

ORIGINAL ARTICLE

Is cultural appropriateness culturally specific? Intersectional insights from a community-based participatory mental health intervention study conducted with diverse cultural groups

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Abstract

Growing evidence supports the importance of culturally appropriate mental health interventions, yet it is not always feasible to develop culturally grounded interventions or adapt existing interventions for each cultural group. In addition, these approaches do not recognize the multiple intersecting aspects of culture and identity that individuals, families, and communities possess. Thus, an essential question is whether culturally appropriate mental health interventions have to be culturally specific. We address this question by examining processes of the Refugee Well-being Project (RWP), a community-based mental health intervention for refugees resettled in the United States, which included people from multiple cultural groups (Afghanistan, Great Lakes region of Africa, Iraq, and Syria) and was grounded in common experiences of forcibly displaced people from marginalized backgrounds. RWP incorporates a practice-based concept of culture, an intersectional view of identity, and a multilevel approach to address postmigration stressors. Semistructured qualitative interviews were conducted with 290 participants at preintervention, followed by interviews at three timepoints with a purposively selected subsample ($n = 66$). Additional interviews ($n = 101$) were conducted with refugee and student partners. Four themes demonstrated key principles for creating culturally appropriate interventions with diverse groups: (a) recognize cultural complexity in practice; (b) focus on how racism and discrimination are experienced in everyday life; (c) de-center dominant US culture; and (d) create an egalitarian, inclusive space to put principles into action. We conclude that mental health interventions implemented with multiple, diverse groups can be culturally appropriate and effective without being culturally specific.

KEYWORDS

cultural competence, culturally appropriate, intersectionality, intervention, mental health, refugees

Highlights

- Culturally appropriate mental health interventions are increasingly important.
- Developing or adapting interventions for specific groups can be resource intensive.
- Mental health interventions can be culturally appropriate without being culturally specific.
- Important emphases are cultural complexity, intersectional identities, and impacts of racism.
- It is also essential to de-center dominant US culture and create egalitarian, inclusive spaces.

Since the advent of the US Refugee Resettlement Program, the United States has been one of the largest third-country recipients of refugees designated by the United Nations High Commission for Refugees (UNHCR, 2022). Forcible displacement and refugee movement continue to be a rapidly increasing social reality in the wake of political unrest, the rise of authoritarianism, and climate change. Consistent with these events, the foreign-born share of the total US population has risen steadily since 1965 to almost 15% of the total US population (Budiman, 2020). Refugees and immigrants have higher rates of emotional and psychological distress when compared to the general US population, largely as a result of disproportionate access to resources, racism and other forms of discrimination, and marginalization of their cultural values and beliefs. This diversity and these disparities highlight the importance of ensuring that mental health interventions are available, accessible, and culturally appropriate.

Many important efforts have focused on developing culturally specific mental health interventions for and in partnership with different populations, but these interventions can be resource intensive, may not be realistic for smaller groups, and do not consider individuals' intersectional identities. Thus, an essential avenue for further investigation is whether and how mental health interventions can be culturally appropriate across multiple cultural groups. We build on insights from a community-based participatory randomized controlled trial of the Refugee Well-being Project (RWP) intervention for refugees from multiple national and cultural backgrounds (Goodkind et al., 2020) to address these questions and demonstrate the ways in which a mental health intervention can be culturally appropriate without being culturally specific.

BACKGROUND

In the mid-1990s, numerous mental health researchers called attention to the need for culturally appropriate interventions that did not assume a one-size fits all approach given that people have diverse understandings of mental health and culturally specific meanings and paths to healing. Among them were Marín, (1993), who defined culturally appropriate interventions as having three key components: being based on the cultural values of the particular group, having intervention strategies that reflect the attitudes and norms of the group, and having intervention components that are congruent with the behavioral preferences and expectations of the group. Bernal et al. (1995) developed a conceptual model for making cultural adaptations to interventions that emphasized the importance of attending to language, people, metaphors, content, concepts, goals, methods, and context. Research and practice in this area continued to

grow, and multiple other terms entered the lexicon, including cultural sensitivity, cultural responsiveness, and culturally centered or culturally grounded interventions (Bernal & Sáez-Santiago, 2006; Pedersen, 2002; Rogler, 1989). These efforts have been critical in questioning the assumption that evidence-based mental health therapeutic approaches developed primarily by and tested with White, English-speaking people are universally effective and appealing. Trickett (2011) further highlighted the blind spot among many researchers and practitioners in not recognizing the Western-based culture of mental health intervention approaches themselves.

Since these important insights, numerous efforts have focused on adapting evidence-based treatments for specific cultural groups, and several meta-analyses have found that culturally adapted interventions are typically (although not uniformly) more effective than unadapted interventions (Chowdhary et al., 2014; Hall et al., 2016; Smith & Trimble, 2016). In addition, many other researchers have focused on testing culturally grounded or centered interventions that are developed with particular cultural groups based on their values and ideas about mental health. Evidence on the effectiveness of culturally grounded interventions is growing (Fox et al., 2019; Hall et al., 2016; Kerr et al., 2010; Vaughn et al., 2017). This vast body of research has made important contributions to ensuring that mental health interventions are engaging and effective for racially, ethnically, culturally, and linguistically minoritized populations. Yet, several questions, which are crucial for developing health interventions that are maximally relevant and effective across multiple cultural groups and intersecting identities, remain unanswered: What might community-based, culturally diverse intervention processes look like? Can interventions be simultaneously culturally inclusive and culturally grounded? Is cultural appropriateness culturally specific? This paper attempts to answer these questions and fill a gap in the literature by (1) providing insights into the development of an intervention with culturally diverse refugees that is grounded in theory, and (2) describing what such an intervention looks like in practice.

