportunity to achieve her goals; however, notes the challenges of needing to prove to be a productive member of society. When asked about support in managing stress, Participant C identified education and employment as ways of managing stress and negating stereotypes about Arab women. Lastly, when addressing what would be beneficial for stress reduction for women of Arab descent living in the U.S., she noted "integration into American culture."

Integration of Data and Curriculum Content

The extensive review of the literature and the data from the three preliminary questionnaire interviews were used to inform the content of the curriculum for the one-day workshop: *Addressing Stress and Well-Being among Women of Arab Descent Living in the United States* (hereafter referred to as the "curriculum"). The content, discussion points, case examples and activities provided, developed and offered in the curriculum were based on the extensive literature review of areas that were pertinent in better understanding the identity, stressors and overall well-being of immigrant and first generation Arab American women. The content provided can be used to offer psychoeducation for the facilitator and/or the workshop participants to ensure a more comprehensive understanding of what embodies the types of female Arab American identities

The curriculum is 54 pages in length (not including references and appendices) and is comprised of seven sections that can be delivered within a 5-8 hour time frame in total. The length of time for each section is indicated and ranges from 10 minutes to 60 minutes. Each section includes content that can be used to provide psychoeducation on the topic and various

interactive activities (including materials needed), discussion points/questions, and/or case examples. Each section includes a thorough explanation of the interventions that can be used and their efficacy. A list of appendices (A through J) is included at the end of the curriculum to provide separate documents of case examples and/or activities that were used throughout the workshop to assist facilitators in distributing those documents separately to participants.

Section one of the curriculum consists of broad information and rationale for providing this workshop for mental health clinicians working with women of Arab descent living in the United States. The objective of the workshop and a tentative agenda is also provided in this section. Additionally, a basis of who is considered to be of Arab American descent is provided. Lastly, a group activity (e.g., an ice breaker) is used to promote cohesiveness within the workshop participants and allow time for introductions.

Section two focuses on providing psychoeducation about stress and its implications on mental health for women of Arab descent living in the United States. This includes contextual information that is essential to understanding Arab culture before working with women of Arab descent living in the United States. This section also offers data and literature to provide a rationale for the need of culturally-syntonic practices with women of Arab descent living in the United States. The first half of this section includes general content on stress, gender and stress, a coping and social support (e.g., emotion-focused coping, problem focused coping, meaning making coping, social support). This is followed by a case example and discussion questions in order to facilitate a discussion around possible stressors women of Arab descent face. The second half of this section includes psychoeducation on the development of the Arab identity. More specifically, this section extensively describes the role of family, gender role identification, religion, sexuality, and education and employment have in developing a female Arab identity.

Under each of the above mentioned topics, the facilitator is provided with *hot topics*, which are identified themes that may come up around those topics during therapy.   Following the second portion of the psychoeducation (i.e., development of Arab American identity), the same case example is provided in order facilitate a discussion comparing and contrasting previous ideas and approaches to this clinical case. An interactive discussion regarding current stress-reduction interventions that have been particularly useful is encouraged during this portion of the workshop. Visual aids are used during this part of the workshop to further illustrate the impact of stress on mental health and current resources used to reduce stress for women of Arab descent living in the United States

Section three of the curriculum aims to provide information on historical and current events that are relevant to women of Arab descent living in the U.S. Initially, an activity around stereotypes is used to promote a discussion around the participants' own biases about issues pertaining to Arab culture and Arab American women (e.g., Islam, hijab, terrorism, etc.,). The activity entails watching a video on "selective attention" and participating in the selective attention activity. Additionally, a facilitation of discussion was used to identify current sociopolitical issues that may be increasing stress levels for women of Arab descent living in the United States (e.g., discrimination, changes in bills/laws, changes in accessible resources, etc.). Furthermore, a visual activity around biases and stereotypes is done during this section. Participants are asked to break up into smaller groups and reflect on their reactions to a list of words that are presented at the beginning of this section, the words include: Arab, Terrorist, Muslim, Hijab, 9/11, Arab American, Immigrants. Through the use of multi-colored sticky notes, the facilitator is able to illustrate the stereotypes and biases that the participants hold in reaction to the presented list of words. As a result, a discussion around how those stereotypes and biases

influence their clinical work takes place. Furthermore, participants are encouraged to provide case examples that illustrate the impact of stereotypes and/or biases. Additional discussion points pertaining to the clinical impact of holding stereotypes and/or biases are offered in this section.

Section four of the curriculum is crucial to educating the participants on the stressors that women of Arab descent face while living in the United States. Using an interactive discussion style (e.g., brainstorming) and two case vignettes with discussion questions and analyses, stressors, including acculturative and immigration stress, are emphasized in this section. Special attention is given to sources of traumatic stress relevant to women of Arab descent living in the United States. The psychological and physiological manifestations of stress among women of Arab descent living in the United States are extensively described during this part of the workshop. Furthermore, the specific stressors that women of Arab descent face around religiosity, current events, parent-child relationships, and gender role expectations are thoroughly discussed in this section as well. Additionally, information around resiliency and protective factors for women of Arab descent living in the U.S. are also covered in this section. Lastly, discussing the obstacles of working with women of Arab descent living in the United States and facilitating an interactive discussion of the participants' current experience with this population are emphasized in this section.

Section five begins with a group activity (e.g., Compassionate Breathing In and Out), which is particularly identified as a culturally syntonic stress management exercise. This allows space for participants to share their experiences and reactions to this breathing exercise and discuss how it may or may not be beneficial for their Arab American female clients. Participants are also educated about various skills-building exercises to enhance their clinical work with women of Arab descent living in the United States. Primarily, stress management

interventions are introduced and cultural adaptations are explored that fit the needs of women of Arab descent living in the United States. The suggested stress management interventions fall under the areas of mind-body, diaphragmatic breathing, progressive muscle relaxation (PMR), and social support. Additionally, cultural considerations are emphasized in this section as approaches to therapy with this particular population are thoroughly explained. Other experiential activities that are used during this time include role plays and case vignettes, and implementing culturally-syntonic stress management interventions (e.g., compassionate breathing, PMR). The role-play provides participants with an opportunity to conceptualize women of Arab descent living in the United States from a culturally congruent perspective while allowing them to highlight key stressors that are unique to that population. Participants are encouraged to apply their teachings from the workshop in order to identify culturally-relevant needs of women of Arab descent living in the United States and possible ways to adjust current stress management interventions to fit those needs.

The final segments of the workshop consist of other resources available (section six) and an opportunity for participants to network (section seven). Section six includes a list of resources (also included in the appendices) that both mental health professionals as well as Arab American clients can use for additional information and resources. Section seven provides an opportunity for participants to network and allows for flexibility by providing activities to facilitate networking. These sections provide resources including agencies that specifically work with Arab Americans in the community, support groups, and cultural centers. Resources for civil rights organizations, academic information on Arab culture and religion, other Arab American online communities are also provided. Facilitators are also able to adjust resources by adding or removing some to fit the needs of the participants and/or based on location for providing

additional resources. Section seven provides an opportunity for participants to network and provides the facilitator with five different optional networking activities to facilitate engagement. Lastly, appendices that include the group activities, discussion questions, case examples, stress management interventions and other resources are incorporated at the end of the curriculum to allow the option for the facilitator to distribute them to the participants.

Overview of Evaluators' Feedback

Two evaluators completed the assessment of the curriculum and provided additional feedback on open-ended items, including strengths and weakness of the curriculum, suggestions for other stress-reduction/management interventions that are culturally appropriate for Arab American women and any other suggestions for improving the curriculum.

Summary of Evaluators' Responses

Overall, the average of the evaluators' responses on the eight Likert-scale items (e.g., scale of one to five, one being "Strongly Disagree" and five being "Strongly Agree") regarding the overall quality of the curriculum was 4.34. Across all items, the average of Evaluator 1's responses was 5.00, while the average of Evaluator 2's responses was 3.69. Figure 1 illustrates the ratings for each of the evaluators on the eight Likert-scale items and Figure 2 presents the average ratings for both evaluators on each of the eight Likert-scale items.

Regarding content of the curriculum (i.e., does it appropriately depict women of Arab descent living in the United States in regards to stress and stress management, is it culturally responsive), the average score was a 4.58 on items number one, two and five. On item one, "The curriculum is thorough and provides adequate information on how to work with women of Arab descent living in the United States", of the average was 4.5. On item two, "The curriculum is thorough and provides adequate information regarding the stressors that are unique to women of

Arab descent living in the United States" of the average was 4.75. On item five, "The curriculum provides adequate guidelines for mental health clinicians working or hoping to work with women of Arab descent living in the United States", the average was 4.5. Evaluator 1 scored one point higher on items one and five, and 0.5 points higher on item 5.
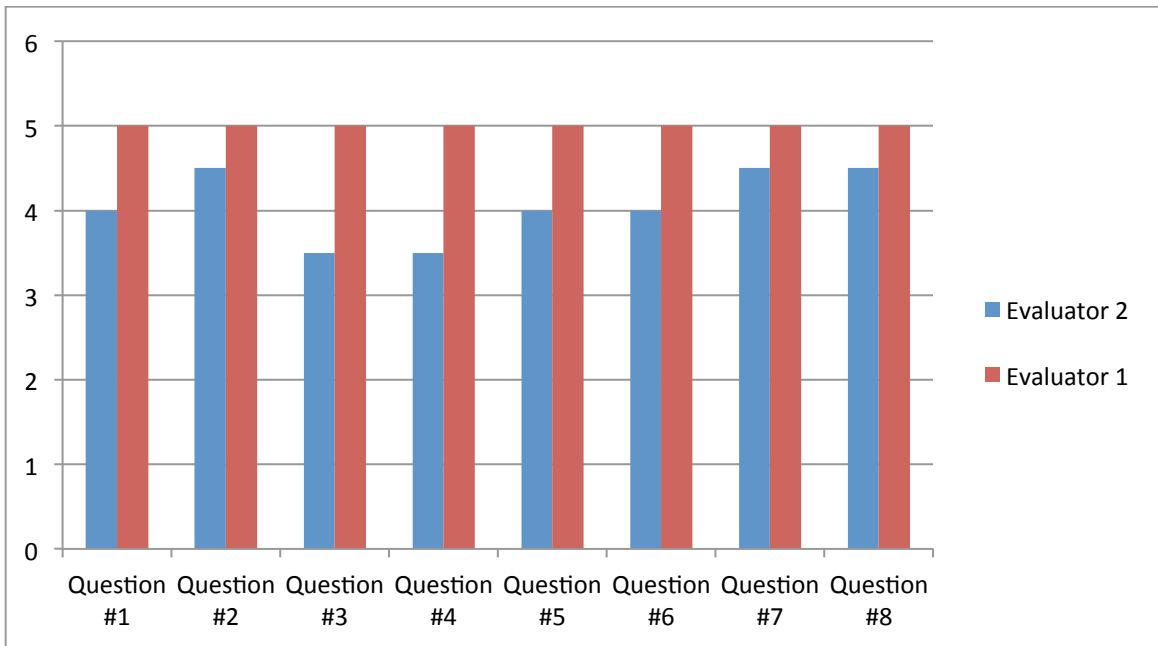
Figure 1. Evaluators' responses to eight Likert-scale items.
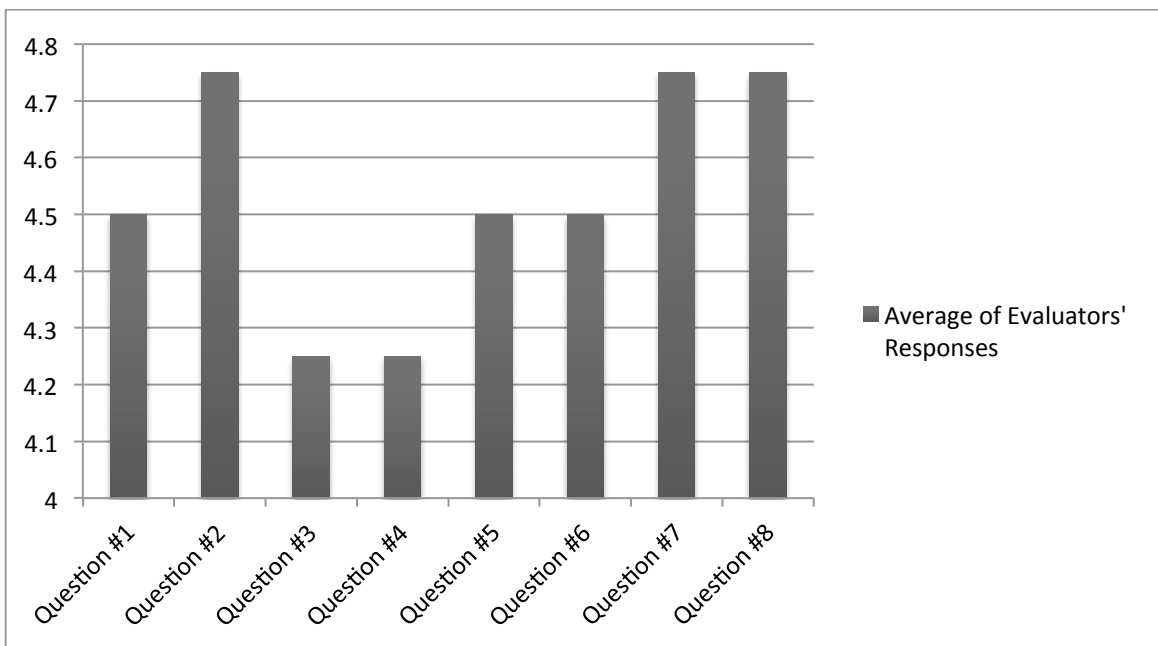
Figure 2. Average of evaluators' responses to eight Likert-scale items.

Regarding the organization of and use of the curriculum (i.e., format, style, applicability), the average was 4.5 on items three, four, six, seven and eight. On item three, "The curriculum is easy to read and understand," the average was 4.25. On item four, "The curriculum is well organized," the average was 4.25. On item six, "The curriculum addresses the stated purpose of the workshop," the average was 4.5. On item seven, " The learning activities in the curriculum seem appropriate and sufficient for a workshop," the average was 4.75. Additionally, on item eight, "This is a program that mental health professionals will realistically be able to access," the average was 4.75. Evaluator 1 scored 1.5 points higher on items three and four, 1 point higher on item 6 and 0.5 point higher on items seven and eight.

Both evaluators noted strengths of the curriculum to include the description of stressors that Arab American women face while living in the United States and the case examples and exercises utilized in each section. Evaluator 1 identified other strengths including the research included and the culturally congruent treatment approaches that were explained and provided. Both evaluators provided additional written feedback regarding the strengths of the curriculum, which included its "applicability and value as a resource that is needed for women of Arab descent living in the United States." More specifically, both evaluators noted the "excellent content" included in the curriculum to assist mental health professionals who are currently or are interested in working with women of Arab descent living in the U.S.

Evaluator 2 noted one of the weaknesses of the curriculum to include the organization of the psychoeducation. More specifically, evaluator 2 suggested that the psychoeducation "should be put out first-and it should be prioritized in ways that make sense with the headings. " Additionally, evaluator 2 recommended organizing the therapeutic intervention section " a little better." Lastly, evaluator 2 also suggested including additional case examples in each section and

providing more guidance for intervention in "earlier sections." Evaluator 1 indicated that there

were no weaknesses.

Tables 1 through 4 present the evaluators' responses to items nine, ten and the open-

ended questions included in the curriculum's assessment questionnaire.

Table 1

Evaluators' Responses to Item 9: What Do You Consider to Be the Strengths of the Curriculum?

Evaluators' (1 and 2) comments:
1. The psychoeducation, the amount of research, the thoughtfulness behind the exercises and the tools, the treatment approaches, the sensitivity to the cultural values and norms, etc.   2. A description of the stressors Arab American women face while living in the U.S.- gender role expectations, religious pressures (and comfort), sexuality, education and employment, historical factors, reason for immigration, etc. I also felt the case examples were excellent .

Table 2

Evaluators' Responses to Item 10: What Do You Consider to Be the Weaknesses of the

Curriculum?

Evaluators' (1 and 2) comments:
1. None   2. It feels a little disorganized. I'm not sure why it is broken down into sections in the manner that it is done. It feels like all of the psychoeducation should be put out first- and it should be prioritized in ways that make sense with headings. Also the therapeutic intervention section feels like it needs to be organized a little better (i.e., 1). conceptualization, 2). rapport-building, 3). discussion of cultural factors, 4). culturally sensitive effective interventions, 5). referrals

Table 3

Evaluators' Responses to Item 11: What Are Some Suggestions of Stress-Reduction/Management

Interventions That Are Culturally Appropriate for Women of Arab Descent Living in America?

Evaluators' (1 and 2) comments:
1. Using/playing musical instruments. 2. Are you asking for additional ones that have not been listed in the manuscript? If so-certainly referrals to Arab American agencies in which women of Arab descent can serve as mentors or agents of support. Being able to talk openly and honestly about the stressors, gender role strains, abuse, and oppression they have experienced.

Table 4

Evaluators' Responses to Additional Comments: Please Provide Any Other Suggestions for

Improving This Curriculum?

Evaluators' (1 and 2) comments:
1. The guide is excellent. A very valuable, applicable, and timely guide. Excellent work overall. 2. There is excellent content in here and very important information for therapists/counselors. I also like involving case examples of Mona two times, once before the psychoeducation and then again afterwards. I think each section should have a case example-then conceptualize the problem, intervene. Also it is not clear to me why in some sections the therapists are not given guidance on how to intervene and then in later sections they are. It is a very valuable resource and very important, just needs to be tightened up a bit.

Chapter IV: Discussion

The current project involved the development of a curriculum for a 1-day workshop addressing stress and well-being in women of Arab descent living in the United States. The curriculum was designed to further inform mental health professionals who work with or are interested in working with Arab American women in regards to various stressors experienced by that population, psychoeducational information regarding immigration, acculturation, identity development and culturally congruent treatment considerations and well-being for that group. Two evaluators conducted an extensive review of the curriculum via questionnaires regarding limitations, areas for improvement, and strengths of the curriculum for the one-day workshop.

Identified Strengths of the Curriculum

Multicultural theorists have emphasized the need to learn and understand their clients' behaviors in the context of their culture at both a micro and macro level (Ahmed & Reddy, 2007; Erickson & Al-Timini, 2001; Kim & Abreu, 2001; Read & Reynolds, 2012; Sue & Sue, 2003). The curriculum serves as a guide for mental health professionals by providing psychoeducation on the background and development of Arab culture and identity, as well as unique stressors that women of Arab descent face while living in the U.S. Both evaluators noted the culturally congruent stress management interventions as a source of guidance for mental health professionals and further identified it as a strength of the curriculum. Those components of the curriculum were intended to address the deficit in culturally competent mental health services provided to Arab American women as identified by the literature (Abu-Ras, 2007; Ahmed & Reddy, 2007; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim-Larson, 2003; Youssef & Deane 2006). Additionally, the use of case examples and group exercises throughout the curriculum were

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reported to be strengths of the curriculum which is congruent with research regarding the need for mental health professionals to develop a multidimensional approach to mental health and increase their awareness of their own biases and further challenge the stereotyped images of their clients (Ahmed & Reddy, 2007; Erickson & Al-Timini, 2001; Kim, & Abreu, 2001; Mourad & Abdella, 2010; Read & Reynolds, 2012; Sue & Sue, 2003). Overall, both evaluators described the curriculum as valuable and essential resource for mental health professionals currently working with or interested in working with women of Arab descent living in the U.S. in regards to stress reduction and overall well-being which is congruent with the literature emphasizing the need for these resources (Aroian et al., 2010; Erickson & Al-Timimi, 2001; Norris et al., 2011).

Identified Weaknesses of the Curriculum, Limitations and Recommendations for Future Steps in Program Development

One of the evaluators identified the organization of the curriculum as an area of improvement. More specifically, it was noted that the psychoeducation that is provided in each section would be more appropriate as part of the introduction of the curriculum all together before all of the sections, instead of included in each section. Furthermore, it was suggested that Section 5 of the curriculum: *Examples of Culturally-Syntonic Stress Management Activities and Coping Skills Building,* can be better organized into the following sequence: introducing the conceptualization of treatment, rapport-building, discussion of cultural factors, culturally sensitive interventions and referrals. Lastly, it was also suggested that each section provides a case example illustrating how mental health professionals should intervene instead of utilizing case examples only in sections two, four and five.

Apart from the weaknesses of the curriculum noted by the evaluators and described above, there exist additional limitations for the implementation of this curriculum in a workshop.

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First, the increased amount of psychoeducation necessary to provide an in-depth understanding of Arab American women can make it challenging for the facilitator to cover the material and implement the group activities in a single session. Second, due to this extensive amount of content provided and the potential variation in numbers of attendees, breaks including lunch, were not included in the curriculum. However, this can be added by the facilitator depending on the size of the group and whether the workshop will be five to eight hours in length. Additionally, as noted in the curriculum, there is a significant need to provide culturally syntonic stress reduction interventions to Arab Americans However, there is not much existing research in this area, particularly for women of Arab descent living in the U.S (Abu-Ras, 2007; Ahmed & Reddy, 2007; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim-Larson, 2003; Youssef & Deane 2006). As a result, the suggested interventions have been selected based on an integration of available literature and the researcher's professional experience working with Arab American women, stress and wellbeing.

Another noted limitation includes the sample size of participants recruited (three) to gather preliminary data regarding experiences and understandings of stress, cultural values, Arab and American identity, strengths of identifying as an Arab American women, and any resources they felt their community needed to assist with stress management. This limitation was primarily a function of the planned scope of this specific project; however, it would have been more ideal to gather this data from a larger sample of women of Arab descent in order to better represent the range and diversity of experiences within this group. Additionally, contacting psychologists who had extensive experience with the Arab community was very challenging, as many psychologists did not respond to the investigator's emails and/or did not want to be included in the study.

Furthermore, several Arab American agencies did not respond to multiple contact attempts to recruit psychologists experienced with working Arab American individuals for this study. Consistent with the literature (Dutton, 2003; Jaber, 2003; Keller, Gonzales & Fleuriet 2005), ethnic minorities may pose recruitment challenges due to barriers including language differences, mistrust regarding perpetuating stereotypes and exploitation, and cultural differences. In order to rectify these challenges in the future, it is recommended that recruiters build trust and ongoing culturally sensitive relationships with ethnic groups and/or agencies, seek endorsements from key community gatekeepers (e.g., Imams of local mosques and/or political Arab activists), and emphasize possible altruistic contributions as an incentive (Aroian, Katz, & Kulwicki, 2006).

The results from the assessment of the curriculum suggest that the following modifications to the next version of the curriculum would strengthen its effectiveness:

- Section 5: *Examples of Culturally-Syntonic Stress Management Activities and Coping Skills Building* should be better organized with discussion of cultural factors and culturally sensitive interventions following conceptualization and rapport-building.

- Including more case examples, similar to that of *Mona*, found in section two. More specifically, providing the same case example before and after psychoeducation in each section.

- Add more specific information about the unique experiences of the women reflecting issues relevant to their country of origin and distinct from the general Arab American information (e.g., current political state of Syria, laws regarding dress for women, etc.).

- The administration and collection of an open-ended evaluation at the end of the workshop to elicit feedback about the format of the workshop (e.g., time, breaks, activities) and the

content provided from the participants. This will allow for future modifications of the curriculum based on feedback from the participants.

- Locating and including more mental health resources or agencies that are willing to be included or identified as a resource in the curriculum.

- Providing additional resources for the facilitator to review prior to administering the workshop. Examples include: information regarding current events occurring in Arabic-speaking countries, political changes that impact Arab Americans, information outlining the prominent religious beliefs. This can help the facilitator become more familiar with content available in the curriculum as well as maintain the most current perspective on issues pertaining to this particular population.

Future steps. Future steps include conducting a pilot study of the workshop to examine the feasibility of the workshop with mental health professionals (Leon, Davis, & Kraemer, 2011). More specifically, assessment measures can be used to gather information regarding the content and structure of the workshop and the knowledge retained by the mental health professionals about Arab American women's identity development and stressors, and the culturally congruent interventions used. This can be done through incorporating an adaptation of a popular organizational training framework, Kirkpatrick's four level model of training (Kirkpatrick, 1959, 1976, 1999; Kirkpatrick & Kirkpatrick, 2007) in order to assess the participants perceptions and feelings about the training workshop (level I: reaction) and to measure the resulting increase in knowledge and/or skills after attending the workshop (levels II: learning). Level II can be used as a pre and post measure to illustrate the change in attainment of knowledge and/or skills through attending this workshop. Although there have been new models proposed, Kirkpatrick's models remain to be the most widely reviewed and used evaluation

criteria (Alliger, Tannenbaum, Bennett, Traver & Shotland, 1997; Arthur, Tubre, Paul & Edens, 2003; Kirkpatrick & Kirkpatrick, 2007; Praslova, 2010; Salas & Cannon-Bowers, 2001).

Reaction criteria (level I) assess the perceptions of the participants about training and can be used in self-report measures (Alliger et al., 1997; Kirkpatrick & Kirkpatrick, 2007; Praslova, 2010). The learning criteria (level II) measure the learning outcomes as a result of participants attending the workshop. These measures are usually assessed through pre and post tests and can be direct measures of learning (Kirkpatrick & Kirkpatrick, 2007; Praslova, 2010). Level III (behavior) and level IV (results) are not recommended in this pilot study due to the extensive time requirements and cost (e.g., financial and resources) needed to complete both of those levels. As a result, an adaptation of Kirkpatrick's model appears to be more appropriate for conducting a pilot study of this training workshop for mental health professionals. All the information collected through the above-mentioned criteria can be used to further modify both the content and utility of the curriculum.

In addition, a small-sample qualitative study can be incorporated in the workshop training by conducting interviews with the participants to elicit perceptions and attitudes towards providing mental health treatment to women of Arab descent, beliefs held about Arab Americans, perceived barriers for providing treatment to this particular population, and new developments and understanding of clinically working with women of Arab descent (Siriwardhana, Adikari, Jayaweera, Abeyrathna & Sumathipala, 2016). The interviews can be further analyzed using both thematic and content analytic approaches (Siriwardhana et al., 2016). Overall, the results from the pilot study can assist in guiding the design and implementation of the workshop on a larger-scale basis. This would allow for additional identification of strengths,

weaknesses, and areas of improvement that could be then refined and included into the curriculum.

Additionally, a focus group with women of Arab descent living in the United States (e.g., immigrant and/or first generation status, ages 25 to 65 years old) can be developed to elicit more diverse and comprehensive feedback about the various types of stressors women of Arab descent face while living in the U.S., resources that are needed (e.g., mental health, access to care, financial, educational, support groups), strengths related to identifying as a woman of Arab descent, and other information relevant to the development of the curriculum. The interviews conducted in the focus group allow the research investigator to become closer to the research question, in this case, understanding the unique stressors that Arab American women face, while also strengthening the relationship with the participants (Vaughn, Schumm & Sinagub, 1996). As mentioned previously, recruitment of participants was challenging during this study due to barriers such as language differences, mistrust regarding perpetuating stereotypes and exploitation, and cultural differences (Dutton, 2003; Jaber, 2003; Keller et al., 2005). However, through focus groups, the facilitator's relationship with the participants and the group dynamics that unfold can be an asset to facilitating increased and more in-depth responses, and provide opportunities for the women to elaborate and clarify their responses (Vaughn, Schumm & Sinagub, 1996). Lastly, through the group format, women receive social support from other members in the community further encouraging more discussion around specific topics and providing an opportunity for the women to have shared experiences (Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013; Vaughn, Schumm & Sinagub, 1996). Lastly, the proposed stress management techniques in the curriculum can be implemented in the focus group to further elicit feedback (e.g., pre and post measures of stress

reduction) from the women about the effectiveness of the stress management exercises. This can also help strengthen the use of the proposed exercises and/or identify weakness in those exercises thus informing ways to refine the curriculum for better effectiveness.

Conclusion and Implications of this Study

The curriculum was developed to guide and implement a one day workshop to inform mental health professionals currently working with, or interested in working with, Arab American women. The curriculum focuses on various stressors experienced by that population, psychoeducational information regarding immigration, acculturation and identity development, and culturally congruent treatment considerations and well-being for that group. The development of the curriculum was intended to be responsive to the existing literature suggesting a need to target specific stressors that women of Arab descent living in the United States (Aroian et al., 2010; Erickson & Al-Timimi, 2001; Nobles & Sciarra, 2000; Norris et al., 2011). The curriculum was evaluated by two current psychologists who offered strengths, weaknesses and suggestions for improvement. All of the responses and comments were reviewed and are considered for inclusion in future versions of the curriculum. It is hoped that this initial curriculum can serve as a foundation for developing workshops to help mental health professionals gain more education on the Arab culture and specific stressors that women of Arab descent living in the U.S. face and enhance their skills and knowledge on more on culturally syntonic stress management techniques that can be provided. Various community mental health centers, hospitals, treatment centers, academic centers and/or cultural centers could use this curriculum to conduct workshops for mental health professionals working with or interested in Arab American women in an effort to increase awareness, knowledge, skills and to promote culturally syntonic interventions used in mental health treatment. Furthermore, Arab Americans

have been continuously labeled as the 'invisible' racial and ethnic group (Naber, 2000), further

indicating a need to enhance the cultural understanding of this particular population and the

overall cultural competence of mental health professionals working with this population. More

specifically, the content included in the curriculum responds to the greater need for culturally

competent health care to address mental and physical health disparities related to racial and

ethnic minority status, socioeconomic status, immigrant status, language barriers, gender

differences, and access to care (L. Anderson, Scrimshaw, Fullilove, Fielding & Normand, 2003)

In addition to the above, this curriculum was developed in order to continue to bring awareness

about a minority population (e.g., Arab American women) that continues to grow in size in the

United States.

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APPENDIX A

Preliminary Brief Questionnaire Interview

APPENDIX A

Preliminary Brief Questionnaire Interview

For Immigrant Status Women:

1. Where did you immigrate from? How long have you been residing in the United States for?

2. What were some of the difficulties you faced while immigrating to the U.S.?

3. How do you identify yourself? Age? Ethnic-Cultural Identity? Religion? Sexual Orientation? Relationship? Children?

4. What are your most important values? Have you experienced any conflict between your cultural values and American values? (please describe) If yes, how have you negotiated your cultural values with American values?

5. How do you understand the experience of stress within your country of origin? What kinds of stressors do women from your country (living in the USA) experience?

6. How is distress (e.g., pain, suffering, concerns) expressed? What do people from your country of origin do to manage distress (e.g., pain, suffering, concerns)?

7. What are some of the advantages and disadvantages for you regarding residing in the U.S?

8. Now that you live in the United States, can you identify some of your stressors that you believe are unique to being an Arab American woman?

9. How have you coped?

10. What support do you feel you need to help manage any stress that you experience as an Arab American woman?

11. What have been some of the difficulties while adjusting to the American lifestyle?

12. How much do you feel you've adjusted to living in the U.S? What about to the American culture?

13. What are some of the challenges of being an Arab woman living in America?

14. Anything else you would like to suggest for mental health clinicians working or hoping to work with women of Arab descent living in the United States?

15. What are some strengths of being a woman of Arab descent with immigrant status living in the United States?

APPENDIX B

Preliminary Brief Questionnaire Interview

APPENDIX B

Preliminary Brief Questionnaire Interview

For First Generation Status Women:
1. How do you identify yourself? Age? Ethnic-Cultural Identity? Religion? Sexual Orientation? Relationship? Children?

2. Where are your parents from? Have you ever visited the country?

3. What are your most important values? Have you experienced any conflict between your cultural values and American values? (please describe) If yes, how have you negotiated your cultural values with American values?

4. How do you understand the experience of stress within the United States? What kinds of stressors do women from your family's country experience?

5. How is distress (e.g., pain, suffering, concerns) expressed? How have you managed distress (e.g., pain, suffering, concerns)?

6. What are some of the advantages and disadvantages of residing in the United States?

7. What are some stressors that you believe are unique to Arab American women?

8. How have you coped?

9. What support do you feel that you need to help manage any stress that you experience as an Arab American woman?

10. What mental health resources do you feel you need as an Arab American woman?

11. Have you had difficulties balancing your Arab culture with the American culture? If so, what were the difficulties?

12. What are some of the challenges you have faced as an Arab American woman?

13. Anything else you would like to suggest for mental health clinicians working or hoping to work with women of Arab descent living in the United States?

14. What are some strengths of being a woman of Arab descent living in the United States?

APPENDIX C

Preliminary Participant E-mail Script

APPENDIX C

Preliminary Participant E-mail Script

Dear (Potential Participant):

My name is Hoda Abou-Ziab and I am a doctoral student of clinical psychology at Pepperdine University. I am contacting you to determine whether you would be willing to complete an online questionnaire about being woman of Arab descent living in the United States. I am developing a workshop for mental health clinicians working or hoping to work with women of Arab descent living in the United States to reduce stress. The curriculum for this workshop is part of my dissertation research.

I am conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop curriculum for a one-day workshop for mental health clinicians working or hoping to work with women of Arab descent living in the United States to ensure culturally congruent approaches to stress reduction. At this point in the project, I am seeking participants who are immigrants or first generation women of Arab descent living in the United States to assist me.

If you decide to participate, I will e-mail you an informed consent and online questionnaire to complete. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. If this is something that you are interested in doing, please reply to this email. If you are not interested in participating and/or know any other women of Arab descent living in the United States who may be interested in participating in this study, please provide them with my contact information: ███████████████████████████. Furthermore, if you know of any agencies that meet the above-mentioned criteria, please also provide them with my contact information as well.

Thank you sincerely for taking the time to read this email and consider my request. If you have any additional questions regarding my research project, feel free to contact me, Hoda Abou-Ziab, M.A., or Shelly Harrell, Ph.D (███████████████████████).

Sincerely,
Hoda Abou-Ziab, M.A.
████████████████████████

APPENDIX D

Agency E-mail Script

APPENDIX D

Agency E-mail Script

Dear (Director of Agency):

My name is Hoda Abou-Ziab and I am a clinical psychology doctoral student at Pepperdine University. I am contacting you to determine whether your agency would be willing to assist me with my dissertation research by providing me with a list of women of Arab descent living in the United States of either 1st generation or immigrant status. I am conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. This study aims to develop a one-day workshop training for mental health clinicians that focuses on the treatment of women of Arab descent living in the United States experiencing significant distress.

The initial stage of the project consisted of an extensive review of the literature regarding stress faced by women of Arab descent as well as research relevant to treatment and cultural considerations while working with women of Arab descent. This information will be integrated and compiled for inclusion into the development of the manual. I am now in the process of recruiting three women of Arab descent to collect additional information pertaining to resources available to women of Arab descent living in the United States for stress reduction, resources they would like to see implemented in mental health services, and other information relevant to the development of one-day workshop for mental health clinicians working with women of Arab descent living in the United States..

If your agency agrees to assist with the study, I will ask you to provide your female members with my contact information ███████████████████████████. Your agency's participation in this study is completely voluntary. If you are willing to participate, please complete and return the attached form authorizing me to reference that I have received permission from your agency.

Thank you very much for taking the time to read this email and consider my request. If you have any additional questions about my research, feel free to contact me, the research investigator, Hoda Abou-Ziab, M.A., or Shelly Harrell, Ph.D (████████████████████)

Sincerely,
Hoda Abou-Ziab, M.A.
███████████████████████

APPENDIX E

Recruitment Flyer: Flexible (Subject to Change)

Recruitment Flyer: Flexible (subject to change)

APPENDIX F

Assessing Eligibility for Women of Arab Descent Participants

APPENDIX F

Assessing Eligibility for Women of Arab Descent Participants

1. How do you identify yourself?   ❑Female   ❑ Male   ❑ Other_____

2. Are you a first generation Arab American?   ❑Yes❑ No

3. Did you immigrate to the United States?   ❑Yes❑ No

4. If yes, when and from where did you immigrate?

   _____

5. Do you currently reside/live in the United States of America (USA)?   ❑Yes❑ No

6. Are you between the ages of 25 to 65 years old?   ❑Yes❑ No

7. How old are you?

   _____

8. Have you in the past or are you currently experiencing stress (i.e., family problems, financial issues, employment/unemployment, adjusting to American culture, emotional issues, relationship difficulties, parenting difficulties, etc.) in your life?
      ❑Yes❑ No

9. Which Arab ancestry to identify with the most: ❑ Lebanon, ❑ Syria, ❑ Egypt, ❑ Iraq, ❑ Jordan, ❑ Palestine, ❑ Morocco, ❑ Algeria, ❑ Bahrain, ❑ Djibouti, ❑ Kuwait, ❑Libya, ❑ Oman, ❑ Qatar, ❑ Saudi Arabia, ❑ Tunisia, ❑ United Arab Emirates, and ❑ Yemen? ❑ Other_____

APPENDIX G

Participant Consent Form

Participant Consent Form

PEPPERDINE UNIVERSITY

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

Development of a Training Workshop for Mental Health Professionals to Address Stress and Well-Being among Women of Arab Descent Living in the United States

You are invited to participate in a research study conducted by Hoda Abou-Ziab, M.A. and Shelly Harrell, Ph.D., at Pepperdine University, because you are a woman of Arab descent living in the United States between the ages of 25 to 65 years old. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for your records.

PURPOSE OF THE STUDY

The purpose of the study is to develop a one-day workshop for mental health clinicians working or hoping to work with women of Arab descent living in the United States in further assisting with culturally congruent stress management techniques.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to complete a questionnaire regarding your experiences as a woman of Arab descent living in the United States, the stressors you have experienced, and how you have coped with them. Your participation in this study will last approximately 30 to 60 minutes, which will consist of an online interview.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study are minimal, but may include mild levels of boredom during the interview and/or experiencing increased levels of stress as a result of discussing the topic. In addition, you have the right to not answer any particular question and may withdraw from the study at any time without penalty. In the event that you experience discomfort or stress during the interview you will be encouraged to take

breaks, discuss the discomfort with the interviewer, and/or will be provided with necessary referrals for support if needed.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society that include contributing to the development of a workshop addressing well-being and stress of women of Arab descent living in the United States.

CONFIDENTIALITY

Your records for this study are confidential as far as permitted by law. However, if required to do so by law, your information may be disclosed. Under California law, an exception to the privilege of confidentiality includes but is not limited to the alleged or probable abuse of a child, physical abuse of an elder or a dependent adult, or if a person indicated she/he wishes to do serious harm to self, others, or property

The data collected for this study will be stored on a password-protected computer in the principal investigator's place of residence for three years after the study has been completed and then destroyed. Any identifiable information obtained in connection with this study will remain confidential. Your responses will be coded with research subject numbers to match screening questionnaire responses to interview responses. Your name, address or other identifiable information will never be paired with any research document, nor will such personal information be stored or saved.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items with which you feel comfortable.

INVESTIGATOR'S CONTACT INFORMATION

The investigator, Hoda Abou-Ziab, M.A., ████████████████████████, is willing to answer any inquiries you may have concerning the research herein described. You may also contact Shelly Harrell, Ph.D., ███████████████; 310-568-5600 **i**f you have any other questions or concerns about this research

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____   _____

Signature of Participant   Date

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

_____

Name of Person Obtaining Consent

_____   _____

Signature of Person Obtaining Consent   Date

APPENDIX H

Evaluator's E-mail Script

Evaluator's E-mail Script

Dear (Potential Participant):

My name is Hoda Abou-Ziab and I am a doctoral student of clinical psychology at Pepperdine University. I am contacting you to determine whether you would be willing to review a curriculum for a one-day workshop I am developing for mental health clinicians working or hoping to work with women of Arab descent living in the United States in regards to stress reduction and management, as well as answer a few questions regarding the curriculum. This workshop is part of my dissertation research.

I am conducting my dissertation research under the supervision of Dr. Shelly Harrell, a professor at Pepperdine University. The overall purpose of this research project is to develop curriculum for a one-day workshop for mental health clinicians working or hoping to work with women of Arab descent living in the United States to ensure culturally congruent approaches to stress reduction. At this point in the project, I am seeking experts in the field of stress, women, and/or Arab Americans to review the curriculum and respond to a brief questionnaire regarding their perceptions of the curriculum/workshop through an online questionnaire.

If you decide to participate in this study, I will e-mail you a copy of my curriculum with an informed consent. Your input in this project will be strictly confidential and you are under no obligation to complete the study at any time. If this is something that you are interested in doing, please reply to this email. You may also respond to the questions within the body of the email if that is more convenient.

Thank you sincerely for taking the time to read this email and consider my request. If you have any additional questions regarding my research project, feel free to contact me, Hoda Abou-Ziab, M.A., or Shelly Harrell, Ph.D (███████████████████).

Sincerely,
Hoda Abou-Ziab, M.A.
████████████████████████

APPENDIX I

Evaluator Consent Form

Evaluator Consent Form

PEPPERDINE UNIVERSITY

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

A Training Workshop for Mental Health Professionals to Address Stress and Well-Being among Women of Arab Descent Living in the United States

You are invited to participate in a research study conducted by Hoda Abou-Ziab, M.A. and Shelly Harrell, Ph.D., at Pepperdine University, because of your expertise in acculturation or immigration stress, women and/or women of Arab descent. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for your records.