WORKING FROM A PRACTICE-BASED CULTURE CONCEPT

Consideration of the culture concept is essential for moving from foundational principles of inclusive, culturally diverse community-based interventions to actual processes and components of these interventions. The culture concept—the recognition that groups of people have and share culture—is now an almost universal construct understood and used in everyday life around the globe. Yet, it is often narrowly focused on cultural



maintenance, adherence to “traditional” values, or some time-honored construction of the past. Another outdated understanding of culture, as Kleinman and Benson (2006) note, is that culture is often conceptualized as static. Over the last several decades, social theorists have elaborated theories of culture that are more dynamic and focused on *praxis*, or practice (Bourdieu, 1977; Ortner, 2006). Viewed through a praxis lens, culture is dynamic and constantly in flux. Practice-oriented approaches also include a consideration of power. A focus on power illuminates processes of cultural change and emphasizes the agency of actors who are enabled and constrained by social structural systems to create social change (Ortner, 2006). A view of culture infused by understandings of the potential for individuals and communities to effect change in the context of constraining structures and dynamics is integral to the model we explicate here.

DE-CENTERING US CULTURE/ TACKLING ETHNOCENTRISM

Since the late 19th century, social scientists have grappled with the challenge of ethnocentrism (Herskovits, 1948), which involves “judging another culture solely by the values and standards of one’s own culture” (Omohundro, 2008). Although ethnocentrism is a feature of all cultures, it is important to understand science itself as embedded in a web of sociocultural assumptions and practices, deeply intertwined with colonial, imperial enterprises, and nation-building. Similarly, ethnocentrism is problematic in social sciences and medicine because of the dominance of Western biomedicine and the imposition of Western cultural values and assumptions on healthcare and health practices of peoples throughout the world. Boas, the founder of US anthropology, asserted that human science had to transcend the ethnocentrism of the scientist (Stocking, 1982); unfortunately, this has not yet been achieved.

Ethnocentrism has been especially apparent in the case of understanding mental health, which has typically been conceptualized by physicians and psychologists as an individual attribute, with mental health healing approaches usually focusing on treatments for individuals, such as medication or individual therapy. Concepts essential to biomedicine such as trauma are considered to be universal, ignoring their cultural underpinnings and historical development (Fassin & Rechtman, 2009). The result is that Western mental health prevention and treatment practices are implicitly considered to be universal, legitimate, and superior (Debebe, 2012). Moreover, researchers and practitioners have traditionally ignored the epistemological frameworks and healing traditions of nondominant groups, as well as the impact of social and structural factors on mental health

(Gone, 2016). Importantly, the Western hegemonic approach to mental health has begun to shift in the past several decades, with numerous researchers and practitioners critiquing the primacy afforded to evidence-based treatments, with particular emphasis on questioning the epistemologies and methodologies underlying the “evidence” for these approaches (Gone, 2012) and also noting the importance of community-based approaches for conducting mental health research with and promoting the mental health of marginalized communities (Gone, 2006; Goodkind et al., 2011).

INTERSECTIONALITY AS A FRAMEWORK IN MENTAL HEALTH INTERVENTIONS

One central aspect of addressing the mental health of refugee communities that has received attention in recent years involves the recognition that individuals have multiple aspects of their identities that shape their experience (Al-Hamad et al., 2022; Barbo, 2023; Goodkind et al., 2022; Magan, 2020; Magan et al., 2023; Vasquez Guzman et al., 2020; Vervliet et al., 2014). In particular, the framework of intersectionality emerged from the discourses and scholarship of Black feminist scholars and activists (Collins, 2002; Combahee River Collective, 1977; Crenshaw, 1989, 1991; Truth, 1851). Intersectionality as a framework argues for the need to understand inequities through the lens of how multiple social categories, including race, gender, and class interact with and impact each other (Bowleg, 2012; Hill Collins & Bilge, 2016). Yet, we cannot employ intersectionality as a framework without questioning the role of power in creating and maintaining these social categories (Bowleg & Bauer, 2016; Davis, 2008). In the case of creating mental health interventions for refugees, it is vital to consider how concepts such as cultural specificity or culturally centered approaches may in fact miss the complex and multilayered experiences of individuals from similar cultural backgrounds. Furthermore, such analysis is devoid of how refugees’ migratory and resettlement experiences are impacted by existing structures of power (Hess et al., 2022; Magan, 2020; Vasquez Guzman et al., 2020).

Intersectionality allows us also to move away from the one-size fits all approach to refugee resettlement and service delivery model that is inclusive of diversity within refugee populations (Goodkind et al., 2022; Magan, 2020). As such, it is imperative for mental health interventions with refugee populations to employ intersectionality as a framework that values the diversity in identity, experience, and history of refugees irrespective of their ethnic, racial, and/or cultural similarities. For refugee populations, intersectionality is a useful tool to employ in designing antioppressive research agendas that center their diverse histories, backgrounds, and life narratives.

REFUGEE MENTAL HEALTH AND WELL-BEING

Refugees are at high risk for PTSD, depression, and other mental illness because of their exposure to trauma during premigration (e.g., sustained warfare, death of family/friends), migration (e.g., fleeing under life-threatening conditions, separation from family/friends), and encampment (e.g., prolonged stays in unsafe, overcrowded camps), and because of the extensive stress associated with beginning new lives in exile (Hou, 2020; Sangalang et al., 2019). A meta-analysis of 145 studies revealed a prevalence of PTSD of 30.6% among refugees (Steel et al., 2009). Refugees are also at high risk for developing mental health disorders because of trauma exposure in the United States related to living in poverty. Past trauma exposure and current conditions combine to increase refugees' risk for mental health disorders (Cooley-Quille et al., 2001; Hou, 2020), particularly because a strong predictor of developing PTSD after a current traumatic experience is past trauma exposure (Ozer et al., 2008). In several qualitative studies, refugee respondents have indicated that post-migration stressors were more influential on their current mental health than past trauma and torture experiences (Carlsson et al., 2006; Isakson & Jurkovic, 2013). In fact, the effects of postmigration stressors on refugee mental health may increase over time while the effects of war and torture exposure decrease in impact (Carlsson et al., 2006). Taken together, these findings highlight the importance of addressing postmigration social determinants of mental health to reduce disparities experienced by refugees.