PURPOSE OF THE STUDY

The purpose of the study is to develop a one-day workshop for mental health clinicians working or hoping to work with women of Arab descent living in the United States in further assisting with culturally congruent stress management techniques.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be asked to review the proposed workshop curriculum based on your expertise in acculturation or immigration stress, and/or women of Arab descent, and to respond to a brief questionnaire regarding your perceptions of the curriculum/workshop through an online interview. Your participation in this study will last approximately 60 to 90 minutes, which will consist of an online interview.

POTENTIAL RISKS AND DISCOMFORTS

The potential and foreseeable risks associated with participation in this study are minimal, but may include mild levels of boredom during the interview and/or experiencing increased levels of stress as a result of discussing the topic. In addition, you have the right to not answer any particular question and may withdraw from the study at any time without penalty. In the event

that you experience discomfort or stress during the interview you will be encouraged to take breaks, discuss the discomfort with the interviewer, and/or will be provided with necessary referrals for support if needed.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society that include contributing to the development of a workshop addressing well-being and stress of women of Arab descent living in the United States.

CONFIDENTIALITY

Your records for this study confidential as far as permitted by law.

The data will be stored on a password-protected computer in the principal investigator's place of residence for three years after the study has been completed and then destroyed. Any identifiable information obtained in connection with this study will remain confidential. Your responses will be coded with research subject numbers to match screening questionnaire responses to interview responses. Your name, address or other identifiable information will never be paired with any research document, nor will such personal information be stored or saved.

PARTICIPATION AND WITHDRAWAL

You may withdraw your consent at any time and discontinue participation without penalty.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items with which you feel comfortable.

INVESTIGATOR'S CONTACT INFORMATION

The investigator, Hoda Abou-Ziab, M.A., ███████████████████████████, is willing to answer any inquiries you may have concerning the research herein described. You may also contact Shelly Harrell, Ph.D., ███████████████████ 310-568-5600 **i**f you have any other questions or concerns about this research

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

_____

Name of Participant

_____   _____

Signature of Participant   Date

SIGNATURE OF INVESTIGATOR

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

_____

Name of Person Obtaining Consent

_____   _____

Signature of Person Obtaining Consent   Date

APPENDIX J

Evaluator Eligibility Form

APPENDIX J

Evaluator Eligibility Form

1. What is the highest degree you have earned?   ❑Masters   ❑ Doctorate

2. What discipline is your degree in?

_____

3. What type of license do you have?

❑ Psychology (Psy.D.,Ph.D.)   ❑ Marriage Family Therapy (MFT)   ❑Clinical Social Work (LCSW)

4. Do you have at least 5 years of post-graduate experience working with individuals of Arab descent?
❑Yes❑ No

5. If yes, how many years of post-graduate experience do you have working with individuals of Arab descent?

_____

6. How many years of post-graduate experiences do you have working *specifically* with women of Arab descent living in the United States?

_____

APPENDIX K

General Mental Health Evaluator Eligibility Form

APPENDIX K

General Mental Health Evaluator Eligibility Form

1) What is the highest degree you have earned?   ❑Masters   ❑ Doctorate

2) What discipline is your degree in?

   _____

3) What type of license do you have?

   ❑ Psychology (Psy.D.,Ph.D.)   ❑ Marriage Family Therapy (MFT)   ❑ Clinical Social Work (LCSW)

4) Do you have at least 10 years of clinical work or counseling experience working with immigrant populations and/or 1st generation individuals?
   ❑Yes❑ No

APPENDIX L

Assessment of Curriculum

APPENDIX L

Assessment of Curriculum

1. The curriculum is thorough and provides adequate information on how to work with women
of Arab descent living in the United States.

      1   2   3   4   5
      Strongly   Strongly
      Disagree   Agree

2. The curriculum is thorough and provides adequate information regarding the stressors that are
unique to women of Arab descent living in the United States.

      1   2   3   4   5
      Strongly   Strongly
      Disagree   Agree

3. The curriculum is easy to read and understand.

      1   2   3   4   5
      Strongly   Strongly
      Disagree   Agree

4. The curriculum is well organized.

      1   2   3   4   5
      Strongly   Strongly
      Disagree   Agree

5. The curriculum provides adequate guidelines for mental health clinicians working or hoping
to work with women of Arab descent living in the United States.

      1   2   3   4   5
      Strongly   Strongly
      Disagree   Agree

6. The curriculum directly addresses the stated purpose of the workshop.

      1   2   3   4   5

Strongly   Strongly
Disagree   Agree

7. The learning activities in the curriculum seem appropriate and sufficient for a workshop.

    1   2   3   4   5
    Strongly   Strongly
    Disagree   Agree

8. This is a program that mental health professionals will realistically be able to access.

    1   2   3   4   5
    Strongly   Strongly
    Disagree   Agree

9. What do you consider to be the strengths of the curriculum?

    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

10. What do you consider to be the weaknesses of the curriculum?

    _____
    _____
    _____
    _____
    _____
    _____
    _____

11. What are some suggestions of stress-reduction/management interventions that are culturally
appropriate for women of Arab descent living in America?

    _____
    _____
    _____
    _____
    _____

Please provide any other suggestions for improving this intervention guide.

_____

_____

_____

_____

_____

_____

_____

_____

Additional comments:

_____

_____

_____

_____

_____

_____

_____

Thank you for your time!

APPENDIX M

Curriculum for Mental Health Professionals

A Training Workshop for Mental Health Professionals:

Addressing Stress and Well-Being among Women of Arab Descent Living in the United States

Section 1: Introductions and Purpose of Workshop

Welcome!

Icebreaker

> Read instructions aloud: [*Please break into pairs and take a few minutes to interview each other. Each interviewer will need to find and remember three interesting facts about their partner. Then we will reconvene into our bigger group*]
>
> [Being mindful of the time, bring back everyone together and have the partners present the three interesting facts that they learned about their partner to the rest of the group]
>
> > ***Depending on the number of participants, facilitator can choose whether he or she would like to do an icebreaker, or to modify the activity by changing the time accordingly and/or changing the number of interesting facts required.

Introductions

> [Encourage individuals to share his/her name, where he/she is from, his/her experience working with Arab American women, what he/she would like to learn from this workshop today]
>
> > ***Depending on time and the number of participants, facilitator can choose how and if he or she would like to modify this activity.

Review Objective: *Appendix A

Roadmap: "agenda:" *Appendix A

Objective: Today's workshop is meant to facilitate an atmosphere of learning and engagement around issues regarding mental health and wellbeing that women of Arab descent face while living in the United States. More specifically, this workshop will address the various stressors, coping mechanisms, strengths and barriers relevant to this population. Mental Health professionals will have access to additional resources and are encouraged to continue to deepen their understanding of stress and wellbeing related to women of Arab descent living in the United States.

<u>Roadmap:</u> 5 to 7 hours (flexible)

1. Introductions and Purpose of Workshop (30-45 minutes)
2. Understanding Stress and Women of Arab Descent Living in the United States (60 minutes)
3. Discussion of Historical Events and Current Issues Relevant to Women of Arab Descent Living in the United States, (60-90 minutes)
4. Identifying Stressors experienced by Women of Arab Descent Living in the United States (60 minutes)
5. Examples of Culturally-Syntonic Stress Management Activities and Coping Skills Building (60 minutes)
6. Provide Additional Resources (10 minutes)
7. Networking (30 min-60 minutes)

Section 2: Understanding Stress and Women of Arab Descent Living in the United States
(60 minutes)

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Group Activity #1: Discussion

Below is background information on stress, gender and stress, stress response, coping and social support. Please feel free to use the material in any way that seems relevant and effective for the workshop (e.g., PowerPoint, create a handout, visual diagram, formulate a game).

[Begin by asking participants to define stress and share his/her understanding of how it is related to gender and the types of coping styles]

- What is stress?
- What is a stressor?
- Does gender effect stress? How so?
- What are some effects of stress?
- What type of coping styles are you familiar with?

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Stress: Stress, a widely used term, can be defined as a person-environment transaction that an individual appraises as being personally salient and places demands on the individual that tax or exceed his/her resources to efficiently cope (Lazarus & Folkman, 1984; Folkman, 2010). It has also been referenced in literature when discussing an individual's physiological reaction to a response in addition to when an individual's well-being or survival is threatened (Kemeny, 2003; Lucassen et al., 2014). Specific to this dissertation study, the term *stress* will refer to the cumulative "cognitive, emotional, behavioural and physiological responses to a stressor" (Clark, Bond, & Hecker, 2007, p. 18).

Stressor is a term commonly used to explain the various incidents, circumstances, and roles in an individual's life that elicits a stress response which can impact different areas of life including occupation, school, personal and professional relationships (e.g., partners, children, relatives, supervisors), finances, chronic illness, caregiving responsibilities, discrimination and periods of bereavement (APA, 2013; Boss, 2011; Clark, Anderson, Clark, & Williams, 1999; Clark et al., 2007; Harrell, 2000; Lucassen et al., 2014; Mendenhall et al., 2012; Shah, Trivedi, Diwan, Dixit, & Anand, 2009). Stress can tbe present in various forms ranging from daily experiences (e.g., commuting to work) to chronic conditions (e.g., caregiving for an elder, domestic violence in a partnership). Of note, life transitions,

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including immigration and issues of acculturation, menopause, and new parental roles can also trigger significant stress responses for individuals. Lastly, past or current traumatic events (e.g., natural disasters, exposure to violence) can also become stressors for individuals further increasing a stress response. Stressors occur in various contexts, such as family, occupation, and relationships can exacerbate stress and contribute to negative health outcomes (Au, Chan, Cheung, Yuen, & Lee, 2008; Tausig & Fenwick, 2001; Tennant, 2002). Additionally, excessive demands and/or stress in one context or role can interfere with and affect life in another context or role (Klitzman et al., 1990).

Gender and Stress: Gender is embedded in everyday life, including stereotypes related to emotional expression, relational style, temperament, cognitive abilities, and roles within the family and in society. Gender is a construction of personal experiences and social expectations associated with being male or female in any group or culture (Cosgrove, 2003; Deaux & Major, 1987; Stewart & Dottolo, 2006;). Stereotypic male-female imbalances result from power asymmetries which is seen across age, class, color, ethnicity, religion and sexual orientation (Worell & Goodheart, 2005). Women at a young age are culturally expected to assume the role of caretaker for the feelings and welfare of others, oftentimes resulting in difficulties expressing their own feelings, thoughts or preferences (Dedovic et. al., 2009; Pomerantz & Ruble, 1998; Worell & Goodheart, 2005). This can lead to gender intensification, resulting in increased role strain in interpersonal relationships, stress, chronic low self-esteem, and body-image disorders (Dedovic et. al., 2009; Pomerantz & Ruble, 1998; Worell & Goodheart, 2005). Socioeconomic status, in addition to ethnicity and gender, has contributed to increased risk for physical and mental health conditions for women (Fredrickson & Roberts, 1997; Moradi & Huang, 2006; Worell & Goodheart, 2005). Women continue to make less money than men in the workplace and have a higher likelihood of living in poverty. Across all cultures, gender appears to be a variable that has critically influenced individuals throughout the lifespan. More specifically, gender roles have created social expectations, influenced and shaped behaviors, and illuminated gender differences. Familial socialization has been shown to be the most influential in shaping the child's gender learning and perception of gender roles (Casey, Brabeck, & Nuttall, 1995; Jenkins, 2013; Whiting & Edwards, 1998).

Stress Response: The fight, flight, freeze or faint response is triggered when the homeostasis of an individual's body is threatened by a stressor (Bracha, 2004; Kolb & Whishaw, 2014). According to recent literature, the fight, flight, freeze, fright and faint response appears to be a more complete depiction of the stress response that humans engage in (Bracha, 2004). However, more specific to women, Taylor and colleagues (2000) have shown that women tend to adopt a "tend-and-befriend" reaction to stress, which has evolved and become more favorable to protecting the self and the offspring. It is suggested that behaviors that protect offspring and reduce neuroendocrine responses that can

jeopardize the health of their offspring are more common for women (Taylor et al., 2000). Females are documented to have a higher release of oxytocin than men in response to threat which has a bidirectional effect in that it promotes nurturing behaviors that enhance physical contact with offspring and subsequently enhances the flow of oxytocin - the increased oxytocin has a calming effect and ameliorates the arousal response (Taylor et al., 2000).

Additionally, when faced with a stressor, the homeostasis of an individual's body is challenged and she is triggered into a state of arousal (i.e., fight, flight, fright, freeze or faint; Bracha, 2004; Kolb & Whishaw, 2014). This results in the arousal of two endocrine response systems, the hypothalamic-pituitary-adrenocortical axis (HPA) and the sympathetic-adrenal-medullary (SAM) system (Cohen, Janicki-Deverts, & Miller, 2007). The mediating effects of stress on illness and disease through the engagement of the SAM and HPA systems are well documented in research with both humans and animals (Cohen, Janicki-Deverts, & Miller, 2007). Repeated and chronic activation of the HPA and SAM systems can compromise their ability to govern other physiological systems and ultimately result in an increase in risk for both physical and psychiatric disorders (Cohen, Janicki-Deverts, & Miller, 2007).

Coping and Social Support: Research on the stress process frequently includes attention to mediators of the relationship between stressors and health outcomes (Benson, 2008; Carlson, Speca, Faris, & Patel, 2007; Ghoncheh & Smith, 2004; Hall & Long, 2009; Harrell, 2000; Ludwig & Kabat-Zinn, 2008). Coping and social support are among the most frequently studied mediator variables. Taylor and colleagues (2000) postulate that there are significant physiological effects of social support which includes increased nurturing behaviors that enhance hormonal factors (i.e.oxytocin) which alleviate the negative effects of stress (Taylor et. al., 2000). Coping can be defined as a way of changing the experience of psychological stress within a disadvantageous environment through managing external and/or internal demands that are perceived to be dangerous to one's well-being (Bauman, Haaga, & Dutton, 2008; Lazaraus, 1993; Lazaraus & Folkman, 1984). According to Lazaraus and Folkman (1984), coping is understood as a shifting process that includes continuous appraisal and reappraisal of stressful situations in the environment or directed inward to change the meaning of an event or the way an individual understands the event. Lazarus and Folkman initially divided coping into two types: emotion-focused and problem-focused forms of coping (Carver, Scheier, & Weintraub, 1989; Chao, 2011; Lazarus & Folkman, 1984).

Lastly, individuals and families that have immigrated to the United States have successfully utilized active coping in the face of acculturative stress (Torres, 2010). Active coping involves individuals relying and accessing their knowledge and strengths in managing

cultural tasks and various negative circumstances successfully (Torres, 2010). More importantly, active coping seems to be a catalyst for individuals experiencing acculturative stress, especially women, including seeking social support, developing relationships, solving problems and engaging in social interactions (Hobfoll & Schroder, 2001; Torres, 2010).

Emotion-focused Coping: Emotion-focused forms of coping emphasize modifying the way one interacts with the environment to manage the experience of stress, or the relational meaning of a stressful situation, without changing the actual situation (Bauman et. al 2008; Lazarus & Folkman, 1984). Some research suggests that emotion-focused coping is more common among women than men (Bagherie-Nesami, Raffi, & Oskouie, 2010; Bellman, Forster, Still, & Cooper, 2003; Long, 1989; Martire, Stephens, & Townsend, 1998; Matisse, 2002. These strategies include "...avoidance, minimization, distancing, selective attention, positive comparisons, and wresting positive value from negative events" (Lazarus & Folkman, 1984, p. 150). Some individuals can also engage in self-blame or other forms of self-punishment to relieve their distress (Lazarus & Folkman, 1993). Lazarus & Folkman (1984) further incorporate cognitive reappraisals, instances where an individual changes the meaning of a situation without changing it objectively, as part of the coping process and is thus targeted to regulate emotions (Chao, 2011; Lazaraus & Folkman, 1984). Varied literature suggests that although emotion-focused coping, specifically social support, is correlated with decreased levels of stress, some studies have indicated that stress outcomes may be exacerbated due to unhealthy social relationships (Bellman, Forster, Still, & Cooper, 2003;Sabina & Tindale, 2008; Turner-Cobb et. al., 2002). Securely attached individuals tend to perceive and seek higher levels of emotional support whereas insecurely attached individuals avoid interpersonal interactions and social connections. Furthermore, positive social interactions may enhance mood; however, negative social relations form insecure attachments can result in decreases in mood and increased stress (Bellman, Forster, Still, & Cooper, 2003;Sabina & Tindale, 2008; Turner-Cobb et. al., 2002). However, Folkman and Lazarus (1988) suggest that individuals generally use both types of coping, and the predominant coping style is determined by the individual's personal style and the stressful situation.

Problem-focused Coping: Problem-focused coping strategies focus on eliminating or reducing stress through identifying and defining a problem, as well as creating alternative solutions through problem-oriented strategies (Lazarus & Folkman, 1984). Two types of problem-coping strategies include confrontive coping and planful problem-solving (Folkman & Lazarus, 1988). Confrontive coping entails directly dealing with the problem or issue using aggressive efforts or risk-taking, such as, "I stood my ground and fought for what I believe in" (Chao, 2011; Folkman & Lazarus, 1988; Kaiser & Miller, 2004). On the other hand, planful problem-solving incorporates deliberate problem-focused strategies to

alter the situation, such as "I doubled my work and efforts because I knew I had to get it done" (Folkman & Lazarus, 1988; Mahat, 1997). Studies have shown that problem-focused coping increases self-efficacy and self-esteem across individuals (Chao, 2011; Holahan & Moos, 1987). Furthermore, it has been associated with decreased hopelessness amongst women in abusive relationships (Clements & Sawhney, 2000; Sabina & Tindale, 2008). Additionally, social support has been seen to result from problem-focused coping strategies and promotes adaptive coping strategies that increase self-confidence and promote health (Chao, 2011; Holahan & Moos, 1987; Lazarus & Folkman, 1984; Sabina & Tindale, 2008).

Meaning-making Coping: Coping has been shown to be an important mediator between stressful events and improved quality of life experiences (Lazarus & Folkman, 1984; Manning-Walsh, 2005; Park, 2005). The role of meaning-making as a coping strategy has been examined most commonly in association with trauma or extreme stress. Literature suggests meaning-making has impacted trauma survivors by influencing personal growth through cognitive adaptations (Ching, Martinson, & Wong, 2012; Kashdan & Kane, 2010; Park, 2005). Meaning-making coping strategies serve as a mediator between increased experiences of stress and physical health outcomes (Koltko-Rivera, 2004; Park 2010; Park 2005; Manning-Walsh, 2005). More specifically, post-traumatic growth, which results from a positive adjustment to an individual's experience, helps rebuild the life changing event that was experienced (Kashdan & Kane, 2010; Tedschi & Calhoun, 1996). Individuals will then often develop a greater appreciation for life, increased close relationships, recognition of personal strengths, increased sense of self, and at times, spiritual development (Kashdan & Kane, 2010). Studies have also shown that recovery from trauma can be facilitated through behaviors directed towards meaning-making aims instead of solely on the regulation of emotions (Batten, Orsillo, & Wasler, 2005; Kashdan & Kane, 2010).

Social Support: Shared experiences, another type of social support and emotion-focused coping strategy, have been seen to improve physical health outcomes and decrease feelings of isolation (Kim, Valdimarsdottir, & Bovbjerg, 2002; Manning-Walsh, 2005). Furthermore, through relational interactions, patients have demonstrated an alleviation of physical symptoms (i.e., decreased blood pressure, decreased heart rate, etc.) as well as an increased sense of collecting additional coping strategies (Abdou, Dunkel, Campos, Hilmert, Dominguez, Hobel, Glynn, Sandman, 2010; Manning-Walsh, 2005). Social support is also seen as satisfying attachment needs, increasing a sense of self-worth, increasing psychological well-being and providing direction for individuals (Chambers, Ryan, & Connor, 2001; Klienke, 1991; Martire et al., 1998). More specifically, the literature suggests that social and emotional support increases overall emotional well-being for caregivers, including decreasing feelings of loneliness and isolation (Chambers et al., 2001; Greenberg, Seltzer, Kraus, & Kim, 1997). Additionally, emotional support has been shown to help decrease the stress burden for women who have multiple family and work roles and

experience increased demands on time and energy from these roles (Martire et al., 1998). As a result, a decrease in depressive symptomatology, anxiety and role strain has been linked to increased social and emotional support for women (Bagheri-Nesami et al., 2010; Martire et al., 1998). Additionally, women with higher communalism appear to have better emotional health than those who have lower communalism (Abdou et. al., 2010). Literature also suggests that collectivist cultures tend to develop more stable social relationships which have been shown to contribute to overall higher subjective well-being (Ahuvia, 2002; Chamber et al., 2001; Klienke, 1991; Martire et al., 1998). This is highlighted with immigrant cultural groups facing acculturative stressors such as, participating with the mainstream culture, separation versus assimilation, language barriers, gender-role reversals, occupational changes, and loss of family ties (Berry, 2005; Torres, 2010; Wrobel, Farrag, & Hymes, 2009). Social support as a form of active coping has effectively helped individuals across all cultures manage stressful situations and improve overall well-being.
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Group Activity #2: Case Example-Mona

[Instructions to read aloud: *Now that we have a good understanding of stress in general, let us learn about our target population: women of Arab descent living in the U.S./Arab American women. We will be going over specific stressors that Arab American women face later on in the workshop*]

[Instructions to read aloud: *Let's start with a case example. Instructions to read aloud: Please split into groups* (2, 3, 4 people in one group depending on number of participants) *and take a few minutes to read the vignette and discuss pertinent issues that may come up while seeing Mona in therapy*]

Mona's arrival to the United States (Appendix B)

Mona emigrated to the U.S. from Jordan when she was 18 years old with her husband. She did not complete a highs school education, instead, she was encouraged to get married and have children. She had mixed feelings about her new husband, Bassam and her responsibilities towards him. She expressed sadness around not completing her educations as she had always dreamed of being a nurse. Bassam brought her to Los Angeles, a city that was completely foreign to her and a place where she did not know anyone. She left behind her parents, six siblings, best friends and extended family. She spent several hours every day FaceTiming with her family, which made the distance harder to handle as she noticed that would miss them more after the

conversations ended. Mona also found herself learning how to cook, clean, and do laundry all by herself. Bassam would come home every night expecting dinner to be ready. Mona noticed that was finding herself trying to connect with her husband, but he was always tired after work and chose to watch T.V. instead of socialize with her. Eventually, she became pregnant with her first child. Her mother was unable to leave Jordan because she was not given a visa, so Mona found herself alone through this pregnancy. Bassam's mother stayed with them for three months after the birth of their child; however, Mona felt that she was constantly being criticized and judged for everything she was doing "wrong." The little moments she had to herself, she would spend fantasizing about the life she had always dreamed for herself, receiving a degree for nursing, working at a hospital, falling in love with a doctor at the hospital, getting married and having children in Jordan while living near her family. Realizing that she was far away from this dream, Mona became more and more isolated and withdrawn. She was able to fulfill her duties as a mother, but as soon as Bassam came home and could watch their son, she would cry herself to sleep and spent most of the time in bed. During one of her post-natal appointments with her gynecologist, she was given a PHQ-9 and scored 19 (moderately severe). The gynecologists further assessed her depressive symptoms and made a referral for her to see a psychologist. However, Mona, panicked and said that she would not be able to share this with her family because they would think she was "crazy" and that she wasn't "fit to be a mother."

[Read aloud: *Now, imagine that you have received the referral and will be scheduling an intake with Mona in the upcoming days. What are some important things to consider while working with Mona?]*

[Instructions to facilitate a discussion with participants: *Which group would like to go first to discuss some issues they would consider or that they would anticipate while working with Mona? Continue to ask groups to share their discussion points.]*

[Facilitator may use a white board/poster board/chalk board to write out important points participants share]

[Below is a list of questions to further generate a discussion around Mona before providing background information about Arab American women]

Discussion questions: *Appendix C

1. What are some assumptions you might make about Mona based on her demographics?
2. To what extent, if any, do you believe that other members should be involved in Samar's therapeutic treatment? Which family members? How so?
3. What stereotypes may be supported or challenged from this case?
4. What are some of your personal reactions that you had while reading this case study?
5. Are there other areas you would like to assess further? If so, which areas and why?
6. What do you anticipate are Mona's strengths? How can her strengths be used/highlighted in session?
7. What are some challenges you can anticipate in your work with Mona?
8. What are other cultural/diversity issues that you should be aware of?

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Arab American Women:

- ***"Hot Topics": consist of themes that may come up around these specific topics during therapy.***

The vast immigration experiences and sociopolitical history between the Western and Arab world has shaped the development of Arab identities in the United States. (Abboud et al., 2015; Erickson, & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013). The continued interactions between the traditional homeland and new homeland have also shaped the way Arab Americans perceive themselves and how others have portrayed them (El-Aswad, 2010; Abboud et al., 2015; Nassar-McMillan et al., 2013). More specifically, family, religion, ethnicity, sexuality, gender, politics and immigration experiences have greatly influenced their lives (Abboud et al., 2015; Nassar-McMillan et al., 2013). Of note, research shows there has been increasing self-identification as Arab rather than Americans, illustrating a stronger identification with ethnicity (Abboud et al., 2015; Marshall & Read, 2003; Nassar-McMillan et al., 2013).

Often times, second-generation Arab Americans find themselves living between two worlds (i.e., Arab world and American world) and adopting values from both cultures. This bifurcated way of living has and can create difficulties negotiating individualist American/Western values with more collectivist conservative Arab values. As a result, identity development is multifaceted and a complex process for Arab American women in

terms of their sexuality, gender roles, dress, family and religion. Furthermore, understanding the complexities between U.S policy , country of origin politics, cultural stereotypes assumed by Americans, intergenerational differences and intragroup relations will assist clinicians in providing culturally-syntonic treatment to women of Arab descent living in the United States.

Family: Family is a central part of Arab culture, rooted in collective and family support systems, significantly influencing the development of individual and collective identities of Arab Americans (Erickson, C. D., & Al-Timimi, 2001; Read, 2004; Marshall & Read, 2003; Nassar-McMillan et al., 2013). Traditional Arab families are larger in numbers and rely on each other socially, economically, culturally and religiously (Cohen & Savaya, 2003; Nassar-McMillan et al., 2013). However, some research has shown that with increased educational opportunities for women, changing government policies, Western influence, and women's desire for equality, there is a recent desire for smaller families (Mare & Maralani, 2006). Family has also been seen to be a protective factor and a great source for coping for many Arab Americans who have experienced war, violence, and/or discrimination (Al-Krenawi & Graham, 2000; Kakoti, 2012; Nassar-McMillan et al., 2013). However, at times, families of higher social status and/or financial status tend to restrict women's interactions with males, including in the U.S health care system, thus presenting barriers for women of Arab descent living in the U.S. seeking medical services (Nassar-McMillan et al., 2013).

Arab American families are deeply rooted in patrilineality, where there is an emphasis on males passing down their titles and kinship through family lineage (Joseph, 1996; Kakoti, 2012; Nassar-McMillan et al., 2013). Thus women retain membership in their father's kin group who are responsible for her through out her life (Al-Krenawi & Graham, 2000; Joseph, 1996). Western values and the United States' strong women's rights impact patrilineality and are a source of stress for women of Arab descent living in the United States (Abu-Ras, 2007; Kakoti, 2012; Nassar-McMillan et al., 2013). Furthermore, the availability of education, work and welfare have challenged the structure of patrilineality and influenced the transitions in traditional gender roles (Al-Krenawi & Graham, 2000; Nassar-McMillan et al., 2013). The father is the dominant authority in the family and tends to be responsible for significant family decisions (Al-Krenawi & Graham, 2000; Haboush 2007). However, more educated women of Arab descent tend to have increased autonomy and power in familial decision-making compared to the traditional patriarchal family system (Marshall & Read, 2003; Read, 2003). In contrast to Western culture, women of Arab descent living in the United States tend to exert their influence in their families less explicitly (Erickson & Al-Timimi, 2001). Often times, this results in the common perception that these women are passive or oppressed (Abu-Lughod, 2002; Erickson & Al-Timimi, 2001; Kakoti, 2012).

Decisions in the family are made with the intention of preserving family unity, honor and stability, females being primarily responsible for maintaining that stability (Al-Krenawi & Graham, 2000; Cohen & Savaya, 2003; Haboush 2007; Marshall & Read, 2003; Nassar-McMillan et al., 2013; Read, 2004). This also holds true with expression of emotions with the exception of anger for males, in fear of shaming and dishonoring the family reputation (Al-Krenawi & Graham, 2000; Haboush 2007). Additionally, the woman is expected to prioritize her family's needs over her individual needs or desires (Mourad & Abdella, 2010). Relying on family for solutions to problems and for support is a strong value of Arab Americans; however, it can often create future difficulties for children due to not developing and relying on their own coping mechanisms (Haboush 2007). Hospitality and generosity are highly valued within the family system, and women are expected to carry out those values (Erickson & Al-Timimi, 2001). Furthermore, separation from the family is not encouraged until marriage, especially for females (Al-Krenawi & Graham, 2000; Cohen & Savaya, 2003; Haboush 2007; Nassar-McMillan et al., 2013). In the 2000 U.S Census data, it was less common to find Arab female heads of household, without the male present, illustrating the importance of maintaining the traditional value of family cohesion and unity (Al-Krenawi & Graham, 2000; Haboush 2007). However, having strong family connections and identifying with one's cultural community can be seen as a source of resilience and offer support for women of Arab descent living in the United States.

Arab American's values of love and marriage differ greatly than those of Western society (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).. The decision to marry is not based on the couple's romantic love, but instead, on gaining approval from extended family members. Therefore, family involvement is highly common in marriages and in overall decision-making. Divorce is generally looked at as a last result, and the mother/wife is expected to endure marital conflict to avoid the stigma of divorce and creating a divide for the children (Al-Krenawi & Graham, 2000). However, as social and legal reforms of women's roles and rights continue to develop and women are more educated, young adults are starting to resist family involvement (Nassar-McMillan et al., 2013; Raz & Atar, 2005).

Hot Topics*: value system differences, pressure to preserve values, shame, honor, reputation, female's role in the family, biculturalism (advantages and disadvantages), treatment resistance, unable to separate from family, feeling misunderstood by clinician, individualist versus collectivist expectations, support, privacy,*

Gender Roles: Women of Arab descent living in the U.S. play a significant role in the family's upbringing and maintenance of gendered norms, and ethnic and social expectations. This, in turn, can heighten a female's sensitivity to the gender differences present in the United States. (Abboud et al., 2015; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). Therefore, gender differences can be a strong part of Arab culture

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and are manifested in social, educational and occupational structures (Al-Krenawi & Graham, 2000). However, gender attitudes vary depending on social class, generational status and level of education. Less educated individuals tend to have stronger attachments to traditional values and gender roles. Religion and level of religiosity also impacts gender dynamics within a family structure (Read, 2003 2004).

In a collectivist culture, each family member has a role to fulfill. For women of Arab descent living in the United States, they tend to fall into two primary roles, the *daughter role* and the *wife role* (Mourad & Abdella, 2010). Depending on the level of conservativeness of the family system, these roles may be more or less flexible. Females are expected to protect the family honor, care for their families and are discouraged from any sexual activity until marriage (Nassar-McMillan et al., 2013). As a result, stricter rules apply towards daughters including stricter dating guidelines, curfews, and dress code (Ajrouch, 2000; Al-Krenawi & Graham, 2000; Nassar-McMillan et al., 2013). Women of Arab descent living in the United States can find themselves clashing with American culture as they negotiate between varying cultural and familial expectations.

Marriage is highly valued in Arab culture and women are discouraged from leaving the marriage and expected to stay despite conflict and domestic violence issues (Nassar-McMillan et al., 2013). Divorce has a strong stigma for women of Arab descent living in the United States. For example, a divorced woman will experience social and emotional turmoil within her Arab community and face difficulties remarrying (Al-Krenawi & Graham, 2000). However, family members and/or religious leaders will play a vital role in intervening, providing support, and encouraging the woman to maintain the marital cohesion (Al-Krenawi & Graham, 2000; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Motherhood is strongly emphasized in Arab culture and often brings status to women in family and society, particularly in relation to sons (Crabtree, 2007; Haboush, 2007). Women play a pivotal role in the transmission of ethnic beliefs and traditions through child-rearing practices (Crabtree, 2007; Eid, 2003; Nassar-McMillan et al., 2013). Furthermore, mothers are responsible for mediating situations between the children and their father, and are often the ones providing punishment on behalf of their father (Amer & Awad, 2016). Although some women are encouraged to seek out employment outside of the home, the woman's first responsibility is understood to be the family (Mourad & Abdella, 2010).

Arab American women's multiple roles and cultural expectations have both negatively and positively impacted women's mental and physical health. For example, due to a woman's familial and domestic role, they tend to interact with health care providers more frequently and receive medical care as a result of seeking care for their family members. The multiple

roles have also shown to increase feelings of self-worth and increased connection with others, often times leading to overall improved well-being (Black, Murry, Cutrona, & Chen, 2009; Barnett, 2004). However, the combination of family roles, unappreciated work and other competing demands has created physical and mental health stressors for Arab American women (Al-Krenawi & Graham, 2000; Barnett, 2004). These stressors are commonly expressed through physical symptoms (e.g., gastrointestinal issues, migraines, physical pain) and are often more "morally" acceptable expressions of pain (Al-Krenawi & Graham, 2000; Nassar-McMillan et al., 2013).

Hot Topics: *interpersonal responsibility and influence, managing the harmony in the family at the expense of her own needs and desires, negotiating American mainstream and Arab familial expectations, guilt, issues around identity, reputation, gender role expectations, complacency,*

Religion: Religious diversity of Arab Americans is central to developing a thorough understanding of the culture and its positive and negative implications. The majority of this population is affiliated with a Christian denomination, with 63% of Arab Americans identifying with Christian origins, 24% identifying as Muslim and 13% as other or no affiliation (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). Within each religious group there aare also divisions including Sunni, Shite, and Druze in Islam, and Orthodox (e.g., Syrian, Protestant) and Catholic (e.g., Maronite, Syrian) Christianity (Haboush, 2007; Nassar-McMillan et al., 2013). Additionally, there is a longstanding history of conflict among the different religious groups that has created mistrust among the subgroups of each faith (Haboush, 2007). It has also been indicated that there are differences in the assimilation process based on religious identification. Arab Christians have been shown to assimilate quickly and better to the American mainstream due to similarities in Christian faith and higher rates of marriage outside the ethnic community (Nassar-McMillan et al., 2013; Read, 2004). On the other hand, Muslim Arabs had increased difficulties with the assimilation process due to prejudicial barriers that conceptualized Arab Muslims as violent, extreme, and patriarchal (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). As a result, their religious affiliation plays a strong role in the development of their ethnic identity and tendency to exclude themselves from American mainstream (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Religion also influences Arab American women's labor force activity and their familial and gender role responsibilities (Ghazal, 2004; Nassar-McMillan et al., 2013). Stronger religious affiliation has been shown to have lower employment rates and higher fertility rates (Erickson & Al-Timimi, 2001;Ghazal, 2004). Furthermore, religion can be seen as an important structure for Arab Americans where a community of belonging and hope is provided and problems are constructed and resolved (Al-Krenawi & Graham, 2000;

Erickson, & Al-Timimi, 2001; Nassar-McMillan et al., 2013). At times, religion can also create stressors for Arab American women, especially around dating and sexuality (Abboud et al., 2015; Naber, 2012; Nassar-McMillan et al., 2013). Young women are discouraged from expressing individuality by rebelling, as it can be portrayed as threatening the identity structure of the family (Al-Krenawi & Jackson, 2014; Erickson, & Al-Timimi, 2001). Additionally, Arab Americans may view strife as a religious punishment resulting from evil spirits inhabiting the individual and may seek help from religious leaders, engage in religious practices to rid the evil spirits and/or reach out to family members for support (Al-Krenawi & Jackson, 2014). More specifically, Arab American women may be described as being possessed with evil *jinns* (Al-Krenawi, et. al., 2004; Al-Krenawi & Jackson, 2014). For some, religion is the central aspect of their identity and may be the differentiating factors amongst the community versus nationality, marital status or occupation (Erickson, & Al-Timimi, 2001).

Of note, developing a strong understanding of Islam (including different sects: Shia, Sunni, and Druze) and Christianity is important for appreciating the issues that may present while working with Arab American women (Al-Krenawi & Jackson, 2014). Both the Qu'ran and the Bible provide directions on how to live one's life from marriage to death and any resulting consequences one may face when one deviates from those directions (Al-Krenawi & Jackson, 2014). Additionally, some Arab countries may be governed by Sharia Law (i.e., words of the Qu'ran are considered primary), which can at times, trump civil law of the country (Al-Krenawi & Jackson, 2014). Therefore, some may be following the Sharia Law around issues of marriage and family responsibility which may be in defiance of the civil law and create complicated feelings for an Arab American women adjusting to American mainstream (Al-Krenawi & Jackson, 2014; Mourad & Abdella, 2010; Erickson, & Al-Timimi, 2001; Nassar-McMillan et al., 2013)

Additionally, religion can be a source of resilience, providing Arab Americans with additional coping strategies and support (Al-Krenawi, et. al., 2004; Dalky, 2012; Nassar-McMillan et al., 2013). Arab Americans tend to seek out traditional healers or look to religion for treatment when dealing with mental health issues and various stressors. Furthermore, increased religious practices can be seen as a way of coping with psychosocial stressors and medical illnesses (Al-Krenawi, et. al., 2004; Al-Krenawi & Jackson, 2014). Greater psychological wellbeing as been shown to be related to higher degrees of religious affiliation or no religious affiliation among Arab Americans. However, religious affiliation may also be a source of stress due to increased religion-based discrimination in the U.S. More specifically, Muslim women are at higher risk for experiences religion-based discrimination and/or violence due to their visible traditional clothing (e.g., hijab). Also, religious practices can often provide soothing effects in place of drugs, alcohol, sex, and other behaviors ((Al-Krenawi, et. al., 2004; Al-Krenawi & Jackson,

2014) Of note, clinicians are encouraged to understand how the level of religiosity for Arab American women can cultivate a conservative approach to family issues, marital problems, gender roles and other psychosocial issues (Al-Krenawi & Graham, 2000; Erickson & Al-Timimi, 2001).

Hot Topics*: belonging, faith, spirituality, conservative, hijab, Islam, Druze, Christianity, Allah ("God"), self-image, emphasis on prioritizing family, "keepers of faith" (e.g., family, community), obedience, internal conflicts, shunning, holistic sense of well-being versus individualist split between mind and body, meaning, purpose, supernatural world, evil spirits (eblees jinns), angels, will of God (e.g., Insha'Allah), piety, Malak ("Angel"), Shaytan ("devil"), mertad, kafer, moulhed*

Sexuality: Sexuality and virginity are important categories that influence the identify formation of Arab American women; however, these categories are understudied (Abboud et al., 2015; Naber, 2006). They are also embedded in ideas around modesty, honor, and morality (Abboud et al., 2015). Generally, enacting and upholding honor influences the actions of both Arab American men and women (Abboud et al., 2015; Nassar-McMillan et al., 2013). However, for Arab American women, honor is enacted through the upholding of chastity and sexual virtue (Abboud et al., 2015; Al-Krenawi & Jackson, 2014; Naber, 2012; Naber, 2006). Women of Arab descent living in the U.S. struggle to negotiate the more liberal Western view of sexuality and virginity with that of the conservative Arab viewpoint (Al-Krenawi & Jackson, 2014; Abboud et al., 2015; Naber, 2006). As a result, Arab American women tend to be socialized to preserve their "good Arab girl" identity through maintaining their virginity and adhering to traditional gender roles (Abboud et al., 2015; Al-Krenawi & Jackson, 2014). They are often understood by the Arab American community to be different and better from "American girls" by limiting contact with males outside of the family, controlling their sexuality, and dressing modestly in public ((Abboud et al., 2015; Nassar-McMillan et al., 2013). However, Arab American women face double standards within Arab society, where men are allowed to engage in premarital sex while women uphold to the traditional values. Violations of gender role expectations (e.g., premarital sex) among women can damage the reputation of the whole family and leave women in a vulnerable position of having few resources to seek support and information from (Abboud et al., 2015; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Often times, sexuality for Arab American women is understood through binary lens, Al Arab (the arab) or Al Amerikan (the American). It highlights the dichotomy between Arab girls and American girls through maintaining heterosexuality and normative sexualities (Naber, 2012). Issues related to Arab American women's sexuality are often conceptualized from a patriarchal and collective point of view, omitting a woman's subjective identity. Within Arab cultural authenticity (Naber, 2012) there is an expectation for women to be

ideal wives, mothers and daughters while also upholding their premarital chastity. Distinct boundaries between masculinity and femininity have been defined in order to limit the threat to identity by external forces (Ghafari, 2002; Ilkkaracan, 2002; Naber, 2006) Literature also suggests that Arab culture tends to blame Western Feminism for sexual variance and ambiguity that members of Arab society may be expressing. However, it has been indicated that the fluid and dynamic concept of sexuality has been present since the Califates (623-656) and through the Ottomons (1281-1922) within Islamic history (Naber, 2012; Naber, 2006). Furthermore, in recent change, there have been attempts to shift sexual polarities within Arab culture despite the resistance encountered (Ghafari, 2002; Ilkkaracan, 2002). Often times, women of Arab descent living in the U.S. find themselves struggling to fit in within their cultural and religious communities and their sexual orientation challenges their belongingness. Similar to white-middle class ideology, where marriages require heteropatriarchy and homosexuality is prohibited, Arab American females are also encouraged to pursue heteronormative marriages (Naber, 2012; Naber, 2006).