CURRENT STUDY

Research and implementation history of the RWP

The RWP was established by the senior corresponding author to address postmigration stressors through a multilevel, holistic, strengths-based model that pairs university students with recently arrived refugees to engage in mutual learning and advocacy. The goals of RWP are to reduce mental health disparities experienced by refugees by: (1) building social support and recreating valued social roles; (2) helping refugees navigate their new communities and access community resources; (3) creating an environment organized around mutual learning among newcomers and Americans, whereby refugees' cultures, knowledge and experiences are valued; (4) providing opportunities for learning English and other instrumental knowledge; and (5) increasing community responsiveness to refugees.

The model was first developed in Michigan with Hmong refugee women (Goodkind, 2005, 2006;

Goodkind et al., 2004), then implemented in New Mexico among Africans from the Great Lakes Region (Goodkind et al., 2011, 2014), followed by an implementation with Iraqis (Goodkind et al., 2017; Nelson et al., 2016). In this paper, we discuss processes from a randomized controlled trial (RCT) of RWP with refugees from the Great Lakes region of Africa, Iraq, Syria, and Afghanistan, which demonstrated the intervention's effectiveness at increasing protective factors and reducing depression and anxiety symptoms (Goodkind et al., 2020).

RWP model

The RWP model has two primary modalities: Learning Circles and advocacy, which are engaged in together by refugees and university students enrolled in a course. Students in the course make a two-semester commitment to the project, receive ongoing supervision, and earn course credit. Learning cCircles consist of weekly 2-h meetings where refugee and student participants meet for cultural exchange and one-on-one learning. Cultural exchange is facilitated and includes interpreters for all languages. Topics range from cultural traditions, education, parenting, civil rights, healthcare systems, and more. Learning Circles are a mutual exchange in which university students learn about refugees' cultures, values, and experiences, just as refugees learn about life and culture in the United States. Refugees' knowledge and experiences are viewed as strengths upon which they can build in resettlement. The second part of Learning Circles consists of one-on-one learning, in which student-refugee pairs focus on learning according to refugees' goals and unmet needs (e.g., English-language, building resumes, learning to use a computer). Students and refugees also work together for 6 months (for 4–6 additional hours each week) on advocacy. Students partner with refugees to identify and mobilize resources to address refugees' goals and unmet needs, including engaging in efforts to change inequitable practices and policies at organizational and systemic levels. Students transfer their knowledge and skills to their partners to foster empowerment with respect to accessing resources once the program is concluded. In the results, we provide examples from the course, learning circles, and advocacy components of RWP demonstrating how intervention processes are culturally appropriate.

Integrating multiple national/ethnic origin groups into RWP

RWP was developed collaboratively with refugee community members. For further discussion of the transdisciplinary, community-engaged research approach of the RWP, please see Goodkind et al. (2011).



After many years of implementing RWP separately with refugees from Southeast Asia, Africa, and the Middle East, there was a growing consensus among RWP staff, participants, community advisory council members, and service providers that including refugees from diverse national, ethnic, religious, and linguistic backgrounds within the group intervention was needed to meet the needs of the growing refugee populations. This approach was supported by research with refugees that has shown that most prefer multiethnic peer support groups because they make it less likely for political, religious, or ethnic conflicts among refugees from the same country to emerge and they help refugees focus on current life conditions as opposed to past problems (Behnia, 2003). Although we anticipated that multiethnic groups might pose challenges around interpretation for multiple languages during cultural exchange, the result could be a more feasible intervention model for refugees throughout the United States, who are typically resettled in mid-sized cities with diverse refugee populations and in proximity to universities.

METHODS

Participants

Data were collected as part of a mixed method analysis of the efficacy of the RWP model, which was tested in a RCT that enrolled 290 adults from Afghanistan ($n = 36.2\%$), Iraq and Syria (32.8%), and the Great Lakes Region of Africa (Burundi, Democratic Republic of Congo, and Rwanda; 31.0%). About half were women (52.2%), with an age range of 18–71 (mean 34.60, SD 11.53). Most were married (58%), with 33% single, 7% widowed, and 2% divorced. Participants had been in the United States for up to slightly more than 3 years (range from 0 to 166.57 weeks, mean: 29.91 weeks, SD: 27.97 weeks). In terms of mental health, 22.1% of participants were experiencing clinically significant distress (depression and anxiety symptoms) and 20.1% had clinically significant PTSD symptom scores at study enrollment. The research was approved by the University of New Mexico Human Research Protections Office (#12-670) and written consent was obtained in participants' languages.

Ninety-two student participants enrolled in the RWP class over the course of the study. Their average age was 23.6 years with a range of 18–54 years. Eighty percent were women. About half (49%) identified as non-Hispanic White/Caucasian, 32% as Hispanic/Latino/a, 4% as Asian, 2% as Black, 2% as Middle Eastern, 1% as Native American, and 10% did not indicate their race/ethnicity or responded with terms including “mixed” or “other.”

Qualitative data

Extensive qualitative data were collected during the RCT. Participants were interviewed at four timepoints over a 12-month period: pre-, mid-interview (3 months after preinterview), postinterview (6 months after preinterview) and a follow-up interview (12 months after preinterview). Participant interviews assessed health and well-being and intervention impacts. For this article, we analyzed qualitative data that were collected at the preinterview timepoint for all participants ($N = 290$) and then from a purposively selected subsample ($n = 66$) at the subsequent 3 timepoints (it was not feasible nor necessary to collect qualitative data from all 290 participants at all 4 timepoints). The subsample of 66 participants was a stratified random subsample (by intervention/control group, gender, nationality, and level of PTSD symptoms) with the goal of achieving maximum variation. Refugee participants were interviewed in their native languages and interpreters were present. We also analyzed data from all 101 semistructured group interviews conducted with refugee participants and their student partner(s) at the end of their participation in the intervention. All participant-student dyads/groups were invited to participate in these interviews, which were conducted with interpretation. Generally, all refugee adult participant family members and their student partners were interviewed together. If student advocates worked primarily with children in the family, these interviews were conducted separately. Interviews were designed to elicit students' and participants' experiences in RWP and to provide the opportunity for participants to explain to their partners how RWP impacted their lives. Questions included, “What is the most important thing you learned from your partner?”, “What are the most significant things you accomplished together in this project?”

Students also interviewed each other in pairs at the end of their participation in RWP ($n = 45$). These interviews were conducted independently without RWP staff or faculty present to encourage honest reflections and were not transcribed or analyzed until after the end of the course. Students asked each other about the course and their experience with their refugee partners, including the Learning Circle and Advocacy components of the project. Questions included, “How has your perception of refugees changed from before you took the course to now?”, “What was the most unexpected thing you encountered when working with your refugee partner(s)?” and “How could the RWP have prepared or supported you better in your work with your partner(s)?” Additionally, we analyzed observation notes from Learning Circles and notes from Community Advisory Council meetings.

Data analysis

Qualitative data analysis was conducted collaboratively with a phased approach. All English portions of interviews were transcribed by a professional transcription service. The research team checked transcripts for accuracy, anonymized, formatted and then imported them into NVivo 11 (Lumivero, 2015). The codebook was collaboratively developed at the beginning of the study, with codes defined using a team approach and then applied to all data. Codes were developed deductively, based on study research questions (e.g., mental health and resettlement stressors) and inductively (e.g., codes that emerged from participants' responses such as gender roles). The data analysis team was led by the first author assisted by a research team member from Iraq, and graduate and undergraduate research assistants. Transcripts were cleaned, anonymized, and imported into NVivo 11 (Lumivero, 2015). Entire transcripts were coded by two independent coders. The first cycle coding was largely characterized by descriptive codes, as well as some emotions and values coding, all of which were applied using simultaneous coding techniques (Miles et al., 2014). The next step, memo writing, developed interpretive frameworks for a code, or intersecting set of codes, looking for patterns across the data (2014). Focused coding initially focused on codes central to RWP research questions (e.g., health [mental and physical]; access to resources, and intervention related coding), and matrix coding to facilitate examining large amounts of data quickly (e.g., changes related to the intervention crossed with all coding related to the intervention to determine which changes were most discussed, and conversely, which were not). As the research team met and discussed both prominence of themes and themes of particular interest to researchers, more focused coding was conducted. Focused coding on the following codes contributed to analyses for this paper: Discrimination, Racism; Culture and Societal Differences, Student Learning in Program; Refugee Participant Learning in Program. Further, queries to examine the intersection of codes related to our research questions and the themes described here, were performed (e.g., "Culture, Cultural, Societal Difference or Comparison" crossed with the parent node "Learning in Program" and all related child nodes).

Author positionality

For more detailed descriptions of RCT methods, results, and study team members, please see Goodkind et al., (2017, 2020). Here, we aim to consider the theoretical and practical questions and implications of culturally appropriate mental health interventions that are not culturally specific. Given this focus, our positionality as authors of this paper is important. The first author is a

White, cultural anthropologist with over 25 years' experience conducting ethnographic and qualitative research with newcomers in the United States. The second author identifies as a Black Muslim woman and social work faculty member with lived experience as a refugee and extensive experience working with diverse refugee communities as a researcher and practitioner. The senior corresponding author is a White Jewish woman and community psychologist who has partnered with refugee and immigrant communities for more than 30 years.

RESULTS

We report on qualitative findings related to processes and outcomes of a community-based, multinational origin/multiethnic mental health intervention for refugees that address three critical questions: (1) What do culturally inclusive community-based intervention processes for refugees look like?; (2) Can mental health interventions be simultaneously inclusive across multiple groups and culturally grounded?; and (3) Is cultural appropriateness culturally specific? Our analyses revealed four practices that illustrate culturally inclusive, community-based mental health intervention processes: (a) recognize cultural complexity in practice; (b) focus on how racism and discrimination are experienced in everyday life; (c) de-center dominant US culture; and (d) create an egalitarian, inclusive space to put principles into action.

We answer the first research question, "What do culturally inclusive community-based intervention processes for refugees look like?" in the sections that follow, showing how each of the four identified practices is enacted in the university course and the Learning Circle and advocacy components of RWP. These themes build on one another and mirror the trajectory students take: an initial emphasis on the course, followed by putting the course material into practice in the advocacy component, and finally, examples of the ways multiple aspects of cultures and identities are valued and validated within the Learning Circles. The themes and accompanying examples provide empirical support to address our second and third research questions about whether interventions can be simultaneously multicultural and culturally grounded and whether cultural appropriateness is necessarily culturally specific.

Recognize cultural complexity in practice

An understanding of cultural complexity must be the foundation of a culturally grounded mental health intervention that includes multiple groups, and this represents our first theme. The culture concept that undergirds the RWP is dynamic, complex, and holistic; further, it is integrated into student and refugee participant



practice and experience throughout the intervention: in the course, the advocacy component, and Learning Circles. A view of cultural complexity refutes the idea of culture as primarily “tradition” rooted in the past, wherein every member thinks and does things in a culturally proscribed way. The course readings include background materials on each refugee group included in RWP; however, these are extended by readings and discussions on cultural humility and values clarification, and an emphasis on multiple and intersecting components of refugees' identities that promote the notion of culture complexity.