Arab American lesbians are seen and/or portrayed to be sexual deviants and potentially threatening the reputation of the family and the preservation of the Arab ethnic identity (Al-Ghafari, 2002; Naber, 2012; Naber, 2006). Moreover, the lesbian identity does not seem to completely exist in the Arab world due to the lack of language used in Arabic to describe practices that would be defined as lesbian in Western society (Ghafari, 2002). As a result, the expressions in classical Arabic are usually negative and degrading, 'sihaq' (homosexual act among women), 'shouzouz jinsi' (unnatural or abnormal sexuality; Ghafari, 2002; Ilkkaracan, 2002) . Research suggests that for lesbians of color, engaging in sexual behavior refute the moral prohibitions of both sexuality and homosexuality (Naber, 2006). It is important to note that in recent years, the Arab feminist movement has gained momentum in areas of gender equity and equality in the Arab world (Dialmy, 2005; Ilkkaracan, 2002). However, sexuality is still a source of distress for women of Arab descent living in the United States as they continually struggle with navigating through religion, familial expectations, gender role expectations and western and Arab influences.

Hot Topics*: sexism, gender discrimination, shame (e.g., 'aib'), honor (e.g., 'sharaf'), reputation, morality, patriarchy, heteronormative expectations, virginity, lesbianism (e.g., 'sihaq'), bisexuality, marriage, secrecy, 'double-life', isolation, queer, piety, homosexuality,*

Education and Employment: Statistics reflect Arab Americans' strength in education and have demonstrated higher rates of educational attainment than that of the US population as a whole (Nassar-McMillan et al., 2013). This may be due to a mix of values within the family, ambitions, need, and opportunity for education in their native country and/or host country. Furthermore, continuing education for females has been seen to be a legitimate

reason to delay marriage across various Arab American communities, including conservative ones (Kakoti, 2012; Nassar-McMillan et al., 2013). Some Arab American females may easily embrace Western culture and ideology, thus excelling in higher education, career advancement and participate in government and civil sectors, opportunities that may have not been available for women in their native countries (Kakoti, 2012). Research suggests that higher socioeconomic status and less traditional values is generally correlated with higher rates of premarital educational attainment for females (Nassar-McMillan et al., 2013; Read, 2004). Research also suggests that many Arab Americans view education as a family resource, more specifically assisting females with parenting and familial values as opposed to career advancement (Nassar-McMillan et al., 2013; Read, 2004). Female Arab immigrants and first generation Arab American women who are active participants in their community (e.g., live in ethnic enclaves) tend to view women's education as a family resource (Nassar-McMillan et al., 2013)

Furthermore, ethnic identity, religiosity, family structure and social class play a role in Arab American women's participation in the labor force (Nassar-McMillan et al., 2013; Read, 2004). Arab American women from more traditional families are less likely to be employed and adhere to cultural traditions, such as domesticity and childrearing (Nassar-McMillan et al., 2013; Read, 2004). Second generation Arab American women demonstrate a higher overall labor force participation, which may be attributed to increased interaction with mainstream American values and separation from traditional gender ideologies (Nassar-McMillan et al., 2013; Read, 2004). Cultural views on appropriate type of work for women influence Arab American women's' decisions to enter the labor force and preference of employment (Nassar-McMillan et al., 2013). This tends to create many challenges for Arab American women seeking employment with low levels of education and for Arab refugees in the U.S. who are required to work for pay to receive benefits for their families as soon as they have arrived (Nassar-McMillan et al., 2013; Read, 2004). Lastly, the presence of children in the home can create barriers or challenges for Arab American women seeking employment opportunities, and the presence of nonspouse adult family members may alleviate that stress through helping with domestic responsibilities and providing care for the children (Nassar-McMillan et al., 2013; Read, 2004). As Arab American women assimilate into American mainstream, their traditional gender ideologies and other factors start to change (Nassar-McMillan et al., 2013; Read, 2004).

Hot Topics: *multiple role stressors (e.g., in home, at work), work-family balance, cultural expectations, empowerment, self-agency, familial expectations, reason for pursuing higher education, social pressures impacting academic and/or occupational functioning, guilt, achievement, Arab identity portrayed in academic and/or occupational setting (e.g., wearing a hijab or more conservative dress)*

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Group Activity #3: Compare and Contrast

After providing background information on the areas/experiences that influence Arab American women, use the previous case example (e.g., Mona's Arrival to the United States) to see if participants can incorporate new learned information with previous discussion points. This activity will illustrate any biases that participants hold, address any misinformation, clarify any areas of confusion and provide new material for participants to incorporate in their work.

[Now refer back to Mona's case and have participants share any changes to their treatment/clinical work with Mona after learning about the areas of Family, Gender Roles, Sexuality, Religion, Employment and Education]

Mona's arrival to the United States (Appendix B)

Mona emigrated to the U.S. from Jordan when she was 18 years old with her husband. She did not complete a highs school education, instead, she was encouraged to get married and have children. She had mixed feelings about her new husband, Bassam and her responsibilities towards him. She expressed sadness around not completing her educations as she had always dreamed of being a nurse. Bassam brought her to Los Angeles, a city that was completely foreign to her and a place where she did not know anyone. She left behind her parents, six siblings, best friends and extended family. She spent several hours every day FaceTiming with her family, which made the distance harder to handle as she noticed that would miss them more after the conversations ended. Mona also found herself learning how to cook, clean, and do laundry all by herself. Bassam would come home every night expecting dinner to be ready. Mona noticed that was finding herself trying to connect with her husband, but he was always tired after work and chose to watch T.V. instead of socialize with her. Eventually, she became pregnant with her first child. Her mother was unable to leave Jordan because she was not given a visa, so Mona found herself alone through this pregnancy. Bassam's mother stayed with them for three months after the birth of their child; however, Mona felt that she was constantly being criticized and judged for everything she was doing "wrong." The little moments she had to herself, she would spend fantasizing about the life she had always dreamed for herself, receiving a degree for nursing, working at a hospital, falling in love with a doctor at the hospital, getting

married and having children in Jordan while living near her family. Realizing that she was far away from this dream, Mona became more and more isolated and withdrawn. She was able to fulfill her duties as a mother, but as soon as Bassam came home and could watch their son, she would cry herself to sleep and spent most of the time in bed. During one of her post-natal appointments with her gynecologist, she was given a PHQ-9 and scored 19 (moderately severe). The gynecologists further assessed her depressive symptoms and made a referral for her to see a psychologist. However, Mona, panicked and said that she would not be able to share this with her family because they would think she was "crazy" and that she wasn't "fit to be a mother."

[Instructions to read aloud: *Given the new information you have learned and the different experiences that influence identity development of Arab American women, how would you work differently with Mona, if so at all?*]

[Using the white board/chalk board/poster board write down new discussion points using a different color pen/marker/chalk to illustrate the new information and new themes that may come for clinicians working with women of Arab descent living in the United States.]

[Instructions to read aloud: *Now, from what we have written on the board, what are some stereotypes you notice? Using a red marker/pen/chalk circle stereotypes that participants point out*]

[After completion of activity, ask participants for their reactions. Instructions to read aloud: *Now that you have discussed Mona's situation pre and post the information provided about Arab American women, are there any reactions you had that you can share with the group? Any surprises? What was one of the most important take away from this activity?*]

"*The single story creates stereotypes, and the problem with stereotypes is not that they are untrue, but that they are incomplete. They make one story become the only story*"

-Chimamanda Ngozi Adichie

Section 3. Discussion of Historical Events and Current Issues Relevant to Women of Arab Descent Living in the United States
(60-90 minutes)

- *"Hot Topics": consist of themes that may come up around these specific events during therapy.*
- *"Talking Circle": small discussion groups to reflect and debrief about current topic (s)*
- *Before providing background information about historical and current events related to Arab Americans, please see Group Activity below.*

**This section will be updated by the facilitator to include any current events related to Arabs and/or Arab Americans that are occurring.*

Many scholars have cited two (Read, 2003; Suleiman, 1999) to four (Nassar-McMillan & Hakim-Larson, 2003) waves of immigration to the United States over a period 125 years. The earliest was a group of laborers joining the *Great Migration* seeking better economic opportunities, fleeing the Ottoman Empire and which consisted of poor Christian Arabs (Haboush, 2007; Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim-Larson, 2003; Orfalea, 2006). Although there is no record of the number of immigrants after the first wave, it is estimated that by 1924 there were approximately 200,000 Arab immigrants (Naber, 2000). The second wave of immigration occurred immediately after World War II, as many as 80,000 Arab immigrants came to the USA due to political tensions in their regions and consisted primarily of well-educated Muslims (Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim Larson, 2003; Orfalea, 2006). In the following years, more specifically during the 70's and 80's, a great number of Lebanese migrated to the USA after the Civil War and Israeli invasion of Lebanon. Finally, the Persian Gulf War resulted in an influx of Iraqi refugees to immigrate to the USA and later, continued to immigrate for various reasons.

Historically, Arab culture has been shaped by many political, religious, and territorial disputes, which play a significant role in assimilation patterns for Arabs (Abboud et al., 2015; Erickson, & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013). The early waves of Arab immigrants to the United States who were mostly Christians assimilated more readily to the predominantly white American middle class due their similar Christian religion, identifying as white/Caucasian, Anglicizing their Arabic names, readily accepting American ideals and engaging in peddling activities (Naber, 2006; Nassar-McMillan et al., 2013; Nassar-McMillan & Hakim-Larson, 2003; Orfalea, 2006; Read, 2003). This is in contrast to the post-1965 and more recent wave of immigrants who are mostly Muslims and demonstrate strong transnational linkages to their homelands (Erickson, &

Al-Timimi, 2001). More specifically, after the 9/11 attacks, there were increased instances of racial profiling and stigmatization of Arab Americans leading to increased interest in establishing "ethnic communities" in order to protect themselves using their own resources. In order to develop a contextualized understanding of Arab Americans and their mobilization, it is imperative that one becomes aware of the significant role American Foreign Policy has played in the political situations that have indirectly or directly impacted Arab immigration, including the Gulf War (e.g., those who fought on the side of the USA were allowed to immigrate to the USA), and the U.S.-initiated War on Terror (Nassar-McMillan et al., 2013;Haboush, 2007; Erickson, & Al-Timimi, 2001).

Furthermore, the most recent wave of Arab immigrants identifies strongly with their religious ties as a means of defining their ethnic identity, further distancing them from the American mainstream. As a result, religion plays an important role in the development of a collectivistic identity within their children (Erickson & Al-Timimi, 2001;Read, 2003). This is crucial to one's work with Arab American women and further understanding the difficulties of balancing, accepting and/or rejecting the Arab identity with that of the mainstream American (Abboud et al., 2015; El-Aswad, 2010; Marshall & Read, 2003). Additionally, increased military U.S. involvement in the Middle East has increased the salience of gender, religious and ethnicity identities among Arab Americans ((Nassar-McMillan et al., 2013;Haboush, 2007; Marshall & Read 2003; Read & Bartkowski, 2000). As a result, many Arab American women are prompted to reject or differentiate themselves from the Western idea of gender equality and feminism as a form of solidarity (Marshall & Read, 2003; Read & Bartkowski, 2000). Furthermore, age, class and level of assimilation must be considered when working with women of Arab descent living in the United States.

Prominent and Current Events:
9/11 events and Global War on Terror: The terror attacks on September 11, 2001 and the resulting Global War on Terror further contributed to the widespread negative perceptions of Arab Americans and Arab culture (Nassar-McMillan et al., 2013;Haboush, 2007). Arab Americans demonstrated an increased awareness of discrimination, exclusion and anger towards their community. Furthermore, the anti-Arab violence and increased racial profiling motivated many Arab Americans to reestablish their roles in American society and motivated mobilization towards transnational and global issues pertaining to Arabs. Many Arab American families faced continued discriminatory attacks, grieved the loss of family and friends and had to cope with the directed anger of many Americans during this time (Beitin, & Allen, 2005).

In 2001, the relationship between Muslim women wearing a hijab, or headscarf, and the idea of oppression that many Americans constructed became a central theme in mainstream media and gender discourse (Abu-Lughod, 2002). Often times, this resulted in

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viewing the use of hijab as prescribing to male domination as opposed to an expression of faith or a cultural choice (Abu-Lughod, 2002). As a result, women were subjected to violent acts including assault, road rage, and hostile comments and were perceived as threats to American culture (Nassar-McMillan et al., 2013; Abu-Lughod, 2002). Furthermore, the resulting effects of the Global War on Terror, including the Patriot Act signed into law in 2001, increased experiences of rejection, isolation and distrust from Arab Americans and American Muslims towards the government and the Federal Bureau of Investigation (Ahmed & Reddy, 2007; Fine & Aziz, 2013; Nassar-McMillan et al., 2013). As a result, Arab Americans and Muslim Americans became the targets of discrimination and racial profiling which increased psychological distress, decreased general happiness levels and contributed to an increase in health problems (Ahmed & Reddy, 2007; Al-Krenawi & Graham, 2000; Nassar-McMillan et al., 2013; Read & Reynolds, 2012).

Hot Topics: *discrimination, exclusion, issues of identity, disempowerment, marginalization, retraumatization (e.g., brought back memories and feelings of terrorism and war that was experienced in country of origin), negative perceptions, anger towards Arabs, fear, anxiety, isolation, distrust*

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Group Activity #1:

[Play this video about selective attention "The Original Selective Attention Task" on YouTube: https://www.youtube.com/watch?v=vJG698U2Mvo]

Ask participants to: [*Pay attention to how many passes the people with the white T-shirts make*] [Play video]

Discuss: [*Were you able to see the gorilla? Did you notice how the gorilla danced in the middle of the circle?*] [Facilitate a brief discussion about participants' reactions]

[Explain the video]: *This video is illustrating how we are primed to see certain things, for example, we were primed to count the number of passes and completely miss the gorilla. Stereotypes function very similarly and can form implicit biases that prevent us from perceiving situations and people. So I want to do this next activity to help us generate a list of some of the biases we may hold when we work with women of Arab descent living in the United States.*

Facilitator: [On a chalkboard, white board and/or poster board, write out the following words and keep them up during the discussion.]
- Arab
- Terrorist
- Muslim
- Hijab
- 9/11
- Arab American Women
- Immigrants

[Ask participants to break into small Talking Circles and then pass out different colored sticky notes (e.g., pink, purple, yellow, green, neutral, blue, etc.), one color for each word listed for each group, along with markers or pens.]

Instructions (read out loud) to participants: [*Discuss amongst your Talking Circles the stereotypes and emotional reactions you notice when you read each word on the board. As a group, decide which reactions are the most salient and write them down on the corresponding colored sticky note (i.e., each color represents one of the words listed). When you are finished, I will come around to collect the sticky notes.*]

[Post the sticky notes next to the relevant word to illustrate the reactions/stereotypes that are most common in this community]

Ask participants to share how these stereotypes/reactions may influence your clinical work with women of Arab descent living in the United States.
[Common issues: negative countertransference, fear of working with that population, anger from the clinician present in session, resistance to listening to the individual's story, little to no empathy, assumptions].

Ask participants: [*If you feel comfortable sharing, does anyone have an example of a time where they were working with an Arab American female and some of the above mentioned stereotypes/reactions came up for you?*
***If participants do not have an example, continue to discuss how those stereotypes/reactions can influence treatment:

- Difficulties developing rapport
- Invalidating your patient's experiences
- Patient feels misunderstood
- Patient feels that clinician cannot help her
- Providing inappropriate interventions
  - Example: asking an Arab American woman to remove her Hijab to avoid discrimination (Kakoti, 2012).
- Making assumptions about patient's presentation
  - Example: Therapist views shyness and guilt as maladaptive from a Western point of view, while in some Arab cultures they are viewed as virtuous traits (Kakoti, 2012).

[Allow for some discussion around these issues while also introducing the relevant topics at the beginning of this section (e.g., historical and current events)]

"I am Woman. Phenomenally. Phenomenal Woman, that's me."

-Maya Angelou

Section 4: Identifying Stressors experienced by Women of Arab Descent Living in the United States
(60 minutes)

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Group Activity #1: Brainstorming

- *Brainstorming activates prior knowledge by asking participants to tell all they know about a topic or idea.*

[Before using the background information provided below, facilitate a discussion around acculturation, acculturative stress, and what stressors participants believe women of Arab descent living in the U.S. face]

Materials needed: Poster board/white board/chalk board with writing utensils (for facilitator), notepads or paper with writing utensils (for participants)

[If there are a large number of participants, have participants break into smaller groups of 2 or 3 people. Instruct them to write down all the ideas and comments they have around the topic of acculturation, acculturative stress and stressors that women of Arab descent living in the U.S. face]

[Read instructions aloud: *We will be identifying stressors experienced by women of Arab descent living in the U.S. Before we begin our discussion please break into a group of __participants. Using your notepads/paper, please write down thoughts around acculturation? What type of stressors do you think women of Arab descent living in the U.S. face?* Allow up to 15 minutes for discussion before providing information about the stressors] [As groups share, write down their understanding, thoughts and reactions up on the board with a single colored marker/pen/chalk....you will add to this after providing information and before using the case example]

[Encourage participants to write down their thoughts and reactions when each stressor is discussed: *As we learn about the specific stressors that these women face, I would like you to keep track of any thoughts or reactions that come up for you. This will be important for our discussion later*]

Optional after initial discussion: [Facilitator may provide handouts with "resultant stressors" listed below for participants to visually follow along with]
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Arab American identity has been significantly shaped by factors internal and external to the Arab American community (Abboud et al., 2015;Erickson, & Al-Timimi, 2001; Haboush, 2007; Mourad & Abdella, 2010; Naber, 2000; Nassar-McMillan et al., 2013). Historically, they have been attempting to define their ethnic identity; however, with the most recent group of immigrants, anti-Arab attitudes and misrepresentations in the media have significantly increased. More specifically, Arab women are portrayed and understood as oppressed and inferior to American women. Furthermore, on a socio-structural level, Arab Americans are not represented within the U.S. census's racial/ethnic classification; instead they are rendered invisible (Naber, 2000; Nassar-McMillan et al., 2013). Using an ecological approach which includes the intersectionality of both macro system issues (e.g., historical events, internal and external culture, societal beliefs and stigma) and micro system issues (e.g., family dynamics, community participation) is crucial to understanding the multiple influences and contexts that make up the identity of women of Arab descent living in the Unites States (Naber, 2000).

Acculturation and Acculturative Stress:
Acculturation is conceptualized as a multidimensional process that occurs as a result of contact with a new or host culture and involves changes in many aspects of immigrants' lives. These changes can include language competence and use, cultural identity, attitudes and values, types of food and music preferred, media use, ethnic pride, ethnic social relations, cultural familiarity, and social custom (Schwartz, Unger, Zamboanga, & Szapocznik, 2010; Yoon, Langrehr, & Ong, 2010; Yoon, Lee, & Goh, 2008). It allows for a bidirectional impact, where two cultures of contact are interacting through giving and receiving to and from each other (Kim & Abreu, 2001; Schwartz et. al., 2010; Yoon et al., 2010). In other words, there can be a reciprocal process occurring between two different cultures. Changes that arise from the intercultural interactions can include both positive (i.e., eustress) and negative effects (i.e., negative stress). Positive effects include individuals developing a broader range of cultural skills and a stronger "world-mindedness;" while negative effects can include intergroup anxiety or identity conflict due to "culture shock" (Yoon et al., 2008, 2010). Furthermore, during this process, immigrants and their descendants are faced with the challenge of navigating and negotiating aspects of both cultures while also developing a cohesive sense of self (Nassar-McMillan et al., 2013).

Berry (1994) posits four possible outcomes of the acculturation process: assimilation (i.e., movement towards the dominant culture), integration (i.e., synthesis of both cultures),

rejection (i.e., reclaiming of the traditional culture) or marginalization (i.e., isolation/alienation from host culture; Berry, 1998; Berry, 1994; Berry, 1997). It has been suggested that the level of the immigrant's psychological distress can be attributed to stressors that emerge from their acculturation process, such as obtaining employment and housing, accessing health care, language barriers, and interpersonal social support (Berry, 1997; Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006). Immigrants are faced with a myriad of psychosocial stressors such as adjusting to their new host country, negotiating between their native culture's expectations and their host culture's, reidentifying their value system and redefining their roles in the family and at work. As a result, many immigrants experience ***acculturative stress*** associated with a perceived imbalance of cultural expectations and actual resources available (Berry, 2005; Torres, 2010). Although individuals or families migrate to improve their well-being, the World Health Organization (2001), claims that "migration does not bring improved social well-being, rather...it often results in...exposing migrants to social stress and increased risk of mental disorders" (p. 13). Pressures to assimilate into the host culture may be felt differently across various individuals, and the qualitative nature of the acculturation process may also vary across contexts (Neggy, Hammons, Reig-Ferrer & Carper, 2010).

Acculturative stress can be understood broadly as the "psychological impact of adapting to a new culture" (Smart & Smart, 1995). Working with immigrants illuminates the need to understand transnational lifestyles including family relationships, gender roles, cultural and sociopolitical issues (Falicov, 2007). Furthermore, understanding how people connect and change within a context such as new definitions of family life, various forms of relational stress and acculturative stress manifested in gender and generational relationships is essential to monitoring stress levels for female immigrants (Falicov, 2007). Due to the challenges of negotiating aspects of both cultures and one's own cohesive sense of self, it can be assumed that individuals who demonstrate higher levels of traditional cultural identification may face increased acculturative stress (Nassar-McMillan et al., 2013). Furthermore, this self-identification with traditional culture is understood as *ethnic identity* and refers to the emotional attachment and belonging an individual experiences towards an ethnic group (Nassar-McMillan et al., 2013; Phinny & Ong, 2007). Exposure to discrimination and racism (i.e., negative aspects of stress) may be daily experiences for many immigrants. These experiences not only influence an individual's mental and physical health, but also can change relationships within a family or institutional context thus transforming identities for female immigrants (Falicov, 2007; Suarez-Orozco & Suarez-Orozco, 2001). In addition to negative stress, acculturation can also provide new opportunities and new skills to learn for individuals adjusting to a new environment (i.e., eustress).

Factors Influencing Acculturation for Women of Arab Descent Living in the United States:

Religion, community culture and family are central to the development and continued association with the Arab ethnic identity (Abboud et al., 2015; Erickson, & Al-Timimi, 2001; Haboush, 2007; Nassar-McMillan et al., 2013). For first generation Arab Americans, their Arab ethnic identity is influenced through extended family dynamics and socialization as a result of explicit instruction, religious participation, or implicit processes (e.g., patrilineality in their family system; Erickson, & Al-Timimi, 2001; Nassar-McMillan et al., 2013). For many immigrants and first generation Arab Americans, living in the United States has created challenges in negotiating their ethnic and American identities in order to promote an overall cohesive sense of self (Nassar-McMillan et al., 2013). Of note, the "invisibility" of Arab Americans as an identified ethnic group in the United States, the experience of racial stigma and discrimination, the heterogeneity in religious affiliation and country of origin, and the levels of acculturation have contributed to the difficulties of Arab Americans developing a positive individual ethnic identity (Erickson, & Al-Timimi, 2001; Nassar-McMillan et al., 2013; Wrobel et al., 2009). Being part of the invisibility, more specifically, Arab American's women are often misrepresented and misunderstood by Western culture further increasing the various stressors they face while living in the United States (Abboud et al., 2015; Kakoti, 2012).

Acculturation also plays a significant role in how Arab American families adjust to living in the United States and further influences their values, traditions and relationships (Nassar-McMillan et al., 2013). Often times, the expectations that are associated with acculturation can create high levels of stress for families (Nassar-McMillan et al., 2013). Arab Americans who demonstrate difficulties with English, lower education levels, shorter length of residence in the U.S., and involuntary immigration have an increased likelihood of experiencing acculturative stress (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013). More specifically, women of Arab descent who have immigrated to the United States are considered to be at risk for developing mental and physical health symptoms as a result of the pressures of adjusting to American mainstream behaviors and influences on their children and family in addition to experiencing their own social discomfort (Wrobel et al., 2009).

Impact of Historical and Current Events: After the 9/11 attacks, Arab Americans became the target population for hate crimes and discriminatory acts (Nassar-McMillan et al., 2013;Haboush, 2007). As a result, Arab American women faced negative stereotyping, open prejudice, hate crimes and increased suspicion and distrust of Arabs, all of which were significant stressors and negatively impacted their overall wellbeing (Al-Krenawi & Jackson, 2014; Kakoti, 2012). During this time, many Arab American also males faced difficulties obtaining employments, or experienced lay-offs which resulted in a greater

need for Arab American women to become earners or seek out other means of income (e.g., public assistance) to help the family. This also created a new role for Arab American women while also maintaining familial and domestic responsibility. As a result, many women of Arab descent face multiple role stressors. Discrimination is considered to be a risk factor for acculturative stress as it can result in increased segregation of Arab Americans from other cultural groups (Nassar-McMillan et al., 2013;Haboush, 2007). These stressors may impact the way they interact with other women, feeling as though they do not belong or are misunderstood by American women. As a result, women may report lower pscychological well-being and feelings of inferiority during the acculturation process when they have experienced discrimination from the host or dominant culture (Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Of note, many Arab American families have experienced decades of political instability in their home countries and with the increased negative portrayal of their culture, many Arab American women may have an apprehensive worldview towards American mainstream (Erickson, C. D., & Al-Timimi, 2001; Nassar-McMillan et al., 2013) Additionally, research suggests (Nassar-McMillan, & Hakim-Larson, 2003; Erickson, & Al-Timimi, 2001) that many of the immigrants that have entered the United States in response to the Gulf and Iraq wars have presented with symptoms of posttraumatic stress disorder (PTSD), lower education levels, little economic resources and are less culturally assimilated. As a result, transgenerational trauma may impact the individual, family and the community and should be taken into consideration while working with women of Arab descent who have grown up in families who have emigrated from countries with repressive regimes and/or war-torn regions (Goodman 2013; Evans-Campbell, 2008; Beitin, & Allen, 2005).

Resultant Stressors:		
Discrimination	fear	low self-esteem
Isolation	anxiety	"the other"
Prejudice	mistrust	ostracized
PTSD	inferiority	misunderstood
Hiding identity	Harassment	Social rejection

Impact of Religious Affiliation: Arab Christians have demonstrated higher indicators of immersion than Muslim Arabs noting less taxing processes of acculturation possibly due to the common religion (e.g.., Christianity) between dominant culture that they hold (Nassar-McMillan, & Hakim-Larson, 2003).Muslim Arab Americans are more likely to be seen as outsiders and experience more stressors acculturating to the American culture due to the hostile prejudices, discriminatory acts against them and misrepresentations in the media (Mourad & Abdella, 2010; Naber, 2000; Nassar-McMillan et al., 2013; Nassar-McMillan, &

Hakim-Larson, 2003). Women of Arab descent living in the United States who identify as Muslim experienced confusion, distrust towards Western society and fear to express themselves religiously (e.g., hijab, verbally identifying as Muslim). As a result, Arab American women may experience increased worries, emotional distress, and further marginalization from American society due to their religious beliefs and/or identification (Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan, & Hakim-Larson, 2003). Furthermore, some women will reject their religious identity or beliefs in order to feel accepted in the dominant culture.

Resultant Stressors:	
Religious confusion	internal conflicts
Negotiating religious beliefs	distancing from religion
Discrimination	changing dress/garb
Isolation	negotiating values
Rejection	moral superiority

Impact of Parent-Child Relationships: A common theme that emerges within Arab American family systems includes intergenerational and intercultural conflicts (Henry et. al., 2008; Nassar-McMillan et al., 2013). For first generation Arab American women, their parents' immigration process, including reason for immigrating, openness to American culture, and level of ethnic identity can create tensions between parent-child relationships and impact the child's overall wellbeing (Henry et. al., 2008; Nassar-McMillan et al., 2013). Immigrant parents and first generation Arab Americans experience increased anxieties over adopting American cultural values and mothers may tend to become restrictive over their children, more specifically their daughters (Henry et. al., 2008; Nassar-McMillan et al., 2013). As a result, mothers may feel increased pressures to hold on to their traditional values while simultaneously encouraging their children to integrate with American society.

Women of Arab descent living in the U.S. fear that their children will assimilate into the U.S. culture and lose their Arab values and identity. This often leads to restrictive upbringings (e.g., strict disciplining and limiting social interactions). Furthermore, mothers may feel increased pressure to share cultural values, traditions and religious views with the family and their children. In relation to acculturation, often times, children tend to acculturate faster than their parents. This creates a shift in hierarchical power and disrupts the traditional family structure and cohesion. To compensate for such changes, parents will send their children to Arabic school and/or Christian or Muslim cultural centers. Arab American women are also expected to maintain family cohesion, care for and raise children, protect the family and extended family members while excelling in her duties as a wife, sister and daughter. Additional stressors include increased pressure from society to

raise children to become successful, educated, and well-liked individuals as her children become the reflection of herself.

Resultant Stressors:	
Need to protect children	internalize feelings of failure
Pressure to teach cultural values	worry
Responsibility for children upholding	helpless
Arab values and traditions	
Judgment from community	
Protection from American mainstream influences	

Impact of Gender Role Expectations: Arab American women are expected to uphold traditional gender roles in order to adhere to the collectivist Arab ethnic identity (Al-Krenawi & Jackson, 2014). Although an Arab American woman may pursue higher education and develop a career, she is still expected to be responsible for the family. As a result, Arab American women may face increased stress and difficulties fulfilling multiple roles expectations. Additionally, as females, they are expected to continue to care for their siblings and parents well-after marriage and having their own children. This can often create increased pressure to maintain cohesion for both nuclear and extended families while also relinquishing her own needs and desires. At a very young age, both immigrant and first generation Arab American females are taught that their behaviors reflect the family's honor and reputation. This can create difficulties for females that are acculturating to American mainstream, where individual needs and desires over familial needs are emphasized.

Arab American women are expected to maintain honor also through upholding of chastity and sexual virtue (Abboud et al., 2015; Al-Krenawi & Jackson, 2014; Naber, 2012; Naber, 2006). This can create difficulties for women who start to date in the U.S., as they attempt

Resultant Stressors:	
Identity confusion	Arab versus American expectations
Maintaining "good girl" identity	individual needs/desires vs. family's
Family reputation	
Upholding honor for family	
Familial expectations	
Employment Expectations	

to negotiate liberal Western view of sexuality and virginity with that of the conservative Arab viewpoint. Additionally, Arab American women's sexualities are often conceptualized from a patriarchal and collective point of view, omitting a woman's subjective identity. As a result, women face challenges understanding their sexual orientation in relation to their cultural and religious communities.

Implications for Mental and Physical Health: Physical and mental health has been linked to level of acculturation including immigrant status, educational attainment, occupation, gender roles, and the individuals place in her family and community (Al-Krenawi & Graham, 2000; Jadalla, Hattar & Schubert, 2015; Kakoti, 2012; Nassar-McMillan et al., 2013). Furthermore, Arab American women's mental health is greatly affected by the conditions under which they immigrated (e.g., planned/unplanned, refugees, choice/no choice, educational, career). Some studies have indicated less depression and acculturation stress and increased life satisfaction with Arab Americans who have integrated into American mainstream culture and have adopted American beliefs (Kakoti, 2012; Nassar-McMillan et al., 2013; Read & Reynolds, 2012). On the contrary, some studies have also indicated that exclusively maintaining an Arab ethnic identity is associated with a positive psycho-social wellbeing, and that high biculturalism may result in lower personal self-esteem and lower emotional adjustment (Nassar-McMillan et al., 2013). Of note, affective experiences may be expressed in physical symptoms (e.g., headaches, stomach aches, difficulties sleeping) as the expression of conflict or negative feelings is not readily accepted in Arab culture (Al-Krenawi & Graham, 2000; Al-Krenawi & Jackson, 2014; Kakoti, 2012). Physical symptoms are seen to be more legitimate and motivate Arab Americans to seek medical treatment (Al-Krenawi & Graham, 2000). Lastly, navigating between traditional Arab culture and American mainstream has been shown to create psychological distress for women of Arab descent living in the U.S., including anxiety, depression, low self-esteem, and internal conflicts (Al-Krenawi & Graham, 2000; Jadalla & Lee, 2012; Kakoti, 2012; Nassar-McMillan et al., 2013).

Resultant Mental Health and Physical Health Symptoms:	
Depression	Digestion issues
Anxiety	Headaches/migraines
Social Anxiety	Chronic Pain
PTSD	Diabetes
Fearful	Other somatic complaints
Avoidance	Fibromyalgia
Shame	
Loneliness	
Emotional distress	

Other Acculturation Stressors:	
Changes in primary support network	Degree to which socioeconomic status changed since arrival in U.S.
Loss (e.g., relationships, family, ethnic ties)	Community support
Increased spousal dependence	Access to care
Potential loss of ethnic connection	Employment changes
Reasons for leaving country of origin	Identity Confusion
Proficiency in English	Periods of disharmony
Lack of ties with ethnic and/or host communities	
Ability to return to or visit home country	

Strengths and Resiliency Factors: Religion has played a key role in maintain the Arab collective identity and culture. It is used as a source of strength while negotiating contradicting American values and behaviors with that of Arab ethnic culture. Specifically, for Christians, religious affiliation has decreased the distress associated with acculturation due to sharing the same religion with the dominant culture. However, Muslims, tend experience increased prejudices and stressors when adapting to American culture. Religion has been used as a coping strategy with Arab American adults and youth, especially to manage post 9/11 stressors. The Hijab, which can create challenges for acculturation, can also be a source of resilience as it is representative of their community and cultural ties. For students, resilience may be mediated by the dynamic interaction of the individual's developmental stages and Arab cultural values, including support from parents, religious leaders, and mental health professionals.

Family support for social needs, economic support and cultural and religious maintenance and can buffer against effects of acculturative stress

Furthermore, family has been used for coping with the impact of war and violence. This is due to Arab Americans characterizing the struggles as collectivist and utilizing meaning making coping strategies. A more positive physical and mental health outcome was linked to increased satisfaction with their social support system and lower levels of depression and anxiety. For first generation Arab Americans, strong family support has been identified as a significant factor in their development and maintenance of their ethnic identity. Both immigrant and first generation Arab Americans engage in selective acculturation, where they maintain a strong ethnic identity but have a desire in interacting socially with American mainstream culture (Ajrouch, 2000). Spousal support/marital relationships are highly valued and can be protective factors during the acculturation process. Fostering cultural identify and self-esteem enhances individuals' motivation and drive to work hard. A strong immigrant community and networks can help mitigate challenges of acculturation due to the Arab collectivist value of emphasizing the receipt of emotional support from others. Lastly, education and English skills appears to be protective factors against acculturative stressors.

Resiliency and Protective Factors:
Family
Religious affiliation
Religious/spiritual leaders
Spousal support
Strong Arab ethnic identity
Community involvement
English proficiency
Meaning-making coping

Group Activity #2: Discussion

[Before going over the case examples below, encourage participants to share their reactions to the particular stressors that women of Arab descent living in the U.S. face]
[Read directions aloud: *You were given a significant amount of information about acculturation, acculturative stress and the unique stressors that women of Arab descent living in the U.S. face. Before we dive into case examples, I would like us to go over some of our own reactions, thoughts and preconceived notions about stress in relation to Arab American women.* Request for volunteers to begin the discussion by sharing

their reactions.] [Use different colored markers/pens/chalk to write down participants' responses to illustrate any differences or similarities before the psychoeducational process]

***For Facilitator: It is important to pay attention to any stereotypes and/or biases that are presented. This can be a sensitive discussion and being mindful of others' reactions will be important. Also providing a place of open discussion

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Group Activity #3: Ghada (Appendix D)

[Instructions to read aloud: *Let's start with a case example.* Instructions to read aloud: *Please split into groups* (2, 3, 4 people in one group depending on number of participants*) and take a few minutes to read the vignette and discuss pertinent issues that may come up while seeing Ghada in therapy. Specifically identifying particular stressors that seem to be impacting her overall wellbeing.*]

Ghada's experience of new familial changes (Appendix D)

Ghada is a 45 year old, married, Syrian Christian woman who immigrated to the U.S. when she was 18 years old after marrying her husband (15 years older) in a small Christian village in Syria. She was receiving her annual physical with her primary care physician (PCP) whom she has known for over 20 years. She began to complain about persistent migraines, stomach aches and increased heartburn. Ghada noted that nothing in her diet changed, in fact, she was eating healthier and engaging in regular exercise. Her PCP began to ask her questions about her children and how things were going at home. Ghada updated her PCP and shared that all of her children have moved out of the home, her oldest is in medical school, her middle daughter is finishing up law school and her youngest is in her first year of college. She further expressed how proud she was that all of her children were doing well and pursuing their dreams. Ghada shared that things were going well with her husband, he recently opened up his own liquor store and was having to work late hours and through the weekends, but business was booming. Ghada reported that she was looking for a part-time job to fill her time during the week as she noticed that she was starting to feel lonely without her children in the home. As the PCP continued to listen to Ghada, she noticed that Ghada was tearful and on the verge of crying when she would talk about

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her life. Ghada shared more of her difficulties adjusting to all of these changes and expressed that she was not used to the children permanently living outside of the home, especially since they were not married. She also explained that her son, the oldest of the children, recently shared that he is "agnostic" and that created confusion for her that he did not believe in God. She shared that before he went back to school in Arizona, he told her that he does not want to attend church anymore, does not want to celebrate Christian holidays, and would rather just focus on his studies. Ghada expressed that she was unable to sleep at night as she was up thinking about what she did wrong and what she could have done differently so that her son would not reject their family religion. She also noted that she is concerned that her daughter, who is 28 years old, is not dating or even close to marriage yet. She reported that she heard other Arab women talking about her daughter's age and relationship status. Ghada realized that the appointment was coming to an end, so she looked at her PCP and said "I don't know what to do, why we came to America. I don't know who I am anymore." As a result, her PCP provided some background information about her physical symptoms (e.g., migraines, stomach aches, acid reflux) and how they may be related to all of the stressors around her children and how she was feeling. She highly recommended that Ghada go see a therapist, which at first, Ghada expressed some worry about the therapist sharing her information with other people. After assuring Ghada that everything remains confidential and the process of therapy, her PCP provided her with three referrals to female therapists.

[If participants need assistance generating discussion points and identifying stressors, facilitator can pose these questions to the groups.]

Discussion questions: (Appendix E)
1. What is Ghada's presenting problem?
2. What factors may be impacting her acculturation in the U.S.?
   a. Social Support?
   b. Community involvement?
   c. Gender role expectations?
3. What is the impact of her religious affiliation (e.g., Christianity) on her beliefs about her children? Her relationship? Herself?
4. How do you understand her somatic complaints (e.g., migraines, stomach aches, heartburn)?

5. What impact are her children's decisions having on Ghada? How do you reconcile that?
6. How would you address issues of privacy and confidentiality with Ghada?
7. What are some resiliency factors that have assisted Ghada in her transition in the U.S. and her coping with stressors?
8. Are there other areas you would like to assess further? If so, which areas and why?

Analysis:

Initially, it is important for the therapist to address issues of confidentiality as privacy and self-disclosure are important topics when working with women of Arab descent living in the United States (i.e., issues of mistrust due to discrimination). Also recognizing that Arab Americans generally present with physiological symptoms which can be a reflection of the stress and emotional pain they may be experiencing, thus bringing attention on to her somatic symptoms in relation to her stress and mood would be important. Also recognizing that Ghada sought treatment through her medical physician at first, not thinking about reaching out to a mental health professional. Exploring Ghada's understanding of mental health treatment, stigma related to it, and any ideas that may contribute or impact treatment. Understanding Ghada's immigration experience including reasons for leaving Syria, how much family did she leave behind, and the political status of her country is also important to better understanding her and her presentation. For Ghada, it will be really important to have a good understanding of the current situation and political unrest taking place in Syria and how that may be impacting her and her family (e.g., are there family members still residing in Syria? Has there been loss since the political unrest?).

Furthermore, recognizing that as a mother and a wife, Ghada may be internalizing some of the familial stressors (e.g., her children moving away from religion and not following traditional Arab values of marriage and relationships) in order to maintain cohesion in the family system. As a result, issues of self-blame, shame and guilt may be present for Ghada. Further exploring Ghada's social network and role in her community will be helpful in understanding how she is coping with her stressors. Additionally, recognizing that family is a source of strength and support for many Arab American women, but can also create stress and pressure, especially around parenting and transferring values down to children and other family members. Ghada may also be

struggling with the changes in her role as a mother after her children have left the home, feeling loss. Additionally, the desire to start to work may change the dynamics in her marital relationship and the pressure to balance her work with her domestic and familial responsibilities.

A discussion around Ghada's strengths which may include raising three children in a new country, her faith, the success of her children, her role as a mother and wife, her skills in integrating into a new society, reaching out for help, etc., would be important. Also, really understanding her preimmigration and postimmigration process will give insight into some more of her strengths. Also, identifying resiliency factors from her Arab culture that have assisted her through her time in the U.S. is also very important to discuss and understand.