The RWP model enables refugee and university student participants to understand these important aspects of culture through direct experience or practice. For example, a 19-year-old Latina student described how her knowledge of Iraqi culture was complicated in the process of working with her partner family:

Seeing the gender roles within the family makeup and the dynamics of them being like the male is predominant, and he's always going to be with the ladies and will speak up for his family and everything like that. Whereas in the case of mine [refugee partners], they were a team. Most of the time [with other students' partners] the guys kind of just stayed by themselves and stayed home, and I would go out alone with the women. That was never an issue. Ekbal¹ was very independent, and she didn't play the generic “stay home and clean.” She was the one working. She would go out and do stuff, and Mushin did his part with taking care of the kids. It was definitely interesting to see that. Even though so many people are so strict on what they think is true because they read it in a book, that's not always the case. Even though what I learned about Iraq and the dynamics of their culture and family and religion, the family that I worked with from Iraq was completely different, and so it was just a constant reminder, like just reiterated it within myself, that you always have to be open minded with every single situation, even when you feel like you're pretty well versed on it, there is always going to be something different that could possibly pop up.

Course readings prompt the students to think beyond a cultural specificity model to a culture-centered model that encourages them to be attentive to the ways cultural

difference infuses motivations, expectations, values, and understandings. Students participate in values recognition/clarification and empathy building exercises that emphasize careful listening and attempting to understand the underlying values of their own and others' beliefs and practices. These skills are a basis for co-advocacy in which students and refugees work together to identify refugees' goals and needs and mobilize community resources to address unmet needs.

Students and participants also realized they could explain cultural differences to one another, and even if they disagreed, they benefited from this shared understanding. As an 18-year-old White female student explained:

I talked about this a little bit before but the most unexpected thing for me was just when cultural differences, like obvious ones happened, they were always really subtle like when one time one of [refugee partner's husband's] friends came to the door and she opened the door and stood behind the door and like talked to him through the door or something 'cause she wasn't allowed to talk to, I mean, she doesn't, in her culture, she doesn't talk to men, well, without her husband present and she did that and then she went back down and sat down and we played cards and then later on she was like, “Oh, I just,” and she told me exactly like the reason I just told you, and I was like, “Okay.” And then we just kept playing cards and it was really like, the most unexpected thing was how easy it was to have these huge differences and then have it go right back to being comfortable.

Finally, in terms of cultural complexity, course readings on refugee mental health focus on pre- and postmigration trauma and stressors, while students are simultaneously learning that Western concepts of mental health must be understood as culturally- and historically produced (Honwana, 1998; Isakson & Jurkovic, 2013). Thus, students come to understand that concepts such as posttraumatic stress disorder (PTSD) and trauma-focused mental health treatments are Western constructions that may have other valences and mixed applicability for participants and that when universally applied may ignore other mental health healing modalities.

Focus on how racism and discrimination are experienced in daily life

The experience of accompanying refugees as they navigate a new society often reveals to students how racism and discrimination are enacted on multiple levels (e.g.,

¹All names for refugee and students in the RWP are pseudonyms to protect participants' privacy.

interpersonally, institutionally, structurally), and the ways these are internalized. Readings and activities emphasize the relationship between racism, discrimination, and social determinants of health. Although the course heightens students' awareness of racism and its impacts, the advocacy component shows how these are enacted in racist structural systems and everyday interactions. The advocacy component compels students and refugee partners to address racism and discrimination to improve refugees' mental health. As students accompany their partners as they learn to drive, access health care and housing, and discover recreational opportunities, students witness everyday encounters with racist institutions and people. Experiencing what was once familiar through the eyes of a newcomer bestows newfound understanding and knowledge of how racism, discrimination, and intersectional identities play out in practice. For example, interpersonal racism was observed by a student who identified as both White and Latina as she accompanied her partner during the advocacy component:

Because people have been rude to us before or people have said stuff like, [student and refugee partner were] driving and they were like, "Get out of this country!" All this stuff while she was driving at a stoplight. So now, I'm really hyper aware of stuff like that. When we're in a big setting, I check to see who's around and stuff like that. When we go to the park or something with a lot of people, I just worry a lot.

Students also had many examples of observing discrimination against their refugee partners within institutional settings. For example, a 22-year-old Latina student responded to a question about how her attitude toward her own life and life in the United States changed as a result of the project:

...the judgment they [refugees] get just in everyday life, just because they don't speak English. And it's just a simple thing, it's not like they're not educated or anything, it's just that they don't know the language and people treated my family like they weren't worthy of their time. Like when I take them to [the Department of Motor Vehicles], people would be kind of dismissing him and stuff and I don't know, it kind of made me mad that they even have to experience that. And it just made me see that you know America's, I like it here, but people need to change their views on other people.

Another Latina student, aged 24, described similar experiences with her family:

That was really upsetting to me to see how they're treated just because they're different, or they're from another country. The worst part was seeing them have to struggle with their apartment complex and their apartment manager and then being promised things that were never fulfilled just because they didn't have the knowledge to be writing things down and keeping track of things and making notes and lists of things. Because this is just things that they didn't know they had to do, you know?

Some refugee participants also discussed racism and discrimination they had experienced and how their student partners helped them respond. A woman from Republic of the Congo described how interactions with her student comforted her after interactions with a neighbor:

And so, when the students are there, they understand already because pretty much [our neighbor] doesn't think we're human beings because he doesn't understand. He doesn't even treat us like one. And so, the student would just tell us, sorry about that. Because they understand in his mind, he doesn't really see us as humans because of the way he treats us. But then to us, we just think you know it's okay if he acts like that. [The students] don't have to tell us sorry. Even though, it felt better because [the student] understood and they treat us like normal people. But we just say, it's okay. They don't have to say sorry because he's going to know himself with God. But it was good getting that comfort from the student.

These descriptions from student and refugee participants demonstrate how spending time together in their everyday lives bears witness to interpersonal and systematic racism, which can promote well-being and healing on multiple levels, from validation and support for refugees experiencing inequities to increased awareness of how racism functions and how to address it.

Decenter dominant US culture

Decentering dominant US culture is the third theme to build on to create nonspecific culturally appropriate mental health interventions. Decentering US culture involves respecting refugees' cultural values alongside the recognition that refugees desire and need to learn about the United States to live productive lives in their new society. Decentering US culture begins in the course with the first unit that emphasizes migration as an essential part



of what makes us human and examines the many causes and consequences of migratory movement worldwide. This is followed by a unit that provides background on the specific countries and regions from which refugees in the project resettled, and then a section on US refugee policy, which is situated within a framework of global engagements including war, colonization, US imperialism, economic and political activities, and migratory flows. Students shared how learning about the events and processes that led to the presence of Afghan, Iraqi, Syrian, Congolese, Rwandan, and Burundian refugees in the United States helped them understand migration and how it is situated in a global context. For example, a Latina student talked about her increasing awareness:

How has my attitude changed? I guess, well, I think even just from first semester it was just like an awareness issue. There were so many things that I didn't even know about or ever heard about or really looked into. So, it's just like to stop being ignorant about what's going on in different places and about what's going on with different people, which opened my eyes. Actually, working with the families and seeing how many [refugee] families we have here in [name of city].

In Learning Circles, rather than a focus on how native-born Americans do things in the United States, discussions give equal time to refugee perspectives on each topic. Mutual learning creates a context in which refugee experiences are valued. For all topics, whether it is cultural (e.g., baby naming, dating/romance, marriage, parent-child relationships), or more pragmatic (e.g., employment, health care, public safety), questions are open-ended, for example, "What has been your experience with [this topic] in your country/place where you come from/culture?" In this way, refugees' experiences, as well as students' multiple cultural perspectives within the United States, inform the discussion and contribute to an overall understanding of the topic. As a man from the Democratic Republic of Congo in his late 40s stated:

When we have a topic for Learning Circles, when they [students and refugee partners] bring a topic to talk about it, we had an open debate. We were learning from each other to hear from people how they think. And some people were bringing their ideas and you find out their way of living is very similar to my way of living. And some say their way of living is totally different from our own, but it gave me an idea that okay, even though I'm welcome to live like other people are living. Because there are differences and there are similarities, but we are living in the same community.

Hearing multiple perspectives helps students and refugees recognize the validity of different views and cultural practices, rather than reinforcing the typical implicit emphasis on U. cultural norms. Thus, the inclusion of people from multiple cultural backgrounds in the intervention furthers the goal of making it culturally appropriate.

Create an egalitarian, inclusive space to put principles into action

Finally, we found that RWP was able to be a culturally centered mental health intervention because it promoted understanding and respect of diverse cultural values and practices and a simultaneous recognition of commonalities and human equality. These were taught in the course and put into practice during the Learning Circles and the advocacy portion of the project, and participants often discussed the impacts of creating such an inclusive space.

In most mid-sized US cities where the majority of refugee resettlement occurs, there are limited organized opportunities for refugees to interact with people in the host community in public settings. Although there are some spaces where recently arrived refugees encounter other national-origin groups (e.g., orientations or classes offered by resettlement agencies; ESL classes), these do not usually provide opportunities to interact and build relationships with diverse members of the host community. As one Iraqi woman in her early 40s noted: "It's because the program was my only chance to interact with Americans because I was isolated so I have no one, no way to interact with them and then I have the student and she's very close to me and we really like and love each other as a friend."

Establishing a welcoming environment, with interpretation, so that newcomers and students can fully express themselves is key to relationship building. An Afghan woman described how this operates in practice: "My life changed because of this program because it gives us more understanding of the culture, and since we can express our feelings, we can talk now more rather than when you cannot speak the language." A 21-year old White student who had previously participated in groups with refugees run by a different organization, reported that her view of Iraqi refugees changed after she learned more about the US role in the forcible displacement of Iraqis and interacted with Iraqi newcomers in the RWP, "[Before] I felt like many of them felt entitled and I had this perception that they just felt like they deserved everything and that America should just be giving them that. Because that was the impression that I got from [my experience with another organization] and that wasn't the case."

Learning Circles provide an inclusive, open, safe space which is guided by the themes described above (a practice-oriented culture concept, decentering US

culture, tackling ethnocentrism and an antiracist approach). Yet, naming these themes does not describe *how* they are put into practice and *how* participants experience them. Thus, in this section, we emphasize how mutual learning operates in practice in RWP. For example, in Learning Circles, having refugee and student participants share their experience and perspectives on all topics ensures that discussion is not primarily on what refugees need to know to live in the United States, but rather underscores their knowledge and expertise gained from experiences in their home countries and elsewhere. An Iraqi man described how he experienced mutual learning:

Actually, we learn together. I didn't learn myself. She didn't learn by herself. We learn together. From being together, we learn together. I've learned more about the people here. I've learned that they have their own values and morals. They have their own traditions. It's not as we expected them. It's not that bad idea or that negative idea about them. It was not real. We learned that they are nice people, and they can be together with us. That's communication we were missing before.

Other participants reflected on the impact of mutual learning. An Iraqi woman in her early 30s shared, "Actually my experience with Kelsey [student advocate] taught me that I can respect and live with others no matter they are different from me. And this is something I never imagined I could do in my country." Her statement expands on students' reflections earlier about how learning to work through cultural differences goes beyond RWP and is applied to life in general. In addition, refugee participants observe students becoming more comfortable, becoming more open, and gaining skills that enable them to share in cultural exchange. An Iraqi man in his 50s shared these observations about the students he was working with:

Leslie and Lauren and other students were a little bit shy when we started having these conversations. They were a little bit conservative, but I think throughout the Learning Circles and the more we talked about topics, they were more open to have conversations with us, and maybe lose some of their shyness in the conversation.

Further, many participants in RWP spoke about how they had grown to love their partners and thought of them like family. This quote from a woman from Burundi in her late 30s points to how this is related to learning about culture and cultural difference in relation with others: "We learned a lot about people's cultures,

differences, how to live with people, how to love each other, different things like that." To develop this point further, participants' reflections on what they learned in RWP hinge primarily on the *relational* aspect, the interactions between paired students and refugees, and also interactions between refugee participants, as well as cultural exchange, which includes all participants.

As noted above in the section on ethnocentrism, in the course students learned how to identify ethnocentric reactions through values reflection, and it is clear from refugee participants that interacting with students and others in Learning Circles and developing relationships with students helped them develop greater understanding of cultural stereotypes and biases. This kind of transformational learning is relational and occurs when there is a foundation of respect and openness. A quote from a woman from the Republic of the Congo in her early 30s shows that she made these connections:

Yeah, I was thinking about the differences between the cultures. However, once I started going to the Learning Circle and I got my students, they pretty much helped me understand the American culture. And that kind of helped me grow my heart and pretty much helped me spiritually and emotionally. I know a little bit about the American culture and so, it's not as bad as I was thinking.

This is not to say that this results in an extreme openness to all cultural practices and values. Like students quoted previously, refugee participants also recognized that they should reflect on which values were important to them. For example, a woman in her early 20s from the Democratic Republic of Congo said:

I've learned a lot. She [student partner] has taught me how to live with people. So, she's teaching me the American culture and like I said, there's a difference between the cultures. There's other times where this is American culture that I could go along with it. Like okay, this is what they do. Okay, that seems fine. I'm going to go with it. But there's sometimes in other cultures where I just feel like I can't go with those cultures like that. So, I have to either deny or go with it.

A further insight of many participants is a recognition of a common humanity, and the idea of equality. For example, an Iraqi man in his early 40s said he learned that: "Everyone is equal." He continued, "That's what I've learned. Not where did you come from? What's your religion? What's your color? Everyone is one. Everyone is equal. There is no differentiation between one another. That's what's really—I've learned



from that. Nice to know everyone and knowing everyone's culture." It's notable that in all these instances, participants paired their insights with learning about culture and cultural differences in a large diverse group.

Finally, participants shared the recognition that these lessons, relationships, and practices could be applied outside RWP. For example, an Iraqi woman in her 50s said:

Before participating in the program, I would have been hesitant and even if by sharing or participating with simple sentences or your opinion or offering simple things that you don't feel that it's really worthy but on the contrary. They will receive that in a very nice way, they will compliment you, they will be happy that you are sharing your opinion... But then when I was encouraged to say it everyone was happy, they were clapping for me, that makes me proud, they make me feel that I achieved something and they make me feel like I [have] confidence to do other things and to participate and to give more and more because I feel that this, even if these simple things they were appreciated, that encouraged me to say them more and they make things like more active in my life so I want to give more than before. So that's really huge also.

Students also had the desire to apply what they learned from their RWP experiences to interactions outside RWP. A White student in her mid-30s explained:

And it's been interesting that I myself have to take a step back and be like oh. For instance, perception of time or something. Like if you're living in a close-knit community where people are and you can walk to each other's houses or things like that, it's different from having a culture where everybody has to be right on time for everything. And it's really complicated to get everywhere and all those kinds of things. And so, just trying to see it from the other person's perspective and kind of trying to translate that to other agencies also. Because I hear all the time agencies making assumptions. Like oh, this person is just late all the time or something instead of looking at why or trying to understand better like what's going on or how to explain something to someone so that it's culturally translatable.

Taken together, the four themes enabled us to demonstrate our response to the first research question which asks what culturally inclusive interventions for refugees

look like, and to answer our second and third research questions: Can mental health interventions be simultaneously inclusive and culturally grounded? Is cultural appropriateness culturally specific? Our explication of RWP intervention processes demonstrates the ways in which cultural appropriateness does not depend on cultural specificity. Rather, culture-centeredness can reflect a sensitivity to multiple cultural perspectives and viewpoints if it attends to and dismantles power inequalities that implicitly foreground US cultural values and health practices; acknowledges and addresses racism and discrimination; and creates inclusive opportunities for participants to identify commonalities and differences and build meaningful relationships. These processes do not entail a homogenization of culture, or on the other end of the spectrum, extreme cultural relativism; instead, they build upon insights of intersectionality, practice theory, and other social theoretical concepts and put them into practice.

DISCUSSION

As the importance of ensuring that mental health interventions are culturally appropriate for individuals and families from nondominant cultural groups has been increasingly recognized, so has the imperative to develop evidence-based mental health interventions that do not require time-intensive adaptation for each cultural group. Thus, an essential question is whether mental health interventions can be culturally grounded and appropriate for multiple cultural groups. In other words, does a culturally appropriate intervention have to be culturally specific? What do culturally appropriate, culturally diverse interventions look like? We aimed to answer these questions by examining the processes of a community-based mental health intervention for refugees resettled in the United States, which was designed to include people from multiple cultural groups and be grounded in common experiences of forcibly displaced people from marginalized backgrounds. A mixed method RCT of the RWP provided an opportunity to address these questions.

Our first research question was: What do culturally inclusive community-based intervention processes look like? To arrive at the endpoint where people from diverse socioeconomic, national origin, racial, ethnic, cultural, linguistic, and religious backgrounds can share and learn from each other in a way that contributes to well-being and healing and change on multiple levels, our analyses revealed the importance of four interrelated themes that demonstrate how the RWP moves theory into practice, including: a dynamic, practice-based culture concept; efforts to dismantle ethnocentrism; and the recognition of intersectionality—all of which are central to an anti-racist intersectional approach. These practices are implemented in every aspect of RWP: the student course,

cultural exchange/mutual learning within Learning Circles, and collaborative advocacy.

CBPR scholarship has provided important guidance and insight about grounding interventions in communities and culture-centeredness (Dutta, 2007; Wallerstein et al., 2019). The literature that emerged from a concern with cultural competency has been deepened with understandings that learning all the specifics of another's culture cannot be the goal. Kleinman and Benson highlighted these principles in clinical settings by emphasizing that cultural humility, being open and respectful of cultural differences, attending to and redressing power dynamics, and building equitable partnerships are more important than gaining specific cultural knowledge to guide treatment (Kleinman & Benson, 2006). Here we suggest that applying a similar approach to inclusive, nonstigmatizing mental health interventions can contribute to culturally appropriate healing that does not necessarily require cultural specificity.

The practice-oriented approach of RWP leads to the dismantling of ethnocentric assumptions and underscores the importance of examining the history and context of knowledge production. Notably, this orientation affects students' perspectives on mental health as well. The advocacy component of RWP is designed to build on and highlight refugees' coping skills, strengths, and capacities in vivid terms that ensures students move beyond the predominant trauma focus of refugee mental health (Fassin & Rechtman, 2009). Further, mental health is also shown to be historically and culturally constructed—thus, making strange the familiar on a conceptual and philosophical level in addition to one focused on cultural practice.

Addressing ethnocentrism—the orientation that sees one's own culture as the correct way to interpret others' actions—works on multiple levels as well. Bringing together people from multiple diverse cultures to engage in mutual learning serves to de-center US culture. For students, de-centering US culture involves multiple processes: coursework that contextualizes migratory movement in a global context of war and imperialism, coupled with first-hand experience and building relationships with refugees, demonstrating how individuals survive traumatic events, overcome obstacles, and build new lives far from home. Similarly, for refugees who may paint Americans or US culture with a broad brush, personal interactions and group cultural exchange show the diversity of US cultural practices. Because Learning Circles provide time and space to discuss multiple cultural practices and values, refugee participants' cultural knowledge and previous experiences are elevated and seen as strengths to build upon in the resettlement context. In this way, the narrow focus of integrating refugees into US society is broadened, and results in higher levels of integration and connection to

US culture (Goodkind et al., 2020). The focus on mutual learning serves to decenter US culture and also make it understandable for participants. For refugees and students, discussing mental health in a group setting destigmatizes it and increases help-seeking.

Experiences with racism when advocating with their partners force students to recognize how racism and discrimination are enacted in everyday life. Accompanying refugees as they interact with institutions reveals the ways systemic racism orders society. For refugees, having students recognize and express dismay in relation to these experiences serves to acknowledge not only the existence of racism and discrimination in a new, unfamiliar context, but also, through discussion, provides refugees and students tools for responding to discrimination and racism. The effects of racism and discrimination on refugee and immigrant mental health are increasingly recognized (Alemi & Stempel, 2018), and effecting social change in these areas is critical to improving mental health.

Limitations and directions for further research

It is possible that our findings are limited to the particular setting and context of the RWP study and intervention in a mid-sized Southwestern city in the United States, with a specific constellation of service providers and newcomer and host community demographics. Although the RWP intervention is explicitly designed to adapt to participants' multiple intersecting identities across diverse contexts, further research in other settings and with additional newcomer and non-newcomer populations is warranted and would be an important next step in testing our nonculturally specific approach to cultural appropriateness. Moreover, the data are limited to participant (newcomer and student) experiences and reflections that occurred within or near the context of the intervention, which were collected by interviewers who were associated with the RWP, which may have operated as a constraint and/or led some participants to express more positive reactions to the program. Yet, we do believe the richness of our qualitative data convey the depth of meaning and experience that newcomers and students had in the RWP and the impact on their lives, whether positive, negative, or neutral. Conducting additional follow-up interviews over longer periods of time would help to further explore impacts and the sustainability of any changes over time. Because the newcomer participants in this study were recent arrivals (in the United States less than 3 years), it will be important to study intervention adaptations and outcomes with other newcomer groups who have been in the United States longer. Finally, further study of other culturally appropriate interventions that are not culturally specific is needed.



Conclusion

The themes that emerged throughout the ongoing implementation of the RWP model have demonstrated not only that mental health interventions can be culturally appropriate without being culturally specific, but also how to achieve this. These findings have critical implications given that culturally specific mental health interventions for different populations can be resource intensive and do not consider individuals' intersectional identities. Thus, we conclude that mental health interventions implemented with multiple and diverse cultural groups can be culturally centered and effective. Attention to cultural practices and beliefs, values, and mutual learning result in a positive environment that encourages change on multiple levels. The pairing of theory and practice—complexifying course readings by putting them into practice in the Learning Circle and advocacy portions of the intervention—show the importance of applying practice-oriented approaches to the foundational constructs we discuss in this article: culture, intersectionality, mutual learning, advocacy, and mental health. Although implementing mental health interventions with multiple national, cultural, and language groups can seem daunting, the experience of RWP has shown that the benefits make the challenges well worth it. Complexity mirrors the human condition and serves to make these intervention approaches more, not less, applicable to navigating stressful situations such as resettlement in a new country.

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CONFLICT OF INTEREST STATEMENT

Jessica R. Goodkind is a Board Member of United Voices for Newcomer Rights, a partner organization in the study.

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