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Group Activity #4: Jamilla (Appendix F)

[Instructions to read aloud: *Here is another case example, this one has a few more complexities to think about.* Instructions to read aloud: *With your same groups, take a few minutes to read the vignette and discuss pertinent issues that may come up while seeing Jamilla in therapy. Specifically identifying particular stressors that seem to be impacting her overall wellbeing.*]

Jamilla (Appendix F)

Jamilla is a 35-year old married Egyptian woman who immigrated to the U.S. with her husband, son (age 18) and daughter (age 16). Jamilla's family immigrated to the U.S. by way of the Diversity Visa (or the "lottery" as many call it). Jamilla has a sixth-grade education and does not speak any English. Her son graduated from high school and is attending community college, and her daughter is a junior in high school. Her husband, who no longer resides with the family, is unemployed.

Jamilla was referred for individual counseling by her case manager, who reported that Jamilla was struggling to cope with her marriage. At intake, Jamilla reported that several months ago her daughter had discovered that her father had been sending romantic emails to another Arab woman overseas. After Jamilla confronted her husband, he informed her that he is actually married to the woman and they are

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expecting twins. He further informed Jamilla that he would like her and the children to leave the home and return to Egypt so his second wife could join him in the U.S. Jamilla reported that when she refused to return to Egypt, her husband became verbally and physically abusive toward her. He locked her in their home; removed most of the furniture, expect items he used; removed all of the kitchenware to prevent her from cooking; and refused to provide her with any money to purchase food or necessities. However, he did ensure that the children had food to eat.

With the assistance of her case manager, Jamilla was able to go to a hospital for a physical exam to document the abuses. With documentation, she was able to have her husband arrested and removed from the home. She was also able to get a restraining order to prevent her husband from returning to the home.

Jamilla now struggles with being the sole wage earner in the home, as her husband is unable to pay child support because of being unemployed. He also fled the country and cannot be held accountable unless he returns to the U.S. Jamilla believes she will be able to find employment immediately even though she has no language skills or transferrable job skills. Jamilla would like to start her own day care center and wants assistance with becoming certified. Yet, without any English language skills, she is unable to participate in the training courses. Jamilla does not believe she needs to take English language classes and intends on relying on her children to interpret when needed, as she has been doing since her arrival into the U.S.

Jamilla views counseling as additional case management and expect the counselor to assist her in meeting her basic needs despite already having a case manager. She shows up unannounced to see the counselor and calls several times a week asking the counselor to interpret for her or to advocate for her needs. Jamilla also struggles with regulating her emotions and has limited coping skills, which causes her to have meltdowns and temper tantrums in counseling any time she is confronted or something does not go as she expects (e.g., when she learned she was unable to attend child care certification courses because of her limited language skills). She has also become verbally abusive towards her children, especially her son, whom she suspects is in contact with his father and "spying" on her. Jamilla is unable to acknowledge the breakdown in her communication skills and coping behaviors and has a skewed sense

of reality and what she can accomplish. Her children are becoming increasingly impatient with her and are beginning to isolate themselves form her.

**adapted from Amri, S., Nassar-McMillan, S., Amen-Bryan, S., & Misenhimer, M., (2013). Counseling Arab Americans. In C. Lee (Eds), *Multicultural issues in counseli: ng: New approaches to diversity:* (pp. 87-104). Alexandria, VA: American Counseling Association.

Analysis:

It is important to highlight all the stressors that Jamilla is facing: acculturation stress, language difficulties, issues of infidelity and husband leaving family (contrary to values of a cohesive family unit), physical abuse, immigrant status, gender role changes (e.g., becoming sole wage earner), limited education, multiple role stressors, internalization of loss of marriage, lack of social support, possible somatization, loss, etc. Furthermore, providing psychoeducation about the process of individual therapy, the role of the counselor and what treatment will entail is very important for transparency, building rapport and helping Jamilla understand her referral. Also helping her understand boundaries between client and counselor and expectations of treatment are important; however, these topics should be addressed in a culturally responsive manner. Using your understanding of acculturation stress and stressors unique to women of Arab descent living in the U.S., it will be important to have a discussion around expected cultural norms for Jamilla and the differences and challenges she is experiencing. In particular, what her preimmigration and postimmigration processes entail. Also, helping Jamilla gain insight into the impact of her communication and challenges are having on her children and possible ways to incorporate them into treatment.

Another area is to help Jamilla understand the implications of domestic violence and the impact it is having on her sense of self and feelings of helplessness. It will be important to think about cultural factors influencing Jamilla's perception of domestic violence (e.g., reputation and image in Arab community, expectations on Arab women to maintain peace and family cohesion). Further, assisting Jamilla in developing an increased coping skills and resiliency by increasing her self efficacy by learning to complete small tasks that her husband was expected to do (e.g., learn to use public transportation, complete necessary applications for needed services). Additionally, assessing the role of religion in her life and how it's impacting her perception and way of being in the world is another area to explore with Jamilla. Lastly, think about what

additional cultural resources could be beneficial for Jamilla and her family and other areas of support she can use while in treatment and after treatment terminates.

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(Optional) **Group Activity #5: Open Discussion**

***Facilitator can decide if she/he would like to include this activity and if there is enough time.

[Facilitator can elicit case examples from participants and/or share her/his own examples. The purpose of this discussion is to further explore and understand the unique stressors that women of Arab descent living in the U.S. face. Additionally, it allows for a safe space to discuss any reactions participants may have to the case examples given or the stressors that women of Arab descent face.]

[Facilitator can refer back to the board where ideas were recorded around acculturation, acculturative stress, and stressors women of Arab descent living in the U.S. face]

"Can I see another's woe,
And not be in sorrow too?
Can I see another's grief,
And not seek for kind relief?"

-William Blake

Section 5: Examples of Culturally-Syntonic Stress Management Activities and Coping Skills Building
(60 minutes)

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Group Activity #1: Compassionate Breathing In and Out (Appendix G)

[Facilitator will begin this section by guiding a compassionate breathing exercise]

> *This guided meditation is adapted from: Mindful Self-Compassion, Christopher Germer, PhD and Pennington, B. (1982). Centering Prayer: Renewing an ancient Christian prayer form. Garden City, NY: Image Books.

[Please read aloud]:

Inviting you to sit comfortably with your feet on the floor, closing your eyes or looking down, whatever feels the most comfortable, and take a few relaxing breaths (pause for a few seconds)

Scan your body for physical stress, noting the location and quality of the discomfort. Also allow yourself to become aware of any stressful emotions that you may be holding in your field of awareness. If a challenging person comes to mind, let yourself be aware of the stress associated with that person. If you are experiencing the suffering of another person through empathy, let yourself be aware of that discomfort as well (pause for a few seconds)

Now, aware of the stress you are carrying in your body, inhale fully and deeply, drawing compassion inside your body and filling every cell in your body with compassion (pause for a few seconds) *Let yourself be soothed by inhaling deeply, and by giving yourself the compassion you deserve when you experience discomfort* (pause for a few seconds). *As you exhale, send out compassion to the person who is associated with your discomfort, or exhale compassion to living beings in general.*

Continue breathing compassion in and out. Occasionally scan your inner landscape for any distress and respond by inhaling compassion for yourself and exhaling compassion for those who need it (allow for some time to continue breathing).

When you are ready, Gently open your eyes and bring your awareness back to the room

[Facilitate discussion around participants' reactions and experiences with this activity]
[See below to provide rationale for compassionate breathing exercise]
....

There is a paucity of research on the effectiveness of Western psychological interventions with Arab Americans (Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010); however, it is essential to take into consideration all of the biopsychosocial factors while working with this population. More specifically, keeping in mind that family and community are prominent values for Arab American women. Furthermore, clinicians need to recognize not only the outward expression of mental or emotional distress but also Arab American women's beliefs and ideas about mental health treatment in order to provide culturally syntonic interventions (Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Mind-body: Mind-body medicine, a popular element of complementary and alternative medicine (CAM), has become a widespread treatment option to improve physical and psychological health as well as overall quality of life (Woods-Giscombé, & Black, 2010). This includes practices such as yoga and relaxation training that are aimed at decreasing sympathetic arousal, promoting present-moment awareness, relaxation, awareness of the body, and compassion towards others and the self (Woods-Giscombé, & Black, 2010). According to Mercer (2009), stress management programs that are successful tend to use a comprehensive approach including addressing biopsychosocial aspects that are promoting a stress response in individuals. Furthermore, implementing relaxation exercises, meditation and lifestyle changes into an individual's life can help decrease stress and the risk for developing psychopathology or physical disease as well as promoting overall well-being (Benson, 2008; Carlson et al., 2007; Cohen, Janicki-Deverts, & Miller, 2007; Hibbeln, 2009; Ludwig & Kabat-Zinn, 2008; Mattison & Nemec, 2014; Niemoller, Stark & Bazan, 2009; Ramel, Goldin, Carmona, & McQuaid, 2004; Rosenzweig et al., 2007).

Furthermore, when an individual perceives a threat by an external danger, the fight, flight, freeze response becomes activated; however, when threatened internally by feelings of dread and shame, the physiological response (i.e., fight-flight-freeze) will become a pattern

of self-criticism, self-isolation and self-absorpotin (Germer & Neff, 2015). Through *self-compassion*, an individual has the capacity to respond to her own suffering in a healing and soothing manner (Germer & Neff). With increased self-compassion, there is also an improved overall wellbeing and psychological health (Germer & Neff, 2015; Yarnell & Neff, 2013). However, for Arab American women, the concept of *self-compassion* may be overwhelming, as the focus becomes the self versus others. Moreover, engaging in this process may allow for a new experience for Arab American women to care for themselves in order to become better caretakers for their family members and achieve overall improved wellbeing. Through compassion, Arab American women can also learn to transform suffering which can range from discriminatory acts they face while living in the U.S., or trauma from their country of origin.

Diaphragmatic breathing: Diaphragmatic breathing (DB), a relaxation technique promoting deep-breathing and described as an essential component in Pranayama, Yoga, Zen and transcendental meditation, is one of the most highly endorsed relaxation approaches (Donovan & Kleiner, 1994; Martarelli, Cocchioni, Scuri, & Pompei, 2011). Through DB, an individual is encouraged to deeply breathe into the lungs and contract the diaphragm allowing the belly to expand as air enters the lungs (Martarelli et al., 2011). Moreover, the individual's goal is to change their way of breathing and move away from shallow and rapid anxious breaths to a more relaxed and deep style of breathing (Marcus & Deodhar, 2012). Generally, it is recommended that the individual inhale and exhale for five counts as a means of regulating the rate of breathing (Donovan & Kleiner, 1994). Meditations that tend to use this type of breathing practice have shown to increase melatonin levels and decrease levels of cortisol and oxidative stress (Martarelli et al., 2011). Furthermore, DB interrupts the fight-or-flight response activated during stressful situation as a result of the increase of oxygen in the blood stream and further stimulates the natural relaxation response of the body (Donovan & Kleiner, 1994). However, the peer reviewed literature on the use of DB with women is limited, and instead, tends to suggest the use of DB for women suffering form fibromyalgia as a way of reducing pain related to stress (Marcus & Deodhar, 2012) and women at risk for preterm labor (Janke, 1999). Furthermore, since many Arab Americans express stress and emotional pain through somatic complaints, targeting the physiological response of the body can alleviate some of the somatic symptoms.

Progressive muscle relaxation (PMR): Progressive Muscle Relaxation, a technique developed by Edmund Jacobson in the 1920's, has been shown to assist individuals achieve a state of relaxation through learning how to control and monitor muscular tension (Hall & Long, 2009; Janke, 1999; McCallie, Blum & Hood, 2006). Furthermore, PMR has been shown to be the most common type of relaxation approach used by clinical psychologists when compared to the six major relaxation approaches including autogenic training,

breathing exercises, yoga, stretching, imagery, and meditation (Ghoncheh & Smith, 2004). Through PMR, an individual learns how to notice tense muscles in comparison to relaxed muscles in the body further allowing them to achieve a state of relaxation during stressful instances. PMR also helps control various physiological states through the progressive relaxation of different muscles in the body and further reduces heart rate, sweating, and startle response (Davis, Eshelman, & McKay, 2008). In addition, calmness and overall wellbeing has been correlated to alpha and theta waves in the brain, which have been shown to increase through the use of PMR (Hall & Long, 2009; Benson, 2008). Literature has deemed PRM to be efficacious in managing and treating symptoms related to anxiety, depression, insomnia, cancer, chronic pain, stress, trauma, tension head aches, arthritis, irritable bowel syndrome, high blood pressure, stuttering, minor phobias, anger and acute schizophrenia in addition to improving sleep, energy and overall relaxation (Chen et al., 2009; Davis et al., 2008; Hall & Long, 2009; McCallie et al., 2006; Parlow & Jones, 2002).

According to literature, PMR has been shown to be efficacious with a limited population of women including moderate security inpatient females with mental illness, pregnant women, women undergoing chemotherapy for breast cancer and overweight/obese women (Akmeşe & Oran, 2014; Christaki et al., 2013; Demiralp, Oflaz, & Komurcu, 2009; Gawande, Vaidya, Tadke, Kirpekar, & Bhave, 2011; Hall & Long, 2009). Additionally, some clinicians have noted early dropout within participants due to PMR's tendency to be less intrinsically rewarding than other relaxation exercises (Smith, 1999).

Social Support: Further, social support is a mechanism through which women can connect, create meaning out of stressors, regulate their biochemistry via the release of oxytocin and endure the benefits of improved health and well-being (Bellman, Forster, Still, & Cooper, 2003; Goodwin, Costa, & Adonu, 2004; Ogden, 2012; Sabina & Tindale, 2008; Taylor et al., 2000; Turner-Cobb et. al., 2002). More specifically, for Arab American women, utilizing meaning making coping strategies are congruent with their collectivist struggles and have shown to lower levels of depression and anxiety. Furthermore, Arab American women tend to use their social support networks (e.g., family support, friends in the community) as their primary source for problem solving (Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Approaches to Therapy: Contrary to Western therapeutic approaches that focus on the individual and her needs, approaching treatment with women of Arab descent living in the United States in the context of family, community, and religious affiliation is crucial (Al-Krenawi & Graham, 2000; Dwairy, 2009; Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010;Nassar-McMillan et al., 2013). Additionally, it is important to recognize that seeking mental health treatment and/or disclosing family problems can be a shameful experience for many Arab American women and may create some barriers for

treatment (Erickson & Al-Timimi, 2001;Mourad & Abdella, 2010). As a result, providing psychoeducation around mental health treatment, openly discussing the client's expectations of treatment, explaining the client-clinician relationship and thoroughly and continually discussing their rights to confidentiality are culturally syntonic approaches to treatment with Arab American women (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013).

Congruent with their hierarchical and patriarchal society, many Arab American women may also expect a hierarchical setting in therapy, often times, viewing the clinician as an "expert" who will provide knowledge and teach them how to solve a problem (Erickson & Al-Timimi, 2001; Kakoti, 2012; Mourad & Abdella, 2010). Some authors have suggested approaching treatment with Arab American women from a more directive or advisory role as it may strengthen the alliance and trust (Nassar-McMillan et al., 2013; Mourad & Abdella, 2010). Due to the inconsistent literature on treatment approaches with Arab American women, there does not seem to be one theoretical orientation that seamlessly fits with this particular population. Instead, it is important that the clinician use her/his clinical judgment and cultural understanding of the individual's presenting issues. This may include utilizing an integrative approach and additional self-disclosure from the therapist to facilitate an open discussion around cultural differences as additional ways of strengthening the client-therapist relationship (Erickson & Al-Timimi, 2001; Mourad & Abdella, 2010; Nassar-McMillan et al., 2013).

Metaphors are readily used in Arab culture to describe experiences and emotions. The use of metaphors in session, a culturally syntonic approach to treatment, allows clients to process unconscious content that may be contributing to their distress without direct confrontation creating increased discomfort (Al-Krenawi & Graham, 2000; Dwairy, 2009; Nassar-McMillan et al., 2013).

Furthermore, incorporating a *multi-systemic approach* to the presenting problems allows Arab American women to reach out for support from family and friends while addressing any system challenges versus individual conflict (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013). Exploring and thoroughly understanding an Arab American woman's family and religious life will help guide the therapeutic interventions and acknowledge the important cultural values that are integral parts of an Arab American woman's identity (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013). Additionally, explicitly discussing discrimination, stresses of acculturation including the immigration process and biculturalism will give the clinician insight into the particular stage and developmental tasks that are prominent for the individual (Erickson & Al-Timimi, 2001; Kakoti, 2012; Nassar-McMillan et al., 2013).
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Group Activity #2: Role Play

<u>Materials</u>: case vignette on a separate sheet of paper.

[During this activity, participants will divide into dyads]

[Read Instructions Aloud: *Please break up into pairs of two for this role-play activity. Each pair will be given the same case vignette to act out for approximately ten minutes. Each person will have an opportunity to play the client and play the therapist within the ten minutes.*] [Once participants are in their groups and identify who will be playing the therapist, pass out the case vignette]. **See appendix H for a handout of the case example

[Guidelines to the role-play to be read aloud: While doing the role-play, therapists please incorporate culturally-syntonic approaches to treatment and therapy that we just finished discussing. If appropriate, think about how you would incorporate the stress-management interventions to address the stressors that your client presents with]

[After the role play is completed, facilitatory will ask the questions below to encourage a discussion around the participants experiences as both client and therapist, culturally-syntonic stress management interventions used, stressors unique to Arab American women presented, and other challenges that may have come up].

Case Example #4: Maysa's Transition (Appendix H)
*Adapted from: Mourad, M., & Abdella, C. M. (2010). An Ecological Approach to Culturally Sensitive Intervention for Arab American Women and Their Families. The Family Journal, 18, 2, 178-183

Maysa a 40-year-old Muslim woman who immigrated from the conservative part of Lebanon to Dearborn Michigan three years ago with her husband Ali, 61, and three children aged 10 to 16. Ali was laid off from a custodial job the year before and has not been able to find work. Maysa has been seeking employment but has little formal education and English language ability and is also uncomfortable leaving her children home without any female relatives to care for them. Ali does not believe childcare is his

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responsibility and when forced to do so, he becomes impatient and inattentive. Due to their financial situation, Maysa has felt embarrassed to share her struggles with her friends from her Mosque and instead, has stopped attending prayer groups and other social engagements within the community. During her children's annual check up at their pediatrician's office, Maysa presented very anxiously and shared feelings of disappointment in herself for being unable to send her family money due to her current financial situation. As a result, the pediatrician suggested that Maysa seek counseling and provided her with some names of mental health professionals.

[Facilitator can ask: *What is Maysa's presenting problem? What parts of her Arab American identity are impacting her presenting problem? How are those stressors manifesting in her life? What areas did you pay particular attention to? What types of culturally syntonic stress management interventions could you possibly implement in your work with Maysa? How would you therapeutically approach treatment with Maysa?*]

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Group Activity #3: Progressive Muscle Relaxation Exercise (Appendix I)

*If time permits, end this section with a PMR exercise to demonstrate this stress reduction intervention

[Facilitator please read script aloud]:

This relaxation strategy is used to help relax muscles that have become tense due to stress. This exercise takes frequent practice for your to become more aware of when and where you are experiencing tension. You will be tensing (not to the point of pain) and releasing each muscle in your body. However, if you have any injuries or pain, you can skip those specific areas.

Inviting you to take a comfortable position, closing your eyes or looking down, whatever feels right for you. Begin by taking a few deep breaths, filling your lungs with air. Hold the breath for a few seconds.

[Brief pause]

Exhale slowly and release the tension from your body, let it go. As you continue to breathe, with each exhale, imagine the tension leaving your body.

Now move your attention to your feet and begin to feel the tension as you curl your toes downward. Hold onto the tension and notice what it feels like.

[5 second pause]

Now release the tension in your feet and notice the new feeling of relaxation.

Shift your focus to your lower legs; tighten your calf muscle paying attention to the tension.

[5 second pause]

Release the tension in your lower legs, again noticing the feeling of relaxation while continuing to take deep breaths.

Now, begin to tense your upper leg and pelvic area by squeezing your thighs together gently, noticing the tension.

[5 second pause]

Release the tension. Notice the tension leave your muscles
Start to tense your stomach muscles by sucking in your stomach and holding the tension.

[5 second pause]

Release and imagine the tension just leaving your stomach. Allowing your body to go limp and noticing the relaxed feelings.

Remember to continue taking deep breaths, imagining your lungs filling with air. Now tense the muscles in your back by bringing your shoulders behind you and holding them tightly.

[5 second pause]

Release the tension from your back. Notice the new feeling of relaxation

Now tense your arms, hands and shoulders all together by making a fist and squeezing all the way up your arm. Hold it.

[5 second pause]

Now release the tension from your arms and shoulders. Pay attention to the feeling of relaxation in your fingers, hands, arms and shoulders.

Next, going up to your neck and head, tense your face and your neck by closing your eyes tights and opening your mouth like you are yawning.

[5 second pause]

Release the tension noticing the feeling of relaxation over your muscles.

Now tense your entire body including feet, legs, stomach, arms, head and neck. Hold that tension gently without straining.

[5 second pause]
Release the tension allowing your body to go limp and noticing the feeling of relaxation.
Slowly begin to wake your muscles, adjusting each body part and opening your eyes when you are ready. Stretch your muscles.

Section 6: Additional Resources (Appendix J)

(10 minutes)

[Facilitator can review resources with participants.]

Arab Community Center for Economic and Social Services (ACCESS)
https://www.accesscommunity.org
*Includes resources on cultural arts, employment and training, public health and education

American Arab Anti-Discrimination Committee (ADC)
http://www.adc.org
*ADC is a civil rights organization committed to defending the rights of people of Arab descent and promoting their rich cultural heritage

Arab American Institute (AAI)
http://www.arab-aai.org
* Promotes Arab American participation in the U.S. electoral system, AAI has developed a host of services, from voter education to liaison with the national parties, to support the community's activities. They are also the leading policy and research organization on domestic and policy concerns of Arab Americans.

Institute on Religion and Civic Values
http://www.irvc.org
*Scholars that provide academic information on Islam

Middle East and Middle Eastern American Center (MEMEAC)
http://memeac.gc.cuny.edu
*Based in City University of New York, promotes the study of the Middle East and Middle Eastern Americans.

Network of Arab-American Professionals (NAAP)
http://www.naaponline.org
*A nonpartisan, volunteer-based organization dedicated to strengthening the Arab American community.

Section 7: Networking
(30 to 60 minutes)

[Use the remaining time to allow participants to network with each other.]

[The following activities can be used to facilitate a friendly networking experience and are optional]

Activity 1: [Read instructions aloud: *In the next two minutes, go up to as many people in the room, shake their hands, and give them your business card. The catch: no two handshakes/introductions can be the same. This will allow you to be creative and also exchange information with each other.*]

Activity 2: [Read instructions aloud: *Split into pairs but make sure to pair off with someone that you do not know. Find three things you have in common that may not be obvious. Exchange business cards.*]

Activity 3: [If there are a large number of participants, then break up into small groups. If the total number of participants is small, you can stay as one group for this activity] [Read instructions aloud: *Share one misconception/misperception you may have had about women of Arab descent living in the U.S. before attending the workshop, and how that has changed*]

Activity 4: [If there are a large number of participants, then break up into small groups. If the total number of participants is small, you can stay as one group for this activity] [Read instructions aloud: *What new knowledge and ideas do you feel have enriched your understanding of working with women of Arab descent living in the United States?*]

Activity 5: You will need a ball of yarn and scissors for this activity (or more than one ball of yarn depending if you split into smaller groups). [If there are a large number of participants, then break up into small groups. If the total number of participants is small, you can stay as one group for this activity] [Read instructions aloud: *Make sure to sit in a circle. One person will start with one end of the yarn. They will share their*

commitment to work on _____ (ex: asking about country of origins political relations to U.S.) Then, that person will pass the yarn to someone else and so forth. After it has circled to everyone, each person will take a piece of that yarn and tie it onto his or her wrist as a bracelet of commitment.]

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Appendices

Appendix A: Objective of Workshop and Road Map

Objective: *Today's workshop is meant to facilitate an atmosphere of learning and engagement around issues regarding mental health and wellbeing that women of Arab descent face while living in the United States. More specifically, this workshop will address the various stressors, coping mechanisms, strengths and barriers relevant to this population. Mental Health professionals will have access to additional resources and are encouraged to continue to deepen their understanding of stress and wellbeing related to women of Arab descent living in the United States.*

Roadmap: 5 to 7 hours (flexible)
1. Introductions and Purpose of Workshop (30-45 minutes)
2. Understanding Stress and Women of Arab Descent Living in the United States (60 minutes)
3. Identifying Stressors experienced by Women of Arab Descent Living in the United States (60 minutes)
4. Discussion of Historical Events and Current Issues Relevant to Women of Arab Descent Living in the United States, (60-90 minutes)
5. Examples of Culturally-Syntonic Stress Management Activities and Coping Skills Building (60 minutes)
6. Provide Additional Resources (10 minutes)
7. Networking (30 min-60 minutes)

Appendix B: Case Example-Mona

Mona's arrival to the United States

Mona emigrated to the U.S. from Jordan when she was 18 years old with her husband. She did not complete a highs school education, instead, she was encouraged to get married and have children. She had mixed feelings about her new husband, Bassam and her responsibilities towards him. She expressed sadness around not completing her educations as she had always dreamed of being a nurse. Bassam brought her to Los Angeles, a city that was completely foreign to her and a place where she did not know anyone. She left behind her parents, six siblings, best friends and extended family. She spent several hours every day FaceTiming with her family, which made the distance harder to handle as she noticed that would miss them more after the conversations ended. Mona also found herself learning how to cook, clean, and do laundry all by herself. Bassam would come home every night expecting dinner to be ready. Mona noticed that was finding herself trying to connect with her husband, but he was always tired after work and chose to watch T.V. instead of socialize with her. Eventually, she became pregnant with her first child. Her mother was unable to leave Jordan because she was not given a visa, so Mona found herself alone through this pregnancy. Bassam's mother stayed with them for three months after the birth of their child; however, Mona felt that she was constantly being criticized and judged for everything she was doing "wrong." The little moments she had to herself, she would spend fantasizing about the life she had always dreamed for herself, receiving a degree for nursing, working at a hospital, falling in love with a doctor at the hospital, getting married and having children in Jordan while living near her family. Realizing that she was far away from this dream, Mona became more and more isolated and withdrawn. She was able to fulfill her duties as a mother, but as soon as Bassam came home and could watch their son, she would cry herself to sleep and spent most of the time in bed. During one of her post-natal appointments with her gynecologist, she was given a PHQ-9 and scored 19 (moderately severe). The gynecologists further assessed her depressive symptoms and made a referral for her to see a psychologist. However, Mona, panicked and said that she would not be able to share this with her family because they would think she was "crazy" and that she wasn't "fit to be a mother."

Appendix C: Discussion Questions-Mona

Discussion questions:

1. What are some assumptions you might make about Mona based on her demographics?
2. To what extent, if any, do you believe that other members should be involved in Samar's therapeutic treatment? Which family members? How so?
3. What stereotypes may be supported or challenged from this case?
4. What are some of your personal reactions that you had while reading this case study?
5. Are there other areas you would like to assess further? If so, which areas and why?
6. What do you anticipate are Mona's strengths? How can her strengths be used/highlighted in session?
7. What are some challenges you can anticipate in your work with Mona?
8. What are other cultural/diversity issues that you should be aware of?

Appendix D: Case Example-Ghada

Ghada's experience of new familial changes

Ghada is a 45 year old, married, Syrian Christian woman who immigrated to the U.S. when she was 18 years old after marrying her husband (15 years older) in a small Christian village in Syria. She was receiving her annual physical with her primary care physician (PCP) whom she has known for over 20 years. She began to complain about persistent migraines, stomach aches and increased heartburn. Ghada noted that nothing in her diet changed, in fact, she was eating healthier and engaging in regular exercise. Her PCP began to ask her questions about her children and how things were going at home. Ghada updated her PCP and shared that all of her children have moved out of the home, her oldest is in medical school, her middle daughter is finishing up law school and her youngest is in her first year of college. She further expressed how proud she was that all of her children were doing well and pursuing their dreams. Ghada shared that things were going well with her husband, he recently opened up his own liquor store and was having to work late hours and through the weekends, but business was booming. Ghada reported that she was looking for a part-time job to fill her time during the week as she noticed that she was starting to feel lonely without her children in the home. As the PCP continued to listen to Ghada, she noticed that Ghada was tearful and on the verge of crying when she would talk about her life. Ghada shared more of her difficulties adjusting to all of these changes and expressed that she was not used to the children permanently living outside of the home, especially since they were not married. She also explained that her son, the oldest of the children, recently shared that he is "agnostic" and that created confusion for her that he did not believe in God. She shared that before he went back to school in Arizona, he told her that he does not want to attend church anymore, does not want to celebrate Christian holidays, and would rather just focus on his studies. Ghada expressed that she was unable to sleep at night as she was up thinking about what she did wrong and what she could have done differently so that her son would not reject their family religion. She also noted that she is concerned that her daughter, who is 28 years old, is not dating or even close to marriage yet. She reported that she heard other Arab women talking about her daughter's age and relationship status. Ghada realized that the appointment was coming to an end, so she looked at her PCP and said "I don't know what to do, why we came to America. I don't know who I am anymore." As a result, her PCP provided some background information about her physical symptoms (e.g., migraines, stomach aches, acid reflux) and how they may be related to all of the stressors around her children and how she was feeling. She highly recommended that Ghada go see a therapist, which at first, Ghada expressed some worry about the therapist sharing her information with other people. After assuring Ghada that everything remains confidential and the process of therapy, her PCP provided her with three referrals to female therapists.

Appendix E: Discussion Questions-Ghada

<u>Discussion Questions</u>

1. What is Ghada's presenting problem?
2. What factors may be impacting her acculturation in the U.S.?
   a. Social Support?
   b. Community involvement?
   c. Gender role expectations?
3. What is the impact of her religious affiliation (e.g., Christianity) on her beliefs about her children? Her relationship? Herself?
4. How do you understand her somatic complaints (e.g., migraines, stomach aches, heartburn)?
5. What impact are her children's decisions having on Ghada? How do you reconcile that?
6. How would you address issues of privacy and confidentiality with Ghada?
7. What are some resiliency factors that have assisted Ghada in her transition in the U.S. and her coping with stressors?
8. Are there other areas you would like to assess further? If so, which areas and why?

Appendix F: Case Example-Jamilla

Jamilla

Jamilla is a 35-year old married Egyptian woman who immigrated to the U.S. with her husband, son (age 18) and daughter (age 16). Jamilla's family immigrated to the U.S. by way of the Diversity Visa (or the "lottery" as many call it). Jamilla has a sixth-grade education and does not speak any English. Her son graduated from high school and is attending community college, and her daughter is a junior in high school. Her husband, who no longer resides with the family, is unemployed.

Jamilla was referred for individual counseling by her case manager, who reported that Jamilla was struggling to cope with her marriage. At intake, Jamilla reported that several months ago her daughter had discovered that her father had been sending romantic emails to another Arab woman overseas. After Jamilla confronted her husband, he informed her that he is actually married to the woman and they are expecting twins. He further informed Jamilla that he would like her and the children to leave the home and return to Egypt so his second wife could join him in the U.S. Jamilla reported that when she refused to return to Egypt, her husband became verbally and physically abusive toward her. He locked her in their home; removed most of the furniture, expect items he used; removed all of the kitchenware to prevent her from cooking; and refused to provide her with any money to purchase food or necessities. However, he did ensure that the children had food to eat.

With the assistance of her case manager, Jamilla was able to go to a hospital for a physical exam to document the abuses. With documentation, she was able to have her husband arrested and removed from the home. She was also able to get a restraining order to prevent her husband from returning to the home.

Jamilla now struggles with being the sole wage earner in the home, as her husband is unable to pay child support because of being unemployed. He also fled the country and cannot be held accountable unless he returns to the U.S. Jamilla believes she will be able to find employment immediately even though she has no language skills or transferrable job skills. Jamilla would like to start her own day care center and wants assistance with becoming certified. Yet, without any English language skills, she is

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unable to participate in the training courses. Jamilla does not believe she needs to take English language classes and intends on relying on her children to interpret when needed, as she has been doing since her arrival into the U.S.

Jamilla views counseling as additional case management and expect the counselor to assist her in meeting her basic needs despite already having a case manager. She shows up unannounced to see the counselor and calls several times a week asking the counselor to interpret for her or to advocate for her needs. Jamilla also struggles with regulating her emotions and has limited coping skills, which causes her to have meltdowns and temper tantrums in counseling any time she is confronted or something does not go as she expects (e.g., when she learned she was unable to attend child care certification courses because of her limited language skills). She has also become verbally abusive towards her children, especially her son, whom she suspects is in contact with his father and "spying" on her. Jamilla is unable to acknowledge the breakdown in her communication skills and coping behaviors and has a skewed sense of reality and what she can accomplish. Her children are becoming increasingly impatient with her and are beginning to isolate themselves form her.

**adapted from Amri, S., Nassar-McMillan, S., Amen-Bryan, S., & Misenhimer, M., (2013). Counseling Arab Americans. In C. Lee (Eds), *Multicultural issues in counseli: ng: New approaches to diversity:* (pp. 87-104). Alexandria, VA: American Counseling Association.

Appendix G: Compassionate Breathing In and Out

Inviting you to sit comfortably with your feet on the floor, closing your eyes or looking down, whatever feels the most comfortable, and take a few relaxing breaths (pause for a few seconds)

Scan your body for physical stress, noting the location and quality of the discomfort. Also allow yourself to become aware of any stressful emotions that you may be holding in your field of awareness. If a challenging person comes to mind, let yourself be aware of the stress associated with that person. If you are experiencing the suffering of another person through empathy, let yourself be aware of that discomfort as well (pause for a few seconds)

Now, aware of the stress you are carrying in your body, inhale fully and deeply, drawing compassion inside your body and filling every cell in your body with compassion (pause for a few seconds) Let yourself be soothed by inhaling deeply, and by giving yourself the compassion you deserve when you experience discomfort (pause for a few seconds). As you exhale, send out compassion to the person who is associated with your discomfort, or exhale compassion to living beings in general.

Continue breathing compassion in and out. Occasionally scan your inner landscape for any distress and respond by inhaling compassion for yourself and exhaling compassion for those who need it (allow for some time to continue breathing).

When you are ready, Gently open your eyes and bring your awareness back to the room

*This guided meditation is adapted from: Mindful Self-Compassion, Christopher Germer, PhD and Pennington, B. (1982). Centering Prayer: Renewing an ancient Christian prayer form. Garden City, NY: Image Books.

Appendix H: Case Example-Maysa

Case Example #4: Maysa's Transition (Appendix H)

Maysa a 40-year-old Muslim woman who immigrated from the conservative part of Lebanon to Dearborn Michigan three years ago with her husband Ali, 61, and three children aged 10 to 16. Ali was laid off from a custodial job the year before and has not been able to find work. Maysa has been seeking employment but has little formal education and English language ability and is also uncomfortable leaving her children home without any female relatives to care for them. Ali does not believe childcare is his responsibility and when forced to do so, he becomes impatient and inattentive. Due to their financial situation, Maysa has felt embarrassed to share her struggles with her friends from her Mosque and instead, has stopped attending prayer groups and other social engagements within the community. During her children's annual check up at their pediatrician's office, Maysa presented very anxiously and shared feelings of disappointment in herself for being unable to send her family money due to her current financial situation. As a result, the pediatrician suggested that Maysa seek counseling and provided her with some names of mental health professionals.

*Adapted from: Mourad, M., & Abdella, C. M. (2010). An Ecological Approach to Culturally Sensitive Intervention for Arab American Women and Their Families. The Family Journal, 18, 2, 178-183

Appendix I: Progressive Muscle Relaxation Script

This relaxation strategy is used to help relax muscles that have become tense due to stress. This exercise takes frequent practice for your to become more aware of when and where you are experiencing tension. You will be tensing (not to the point of pain) and releasing each muscle in your body. However, if you have any injuries or pain, you can skip those specific areas.

Inviting you to take a comfortable position, closing your eyes or looking down, whatever feels right for you.Begin by taking a few deep breaths, filling your lungs with air. Hold the breath for a few seconds.

[Brief pause]

Exhale slowly and release the tension from your body, let it go. As you continue to breathe, with each exhale, imagine the tension leaving your body.

Now move your attention to your feet and begin to feel the tension as you curl your toes downward. Hold onto the tension and notice what it feels like.

[5 second pause]

Now release the tension in your feet and notice the new feeling of relaxation.

Shift your focus to your lower legs; tighten your calf muscle paying attention to the tension.

[5 second pause]

Release the tension in your lower legs, again noticing the feeling of relaxation while continuing to take deep breaths.

Now, begin to tense your upper leg and pelvic area by squeezing your thighs together gently, noticing the tension.

[5 second pause]

Release the tension. Notice the tension leave your muscles
Start to tense your stomach muscles by sucking in your stomach and holding the tension.

[5 second pause]

Release and imagine the tension just leaving your stomach. Allowing your body to go limp and noticing the relaxed feelings.

Remember to continue taking deep breaths, imagining your lungs filling with air. Now tense the muscles in your back by bringing your shoulders behind you and holding them tightly.

[5 second pause]

Release the tension from your back. Notice the new feeling of relaxation

Now tense your arms, hands and shoulders all together by making a fist and squeezing all the way up your arm. Hold it.

[5 second pause]

Now release the tension from your arms and shoulders. Pay attention to the feeling of relaxation in your fingers, hands, arms and shoulders.

Next, going up to your neck and head, tense your face and your neck by closing your eyes tights and opening your mouth like you are yawning.

[5 second pause]

Release the tension noticing the feeling of relaxation over your muscles.

Now tense your entire body including feet, legs, stomach, arms, head and neck. Hold that tension gently without straining.

[5 second pause]

Release the tension allowing your body to go limp and noticing the feeling of relaxation.

Slowly begin to wake your muscles, adjusting each body part and opening your eyes when you are ready. Stretch your muscles.

Appendix J: Resources

Arab Community Center for Economic and Social Services (ACCESS)
https://www.accesscommunity.org
*Includes resources on cultural arts, employment and training, public health and education

American Arab Anti-Discrimination Committee (ADC)
http://www.adc.org
*ADC is a civil rights organization committed to defending the rights of people of Arab descent and promoting their rich cultural heritage

Arab American Institute (AAI)
http://www.arab-aai.org
* Promotes Arab American participation in the U.S. electoral system, AAI has developed a host of services, from voter education to liaison with the national parties, to support the community's activities. They are also the leading policy and research organization on domestic and policy concerns of Arab Americans.

Institute on Religion and Civic Values
http://www.irvc.org
*Scholars that provide academic information on Islam

Middle East and Middle Eastern American Center (MEMEAC)
http://memeac.gc.cuny.edu
*Based in City University of New York, promotes the study of the Middle East and Middle Eastern Americans.

Network of Arab-American Professionals (NAAP)
http://www.naaponline.org
*A nonpartisan, volunteer-based organization dedicated to strengthening the Arab American community.

APPENDIX N

Agency Authorization Form

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Agency Authorization Form

Our agency authorizes Hoda Abou-Ziab, M.A., a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, working under the supervision of Shelly Harrell, Ph.D., to include our agency in the research project entitled "A Training Workshop for Mental Health Professionals to Address Stress and Well-Being among Women of Arab Descent Living in the United States." We understand that our agency's participation in this study is strictly voluntary. Our agency has been asked to participate in this study, which will include the development of a one-day workshop training for mental health clinicians that focuses on the treatment of women of Arab descent living in the United States experiencing significant distress.

Our participation in this study will consist of providing our female members the researcher's contact information in order to participate in the study.

Our agency understands that the members will be provided with the researcher's contact information in order to voluntarily participate in the research study by providing additional information pertaining to resources available to women of Arab descent living in the United States for stress reduction, resources they would like to see implemented in mental health services, and other information relevant to the development of one-day workshop for mental health clinicians working with women of Arab descent living in the United States. Furthermore, we understand that our agency's name will be given to the clinician as the referring agency.

Our agency understands that by providing our members the researcher's contact information, our agency's name may be published or presented to a professional audience as an agency that was contacted to participate in this study. We also understand that the names of the members will remain confidential and unassociated with our agency.

We understand that all information obtained in this study will be kept confidential. This authorization form, along with all other research materials, will remain in a locked file cabinet for five years, at which time the data will be destroyed.

We understand that if we have any questions regarding the study procedures we can contact Hoda Abou-Ziab, M.A. or Shelly Harrell, Ph.D., Dissertation Chairperson, at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, to obtain answers to any of our questions. My signature below indicates that I am a representative qualified to sign this authorization form on behalf of the agency. I have read and understand the information in this document and agree to abide by its terms.

Signature _____

Date_____

Agency_____

Printed Name_____

Title_____

APPENDIX O

Institutional Review Board Approval Notice

APPENDIX O

Institutional Review Board Approval Notice

PEPPERDINE

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: March 30, 2016

Protocol Investigator Name: Hoda Abou-Ziab

Protocol #: 15-11-131

Project Title: A Training Workshop for Mental Health Professionals to Address Stress and Well-Being among Women of Arab Descent Living in the United States

School: Graduate School of Education and Psychology

Dear Hoda Abou-Ziab:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today March 30, 2016, and expires on March 29, 2017.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond March 29, 2017, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

PEPPERDINE

Judy Ho, Ph.D., IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist