

LAOTA, ZOBAIDA, Ph. D. Counseling Refugees: Examining Mental Health Professionals' Learning Experiences and Recommendations for Effective Training (2019) Directed by Dr. Craig Cashwell, 224pp.

Refugees experience a variety of complex mental health, trauma, and wellness concerns (Bhugra & Gupta, 2011; Kirmeyer et al., 2011) and often do not have access to mental health services. The underutilization of mental health services by refugees and the limited availability of culturally appropriate care highlights the mental health disparity that exists for this culturally and linguistically diverse population (Gong-Guy, Cravens, & Patterson, 1991; Kirmayer et al., 2011; Vasilevska, Madan, & Simich, 2010). One significant barrier to access is the limited availability of mental health professionals adequately trained to provide culturally competent services (Bartolomei et al., 2016; Gozdiak, 2004; Posselt et al., 2017). While there is significant literature on refugee populations and mental health, there is a scarcity of research on how to effectively work with this population. Furthermore, although mental health training programs emphasize cultural competence and multicultural training, there is evidence that mental health professionals are not adequately prepared to effectively provide services to refugees (Khawaja & Stein, 2016; Posselt et al., 2017; Robinson, 2013; Schweitzer et al., 2015). This may be influenced by the lack of focus on refugee populations in formal training and education (Pietrese, et al., 2009; Priester et al., 2008).

Considering the limited knowledge about the training and educational learning experiences that prepare counselors to effectively work with refugee populations (Engstrom, Roth, & Hollis, 2010; Khawaja & Stein, 2016; Lee & Khawaja, 2014), a foundational qualitative study was proposed to explore the experiences of preparation,

learning, and training of mental health professionals who have provided counseling to refugees, and better understand how they learned to serve this population. Interpretative Phenomenological Analysis (IPA) was utilized to explore the preparation, training, and learning experiences of counselors who work with refugees, including both formal training (i.e., graduate preparation) and informal learning (i.e., learning from experience). Furthermore, this study aimed to gather recommendations from mental health professionals based on their own experiences as to what is needed in mental health curricula to better prepare mental health professionals to work with refugees. Nine superordinate themes emerged from the data analysis process: *Personal Identity, Values and Worldview; Language Barriers and Use of Interpreters; Ethics and Boundaries; Barriers, Access and Systems; Knowledge; Working with Trauma; Role of a Counselor; Developing Confidence; and Learning Strategies*. Ultimately, this knowledge will serve to inform education, training, and preparation to work with a population with an immense need for access to culturally competent counseling services. The theoretical framework that guided this study is the Cultural Competence and Confidence Model (CCC), defined as “a conceptual model that depicts the multidimensional components of the teaching-learning process of cultural competency that could serve as a valuable cognitive map to guide educators, researchers, and learners” (Jeffreys, 2010, p. 45). Implications for practice, education and training, and research are offered based on the results of this study.

COUNSELING REFUGEES: EXAMINING MENTAL HEALTH  
PROFESSIONALS' LEARNING EXPERIENCES  
AND RECOMMENDATIONS FOR  
EFFECTIVE TRAINING

by

Zobaida Laota

A Dissertation Submitted to  
the Faculty of The Graduate School at  
The University of North Carolina at Greensboro  
in Partial Fulfillment  
of the Requirements for the Degree  
Doctor of Philosophy

Greensboro  
2019

Approved by

---

Committee Chair

© 2019 Zobaida Laota

APPROVAL PAGE

This dissertation written by Zobaida Laota has been approved by the following committee of the Faculty of The Graduate School at The University of North Carolina at Greensboro.

Committee Chair \_\_\_\_\_

Committee Members \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date of Acceptance by Committee

\_\_\_\_\_  
Date of Final Oral Examination

## ACKNOWLEDGEMENTS

Bismillah Al-Rahman Al-Raheem. In the name of Allah, the most gracious, the most merciful. There are moments in life when I can so beautifully see the pieces of God's plan come together in ways that overwhelm and unravel me, reminding me of love that is boundless and eternal, and a higher purpose greater than what my inspired mind could ever imagine. In the midst of my journey through this PhD process, I have had many of these moments and they have reminded me to pause and let in the glory of the higher design. Throughout these past years, I have said many times that I am on a spiritual journey and knew even then that I would leave changed. There are some ways that I know my heart has been changed, and ways that I still have yet to discover. As difficult as these years have been, I leave grateful. Trusting the wisdom of the one who created me. Curious to see how the portrait of my spiritual heart will continue to evolve in color, depth, and texture. Amazed at how God has moved me.

There are no words that can adequately capture this process for me, just as I know that I cannot capture in writing the depth of my gratitude and appreciation for those who have been a part of my journey. My family is my heart and light, unfailingly believing in me and loving me through every stage of my life. I am grateful to my parents, who have taught me deep compassion, endless generosity, and commitment to serving others. To my brothers who amaze me in who they are and how they care. To the friends who have become family for the gift of their friendship. To my extended family and elders who

have influenced generations of their children, passing down values that ground us in faith and in love.

Thank you to the teachers, mentors, peers, and supervisors who have poured into me, both professionally and personally, and have continued to support and uplift me. Along the way, I came to discover a network of incredible individuals in this profession: fellow doctoral students, counselors, and counselor educators who change lives through their dedication to this work. Thank you for giving the world sparks of hope in the ways that you shine. My deep gratitude goes to everyone who has been a part of my personal, spiritual, and professional transformation at UNCG. The students and clients I work with influence me more than they know and through my work with them, I have leaned into a spiritual calling in a way that I never expected to through my roles as counselor, teacher, and supervisor. To my faculty, thank you for the many ways that you have contributed to my process. I leave with special moments and experiences imprinted in my heart. I hope you know who you are, and that I have let you know what you have meant to me.

This dissertation would not be possible without the support of my committee. Thank you to Drs. Christine Murray, Tamaki Onishi, and Pamela Harris for your investment in this project and the ways that you have contributed to its power. I am blessed to have such phenomenal women as role models. To my chair, Dr. Craig Cashwell, you have so lovingly and compassionately guided, encouraged, and uplifted me in more ways than you know. Thank you for the sacred space and time that you created for me, and for a relationship and connection that I will cherish forever.

This dissertation is dedicated to the refugees of the world, those who have come before my time and those who continue to be displaced today. May you be protected, honored, empowered, and loved always. Ameen.

## TABLE OF CONTENTS

CHAPTER	Page
I. INTRODUCTION.....	1
Refugee Mental Health Overview .....	4
Refugee Specific Multicultural Training .....	6
Theoretical Framework.....	8
Statement of the Problem.....	9
Purpose of the Study .....	11
Research Question .....	12
Significance of the Study.....	12
Definition of Terms.....	13
Organization.....	15
II. LITERATURE REVIEW .....	16
Overview of Refugees.....	16
Refugees in the United States .....	20
Policies Affecting Refugees.....	21
Resettlement Needs.....	22
Migration Stressors .....	23
Premigration.....	24
Migration.....	24
Postmigration .....	25
Economic Strain.....	27
Discrimination and Backlash .....	28
Changes in Social Roles and Family Dynamics .....	28
Refugee Mental Health .....	29
Protective Factors and Resilience .....	30
Challenges in Mental Health Research and Assessment .....	31
Theoretical Framework: Cultural Competence and Confidence Model.....	33
Cultural Competence Dimensions .....	35
Transcultural Self-efficacy (Confidence) .....	36
Rationale for the CCC Model .....	38
Counseling Refugees: The Need for Training and Education .....	38
Counseling Refugees: Barriers. ....	41
Language Barriers.....	42
Training and Education Barriers.....	47

Educational Strategies in Cultural Competence Development .....	50
Refugee Specific Training Models .....	53
Training Models.....	54
Limitations .....	59
Need for Additional Research.....	61
III. METHODOLOGY .....	65
Overview.....	65
Research Design.....	65
Research Question .....	68
Participant Inclusion Criteria .....	69
Sampling .....	70
Overview of Participants.....	72
Participant 1 .....	73
Participant 2 .....	74
Participant 3 .....	75
Participant 4 .....	75
Participant 5 .....	76
Participant 6 .....	77
Participant 7 .....	78
Procedures.....	79
Interview Protocol.....	82
Trustworthiness of the Data .....	85
Bracketing.....	85
Research Team.....	86
Independent Bracketing .....	88
Auditing Process .....	89
Data Analysis .....	90
A Priori Limitations .....	92
Pilot Study.....	93
IV. RESULTS .....	100
Research Question .....	100
Overview of Themes.....	100
Personal Identity, Values, and Worldview .....	102
Ethics and Boundaries.....	105
Language Barriers and Use of Interpreters .....	108
Barriers, Access, and Systems .....	110
Knowledge .....	112
Cultural Diversity, Norms, and Migration.....	112
Political Influence .....	115

Family Dynamics .....	117
Modality .....	118
Research and Evidence-Based Practice .....	119
Working with Trauma.....	120
Role of Counselor .....	122
Counselor as Educator .....	122
Counselor as Advocate .....	124
Developing Confidence .....	126
Learning Strategies .....	128
Graduate Training .....	129
Self-directed Learning .....	130
Mentoring and Supervision.....	131
Professional Development .....	132
Immersion Experiences.....	134
Recommendations.....	135
Summary .....	139
 V. DISCUSSION.....	 141
Introduction.....	141
Summary of Findings.....	142
Comparison to Existing Knowledge .....	143
Learning Content .....	143
Learning Process.....	151
Graduate Training .....	152
Self-directed Learning .....	154
Mentorship and Supervision .....	155
Professional Development .....	156
Immersion Experiences.....	157
Developing Confidence .....	159
Learning Influences .....	160
Theoretical Grounding.....	162
Limitations .....	164
Implications for Practice.....	168
Implications for Education and Training .....	172
Graduate Training and the Infusion of Multicultural Education .....	174
Preparing Educators and Supervisors .....	177
Developing Resilient Learners.....	179
Meeting the Needs of Diverse Learners.....	182
Considerations in Educational Leadership.....	183
Implications for Research .....	185
Conclusion .....	191

REFERENCES .....	193
APPENDIX A. DEMOGRAPHIC QUESTIONNAIRE .....	207
APPENDIX B. RECRUITMENT STATEMENT .....	213
APPENDIX C. INSTRUCTIONS FOR PARTICIPATION .....	215
APPENDIX D. INFORMED CONSENT FORM .....	217
APPENDIX E. INTERVIEW SCHEDULE .....	220
APPENDIX F. RESOURCES TO MINIMIZE RISK .....	221
APPENDIX G. INDEPENDENT BRACKETING SUMMARY.....	222

## **CHAPTER I**

### **INTRODUCTION**

The population of refugees world-wide has grown substantially from 33.9 million in 1997 to 65.5 million in 2016 (The United Nations Refugee Agency [UNHCR], 2016). Of this record high number, an estimated 22.5 million will never return home and become classified as refugees (UNHCR, 2016). The number of refugees resettled in the United States has fluctuated with global events and U.S. priorities (Pew Research Center, 2018). Since 1975, the United States has admitted 3,405,564 refugees, with 685,705 of those admissions occurring in the last decade (Refugee Processing Center, 2018). Refugees resettled in the United States comprise a wide variety of cultural backgrounds coming from every region of the world. Altogether, refugees from Syria, Afghanistan, South Sudan, Myanmar, Somalia, Sudan, Democratic Republic of the Congo, Central African Republic, Eritrea, and Burundi account for 79% of the refugee population worldwide (UNHCR, 2016). It is important to note that while refugees have similar experiences, they remain extremely diverse in many ways (culture, language, religion, etc.). This population faces a range of unique stressors and mental health issues, such as migration and acculturation stress, grief and loss, and trauma (Bogic, Njoku, & Priebe, 2015; Kirmayer, Narasiah, Munoz, Rashid, Ryder, Guzder, Hassan, Rousseau, & Pottie, 2011). In fact, researchers have found high rates of trauma related issues and Post-Traumatic Stress Disorder (PTSD) across the lifespan among refugees (Murray,

Davidson, & Schweitzer, 2010). Many refugees experience grief and loss not only for loved ones, but also for their homes, lives, cultures, and identities prior to war and political turmoil (Bemak et al., 2003; Scheitzer et al., 2015; Villalba 2009; Williams & Westermeyer, 1986). Unfortunately, for many this is compounded by experiences of torture, violence, and sexual violence (Bogic et al., 2015). These experiences, when left unaddressed, can lead to mood, anxiety, and depressive symptoms in individual immigrants and their families (Kirmayer et al., 2011; Villalba, 2009). Additionally, discrimination and prejudice can result in further trauma symptoms (Bemak & Chung, 2015; Villalba, 2009). This is particularly relevant in the United States, as public polls throughout history have consistently demonstrated opposition towards the admission of refugees fleeing war and oppression (Pew Research Center, 2015). Thus, it is evident that the need for mental health services for these populations is critical.

Despite the growing population of refugees in the world, mental health resources are chronically underutilized by this population (Vasilevska et al., 2010). This is likely due to the multiple barriers to mental healthcare faced by refugees, including language barriers, limited mental health knowledge, lack of awareness about available services, fear of being stigmatized by their communities, fear of lack of confidentiality, fear of having their legal refugee status threatened or retracted, and lack of culturally sensitive counseling services (Bartolomei et al., 2016; Posselt et al., 2017). Furthermore, researchers have found that counseling professionals often lack access to adequate preparation and competent training to work with refugees (Gartley & Due, 2017).

Although scholars argue that the need for services for this population is essential, there are considerable challenges faced by mental health practitioners in providing these services (Engstrom, Roth, & Hollis, 2010; Scheitzer, Wyk, & Murray, 2015; Sonethavilay et al., 2011), exacerbating mental health disparities for refugees (Kirmayer et al., 2011). These challenges include lack of formal training and preparation to adequately prepare therapists to work with unique refugee needs, barriers in working with interpreters and other communication concerns, and lack of resources to gain needed preparation to provide effective culturally competent services to refugees (Bartolomei et al., 2016; Posselt et al., 2017). There is a clear need, then, for mental health professionals to be more informed about the mental health needs of refugee populations and how to provide culturally competent services. Often, however, mental health professionals do not receive opportunities to learn more about working with this population, which has the potential to influence self-efficacy and motivation to serve refugees (Gartely & Due, 2017; Posselt et al., 2017). When mental health professionals self-perceive a lack of competence in working with refugees, they tend to disengage from this population, lose hope of successfully being able to serve the population, and lack motivation to work with the complexities of this diverse and complex cultural group (Gartley & Due, 2017). Lack of access to sufficient and/or effective training also negatively impacts mental health professionals' self-efficacy when working with linguistically diverse refugees, as mental health professionals receive limited training on how to effectively work with interpreters (Century et al., 2007; Engstrom et al., 2010; Jacobs et al., 2006). It seems, then, that limited training may lead to low self-efficacy related to counseling refugee populations.

Unfortunately, this may influence mental health professionals to not actively engage in wellness and mental health advocacy for refugees and may prevent mental health professionals from offering services to this population. The shortage of mental health practitioners available to serve refugees can be inferred to be partially a result of the lack of expertise and self-efficacy in refugee specific diagnostic, assessment, and treatment methods (Vasilevska et al., 2010). In turn, although there are many refugee-centered factors that are barriers to receiving mental health services, it seems clear that access to care by refugees is influenced by counseling professionals' competence to work with this population. More research is needed to understand how mental health professionals can best be trained to work with refugees in order to increase refugee access to mental health care.

### **Refugee Mental Health Overview**

The most common mental health concerns among refugees from different cultures include depressive disorders, anxiety disorders, suicidal ideation, and post-traumatic stress disorder (Bogic et al., 2015; Kirmayer et al., 2011; Lambert & Alhassoon, 2015). Refugees experience traumatic events and stress throughout the various stages of migration (pre-migration, migration, post-migration/resettlement that contribute to their mental health outcomes (Kirmayer et al., 2011). Often, refugees are forced to depart from their homes quickly to escape life-threatening situations of war and conflict. The conditions refugees encounter pre-displacement may include experiencing and witnessing torture, genocide, exposure to war crimes and violence, incarceration, starvation, sexual abuse and rape, and physical violence (Bemak et al., 2003; Bemak & Chung, 2015; Davis

& Alchukr, 2014; Kirmayer et al., 2011; Sue & Sue, 2015). Studies on the pre-migration experiences of refugees clearly indicate a relationship between refugee status and increased mental health problems (Bemak et al., 2003; Kirmayer et al., 2011; Lambert & Alhassoon, 2017; Murray et al., 2004). In fact, pre-migration trauma is consistently found to be a predictor of mental health outcomes such as posttraumatic stress disorder, depression, anxiety, and suicide (Bogic et al., 2015; Kirmayer et al., 2011; Lambert & Alhassoon, 2017; Murray et al., 2004).

In the migration process, refugees continue to face tremendous danger even after arrival to a refugee camp or temporary asylum. Often, these temporary asylums do not provide access to basic needs such as food, shelter, and health care. Furthermore, these temporary asylums are often overcrowded, low on resources, physically unsafe, and unsanitary (Bemak et al., 2003; Kirmayer et al., 2011). Exposure to physical health concerns (severe malnutrition, malaria, HIV/AIDs, tuberculosis) as a result of the conditions of displacement and time spent in refugee camps may further impact mental health (Bemak et al., 2003). In post migration, the impact of trauma in premigration is exacerbated by the multiple challenges of adjustment and integration into a new society (Bemak et al., 2003; Bhugra & Gupta, 2011; Bogic et al., 2015; Kirmayer et al., 2011; Sue & Sue, 2015). Some of the post migration stressors that refugees experience include acculturation, social and economic hardships, lack of proficiency in the host country's language, changing family dynamics, alienation, discrimination, poverty, and continued grief and loss (Bemak et al., 2003; Bemak & Chung, 2015; Bhugra & Gupta, 2011; Villalba, 2009).

Refugee mental health must also be considered within the context of refugee resilience. Factors such as family and/or social support, spirituality and religious coping, cultural beliefs and customs, community, and individual characteristics such as hope and optimism, serve as protective factors that contribute to posttraumatic growth among refugees (Besser et al., 2014). Considering the unique experiences of refugees through these stages of migration, it is critical that mental health professionals are adequately trained to serve this population effectively, both to mitigate the negative impact of trauma and to support post-traumatic growth. It is clear that providing mental health services to refugees may provide unique challenges, and mental health professionals must be trained to understand and appropriately serve this population.

### **Refugee Specific Multicultural Training**

Research on multicultural education demonstrates that counselor trainees who receive training in multicultural topics are better prepared to serve diverse clientele. However, a content analysis of multicultural course syllabi in counseling psychology and counselor education courses indicates that refugee-specific education is often not included in training (Pieterse et al., 2009). Mental health training programs emphasize cultural competence, but do not provide adequate training to work with the unique needs of refugee populations (Villalba, 2009). Considering the rising numbers of refugees in the United States, the lack of attention paid to the mental health needs of this population seems problematic. Cultural competence and effective training is essential for providing services refugee clients. Further, to address the existing health disparity refugees face,

there is a need for increased focus on appropriate cultural competence training and preparation specific to this population.

An important consideration on the topic of preparing mental health professionals to effectively work with refugees is effective training practices. Teaching strategies such as immersion experiences, multicultural supervision, integration of multicultural education into practicum and internship, experiential activities, broaching cultural identity, and self-reflection activities have been suggested as particularly helpful interventions for teaching individuals to work with diverse clients, including refugees (Sheely-Moore & Kooyman, 2011; Vereen, Hill, & McNeal, 2008). There is a scarcity of empirical evidence, however, on effective educational strategies specific to working with the unique needs of refugees. While some training programs that have provided formal and immersion service learning experiences to counselors-in-training have demonstrated success in increasing trainees' multicultural competence and preparation to work with refugee populations (Midgett and Doumas, 2015; Nilsson, Schale, & Khamphakdy-Brown, 2010), these refugee specific training opportunities are limited and not easily accessible. Since formal education often excludes content and experience specific to refugee populations (Engstrom, Roth, & Hollis, 2010; Pietrese et al., 2009) and opportunities for additional learning experiences are limited, it is unclear how mental health professionals who work with refugees can best develop the competence they need to work with this population.

## **Theoretical Framework**

Since the development of the Multicultural Counseling Competencies (MCC) (Sue, Arredondo, & McDavis, 1992), the counseling profession continues to provide standards for culturally competent practice. Multicultural coursework in counseling professions often details aspects of the MCC by emphasizing the knowledge, awareness, and skills framework (Pieterse et al., 2009). Although the MCC provide a framework for counseling practice and education, this framework does not directly examine the learning processes associated with developing cultural competence over time. The Cultural Competence and Confidence Model (CCC) is a model derived from nursing literature that has similar components to the MCC. Specifically, the CCC model describes cultural competence in terms of cognitive, practical, and affective dimensions, which parallel the knowledge, skills, and awareness components of the MCC. Similar to the MCC, the CCC model is grounded in the assumption that cultural competence skills and confidence can change over time as a result of education, training, and learning experiences (Jeffreys, 2010). However, unlike the MCC, the CCC model more clearly outlines a process for teaching cultural competence and a framework by which to conceptualize cultural competence learning and development (Jeffreys, 2006). As such, the CCC model served as the theoretical framework for this research study.

The CCC model was designed as a way to (a) identify professionals at risk of not providing culturally competent care; (b) develop strategies to facilitate learning and training in cultural competence; and (c) evaluate the effectiveness of these training strategies (Jeffreys, 2006). Cultural competence is defined in the CCC model as a

learning process that integrates the cognitive, practical, and affective dimensions of competence with the concept of transcultural self-efficacy (confidence) to achieve culturally congruent care, which is defined as the ability to provide effective services to multicultural populations (Jeffreys, 2010). In addition to providing a framework by which to understand the dimensions of cultural competence and confidence, the CCC model also identifies various factors of cultural competence learners that may influence their development, such as demographic, cultural, educational, psychological, and health literacy factors (Jeffreys, 2010). This provides a basis by which to understand the factors that influence mental health professionals' cultural competence and confidence in working with refugees. For the purpose of this study, the CCC framed the types of questions asked to participants about the formalized educational experiences and other learning experiences that influenced mental health professionals' learning experiences. Because of the phenomenological study design, the data was not forced into the CCC framework. Instead, the core themes were allowed to emerge organically from the data and were then considered in the context of the CCC model in Chapter 5.

### **Statement of the Problem**

Researchers in counseling, healthcare, and nonprofit sectors indicate that few service providers are adequately prepared to serve the unique needs of the culturally heterogeneous and linguistically diverse refugee population (Bartolomei et al., 2016; Gong-Guy et al., 1991; Griffiths & Tarricone, 2017; Gozdzik, 2004). Inadequate preparation results in mental health professionals feeling ill-prepared in the areas of cultural knowledge, skills, and overall awareness needed to serve this population.

Considering the vast range of complex mental health presentations of refugee populations, complex trauma, and the diverse cultures from which they come, it seems clear that many refugees need mental health care and that mental health professionals need to be properly trained to serve them. Unfortunately, however, there is limited knowledge on the training and preparation experiences of mental health professionals who work with refugees. Formal education often excludes content specific to refugee populations (Engstrom, Roth, & Hollis, 2010; Pietrese et al., 2009) and opportunities for additional learning experiences are limited. Further, training programs that provide formal and immersion service-learning experiences to counselors-in-training have successfully increased multicultural competence and preparation to work with refugee populations (Midgett and Dumas, 2015; Nilsson, Schale, & Khamphakdy-Brown, 2010). However, service-learning opportunities to work with refugees are not readily accessed in mental health training programs in the United States, so many mental health professionals receive neither training nor experience in working with refugees. Thus, it is unclear how mental health professionals who work with refugees gain the preparation and training they need to work effectively with this population. Although conceptual pieces on training mental health professionals to work with refugees have emerged in recent years, there is a dearth of empirical research that describes how mental health professionals can effectively be prepared to serve this population. Accordingly, a knowledge gap exists as researchers have not addressed how preparation and training can adequately equip mental health professionals to work with refugee populations. Additionally, there is limited direction on how to incorporate concepts of multicultural competence into practice for

multicultural counseling with refugees. Considering this gap in knowledge, a foundational study was needed to understand the experiences of preparation, learning, and training of mental health professionals who have provided counseling to refugees. Understanding the learning experiences of mental health professionals who work with refugees may be essential for informing future research, practice, and training on counseling refugees.

### **Purpose of the Study**

The purpose of this study was to explore and better understand the learning and preparation experiences of mental health professionals who have worked with refugee clients, and better understand how they describe the educational and learning experiences they had to prepare them to work with this population. This research was intended to take a preliminary step towards filling the gap in current literature on the training and preparation of mental health professionals to work with refugee populations. Experiences, reflections, and accounts of the process of learning how to work with refugees were gathered. Specifically, participants were asked to reflect on how their learning experiences have prepared them to work with refugees. Both formal and informal educational experiences and other learning experiences and factors were explored. Furthermore, this study aimed to gather recommendations from mental health professionals based on their own experiences as to what is needed in the counseling curriculum to better prepare mental health professionals to work with refugees. To this end, a phenomenological method of inquiry was used to understand the learning experiences of mental health professionals, explore potential deficits in training and

preparation, and ultimately expand literature on refugee specific training and preparation. The knowledge gained from this study provided significant implications that inform practice and education, and thereby contributed to literature aimed at addressing the immense need for access to culturally competent counseling services.

### **Research Question**

1. How do mental health professionals who work with refugees describe their experiences of learning how to counsel this population?

### **Significance of the Study**

The number of refugees continues to grow significantly as world crises leave many individuals displaced (The United Nations Refugee Agency, 2016). As such, the number of refugees in the U.S. continues to increase, even with recent changes in U.S. policies reducing refugee resettlement. Accordingly, mental health professionals need to be prepared to provide services to this population. Refugees experience a variety of mental health, trauma, and wellness concerns (Kirmeyer et al., 2011) and often do not have access to services due to limited availability of mental health professionals able to provide services to this population. While scholars have focused on the experiences and mental health of refugees (Bogic et al., 2015; Kirmeyer et al., Vasilevska et al., 2010), there is limited research examining the experiences of mental health professionals who work with refugees and the training they receive to prepare them to work with this population (Gozdiak, 2004; Khawaja & Stein, 2006). Although counseling training programs emphasize cultural competence and multicultural training, there is limited research that is focused on the training of therapists to work with refugees in particular

(Pietrese et al., 2009), and it is unclear how traditional multicultural training transfers to counseling refugee populations. Consequently, the refugee population is at risk for receiving inadequate mental health services because of the lack of effective preparation. Further, mental health professionals who are not adequately prepared to work with refugees may not seek out opportunities to advocate for and provide services to this population. Learning the experiences of mental health professionals who have worked with refugees may provide insight on how to better prepare mental health professionals to work with this population. Results from this study can be used to provide mental health professionals with knowledge of critical aspects of preparation to inform those who are working, or intend to work, with refugee clients, furthering the knowledge base on multicultural counseling training. Further, information gleaned from this study may help educators better understand the training needs of students who will work with refugees. Specifically, results may inform curriculum and training design, supervision, practice, and supplemental training of professional mental health professionals. Finally, results of this study will inform policies, including those established as legislated law and those that specifically influence counselor preparation, such as curriculum standards established by the Council for Accreditation of Counseling and Related Education Programs (CACREP).

### **Definition of Terms**

**Refugees:** Refugees are individuals who have fled their country of origin due to persecution or violence (UNHCR, 2016).

**Mental health professionals:** Mental health professionals are licensed helping professionals who have received clinical training from accredited master's and/or doctoral institutions in counseling, marriage and family therapy, social work, or psychology.

**Multicultural Competence:** Multicultural competence is defined as the cognitive, affective, and practical skills a counselor possesses to provide culturally competent care to diverse populations (Jeffreys, 2006).

**Preparation:** Preparation is defined as any formalized educational experiences or other informal learning experiences.

- **Formalized educational experiences:** This describes learning gained through educational institutions, professional organizations and associations, and other formal systems (Jeffreys, 2010). This may include coursework, clinical training, presentations, supervision received, continuing education, webinars, formal immersion or study abroad experiences, experiential learning activities, seminars, conference activities, etc.
- **Informal learning experiences:** This describes all learning that is not acquired through formal and educational systems (Jeffreys, 2010). Informal learning experiences may include learning gained from self-directed educational experiences, societal and environmental influences, personal cultural identity and background, prior work experience or volunteerism, personal relationships, spiritual or religious teachings, values, experiences with individuals from diverse cultures, etc.

**Learning Process:** The learning process is defined as the experiences of gaining skills, awareness, and knowledge that contribute to multicultural competence and influence attitudes, decisions, or actions in counseling practice.

### **Organization**

The proposed research will be presented in five chapters. This introductory chapter provided a brief overview of the research on refugee mental health needs and mental health professionals' training and preparation. The statement of the problem, research question, purpose of the study, significance of the study, and definition of key terms were presented. The second chapter includes a detailed literature review on topics of refugee mental health, mental health practitioners training and education to work with refugees, and the conceptual model that will be used to frame this research. The third chapter presents a detailed methodology section which includes a rationale for the use of interpretative phenomenological analysis, participant information, data collection and procedures, analysis methods, and limitations. This chapter also includes an overview of the completed pilot study and a description of how this pilot study informed the research. The fourth chapter will present the results of the study, including the identified themes emerging from the data. Finally, the fifth chapter will include a discussion of (a) results and limitations, (b) implications for application, research, education, and practice, and (c) directions for future research.

## **CHAPTER II**

### **LITERATURE REVIEW**

#### **Overview of Refugees**

Refugees are persons who have been forced to flee their country of origin due to persecution, war, or violence (UNHCR, 2017). Persecution leading to forced displacement can result from various concerns, including religion, race, nationality, and membership in particular social groups. Asylum seekers are persons who flee their countries of origin for the same reasons and seek asylum or the right to be recognized as refugees after fleeing persecution or violence. Often, the terms *refugee* and *asylum seeker* are used interchangeably to describe populations who have escaped violence and persecution to seek refuge in a safer country. The primary difference between a refugee and asylum seeker is their legal status. Refugee status provides certain rights and protections to those who hold it, including the significant right to not be forced to return to their country of origin. In order to gain these rights, asylum seekers must be able to demonstrate that their reason for fleeing their country is substantiated. This legal application for refugee status is a difficult one, and not all asylum seekers have sufficient funds, resources, and abilities to successfully complete applications and earn refugee status (Bhugra & Gupta, 2011). As such, those who successfully gain refugee status, particularly those resettled in Western countries such as the United States, often come

from socioeconomic backgrounds, privileged circumstances, or access to additional supports that many other asylum seekers with limited opportunities do not have.

Although the number of refugees is well documented due to this legal status, there are a significant number of asylum seekers still awaiting approval who may never have access to the rights and protections of refugees.

According to the United Nations Refugee Agency, at the end of 2017 the global refugee population totaled 25.4 million. This total is a 2.9 million increase from 2016, and the highest known number of refugees in history (UNHCR, 2017). There are numerous crises in the world contributing to the displacement of these individuals. The largest population of refugees currently originate from Syria, where the civil war and political violence continues to force people to flee the country for safety. The second largest population of refugees originates from Afghanistan, where ongoing war and violence continues to displace citizens. In 2017, the largest increase of refugees was from South Sudan, where armed conflict, disease, and malnutrition led to the displacement of 2.4 million people. Refugees from Myanmar (Burma) make up the fourth largest group in the world as a result of continued deprivation of human rights, targeted violence, and genocide. Somalia represents the fifth largest group of refugees, displaced by its continued violent civil war and unrest. In addition to these five countries, refugees from Sudan, DR. of the Congo, Central African Republic, Eritrea, and Burundi make up about 82% of the global refugee population (UNHCR, 2017). It is evident that the term *refugee* is applied to individuals from diverse cultural backgrounds seeking asylum from various forms of persecution and safety. With these diverse cultural

backgrounds, refugees represent a wide range of languages, values, religions, beliefs, customs, and worldviews. What refugees uniquely have in common is the abrupt, involuntary, and often traumatic experience of departing their countries of origin in search of safety and refuge (Bemak et al., 2003; Bhugra & Gupta, 2011; Gorman, 2001; Villalba, 2009; Williams & Westermeyer, 1986).

While the similar experiences of refugees will be highlighted in this literature review, it is important to note that refugees remain extremely diverse in many ways. For example, the cultural backgrounds of refugees cannot be assumed to be similar, considering the many different countries of origin from which they migrate. Even refugees from the same home countries often come from different cultural groups, races, socioeconomic backgrounds, religions, languages, and worldviews. While the cultural diversity of refugees is critical to note so as to not disregard their important differences and experiences, refugees in the United States share some similarities. For instance, many refugees share a collectivist orientation. Family and community relations are valued, and interdependence is expected. Many refugees originate from collectivistic cultures, which value family, community, social networks, and interdependence. Western philosophies of wellness may be based on individualistic cultural values, including individual achievement, personal gain, and independence. As such, it may be important to note that the Western theories of psychosocial wellness may be based on cultural values and beliefs that do not align with those of refugees. Many refugees also share a value of the use of traditional medicines, such as culturally specific healing practices and religious or spiritual understandings of mental health and wellness.

Additionally, refugees are a linguistically diverse group. A report on refugees admitted to the United States between 2002 and 2013 found that refugees represented 113 countries and 228 languages (Migration Policy Institute, 2015). The most common native languages of this population include Arabic, Nepali, Somali, Spanish, Sgaw Karen, Russian, Farsi, Hmong, Chaldean, and Burmese (Migration Policy Institute, 2015). The expansive linguistic diversity of refugees may serve as a challenge for resettlement agencies and healthcare providers who seek to provide services for this population, as identifying trained interpreters and staff to meet refugees' linguistic needs may be difficult or costly. Another important language consideration is that refugees may have different levels of language proficiency in the host country's language upon arrival. For instance, English may be taught in formal educational systems in many of the countries from which refugees originate. As such, refugees arriving in English-speaking countries may represent a wide range of English proficiency, which varies greatly by nationality and refugees' educational experiences prior to displacement. Further, there is a wide range of diversity in refugees' literacy in their native languages. This is important to note, as limited literacy in refugees' native languages may indicate a lack of educational experiences and attainment (Migration Policy Institute, 2015). For refugees without the foundation of literacy and educational attainment in a native language, developing language skills necessary for integration into their countries of resettlement may be a challenge (Migration Policy Institute, 2015).

## **Refugees in the United States**

The majority of refugees are hosted by non-Western countries. In 2017, the countries that hosted the greatest population of refugees included Turkey, Pakistan, Uganda, Lebanon, Iran, Germany, Bangladesh, Sudan, Ethiopia, and Jordan (UNHCR, 2017). However, the United States was the world's largest recipient of applications for asylum, with a total of 331,700 persons applying for refuge in 2017 (UNHCR, 2017). The United States is a desired location for resettlement for a number of reasons and refugees have been resettled in the United States for many decades. Since 1975, over 3 million refugees have been resettled in the United States (UNHCR 2018). The United States Refugee Act of 1980, in particular, established a formal, systemic process for refugee admission and resettlement that allowed refugees to gain access to services to help them resettle and sustain their new lives in America.

Refugees in the United States are resettled in many states, with the top states for resettlement in 2017 being California, Texas, New York, Washington, Ohio, Michigan, Arizona, Pennsylvania, North Carolina, and Georgia (Cepla, 2018; U.S. Department of State, 2018). Upon acceptance, these refugees are assigned to one of nine U.S. nongovernmental organizations to handle their resettlement process and integrate them into the country. Refugees arriving in the U.S. have access to services provided by federal agencies, nongovernmental organizations, and nonprofit organizations. As such, refugees' resettlement needs often involve the coordination and collaboration of services between these organizations (Agrawal & Venkatesh, 2016). Since the availability of

local services and nonprofit organizations in different states and cities in the US may vary, some refugees may receive significantly less access to resources than others.

### **Policies Affecting Refugees**

Refugee admission policies have changed throughout history and are influenced by political, economic, and environmental influences (Agrawal & Venkatesh, 2016). For the 2018 year, the United States president has reduced the refugee admission cap to 45,000, the lowest count since the introduction of the Refugee Act of 1980. Despite this reduction in refugee admissions, the number of refugees already resettled in the United States in addition to new admissions indicate a significant need for continued access to healthcare and wellness services for this population. Further, it is critical that mental health professionals who work with refugees understand the impact of changing policies on resettled refugees. For instance, although the majority of the world's refugees today hail from predominately Muslim countries-of-origin, new legal policies have banned the admission and resettlement of refugees from these countries in the United States (Connor & Krogstad, 2018). Often, refugees face increased discrimination, direct and indirect health care disparities, are less likely to have insurance and other protections, and are more likely to experience unequal access to quality health care and racist attitudes and discrimination among providers (Hemmings & Evans, 2017). Muslim identified refugees may be likely to face this discrimination at an increased rate given their intersectional identities in the current political climate. Furthermore, individuals who are resettled in the United States but experience anxiety and fear about other family members or loved ones who are still awaiting decisions about admission and resettlement also may be impacted

by these changes in policies. These policies are likely to continue changing, and knowledge of current and historical policies are important to understand and work with the unique experiences of refugees.

### **Resettlement Needs**

The most immediate goals for refugee resettlement in the United States are related to establishing stability. Governmental refugee agencies provide newly resettled refugees with basic housing, clothing, and food security for three months, after which they are expected to sustain their living needs. Refugees also receive initial assistance finding employment. Establishing economic stability and sustainability is critical, as refugees are expected to support themselves after the end of their three-month benefit eligibility. Additionally, refugees are required to pay the agencies back the cost of their tickets into the country and other admissions finances, resulting in financial stress for many refugees as they quickly seek to integrate into society. Refugees are provided with short-term language, employment, and social service access during this period of resettlement (Cepla, 2018; U.S. Department of State, 2018). Refugees who were highly educated in their countries of origin may face significant barriers in employment due to lack of certification and documentation of their past education and work experience that is accepted by licensure boards and other employment agencies. Additionally, housing is a critical resettlement issue for refugees. In the United States, refugees face a number of concerns related to housing (Bemak & Chung, 2017; Bhuhra & Gupta, 2011; Williams & Westermeyer, 1986). One concern for refugees is being housed in unsafe neighborhoods, particularly considering the anti-refugee sentiments in society that may further impact

their ability to settle into new neighborhoods. In terms of health, resettlement agencies, particularly the Office of Refugees and Resettlement, often provide resources for refugee medical care (Cepla, 2018; UNHCR, 2017). Refugees are able to gain access to medical education, initial medical screenings, and other health assistance to support them. This is particularly critical considering the circumstances of forced migration that may impact their physical health and mental wellbeing. These basic needs are important for refugees' resettlement process and cannot be ignored. In fact, mental health professionals need to be aware of the holistic needs of refugees in order to best serve their mental health care. Efforts to provide health assistance often focus on physical health concerns rather than mental health concerns, however, and the myriad mental health concerns faced by many refugees may go unnoticed and untreated (Gozdziak, 2004; Murray et al., 2010; Patil et al., 2012; Posselt et al., 2017; Williams & Westermeyer, 1986). Not surprisingly, there are many migration stressors that may impact both the mental and physical health of refugees.

### **Migration Stressors**

The impact of refugees' migration process is well documented in literature. Refugees face forced displacement, elongated periods of crisis, hardships in migration, and difficulties in adjustment that often influence their mental health and well-being (Bemak & Chung, 2015; Bemak et al., 2003; Besser et al., 2014; Bhugra & Gupta, 2011; Bogic et al., 2015; Kirmayer et al., 2011; Williams & Westermeyer, 1986). The process of migration itself creates extenuating circumstances that have psychological

consequences for refugees (Bemak et al., 2003; Bogic et al., 2015; Lambert & Alhassoon, 2015) and these impacts continue even after resettlement to a new country, as the process of adjustment to a new society and redefining of their new realities continues to affect the wellbeing of refugees. Understanding the process of migration and its impacts on refugee mental health is essential for mental health professionals working with this population.

### **Premigration**

While premigration experiences are likely unique to each individual and dependent on the circumstances of their displacement, there are many common premigration experiences. Often, refugees face tremendous peril prior to displacement and in the process of involuntary migration to a new country (Bemak et al., 2003; Kirmayer et al., 2011; Sue & Sue, 2015; Villalba, 2009; Williams & Westermeyer, 1986). Commonly, refugees are forced to depart from their homes quickly to escape life-threatening situations of war and conflict, continuing their experiences of prolonged crisis. These situations may include experiencing and witnessing torture, being exposed to war crimes and violence, starvation, sexual abuse and rape, and physical violence (Bemak et al., 2003; Kirmayer et al., 2011; Sue & Sue, 2015).

### **Migration**

The trauma of premigration often continues even after arrival to a refugee camp or temporary asylum, as refugee camps are often overcrowded, low on resources, physically unsafe, and unsanitary (Bemak et al., 2003; Kirmayer et al., 2011). Additionally, the resettlement process is a significant stressor for many refugees, as this process is long and complicated. It begins with a referral by the United Nations High

Commissioner for Refugees, which screens applicants to determine if they meet requirements to be classified as refugees. Once refugee status is granted, these refugees are referred to countries for resettlement and refugees then complete applications for resettlement in these countries. In order to be resettled in the United States, refugees face extensive U.S. security measures in addition to those conducted by the UNHCR. This security process in the United States involves 5 background checks, 6 security databases, 3 extensive in-person interviews, and interaction with 8 separate U.S. governmental agencies. Gaining admission into the United States as a refugee takes approximately two years and can often be a stressful experience for many as they complete these extensive investigations and await approval for entry. Once they arrive at a U. S. airport, these refugees undergo exhaustive screenings by U.S. Customs and Border Protection. These procedures are important to note, as this resettlement process often can impact the mental health of refugees even after they are officially resettled.

### **Postmigration**

Refugees face complex layers of adjustment issues and trauma in their new host countries postmigration. Often, the impact of trauma in premigration is exacerbated by the multiple challenges of adjustment and integration into a new society (Bemak et al., 2003; Davis & Alchukr, 2014; Kirmayer et al., 2011; Williams & Westermeyer, 1986). Although migration lends to a newfound sense of safety for refugees, refugees are then left to cope with profound loss and separation of home and culture, family and loved ones, changes in socioeconomic status and employment, and new social roles (Villalba, 2009). Researchers in Scotland conducted a participatory action research study exploring

refugees and asylum seekers' views and attitudes on mental health in relation to experiences of stigma and discrimination (Quinn, 2014). Members of refugee communities were trained by experienced researchers to conduct focus group interviews with 101 asylum seekers and refugees from a wide range of countries resettled in Scotland. Data were then analyzed by the researcher and reviewed by refugee community partners. From this study, researchers demonstrated that the mental health of refugees is impacted not only by the migration and asylum process, but also by discrimination, stigma, isolation, and other adjustment difficulties experienced after resettlement. As stated by one participant, an African woman, in one of the focus groups in this study:

Human beings are the same everywhere but different circumstances cause mental health problems. In Somalia, it's poverty and civil war. But it's different here- worse- because of the isolation, not being supported by many people and fear of being deported back. In this country, we can't relax. We can become sick and stressed inside with bad news from the Home Office (Quinn, 2014, p. 63).

This statement represents the complexity of mental health in refugee populations, particularly in highlighting how adjustment factors faced postmigration may exacerbate mental health problems that began premigration. Many participants reported that their lives were dominated by feelings of loneliness and isolation, which was exacerbated by racism experienced in their host countries (Quinn 2015). These experiences, in addition to prior held mental health stigma, were found to impact help-seeking behaviors. In particular, many refugees reported a distrust of professionals and individuals in authoritative positions after negative experiences with professionals who they perceived as being apathetic, mistrusting, and/or racist towards refugees. This was found to lead to

a sense of hopelessness that may discourage refugees from seeking help from professionals (Quinn, 2014). Quinn highlighted the importance of considering postmigration influences on the mental health and wellbeing of refugees. While there are many postmigration factors that influence the experience of refugees, a few of the most salient experiences are briefly highlighted below. These include economic strain, discrimination and backlash, changes in social roles and family dynamics, and language and cultural barriers.

**Economic Strain.** Social and economic hardships significantly influence the postmigration adjustment of refugees. One of the factors that influences economic adjustment is the lack of proficiency in the language of the host country, which subsequently influences employment, educational success for both children and adults, and ability to establish meaningful social relationships. Economic strains are further heightened by the pressure for refugees to become economically self-sufficient within six months of arrival to the host country, and their requirement to repay airfare and transportation costs to the government (Bemak & Chung, 2017; Davis & Alchukr, 2014). Furthermore, refugees often experience downward changes in socioeconomic status (Bemak & Chung, 2017; Davis & Alchukr, 2014). It is common, for example, for educational qualifications and professional certifications from the country of origin to not transfer to the country of resettlement. In addition to the impact of these social changes on employment and economic success, refugees may be coping with loss of identity, roles, and work related to these changes.

**Discrimination and Backlash.** Refugees may face racial and political discrimination and backlash which has the potential to negatively impact their adjustment and integration into the United States (Kira & Tummala-Narra, 2015; Quinn, 2015). In addition to individual experiences of hostility and exclusion that refugees might face (Kira & Tummala-Narra, 2015), this backlash also may take the form of systemic discrimination related to employment, housing, professional development, educational opportunities, and health care, among other factors necessary for living (Bemak & Chung, 2017). Media coverage on refugees may lead to views of refugees as terrorists, or as stealing opportunities for employment and resources from society. The results of a 2016 poll revealed that 41% of the U.S. population opposed admitting entrance to refugees, and noted concerns with terrorism, economic strains on society, and the rise of the number of Muslims living in the United States (Telhami, 2016). This data points to the importance of addressing issues of safety, inequality, and discrimination for refugee clients. This is particularly important as forced displacement may lead to a sense of disempowerment that continues post migration (Quinn, 2014) as refugees adjust to a society in which they continue to face discrimination. Racism and discrimination can affect mental health in many ways, such as increased psychological distress, depression, negative self-esteem, stress, unhealthy coping behaviors, maladaptive cognitive emotional processes, and decreased quality of life (Anderson, 2013; Hemmings & Evans, 2017; Schwartz & Meyer, 2010).

**Changes in Social Roles and Family Dynamics.** Social and family dynamics may change for refugee populations in a number of ways. Social support for refugees

may include family, friends, community members, spiritual leaders, and neighbors. Upon arrival in the United States, refugees may experience feelings of isolation due to the loss of critical social support systems (Bemak & Chung, 2003). Additionally, it is important to note that children often acculturate faster than adults, which may influence their caregivers' relationship with them and/or create conflict as a result of contradicting views, values, and worldviews within families (Bemak et al., 2003; Bemak & Chung, 2017). Furthermore, children are likely to learn the host language faster, and are then used by their caregivers' and other service providers as translators of both language and culture. Caregivers may be forced to rely on their children for communication and access to resources, which may influence family dynamics and roles within the family. Finally, gender roles are also a consideration. For instance, in situations where refugee women must work for the first time in their host countries, this may lead to changes in relationship dynamics if the new roles of these women as financial providers are different from their traditional or cultural values in their host country (Bemak et al., 2003; Bemak & Chung, 2017).

### **Refugee Mental Health**

The mental health of refugees is well documented in literature and is influenced by the unique migration stressors refugees experience. As noted previously, there is potential for three-fold trauma experiences (premigration, migration, and postmigration) for refugees. Studies on the premigration experiences of refugees clearly indicate a relationship between refugee status and increased mental health problems (Bemak et al., 2003; Kirmayer et al., 2011; Lambert & Alhassoon, 2017; Murray et al., 2004).

Premigration trauma, consequently, is considered a major predictor of psychological problems such as posttraumatic stress disorder, depression, anxiety, and suicide (Kirmayer et al., 2011; Lambert & Alhassoon, 2017; Murray et al., 2004). An additional factor that influences refugees' mental health is the exposure to physical health concerns as a result of the conditions of their displacement and time spent in refugee camps. Experiences of major physical health concerns in refugees or their family members, such as severe malnutrition, malaria, HIV/AIDS, and tuberculosis may lead to even more psychological issues for these refugees (Bemak et al., 2003). Furthermore, postmigration experiences also serve as a complex layer of trauma and adjustment that may influence refugees' mental health, as refugees transition to a new society and rebuild their lives. Longitudinal studies also have documented that post-traumatic stress may persist even years after migration and resettlement (Bogic et al., 2015).

### **Protective Factors and Resilience**

While refugees' experiences of migration trauma and the negative impact of these experiences on mental health are clearly documented, it is also important to consider refugees' strengths and resilience. Many refugees are able to make a healthy transition to life in their countries of resettlement, and this successful transition is influenced by the strengths of refugee populations (Hutchingson & Dorsett, 2012). For example, scholars have identified both internal and external factors that serve as protective factors contributing to refugees' resilience and positive mental health outcomes (Besser et al., 2014; Goodman et al., 2015; Hutchingson & Dorsett, 2012; Sossou et al., 2008). Internal factors include individual qualities (i.e. optimism, adaptability, perseverance), coping

abilities, and religion and spirituality whereas external factors include social support systems such as family, peers, and the community (Besser et al., 2014; Goodman et al., 2015; Hutchingson & Dorsett, 2012; Sossou et al., 2008). A deficit-oriented and pathology focused approach to conceptualizing refugees neglects the strength and resilience that facilitates refugees' migration and resettlement process and may serve to further alienate refugees from full inclusion into their new societies (Hutchingson & Dorsett, 2012). While understanding the migration experiences of hardship, trauma, and distress is essential to understanding the mental health of refugees, it is important to consider how trauma and stress are likely normal responses to extreme adversity. Failure to consider refugees' resilience serves as one of the challenges in mental health research on refugees. Additional challenges are discussed below.

### **Challenges in Mental Health Research and Assessment**

Clearly, scholars point to significant mental health needs of refugee populations. However, the research on the mental health of refugees presents significant challenges that are important to note. In particular, the imposition of Western diagnostic constructs on diverse populations has been widely criticized (Ahearn, 2000; Bhugra et al., 2010). As noted in the previous section, many researchers have examined PTSD symptoms in refugees (Bogic et al., 2015; Bhugra & Gupta, 2011) but, in fact, diagnostic constructs such as *posttraumatic stress disorder* may not be culturally relevant to some refugee populations. This construct assumes a universal reaction to and experience of trauma that may provide an incomplete account of the experiences of diverse populations. In examining refugee mental health care, Summerfield (1999) makes the case that the use of

a psychiatric diagnosis from Western constructs removes the experience of trauma from the socio-political context. Rather, he argues that the understanding of trauma responses needs to be considered in reference to the social, cultural, and political sphere in order to understand the totality of refugee reactions to the violence, torture, and persecution refugees face before resettlement. Similarly, Eisenbruch (1992) argued that the use of diagnostic criterion such as PTSD and major depressive disorder may not present an accurate account of refugee distress and experience. He proposes the use of concepts such as *cultural bereavement* to map and understand the distress and experiences of refugees, including factors such as personal meaning, cultural expressions, interpretations of distress, and cultural understandings of resilience and survival. These challenges are important to note, as research conducted on refugees often uses Western psychiatric constructs to understand trauma, depression, and other mental health experiences that they face.

Furthermore, the assessments used to measure these psychological constructs are undoubtedly limited considering the potential for language and cultural barriers to assessment and measurement. Also important to note is that literature on refugees disproportionately emphasizes refugee trauma (Ahearn, 2000; Patil et al., 2012). The diagnostic construct of PTSD has the potential to restrict the understanding of the influences that create distress in refugee clients, such as factors associated with grief, struggles and complications of resettlement, individual qualities, and other experiences that may not be considered traumatic events (Ahearn, 2000; Eisenbruch, 1992; Summerfield, 1999). Because the majority of literature on refugee mental health has

emphasized PTSD and trauma, researchers have insufficiently explored how events not perceived as traumatic influence refugee mental health and wellness. While this emphasis on trauma may be justified, the attention paid to the trauma and the constructs related to mental health in scholarly literature may lead to biases. For instance, the separation of mental health and trauma constructs from other indicators of health represents the mind-body Western concept of dualism and may not adequately capture how refugees might describe their well-being (Ahearn, 2000; Patil et al., 2012). Furthermore, as previously mentioned, emphasis on diagnostic constructs in literature has the potential to contribute to a deficit perspective of refugees that fails to take into account the strength and resilience of this population. Nonetheless, there is sufficient evidence that the migration process and experiences of refugees are associated with increased levels of distress that are recognized as deserving of the attention of health care providers or cultural healers by both Western diagnostic standards and culturally specific concepts of distress (Ahearn, 2000; Bemak et al., 2003; Bhugra et al., 2010; Kirmayer et al., 2011). It is critical, then, that mental health providers who work with refugees understand these nuances and complexities to effectively serve refugees. One framework that provides important context for effectively serving refugees is the Cultural Competence and Confidence Model (CCC; Jeffreys, 2010).

### **Theoretical Framework: Cultural Competence and Confidence Model**

Considering the wide range of multicultural counseling considerations prevalent in providing services to refugee populations, it is essential to consider the training of professionals from a theoretical framework that adequately considers the development of

cultural competency from an educational perspective. The CCC model (Jeffreys, 2010) provides a teaching-learning specific framework for culturally competent nursing practice. Although developed originally for the nursing field, this model provides important direction for exploration of factors that influence the ability of mental health professionals to provide culturally competent care to diverse populations (Jeffreys, 2006). Specifically, the CCC model is grounded in the assumption that the appropriate preparation and training of culturally competent health care professionals requires “a diagnostic-perspective plan guided by a comprehensive understanding of the teaching-learning process of cultural competence development” (Jeffreys, 2010, p.17). The CCC model serves as “a conceptual model that depicts the multidimensional components of the teaching-learning process of cultural competency that could serve as a valuable cognitive map to guide educators, researchers, and learners” (Jeffreys, 2010, p. 45).

In order to create effective educational trainings, there must be an understanding of how learners’ characteristics and experiences may influence their learning process (Jeffreys, 2010). In considering how the teaching-learning process may contribute to cultural competence development in graduate programs, Jeffreys (2010) identified potential barriers to effective training: lack of faculty adequately prepared to train and teach students to become culturally effective practitioners, and limited research evaluating the effectiveness of teaching interventions on the development of cultural competence. The CCC model also emphasizes the importance of meeting the needs of diverse learners. That is, awareness of how characteristics of the learner, such as age, race, ethnicity, gender, primary language, prior educational experience, prior work

experience, and other factors related to a learner's identity may be important in understanding the multidimensional process of cultural competence development (Jeffreys, 2010). Emphasis is put on educators to learn how to implement creative, evidence-based educational activities that promote cultural competence learning outcomes. The CCC model was designed as a way to (a) identify individuals at risk of not providing culturally competent care; (b) develop strategies to facilitate learning and training in cultural competence; and (c) evaluate the effectiveness of these strategies (Jeffreys, 2006). Cultural competence is defined as a learning process that integrates the cognitive, practical, affective dimensions of competence with the concept of transcultural self-efficacy (TSE; confidence) in order to achieve culturally congruent care, which is defined as the ability to provide effective services to multicultural populations (Jeffreys, 2010). The CCC model is grounded in the assumption that cultural competence skills and TSE can change over time as a result of education, training, and learning experiences (Jeffreys, 2010). In other words, cultural competence is a lifelong process that can be optimized through different educational and learning experiences. If skills in the cognitive, practical, and affective dimensions are increased, optimal cultural competence and confidence can be achieved.

### **Cultural Competence Dimensions**

The CCC model describes cultural competence in terms of cognitive, practical, and affective learning dimensions (Jeffreys, 2006). This model provides an understanding of the dimensions of competence as well as a framework for conceptualizing cultural competence learning by interrelating concepts that “explain,

describe, influence, and/or predict the phenomenon of learning (developing) cultural competence” (Jeffreys, 2010, p. 46). The learning process is defined as the development of cognitive, practical, and affective dimensions over time as a result of formalized education and other learning experiences. The cognitive dimension focuses on knowledge, intellectual abilities, and skills (Jeffreys, 2010). This includes the knowledge and critical thinking ability needed to understand the different ways that cultural factors influence clients. This dimension emphasizes knowledge of cultural influences and ability to comprehend, apply, analyze, synthesize, and evaluate knowledge to appropriately work with the population (Jeffreys, 2010). The practical dimension is centered on the practical application of skills. This includes factors such as the verbal and nonverbal communication skills needed to work with clients (Jeffreys, 2010). The practical dimension addresses ability to effectively work with language barriers and/or communicate and respond in ways that are Finally, the affective dimension is focused on attitudes, values, and beliefs (Jeffreys, 2010). This includes self-awareness, awareness of cultural differences, the ability to recognize and appreciate cultural differences, and issues related to advocacy (Jeffreys, 2010). Each of these three dimensions is contextualized by transcultural self-efficacy, or the confidence an individual has that they can provide culturally responsive services.

### **Transcultural Self-efficacy (Confidence)**

Transcultural self-efficacy (confidence) is defined as the perceived confidence in performing or learning the cultural competence dimension skills (Jeffreys, 2000). The concept of TSE is based on Bandura’s social cognitive theory, which emphasizes that

learning and motivation for learning are influenced by self-efficacy perceptions (Jeffreys, 2000). A strong sense of self-efficacy results in higher levels of motivation, commitment and ability to learn and effectively practice skills (Jeffreys, 2000). Jeffreys (2006) suggested that confidence can play an important role in an individual's actions, performance, and motivation to develop cultural competence. Low confidence is associated with poor motivation, lack of commitment, or reluctance to actively seek help in developing cultural competence skills (Jeffreys, 2010). Individuals with low confidence considered at risk for avoiding cultural competence practice and are therefore unlikely to achieve culturally competent care. These individuals are also more likely to abandon skill development after experiencing obstacles or perceived failures (Jeffreys, 2000). In contrast, overconfidence may be associated with a lack of awareness of cultural competence limitations (Jeffreys, 2010). Overconfident individuals are at risk for overestimating their abilities and skills, have little motivation to seek additional learning opportunities, and may consequently be unable to recognize the need for further cultural competence development. Thus, they are also unlikely to achieve culturally competent practice. Those with medium-high measures of confidence are labeled as resilient (Jeffreys, 2010). These individuals are considered highly motivated and consequently more likely to actively seek opportunities to gain cultural competence skills and strive for continued development. Individuals with this confidence level are considered most likely to succeed in providing culturally competent care (Jeffreys, 2010).

### **Rationale for the CCC Model**

Conceptual models and frameworks in mental health professional literature have explained cultural competence in a variety of ways. For example, the Multicultural Counseling Competencies (MCC) provide critical standards for multicultural counseling practice. While the MCC framework provides guidelines and standards for cultural competence and training, it does not directly describe a teaching-learning specific model that explains the process of developing these competencies. Although the CCC model discusses dimensions of cultural competence that parallel the MCC's knowledge, skills, and awareness framework, the CCC model is primarily focused on understanding the process of learning and developing competence. The CCC was also chosen to serve as a framework for this study due to its focus on the learning attributes of learners. Since this study was focused on understanding the preparation, training, and learning experiences of mental health professionals who work with refugee populations, a model focused on learning processes is essential. It is important to note that although this model is used as a framework for the proposed study, the phenomenological approach of this study emphasizes allowing data to emerge from participants rather than forcing data to fit into a prescribed model.

### **Counseling Refugees: The Need for Training and Education**

Researchers have highlighted the importance of training and professional development to prepare counselors to work with refugee populations (Engstrom, Roth, & Hollis, 2010; Khawaja & Steine, 2016; Lee & Khawaja, 2013; Nilsson, Schale, & Khamphakdy-Brown, 2010). A review of literature on mental health interventions with

refugees found a need for increased awareness, training, and funding to support training to successfully provide services and interventions to refugee populations in many different phases of resettlement (Khawaja & Stein, 2016; Murray, Davidson & Schweitzer, 2010; Robinson, 2013). Many of the training needs identified are related to multicultural education and cultural competence development to better prepare counselors to work with culturally and linguistically diverse clients (Gong-Guy et al., 1991; Khawaja & Stein, 2016; Lee & Khawaja, 2013; Midget & Dumas, 2015; Murray, Davidson & Schweitzer, 2010). Mental health graduate programs have continued to emphasize preparation of students to work with culturally diverse clients and engage in advocacy action to empower diverse individuals and communities (Council for Accreditation of Counseling and Related Educational Programs, 2015). It is clear from the limited research on counselor preparation to work with refugee clients, however, that multicultural competence development does not sufficiently train counselors and therapists to work with the unique needs of refugee populations (Gong-Guy et al., 1991; Griffiths & Tarricone, 2017; Khawaja & Stein, 2016; Masocha & Simpson, 2011; Robinson, 2013).

In considering the dimensions of culturally competent care highlighted in the CCC model, it is noted that training for knowledge, awareness, and skills is recommended in formal educational settings to help practitioners develop cultural competence in practice (Jeffreys, 2016). It remains unclear, however, how formal training in counselor education influences counselors' preparation and ability to provide services to refugee populations. Pietrese et al. (2009) conducted a content analysis of 54

multicultural and diversity-related course syllabi from CACREP and APA accredited counseling and counseling psychology programs to gain a greater understanding of multicultural training in knowledge, skills, and awareness in formal educational settings (Pietrese et al., 2009). The results of this content analysis indicated that the majority of these programs take a population-specific approach to multicultural training (Pietrese et al., 2009). The primary populations addressed across a majority of syllabi include racial and ethnic populations, and a smaller number of syllabi focused on additional content areas such as power, oppression, and systemic inequalities. Notable in this study is that only 3 out of 54 syllabi included content related to refugee populations (Pietrese, et al., 2009), indicating that training specific to this population is limited. A similar content and instructional strategy content analysis of syllabi from introductory multicultural counseling master's counseling programs found that only 6% of 64 courses explicitly covered refugee populations (Priester et al., 2008). The unique needs of refugees warrant specialized training and understanding in order to effectively serve their needs (Engstrom, Roth, & Hollis, 2010; Khawaja & Steine, 2016; Lee & Khawaja, 2013), yet it seems clear that multicultural coursework in counseling and psychology programs often do not prepare students to understand how to approach mental health practice with refugees. Although the content of multicultural syllabi may have shifted since the completion of these studies, it is important to consider how lack of formalized training may influence counselor preparation to work with this population. This suggests that counselors who work with refugees may gain the tools they need to serve this population through other avenues and experiences unrelated to their formalized multicultural

training, at least to the extent they are adequately prepared to serve this population. Furthermore, multicultural training tends to emphasize awareness (Pietrese et. Al., 2009), yet awareness specific to refugee populations is rarely discussed in most counselor education and preparation programs (Villalba, 2009). Negative attitudes towards refugees in the United States significantly impact their adjustment experiences and the discrimination that refugees experience has been found to impact their mental health (Kirmayer et al., 2011). It is essential that counselors who work with refugees examine and challenge their values, beliefs, and feelings about refugees (Villalba, 2009), especially considering the current anti-refugee political sentiment prevalent in media in the United States (Telhami, 2016).

### **Counseling Refugees: Barriers**

There is sufficient evidence in literature to support the need for mental health services for refugee populations. However, the underutilization of mental health services by refugees and the limited access to services highlights the mental health disparity that exists for this culturally and linguistically diverse population (Bhugra & Gupta, 2011; Kirmayer et al., 2011; Vasilevska et al., 2010). This underutilization has been linked to the multiple barriers to mental health care that refugees face. Researchers examining mental health service provision to refugees have provided evidence of a number of barriers and clinical issues in the mental health service delivery to refugees. One significant barrier to services is language. A severe shortage of trained bilingual mental health professional and lack of professionals trained to work with interpreters often influences the quality of services that refugees can access (Gong-Guy et al., 1991).

Another important barrier is refugees' cultural awareness and knowledge of mental health. For instance, there is evidence that many refugees are unfamiliar with mental health services, particularly as they exist within the United States (Gong-Guy et al., 1991). Some refugees may associate mental health with severe pathology requiring institutionalization. Others may stigmatize mental health and the services associated with treatment (Gong-Guy et al., 1991). Furthermore, refugees may need an orientation to counseling and mental health services that includes an explanation of the process of counseling and the need for counseling. A final critical barrier is related to mental health professionals' preparation, training, and competence to serve refugee populations. Many mental health professionals do not receive opportunities to learn more about working with refugees and, consequently, are underprepared to effectively provide services. The barriers commonly linked to the cultural competence of mental health professions to serve refugee populations, language and training/education, are expanded on further.

### **Language Barriers**

Overwhelmingly, scholars who address training practices with refugee populations focus on working with interpreters and language barriers. Researchers examining the experiences of mental health practitioners who work with refugees have demonstrated that working with interpreters poses a significant challenge to providing effective services (Century, Leavey, & Payne, 2007; Engstrom, Roth & Hollis, 2010; Griffiths & Tarricone, 2017; Khawaja & Stein, 2016). For example, in a phenomenological study investigating the experiences of mental health practitioners providing services to refugees in Australia, researchers found that many challenges

associated with working with refugees were related to language factors (Khawaja & Stein, 2016). Notably, practitioners emphasized that factors such as inability to control what an interpreter is doing in the background, meanings getting lost in translation, and translations not providing an accurate cultural representation of the clients' intended meaning all impacted the practitioners' ability to provide effective therapeutic services. Additional scholars have noted challenges in communication with interpreters resulting from poorly trained interpreters, most notably translations that are too concrete, interpreters talking too much, and client's negative relationship with interpreters (Engstrom, Roth, & Hollis, 2010). The CCC model suggests that barriers to communication negatively affect practitioners' abilities to provide culturally competent care and must be addressed in order to adequately prepare clinicians to work with linguistically diverse populations (Jeffreys, 2006). While it can be argued that using interpreters trained specifically to work in therapeutic settings may alleviate some of the communication challenges present in work with interpreters, it is clear that formal training is also needed to help practitioners better work with the challenges inherent in working with an interpreter. Furthermore, access to interpreters trained to work in mental health settings is not always available (Bartolomei et al., 2016; Engstrom et al., 2010; Gong-Guy et al., 1991; Griffiths & Tarricone, 2017; Posselt et al., 2017), indicating that counselors may need to be prepared to work with interpreters who are unfamiliar with clinical therapeutic environments and who might, in fact, be prone to trauma responses to the client's narrative, particularly if the interpreter has a trauma-narrative around their own refugee experience.

The need for training to work with refugees with limited English proficiency has been clearly established in existing literature. For example, Mirza et al. (2017) conducted a qualitative study investigating the factors promoting and hindering communication during interpreter-mediated counseling sessions with 6 Bhutanese and Iraqi refugee men. In this study, interviews were conducted with the clinician who provided the counseling services, the five interpreters who worked with this clinician to translate in these sessions, and the refugee men receiving counseling services. The themes that emerged from this study identified three main categories influencing communication in counseling with refugees: the context of mental health practice, the adaptations and negotiations in interpersonal rapport, and individual roles and responsibilities (Mirza et al., 2017). In the context of mental health practice, it seems clear that mental health interpreting is unique compared to interpreting in other health settings. One factor that was found to be important in counseling was the interpreters' use of first person or third person pronouns in translation. Although there is a preference for the use of first person pronouns in healthcare interpreting, this was found to sometimes cause confusion for the client' in counseling settings, particularly when it was unclear whether a statement made was coming from the interpreter or the clinician. The use of first-person interpretation in counseling also was found to potentially create cognitive dissonance in sessions, such as in the instance that a male interpreter used first person to interpret for a female clinician or client (Mirza et al., 2017). One important finding was that interpreters' communication preferences (i.e. preferences for client and clinician to speak in short sentences) were at times incompatible with the context of counseling. The clinician and clients had to adapt

their speaking styles and abbreviate their thoughts for the purpose of interpretation, which has the potential to affect the counseling relationship and the therapeutic pace of the session (Mirza et al., 2017). The roles and responsibilities of clients, clinicians, and interpreters also emerged as a theme affecting the counseling process. For instance, the clinician was found to take four different communication roles: the *sentinel* took responsibility for lapses in communication and vigilantly asked questions to ensure correct translations; the *guide* worked with less experienced interpreters to direct interpreters to interpret in particular ways; the *reinforcer* reinforced preferred interpreting behaviors that positively influenced the session; and the *verifier* frequently checked in with the interpreter and provided summary statements to the client to ensure that all communication was accurately understood (Mirza et al., 2017).

Similarly, interpreters also served different roles in sessions, at times acting as cultural mediators, stepping out of their roles as language processors to provide cultural context and meaning to client's responses. Interpreters also acted as co-facilitators in some sessions, at times hindering the sessions by taking control of the questions being asked. One interpreter shared that interpreters feel empathy for their clients and should be considered a part of the session, rather than simply acting solely as language processors. It is clear that these dynamics may pose challenges to mental health practitioners who work with refugees and interpreters in counseling sessions. Like much research with refugees, the study by Mirza et al. (2017) had clear limitations, including the use of only one clinician, the potential consequences of using interpreters to interview the refugee participants, and the dominance of interpreter and clinician voices in the study and the

limited depth of participation by the refugee clients. Nonetheless, this study demonstrates the important and unique communication considerations that are needed when working with refugees and interpreters in counseling and points to the importance of specialized training for both clinicians and interpreters. Mental health practitioners who work with refugees are likely to experience complex interpersonal dynamics in triadic working relationships with clients and their interpreters. Understanding how mental health practitioners who work with refugees learn how to work with interpreters can provide needed insight for addressing gaps in training practices.

Existing strategies for mental health practitioners to navigate the challenges of working with interpreters include debriefing the interpreter, constantly checking in to ensure accurate translations, and maintaining control over the sessions by providing structure in the therapeutic space to mitigate the potentially harmful effects of interpreters' behaviors (Khawaja & Stein, 2016). Additional suggestions for working with interpreters include attempting to gain access to interpreters who are well matched with the client, avoiding use of family members as interpreters, and using the same interpreter consistently throughout the entire therapeutic relationship (Engstrom, Roth & Hollis, 2010). It is important to note that a theme in the experiences of practitioners who work with refugees is a lack of formalized training and education to adequately prepare them to work with interpreters, as they described developing these strategies through their experiences of trial and error (Bartolomei et al., 2016; Engstrom, Roth & Hollis, 2010; Griffiths & Tarricone, 2017; Khawaja & Stein, 2016).

## **Training and Education Barriers**

While there is significant literature on refugee populations and mental health, there is limited research on how to effectively work with this population (Khawaja & Stein, 2016; Robinson, 2013). A study of 30 health and social workers working with refugees and asylum seekers in non-governmental organizations resulted in important findings related to training received to work with this population (Robinson, 2013). Specifically, it was found that practitioners indicated a lack of effective supervision and access to specialized support resources, limited applied evidenced based research to utilize in practice, and limited access to training and professional development. Participants emphasized the complexity of work with this population, particularly understanding distress in a cultural context, recognizing culturally appropriate reactions to grief and loss, working with refugee's complex trauma, and managing the multifaceted tasks associated with working refugees. In regard to training practices, participants noted that it was difficult to access higher education courses and trainings on working with refugees and asylum seekers in health and social work curricula. Furthermore, access to effective supervision was needed not only to improve competency in working with this population, but also to help practitioners cope with the stress and potential secondary trauma experienced while working with refugees' extensive trauma and distress. Furthermore, a theme in the findings of this study was a perceived gap between theory and practice: that is, the information found in graduate education and in academic literature did not translate to the day-to-day practical demands of working with refugee and asylum seeker populations. Training, education, and supervision were identified as

necessary strategies to help practitioners develop a deeper understanding, increased competency, and resilience to work effectively with refugees and asylum seekers (Robinson, 2013).

To date, the vast majority of literature on mental health practice with refugees originates from the field of psychiatry and, consequently, is informed by a medical model (Masocha & Simpson, 2011). While the medical model provides an important perspective on mental health, it is critical to consider how Western conceptualizations of mental health may not be culturally appropriate for diverse refugee populations. The potential for various cultural constructs and psychological presentations of distress and mental health signals a need to diverge from looking exclusively to a medical model to inform practice with refugee populations. Furthermore, considering the various migration and resettlement factors influencing refugees' mental health, there is a need to look beyond the medical model to understand the context of refugees resettled in the United States and comprehensively address their mental health needs. Masocha and Simpson (2011) noted that social work practitioners receive limited training to work with refugees and assert that a social, multidisciplinary approach needs to be incorporated into social work literature in order to inform the training of social workers to work more effectively with refugee populations.

In a qualitative study of therapists' experiences working with refugee clients, training emerged as an influential factor (Schweitzer et al., 2015). Participants were counselors, social workers, and psychologists with experience working therapeutically with individuals from refugee backgrounds. These participants noted that the focus of

counseling included complex clinical issues such as grief and loss, political disturbance, existential issues, and considerable trauma. A dissonance between the multifaceted clinical issues encountered in session and the professional training these professionals received to serve this diverse population resulted in participants feeling unprepared and incompetent to effectively serve refugees (Schweitzer et al., 2015). Supervision emerged as a specific component of training and preparation that was critical to work with refugees. The therapists in this study noted three crucial roles of supervision: supporting therapists in coping with difficult emotions and secondary traumatization, providing guidance on working with uncertainty, and increasing therapeutic skill specific to refugee clients. However, therapists described difficulties accessing appropriate supervision, particularly since there are a limited number of supervisors with experience and expertise with refugee populations (Schweitzer et al., 2015). Schweitzer et al. (2015) asserted that “the training received by therapists, regardless of professional affiliation, did not prepare them for the multiple challenges of working with clients from refugee backgrounds exacerbated by insufficient training in cross-cultural issues” (p. 117).

Similarly, Posselt et al., (2017) studied 15 refugee clients and 15 service providers and highlighted insufficient training and preparation as a barrier to refugee mental health care. One of the four primary themes that emerged from the qualitative analysis was training and resources. Mental health service providers working with refugees reported a lack of training offered by universities and training organizations. Several unmet training needs were mentioned, including lack of training to work with interpreters, limited cultural awareness, inadequate understanding of how to adapt therapeutic approaches to

work with refugees, a limited understanding of the intersectionality of the identities refugee populations may hold (Posset et al., 2017). The refugee participants in this study emphasized the need for their service providers to understand their culture, learn about their country, and use an appropriate interpreter in counseling. Clearly, professional development, training, and supervision specific to working with refugees is needed to adequately prepare mental health practitioners to work with refugees. The scarcity of adequate training and supervision to work with this population may be attributed to a limited number of educators and clinical supervisors who are knowledgeable in refugee practice.

### **Educational Strategies in Cultural Competence Development**

The need for multicultural understanding and competence for professionals working in health care, including mental health care, has been well supported in existing literature (Jeffreys, 2010; Lee & Khawaja, 2014; Luquis & Perez, 2005; Prescott-Clements et al., 2012; Sue, 2001; Smith et al., 2006). Research on educational and training strategies to promote cultural competence with cultural groups such as refugees, however, is less readily available. One of the challenges in conducting this type of research is the difficulty in establishing a clear definition by which to measure cultural competence growth and education. Cultural competence training occurs in different health fields, professional conferences, by independent consultants, and through access to literature and books on working with diverse patients and clientele. There is little empirical evidence available, however, to support the efficacy of these programs or how they help professionals grow. Furthermore, a continued trend in cultural competence

education is that most of these programs focus on increasing knowledge rather than on developing culture specific skills (Collins et al., 2015; McRae & Johnson, 1991; Pieterse et al., 2009; Priester et al., 2008).

Although the effectiveness of multicultural development programs has not been well documented, a variety of strategies have been suggested for cultural competence development in different mental health and healthcare fields. In some cases, these teaching strategies have been evaluated to measure the cultural competence development of learners. For example, cultural immersion is a popular method for multicultural education across health professions (Barden & Cashwell, 2013; Kim & Lyons, 2003; Kuo & Arcuri, 2014; Luquis & Perez, 2005; Priester et al., 2008). Researchers have shown that cultural immersion helps students understand how to work with differences, make connections with individuals from diverse cultures, and experience culture from a new perspective (Barden & Cashwell, 2013; Kuo & Arcuri, 2014). Despite the acknowledgement of the importance of cultural immersion or interaction experiences, however, many programs do not provide adequate opportunities for exposure to diverse populations within their fields of study. This may be due to a number of barriers in providing these experiences, such as curriculum structures, opportunities for clinical placements available in the community, lack of funds, and limited personnel to establish community relationships with organizations outside of the university. As such, many teaching strategies are not immersion based. These may include such experiences as supplementary readings, films and movies, role playing, discussion-based learning,

sharing/ reflection, and writing assignments, which may increase cultural knowledge but does not involve the same type of immersive experience.

Researchers also have empirically examined pedagogical strategies in multicultural counseling. For example, Priester et al. (2008) conducted an analysis of content and instructional strategies in 64 master's level multicultural counseling courses to understand how this material was taught and the degree to which courses addressed the three areas of the multicultural counseling competencies: knowledge, skills, and awareness. Overwhelmingly, the majority of syllabi highly emphasized the acquisition of knowledge (84%). Unfortunately, however, only 41% of courses included a high level of emphasis on self-awareness, and only 12% of programs included a high level of emphasis on skill development (Priester et al., 2008). Priester et al. concluded that skill development was notably lacking in the course syllabi examined, with 28% of syllabi including no explicit mention of skills. The most common teaching techniques included journal writing, cultural self-examination papers, reaction papers to books or films, attendance at a cultural event in which the student was the minority, class presentations on a specific cultural group, interviews with members of different cultural groups, research papers on a particular cultural group, and critiques of research articles (Priester et al., 2008). While it cannot be assumed that course syllabi accurately and completely reflect the learning that occurs in the classroom, this content analysis provides a snapshot of multicultural course content and teaching methods. What it does not provide is insight on the effectiveness of teaching interventions and training. Specifically, this study does not reveal how the acquisition of knowledge about particular cultural groups or the

development of awareness translates into culturally responsive skill development and increased ability to effectively counsel culturally diverse populations. Even more important to consider is that only a small percentage of reviewed syllabi included *any* mention of refugee populations. This indicates that mental health practitioners who provide services to refugees may gather the knowledge, skills, and awareness they need to serve this population through learning that occurs outside of graduate didactic coursework. Cultural competence training and development is recognized as necessary for all health care professionals, as researchers have shown that the cultural competence of health professionals affects the outcomes of patient care (Prescott-Clements et al., 2012). However, there is still little known about the most effective design, delivery, implementation, and evaluation of cultural competence across health care fields (Luquis & Perez, 2005; Patil et al., 2012; Prescott-Clements et al., 2012). To a limited extent, researchers have examined the efficacy of multicultural development tools in preparing professionals to work with multicultural populations (Anuar & Jaladin, 2016; Hipolito-Delgado et al., 2011; Jones et al., 2013; Smith et al., 2006). Overall, however, what seems conspicuously missing are clear guidelines and models for counseling refugee clients.

### **Refugee Specific Training Models**

To meet the mental health needs of culturally diverse refugees, a very limited number of training programs have been developed, implemented, and evaluated in scholarly literature. Examining these programs can provide important information on refugee specific training and the preparation of mental health professionals to serve

refugees. An overview including the purpose, structure, and details of each program and study are described, followed by a discussion of the outcomes of these programs as related to skill, knowledge, awareness, and self-efficacy development.

### **Training Models**

Midgett and Doumas (2016) evaluated the impact of service-learning infused courses on multicultural and social justice advocacy skills among first and second year counseling students in a CACREP-accredited counselor education program at a midsized metropolitan university. The purpose of this service-learning project was to examine the effectiveness and timing of counseling courses that incorporated a community based, multicultural service-learning project on students' multicultural competence and social justice skill development. The 38 first and second year students included in this study ranged in age from 21 to 61 years and were predominately white (92.2%). Students participating in the study were either enrolled in a 1<sup>st</sup>-year Foundations in Counseling course or a 2<sup>nd</sup>-year Career Counseling course in which this service-learning program was incorporated. In this program, students served as job coaches for refugee families. The instructor partnered with a refugee serving agency. All students were provided an orientation to working with refugees that covered topics such as general refugee experiences, migration processes, adaptation to the country of resettlement, and social justice challenges. After the completion of this orientation, students were paired with a refugee family that they worked with throughout the course of the semester. Prior to meeting with families for the first time, students read assigned readings and were instructed to examine assumptions and expectations. Throughout their 30-hour service-

learning projects, students used their basic counseling skills to build rapport with families, assess family's needs, and use different approaches to assist family members in reaching their employment related goals. Midgett and Doumas (2016) concluded that the training impacted student cultural competence for working with refugees. For instance, participants reported increases social justice advocacy skills after participating in these service-learning infused courses, supporting service learning as an effective teaching strategy for working with refugees. Additionally, participants also demonstrated a significant increase in multicultural knowledge and reported a greater understanding of multicultural counseling issues (Midgett & Doumas, 2016). Interestingly (and in contrast to results provided below), there were no significant changes in multicultural awareness from pre- to post-test. This may have been a result of the structure of the program, the type of interventions and experiences these students experienced, the stages of the students' development, or limitations in measurement of awareness. Nonetheless, this is an important finding as it demonstrates the need to further investigate mental health professionals' experiences of learning the affective skills needed to provide effective services to refugees.

Another ongoing program involves an 8-month multicultural therapy clinical practicum, established in 2007, that was developed as an extension of a didactic multicultural course for advanced clinical psychology doctoral students at the University of Windsor in Canada. This practicum was developed in partnership with a community agency to meet the needs of the local refugee community. This practicum provides psychology trainees the opportunity to offer mental health services to culturally and

linguistically diverse refugees under supervision. The purpose of developing a multicultural therapy clinical practicum was twofold: (a) the program was specifically designed to incorporate elements of multicultural competence and social justice training, community outreach/service, experiential learning, and trauma therapy and offer live training opportunities for students to gain cross cultural therapy experiences with refugee clients, and (b) the program was developed in response to an appeal made by a local agency to increase access to services for refugees being resettled in their community (Kuo & Arcuri, 2014).

The Multicultural Counseling and Psychotherapy with Refugees Practicum is offered to advanced doctoral students who have completed the prerequisite didactic multicultural and diversity course. At the time that Kuo and Arcuri published their research, the course was in its sixth year of existence. Participants in this study were eight female trainees and one male trainee ranging between 25 and 31 years of age. All participants identified as White. The practicum training begins with 7 weeks of didactic seminars on issues related to working with refugees (e.g. refugee specific PTSD symptoms, use of language interpreters, cultural adjustment and acculturation issues), followed by onsite visits and outreach to community partners. Trainees in the program are then able to provide up to 17 weeks of treatment to refugee clients, under supervision. The format of supervision was a weekly 2-hour group, though individual supervision was available as needed. Kuo and Arcuri (2014) evaluated this practicum by examining the learning experiences of three cohorts of trainees by (a) administering pre-and post-questionnaires that assess changes on measures of the MCC, multicultural self-efficacy,

and the quality of therapist-client alliance, and (b) examining trainees critical incident journals over the course of the practicum, focusing on trainees cognitive, affective, and behavioral changes. The measures used in this study included the Multicultural Counseling Inventory (MCI) and the Multicultural Self-Efficacy Scale-Racial Diversity Form (MCSE-RD). Mixed model analyses of variance were used to examine baseline and follow up scores for multicultural awareness, knowledge, and social justice advocacy skills.

Similar to Midgett and Doumas (2015), Kuo and Acari (2015) found their training model positively influenced student's multicultural competence development. For example, participants' scores in the Multicultural Counseling Skills subscale of the MCI significantly increased between pre- and post-practicum (Kuo & Acari, 2014). Additionally, Kuo and Acari found an increase in cognitive development by trainees throughout their clinical practicum. Specifically, trainees reported that their training and experiential experiences helped them better understand refugees' understanding and expectation of therapy and the importance of incorporating a cultural framework in working with refugee clients. Finally, Kuo and Acari also found that focused clinical practicum experiences increased psychology trainees' awareness of refugee culture compared with their own personal culture. These trainees reported a heightened sense of cultural and self-awareness, which they stated helped inform their counseling work with refugee clients.

A final program, studied by Nilsson, Schale, and Khamphakdy-Brown (2010), examined the influence of a counseling focused service-learning program with immigrant

and refugee women on counselor trainees' learning and development as counselors. This grant-funded mental health program was developed at a counseling department of a mid-western university to increase students' multicultural competency and social justice advocacy. Prior to beginning their service learning experiences, students in this program were trained in refugee and immigration policies and processes and the issues faced by these populations, such as pre-immigration and post-immigration trauma, acculturation, and domestic violence. Some students also were trained in communication and culturally appropriate interaction with families on home visits. Furthermore, students also were provided guidance for engaging in advocacy and community engagement activities and received preparation for using interpreters to provide services. They learned how to engage in activities with refugee families not typically associated with traditional counseling, such as acting as advocating for families by interacting with housing officials, schools, and lawyers on the clients' behalf, communicating with social services, and collaborating with domestic violence shelter staff. At the time of Nilsson et al.'s research, the program was in its 8<sup>th</sup> year. Twelve graduate students in counseling and counseling psychology were interviewed to explore their perceptions and experiences of working with clients in an advocacy capacity. The participants were 3-master's level and 9- doctoral level students. All identified as women, 10 identified as White, one identified as African American, and one identified as Caribbean. Participants were involved in the program at different capacities.

Similar to the other two programs, Nilsson et al. (2010) found the program influenced trainees' cultural competence. Specifically, they found that the

refugee/immigrant mental health program positively contributed to trainees' skill development. Specifically, students who participated in the service-learning program reported increases in the following skills: (1) working with an interpreter, (b) engaging in home visits, (c) practicing advocacy, and (d) improved general counseling skills. The program also appeared to impact trainees' knowledge as counseling trainees demonstrated growth in development of multicultural knowledge after participating in the service-learning project. Specifically, counseling students described increasing their knowledge about culturally diverse populations and the understanding of adjustment difficulties. Finally, the service learning project seems to impact trainee affective skills. Specifically, one of the major themes found by Nilsson et al. (2010) study included personal growth and reactions. This personal growth included reflections of inner changes and view of self, and reported changes in the perceptions of others. Specifically, trainees reported increased self-awareness, a greater appreciation of immigrant and refugee women, a sense of personal reward from the work, and greater motivation to serve this population in the future.

### **Limitations**

Although the mentioned refugee training programs provide perspective on how mental health professionals can be trained to provide culturally competent and effective care to refugee populations, many limitations exist. First, the prevalence of focused, refugee specific training experiences in the United States is extremely limited. While Nilsson et al. (2010), Kuo and Acuri (2014), and Midgett and Doumas (2015) point to possible paths to cultivate cultural competence in working with refugees, it is

unfortunately true that only a limited subset of trainees will ever have access to such experiences during their graduate training and, as such, it is not clear how mental health professionals gain the preparation they need to effectively counsel this population without access such opportunities in graduate programs. Most counselors who work with refugees likely never participated in service infused courses or learning preparation and further study is warranted to understand how these counselors developed their competency. Another limitation inherent in these three studies is that the researchers did not take into account previous learning experiences students may have had prior to their counseling training, such as personal experiences with these populations or lived experiences of cultural immersion. Academic preparation. This provides a further rationale for investigating the preparation and training experiences of counselors who work with refugees to understand their process of learning and gain insight on their experiences of learning how to work with refugees. While such programs have been found to impact student development related to effectively counseling refugees, most mental health training programs do not offer an extended multicultural practicum such as the one described by Kua and Arcuri (2014), Midgett and Dumas (2015), and Nilsson et al., (2010), leaving additional questions. Are people only inclined to work with refugee populations if they receive such specialized training afforded to a small percentage of counselor trainees? If most counselors who work with refugee clients are not trained in these specialized training methods, then how, in fact, do they develop cultural competence to effectively work with refugees?

An important limitation in these studies is that they do not represent a diverse range of learners. For instance, all individuals in these studies are counseling trainees who are not yet licensed. Mental health professionals who have graduated from training programs and gained licensure continue to learn and develop skills and competence over time and, as such, it is essential that researchers examine learning and experiences of post-graduates. It remains unknown how formal and informal training opportunities outside of graduate coursework influence mental health professionals' ability to effectively serve refugees. The limited diversity of learners in these studies is also evidenced by the lack of diversity of culture and race of the trainees across all programs. The majority of participants identified as White, and little is known about the other aspects of their cultural identities that may influence their learning experiences. Consequently, there remains a gap in knowledge in understanding the learning process of culturally diverse learners. This is necessary to examine, as learners' cultural diversity may influence both formal and informal learning experiences contributing to their cultural competence development and sense of preparation and confidence to serve refugee populations. Other aspects contributing to experiences of preparation, training, and learning, such as the quality and accuracy of training and education provided, the cultural competence of educators, and the learning environment, need to be considered to best understand the diverse experiences of learners.

### **Need for Additional Research**

A review of literature reveals that meeting the mental health needs of culturally and linguistically diverse refugees continues to be a challenge for mental health

practitioners. This is due to refugees' complex mental health needs and barriers to access that ultimately influence the utilization of mental health services by refugees. The barriers often cited in literature include language barriers, cultural barriers, and training and education barriers. Although these barriers are described separately in the literature review, they are all connected to the educational and training gaps that exist for mental health professionals. For instance, language barriers serve as an access barrier for refugees seeking mental health services, and effective training on working with linguistically diverse refugees and language interpreters in counseling sessions has been cited as a necessity to increase mental health professionals' communication skills to reduce this barrier. Similarly, it has been suggested that increasing knowledge and awareness of refugee populations could reduce access barriers related to culture. The literature points to a clear need for mental health practitioners to be adequately trained to serve this population. Although mental health training and education often includes an emphasis on multicultural competence training, this broad cultural competence training often excludes specific material on refugee populations and challenges unique to refugees. Furthermore, considering the unique mental health needs of this population resulting from their cultural and linguistic diversity, migration experiences, and resettlement and adjustment needs, it is likely that multicultural training in the form of a singular graduate level course may not be sufficient to prepare counselors to work with this population.

Although there have been limited examples of programs and training models specific to counseling refugees that have been developed and empirically examined, these

programs are limited and have only been applied to a few graduate training programs and were specific to the needs of the communities that the graduate programs were located in, and the resources to which these communities had access. The majority of graduate training programs across mental health fields do not provide focused training on refugee populations, and access to in-depth trainings such as the ones described in this literature review is limited.

Furthermore, considering how little scholarly research has been conducted on effectively training mental health practitioners to work with refugees, there is a need for more focused research to expand literature on cultural competence development specific to this population. Consequently, a training gap exists for mental health professionals. As mentioned, the number of refugees resettled in the United States is expansive, and the lack of appropriate training is a significant barrier to access. Often, resettlement agencies do not provide access to mental health services for refugees and, as such, most refugees are resettled in communities across the United States without specialized access to services. Refugees seeking mental health services therefore need to seek them from mental health professionals in their communities who may have no access to information, knowledge, or training on refugee populations. Considering the limitations on refugee specific mental health training, it is unclear how these mental health professionals learn how to effectively serve this population. Mental health professionals have an ethical duty to serve culturally diverse populations and educators have a duty to train professionals that can provide effective and competent services. Exploring and examining the learning, preparation, and training experiences of mental health professionals who work with

refugees serves as a step to fill the gap in literature on refugee specific training and education. By gaining an in-depth understanding of how mental health practitioners learn how to serve refugees, recommendations for training and education can be gathered.

## **CHAPTER III**

### **METHODOLOGY**

#### **Overview**

Chapter one provided an introduction and rationale for the need to explore mental health professionals' experiences of learning how to counsel refugees. Chapter two then provided a review of literature on refugee mental health, service provision to refugee populations, and education and training in cultural competence development and refugee specific education. This chapter describes a rationale for the phenomenological methodology selected for this study and provides an overview of the research design and analysis. Included in this chapter is (1) a description of phenomenological qualitative research, focusing on interpretive phenomenological analysis; (2) a rationale for the methodology utilized in this study; (3) a description of procedures used, including participant selection, participant profiles, the interview schedule, data collection, and data analysis; (4) measures used to attend to study design credibility and trustworthiness; and (5) an overview of a priori limitations.

#### **Research Design**

To better understand the experience of mental health professionals working with refugee populations, the methodology selected for this study was Interpretive Phenomenological Analysis (IPA), a qualitative approach to research grounded in the philosophical theories of phenomenology, hermeneutics, and idiography (Smith, Flowers,

& Larkins, 2012). Phenomenology is a philosophical approach to the study of experience, hermeneutics is concerned with interpretation, and idiography emphasizes the study of particular phenomena in detail (Smith et al., 2012). IPA combines these theoretical perspectives, detailing an interpretative process that examines human lived experience in a particular context (Smith et al., 2009). This methodology is primarily concerned with “understanding personal lived experience and thus with exploring persons’ relatedness to, or involvement in, a particular event or process (phenomenon)” (Smith et al., 2012, pp. 40). The goal of IPA is to study and interpret, in great depth, participants’ experiences with a specific phenomenon (Smith et al., 2012; Smith & Osborn, 2007). Rather than generalizing experiences, the purpose of IPA is to explore human experience without predefined boundaries or categories. As such, the data collection process allows for data to emerge naturally without the influence of hypotheses in order to explore the significance of the phenomenon being explored (Smith & Osborn, 2007). This approach allows for the emergence of each participant’s personal reflections, understandings, opinions, attitudes, beliefs, and overall experiences (Smith et al., 2012). As such, IPA is an appropriate methodological approach when the purpose of research is to understand how individuals with shared experiences of an identified phenomenon perceive this phenomenon and make sense of their experiences (Smith & Osborn, 2007; Smith et al., 2012).

The phenomenon under investigation is the process of learning, preparation, and training of counselors who work with refugees, including both formal training (i.e., graduate preparation) and informal learning (i.e., learning from experience). In this study,

the participants were mental health professionals who have worked with refugee populations. IPA was selected to best address the research question in this study for several reasons. First, there is limited foundational knowledge about the training and educational learning experiences that prepare counselors to work effectively with refugee populations (Engstrom, Roth, & Hollis, 2010; Khawaja & Stein, 2016; Lee & Khawaja, 2014). It also seems likely that there are a limited number of educators with experience counseling refugee populations to inform curriculum design and continuing education needs of mental health professionals in the trenches working with refugee populations. As such, it is likely that mental health professionals who work with refugees gain the preparation and training they need in a variety of ways, and these may be the most qualified people to speak to these training and preparation needs. Qualitative methodology provides an opportunity to explore the experiences of training to work with this population in order to fill the gap of foundational knowledge (Smith & Osborn, 2007). Second, the diversity of preparation and training experiences of mental health professionals who work with refugees is not fully understood yet and is likely to be very diverse given that trainees' refugee specific graduate coursework and immersion experiences may be limited (Pietrese et al., 2009; Villalba, 2009). Examining the diverse preparation and training needs can provide insight on how counselors navigate to gain the knowledge, skills, and awareness they need to effectively serve the refugee population. Furthermore, this insight may provide additional information about the experiences of training that influenced their learning and preparedness to work with refugees. Qualitative phenomenological methodology allows for the potentially wide

range of diversities and complexities of experiences to be captured without limitations (Smith & Osborn, 2007). IPA provides an opportunity for the rich exploration of participants' lived experiences to develop a broad, deep understanding of their training and educational experiences. Finally, this qualitative inquiry emphasizes the holistic treatment of phenomena, such that a deep understanding of the many contexts of phenomena are allowed to emerge (Stake, 2010). Considering the dearth of scholarly research and literature on the learning and preparation experiences of mental health professionals who work with refugees, taking a phenomenological, qualitative approach was expected to allow for data about learning and training to emerge across a wide range of contexts, including spatial, political, social, cultural, economic, personal, and temporal (Stake, 2010), consequently providing a rich perspective on the experiences of participants. This study allowed for the emergence of themes that described the experiences of mental health professionals who work with refugees as they reflected on and explored their learning experiences in relation to their therapeutic work with refugee clients.

### **Research Question**

To better understand the phenomenological experience of mental health professionals who provide services to refugee populations, one over-arching research question was asked:

How do mental health professionals who work with refugees describe their experiences of learning how to counsel this population?

Consistent with IPA methodology, no a priori research hypotheses were formulated.

## **Participant Inclusion Criteria**

The target population for this study included licensed mental health professionals who have provided direct, face-to-face services to adult refugee clients. Mental health professionals included fully or provisionally licensed individuals in the fields of counseling, social work, marriage and family therapy, and psychology. Since participants were recruited from across the United States, licensure types varied depending on participants' state licensure boards. Examples of licensed mental health professionals include licensed professional counselors, clinical psychologists, licensed clinical social workers, and marriage and family therapists. IPA research requires a fairly homogenous sample, though homogeneity is dependent on a variety of factors (Smith & Osborn, 2007; Smith et al., 2012). In this study, homogeneity was achieved by requiring that all participants hold a recognized professional license in a mental health field following graduate training in a mental health program. The license/mental health field is not specified, however, since the phenomena of learning to work with refugees is experienced across all of these disciplines. Furthermore, collecting data from a variety of mental health counseling providers was expected to allow for the gathering of diverse, rich experiences. This sample excluded individuals who provide services to refugees outside of the context of direct counseling/therapy, such as referral specialists, resettlement employees, case managers, and nonprofit or government employees and volunteers who work with refugee populations outside of the scope of counseling. Participants for this study were required to be able to describe their experiences with the process of preparation, training, and overall learning to work with this population.

## Sampling

IPA studies are conducted on small sample sizes, as “the issue is quality, not quantity, and given the complexity of most human phenomena, IPA studies usually benefit from a concentrated focus on a small number of cases” (Smith et al., 2012, pp. 51). Phenomenological inquiry does not require any absolute number of participant, but rather requires that participants are able to deliberate and reflect on the questions related to the research problem and provide valuable data to the study (Heppner et al., 2008). In addition to the participants’ potential to produce rich data, another factor influencing sample size ranges in IPA studies is the constraints or limitations within which the researcher is operating (Smith & Osborn, 2007). Consequently, there are different recommendations provided on an appropriate sample number for an IPA study, and studies have been published with samples ranging from a single participant to fifteen or more participants (Smith & Osborn, 2007). Since IPA is dependent on a detailed interpretive analysis based on individual participants’ experiences, however, many researchers are recognizing the need for IPA research to be conducted on a very small sample of participants (Smith & Osborn, 2007). According to Smith & Osborn (2007), sample size is dependent on several factors such as: the degree of commitment to the level of analysis and reporting, the richness of interviews, and the constraints the researchers are operating under. Smith et al. (2012) suggested that a sample between three and six participants is sufficient for the development of a meaningful study, though a range of four to ten interviews is suggested to meet the demands of professional doctorate research. Taking these recommendations into account, this study aimed to

include between 6-10 participants. A total of seven participants ultimately participated in the study.

The suggested sampling method for IPA is purposive sampling, as this method allows for the recruitment of a defined group of participants who offer rich insight into a particular phenomenon (Smith et al., 2012; Smith & Osborn, 2007). In this study, purposive and snowball sampling methods were used to recruit participants. A nomination process was utilized to invite participants to the study. To recruit participants, the researcher contacted counseling, social service, and refugee assistance agencies that provide counseling services or referral to counseling services, as well as faculty in mental health departments to inform them about the study and ask for nominations. The Society of Refugee Healthcare Providers listserv and other mental health practitioner listservs and networks also were used to collect nominations. Finally, the researcher's own professional contacts were contacted for nominations, and snowball recruitment through other participants was used as a method for recruitment as suggested by Smith et al. (2012).

Those who were contacted were informed about the study and provided relevant information. They were then asked to identify one or more mental health professionals who provide effective counseling services to refugees. These nominators were then asked to contact their nominee(s) to share information about the study and ask for their permission to nominate them to participate in an interview to share their experiences of learning how to counsel refugees. The recruitment instructions asked nominators to submit their nominations by emailing the researcher and copying their nominees in the

email, in order to ensure that the nominators have informed their nominees about the study. Individuals identified through these methods who expressed interest in participation were then contacted, screened for eligibility, and invited to participate in the study. Snowball sampling also was used, as participants who were recruited for the study were asked to nominate other mental health professionals who provide effective counseling to refugees. Nominations were provided from listservs, the researcher's professional network, and nonprofit refugee organizations. Of the nominations provided, seven nominees were recruited as participants in this study. An overview of these seven participants is provided, followed by a brief description of each participant based on data gathered from demographic questionnaires and the interview process.

### **Overview of Participants**

Participants were 7 mental health professionals with diverse educational and clinical experiences. The licensure qualification of these participants included Licensed Professional Counselor or Associate (4), Licensed Psychologist (1), Licensed Marriage and Family Therapist (1), and Licensed Clinical Social Work Associate (1). Of the participants who were Licensed Professional Counselors, one was also licensed as a Registered Expressive Arts Therapist and two were additionally trained as school counselors. Three participants held both master's and doctoral degrees in counseling fields, three participants were trained at the master's level, and one was currently enrolled in a doctoral program. Five of these participants were geographically located in the South, and two participants were located in the Midwest regions of the United States.

In terms of reported demographics, six participants identified as White and one participant identified as Middle Eastern. Of the participants that identified as White, one of these participants also identified as a former refugee from the USSR, and only one identified as male. In regard to religious, spiritual, or existential orientation, two participants identified as Christian, two identified as Jewish, one identified as Muslim, one identified as Atheist/Altruistic, and one identified as spiritual. Furthermore, four participants also identified either full professional proficiency or intermediate/advanced proficiency in languages other than English. Further insight on each participant is provided.

### **Participant 1**

Participant 1 was a White, Christian woman in her mid-twenties located in the Southern region of the US. She is a Licensed Clinical Social Work Associate who received her masters' level training in social work. Participant 1 received no formal training on counseling refugees prior to beginning her work with this population. She reported that she independently sought immersion and volunteer experiences in order to learn how to best work with this population. Participant 1 reported that she had provided between 26-50 hours of counseling services to refugee clients in the form of individual counseling and community based intervention. This work occurred in the context of private practice settings, mental health agencies, nonprofit organizations, and refugee agencies. In her work, she primarily counseled refugees from the Democratic Republic of the Congo (DRC) and Pakistan. Participant 1 reported language proficiency in both English and French, the official language of the DRC. She has provided counseling

services in both English and French, and utilized interpreters in counseling sessions.

Participant 1 reported receiving basic training to prepare her to work with interpreters but no training to counsel in a second language.

### **Participant 2**

Participant 2 was a White male in his mid-thirties located in the Southern region of the US. He identified his religion, spiritual, or existential orientation as atheist and altruistic. Participant 2 was a Licensed Psychologist who received his training at the master's and doctoral level in counseling psychology. He shared that his graduate education was heavily oriented towards social justice, although he received no formal instruction in counseling refugees. However, Participant 2 reported formal training in the form of a practicum experience in his doctoral program in which he counseled refugees and received supervision from a supervisor with extensive background and experiences in this area. He had provided between 26-50 hours of individual and community based counseling to refugees in mental health and refugee agencies. Additionally, Participant 2 shared that he had significant cross cultural immersion experiences throughout his undergraduate and graduate education, even though these were not related to counseling practice or specific to refugee populations. He also reported that his doctoral research focused on cross-cultural topics. Participant 2 relied on interpreters to counsel refugees with limited English proficiency. He received no formal training on working with interpreters prior to beginning this work. His experience has primarily been with refugees from Myanmar and the Democratic Republic of the Congo.

### **Participant 3**

Participant 3 was a white woman in her late thirties located in the Midwest region of the USA. She identified as a former refugee from the USSR and is fluent in multiple languages including English, Russian, Spanish, and Hebrew. Participant 3 identified her religious and spiritual orientation as “complicated, but Jewish overall.” Participant 3 was a Licensed Professional Clinical Counselor, who received her master’s level training in school counseling and was a doctoral student in counselor education and supervision. She held certifications in special education and teaching English as a Second Language. The types of services she provided to refugee clients included individual counseling, family counseling, and community based practice. This counseling was provided in private practice and nonprofit organization settings. Participant 3 provided counseling services in both English and other languages in which she has fluency. She reported that she has not used interpreters or cultural brokers in counseling sessions, indicating that counseling was conducted in the counselor’s proficient languages. Participant 3 also reported receiving no training specific to refugees or counseling in non-English language. She has worked with refugees from a wide range of backgrounds including Afghanistan, Somalia, Sudan, Central African Republic, Ukraine, Eritrea, Uzbekistan, Kyrgyzstan, Russia, and Palestinian territories.

### **Participant 4**

Participant 4 was a white, Christian woman in her late twenties located in the Southern region of the USA. She was a Licensed Marriage and Family Therapist who received her master’s level training in a marriage and family therapy program, and was

also trained as a Certified Expert Trauma Professional. Prior to beginning work with refugees, Participant 4 had received no formal training on counseling refugees and had no prior experiences with immersion in her educational programs. She had provided over 500 hours of counseling services to refugee clients which included individual, family, group, and couples and marriage counseling as well as community based interventions. These services were provided in the context of a nonprofit refugee agency. She utilized both interpreters and cultural brokers in her counseling work but had received no prior training to prepare her to do so. Participant 4 had provided counseling services to refugees from a wide range of countries including Syria, Afghanistan, Sudan, South Sudan, Somalia, Eritrea, DRC, Myanmar, Yemen, Iraq, Colombia, Burundi, Central African Republic, Honduras, Guatemala, Mexico, Ethiopia, Cuba, Iran, Vietnam, Cambodia, Bhutan, and Nepal.

### **Participant 5**

Participant 5 was a white woman in her mid-thirties located in the Southern US who identified as Jewish and held language proficiency in both English and Spanish. Participant 5 is a Licensed Professional Counselor Supervisor and a Registered Expressive Arts Therapist. She received her training at the master's level in expressive arts therapies and mental health counseling, and at the doctoral level in expressive therapies. Participant 5 received no formal training on counseling refugees or immersion opportunities in her education prior to beginning this work, although she had had experiences teaching abroad. After having significant experience with this population, Participant 5 began a doctoral program and focused her research on refugees. She had

provided over 500 hours of counseling services to refugees which included individual and group counseling, art therapy, and community based counseling. These services were provided in the context of mental health agencies, refugee agencies, nonprofit organizations, hospital or integrated healthcare settings, or religious institutions. Additionally, she shared that she provides art therapy programs in school settings. She had sought formal training in working with interpreters and cultural brokers in order to prepare her for this work. Participant 5 had counseled extensively diverse groups of refugees including those from Syria, Afghanistan, Myanmar, Sudan, DRC, Central African Republic, Burundi, Iraq, Ukraine, Honduras, Yemen, Angola, China, Colombia, Cuba, El Salvador, France, Kenya, Lebanon, Liberia, Malaysia, Mexico, Nepal, South Korea, Tanzania, Zambia, Vietnam, Rwanda, Philippines, Guatemala, Saudi Arabia, Turkey, and Surinam.

### **Participant 6**

Participant 6 was a Middle Eastern, Muslim woman in her late thirties from the Midwest region of the US. She was a Licensed Professional Counselor and had received training at both the master's and doctoral level in school counseling and counselor education, respectively. Although she received no formal training in counseling refugees in her graduate programs, she had opportunities for cultural immersion experiences not specific to refugee populations. Furthermore, she had conducted research on refugee populations as part of her professional roles. Participant 6 has provided over 500 hours of services to refugees in the form of individual counseling, family counseling, and community-based practice. The settings for the provision of these services included

private practice, mental health agencies, and refugee agencies. Although she was asked to reflect primarily on her experiences working with refugees for this study, Participant 6 also described having extensive experiences working with refugees in school settings and agency-school partnerships. Participant 6 was fluent in English and Arabic and reported that she had not used interpreters in her counseling work. She conducted counseling in both the English and Arabic languages, and navigated language barriers without the use of interpreters. Participant 6 had counseled refugees from Syria, Somalia, Sudan, Iraq, Yemen, and Honduras.

### **Participant 7**

Participant 7 was a white woman in her early fifties located in the Southern region of the US. She identified with a spiritual, “all paths to God” existential orientation. Participant 7 was a Licensed Professional Counselor Associate with master’s level training in clinical mental health counseling. She reported formal training on counseling refugees in the form of self-sought workshops and trainings in topics such as suicide, torture, and trauma with refugee populations though she received no formal training on counseling refugees at the graduate level. Participant 7 also reported no formal educational immersion experiences, but described extensive experience working with refugees in non-clinical capacities at refugee agencies. In terms of her counseling practice, she reported that she had provided between 26-50 hours of counseling services to refugees in the form of individual counseling, family counseling, and community intervention. This counseling work was set in private practice and refugee agency settings. Participant 7 had worked with interpreters and cultural brokers in her work but

had received no prior training in these areas before beginning practice with refugees. She had worked with refugees from Syria, Somalia, Sudan, DRC, Burundi, Colombia, Iraq, El Salvador, and Nepal.

### **Procedures**

The researcher collected data based on recommendations from phenomenological methodology literature, which suggests that after identification of a phenomenon and the appropriate research questions to study it, data should be collected primarily through interviews (Miller & Salkind, 2002) and analyzed using procedure steps to capture the lived experiences of participants (Smith & Osborn, 2007; Smith et al., 2012). In depth interviews allow participants the greatest opportunity to offer detailed, personal accounts of their experiences and facilitate the sharing of stories, reflections, thoughts, and feelings about the phenomenon being studied (Smith et al., 2012).

After obtaining approval from the Institutional Review Board of the University of North Carolina at Greensboro, seven mental health professionals were recruited to participate in this study through purposive and snowball sampling techniques. Each participant received: (a) an invitation to participate in the study with a brief description of the research and its goals, (b) a copy of the consent form to review and information about the IRB approval, (c) selection criteria for participants and instructions to confirm their eligibility to take part in the study, and (d) a copy of a demographic questionnaire to complete. Although this information was provided to participants ahead of time, time was also allotted to address any questions and concerns at the time of the interview, and participants were invited to contact the researcher with questions via email. To confirm

eligibility, participants were asked to: (a) provide information about their mental health practitioner license, (b) briefly describe their experience working with refugee clients, and (c) provide a statement that indicates their ability and willingness to share in-depth reflections on their experiences of training, preparation, and overall learning to work with refugee populations. Eligible participants were then contacted via email communication to schedule an interview time and determine a preferred location. The interview was conducted by the researcher, who identifies as a Muslim, black, Arab, first generation immigrant woman who is a counselor and future counselor educator. Participants were offered the option of face-to-face interviews, virtual video interviews, or phone interviews. Two participants were interviewed in person, two interviews were conducted over the phone, and three interviews were conducted via Zoom video conference. Each participant was invited to access a secure folder on Box, which was used to upload documents related to the study.

At the time of the interviews, the researcher reviewed details of the study and semi-structured interview, provided information about the researcher and contact information, and discussed informed consent. Participants were provided the opportunity to ask any questions for clarification. At the time of interviews, participants were encouraged to engage in the process without reservations about expectations or judgements from the researcher, particularly in regard to cultural differences between the researcher and participant. The demographic information collected from participants included details such as age, race and ethnicity, gender, language, and religious affiliation. In addition to this demographic information, the questionnaire also requested

information about participants' educational and training experiences. These included questions about participants' formal education, experiences with refugee populations, service learning or immersion experiences, continuing education participation, and other training related factors. The items included in this questionnaire were informed by recommendations in the CCC model.

The confidentiality of participants was maintained through the retraction of names and identifying information for all participants in the study. Any information or identifiers that had the potential to disclose a participant's identity were removed from the data analysis. All interviews were conducted by the researcher. Each interview was audio recorded and transcribed. The researcher organized participants' information and documents in a secure and password protect Box folder. This folder was used to store transcribed interviews, demographic questionnaires, and copies of participants' consent forms. A master list linking participants' names to their Participant ID was stored in a separate folder, only accessible by the researcher for the duration of the study.

Transcription services were used to transcribe the interviews. The audio files shared with the transcriber were labeled in ways that protected participants' identities. The transcriber recruited for this study was required to sign a privacy and confidentiality form, the UNCG Research Confidentiality Agreement, prior to receiving any research information and audio recordings in order to protect the confidentiality of participants. Once the recorded interviews were transcribed and identifying information was removed from transcriptions, audio recordings were erased. A second coder was also a part of the

research team and was similarly required to sign the UNCG Research Confidentiality Agreement prior to gaining access to de-identified participant transcripts.

Minimal risks were expected in this study. Participants were asked to reflect on their experiences working with refugee populations. Considering the potential trauma experiences and mental health needs of this population, participants were informed of the possibility that they might experience psychological reactions as they recalled some of their experiences of working with refugees. However, this study was focused on exploring experiences of learning and education in particular, so the likelihood for this risk was expected to be minimal. Participants were encouraged to only share information that they feel comfortable sharing during this interview. Furthermore, information on secondary trauma and self-care strategies was provided at the end of the interview for participants who would benefit from this material to account for this risk. Although passion and emotion emerged in participants' accounts and reflections in their interviews, no participant experienced any harmful psychological reactions during their interviews. Participants were provided a \$30 gift card of their choice as a thank you for donating their time to this study.

### **Interview Protocol**

The format of the interviews followed recommendations from phenomenological methodology (Smith & Osborn, 2007). A semi-structured interview format was used for a variety of reasons. First, a semi-structured interview allows for participants to tell their stories, reflect on, and explore their experiences openly, and have the freedom to develop their thoughts and elaborate as needed. At the same time, a semi-structured interview

allows the researcher to engage in dialogue with the participants, and provides opportunities for the researcher to probe, encourage, and guide participants to engage in deeper, richer disclosure of their experience of the phenomenon (Smith et al., 2012). The semi-structured format was selected over a highly structured interview, which may limit and boundary participants' ability to fully share their lived experiences. IPA researchers typically create an interview schedule in order to best facilitate the discussion of the phenomenon being studied and answer the research question (Smith & Osborn, 2007; Smith et al., 2012). This interview schedule allowed the researcher to consider what topics the interview might cover, what difficulties might be encountered in the interview, and how any barriers to a successful interview might be handled (Smith & Osborn, 2007). In other words, the development of an interview schedule allowed for the creation of "virtual maps for the interview, which can be drawn upon if, during the interview itself, things become difficult and stuck" (Smith et al., 2009, pp. 59). This allowed for the most comfortable and productive interview interactions as it facilitated an environment in which both researcher and participants were engaged, and the researcher was more prepared to actively listen and respond to participants. For adult participants, an interview schedule with six to ten open-ended questions is recommended, along with possible prompts (Smith et al., 2012). The interviews with these seven participants ranged between 40 and 90 minutes, with an average length of 70 minutes. The interview schedule of questions and prompts is provided below:

1. Describe your experiences of providing counseling to refugees.
  - a. How would you describe the context of the services you provided?

- b. How has your experience of working with refugees changed over time, from your first client to your most recent client?
2. How did you learn how to effectively counsel refugees?
  - a. What has supported or facilitated your learning process?
  - b. What has hindered your learning process?
3. What has been most rewarding in working with refugees?
4. What has been most challenging in working with refugees?
5. What has helped you gain confidence in your work with refugees?
6. Describe the educational and training experiences that have prepared you to work with refugees.
  - a. How has your formal education and training contributed to your learning process? This may include, but is not limited to, training in graduate coursework, educational opportunities, practicums and/or internships, and clinical supervision experiences.
  - b. How has your informal training or other learning experiences prepared or not prepared you for work with this population? This may include, but is not limited to, self-directed learning, prior work/volunteer experiences, societal or environmental influences, informal mentorship, etc.
7. In what ways has your own personal identity or culture influenced your experiences of preparation to work with refugees?
8. Based on your experiences working with refugees, what could have better prepared you to work with this population?

- a. How can graduate training programs better prepare future mental health professionals to work with refugees?
9. How do you know that your work with refugees has been effective?
  10. What additional learning, training, and support do you need to further your learning process?
    - a. Based on your experience of preparation and training, what recommendations would you provide to a mental health professional who is seeking training to work with refugees?

### **Trustworthiness of the Data**

The relationship between a researcher and a participant in a qualitative study is complex, as the researcher is the instrument of research in the interview process, and the research relationship has the ability to facilitate or hinder the data collection process (Maxwell, 2013). In an effort to remain objective about the outcomes of the interview and data analysis process, and allow for data to emerge without judgment, a bracketing process was utilized and an auditor was recruited to participate in the data analysis process.

### **Bracketing**

Two methods of bracketing were used in this study. First, the research team met prior to the beginning of the data collection process to discuss their positionality, reflect on internal suppositions and preconceptions, discuss connections to the topic and prior experiences with refugees, consider how emotional connections or prior experiences may present challenges to data analysis, and discuss how to collaborate in order to support the

research process and maintain objectivity. The second method was utilized by the primary researcher, who was also the interviewer in the data collection process. The primary researcher kept a journal in which she bracketed her positionality, experiences, and reflections before the data collection process, throughout the interview process, and after the completion of interviews. These bracketing methods are further described.

**Research Team.** The primary researcher identified as a Sudanese American Muslim woman. In the bracketing meeting, she shared that she recognized how her background with refugee populations, attitudes about the political climate in the United States, personal experiences with and opinions on multicultural training in counselor education programs, and her own identity as a culturally diverse Muslim woman may influence her interpretation and analysis of data. For instance, the researcher's identity as a first-generation immigrant woman from Sudan, one of the countries with the highest numbers of refugees resettled in the United States, was identified as an experience that had the potential to influence aspects of data collection and analysis this is not accounted for in the research process. Although she had no experience providing counseling to refugees and had not been personally trained to serve this population, she has extensive experience volunteering with refugees through nonprofit organizations. Her primary experience had been in working with Burmese refugees. Her reflections were focused on prior experiences in this volunteer work, as well as her own emotional reactions to the injustice being experienced by refugees across the world. She also reflected on the distance she had tried to create between her emotional reactions to the social and political

injustice and her role as a researcher and interviewer focusing not on the experiences of refugees, but on the training of professionals who are striving to meet their needs.

The second coder is an assistant professor in counselor education who identified as a White Christian woman. She shared that while she had no formal experience counseling refugee populations, this topic continues to come up in her teaching, particularly in crises courses. She shared her perspectives that counselor educators are not preparing students to sufficiently meet the needs of culturally diverse populations and had been reflecting on how to best prepare counselors to meet the needs of populations such as refugees prior to joining this research study. Her views on the inadequacy of multicultural training in counselor education were noted as having the potential to influence the research process if left unchecked. Additionally, she reflected on her own experiences as a career counselor working with immigrants who are navigating the career and work process in the United States, sharing that she is particularly sensitive and passionate about the needs of individuals who face barriers to career and work due to their citizenship status and broader socio-political influences.

The auditor is a professor in counselor education who identified as a White Christian man. He was also the primary researcher's major advisor and directed her dissertation process. The auditor shared that his experience working with refugees was fairly limited, though he has had some minimal experience with immigrant populations. In the bracketing process, he reflected on how his early career working with children, and how his attachment lens heightened his sensitivity to aspects of the socio-political climate that impact refugees, particularly in regard to seeing the trauma experienced by children

politicized and manipulated in current events and media. He reflected on his impressions and emotional reactions to the current political climate, and shared that where he may need to be mindful in this research process is in paying attention to his reactions to events happening at a broader political context, which have the potential to influence the lens at which he reads data, particularly noting an expected bias of reading social activism into the data because of his desire to see it represented.

After sharing initial reflections and positionality, the research team discussed how their experiences may influence data collection or analysis in various ways. Additional areas of discussion emerged in this process, including reflections on the use of conservative Christianity and religion as a justification for social injustice, experiences training counselors in a rural setting, and emotional reactions to description of refugees as societal burdens by others. Throughout this discussion, the research team also discussed how they would hold each other accountable to objectivity and collaborate to ensure that their own experiences and suppositions do not impact the research process. The focus of the remainder of the meeting was on strategies to ensure objectivity throughout the data analysis process in light of the identified influences.

**Independent Bracketing.** The primary researcher, who is also the only interviewer, also engaged in an independent bracketing process which involved journaling throughout the research process. In her journaling process, she documented thoughts, reflections, expectations, biases, and reflections on her motivation for research, her own cultural identity and experiences, and any significant reactions to information gathered. This bracketing occurred before the start of the interview process, throughout

the interview process, and at the end of data collection. Some reflections were also noted in the data analysis process. In addition to documenting thoughts and reflections, the researcher also journaled about her emotional connection to the topic. Overall, the researcher felt she was able to maintain objectivity throughout the process. Because of her limited experiences providing mental health services to refugees, she approached these interviews as a researcher and learner in the process. She expressed gratitude and appreciation of the work that the participants she interviewed were doing, and felt inspired by their commitment and compassionate perspectives on counseling refugees. A collective summary of the content of this bracketing process is provided in Appendix G.

### **Auditing Process**

In order to assess the validity of the research study analysis and conclusions, Smith et al. (2012) recommended the use of the independent audit. An independent audit allows for an external reviewer to examine the research files to determine credibility and plausibility (Smith et al., 2012). Considering this researcher's prior experience working with refugees in nonprofit settings, her own experiences with training and preparation in counselor education programs and professional development, and her personal connection to the topic, an external auditor was used in order to ensure that the data had been analyzed and interpreted logically and credibly. The research proposal and interview schedule, full transcripts, individual list of themes for each participant, and the final master list of themes were shared with the auditor. The auditor was asked to verify the results of the study from using these documents and was asked to recommend

modifications to the themes and subthemes which were, in turn, considered by the coders in the data analysis process.

### **Data Analysis**

The analysis method used to analyze data was Interpretative Phenomenological Analysis (IPA) in order to identify emerging themes described by participants. The research team included two coders and an auditor. As recommended by IPA methodology procedures, the coders began data analysis by reading and rereading entire transcripts for each interview to gain the entirety of the lived experience of participants (Smith & Osborn, 2007). The coders then re-read the transcripts, this time making note of apparent significant statements and emerging meaning. These statements were then reduced to theme units and re-read to describe the noted meanings that emerged. After each coder independently identified themes within each individual interview, they met to review and discuss the themes that emerged. A list of overlapping themes for each interview were compiled after meetings, with examples from the data included to describe each theme. The themes from individual interviews were shared with the auditor. The coders noted areas of uncertainty in the document shared with the auditor, as the auditor was tasked with serving as the mediator for uncertainty or disagreement on any of the identified themes. The auditor reviewed each transcript as well as the compiled theme lists for each interview in order to minimize any of the coders' potential biases. Feedback from the auditor was minimal and included encouragement to condense and cluster some of the themes that were initially separated by the coders. This feedback was taken into account, and the individual themes for each participant were clustered as

appropriate. The coders then met in-person to collaborate in creating a master list of emerging themes across all seven interviews. This process involved a review of individual transcripts and themes, which were then clustered and connected to capture final statements of meaning as recommended by Smith & Osborn (2007). A master list with a list of overarching themes, description of the themes, and supporting data from the interviews was then sent to the auditor for review. At this point, the auditor reviewed all of the data including transcripts, individual theme lists, and the master list to ensure that all themes developed were consistent with the data and identify whether any additional themes needed to be included in the list. The auditor provided feedback that the master list was consistent with the data and no changes were needed. In order to establish credibility, member checks were completed prior to compiling the master list of themes in order to reduce errors in interpretation (Stake, 2010). A list and description of identified themes was emailed to each participant in the study for review. Participants were asked to clarify any responses, verify whether the summaries accurately reflected their responses to the interview, make corrections, address the accuracy of means revealed, and share any additional missing information or reflections that were not captured in the themes and summaries. Participants were asked to respond within a week if they needed to provide feedback. Five participants responded and confirmed that the list and summaries of themes provided reflected their lived experiences and captured what they expressed in their interviews.

### **A Priori Limitations**

An important limitation of this particular phenomenological study is that it is not generalizable to the general population due to the limited sample size as well as the intention of phenomenological methodology to capture the full breadth of individuals' lived experiences of phenomena (Smith & Osborn, 2007). Undoubtedly, no individuals lived experience is generalizable. However, it is important to note that this study was not *intended* to be generalizable to the general population, but rather to capture the lived experiences of mental health professionals to begin filling a gap in foundational knowledge about the preparation and training of mental health professionals who work with refugees. The methodology was selected with the knowledge that it would not lend to generalizability. The method of data collection was also expected to be potentially limiting. The purposive, snowball sampling procedures have the potential to fail to recruit individuals' representative of diverse experiences. For example, purposive and snowball sampling methods may lead to participants being selected from similar geographic locations. Although the context of participants' educational and professional backgrounds will be gathered in demographic questionnaires and considered in data analysis, factors related to geographical location and environmental influences (cultural, political, educational, societal, racial, etc.) and homogeneity may restrict the ability to explore the full range of factors that may influence cultural competence.

As noted in the literature review, there are inherent limitations in research with refugee populations due to the factors such as the influence of language barriers, the use of Western diagnostic standards to describe refugee mental health, and limitations created

by the unavailability of assessments and measures that accurately capture refugee's diverse cultural experiences. This has the potential to be reflected in mental health professionals' accounts of their efficacy in serving this population and their descriptions of education and training. Without the voice of the refugee in this study, it is difficult to determine if mental health professionals are truly effective in their work. However, the purpose of this study is to fill the gap in understanding the learning, training, and preparation experiences of mental health professionals' who work with refugees and understanding how these professionals describe their efficacy can serve as a foundation for future research that addresses this limitation. Finally, although this study is intended to serve as a small step to fill a gap in knowledge about counselors' experiences of preparation and training by capturing lived experiences, these lived experiences and the accounts of training and preparation do not consider the experiences of the refugee clients, and whether they deemed the services to be effective and helpful. This is important to note, as recommendations were asked of the participants, yet subjective accounts of effecting training and preparation may not capture the full picture of therapeutic care for refugees.

### **Pilot Study**

The purpose of the pilot study was to test the procedures and process of the proposed study. Specifically, this pilot study was used to: a) test the sampling procedures for recruitment, b) gather feedback on the clarity of instructions and guidelines for participation prior to the interview process, including the consent form and demographic questionnaire c) test the semi-structured interview questions including the clarity, order,

and structure of questions, d) gather feedback on the interview process experience, including feedback for the interviewer, and success of questions at prompting and eliciting thoughtful, meaningful reflections related to the purpose of the study, and e) test the time and format of the proposed procedures. The researcher obtained IRB approval from the University of North Carolina at Greensboro to proceed with the pilot study.

To recruit participants for this study, the researcher sent information about her study to colleagues and individuals in her academic and professional networks, prompting them to share the recruitment letter within their own professional networks. Although the proposed study sought participants who work with refugee populations, the pilot study was adjusted to include both immigrant and/or refugee populations. This decision was made to preserve the potential pool of participants for the proposed study, as there may be challenges in identifying a sufficient number of participants who work with refugee populations. Since this proposed study seeks to examine the phenomenon of learning, preparation, and training experiences, the only change made to accommodate for this difference in the pilot study was changing the population from “refugee” to immigrant and/or refugee” in pilot study recruitment and procedures. A total of 7 participants emailed the researcher within a few days to express interest in participation in the pilot study. Decisions on which participants to interview were made based on scheduling availability. The two participants selected for this pilot study both identified as female, Latin(x), bilingual counselors with LPC licenses in two different states in the United States. One participant worked with immigrants from diverse Latin(x) populations, while the other participant worked with both Latin(x) immigrants and

refugees from El Salvador and the Central African Republic. Both participants are current doctoral students in varying stages of their PhD programs.

Participants were sent guidelines for participation in the study, information about scheduling the interview, and instructions for completing the consent form and demographic questionnaire. Prior to the interview, participants were sent the interview guide to review in advance of the interview time. Both interviews took place online using the Zoom Video Conferencing platform and were audio recorded, as participants were located outside of the researcher's geographic location in North Carolina. Participants were sent an invitation to join the video conference. At the start of the interview, the researcher introduced herself, reviewed the purpose of the pilot study and proposed study, and invited participants to ask any clarification questions regarding the consent forms, demographic questionnaires, or procedures prior to the start of the interview. The interview then began using a semi-structured interview process. The first interview lasted approximately 95 minutes, including 15 minutes at the end of the study dedicated to pilot study specific feedback questions and processing. The second interview lasted approximately 65 minutes, including 5-10 minutes at the end of the study focused on pilot study specific feedback and processing. At the end of the study, participants were sent a follow up email with a request for any additional feedback not shared in the pilot study and instructions for claiming their \$30 gift card for participation in the study.

Overall, both participants stated that the recruitment process, invitations for participation, procedures, instructions, and documents were informational and clear. Participants received an earlier version of the interview schedule with questions about

their formal and informal experiences of learning. Referencing the interview guide, participants shared that receiving the questions prior to the interview helped them better understand the purpose of the study and the types of experiences they would be asked about related to the phenomenon of preparation, training, and learning to work with a specific population. Participants reported very positive experiences of the process, shared that they enjoyed the interview experience, and felt that the questions asked, order of the questions, probes to the questions, and the interviewer's reflections of participant statements helped facilitate a thoughtful exploration of learning experiences and helped participants deeply consider how they learned to serve this population. One participant reflected on the surprising emotional experience that these reflections brought on as she considered her process of becoming more effective at serving immigrants and refugees and remembered some of the clients that she had served. Both participants were able to reflect on both personal, informal learning experiences, and formal training, and were able to provide recommendations for the training of practitioners based on these experiences. Although the content of this interview was not analyzed in this pilot study, a variety of topics seemed to emerge from the interviews including trauma training, language barriers, supervision while serving immigrant/refugee clients, self-directed learning, use of social/professional networks, experiences of learning to serve these populations at predominately white institutions, multicultural coursework, perceived faculty multicultural and population specific competence, the impact of personal experiences, reading literature specific to the population, and self-directed doctoral research. Participants also reflected on their process of gaining confidence over time and

shared mistakes/regrets they felt they made in their early experiences of working with this population. One participant shared that she forced herself to begin working with this population despite her lack of confidence and fear of limited competence, since the need for services was great and few practitioners were willing to fill it. Both participants were able to reflect on what training they felt they would have needed to be more competent earlier on in their clinical work.

Feedback was provided by both participants in the study. The earlier draft of interview questions included specific questions inquiring about experiences of gaining cognitive, practical, and affective skills in formal and informal learning experiences. Both participants shared that it was difficult to separate their experiences of learning and preparation into the cognitive, practical, and affective domains of cultural competence. That is, it was difficult to reflect independently on knowledge, skills, and awareness gained in their process of learning when these questions were asked separately. Participants preferred to speak about their overall experiences of learning as it made it easier to share their stories and experiences in narrative form. Feedback was provided that asking generally about these domains in one question with semi-structured follow-up questions or probes to gather more specific experiences on knowledge, skill, and awareness acquisition would be preferred. The interview questions were examined based on this feedback and were ultimately adjusted to allow for more open reflections and descriptions of learning experiences. One participant also shared a suggested question that she wished had been asked in the interview: share an experience of a client you felt you made a huge impact on and describe the process of effectively serving this client

over time. The participant shared that this question would have helped her share a more specific story of how her learning experiences over time allowed her to effectively serve a client. This feedback was considered but was not incorporated into the interview guide due to the phenomenological nature of the study and the desire of the researcher to let participants' experiences of learning emerge without significant structure.

In terms of the structure and format of the interview, the 45-90-minute interview seemed to allow sufficient time for phenomenological experience to emerge, as the non-feedback related portion of both pilot study interviews lasted 50 and 75 minutes. The semi-structured format seemed to be ideal, as participants shared their experiences in different ways. For example, in the first interview, question 1 took approximately 30 minutes for the client to answer, as the participant spent time reflecting on how her experiences of immigrants/refugees changed over time, from her first client to her most recent client. As she answered this question, the participant shared examples and stories of her clients, and addressed content in the later portions of the interview guide with probes. Based on what the participant shared, the order of questions asked changed, and probes to reflections were not completed in the format indicated in the semi-structured guide. Specifically, this participant did not need much guidance, and through a few open-ended questions and inquiries, was able to openly reflect and touch on the many topics included in the interview format without significant direction. In the second interview, the order of questions on the guide was followed more easily, and the sub questions and probes to questions asked was important in facilitating the sharing of stories, reflections, and experiences related to training, preparation and learning to work with immigrant

populations. To account for the limitation of not having the refugee perspective in this study, one additional probe was added to the final interview questions: How do you know that your work with refugees has been effective? This question is intended to gather information about how the mental health professionals recruited for the study measure their efficacy, and was expected to serve to guide discussion of results and future research.

## **CHAPTER IV**

### **RESULTS**

The purpose of this study was to explore mental health professionals' lived experiences of preparation, training, and learning how to work with refugees. In Chapter III, the methodology for this qualitative study was detailed and descriptions of participants were provided. Seven participants engaged in semi-structured interviews in which their experiences, reflections, and accounts of their processes of learning how to work with refugees were gathered. Interpretative Phenomenological Analysis was then used to analyze these data and identify themes that captured participants' lived experiences. The results of this study are presented in this chapter.

#### **Research Question**

How do mental health professionals who work with refugees describe their experiences of learning how to counsel this population?

#### **Overview of Themes**

Nine themes emerged from data analyses across all seven interviews. Three of these themes, *knowledge*, *role of counselor*, and *learning strategies* included subordinate themes.

- Personal Identity, Values, and Worldview
- Language Barriers and Use of Interpreters
- Ethics and Boundaries

- Barriers, Access and Systems
- Knowledge, including:
  - Cultural diversity, Norms, Migration
  - Political Influence
  - Family Dynamics
  - Modality
  - Research and Evidence Based Practice
- Working with Trauma
- Role of a Counselor, including:
  - Counselor as Educator
  - Counselor as Advocate
- Developing Confidence
- Learning Strategies, including:
  - Graduate Training
  - Self-directed Learning
  - Mentoring and Supervision
  - Professional Development
  - Immersion Experiences
  - Recommendations

The first eight themes that emerged describe aspects of the knowledge, skills, and awareness that participants gained in learning how to work with refugees and provide insight about their processes and experiences. The last theme, *learning strategies*, more

specifically details how participants learned, focusing on the actions and conduits that influenced these experiences.

### **Personal Identity, Values, and Worldview**

All seven participants described how various aspects of their personal identities, values, and worldviews influenced their learning experiences or process of working with refugees. Participant 1, Participant 2, and Participant 5 emphasized how their faith in particular influenced their experiences. Faith was discussed as influencing motivation for pursuing work with refugees, social justice understanding and development as an advocate, and ways of building relationships. For instance, Participant 1 shared an account of how attending a religious summit sparked her passion for working with this population, stating:

I went to a big summit of a bunch of missionaries from around the world, I want to say about six years ago. Like right around the end of undergrad. And I met a man who worked with refugees literally washing ashore on the southern part of France. And just hearing about the need, something in my heart just exploded, like this is where you're going. And so that is what pushed me into refugees.

Participant 4 described how her faith influences how she builds relationships with refugees and is able to understand differences and honor every person's value and worth. She connects this to social justice values and what she believes her role as an advocate to be:

I think, obviously with my Christian faith, that has been the major impact and the major push for me because I see people as you know, we are different. We are culturally different, we have different beliefs, but essentially we are all human. And everyone is worth having, you know, the time to sit down with someone and tell their story. Everyone is worth being heard. And in my faith, that is exactly

what God, and what Jesus has expressed and tried to explain to people, was every person is worth it and every person is worthy...It's very much about justice and about making those stories heard so that justice can be understood and be seen and be fought for. And I think that's played a huge role in this. And just even more so the relational aspect of understanding, it's not just about you as a Christian over here fighting for this very vulnerable population. It's looking at the relationship between the two. That I'm not over here, this like Christian fighter, like fighting for social justice, I'm walking alongside these people and in the trenches with them, as they're trying to heal and as they're going through this process, because that's what we're called to do.

Participant 5 also highlighted the influence of faith on her experiences of preparation and learning, but provided a different perspective that emphasized the experience of being a religious minority:

Another part that I have to be honest about is I have a pretty strong Jewish identity. And I hadn't really thought of that really, until we got a grant from an organization that was, it was an organization for immigrants. And it had started I guess when Jewish people had come over in the early 1900s after running from the Russian czar and escaping persecution over there. And I'm like, oh, that's when my family came over. And they had to escape the czar and they did crazy things to get out of Russia at the time. And I think that I haven't explored that as deeply enough, but that is a part of my identity and I think that I do sort of subscribe to that feeling that hello, we are all refugees or immigrants in this country. And we just come in at different times and places and have different privileges and I think that that is just a part of just who I am internally and why I do the work I do.

Participant 5 then shared how awareness and reflection on her Jewish identity and history instilled a sense of responsibility to help others along on their journeys to safe refuge, and how that consequently helped develop her ability to serve as an advocate, sharing "I do feel like as a therapist I definitely get that piece about the advocacy piece, the therapist as a political person. And that I think that comes from my background, too, that sense of responsibility."

This theme was described as being influential at various stages of the learning process. For instance, Participant 7 described how her work with refugees over time influenced her worldview and spirituality, and ultimately allowed her to feel more impactful in her work with this population:

I think I have learned much more from this work than I have actually imparted. That I think it has changed me in ways that are pretty profound. It's made me more inclusive, it's made me better understand human struggle, discrimination, the awfulness that people do to each other for reasons that make no sense. It's made me very spiritual without having to have one religion. To have the right religion. It's just really changed me in much more global ways. I don't see the world as just my bubble. It's really helped me sort of open my eyes to this experience of the globe and how we are all so much the same, we all want to be loved, we all need to be able to be attached to someone, to feel validated and you know, cared for. That we all have emotions, that we all want to have children that we love and want to protect. There's so many more things that we have in common than we really are different.

In addition, two participants described experiences from their childhoods that have primed them for work with refugee populations. Participant 2, for instance, shared:

My mom especially was someone who said all the right things around diversity, even though we weren't exposed to it. Like, she was somebody who would say like, all people are equal, you should be compassionate and care for everybody. It doesn't matter what they look like or where they come from. Like, saying those things stuck with me, even though I didn't have the experience.

In these participants' accounts, it is clear that connection to humanity at large and the inherent value of all people is a significant part of how they approached their work with refugee clients. Participant 3's experiences were different than other participants, particularly as she was the only participant who identified as a refugee. In her words, she shared "It's such a natural kind of state for me" and described how her own experiences

influenced her ability to work with “the population in which I live and breathe.” She went on to detail how some of these personal experiences influenced her sense of preparation, such as “having the experience of knowing that you’re something other than what the dominant culture is. And then having to figure out like, who you are within that context.”

### **Ethics and Boundaries**

The theme of ethics and boundaries emerged for five participants. This theme encompasses participants’ experiences of learning how to navigate ethics and boundaries, particularly as it related to relationships with refugees. Although participants came from diverse mental health professional fields, they all shared that the code of ethics in their fields felt limiting in many ways. Participant 4 shared how she began to recognize that relationships with refugee clients may need to be more personal than what the ethical guidelines of the AAMFT recommend:

Technically, you’re not supposed to like you know, put yourself with this client and build that kind of relationship. So I think trying to figure out for myself what those boundaries are for my self-care and what’s ethically appropriate. Because also, with our refugee and immigrant populations, they get relationships way more than Americans do. And they want that relationship, and they know how to seek it, and they offer everything of themselves. You know, come to my home, I will feed you, I will make you tea. Or come meet my husband, come meet my children, I want to meet your husband, I want to meet your mom and your mother in law, bring your family. They want that, because they see you as a part of their life. They see you as a part of their story. And that’s something that for me, as a Christian, I love that. And that’s what I want to do, that’s the purpose. But also trying to figure out, how do I do that with being that therapeutic relationship there, too. How do you keep yourself from going over those boundaries so far that it does go to an unethical and sticky situation? And that’s really hard. It’s been a really difficult balance.

After gaining experience counseling refugees, she came to an important conclusion about “meeting clients where they’re at”: “That’s what therapists say all the time. Get the client where they’re at, meet the client where they’re at. Well, sometimes meeting the client where they’re at isn’t going to be within your ethical code.” Participant 5 shared similar accounts of her experiences understanding how to interact with her refugee clients over time as well, emphasizing how she had to learn how to “loosen up” what she had learned about appropriate ethical interactions in order to best serve her clients, particularly in the context of community based therapy:

We were talking about ethics and community based work and boundaries and I think that when I first started off as a clinician and I was clearly like oh, if I see one of my families in the grocery store, I don’t know, I don’t think I should say hi, because then they would have to explain. I was very much like that. But then over the years, I was like well, that can actually be way more disrespectful not to say hi to a family that you work with so deeply. I think that the shift came when we started going to community-based events...I think that in this community-based work and working cross culturally and respecting other people’s cultures and just, getting rid of some of those power dynamics almost and just being part of a more family feel and that trust, you know? That’s when I think it shifted for me, this is a different type of work that maybe you were trained to do. Maybe not totally out of the box, but you really need to think about what’s best for your relationship with the clients. And I think that’s when I sort of started to loosen up a bit and joke around more in sessions and appropriate self-disclosure.

For Participant 5, expanding the scope of her relationships with refugee clients also allowed her to build community trust and navigate existing power dynamics.

Most participants described the process of navigating ethics and boundaries with refugees as an individual and often lonely process. Participant 2, however, identified supervision as an important tool for learning how to critically think about ethics and

boundaries with refugees, sharing an influential lesson he learned from a previous supervisor:

There was a time where I had a refugee client who was pregnant. And her husband had recently been taken into custody by immigration. And had been there for a couple of weeks, and he was the primary breadwinner. She didn't have any food in the house. She came in, far along in her pregnancy, and hadn't eaten in over 24 hours. And I went to my supervisor to explain the situation. And he was like, take her to the cafeteria, like go now, here's a meal ticket, go take a meal ticket from my desk. Go to the cafeteria. And that from kind of a professional stand is something you would never do, right? It's like breaking this boundary of something that you wouldn't do in counseling. And in that case, like you take care of people first. It's her safety, it's her health, like throw all of that out the window. Do the right thing. And that was a remarkable experience for me. As a trainee, maybe you don't feel like you have the power to make those calls, so to have somebody who was in an authority position like, give me permission I think has helped me now as I've become a psychologist. To do that for trainees, or to take that initiative myself if a similar situation occurs. To do the right thing first.

The experience of having a supervisor and professional in the field was profound for shifting Participant 2's perspectives on ethical relationships with refugees, and this change then influenced his overall sense of confidence working with this population. Many of these participants also maintained ongoing relationships and friendships with their clients even after they terminated their professional relationships. Although participants described initial hesitation, uncertainty, and difficulties navigating ethical boundaries in their relationships with refugee clients, all of these participants also shared that they came to view these relationships as culturally appropriate through their experiences with this population. They expressed tremendous personal rewards for themselves and their clients from these relationships, and some participants also shared

that their former clients have helped them become better clinicians for refugees by sharing insights, perspectives, and suggestions for practice.

### **Language Barriers and Use of Interpreters**

All seven participants described experiences related to navigating language barriers in counseling and utilizing interpreters in the counseling process. The accounts shared by participants were diverse and included reflections on learning how to collaborate with interpreters, utilizing non-verbal methods in counseling, use of interpreters as cultural brokers, and various barriers to accessing appropriate translation services. Participant 7 shared her experience of learning how to help clients communicate in their native language from a professional she interviewed in the field:

She's a trauma therapist, and she said sometimes people can't, in their secondary language, English, communicate what they're feeling. And to just have them say it in their language can be really helpful and powerful. So I have really carried that with me through my work. So that when I'm working with someone where English is a second language, and I see them struggling for what to say, I'm very quick to say you know what, you can just say that in your language. I don't have to know what it is, I just have to know how you're interpreting what you're saying and the meaning behind it. But to get it out, let's just say it in your language.

Participant 2 shared examples of how he began to learn how to work with language barriers by accessing training in his practicum:

There are some training resources available that talk about kind of how to maintain eye contact with the person when you can't understand what they're saying in that moment. To kind of be aware of dialect and ask clarifying questions to be sure that you're following along. So yeah, there's definitely a learning curve there.

In some instances, participants described their process of learning how to use interpreters as cultural brokers and collaborators in counseling. For instance, Participant 5 shares an account of how one of the interpreters that she works with in the community helped her better understand the culture of her clients:

You know in those car rides to people's houses after family meetings, he would just throw out this knowledge about the community. And again, his take wasn't everything, you know, he isn't the only person. But again, because he was so embedded in the community, and because he knew all the families, and again, oh lord, if we talk about confidentiality, that's a whole other thing, but you know, he would sort of just share ideas or insights into the work and how we could present the work in different ways.

Participant 5 emphasized how she learned how to use interpreters in the process to build trust with her clients and increase her cultural understanding. Some participants similarly noted the benefits of using interpreters as cultural brokers, while also providing perspective that interpreters' involvement with the community can sometimes create confidentiality concerns. Participant 7 shared how learning to develop an understanding within the triadic relationship can help alleviate such concerns:

This is always a challenge because we're small. We're a big city, I guess, but we're a small community, and that refugee interpreter might actually be a neighbor. And so there can be a lot of, especially with those rare languages, a lot of fear that what they say in here is going to go back into the community. So it takes some understanding between the client and I and the interpreter to collaborate to sort of say that this just stays here. And I can do that.

In addition to discussing considerations when working with interpreters in counseling sessions, some participants also shared important dynamics that they became aware of in their counseling work, particularly when working in triadic relationships with the clients

and interpreters. For instance, Participant 4 shared how interpreters' needs and processes also need to be attended to by the counselor in session, and advocated for the creation of interpreter support groups for this reason:

Because of the interpreters we work with, recognizing the secondary trauma that they experience. Knowing that they also, too, have potentially been refugees and have their own trauma stories. And they're trying to interpret for clients in a therapy room, they're experiencing all of that. And learning about that as well and how that process in a therapy room, how that impacts therapy, this triad. The triadic relationship, but then you also have all of this trauma and then this secondary trauma that goes in with an interpreter and a therapist. And how that impacts that. So I've really had to kind of hone that in and train myself in those particular areas. I've really had to train myself on the best ways to work with interpreters, trying to get those resources as well, to make sure that the therapeutic process is complete and it is appropriate and it's working for everyone.

### **Barriers, Access, and Systems**

In sharing their experiences of learning how to work with refugees, all seven participants shared reflections and accounts related to various barriers, issues of access, and systems they encountered. Many participants emphasized that refugees' needs in counseling are influenced by their stage of resettlement. Although many participants were aware of the significant trauma that refugees experience in pre-migration, migration, and resettlement, they emphasized that helping clients navigate these barriers and systems often was a prerequisite to trauma or emotion focused work when working with newly resettled refugees. For instance, Participant 6 reflected on working with new arrivals, emphasizing "You really have to start with meeting their basic needs and getting them to a place where they're stable, so safety and you know, that stabilization is a priority." Participant 3 similarly emphasized this stabilization:

When refugees first come to the United States, they're not in a place where you know, they can process a lot of the trauma. Because if you think of like, Maslow's Hierarchy of Needs, like they still need to meet the needs at the bottom, like safety, shelter, you know? Or food, income, like those types of things. So it really just depends on where the refugee would be in their...acculturation process.

Most participants shared that they had to learn skills related to case management in order to navigate issues of access. For instance, Participant 2 dedicated time to learning the “social work side of things more than I ever did as a therapist. Just do know what services were out there.” Participant 6 shared similar experiences, and makes a connection between helping refugees meet basic needs and building long-term trust with their communities:

One of the ways that they know that they can trust you is helping them meet just their basic needs. And if you can help them and link them to resources and then it goes back to not just that counseling portion, how do we help this population integrate back into society, right? Cause they feel isolated, so if we can do that, that social connectedness piece is important...So understanding the challenges I would say was very important because you can go on the road of recovery and kind of talk about interventions, but you can't get to interventions if you don't remove those barriers.

In addition to discussing some of the barriers that refugees face, some participants also shared barriers that they personally faced in gaining access to opportunities and resources they needed to serve this population. For instance, Participant 4 shared that “the affordability of being able to find opportunities to train, especially as a student and somebody that's at an associate level” was a significant barrier to accessing training opportunities and resources that she felt she needed. In describing how they learned how to navigate some of the systems and barriers to get refugee clients access to culturally

competent care, participants also shared how they coped with the sense of pressure and responsibility to meet the tremendous needs of these clients. Participant 2, for instance, noted how he gained access to reading material and supervision that helped him conceptualize progress with refugee clients:

To focus kind of on incremental change instead of really getting caught up in the circumstances of people's lives who are – that was helpful for me. Just find ways, like how can I take this person one step further. Cause if I'm trying to take them ten steps further it probably doesn't serve them very well, and doesn't serve me very well, because that's a lot of pressure

### **Knowledge**

The theme of knowledge emerged as participants shared accounts of different forms of knowledge they needed or gained when working with refugees. This theme captured what participants felt they needed to know as well as what they learned as they gained experience working with this population. The theme of knowledge has five subordinate themes: cultural diversity, migration, and norms; political influence; family dynamics; modality; and research and evidence-based practice.

#### **Cultural Diversity, Norms, and Migration**

All participants shared how gaining knowledge of refugees' cultural diversity, migration processes, and cultural norms was influential in understanding how to best work with refugee populations. Participants noted that having some knowledge of refugees' backgrounds helped them feel more confident in their work and described the approaches they took to gain this knowledge. For example, participant 6 shared "I took the effort to learn about the culture, versus putting the burden on the client to teach me

that. You can definitely ask the client but you also don't want them to carry the burden to have to educate you." While all participants noted the importance of having background information about diverse refugee cultures, many also shared their awareness of the vast diversity of refugee cultures and experiences and provided insight about how they navigated this in their work. For instance, Participant 2 described initially feeling pressure to acquire in-depth knowledge about different cultural groups of refugees. Over time, he learned how to use his general knowledge to collaborate with clients and learn about more about their cultures and experiences in counseling:

I would simultaneously have people from the Congo, from Iraq, from Myanmar, from Nepal, and I would try as best as I could to learn about these different places. But it was just impossible to get, to learn the language to like, get really fluent in the history of each of these places. And I felt bad about that, but just bandwidth you know, it was just impossible to really get versed...What I found is if you are just asking your clients, they're happy to tell you a lot of the time. You don't have to go in and take the expert role in everything. So yeah, that was something that I learned too, was just tell me where you came from. It's a great way to lead it off, because they could take more of a kind of expert role and realize it was more of a collaborative relationship.

Similarly, participant 7 shared that awareness of refugees' general backgrounds was a helpful foundation for then learning about refugees' specific cultures and experiences directly from the clients, offering "you've got to find out how they see themselves. How they identify. Not assume that just because you are from Burma you speak Burmese. Really ask that question, so what is your language, do you speak other languages, you know, how do you identify?"

An aspect of participants' reflections on gaining knowledge about refugee backgrounds is understanding how the migration process influences clients. Participants

shared how understanding the migration process helped them make connections about refugees' experiences. For instance, Participant 1 described that learning about the conditions of refugee camps and the dangers of various stages of the migration process was influential for her when she first began working with refugees, as she was previously unaware of the immense dangers that existed for refugees after fleeing their countries of origin. Participant 3 discussed how various factors must be taken into consideration to understand refugees' experiences, such as literacy and age at time of migration. She shares "It's very different, you know, to come to the United States as like a nine or ten-year-old, versus like coming here as a 65-year-old. It's different from... a logistical point of view, but it's also different from like where you are developmentally" and "it makes a difference working with someone who came from Cuba who is completely literate and has like, access to a ton of education, you know? And probably their grandparents are literate, etcetera. And then I was working with a family who is from Somalia, and they don't even know what a book is."

Participants also discussed gaining an understanding of cultural norms and expressions. They described accounts of understanding how symptoms and emotions may be expressed differently cross culturally and the importance of having a general awareness of how body language norms may differ depending on clients' cultural backgrounds. For example, Participant 4 shared how understanding Middle Eastern cultural expressions helped her be more effective in her work with refugees from these backgrounds. She gives an example of these expressions, sharing: "Suicide is the biggest thing, the language behind suicide. A lot of Middle Eastern cultures say, oh, I'm just

going to kill myself. And it is a basic expression that is completely normal and acceptable. But here in America, someone says it and it's immediately go through the crisis work." In this instance, understanding cultural expressions and how they are used was important for Participant 4 in being able to accurately assess clients' risk and suicidality. Another example of cultural norms in body language was described by Participant 1 when she shared an experience of learning that "If they don't make eye contact with me, they're actually being super respectful. And if they're super touchy feely or they're not super touchy feely with their kids, that's cultural versus oh this might be some sort of attachment disorder."

### **Political Influence**

In many instances, participants shared how political and societal climates influenced their work with refugees and described various experiences of how they learned to work within the political climate. This was particularly relevant for clients that identify as white. Many participants spoke about how the political environment influenced their process of building trust with clients. For example, Participant 5 reflected:

I think that as much as we are trying our hardest and have over the years been able to build trust, just that totally normal valid mistrust that a lot of these communities have to deal with every day because of what our country is dealing with right now is a barrier to care. Because I think that a lot of times, you know, when we go into the homes, different people are looking at us like, who are these people coming into the homes. I had this one, this one almost broke my heart, but this is the reality of the situation. I was going into a home just last year to do an intake, just a regular meeting, and a couple kids from a neighboring home ran up to me and said, "Are you here to take the kids away again?" And it just, yeah, it just broke my heart. Because I was like, oh, what are they seeing like, a professional lady...walking into this home that has maybe had some problems in

the past with CPS or Child Protective Services and just there's a lot with the police just lots of mistrust in general with providers.

Participant 6 offered similar experiences, and emphasized how the current political climate also influenced refugee clients' mistrust of the research process, which she previously shared was needed and necessary to learn more about how to effectively work with refugees:

There's still trust issues. I mean, even if you work with this population, they trust you, but they don't trust the process. And you have to understand where they're coming from. The political climate doesn't help. And I think that's important, right? Cause it's, if that's the climate, they might trust you as a counselor, but I don't know if they would trust you as a researcher, like what are you doing with my information, right?

While most participants focused on trust between the refugee community and mental health professionals, Participant 7 shared that understanding the political situations in the countries from which refugees migrated was also an important part of her process. She described that in her effort to build connections with communities, she came to realize that there are sometimes significant conflicts between different populations of refugees resettled from the same countries:

Every community is different. I don't know how much you know about the refugee communities that have been resettled here, but just the Burmese people, there are like five or six different people in that group and they don't get along. They don't see themselves as same even though they all come from the same country, they all speak a different language. They just all really have their own way of doing things, it's really tough.

## **Family Dynamics**

One of the areas of knowledge that participants emphasized was family dynamics. This subtheme describes participant's experiences of learning how migration and resettlement potentially impacts refugees' family dynamics. As Participant 4 described, "it's interesting to see, you've got family dynamics that are very intense and can be very difficult. So we've worked with them in those, in that kind of capacity where we've just tried to help them kind of go through that process of change within their own family system." When sharing accounts of these family dynamics, participants shared examples of changes in relationships between parents and children or spouses, in particular. Participant 1, for instance, focused on the changing relationships between children and their parents as she shared stories from two cases in which growing language and cultural barriers between young children and their parents influenced family dynamics and interactions:

Mom and dad, in both cases, are having difficulties relating to their kid. That's hard, seeing. Because both of these families, they moved, they did the refugee process, they came to America for their kids to be healthy and have a good life. But they kind of want to be involved in that. And because of the growing language barrier, they're slowly losing their kids. That was hard.

Participant 3 shared that learning about racial and cultural identity development in her multicultural coursework was important for working with these types of issues in counseling, similarly noting the importance of understanding how children's' identity development influences relationships in refugee families. In regard to relationships

between spouses, changing gender roles were cited as a factor that influenced family dynamics and counselors shared the complexity of working with differing cultural values.

### **Modality**

Gaining knowledge on the use of theoretical perspectives, techniques, and modalities when working with refugees was an important aspect of participants' sense of preparedness. For instance, Participant 2 shares: "I think learning about alternate forms of care, like not just psychotherapy as we know it, or psychiatry as we know it, but these kind of more convenient ways an art space forms that are less stigmatizing, and are just better received by people who aren't as familiar with traditional counseling." Participant 5, who is trained in expressive arts therapy, shared how her background in the arts facilitated her work with refugees. She emphasized that she took her training in arts therapy to another level after beginning her work with refugees in order to expand her understanding of how the arts have been used therapeutically across the world:

The arts background has been huge with this as well, because I really knew that I wanted to bring the arts into counseling which is why I got my degree in that. But just recognizing that the arts are not something that you know, white therapists created in America in 2019 or whatever year we're in. You know, the arts are such an integral part of so many different cultures, from you know, hundreds, thousands of years. Just sort of realizing that if I was going to use the arts in my therapy work, I needed to work with other cultures and understand how the arts had been used therapeutically in their own cultures.

Some participants also shared the importance of storytelling when working with refugees and discussed how they found ways to help clients share their stories in counseling.

Participant 4 described her experience of finding a theoretical approach that she aligns with and how this approach fit with her conceptualization of counseling refugee clients:

I think finding that your theory that you're used to, I'm more of a narrative approach. And so, I think that really fits within the refugee and immigrant population, because their cultures are very story based and narrative, it's exactly that. I mean, it's about the story. It's about the individual's experience, their perspective, and being able to turn that around, to be a more positive perspective. To create that new story for them. And that new outlook on what's happened. And I think for this new population that really fits. So knowing that what I was already learning and really kind of honing in on seemed to fit this population really well, too. Recognizing how that really works.

### **Research and Evidence-Based Practice**

Four participants emphasized the importance of having access to research and evidence-based practice. Participants discussed difficulties gaining access to knowledge of evidence-based practice and expressed the need for culturally responsive research in this area to help them continue their learning. For instance, Participant 3 expressed frustration at the lack of evidence-based knowledge on working with refugees when she stated:

For working with you know, therapy methods with children who are dealing with anxiety, right? There's tons of research studies and there's meta-analyses for that. Okay, so you can go back and reference that and you know, you can review that in graduate school. Okay? When you're looking at like, what has been effective for working with refugee populations, I don't know, you tell me how many research studies have been done on that. And how many of them have been like, you know, reproduced and you know, there's no way that you could find a meta-analysis on the data of techniques available to work with refugee children. Right? Yeah, because like even the, you know, what's an effective therapy technique for with working with African American kids. You look it up, there's research on that.... that doesn't exist for refugees.

In addition to the need for evidenced based practice research on techniques and interventions with refugees, some participants also shared that gaining access to evidence-based treatment methods when working specifically with interpreters in the

room was also needed in the field. Although access to research was limited, one participant shared how learning about evidence-based practice that does not depend on the use of language was helpful in her process, even though it was not centered on refugees. While Participant 6 expressed that “we need to increase evidence-based interventions that work” specifically for refugees, she also shared that “going to these professional development opportunities has really increased my knowledge in some evidence-based interventions at work that don’t require a lot of language, and EMDR is one of them.” Overall, access to information on evidence-based practice and increased with this population seems to be a continued need for mental health professionals who work with refugees.

### **Working with Trauma**

Working with trauma emerged as a theme across 5 participants. The reflections on trauma work were diverse and included: learning about the trauma experiences of refugees; understanding PTSD and cultural considerations in diagnosis with refugees; trauma focused theoretical orientations, training, and certification; secondary trauma for interpreters; trauma interventions in session; and providing trauma focused psychoeducation to refugees. Some participants described particular experiences that allowed them to become more familiar with how trauma may present in refugee populations. For instance, Participant shared how her cultural immersion experience allowed her to better understand how PTSD may present with this population, and how this influenced how she diagnosis clients:

Okay, so 90% of the cases that I saw down in Texas were trauma. And so after the trip when I came back, graduated, started legit counseling, there was this one client that I had to diagnose. And it could have been ADHD and it could have been PTSD. And if I had not gone on that trip I would have diagnosed the child with ADHD by mistake. I wouldn't have known that yes, from the way this child is reacting, this is all indicative of trauma.

More than one participant described experiences of navigating timing when it comes to trauma focused work with refugees. As Participant 6 mentioned, "they may not be ready to go there and it goes back to just even if you are trying to counsel this population you have to meet them where they're at and it goes back to you know, they might not want to go there." Participant 2 discussed how the participants he worked with only disclosed trauma after a relationship had been established over time, sharing "those who had been through really difficult experiences, either in their home country or in resettlement would be maybe less open until later on when you have established more of a relationship with them."

Participants gained the trauma education that they needed in a variety of ways, including accessing trainings at agencies, general trauma education in their graduate coursework, certifications, and utilizing resources and professional development opportunities. For example, Participant 7 discussed her process of learning about refugee trauma as a volunteer with resettlement agencies: "working with the resettlement agency, I was able to take part in trainings that were specifically designed for refugee situations...I learned a lot about trauma in refugee populations. Not necessarily how to deliver those services, more just information this is what's out there, this is what you might see, that kind of thing." Participant 7 then shared how she became a certified

trainer in order to educate others on how to best work with trauma in refugee populations.

Participant 4 shared how she sought trauma specific certification in order to meet the needs of the refugees she was working with, emphasizing the benefits of this training focus in how it made her work more effective both as a clinician and as an advocate:

It was really working with the refugee and immigrant population where I figured out really quickly that I need to have trauma education...that certified expert in trauma provides you the opportunity to go to the next level and focus specifically on what you want to focus on. So, that helped me to focus specifically on the refugee and immigrant population. They give you education on being an expert witness in trauma in a courtroom. That, to me, I'm also able to hone in on. Because I know refugee and immigrant populations. And right now, a lot of court cases are immigration court cases. So if I need to be a trauma witness on a case that's trying to stay here in the United States because what they've experienced, I can do that.

### **Role of Counselor**

The theme *Role of Counselor* emerged for five participants. Participants shared their experiences of navigating roles that are different than what traditional counseling usually entails. These mental health professionals emphasized their process of embracing and developing two roles in particular: (1) *educator*, providing psychoeducation to both refugees and health professionals working with them, and (2) *advocate*, using social justice skills to empower and advocate for clients, navigate systems and increase access, and promote community collaboration.

### **Counselor as Educator**

Participants described multiple experiences of learning how embracing roles as educators helped make their work with refugee populations significantly more effective. The majority of participants shared that the refugees that they worked with often did not

have an understanding of the roles of a mental health professional. These participants discussed how they came to use education as a tool to help refugees understanding how mental health professionals could support them. Participant 7, for instance, describes how she provides information to newly resettled refugees about counseling and the roles of a counselor in order to “plant a seed.”

I think that for me, it feels like I’m planting a seed, so that when their basic living conditions improve and they’re not just surviving, when they get to a place where they’re thriving and they have the luxury of figuring out what that stuff and feelings is about, that I’ve planted a seed where they know that there is someone out there that can help them. That if it’s not me, that they know there is a talking person job to listen and help them with that.

By providing education to refugee communities about mental health and wellness resources, participants helped increase access to services for these communities. Some participants, for example, described how school-community partnerships allowed them to share mental health resources with refugee families that they would otherwise not have encountered.

Mental health stigma was prevalent in many of the refugee communities that participants worked with. For example, Participant 2 found that “the idea of sitting down with a therapist is something that many of them felt was only for crazy people or insane people and that if they had what they see as lesser issues, or just adjustment issues, that it wasn’t really necessary.” Participants shared the importance of the counselor’s role as an educator particularly when working with this mental health stigma. Psychoeducation was a critical tool for addressing stigma with refugee clients, and these mental health professionals learned to embrace their roles as educators in counseling sessions in order

to be more effective in their work. Participant 4, for example, emphasized in her interview that neuropsychology education and education about the biological processes of the brain was particularly effective in helping dispel mental health stigma among the refugee populations that she worked with and described how she learned to use this in the counseling process:

One of the biggest things I think I learned is how freeing it is for clients to know and learn about trauma and the brain. For clients who, with mental health being a huge stigma in refugee and immigrant populations. I mean, stigma in America too, but with those populations, there is still a very large stigma. In you will be an outcast. Or, in your country, you would be shut in and not allowed to leave if you had these symptoms. You were shameful, you bring shame to your family. To knowing that when they come into this room, and I can sit down with them and actually walk them through what their brain is doing, they're able to go home and actually tell their family, there is something going on in my brain. And being able to put that physical component to it helps them to recognize that these symptoms are actually physical. Like, there is actually something going on in my brain that's making me do this. So trying to figure out how to really lessen that stigma and teach them, this really is a physical thing that you're experiencing. It's just, you have to do some things that are kind of odd and different, like breathing, and you know, practicing being aware of what's around you. Having to do those kinds of things, so trying to kind of tweak the way that we talk about it. Because a lot of people talk about mindfulness in just the big center but they don't get down to the science of it. And I've realized that with a lot of our clients, actually getting down to the science of it makes them understand it more and makes them feel better about their diagnosis and knowing I can change some things. So kind of having to tweak the way the therapy session works. A lot of it is really just providing that education first.

### **Counselor as Advocate**

The role of advocate was clearly important for mental health professionals working with refugees. Many participants described how advocacy skills and efforts were critical in providing effective care to this population. As Participant 6 highlighted “The most rewarding for me is giving voice to this population and you are their voice.

It's not just as a counselor. You are an advocate. I don't know if you can actually work with this population without being an advocate." The advocacy skills participants described were multifaceted. Some participants discussed advocacy in the context of reaching the refugee population through community engagement and collaboration. Others discussed how advocacy involved learning how to advocate for their clients at multiple systemic levels, which often meant "working with this population goes beyond the walls of a counseling room (Participant 6)" and "recognizing that I have to be way more engaged with this client and this population, the refugee and immigrant population (Participant 4)." Participant 4 further described what being an advocate for refugees sometimes means:

Having to go to those doctor's visits with them and having to go to the school to advocate, so being a therapist, you really are being more of a clinical social worker in a way. Because you are providing that therapy and clinical work, but you are also providing that advocacy and the case management piece to kind of assist and make sure that that family is actually taking hold of what you are teaching.

Community collaboration and engagement was a significant aspect of advocacy work for multiple participants. Participants described creative approaches that they used to engage with communities. Participant 5, for example, emphasized how expressive arts can be used to help empower refugee clients and communities by fostering social connectedness and community healing. In addition to the actions that these mental health professionals took in their roles as advocates, they also emphasized the importance of promoting cultural empowerment in advocacy work. This involved making it possible for refugees to utilize their refugee experiences, abilities, and power in order to overcome barriers and

promote healing in their own communities. An example of cultural empowerment perspectives is provided by Participant 7:

I wholly believe that we need to have some community lay people in every refugee community who have the ability to work with other refugee communities and the American community. That we're really, really making sure that people stay well. Kind of like a mental helper, that you'd have people out there. And I've done some suicide prevention things with refugees in their languages so that I can help them see signs and symptoms better. I've done a mental health first aid, so that people can see signs and symptoms better in different languages, and it's just a way to help have those communities who are already very collective really take care of one another better.

### **Developing Confidence**

The theme of confidence describes how participants' experiences of working with refugees changed over time, particularly in regard to confidence and self-efficacy. Many participants described a process in which they overcame fear or apprehensions about working with refugees as they came to realize that they could trust their basic skills in counseling as they continued to learn specifics about working with refugees. For instance, some participants described that they were worried about their potential to re-traumatize clients or felt like they received messages from other providers or instructors that the way they worked with refugees or other culturally diverse populations needed to be drastically different. In their interviews, participants shared how they came to trust their skills as counselors and emphasized that they became confident in their ability to work with cultural differences by focusing on authentic connection and honoring their clients' stories. Examples of participants' reflections are provided:

What I would have liked to have known earlier on is that just showing up and being willing to sit with someone and their pain, hear them, connect with them, and really that's it. How mentally healthy that can be for somebody else in pain. I think I was so afraid early on and really talking about or asking questions, or that curiosity, learning more about the trauma. Because there was this fear from other providers that you'll blow them up. You'll say something and you know, they'll go into PTSD. I think that I thought that somehow I could hurt them. And I think now I see how ridiculous that is (Participant 7).

I'm less nervous that I'm going to do the wrong thing. I think going into those initial groups back then I was like, oh my goodness, are we going to re-traumatize someone or, how am I going to really going to be able to communicate, I know that I normally use the arts, but I've also never worked with a population that doesn't speak English...I was so nervous that I was going to say the wrong thing or re-traumatize someone or just not be able to help on the most basic level. And while I still have fears as a therapist or still insecurities, I think now, at this point I've worked with hundreds and hundreds of, you know, different clients from all backgrounds, but especially in this population. And I feel more comfortable with myself and I am trying to authentically connect with someone. I don't love that word, but you know, if I'm really connecting on a heart level, I feel more comfortable going into it and knowing that something will hopefully come out of it. No matter you know, how we communicate (Participant 5).

As evidenced by these examples, a significant part of participants' processes of gaining confidence was overcoming these fears and trusting that they have the ability to use their general skills as a counselor and adapt to refugees as they learn over time. Participant 2 described that it was critical for him to acknowledge that "it's a journey and I'm not going to get there right away. Offering myself forgiveness around those early mistakes and lack of knowledge." Similarly, Participant 4 emphasized the importance of the foundation counseling work, sharing that adaptations to the work do not need to be as significant as she previously believed them to be:

Being able to open that concept of just because they're a refugee or immigrant doesn't mean I need to change a whole lot of what I do. I just need to think about

what are some tweaks...The reflecting, the summarizing, the using your narrative approaches or whatever theory you use, it works with any population. So knowing those kinds of things are obviously transferrable. Just being a therapist and having that open mind and wanting to work with someone that needs that assistance. It's basic and transferrable no matter who you're working with.

Participant 3 did not relate to these participant's initial concerns about working with refugees, noting that her personal background as a refugee prepared her to engage with many diverse populations because of her shared experience. However, she similarly shared that it was her "natural growth as a clinician" that impacted her sense of confidence when working with diverse refugees. For instance, she provided the example of how her ability to work with trauma as a beginning practitioner was limited, but through her work with clients in her professional career, she gained the skills and abilities she needed to become more competent in her work and consequently was better prepared to meet the needs of her refugee clients.

### **Learning Strategies**

Throughout the interviews, participants shared multiple experiences of learning how to work with refugees and provided insight about what it is that they learned. The theme *learning strategies* describes the particular methods, approaches, and sources that influenced participants' experiences of gaining the knowledge, awareness, and skills that they reflected on throughout their interviews. Five subordinate themes describe participants' learning strategies: graduate training; self-directed learning; mentoring and supervision; professional development; immersion experiences; and recommendations.

## **Graduate Training**

All participants shared experiences with their graduate training programs, emphasizing both what they learned and what they felt was missing in their education. One of the main points of reflections was focused on the multicultural/cross-cultural counseling course that is required for students across mental health disciplines. For all but one participant, graduate coursework provided very limited or no mention of refugee populations in their training. For instance, Participant 5 shared “You know, yes, I had my multiculturalism course, but we literally never spoke about refugees or immigrants. And I don’t know if that was the time period, I know that now there’s a lot more discussion about it, and that was back then. But you know, it wasn’t that long ago.” Participant 4 similarly shared “I mean, you’re given one multicultural class. And it covers almost nothing.” Participant 3 noted that access to resources on refugees or examples of how to work with this population were not available: “It wasn’t like, in the textbook. It wasn’t, you know, in any of the case studies that we received.” Some participants shared that the multicultural course provided them with general awareness and perspectives on multicultural counseling and helped them expand their worldview and develop awareness about their own biases. However, participants also shared that this course wasn’t sufficient to help them learn the skills or abilities they needed to work with refugees. As Participant 2 described, “my graduate program, like I mentioned, was really great in terms of multiculturalism more broadly and social justice. But we didn’t have any course work specific for refugees. I don’t recall even very many lectures or readings that were specific to refugees.”

## **Self-directed Learning**

All seven participants emphasized that their learning experiences were self-directed, particularly since their graduate training programs did not provide them with sufficient training on working with refugee populations. For participants who knew that they were interested in working with refugees while they were enrolled in their graduate programs, they were able to take advantage of opportunities to focus their research, projects, and assignments on refugee populations. Three participants shared that having the option to select a topic or population to focus on for graduate assignments was an important part of their process. Participant 1 shared that:

Whenever I was given the chance to choose a population, I always went with refugees. So I looked up research articles, I wrote papers on the research articles, I read books, I've already told you about my friends. Some of my assignments required me to go out into the community and do interviews with people of the group I had selected, and I always selected refugees.

In addition to assignments focused on refugees, Participant 4 also shared that having the opportunity to find her own internship allowed her to focus her counseling experience on diverse populations, and she was able to gather the support she needed to create her own internship. Participant 3 shared similar experiences of tailoring her graduate coursework to focus on refugees and emphasized the sense of responsibility she felt to teach the class about refugees and advocate for this population. She also described how she selected a refugee focused topic for her master's thesis and how this research was influential for her once she graduated and began counseling. The sense of responsibility described by Participant 3 to teach others was also experienced by five additional participants. For

example, Participant 6 shared “to be frank with you, I didn’t find much training, I actually put the training together.”

Participants also described various methods that they used to find resources and information on refugees, including reading books, accessing trainings provided by resettlement agencies and other nonprofit organizations, identifying relevant research articles, watching documentaries or movies, seeking mentors with refugee experiences, and using the internet to identify training programs and continuing education opportunities. Participant 3 emphasized the importance of reading research articles in her learning process. Because of the limited refugee-focused literature available in mental health fields, she utilized research from other disciplines to increase her knowledge, and then applied this knowledge to counseling:

So what I’ve done is, you know, I have a background in school counselling. And I have a background in education. So I have looked for like, ELO methods, for working with ELO populations. And you can find more data there. Because there was a large study done on like mom refugees out in California. So, you know, when you look at multicultural special education, there’s more data for, you know, effective methods for working with diverse counselling populations.

### **Mentoring and Supervision**

Mentoring and supervision emerged as a theme for some participants. These participants shared how relationships or learning gained from mentors or supervisors both in and out of their graduate programs has helped them access important resources, learn how to navigate barriers in this work, and gain skills needed to provide effective culturally competent care. Participant 2, for example, discussed the importance of supervision to his process of learning how to provide services to refugees. In particular,

he discussed how his supervisor provided a wealth of knowledge, resources, and guidance, assisting Participant 2 in navigating the challenges of working with refugees:

I've already mentioned supervision and I think that was huge. To just learn from somebody who had been doing that for a very long time...A lot of people, once they get licensed, debate whether they should still get supervision or not. And I think that if you're working with people of a similar background than you, and you've seen anxiety or depression or whatever a thousand times, you can make a case that you don't maybe need weekly, hourly supervision. But with refugee work, I just felt like I still had a long way to go. And I would certainly seek out regular supervision if I were to see refugee clients regularly.

Participant 4 described her relationship with a mentor and discussed the influence of mentorship on helping her take the steps to begin serving refugees. For her, having someone believe in her ability to do this work, recognize her passion, and help her gain access to the supports and networks she needed to begin this work was influential in her process of becoming a culturally competent professional with refugees:

We recognized the gap in services, and we were like, you know, there's no mental health services. It's hard for people to find. Do they even get to have a mental health assessment? Like, are they being screened? You know, do they have places to go, are they coming here with those problems? And she just kind of was like, why don't you do it? And I never thought about it. And she was like, you could do it. And I was like, I don't have any training, I barely have training to work with Americans right now. And she was like, so? And so it was kind of this push of just her recognizing something in me and saying you do have what it takes, you have this ability. You can do this, we just need to find some of the things that will make you feel a little more comfortable.

## **Professional Development**

The subtheme of professional development describes participants' experiences of learning by accessing resources, trainings, and networks as mental health professionals.

Some participants shared their experiences building connections and networks in communities as a form of professional development. For example, Participant 6 emphasized networking as a critical part of her learning process:

Networking is huge, because let me tell you, counselors can't do it alone, it's a community effort...In regards to networking, you do want to network with people who have worked with this population because that's where you can kind of bounce off ideas, and combine resources that they might, and vice versa, they might provide resources you can't.

Other participants shared that although it was sometimes difficult to find the type of refugee specific training they needed as students and new professionals, access to trainings and presentations on this population have increased in recent years. Conferences and coalitions, in particular, were noted as important sources for learning. For instance, Participant 4 described her experiences attending national marriage and family therapy conferences, stating that “Every single year, they have increased their workshops available for refugee and immigrant populations. I’ve made sure that I’m able to attend those, so that I’m able to see what other people are doing nationally and get connected to them. And see what kinds of tools they’re using. That’s been really great. This past year was the best yet. Participant 2 also shared his experience attending the North American Refugee Health conference for the first time, stating “that was incredible, to just be around like-minded folks who do work in the same area. It was just this treasure trove that I hadn’t been aware of.” Participant 5 described how partnerships with local nonprofit organizations, coalitions, and agencies has been a tremendous tool in her development as a mental health professional serving refugees. In particular, she shared

how these partnerships allowed her to better understand how to meet refugees' needs in multiple ways and provide holistic, comprehensive, and integrated care.

### **Immersion Experiences**

Participants described various forms of immersion experiences that were influential in their learning process, including volunteer work, prior work experiences such as fellowships and internships, international travel experiences, engagement with local community, and experiential immersion activities. Participant 1 described how a service-learning trip that focused on immigrant populations and asylum seekers allowed her to feel significantly more prepared to counsel refugees. In the week that she spent helping asylum seekers in various stages of obtaining asylum, she gained important knowledge about the migration process, trauma experiences, and cultural considerations when working with refugees. Participant 2 described his experience of living and teaching abroad for a year as “formative” in his process, compelling him to continue working with diverse cultures throughout his career. He described how his experience of teaching in Tanzania prepared him to work with refugees in the future:

It was this incredible experience where I was really there to be a teacher but was completely new to the culture. So similar to what I describe with counseling, like this very simultaneous learning and teaching the content I was there to teach, but constantly trying to put it through cultural filters to make sure that it fit to get input from my students that it was on track with what they saw as a cultural fit. So that's where I think a lot of my cultural confidence came from. And then when I started my PhD program, I think working with refugees was kind of an offshoot of that, of continuing that journey.

For Participant 5, engaging in informal community engagement continues to be an important part of her work and service to refugees. She shared experiences of how

“going to festivals, learning about cultures by going to a wrist tying ceremony, or going to a dance festival or a New Year’s festival for different cultures” allowed her to see clients and families in a new way and provided opportunities to learn about their cultures in an authentic, personal way. Participant 7 described her experiences of working with organizations serving refugees prior to counseling this population, and her subsequent continued engagement into the local refugee communities:

I think just being accepted in the community somehow enabled me to learn so much more about each individual kind of population. To at least have enough knowledge going in that I had a sense of what a caste system was like, so that I didn’t, I could understand why somebody from this caste was struggling with another caste member, right? So it was just those kind of little, tiny things, just listening and learning.

### **Recommendations**

After sharing their experiences of preparation, training, and learning how to work with refugees, all participants were asked to share recommendations for training based on their experiences of learning over time. That is, participants were asked to reflect on what they needed in the past to help them feel better prepared to serve this population based on the insight and experience they have now. Resoundingly, participants emphasized the need for the infusion of multicultural education into their graduate programs as a whole:

It has always sort of baffled me a little bit, this idea that the token course in multiculturalism is enough to meet their needs of working with people from different backgrounds and cultures...I just feel like this is such an important part of the work moving forward, that embedding these ideas into literally every class that we have in graduate school, instead of sort of making it like here’s your multiculturalism course. Cause it’s just not enough. And yeah, I just think having more...Just as far as how to not only have those courses, but how to bring in other voices, you know, into the syllabi making sure that people from other

cultures are teaching, or reading things from different folks, or speaking in different classes. Yes I had my multiculturalism course, but we literally never spoke about refugees or immigrants.,,Like, I think there is sort of that idea of if we just do this checkbox to do this course done then we're doing our duty...I just think it needs to be a much bigger part of our programs (Participant 5).

You know, I think one of the things that I recognize in a lot of programs is there's that multicultural competency course. And the course is not bad in itself. It's necessary. But it's not taken outside of that. So when you're learning about theories or you're doing roleplays in your advanced psychopathology class, there is no talk of culture. Like, it's not a part of the entire system. And I think that is where people don't feel prepared to work with refugee and immigrant populations. Because it's made to be this separate kind of group I feel like if we were to use culture in all of the different classes, making sure that aspects of learning different religions and backgrounds and situations, if we used those as our examples and our roleplays, it's going to make people feel more comfortable, and it's going to be like, this is normal. This is not something I can't do, or is completely different... I think it's those kinds of things you can infuse that in all of your classes. (Participant 4).

Participants also shared suggestions for training to help clinicians gain a deeper understanding of refugees' experiences and humanize the population to those who may have preconceived notions about refugees:

Well, I've done a few trainings with providers now. Typically, what I feel like they need to kind of help an idea about is I try to humanize what refugees could go through. So the one exercise that we do is we give them three cards and they put someone they love, a possession they love, and something about their health that they love, something that they value, highly value. And then I come around and I take one of the cards. And we talk about what that loss is like. As a way to just sort of help them understand that coming here as a refugee means loss. And what did you lose? It could be a loved one, it could be things that have been in your family forever. It could be your sight, or you know, your health. You just don't know, but there's always some sort of loss. And I think sort of I think that begins to help the American who has never experienced anything like this get a sense of the beginning of that journey that refugees go through. So yeah, I think that is part of it (Participant 7).

Yes, because right now, I have a fear, I have a concern that one of the things feeding in to like, hey, we're accepting in all of these migrants, all these refugees, and they're just mooching off our system. That idea can only thrive if we don't know what they, if the public doesn't know what the refugees are actually doing. If we put a face on the refugees and say, oh, yeah, this is Tom, he's from the Congo, he's your mechanic. This is Zach, he's your accountant. If you put a face on it, and say here's how they're contributing to society, that whole big bubble of they're moochers just goes away (Participant 1).

Emphasis was placed on immersion and experiential activities as effective ways to develop cultural competence. These immersion and experiential activities were also suggested as methods for building therapeutic relationships and trust with refugee communities, and for recruiting refugees to collaborate in mental health and wellness initiatives.

I think volunteering at the community level. At the community level there were opportunities to mentor, whether it's families or adults or students. Volunteering to just teach them maybe English, volunteering to transport them somewhere, maybe a doctor's appointment, community involvement for me has helped shape some of my experience in working with this population or gaining access (Participant 6).

I think if I had had more natural experience with people from different cultures, that would have been helpful. Frankly, if I had been a member of the community, and I think that's something that we need to try to do better is recruit people from these communities to the mental health profession, so that they are able to provide for one another, in a way that I can't (Participant 2).

Yeah, I would really recommend the experiential component over anything. Like, if you want to know what it's like to be a refugee, go volunteer at a refugee camp. Go volunteer at like, you know, a refugee after school program. If they have one in your city. I would tell them to get a visa to China and go to live somewhere in China where nobody speaks English for a week. And then come back and then try to do it (Participant 3).

I recommend that they volunteer with a place like Church World Services or World Relief, or I think it's Lutheran Family Ministries. Find a place like that to volunteer, take on just one family, and that's only a one to two hour a week commitment right there. That's how you would get your experience to at least get your foot in the door... More refugee case studies in the diagnosing class...I think that maybe having the class watch a movie or a documentary...Mini lecture on the refugee experience. Especially the post migration experience. Because I can't stress enough how I don't see that (Participant 1).

Suggestions were also provided for both general and specific skill, knowledge, and awareness development. These recommendations included topics such as self-care, trauma training, understanding cultural perspectives on mental health, navigating language barriers, and learning alternative and creative methods of counseling:

I think that learning about working with translation in therapy would be a big one, how to use supervision, how to manage your own kind of cultural differences with your clients, how to manage that self-care kind of work, work-life balance piece. And you're hearing that from all the stories. I think learning about alternate forms of care, like not just ways an art space forms that are less stigmatizing, and are better, just better received by people who aren't as familiar with traditional counseling (Participant 2).

I would definitely continue to go to trainings about how to talk about mental health and mental illness in different populations, I think that is always valid. Definitely just trauma-based work in general. Any arts-based stuff to see if other people are doing this type of work and getting tips on that. Research also, that is really important to me, like culturally responsive research and participatory research... doing evaluations that are culturally responsive and effective and how to even do that (Participant 5).

The other part of it is really encouraging them to get comfortable with interpretation. And another interpreter, another person being in the room with them and how to collaborate. And how to relax and just trust that you know, you have the tools, you just now have someone that's going to communicate to your client, and you can work together (Participant 7).

What are some different ways that practitioners or therapists work with different populations, or even in the populations where my clients were coming from, is mental health even a topic of discussion? What words are used with it? What is the idea of healing and mental illness, and how are people viewed and trying to figure out just culturally what that looked like in different countries and different cultures (Participant 5)?

I think another piece is also being able to figure out how to provide that self-care and access a lot more self-care options and opportunities and learning how to do that, without feeling like you're abandoning your clients... Because this is hard work. And it can sometimes be very lonely. Especially when you feel like you're the only person doing refugee and immigrant work (Participant 4).

In addition to these targeted recommendations, participants infused suggestions for learning and practice throughout their interviews as they shared their experiences of developing competence specific to working with refugees.

### **Summary**

The purpose of Chapter 4 was to report the results of the data analysis of interviews with seven mental health professionals in order to answer the identified research question. Rich reflections, experiences, and recommendations emerged from participants' descriptions of their learning experiences in regards to working with refugee clients. From the data analysis process, a total of nine superordinate themes emerged from these participants' interviews describing the lived experiences of learning how to work with refugee populations. In Chapter 5, these themes and results will be discussed in light of existing literature on refugee mental health and multicultural competence training. The Cultural Competence and Confidence Model (Jeffreys, 2006) will also be referenced to provide further insight on the teaching-learning process of cultural competence in relation to culturally and linguistically diverse refugee populations.

Limitations, implications, and future directions will be suggested following discussion of these results.

## **CHAPTER V**

### **DISCUSSION**

#### **Introduction**

While mental health professionals such as counselors, social workers, psychologists, and marriage and family therapists are professionally positioned to respond to the mental health needs of refugees, significant barriers appear to exist that influence their ability to do so. One of the significant barriers that influences the mental health disparity for this population is professionals' limited preparation and training to counsel refugees. The purpose of this study was exploratory, aimed at understanding mental health professionals' experiences of learning how to work with refugees. Specifically, this study was conducted to address a gap in the scholarly literature on how to best train and prepare mental health professionals to provide effective, culturally appropriate services to refugee clients. Interpretative Phenomenological Analysis was used to identify themes across the shared lived experiences of seven mental health professionals. Although these mental health professionals were professionally diverse and had varying experiences in working with refugee clients, they described many related experiences of their process of learning how to work with this population and becoming more effective and confident in their work. In this chapter, results of the current study will be connected to relevant existing knowledge. Additionally, results will be considered within the context of the Cultural Competence and Confidence Model (Jeffreys, 2010) to

understand the findings through the lens of cultural competence learning and education focused theory. Finally, limitations of the current study will be addressed and implications for practice, research, and education discussed.

### **Summary of Findings**

This study aimed to answer the research question: How do mental health professionals who work with refugees describe their experiences of learning how to counsel this population? To answer this research question, seven mental health professionals who have provided counseling services to adult refugee clients were interviewed to gather their reflections, experiences, and accounts of learning how to work with this population. The research team included the primary researcher, a second coder, and an external auditor. Interpretative Phenomenological Analysis was used to analyze transcripts of participants' interviews and identify emerging themes.

The results of data analysis included a total of nine themes: *Personal Identity, Values, and Worldview; Language Barriers and Use of Interpreters; Ethics and Boundaries; Barriers, Access, and Systems; Knowledge; Working with Trauma; Role of Counselor; Developing Confidence; and Learning Strategies*. Three of these themes included subordinate themes. *Knowledge* included six subthemes: *Cultural Diversity, Norms, and Migration; Political Influence; Family Dynamics; Modality; and Research and Evidence Based Practice*. *Role of Counselor* included two subthemes: *Counselor as Educator and Counselor as Advocate*. *Learning Strategies* included six subthemes: *Graduate Training; Self-directed Learning; Mentoring and Supervision; Professional Development; Immersion Experiences; and Recommendations*. These themes captured

various aspects of the participants learning processes, the strategies used to gain the knowledge, skills, and awareness they needed to work with refugees, reflections on *what* they learned, and the informal and formal experiences that contributed to their sense of preparation to counsel refugees.

### **Comparison to Existing Knowledge**

Scholarly literature on the educational, training, and preparation of mental health professionals to work with refugee populations is limited. While numerous researchers have examined the needs of refugees and various barriers to culturally competent mental health services, little is known about mental health professionals' experiences of learning how to provide effective counseling services to this population. To understand the results of this study within the context of existing knowledge, the themes that emerged from this research are discussed in relation to scholarly literature on refugee mental health needs and service provision, multicultural education, and refugee specific training models. This discussion is organized by participants' descriptions of learning content, their processes of learning, and additional influences that impacted their overall lived experiences.

### **Learning Content**

In sharing their experiences of learning how to counsel refugee populations, participants frequently reflected on the knowledge, skills, awareness, and experiences they either felt they needed to work with refugees or gained throughout their process of learning over time. Many of the themes that emerged from this study described various learning content described by participants. These include: *Knowledge; Language Barriers and Use of Interpreters; Working with Trauma; Role of Counselor; Ethics and*

*Boundaries; and Barriers, Access, and Systems.* The learning content emphasized by participants in this study is generally consistent with scholarly literature on culturally competent counseling considerations for refugee populations. For example, the results of a Delphi study aimed at understanding how to best provide effective culturally appropriate mental health first aid interventions to Iraqi refugees resettled in Australia found that the primary knowledge base responders' needed were (1) knowledge of refugee culture and community, (2) cross-cultural communication skills, (3) awareness of traditional and cultural beliefs and attitudes about mental health and (4) common barriers to help seeking and access to care (Guajardo et al., 2016). The cultural considerations and knowledge that were deemed necessary by the mental health experts in the Guajardo et al. study are particularly aligned with the theme of *Knowledge* that emerged in this study and its subthemes, which included participants' reflections on the importance of learning about refugee culture, norms, migration backgrounds, family dynamics, mental health stigma, and issues related to access and barriers.

It is clear from participants' lived experiences that counseling work with refugees required them to take on multidimensional roles that often extended beyond the clinical setting. One such role is *Counselor as Advocate*, a subtheme that described participants' experiences and commitment to advocacy work to best meet the multifaceted needs of refugee clients. Prior to beginning their work with refugees, many participants shared that they were unaware of the issues of *Barriers, Access, and Systems* that would impact refugees' experiences and their work with refugee clients. In order to help refugees meet their basic needs, participants shared experiences of learning how to best assist refugees

in navigating these systems as a part of counseling practice. Many participants shared that they did not expect for their work with refugees to require such extensive case management and advocacy and, as such, learning about barriers, issues of access, and systems was critical to their cultural competence development. Additionally, participants acknowledged the importance of having awareness about *Political Influence* and how the current political climate in the United States influences refugees' experiences. In many ways, the experiences of participants in this study can be related to literature describing socio-political and multisystemic approaches to counseling refugee clients. For instance, Apostolidou (2015) found that mental health professionals who worked with refugees and asylum seekers benefited from having a socio-political grounding and understanding the political influences of their work with this population. Participants emphasized that their work with refugees "had informed and, in some ways, recalibrated the perspective from which they perceived both themselves and others within the world (Apostolidou 2015, p. 496)." Considering that emphasis on incorporating socio-political perspective into conceptualizing and understanding refugees' multidimensional needs and experiences is well documented across literature (Bemak & Chung, 2015; Fondacaro & Harder, 2014; Kirmayer et al., 2011; Summerfield 1999), the findings of this study provide confirmation that this knowledge is important for training mental health professionals to counsel refugees. Participants in this study passionately emphasized that their professional practice with refugees extended beyond the clinical setting and included social interventions, extensive advocacy, and practical assistance in basic living and survival needs for this population. Gaining awareness of the multiple systems affecting

refugees and how to address barriers to access was critical in being able to provide this population with effective, culturally competent care.

Some participants in this study also emphasized the importance of acquiring the *Role of Educator*. The educator role helped participants facilitate counseling with refugees in many ways. For example, many participants discussed extensive mental health related stigma within the refugee population. This stigma impacted refugees' help seeking behavior as well as their limited conceptual understanding of the responsibilities of a mental health professional. In order to address this stigma, participants discovered the importance of using psychoeducation as a tool. Providing this education facilitated communication with refugees by helping them become familiar with the process of counseling. This finding is not surprising, as there is significant evidence in existing literature that refugee populations may be unfamiliar with mental health services, associate them with severe mental illness and institutionalization, or stigmatize mental health overall based on cultural factors (Gong-Guy et al., 1991; Guajardo et al., 2018). One participant in this study heavily emphasized neurobiology and neuropsychology education as an intervention for normalizing mental health issues such as trauma. Although literature has demonstrated the importance of general psychoeducation to refugees, this emphasis is usually on education aimed at providing an orientation to mental health services and processes. The emphasis specifically on neurobiology education for refugees is a critical addition to the literature and is particularly important considering that *Working with Trauma* also emerged as an independent theme in this study. It is widely known that refugees are at a high risk for poor mental health outcomes

due to displacement, migration, and resettlement experiences that lend to high levels of distress, trauma exposure, and deprivation (Guajardo et al., 2018). Participants in this study thus highlighted learning experiences specific to trauma considerations with refugee populations. For example, participants described how knowledge and skills gained about working with trauma, even if this was not specific to refugees, ultimately helped make them feel better prepared to effectively provide services to this population. Additionally, diagnosis was mentioned by multiple participants as being a skill that was necessary in the development of cultural competence. This makes sense in the context that cultural barriers often contribute to the misdiagnosis of refugee clients (Sonethavilay et al., 2011). Refugee mental health scholars and researchers have found that refugees are frequently subject to misdiagnosis for a number of reasons, including different presentations of symptoms, shortage of mental health practitioners experienced in cross-cultural diagnosis skills, and lack of exploration of the clients' migration history and its potential impact on client symptoms (Sonethavilay et al, 2011). It is noteworthy, then, that assessment and diagnosis skills were emphasized by some participants in the current study as critical learning to effectively work with refugee clients.

The most widely researched aspects of training and preparation in regard to working with refugees in a mental health capacity are specific to navigating language barriers in the counseling process services (Century, Leavey, & Payne, 2007; Engstrom, Roth & Hollis, 2010; Griffiths & Tarricone, 2017; Khawaja & Stein, 2016). It is no surprise, then, that *Language Barriers and Use of Interpreters* emerged as a theme in this study. Participants described multiple experiences of working with linguistically diverse

refugees, and shared examples of the challenges they experienced in navigating language barriers. These challenges included being unprepared to know how to work in triadic relationships with interpreters, lack of awareness on how to best use interpreters in counseling, difficulties effectively and efficiently completing intakes and assessment forms without access to translated documents, and limited experience with utilizing modalities and techniques in counseling that do not solely rely on language. The findings in this study were largely consistent with existing literature on mental health providers' experiences of working with interpreters in counseling. For instance, Yakushko (2010) utilized phenomenological qualitative inquiry to explore mental health practitioners' experiences of providing care to limited English proficiency refugees and asylum seekers through interpreters. Two major themes emerged from Yakushko's study that focused on the *personality* and *training* of both the therapist and the interpreter. Personality themes related to providers' flexibility, adaptability, openness, patience, humility, and willingness to learn within the complex triadic counseling relationships. The challenges of working in triadic relationships have similarly been documented in scholarly literature on working with refugees and other limited English proficiency clients. For example, Engstrom et al. (2010) focused on the use of interpreters with refugee clients who endured torture and found that triadic relationships with refugee clients, interpreters, and counselors can impact therapeutic rapport, lead to role conflicts in the session, and spark complex emotional reactions for interpreters who also may have experienced trauma similar to those of the clients. These findings are consistent with research that has demonstrated the importance of attending the dynamics of a therapeutic triad and

potential complex emotional reactions that can arise within this triad and consequently impact the therapeutic process (Miller et al., 2005).

Considering that there is a severe shortage of trained bilingual mental health professionals (Gong-Guy et al., 1991), it seems critical that mental health professionals are prepared to know how to work with language barriers and interpreters. Based on participants' reflections, however, limited training influenced their sense of efficacy and ability to serve the population initially. Researchers investigating the experiences of mental health professionals who work with interpreters have found similar results, indicating that training to work with interpreters is needed to help professionals serve linguistically diverse populations (Engstrom et al., 2010; Miller et al., 2005; Yakushko, 2010). Training themes highlighted participants' limited formal training in working with clients from other cultures through interpreters, and emphasized their need for didactic and practical clinical training in their graduate programs that prepare practitioners to work collaboratively and effectively with interpreters (Yakushko, 2010).

Furthermore, some participants shared that even after gaining experience working with refugees, gaining access to interpreters who are trained to work in mental health settings is not always possible, citing financial barriers and shortage of interpreters as significant barriers. Previous researchers have found similar barriers (Bartolomei et al., 2016; Engstrom et al., 2010; Gong-Guy et al., 1991; Griffiths & Tarricone, 2017; Posselt et al., 2017).

The theme *Ethics and Boundaries* described participants' experiences of learning how to navigate ethics and boundaries, particularly as it relates to relationships with

refugees. Experiences related to this theme included continuing or dual relationships with refugees, use of self-disclosure, refugees' value of intimate relationships even in the context of professional services, and counseling "beyond the walls" of the counseling room. In particular, many participants emphasized that in order to effectively work with refugee populations, they had to become more open to stepping outside of what seems traditionally appropriate in ethical counseling relationships. While ethical codes across mental health disciplines may offer an element of circumspect flexibility in regard to counseling boundaries and dual relationships, many of the participants in this study received clear messages in their training or from other professionals in the field that their counseling professional relationships should be strictly bound. For instance, Section A.6.b. of the American Counseling Association Code of Ethics (ACA, date) highlights recommendations on extending counseling boundaries:

Counselors consider the risks and benefits of extending current counseling relationships beyond conventional parameters...In extending these boundaries, counselors take appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs (pp. 5).

Although ethical codes such as this one provide some allowance for extended boundaries after considering risk and benefit, it is clear that the messages these participants received in their formal training discouraged informal or extended boundaries and relationships with clients. The tension described by participants regarding informal interactions, extended counseling boundaries, or continuing relationships and friendships with former clients from refugee backgrounds was described as being a result of the training they

received, perhaps indicating that graduate training programs are not adequately preparing mental health professionals to navigate ethical decision making with professional relationships but instead focusing on the “rules” of counseling without consideration of nuances of cultural context. Through their experiences over time, the participants in this study learned how to navigate these ethical boundaries and described the benefit that could come from attending social events with refugee clients, maintaining relationships, utilizing more self-disclosure, and engaging with clients more personally and informally. Although literature on ethical decision making specific to navigating relationships with refugee clients is scarce, training models for refugees often include aspects of this content in their programs. For example, *Connecting Cultures*, a specialized training offered to clinical psychology graduate students by a nonprofit training clinic includes content specific to adaptations for clinical boundaries when working with refugee clients (Fondacoro & Harder, 2014). This program’s emphasis on flexibility with boundaries based on culture is consistent with what participants in the present study describe as essential to their process of learning how to effectively counsel refugees.

### **Learning Process**

In contrast to what participants had to learn, they also discussed the process aspects of their learning. The process of learning *how* to counsel refugees described by participants in this study was multiform and multidimensional and was captured in the themes *Learning Strategies* and *Developing Confidence*. The theme *Learning Strategies* described the various methods, strategies, and avenues of gaining the content knowledge, skills, and awareness participants described as needing to effectively counsel refugees.

Consistent with the recommendations found in existing literature on multicultural education (Collins et al., 2015; Lee & Khawaja, 2013, Ratts et al., 2015; Sheely-Moore & Kooyman, 2011), participants identified strategies such as formal graduate training, mentoring and supervision, professional development, and immersion experiences. Additionally, participants reflected on self-directed learning processes and provided recommendations for learning and training based on their own experiences. Throughout their process of learning how to counsel refugees and gaining experience with this population, participants became more effective in their work and gained confidence in their abilities. The theme *Developing Confidence* captures participants' reflections on developing self-efficacy and confidence.

**Graduate Training.** Participants in this study reported varying experiences with graduate training programs. All seven participants shared that they received limited or no formal coursework on counseling refugee populations. Additionally, the majority of participants emphasized experiences of learning within their multicultural coursework, sharing that much of the multicultural education they received in their training programs was limited to this single course. Literature in multicultural education has long asserted that stand-alone multicultural courses are not sufficient to train mental health professionals to effectively meet the needs of diverse cultural groups (Arredondo & Arciniega, 2001; Cates et al., 2005; Dickson & Jepsen, 2007). Nonetheless, the single course design across mental health professional programs continues to be the primary form of multicultural education and training, likely with varying degrees of infusion across the curriculum. For example, Collins et al. (2015) examined the facilitation of

multicultural and social justice competency development by graduate education programs and found that participants predominately attributed their multicultural education to only one course. In this study, participants also reported that the multicultural course that they took focused on awareness and general knowledge of cultural groups. They mentioned how lessons on personal biases, the potential impact of their personal culture and worldviews on their work with clients, power and privilege helped them develop awareness that helped their overall learning process with clients who are culturally different from them. This is consistent with literature that notes that multicultural training emphasizes developing awareness (Collins et al., 2017; Pietrese et al., 2009). It is important to note that although participants reported increased awareness on broad multicultural topics, they also noted that there are some issues of awareness that may be specific to refugees and asylum seekers, such as socio-political and systemic factors related to migration, that may deserve attention in multicultural coursework to better prepare trainees to provide culturally competent care.

Although participants reported benefits in their awareness development in their multicultural coursework, opportunities to gain practical multicultural counseling skills and social justice advocacy competencies were reportedly limited or completely absent from their education, consistent with existing literature (Collins et al., 2017). Too frequently, according to participants, coursework excluded examples and case studies focused on refugee clients as well as other culturally diverse populations. When asked for recommendations for training and education based on their experiences, participants passionately advocated for the infusion of multicultural coursework into all aspects of

their clinical training. Participants reflected that what they needed to feel more prepared to counsel refugees was knowledge and experience of theory, assessment, diagnosis, and skills that were transferrable to work with multicultural populations and that increased their ability to make clinical decisions with diverse populations.

In addition to experiences related to multicultural coursework, participants also shared how their overall general training program influenced their sense of preparation to work with refugees. Only one participant shared that the social-justice infusion throughout his graduate coursework was influential in his overall learning process, and this benefited his overall experiences as he carried this mindset into his work despite not having formal education on counseling refugees. Another participant shared that having a strong foundational training program that prepared her to be an effective clinician allowed her to eventually feel more effective in her ability to adapt her skills to the refugee population.

**Self-directed Learning.** Participants unanimously reported that much of their learning process was self-directed. This was largely due to the reported lack of emphasis or content specific to refugee populations in their graduate programs. Additional barriers that influenced the self-directed nature of their learning process included lack of resources or training materials, financial barriers, and lack of access to the population during clinical experiences. As such, learning occurred primarily through self-directed and initiated strategies. In fact, some participants cited that because of the limited access they had to formal training, they became motivated to teach what they learned to others. Some participants utilized opportunities in their coursework to present on refugee

populations and advocate for this population in their classes, while others provided formal presentations and workshops to clinicians in the field. The self-directed process of participants' learning is not surprising considering scholarly literature that has highlighted deficiencies in refugee specific education and barriers to gaining needed training (Khawaja & Stein, 2016; Posselt et al., 2017; Robinson, 2013; Schweitzer et al., 2015).

**Mentorship and Supervision.** For some participants in this study, mentorship and supervision emerged as important parts of their learning process. Consistent with literature on therapeutic practice with refugees (Fondacaro & Harder, 2014; Robinson, 2013; Schweitzer et al., 2015), supervision was cited as influential in development, when accessible, particularly from a supervisor with extensive clinical experience and knowledge on this population. Two participants shared how having opportunities to counsel refugees in their practicum or internship experiences in their graduate program allowed them to get access to clinical supervision specific to this population. One participant shared how his supervisor, who had extensive experience working with refugees, provided important practical training resources, tools, and guidance on navigating boundaries and ethics when working with refugees. This participant also shared that his own experiences providing supervision to individuals working with refugees in the latter part of his training also added to his overall sense of self-efficacy. In being challenged to provide supervision to others working with this population, this participant became more confident in his own ability, skill, and knowledge. These findings align with the critical roles of supervision in refugee work that emerged in a

study by Schweitzer et al. (2015), which include: supporting the therapist's capacity to tolerate uncertainty and manage difficult emotions; managing the impact of the work; and increasing therapeutic skills. In addition to clinical supervision, one participant discussed how having mentorship and support from someone who believed in her ability to serve refugees in a clinical counseling capacity early on inspired her to develop her own internship experience specific to refugees. The holistic support received from this mentor was not only an influential piece in her ability to access to resources needed to establish services for this population, but also provided her with important personal and professional support that positively impacted her professional development. While scholars have established the positive impact of mentoring relationships on the career and professional development of mental health professionals (Lee & Montiel, 2010), the results of this study suggest that mentorship can inspire confidence and motivation to pursue counseling work with refugees despite perceived challenges.

**Professional Development.** Participants in this study reported seeking and engaging in a variety of professional development trainings, accessing training resources, and utilizing professional networks in their process of learning how to work with refugees. Some participants reported the benefit of attending conferences, workshops, and trainings specific to refugee populations, for example. These opportunities allowed for participants to gain valuable knowledge, learn about tools and resources that exist, and connect with individuals who are similarly seeking to empower and serve the refugee population. Such continuing education opportunities enabled participants to develop in their general multicultural competence as well as in their capacity to counsel refugee

clients. These findings are consistent with literature citing the importance of continuing education for cultural competence development (Beach et al., 2005; Delphin & Rowe, 2008; Schwallie-Giddis et al., 2004). Some participants also emphasized the importance of professional connections, collaboration, and networks. For instance, two participants described how collaborating with nonprofit organizations and local coalitions allowed them to know how to best meet the extensive needs of the population, which were often interdisciplinary. One participant shared how her network provided her a space where she could brainstorm ideas, combine resources, and collaborate to fill missing gaps in their knowledge or skills. The networking and collaboration efforts described by these participants demonstrate important aspects of community-based interventions, which have been cited extensively as critical for effective work with refugee clients (Bemak & Chung, 2015; Kuo & Arcuri; Midgett & Doumas, 2016; Murray et al., 2010).

**Immersion Experiences.** Participants in this study described various forms of immersion and other experiences that were influential in their learning process, such as volunteering, prior work experiences, international travel, service-learning, and engagement with local refugee communities. The emphasis on experiential learning and various forms of cultural immersion are significant. There exists a wide breadth of literature highlighting the use of experiential activities and cultural immersion for cultural competence development and training (Kim & Lyons, 2003; Swazo & Celinska, 2014). For example, Swazo and Celinska (2014) conducted a comparative study of the multicultural competency development of 29 counseling, psychology, and education graduate students. In this study, traditional on-campus and international study abroad

formats of a multicultural counseling course were compared to understand the impact on students' multicultural development, attitudes, and application of multicultural competencies. The researchers' found that students' multicultural learning was more significant for students who engaged in international immersion when compared to peers taking a traditional course. Furthermore, students involved in the international format reported more motivation and interest in working with diverse populations and reported actively seeking interactions with individuals from culturally different backgrounds. These students also provided more in-depth reflections and extensive analyses of their personal and professional growth compared to peers in traditional courses and demonstrated significant applied learning outcomes (Swazo & Celinska, 2014).

One participant shared how formative his experiences of teaching abroad were in helping him understand how to adapt his own style, interventions, and methods to best meet the learning needs of his students. His experience of learning how to adapt within cultural contexts was then transferable to counseling work with refugees. Other participants shared how attending cultural events and engaging with this population beyond the walls of the counseling room allowed them to understand and learn about refugee cultures authentically and influentially. For some participants, these immersion experiences shed light on the obstacles that refugee populations may face in their resettlement process. For example, one participant shared how her service-learning immersion with asylum seekers allowed her to understand the impacts of the process and better understand the trauma and distress that they may face as a result. The experiences shared by these participants confirm previous findings on the impact of experiential and

exposure activities with refugees on trainee's cultural competence development (Kuo & Acari, 2015; Midgett & Doumas, 2015; Nilsson et al., 2010). Participants recommended engaging in various forms of experiential activities and immersion experiences in order to learn how to provide effective services to this population.

**Developing Confidence.** One of the themes that emerged from this study was *confidence*, describing participants' process of developing confidence over time. Many participants described a process of overcoming fear or apprehension of working with refugees for a number of reasons, including working with language barriers for the first time, cultural considerations, and fear of re-traumatizing refugees. At times, these fears about mis-stepping, harming, or offending clients initially influenced participants' interactions with refugee clients. Over time, however, participants described that they came to relax and realize that at the core, refugees needed access to authentic, trusting relationships like any clients from different cultural or experiential backgrounds. These participants described coming to a place of recognizing that although refugees have some unique needs that require additional skillsets, connecting with these clients at the humanistic level and using basic counseling skills and abilities was often enough to help refugees get the help that they needed. Participants reflected back on their earlier anxieties and shared that they wish they knew that working with refugees was just about showing up authentically. Gaining this increased sense of self-efficacy over time is an important part of these professionals' ability to provide care to refugees. Despite their initial fears, their commitment and resilient self-efficacy allowed them to continue to learn as they served this population. Although previous training programs focused on

preparing mental health professionals to counsel refugees have demonstrated increased levels of self-efficacy as a result of educational interventions (Kuo & Acuri, 2015; Midgett & Doumas, 2015; Nilsson et al., 2010), the level of in-depth reflection provided by participants on the process of gaining confidence to work with refugees is missing from scholarly literature. Notable is that for many of these participants, connecting with participants at the humanistic level and trusting not just their basic clinical skills, but also their ability to “hold space” and sit with the emotions, suffering, and resilience of other humans was a critical piece in their confidence development. A few participants shared the spiritual impact of working with refugees and connection at the spiritual level allowed them to build the deep, trusting relationships that served as the foundation for their work with refugees. While sharing recommendations, some participants stated that they wished they knew earlier to trust their basic skills as counselors and their ability to show compassion to others.

### **Learning Influences**

In addition to the content and process described by participants, learning influences were also highlighted in the theme *Personal Identity, Values, and Worldview*. These influences include aspects of the participants’ personal identities and culture, values, and background that in some way impacted their overall sense of preparation or motivation to work with refugee populations. All participants reported that various aspects of their personal identity, values, or worldview impacted both the content and process of learning how to work with refugees. During the interviews, they shared insight about how their personal background contributed their sense of comfort and ability to

counsel refugee populations effectively. Participants reported that many personal life experiences, such as growing up in families that valued diversity and unconditional compassion, being raised in environments with individuals of diverse cultures, personal relationships and friendships with diverse individuals, and personal experiences of migration were influential factors in their ability to counsel refugees. One participant shared that her own personal background as a refugee influenced her ability to understand, at a deep level, what it is like to adjust to a culture where you are a minority. Faith and spirituality were emphasized as being particularly influential to participants' experiences. In particular, faith influenced relationship building with refugees, motivation to counsel this population, and understanding of human condition and suffering.

Researchers have pointed to the value of understanding how personal cultural, values, and worldview impact the counseling process (Arredondo & Arciniega, 2001; Ratts et al., 2016; Sheely-Moore & Kooyman, 2011; Sue, 2001). Much of this literature emphasizes the importance of awareness and how issues of transference and countertransference must be considered in counseling practice. There is limited research, however, on issues of awareness that may be specific to counseling refugee populations (Villalba, 2009). These may include factors such as political and societal perspectives and values that may influence a counselor's ability to offer social justice informed and culturally competent services to refugee clients. Furthermore, researchers to date have not linked the religious and spiritual beliefs of a counselor to their ability and capacity to counsel refugee clients. This finding provides important perspectives when considering how to prepare counselors to work with refugee clients. In regard to motivation, scholars have identified

how personal meaning and intrinsic satisfaction may guide career decisions and drive individuals to seeking careers in helping professions (Ben-Shem & Avi-Itzhak, 1991; Chugani, 2005). Literature on motivation to work with refugee populations, however, is limited. These findings indicate that personal factors such as faith and spirituality may be significant in understanding learners' experiences and may have importance in the development of professional identity and purpose.

### **Theoretical Grounding**

While cultural competence development models exist within mental health professional fields, Jeffrey's Cultural Competence and Confidence model (Jeffrey, 2010) was chosen as the framework for this study because of its strong focus on education and the process of teaching and learning cultural competence. As previously detailed, cultural competence is defined as multidimensional learning process that includes skills in the cognitive, affective, and practical learning dimensions, and includes transcultural self-efficacy (confidence) as a major contributor to this process.

Because phenomenological research designs require that themes emerge without the bounds of a pre-determined framework, the CCC model was not considered in the data analysis process. In this discussion, the results are considered within the framework of the CCC model to ground results in a cultural competence focused guide to teaching and learning. The processes of learning described by participants fit within the major categories of the CCC model: cognitive, affective, practical, and confidence dimensions. The cognitive learning dimension is focused on learner's knowledge outcomes and considers learner's "knowledge and comprehension about ways in which cultural factors

influence professional care among clients of different cultural backgrounds and throughout the lifecycle (Jeffreys, 2010, p. 338).” This also refers to knowledge about clients’ various cultural identities such as race, ethnicity, gender, socioeconomic status, and religion. Numerous themes that emerged from participants’ experiences are consistent with knowledge in the learning dimension, such as the themes of *Knowledge*, *Working with Trauma*, and *Role of Counselor*. The practical learning dimension is centered on skills and practical application. This includes the learner’s communication skills (verbal and nonverbal) and ability to engage with clients of different cultural backgrounds. The theme *Language Barriers and Use of Interpreters* describes many aspects of the practical dimension, as navigating language barriers with refugee clients is clearly a significant skill set for effective work with this population. Further, in some ways the theme *Ethics and Boundaries* fits within the practical dimension, as gaining decision-making abilities in this area allowed participants to gain the trust of their refugee clients and build meaningful therapeutic relationships that facilitated communication and counseling work. The affective learning dimension is concerned with the learner’s attitudes, values, and beliefs. This includes, for example, learning that inspires self-awareness development, awareness of health disparities, recognition and appreciation of cultural differences, and understanding of how the cultural identities of both the helper and the help-seeker may intersect. Participants in this study described the importance of gaining awareness and understanding biases as they discussed their learning process, highlighting the multicultural course in their graduate program as one source for learning in this dimension. Furthermore, the theme *Personal Identity, Values, and Worldview*

connects aspects of participants' personal culture and life experiences to their ability and sense of preparation to work with refugee clients. Finally, the confidence dimension was clearly represented in the results of this study. The confidence dimension is focused on understanding the role of self-efficacy and confidence in the learning process. As participants discussed their experiences of learning how to counsel refugees, they reflected on their growth and development process over time. The theme *Developing Confidence* highlights this development. The stories shared by some participants about how they came to feel more confident in their work is consistent with the CCC model.

### **Limitations**

The results of this study must be considered in light of limitations. First, it is important to note that the sample for this study included participants who primarily identified as White and most of them also identified as Christian. Only one participant, who identified as White, represented a refugee background. Another participant, who was born and raised in the United States, identified as Middle Eastern and Muslim. The learning experiences reported by these participants may have thereby been limited by the demographics of the sample. In contrast, the pilot study for this research included two participants who identified as Latina women. Although the pilot study data was not formally analyzed, different topics emerged in these interviews that did not emerge in the full study. For instance, the pilot study participants' own personal stories of immigration and cultural identity development were significant in their overall sense of preparation to serve this population. Additionally, they emphasized their experiences of attending predominately white institutions and how this affected their learning process as students.

Because all but one participant in the main study identified as White, it is unclear how the experiences of a more diverse sample may have differed. All participants in this study cited language barriers as a challenging part of counseling refugees, and shared various experiences of learning how to work with translators, nonverbal communication, and alternative forms of counseling. While one participant did note that she provided counseling to some individuals who spoke one of the languages in which she was fluent, these reflections were limited. A more linguistically diverse sample who had experiences of providing services to refugees in their native language may have shared different experiences. Learning the experiences of mental health professionals who counsel refugees in their native language may provide additional insight on how to prepare mental health practitioners to work with this population.

Biases also may exist in the data resulting from the researcher's recruitment process. One of the ways that participants were recruited was by reaching out to refugee resettlement agencies and organizations providing services to refugees across the country. Additionally, individuals in her personal and professional networks were contacted and asked to share information about the study to mental health professionals they believed were effective in their work with refugees. Finally, participants also were recruited from relevant mental health or refugee focused listservs and social media sites. While agencies and contacts in other parts of the United States were informed about this study and asked for nominations, it is notable that five out of the seven participants in this study were based in North Carolina, the researcher's place of residence. This was likely influenced by her professional connections in the area, which may have made organizations or contacts in

her network more likely to nominate mental health professionals to participate in the study. It is unknown how these results might generalize, then, to counselors working with refugees in other parts of the country.

Another note is that while this study focused specifically on refugee populations, many of the mental health professionals who participated in this study have worked with both immigrant and refugee populations. As such, they shared experiences working with both populations in some instances and at times used these terms interchangeably. While immigrant and refugee populations share some similarities, particularly in a cultural context, the experiences of refugees who experience forced displacement have the potential to be very different than immigrants who relocate to the United States. Another note regarding terminology is that while refugees have a protected legal status, some immigrants to the United States do not have this protected status. The experiences of undocumented immigrants are different, and this is particularly noteworthy since one of the themes that emerged in this study was *Barriers, Systems, and Access*. Although navigating systems and helping refugees meet their basic needs early on is challenging, refugees have guaranteed access to services offered by the government and agencies that resettled them for a limited time, and their path to citizenship is more clearly outlined. For immigrants or asylum seekers without protected legal status, access to resources may be even more limited. While the researcher focused on refugee populations in the interview, it is possible that some of the accounts that were shared included accounts of participants' work with immigrant populations as well.

Furthermore, when this study was designed, the researcher hoped to focus on mental health practitioners' experiences learning how to work with adult refugees in particular. The rationale behind this was that the developmental stages and experiences of refugee children and the ways that mental health practitioners counsel them are different than the needs of refugee adults. This was also intended to make the sample more homogenous. While all participants worked with adult refugees, many of them also had significant experiences working with children, families, and communities. In describing their learning experiences, they shared stories and accounts of their work with adults, children, and families. On one hand, this serves as a limitation because developmental stages influence the goals, scope of care, and experiences of counseling since needs of refugee children differ from those of adults. In hindsight, however, asking participants to focus on the adult population was limiting and not considerate of the culture and experiences of refugees. That is, because the majority of refugees migrated from countries with collectivist orientations and significant family and community values, it is culturally appropriate to consider them from a socially connected lens.

Field notes also suggested that when the researcher interviewed the participant who identified as a former refugee and the participant who identified as Middle Eastern and Muslim, assumptions may have been made by the participants about the researcher's experiences and ability to make sense of what the participants were saying. While interviewing these two participants, the researcher probed significantly more than with the other participants in order to get more in-depth reflections and accounts of their experiences. In both of these interviews, the participants would often make statements

such as “well, you know” to the interviewer, seemingly with the assumption that she had similar experiences because of her immigration background and cultural identity. Although this is not entirely clear, both the primary researcher and second coder suspected that potential identification with the researcher may have influenced the interview process. If the interviewer identified as White, it is possible that these participants may have shared different reflections, experiences, and expanded on questions differently.

Finally, it is important to note that the voices of the refugee clients were missing from this study. Participants in this study either self-nominated or were nominated by others as professionals with experience providing effective counseling services to refugee clients. The accounts, experiences, and reflections shared are only representative of the participants. It is unclear how hearing refugee voices may have influenced the study. Ideally, for example refugee clients would elect and nominate counselors who have provided beneficial and effective counseling to participate in this study. The researcher incorporated a question in the interview process asking participants to share how they determined that their work with refugees was effective, and many stated that this was based on their clients’ self-reports. Furthermore, since this study was aimed at understanding the learning experiences of mental health professionals, this limitation did not influence the data that was collected.

### **Implications for Practice**

This study was not intended to be a collection of expert recommendations, but rather an effort to understand the experiences of professionals who were motivated to

learn how to work with refugee populations and often had to direct their own learning experiences. As such, there are important implications for mental health professionals on how to develop their cultural competence specifically to counsel refugees. Overall, findings of this study emphasize the importance of developing a wide range of clinical skills, personal awareness, and cultural and clinical knowledge, contributing to general literature on effective counseling and multicultural competence development when working with individuals from refugee backgrounds. Although the participants in this study received limited or no formal training on counseling refugees in their graduate programs, they were recommended for this study by individuals who perceive them as effective. These findings accordingly serve as a guide for learning, offering direction to professionals or trainees who similarly seek to develop their capacity and competency. What is inspiring about these findings is that these participants were committed to learning despite multiple barriers, challenges and, often, limited support. Although they described instances of feeling isolated and tested in their process of learning, they persevered to meet a critical societal need. Much can be learned about how they navigated their learning experiences and development process. Analysis of participants' lived experiences of learning how to counsel refugees led to the emergence of themes that answer the following questions: *What do mental health professionals need to know to effectively counsel refugee clients? How can they learn and gain the knowledge, skills, and awareness that they describe as important? What influences their learning process?*

Related to content, results suggest that having general background knowledge about refugee migration experiences, an understanding of cultural diversity, and

awareness of cultural norms and perspectives is critical. Additionally, understanding the barriers and issues of access refugees face as well as their experiences of navigating systems related to their resettlement processes may allow mental health professionals to attend to the vast, multidimensional needs of this population. Considering the socio-political context and cultural influences, mental health professionals also might benefit from developing in their roles as educators and advocates in order to effectively attend to refugees needs. As participants in this study emphasized, mental health professionals must be prepared to step outside of what may be considered traditional counseling and clinical settings in order to appropriately work with this population. All seven participants in this study emphasized the importance of engaging with refugees in more informal settings and establishing rapport and trust by stepping into refugees' environments.

The findings of this study also pointed to a wide range of skills that may be beneficial for mental health professionals working with refugees, including trauma training and diagnosis skills, working with interpreters and language barriers, navigating triadic counseling relationships, honing skills in case management, building extensive advocacy skills, utilizing various culturally appropriate modalities and styles of counseling, and accessing research and evidence based practice to inform practice. In regard to the process of learning, the lived experiences of these professionals serve as evidence that motivated learners can indeed direct their own learning and become effective in their work with refugees over time. Participants provided insight on how to apply education received in their graduate programs to their overall learning objectives,

despite sharing various limitations of their multicultural training. Strategies for self-directed learning are provided, and perspectives on how to use professional development, mentorship, and supervision to increase competency and self-efficacy are described. Furthermore, the importance of immersion and experiential experiences is clearly highlighted and recommended for any mental health professional who hopes to learn how to effectively counsel refugees. Participants recommended experiences such as volunteering, attending social events, cultural immersion, service trips, and international travel to gain valuable experiences and insight about work with culturally diverse refugees. Participants also passionately reflected on what they wished they had known when they started their process of learning. From these reflections, practitioners may learn that although counseling refugees appears to require specific skills and knowledge that must be learned over time, it is also critical to trust basic counseling skills and know that adapting counseling to fit refugees may not be as complex as it seems. In other words, participants in this study came to learn to trust their counseling abilities and capacity to connect with and work individuals in profoundly meaningful ways. They reflected on their journeys of overcoming their fears of in some way harming refugee clients due to inexperience and limited competence, to understanding that they had many important skills, abilities, and qualities as clinicians to offer that provided therapeutic benefit to refugees. These implications are best summarized in participants' words:

What I would have liked to have known earlier on is that just showing up and being willing to sit with someone and their pain, hear them, connect with them, and really that's it. How mentally healthy that can be for somebody else in pain. (Participant 7)

You're learning, as a therapist, as you go with a client. Why would that be any different with a refugee or an immigrant? (Participant 4)

It's a journey and I'm not going to get there right away. Offering myself forgiveness around those early mistakes and lack of knowledge. (Participant 2)

If I'm really connecting on a heart level, I feel more comfortable going into it and knowing that something will hopefully come out of it. No matter how we communicate. (Participant 5)

Their message is clear: if a clinician values the worth and humanity of people, respects diversity, has the ability to establish meaningful relationships, is willing to learn along the way, and has the capacity to work with emotions and challenges inherent to the human condition, that clinician also the faculty to work with refugees. Mental health professionals can benefit from the reassurance and perspective offered by participants in this study, who overcame their own apprehensions and grew to become confident in the value of their work. Despite the seemingly complex and difficult learning process, these participants trusted their ability to learn along the way and remained committed to the continuous journey of multicultural competence development. Considering the extensive need for refugees to have access to counseling services and the barriers to this access, mental health professionals are encouraged to heed these messages and reflect on how they can contribute to the mental health disparity that exists for this population.

### **Implications for Education and Training**

Political and social conflicts throughout the world have resulted in significant mass migration. The drastic increase in the population of displaced persons worldwide has made it critical to consider how mental health professionals can be prepared and

trained to serve the needs of culturally diverse populations. Considering societal needs and ethical considerations, there is a need to prioritize cultural competence development in order to prepare mental health professionals to meet the needs of culturally diverse populations. It has been widely established that training specific to counseling work with refugee populations is limited or insufficient (Bartolomei et al., 2016; Gozdiak, 2004; Posselt et al., 2017), and this study confirmed the multiple barriers and limitations that mental health professionals face in their education. What seems extensively clear, then, is the demand for effective training, supports, and access to resources to prepare mental health professionals to meet the unique needs of refugee clients. Consequently, there are numerous implications for educators teaching in mental health professional fields. This study supports previous literature that has identified significant gaps in the training and preparation of mental health practitioners to work with refugee clients. This study extends on this literature by gathering in depth experiences and accounts of how counselors who provide effective counseling services to refugees learn to counsel this population despite the limitations in training. Training components were identified as were methods and recommendations for this training based on the experiences of individuals who had to navigate their learning independently. Valuable insight into the lived experiences of seven mental health professionals who have learned how to provide effective counseling services to refugees over time provide important implications for education and training. Although this research focused on the training of mental health professionals to work specifically with refugee populations, the information learned is also applicable to general multicultural and social justice training. Implications for

general education, multicultural education, developing resilient learners, meeting the needs of diverse learners, preparing educators and supervisors, and educational leadership are discussed.

### **Graduate Training and the Infusion of Multicultural Education**

Graduate training prepares mental health professionals to provide counseling services. However, aforementioned limitations in graduate training indicate that mental health professionals are not adequately prepared to work with the needs of refugee populations. One of the most significant and important recommendations provided by participants in this study are related to the infusion of multicultural education into training. Participants in this study reported that they did not receive any education specific to refugee populations in their graduate training, unless they had opportunities to seek or create practicum or internship opportunities. It is also important to consider that these participants emphasized the lack of infusion of multicultural topics and training across their graduate programs. A single multicultural course was the primary method for trainees to gain access on education and learning that would promote their development as culturally competent providers. Some participants clearly benefited from the learning they gained in their multicultural coursework in regard to the awareness and general knowledge they gained. They stressed, however, that they also needed access to knowledge and skills training in courses such as theories, diagnosis, psychopathology, crisis, and techniques. In their recommendations, they advocated for the inclusion of applied learning opportunities specific to multicultural learning such as case studies, practical examples, experiential activities, and discussion opportunities. As such,

educators in these mental health programs must consider how they can infuse multicultural education into all coursework to increase learners' capacity for critical thinking, comprehension, application, and evaluation of multicultural counseling abilities in order to prepare more competent counselors.

In their discussions of multicultural education, participants teetered between sharing experiences of how their multicultural course was relevant and needed and how the knowledge and skills they gained from that course were inadequate and insufficient for preparing them for work with diverse populations such as refugees. It is important to reflect on possible implications for educators specific to course design and content. For instance, it is likely that faculty tasked with teaching students the majority of their multicultural education in a single course face significant restrictions with time and excessive content to be covered. Furthermore, the timing of these courses is important to consider in the context of multicultural competency development. If, for example, trainees are receiving the majority of their multicultural training at the beginning of their graduate program before they have the opportunity to gain a sense of confidence and self-efficacy in their abilities to do counseling work, they may not have the cognitive ability or practical insight to apply the knowledge and awareness gained in their multicultural course into clinical practice. This could potentially explain participants' mixed perspectives on the value of their multicultural course and their advocacy for the infusion of multicultural education throughout their programs. While students may gain awareness from their education in this design, there is a need for focus on preparing trainees to apply awareness and knowledge gained into skillful action in their clinical work. These

findings reveal the importance for educators and leaders in graduate mental health programs to consider how to incorporate holistic, comprehensive multicultural training into course designs and curricula in meaningful, practical ways.

Additionally, some participants emphasized that having a strong foundational training in clinical practice, even if not specific to refugees, allowed them to feel confident in their basic skills. They learned to adapt their skills and frameworks for refugee populations over time but would not have been able to do so without solid training. In regards to general education, the training that appeared to be missing but needed to help prepare mental health professionals to meet the needs of refugees is related to trauma skills and knowledge. The findings in this study indicate that trauma training needs to be incorporated into graduate programs in order to increase counselor's abilities to best counsel refugee clients. The participants in this study shared that they sought continuing education, training, or certification in trauma work after completing their graduate programs, as they were not prepared to meet the needs of clients who had experienced significant trauma. Mental health graduate programs and educators are encouraged to consider how they can incorporate trauma education and skills into coursework, particularly in preparing clinicians to work with culturally diverse populations. Considering the emphasis on issues related to political and societal concerns, encumbering systems, and advocacy and activism in this study, it is also critical that this trauma training contains a social justice focus to prepare counselors to understand and attend to the trauma of social injustice that refugees may face.

## **Preparing Educators and Supervisors**

Just as graduate mental health training programs should invest in preparing learners to work with diverse cultural populations, consideration also should be paid to preparing educators to teach and supervise these learners effectively. It is critical that educators are prepared to teach, integrate, and evaluate teaching-learning strategies with academically and culturally diverse learners. For graduate programs that are preparing educators in the mental health field at the doctoral level, attention needs to be paid to preparing them to teach in ways that develop learners' multicultural competence. Barriers to multicultural education may include (1) shortage of educators in mental health programs who are prepared to teach or knowledgeable about how to best prepare trainees to meet the needs of culturally diverse groups such as refugees, (2) varying levels of commitment for cross cultural education, or (3) limited evidence and research evaluating the effectiveness of teaching interventions on developing mental health professionals to work with refugee clients (Jeffreys, 2010). This exploratory study addresses these barriers and limitations by gathering the learning experiences of mental health professionals who work with refugees, and thereby informing educators on what to consider in their teaching.

When considering this within the context of refugee specific education, it is clear from participants' experiences that their faculty and teachers may have lacked commitment or awareness of the need for cross cultural education, were not prepared to teach in a way that emphasized cultural competence development, or felt constrained by other teaching goals that limited their ability to focus on multicultural topics in their

courses. This was evidenced by participants sharing that they received no formal training in working with refugees in their graduate coursework, and unequivocally emphasized how the integration of multicultural education was necessary in all graduate coursework in order to prepare them to work with diverse cultures. These results point to the need to prepare educators to teach, develop curriculum, integrate, and evaluate multicultural education. By doing so, these educators will be more prepared to teach participants how to counsel populations such as refugees.

Supervisors also have the responsibility to understand how to best support clinicians who provide services to refugee clients. Supervision was emphasized by some participants to be an extremely beneficial avenue for learning to best counsel refugee clients. This provides evidence of how supervisors who are prepared to meet the needs of students working with clients from diverse cultures can positively influence learning. Having access to mentors, networks, or supervisors who have experience with this population allowed participants to gain access to knowledge, resources, and skills that helped them better navigate their work with refugee clients. Supervisors and mentors also were integral in helping participants attend to their own self-care and understand the limitations of their work with this population whilst still instilling hope and confidence in participants about the impact and influence of the work that they do. The implications for supervision and mentorship are critical for this reason, It may be that some supervisors are already well equipped to help supervisees attend to learning needs related to topics such as ethics and boundaries, vicarious traumatization, unique refugee needs and adaptations, and modalities and techniques relevant to refugee work. It may be more

difficult, however, to gain access to supervisors who have the knowledge and experience of working with this population, or awareness of what supervisees who work with refugees may need. Preparing supervisors to provide essential training, guidance, perspective, and evaluation to supervisees who work with culturally diverse populations such as refugees is

### **Developing Resilient Learners**

Many of the participants in this study were aware of their interest and motivation to serve this population, and consequently were able to take advantage of opportunities to focus their learning on refugee populations throughout their graduate programs and subsequent professional development. Participants described how having the option to choose a topic or population of interest for course assignments was a particularly helpful strategy in helping them gain knowledge and awareness of refugees' mental health needs. In this way, students were provided opportunities to direct some of their own learning in order to meet their interests. Some participants described feeling a sense of responsibility or duty to teach other students in their classes about the needs of refugees through their selected presentations in class. As such, these participants in their process of learning about refugees in their graduate programs also imparted this knowledge to their classmates, thereby providing some exposure to refugee mental health and wellness. Considering that most participants shared that refugee topics were not introduced in their coursework and they carried the weight of advocating for focus on this population, it is significant to note that "choose your topic" assignments cannot guarantee that students will gain exposure to refugee populations unless prior motivation already exists. There

were also a few participants in this study who came to work with refugees by chance and had to learn to serve this population because of circumstances that provided exposure to this population and their needs. For these participants, they sought additional training in order to develop their capacity to serve this population. These participants were active and engaged in their learning, similarly displaying clear motivation and interest. Educators must consider how training can be provided to students who may not have prior motivation to focus on issues related to refugee mental health. It may be important to explore how to address issues of motivation in learning and inspire learners to devote energy to learning about the needs of culturally diverse populations.

Confidence emerged as a theme in this study, in line with the CCC model dimension of transcultural self-efficacy (Jeffreys, 2010). Implications for the development of confidence and self-efficacy are crucial for multiple reasons. Jeffreys (2010) identified three levels of self-efficacy in the teaching-learning process that provide insight on some of these implications: inefficacious; efficacious; and supremely efficacious. Inefficacious and supremely efficacious are identified as “at risk” for not providing culturally competent care for various reasons. The inefficacious learner may be avoidant of tasks, lack motivation, commitment, and be reluctant to seek help. The supremely efficacious learner, on the other hand, may overlook tasks, prepare inadequately, and see no need to persist with cross cultural educational learning. Although no formal assessment of efficacy was measured with participants in this study, the ways that they described their overall process of learning and working with refugees were consistent with the qualities of an efficacious learner. The efficacious learner is

described as resilient and most likely to achieve cultural competence growth and development. These individuals are described as highly motivated to learn, willing to engage and prepare for tasks, active in seeking help and support, and exerting energy and effort into the learning process. For the participants in this study, their confidence grew over time due to various experiences in their personal and professional experiences of working and engaging with refugee populations. Their commitment and resilient self-efficacy allowed them to continue to learn as they served this population, despite the fears and the challenges they met in their process. Even when faced with challenges, disappointments, doubts, or difficulties navigating the complex needs of refugees, they were able to learn from these experiences rather than losing hope or motivation to continue on their development journey. The experiences they shared have significant implications regarding the resilience of learners and how educators can best work with different levels of resilience and self-efficacy. The following questions are raised: How do educators promote resilient self-efficacy in learners, particularly when teaching cultural competence? How can educators help learners gain an appropriate level of confidence that will help them thrive in their work? Is it possible that some multicultural education is taught in ways that may lower self-efficacy in a way that impacts learners' motivation? It may be important to consider how cultural competence can be taught in a way that simultaneously challenges students to consider counseling from multicultural perspectives while also instilling confidence in their ability to work with profoundly diverse clients by developing their resilience, capacity for learning, and critical thinking abilities.

## **Meeting the Needs of Diverse Learners**

Jeffreys (2004, 2006, 2010) provided a cognitive guide for teaching cultural competence. One of the areas of focus in this guide is assessment and consideration of the needs of diverse learners. For instance, Jeffreys (2004, 2006) noted that cultural factors, educational factors, and psychological factors may influence what learners need to best develop in their clinical skills and knowledge. One example of psychological factors is the issues of motivation addressed in the previous section. In regard to cultural factors, the findings of this study indicate the potential influence of personal factors and influences on the learning experiences of students. For example, faith emerged as a strong influence, driving both motivation to work with refugees and participants' perceived capacity and ability to build relationships. Other participants noted how their worldviews and personal backgrounds allowed them to approach work with refugees with authentic connection and compassion. One participant identified as a former refugee and described her learning process with a different lens. For example, her own experiences with forced migration and identity development in a society as a minority contributed to her deep understanding of some of the issues refugees face. For this participant, her sense of awareness and knowledge about refugee populations was already significant, but her need for more skills training and practical training was left unmet because of the emphasis on awareness development in her graduate training. Educational factors are also relevant in this example, as the needs of learners who are bilingual, have gaps in educational experience, or have different cultural perspectives on education may also influence their cross-cultural education. Although limitations in the diversity of the

sample provided some restrictions to the experiences that were shared in this study, the implications of these findings are that diversifying learning strategies to meet the needs of diverse learners is essential. The following questions are posed: Are educators prepared to work with learners' diverse worldviews in order to best attend to the factors impacting their capacity to work with refugee populations? Are there ways to assess learners in order to understand how their personal histories, motivation, cultures, and worldviews may be helpful or harmful in their multicultural competence development? How are counselor educators being prepared to train a wide range of learners to meet the dynamic and multifaceted needs of clients from diverse cultural backgrounds? The diversity of learners in a single classroom is undoubtedly vast, yet the question remains about how educational strategies can be designed to teach various types of learners in ways that may be helpful to their overall development. Considering the diversity of learner's experiences and the factors that influence cultural competence development, there may be benefit in assessing learners' prior experiences and needs in order to select and implement appropriate learning strategies and methods to meet the needs of these learners.

### **Considerations in Educational Leadership**

As the demand for culturally competent professionals who are well prepared to meet the needs of culturally and linguistically diverse populations, educational leaders are encouraged to consider how they can recruit students and faculty in their programs to help prepare effective professionals. Furthermore, there are significant implications for curriculum design and evaluation, as mentioned in the discussions of multicultural

education infusion. Ongoing evaluation of curriculum and modifications based on evidence that emerges from research on cultural competence education are also important considerations for leadership. If leaders have limited capacity to consider how curricula can be adapted to meet the needs for impactful multicultural education and diverse learners, it may be necessary to consider external consultation and evaluation. It is important to note that these implications are relevant not just for refugee populations, but also for a wide variety of culturally diverse groups.

Additionally, it is important to note that participants in this study were active learners, facilitating their own learning experiences to support refugee populations after becoming aware of the significant societal need. Considering the severe shortage of mental health professionals who are from refugee backgrounds, are bilingual, or come from diverse cultural backgrounds, there is certainly a need to train *all* mental health professionals to meet the needs of culturally diverse populations such as refugees. Participants in this study also cited the importance, however, of promoting cultural empowerment and finding ways to advocate for refugees to be a part of their own process of healing. This provides an implication for educational leadership. There may be tremendous benefits in intentionally recruiting participants from refugee populations into the counseling fields and providing supports for these students to ensure their success in programs. Educational leaders can consider targeted efforts to recruit students from refugee backgrounds and may consider gaining funding to support the needs of these students along the way.

## **Implications for Research**

The current study aimed to answer the question “How do counselors who have worked with refugees describe their experiences of learning how to counsel refugees.” What emerged from the data analysis were rich descriptions of the content and process of their learning experiences, as well as the influences that primed and motivated them to serve this population. This study was intended to be a foundational research study examining the learning experiences of counselors who provide services to refugee clients. The methodology utilized allowed for participants’ experiences to be shared in great depth without the bounds of a theoretical framework or hypotheses. Considering the foundational nature of this study in identifying broad themes describing the experiences of mental health professionals, the research implications and directions for future exploration are substantive.

First, considering the limitations of the diversity of the sample, it may prove beneficial to explore the learning experiences of mental health professionals who are more culturally and linguistically diverse. The majority of participants in this study described the challenges and process of learning how to work with interpreters and language barriers, yet reflections on counseling refugees in their first language are limited. There may be benefit in understanding how bilingual counselors learn how to provide counseling services, since scholars have shown that counselors are often not trained to provide bilingual counseling services and may require specific competencies to do so (Castano, 2002; Engstrom et al., 2013). Conducting research on a wider sample also may allow for an understanding of the experiences of different types of learners and

further exploration of how learning may differ or need to be adjusted to meet the needs of diverse learners.

Because participants emphasized the centrality of multicultural training infused throughout the curriculum, including behavioral skills such as diagnosis, working within triadic relationships, and working with interpreters, researchers should attend to these issues. Directions for future research may include the application of multicultural topics and training to various courses outside of the singular multicultural course, and subsequently measuring the effectiveness of these training interventions in counselor's perceived readiness and confidence to work with refugee clients. Examples of interventions that could be infused into graduate training and researched might include case studies on assessing or diagnosing refugee populations in diagnoses coursework, role plays and skills training in techniques courses modeling counseling in triadic relationships with interpreters, and alternative modalities lessons in theories courses. Similarly, there may be benefit in evaluating teaching practices and the preparation of educators and supervisors to train learners to work with refugee populations. It is unclear if educators and supervisors are trained to meet the needs of individuals who work with refugees. Interventions can similarly be implemented and evaluated to prepare educators in training and supervisors to best teach and train learners in effective ways.

Examining counselors' prior interest and motivation to work with refugees may provide important perspectives on how to design teaching interventions that promote engagement and resiliency for trainees learning complex skills. The motivation and dedication to learning exhibited by the participants in this study was noted as a strength

that contributed to these learners' resilience. All participants in this study were enthusiastic learners, often actively seeking opportunities to become more culturally competent and effective in their work. Considering the significant number of refugees being resettled across the world, there is an immense need for access to culturally competent counselors prepared to offer services to this population. This lends to research implications and directions in many ways. There may be value in understanding how counselors who do not have prior interest and motivation to serve refugees can be effectively prepared. Additionally, it may be necessary to understand the motivational components of cultural competence training to work with this population.

Further, it may be beneficial to research how interventions in training programs can help build interest and motivation to work with this population. Similarly, learning resiliency is also an important consideration for future research. When working with refugee populations who come from traumatic migration experiences, face significant barriers to health access and basic living needs, and have a wide variety of needs in their resettlement and healing process, it is possible that mental health professionals new to working with this population become overwhelmed. Participants in this study discussed aspects of self-care and learning that influenced their ability to conceptualize progress with refugees in a way that contributed positively to their learning resilience. Researching factors that influence interest, motivation, and learning resilience in multicultural education and refugee counseling work may provide insight on how to best train mental health professionals to provide culturally competent services to this population.

Following interviews, some participants asked to be connected to other participants in the study to share resources and ideas if permission was provided by those individuals. The value that these participants put into networking and learning from others is clear, as was described in their interviews. Although this study utilized a methodology to gather in-depth individual lived experiences from participants, there may be benefit in conducting studies that allow for participants to engage with each other in the collaborative ways that they describe as necessary for their work with refugee populations. There may be benefit in establishing a community of practice for professionals in similar geographic locations and evaluating the benefit of such a community for mental health professional's development, learning, and ability to serve refugee populations. The emphasis on collaboration and community connection may also be considered in future research. For instance, are there ways that local organizations, including training institutions, can pool resources and expertise in order to best meet the training needs of mental health professionals? There may be value in exploring research collaboration between mental health training programs and interpreter training programs, for example, to develop and evaluate training interventions and service provision with refugee populations.

Personal influences were clearly important in participant's overall experiences. The informal learning that occurred as a result of their backgrounds, beliefs, and values influenced their worldviews and benefitted their ability to build relationships with refugees or pursue this work. For the participants in this study, their personal experiences and cultural identity contributed positively to their ability to counsel refugees in a

positive way. There is value in exploring how background and cultural identities may have a varied effect on educational experiences and learning processes. For example, the participants in this study discussed the influence of their faith as contributing to their ability to connect with clients and honor their experiences through compassionate presence. For these participants, their beliefs positively influenced their identities as social justice advocates who empower and honor refugees. This may indicate a need to explore how such values can be maximized in the process of learning to promote positive outcomes in cultural competence development. It is possible, however, that interpretations of faith and worldviews have a different effect on other learners, promoting a detrimental belief of the individual as a savior, which has the potential to create harmful power dynamics in a counseling relationship. Considering that the majority of nonprofit organizations serving refugees are religiously affiliated, understanding the impact of religion and spirituality on the process of working with refugees and providing effective services could lend to significant insights for counselor education and clinicians' development. More research is needed on understanding how additional personal and cultural factors can influence service to refugees and the teaching-learning process overall.

Educational factors and influences can also be further examined in future research. The demographic questionnaire in this study gathered some information about participants' educational experiences such as the context and setting of the education received, instructional formats, percentage of coursework that incorporated multicultural components, and the strategies utilized in their cultural competence training. Exploring if

these and other education specific factors influence factors related to cultural competence learning and development, preparedness to counsel refugees, and self-efficacy can provide further insight on how to design curricula accounting for context, setting, and educational influences.

Additionally, it is important to note that the need for research on refugee mental health and evidence-based practice was explicitly cited by participants in this study. Some of these participants highlighted how difficult it was to gain access to research and evidence-based practice on refugee populations that would enhance their work and allow them to work effectively with this population. It is clear that mental health professionals would benefit from additional research with practical implications for counseling refugees. However, the barriers to conducting research with refugees were also noted. In particular, participants described the valid concerns refugees may have about research. This may point to the need for research practice and methodology that is culturally relevant and appropriate for this population. For instance, the same language barriers that may impede counseling practice also would exist in research with refugees. The barriers to research with refugee populations and other diverse cultural groups has been cited in literature and efforts must be taken to attend to the different realities and experiences of diverse cultural groups in research. Cultural factors cannot continue to be ancillary considerations in research methods and must be prioritized in future research. Creative, innovative research practices are needed to accommodate for diverse cultures without compromising the quality of the research. As such, implications for research include the design and development of creative research methods that can be implemented and tested

to account for the needs of refugee populations. These may include visual, narrative, and social methods of research that allow for the collection and analysis of data from refugee populations in meaningful, transformative ways.

### **Conclusion**

The purpose of this study was to understand the learning experiences of mental health professionals who work with refugee populations. Participants shared experiences and reflections of their experiences of training, preparation, and learning how to work with refugees. They reflected on the learning they gained across a wide range of topics relevant to work with this population, including cultural knowledge, trauma training, working with language barriers, understanding barriers to access, navigating systems, and understanding the roles of a counselor when working with this population. Participants also shared reflections on the formal training and education they received, as well as various additional learning strategies utilized to gain the knowledge, skills, and awareness they needed to work with this population. As they shared the ways they navigated and directed their education to best serve refugees effectively, participants also identified barriers and gaps in the education they received. Recommendations for training and education were provided based on their personal experiences. Participants also identified how personal culture and influences impacted their overall process of working with refugees, including the motivation to serve this population. Their worldviews and values were influential in their process. Although scholarly literature includes a wide breadth of literature on multicultural education, research on training mental health professionals to work with refugee populations is scarce. This study aimed to fill that gap

by gaining foundational knowledge on how mental health professionals learned how to counsel refugee populations.

## REFERENCES

- Agrawal, P. & Venkatesh, A.K. (2016). Refugee resettlement patterns and state-level health care insurance access in the United States. *American Journal of Public Health, 106*(4), 662-663.
- Ahearn, F.L. (2000). *Psychosocial wellness of refugees: Issues in qualitative and quantitative research*. Oxford, NY: Berghahn Books.
- Anuar, A.A., & Jaladin, R.A., (2016). Development and evaluation of a multicultural counseling competencies (MCC) training module for trainee counselors. *Journal of Asia Pacific Counseling, 6*(1), 41-50.
- Apostolidou, Z. (2015). Politicised notions of professional identity and psychosocial practice among practioners working with asylum seekers and refugees. *British Journal of Guidance & Counseling, 43*(4), 492-503.
- Apostolidou, Z., & Schweitzer, R. (2017). Practitioners' perspectives on the use of clinical supervision in their therapeutic engagement with asylum seekers and refugee clients. *British Journal of Guidance & Counseling, 45*(1), 72-82.
- Arredondo, P., & Arciniega, G.M. (2001). Strategies and techniques for counselor training based on the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 29*, 263-27.

- Arredondo, P., Toporek, R. L., Brown S.P., Jones, J., Locke, D.C., Sanchez, J., & Stadler, H. (1996). Operationalization of the multicultural counseling competencies. *Journal of Multicultural Counseling and Development, 24*, 42-78.
- Barden, S.M., & Cashwell, C.S. (2013). Critical factors in cultural immersion: A synthesis of relevant literature. *International Journal for the Advancement of Counselling, 35*, 286- 297.
- Bartolomei, J., Baeriswyl-Cottin, R., Framorando, D., Kasina, F., Premand, N., Eytan, A., & Khazaal, Y. (2016). What are the barriers to access to mental healthcare and the primary needs of asylum seekers? A survey of mental health caregivers and primary care workers. *BioMed Central Psychiatry, 16*(336), 1-8.
- Bemak, F., & Chung, R. C.-Y. (2017). Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development, 95*, 299-308.
- Bemak, F., Chung, R. C.-Y., & Pedersen, P. (2003). *Counseling refugees: A psychosocial approach to innovative multicultural interventions*. Westport, CT: Greenwood Press.
- Ben-Shem, I., & Avi-Itzhak, T.E. (1991). On work values and career choice in freshmen students: The case of helping vs. other professions. *Journal of Vocational Behavior, 39*(3), 369-379.
- Besser, A., Weinberg, M., Zeigler-Hill, V., & Neria, Y. (2014). Acute symptoms of posttraumatic stress and dissociative experiences among female Israeli civilians exposed to war: The roles of intrapersonal and interpersonal sources of resilience. *Journal of Clinical Psychology, 70*(12), 1227-1239. doi:10.1002/jclp.22083

- Bischoff, R.J., Springer, P.R., Reisbig, A.M.J., Lyons, S., & Likcani, A. (2012). Training for collaboration: Collaborative practice skills for mental health professionals. *Journal of Marital and Family Therapy, 38*(1), 199-210.
- Bogic, M., Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systemic literature review. *International Health and Human Rights, 15*(29), 1-42.
- Brownlee, K., Rawana, J., Franks, J., Harper, J., Bajwa, J., O'Brien, E., & Clarkson, A. (2013). A systematic review of strengths and resilience outcome literature relevant to children and adolescents. *Child & Adolescent Social Work Journal, 30*(5), 435-459. doi:10.1007/s10560-013-0301-9
- Bhugra, D. & Gupta, S. (Eds.) (2011). *Migration and mental health*. New York, NY: Cambridge University Press.
- Celinska, D., & Swazo, R. (2015). Multicultural curriculum designs in counselor education programs: Enhancing counselors-in-training openness to diversity. *Journal of Counselor Preparation and Supervision, 8*(3), Doi:10.7729/83.1124
- Century, G., Leavey, G., & Payne, H. (2007). The experience of working with refugees: Counsellors in primary care. *British Journal of Guidance & Counselling, 35*(1), 23-40.
- Cepla, Z. (2018). *Fact sheet: U.S. Refugee Resettlement*. Retrieved from <https://immigrationforum.org/article/fact-sheet-u-s-refugee-resettlement/>
- Collins, S., Arthur, N., Brown, C., & Kennedy, B. (2015). Student perspectives: Graduate education facilitation of multicultural counseling and social justice competency. *Training and Education in Professional Psychology, 9*(2), 153-160.

- Comas-Diaz, L., & Padilla, A. M. (1990). Countertransference in working with victims of political repression. *American Journal of Orthopsychiatry*, 60(1), 125-134.
- Connor, P., & Krogstad, J.M. (2018). *The number of refugees admitted to the U.S. has fallen, especially among Muslims*. Pew Research Center. Retrieved from <http://www.pewresearch.org/fact-tank/2018/05/03/the-number-of-refugees-admitted-to-the-u-s-has-fallen-especially-among-muslims/>
- Delphin, M.E., & Rowe, M. (2008). Continuing education in cultural competence for community mental health practitioners. *Professional Psychology: Research and Practice*, 39(2), 182-191.
- Dickson, G.L., & Jepsen, D.A. (2007). Multicultural training experiences as predictors of multicultural competencies: Students' perspectives. *Counselor Education & Supervision*, 47, 76-95.
- Eisenbruch, M. (1992). Toward a culturally sensitive DSM: Cultural bereavement in Cambodian refugees and the traditional healer as taxonomist. *Journal of Nervous and Mental Disease*, 180, 8-10.
- Engstrom, D.W., Min, J.W., & Gamble, L., (2009). Field practicum experiences of bilingual social work students working with limited English proficiency clients. *Journal of Social Work Education*, 45(2), 209-224.
- Engstrom, D.W., Roth, T., & Hollis, J. (2010). The use of interpreters by torture treatment providers. *Journal of Ethnic and Cultural Diversity in Social Work*, 19(1), 54-72. Doi:10.1080/15313200903547749.

- Fondacaro, K.M, & Harder, V.S. (2014). Connecting cultures: A training model promoting evidence based psychological services for refugees. *Training and Education in Professional Psychology*, 8(4), 320-327.
- Gartley, T., & Due, C. (February 01, 2017). The Interpreter Is Not an Invisible Being: A Thematic Analysis of the Impact of Interpreters in Mental Health Service Provision with Refugee Clients. *Australian Psychologist*, 52, 1, 31-40.
- Gong-Guy, E., Cravens, R.B., Patterson, T.E. (1991). Clinical issues in mental health service delivery to refugees. *American Psychologist*, 46(6), 642-648.
- Gorman, W. (2001). Refugee survivors of torture: Trauma & treatment. *Professional Psychology: Research and Practice*, 32, 443-451.
- Gozdziak, E.M. (2004). Training refugee mental health providers: Ethnography as a bridge to multicultural practice. *Human Organization*, 63(2), 203-210.
- Griffiths, G., & Tarricone, I. (2017). The provision of mental health services to immigrants and refugees in Italy: the barriers and facilitating factors experienced by mental health workers. *Journal of Psychopathology*, 23, 79-86.
- Guajardo, M.G., Slewa-Younan, S.S., Santalucia, Y., & Francis Jorm, A. (2016). Important considerations when providing mental health first aid to Iraqi refugees in Australia: a Delphi study. *International Journal of Mental Health Systems*, 10(54), 1-9.
- Guregard, S. & Seikkula, J. (2014). Establishing therapeutic dialogue with refugee families. *Contemporary Family Therapy*, 36, 41-57.

- Heppner, P., Wampold, B., & Kivlighan, D.M. (2008). *Research design in counseling*. Belmont, CA: Brooks/Cole Cengage Learning.
- Hemmings, C., & Evans, A. (2017). Identifying and treating race-based trauma in counseling. *Journal of Multicultural Counseling and Development, 46*, 20-39.
- Hipolito-Delgado, C.P., Cook, J.M., Avrus, E.M., & Bonham, E.J. (2011). Developing counseling students' multicultural competence through the Multicultural Action Project. *Counselor Education and Supervision, 50*, 402-421.
- Holcomb-McCoy, C. C., & Myers, J. E. (1999). Multicultural competence and counselor training: A national survey. *Journal of Counseling & Development, 77*, 3, 294-302.
- Jeffreys, M.R., (2000). Development and psychometric evaluation of the transcultural self efficacy tool: A synthesis of findings. *Journal of Transcultural Nursing, 11*(2), 127-136.
- Jeffreys, M.R. (2006). *Teaching cultural competence in nursing and health care: inquiry, action, and innovation*. New York, NY: Springer.
- Jeffreys, M.R. (2010). Educational issues for students, organizational staff, patients, and communities. *Journal of Transcultural Nursing, 21*(1), 338-356.
- Jones, J.M., Sander, J.B., & Brooker, K.W. (2013). Multicultural competency building: Practical solutions for training and evaluating student progress. *Training and Education in Professional Psychology, 7*, 12-22.
- Khawaja, N. G., & Stein, G. (2016). Psychological services for asylum seekers in the community: Challenges and solutions. *Australian Psychologist, 51*, 6, 463-471.

- Kim, B.S., & Lyons, H.Z. (2003). Experiential activities and multicultural competence training. *Journal of Counseling & Development, 81*, 400-408.
- Kira, I.A. & Tummala-Narra, P. (2015). Psychotherapy with refugees: Emerging paradigm. *Journal of Loss and Trauma, 20*(5), 449-467.
- Kirmayer, L.J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A., Guzder, J., Hassan, G., Rousseau, C., and Pottie, K. (2011). Common mental health problems in immigrants and refugees: General approach in primary care. *Canadian Medical Association Journal, 183*(12). Retrieved from <http://www.cmaj.ca/content/183/12/E959.short>
- Kuo, B.C.H, & Arcuri, A. (2014). Multicultural therapy practicum involving refugees: Description and illustration of a training model. *The Counseling Psychologist, 42*(7), 1021-1052.
- Lambert, J.E., & Alhassoon, O.M. (2015). Trauma-focused therapy for refugees: Meta analytic findings. *Journal of Counseling Psychology, 62*(1), 28-37.
- Lee, C.D., & Montiel, E.D.C. (2010). Does mentoring matter in the mental health field? *Social Work in Mental Health, 8*(5), 438-454.
- Lee, A. & Khawaja, N.G. (2014). Multicultural training experiences as predictors of psychology students' cultural competence. *Australian Psychologist, 48*, 209-216.
- Lonn, M.R., & Dantzler, J.Z. (2017). A practical approach to counseling refugees: Applying Maslow's hierarchy of needs. *Journal of Counselor Practice, 8*(2), 61-82).

- Luquis, R.R., & Perez, M. (2005). Health educators and cultural competence: Implications for the profession. *American Journal of Health Studies, 20*(3), 156-163.
- Malott, K.M. (2010). Multicultural counselor training in a single course: Review of research. *Journal of Multicultural Counseling and Development, 38*, 51-63.
- Masten, A. S., & Narayan, A. J. (2012). Child development in the context of disaster, war, and terrorism: Pathways of risk and resilience. *Annual Review of Psychology, 63*227-257. doi:10.1146/annurev-psych-120710-100356
- Masocha, S. & Simpson, M.K. (2011). Developing mental health social work for asylum seekers: A proposed model for practice. *Journal of Social Work 12*(4), 423-443.
- Maxwell, J.A. (2013). *Qualitative research design: An interactive Approach*. Thousand Oaks, CA: SAGE Publications, Inc.
- McRae, M.B., & Johnson, JR. (1991). Toward training for competence in multicultural counselor education. *Journal of Counseling & Development, 70*, 131-135.
- Midgett, A., & Dumas, D. M. (2016). Evaluation of service-learning-infused courses with refugee families. *Journal of Multicultural Counseling and Development, 44*, 2, 118-134.
- Miller, D. C., & Salkind, N. J. (2002). Phenomenology. In *Handbook of Research Design & Social Measurement* (152–155). Thousand Oaks, CA: SAGE Publications, Inc.
- Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The Role of Interpreters in Psychotherapy With Refugees: An Exploratory Study. *American Journal Of Orthopsychiatry, 75*(1), 27-39. doi:10.1037/0002-9432.75.1.27

- Mirza, M., Harrison, E.A., Chang, H-C., Salo, C.D., & Birman, D. (2016). Making sense of three-way conversations: A qualitative study of cross-cultural counseling with refugee men. *International Journal of Intercultural Relations*, 56, 52-64.
- Murray, K.E., Davidson, G.R., & Schweitzer, R. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry*, 80, 4, 576-585.
- Nicholl, C., & Thompson, A. (2004). The psychological treatment of post traumatic stress disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health*, 13(4), 351-362.
- Nilsson, J. E., Schale, C. L., & Khamphakdy-Brown, S. (2011). Facilitating trainees' multicultural development and social justice advocacy through a refugee/immigrant mental health program. *Journal of Counseling & Development*, 89(4), 413-422.
- Patil, C.L., Maripuu, T., Haidly, C., & Sellen, D.W. (2012). Identifying gaps in health research among refugees resettled in Canada. *International Migration*, 53(4), 204-225.
- Paone, T. R., & Malott, K. M. (2008). Using interpreters in mental health counseling: A literature review and recommendations. *Journal Of Multicultural Counseling And Development*, 36(3), 130-142. doi:10.1002/j.2161-1912.2008.tb00077.x

- Posselt, M., McDonald, K., Procter, N., Crespigny, C., & Galletly, C. (2017). Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers. *BioMed Central Public Health, 17*(280), 1-17.
- Prescott-Clements, L., Schuwirth, L., Vleuten, C., Hurst, Y., Whelan, G., Gibb, E., & Rennie, J. (2012). The cultural competence of health care professionals: Conceptual analysis using the results from a national pilot study of training and assessment. *Evaluation and the Health Professions, 36*(2), 191-203.
- Pieterse, A., L., Evans, S.A., Risner-Butner, A., Collins, N.M., & Mason, L.B. (2009). Multicultural competency and social justice training in counseling psychology and counselor education: A review and analysis of a sample of multicultural course syllabi. *The Counseling Psychologist, 37*, 93-115.
- Priester, P.E., Jones, J.E., Jackson-Bailey, C.M., Jana-Masri, A., Jordan, E.X., & Metz, A. (2008). An analysis of content and instructional strategies in multicultural counseling courses. *Journal of Multicultural Counseling and Development, 36*, 29-39.
- Quinn, N. (2014). Participatory action research with asylum seekers and refugees experiencing stigma and discrimination: The experience from Scotland. *Disability & Society, 29*(1), 58-70.
- Ringel, S. (2002). To disclose or not to disclose: Political conflicts in the countertransference. *Smith College Studies in Social Work, 72*(3), 347-358.

- Robinson, K. (2013). Supervision found wanting: Experiences of health and social workers in non-government organisations working with refugees and asylum seekers. *Practice: Social Work in Action*, 25(2), 87-103.
- Salami, B., Salama, J., & Hegadoren, K. (2018). Access and utilization of mental health services for immigrants and refugees: Perspectives of immigrant service providers. *Journal of Mental Health Nursing*, 28(1), 152-161.
- Sammons, C.C., & Speight, S.L. (2008). A qualitative investigation of graduate-student changes associated with multicultural counseling courses. *The Counseling Psychologist*, 36(6), 814-838.
- Schwallie-Giddis, P., Anstrom, K., Sanchez, P., Sardi, V.A., & Granato, L. (2004). Counseling the linguistically and culturally diverse student: Meeting school counselors' professional development needs. *Professional School Counseling*, 8(1), 15-23.
- Schweitzer, R., Wyk, S., & Murray, K. (2015). Therapeutic practice with refugee clients: qualitative study of therapist experience. *Counselling and Psychotherapy Research*, 15(2), 109-118.
- Sheely-Moore, A.I., & Kooyman, L. (2011). Infusing multicultural and social justice competencies within counseling practice: A guide for trainers. *Adultspan Journal*, 10(2), 102-109.
- Smith, T.B., Constantine, M.G., Dunn, T.W., Dinehart, J.M., & Montoya, J.A. (2006). Multicultural education in the mental health professions: A meta-analytic review. *Journal of Counseling Psychology*, 53, 132-145.

- Smith, J.A., Flowers, P., & Larkin, M. (2012). *Interpretative phenomenological analysis: Theory, method, and research*. Los Angeles: Sage.
- Smith, J.A., & Osborn, M. (2007). Interpretive phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods*. London: Sage. pp. 53-80.
- Sonethavilay, H., Miyabayashi, I., Komori, A., Onimaru, M., & Washio, M. (2011). Mental health needs and cultural barriers that lead to misdiagnosis of Southeast Asian refugees: A review. *International Medical Journal*, 18(3), 169-171.
- Stake, R.E. (2010). *Qualitative research: Studying how things work*. New York, NY: The Guilford Press.
- Sue, D.W. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist*, 29(6), 790-821.
- Sue, D.W., & Sue, D. (2015). *Counseling the culturally diverse: Theory and practice (7<sup>th</sup> ed.)*. Hoboken, NJ: John Wiley & Sons, Inc.
- Sue, D.W., Arredondo, P., & McDavis, R (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, 70, 477-486.
- Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine*, 48(10), 1449-62.
- Swazo, R. & Celinska, D. (2014). Cutting edge practices to teach multicultural competencies in counseling, psychology, and education: teaching abroad or on campus? *Intercultural Education*, 25(2), 105-113.

- Telhami, S. (2016). *American attitudes on refugees from the Middle East*. Retrieved from <https://www.brookings.edu/wp-content/uploads/2016/07/Key-Findings.pdf>.
- Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture barriers in mental health. *Journal of Mental Health, 18*(3), 233-241.
- Turrini, G., Purgato, M., Ballette, F., Nose, M., Ostuzzi, G., & Barbui, C. (2017). Common mental health disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems, 11*(51), 1-14.
- The United Nations Refugee Agency Reports (2016). Global trends: Forced displacement in 2016. Retrieved from <http://www.unhcr.org/globaltrends2016/>.
- United Nations High Commissioner for Refugees (UNHCR). 2016. *Left behind: Refugee education in crisis*. Retrieved from <http://www.unhcr.org/59b696f44.pdf>.
- United Nations High Commissioner for Refugees (UNHCR). 2017. *Global Trends: Forced displacement in 2017*. [www.unhcr.org/en-us/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html](http://www.unhcr.org/en-us/statistics/unhcrstats/5b27be547/unhcr-global-trends-2017.html)
- U.S. Department of State (2018). *Refugee Admissions*. Retrieved from <https://www.state.gov/j/prm/ra/>
- Vasilevska, B., Madan, A., & Simich, L., (2010). *Refugee mental health: Promising practices and partnership building resources*. Toronto, Ontario, Canada: Centre for Addiction and Mental Health.

- Vereen, L.G., Hill, N.R., & McNeal, D.T. (2008). Perceptions of multicultural competency integration of the curricular and the practical. *Journal of Mental Health Counseling, 30*(3), 226-236.
- Villalba, J. A. (2009). Addressing immigrant and refugee issues in multicultural counselor education. *Journal of Professional Counseling, Practice, Theory, & Research, 37*(1), 1-12.
- White, C.C., Solid, C.A., Hodges, J.S., & Boehm, D.H. (2015). Does integrated care affect health care utilization in multi-problem refugees? *Journal of Immigrant Minority Health, 17*, 1444-1450.
- Williams, M.E., & Thompson, S.C. (2010). The use of community-based interventions in reducing morbidity from the psychological impact of conflict-related trauma among refugee populations: A systematic review of the literature. *Journal of Immigrant Minority Health, 13*, 780-794.
- Williams, C.L. & Westermeyer, J. (1986). *Refugee mental health in resettlement countries*. Washington: Hemisphere Publishing Corporation.
- Yakushko, O. (2010). Clinical work with limited English proficiency clients: A phenomenological exploration. *Professional Psychology: Research And Practice, 41*(5), 449-455. doi:10.1037/a0020996
- Yoon, E., Jeremie-Brink, G., & Kordesh, K., (2014). Critical issues in teaching a multicultural counseling course. *International Journal for the Advancement of Counseling, 36*, 359-371.

**APPENDIX A**

**DEMOGRAPHIC QUESTIONNAIRE**

**Cultural & Personal Factors**

Age: \_\_\_\_\_ years.

**How do you currently describe your gender identity?**

\_\_\_\_\_ Please self-identify: \_\_\_\_\_

\_\_\_\_\_ I prefer not to answer.

**Which categories describe your racial/ethnic background? Please select all that apply**

\_\_\_\_\_ Native American or Alaska Native

\_\_\_\_\_ African American

\_\_\_\_\_ Black

\_\_\_\_\_ Middle Eastern or North African

\_\_\_\_\_ Asian

\_\_\_\_\_ Pacific Islander

\_\_\_\_\_ White

\_\_\_\_\_ Latin(x)

\_\_\_\_\_ Hispanic

\_\_\_\_\_ Multiracial

\_\_\_\_\_ Other, please specify \_\_\_\_\_.

**How do you describe your religion, spiritual practice, or existential worldview?**

\_\_\_\_\_ Please specify: \_\_\_\_\_.

\_\_\_\_\_ I prefer not to answer.

**How do you describe your current social class group?**

\_\_\_\_\_ Please specify: \_\_\_\_\_.

\_\_\_\_\_ I prefer not to answer.

**Where do you live?**

\_\_\_\_\_ Midwest

\_\_\_\_\_ Northeast

\_\_\_\_\_ South

- West
- Puerto Rico or other U.S. territories.
- Other, please specify: \_\_\_\_\_.

**Do you identify as a first or second generation immigrant or refugee?**

- No.
- Yes, [immigrant *or* refugee] please indicate country-of-origin  
\_\_\_\_\_.

**Which languages do you speak at full professional proficiency or intermediate/advanced proficiency?**

- English
- Spanish
- Arabic
- Dari and/or Pashto
- Burmese
- Sgaw Karen
- Somali
- Napali
- Kiswahili
- French
- Other, please specify \_\_\_\_\_.

**Educational Factors**

**Please list all of your earned educational degrees and professional certificates (degree earned, major/specialty). This includes undergraduate, graduate, and certificate programs.**

1. \_\_\_\_\_.
2. \_\_\_\_\_.
3. \_\_\_\_\_.
4. \_\_\_\_\_.
5. \_\_\_\_\_.
6. \_\_\_\_\_.

**How would you describe the context of your graduate educational institutions?  
Please select all that apply.**

- Public.
- Private.

**How would you describe the context of your graduate educational institutions?  
Please select all that apply.**

- Predominately white institution.
- Historically black college.
- Hispanic-serving institution.
- International.

**How would you describe the instructional methods of your graduate educational institutions? Please select all that apply.**

- Predominately online instruction.
- Predominately face-to-face instruction.

**How would you describe the size of your graduate educational institutions? Please select all that apply.**

- Small-sized university (less than 5,000 students)
- Medium-sized university (5,000 – 15,000 students)
- Large-sized university (15,000+ students)

**What percentage of coursework and/or training experiences in your mental health training program discussed topics related to multicultural competence and culturally appropriate care? This includes classes taken, supervision, clinical practicums or internships, etc.**

- 25% or less
- Between 25-50%
- Between 50-75%
- More than 75%

**Which categories describe teaching-learning strategies used in cultural competence coursework or training in your mental health training program? Please select all that apply.**

- Textbooks and reading assignments.
- Films, movies, videos, podcasts.
- Personal cultural discovery/exploration activities.
- Written papers.
- Exams.
- Lecture.
- Case studies.
- Technology or internet resources.
- Skills practice or role play.

- Debates.
- Guided self-reflection.
- Discussion boards or blogs.
- In class-discussion.
- Service-learning.
- Immersion Experiences.
- Field trip experiences.
- Interviews with culturally different groups/individuals.
- Advocacy projects.
- Practicum/internship experiences.
- Observation.
- Individual, triadic, or group supervision.
- Special events (guest presenters, conferences, cultural recognition/celebration events, etc.)

**Have you participated in formal study abroad or cultural immersion experiences in your educational programs?**

- No.
- Yes, please specify: \_\_\_\_\_.

**Refugee Counseling Experiences**

**On average, how many direct counseling hours have you provided to refugee clients:**

- 10 or less hours.
- 11-25 hours.
- 26-50 hours.
- 50-75 hours.
- 75-100 hours.
- 100-250 hours.
- 250-500 hours.
- 500 or more hours.

**How would you describe the type of services you provided to refugee clients? Please select all that apply.**

- Individual counseling.
- Family counseling.
- Group counseling.
- Couple/Marriage Counseling.
- Intake/triage.
- Community-based intervention and/or advocacy.

**How would you describe the setting/s where you have provided counseling to refugee clients? Please select all that apply.**

- Private practice.
- Mental health agency.
- Refugee agency.
- College/university.
- University-based clinic.
- Nonprofit organization.
- Hospital or integrated healthcare practice.
- Psychiatric inpatient hospital.
- Residential care facility.
- Correctional facilities and/or prisons.
- Career centers.
- Religious institution.

**Have you received any formal training (graduate course, continuing education, workshop, etc.) specific to refugee populations or providing mental health care to culturally diverse refugees?**

- No.
- Yes, please specify: \_\_\_\_\_.

**Have you utilized interpreters in your counseling sessions with refugee clients?**

- No.
- Yes, please indicate if you received training on the use of interpreters prior to using them in your session?

**Have you utilized cultural brokers in your counseling sessions with refugee clients?**

- No.
- Yes, please indicate if you received training on the use of cultural brokers prior to using them in your session?

**Which of the following describe the countries-of-origin of the refugee clients you have provided counseling services to?**

- Syrian Arab Republic
- Afghanistan
- South Sudan
- Myanmar
- Somalia
- Sudan

- Democratic Republic of the Congo
- Central African Republic
- Eritrea
- Mali
- Burundi
- Colombia
- Iraq
- Yemen
- Ukraine
- Eritrea
- Honduras
- Other, please specify: \_\_\_\_\_.

## APPENDIX B

### RECRUITMENT STATEMENT

#### Recruitment for Research: Nomination Process

My name is Zobaida Laota, and I am a licensed counselor and current doctoral student in Counseling and Counselor Education at the University of North Carolina at Greensboro. As a part of my dissertation research, I am conducting a qualitative study to explore the learning, preparation, and training experiences of mental health professionals who have provided face-to-face counseling services to adult refugee clients. The purpose of this study is to (a) explore the preparation and training experiences of mental health professionals who have worked with refugee clients, and better understand how they describe the educational and learning experiences they had to prepare them to work with this population, and (b) collect recommendations for training and education.

I am recruiting licensed mental health professionals (counselors, clinical social workers, psychologists, and marriage and family therapists) who have had experience working with adult refugee clients. Ideal participants will be able to reflect on their experiences of the preparation/training they received that have supported or not supported their ability to effectively work with refugees. Additionally, participants will be asked to share their experiences of learning to work with this population, including formal and informal/personal influences to their learning process. Participation in this study will include a 45-90-minute audio recorded face-to face, online, or phone interview with myself. As a token of gratitude for contributing your time to this study, participants will receive a 30\$ gift card of their choice after the completion of the interview. The information shared in this study will be confidential, and participants' identities will be protected. Ultimately, my hope is that this study will help inform best practices in curriculum development and training to provide effective care and access to mental health services for refugee populations.

If you know of mental health professionals who provide effective counseling services to adult refugee populations, I am writing to request that you nominate them for participation in this study. To nominate potential participants please complete the following steps:

1. Send your nominees information about this study via email and request their permission to nominate them as mental health professionals who provide effective counseling to refugee populations. Please ask your nominees for permission to receive a follow up email from me about the study and notify your nominees that I will not follow up with them about potential participation in the study unless they provide permission for me to do so. A suggested script is provided:

*"I have been asked to nominate mental health professionals who have provided effective counseling services to refugee clients for participation in a research study on their experiences of learning, training, and preparation to serve refugee populations. If you are interested in participating in this study, the PI, who is copied in this email, will follow up to provide you with further information and determine your eligibility to participate. She will not follow up with you if you do not provide permission to do so. You can*

*provide permission to be contacted with more information about study by replying to this email or contacting the PI directly at [zalaota@uncg.edu](mailto:zalaota@uncg.edu). Thank you for your consideration!"*

2. Cc me ([zalaota@uncg.edu](mailto:zalaota@uncg.edu)) in your nomination email. I will follow up with nominees who provide permission via email to confirm their interest in participating and provide them additional information about the study.

Thank you so much for your consideration.

## APPENDIX C

### INSTRUCTIONS FOR PARTICIPATION

**Title of Dissertation Research:** Counseling Refugees: Examining Mental Health Professionals' Learning Experiences and Recommendations for Effective Training.

Thank you for your interest in participating in my study on the training, preparation, and learning experiences of mental health practitioners who have worked with refugee populations. Please read the attached consent form and let me know if you have any questions. If after reading this consent form you choose to participate in the study, sign the consent form and return it to me per the instructions listed below. If you prefer to review the consent form with me prior to the beginning of the interview, please know that this is possible. A demographic survey is also attached to this email. This survey is to be completed after you have signed the consent form. I am happy to answer any questions that you have about the demographic survey at any time. Finally, a list of the interview questions is attached for review.

**Uploading Documents:** You will receive an invitation from me to upload your signed consent form and completed demographic questionnaire to a folder on Box, a secure and password protected content storage and management tool. Your confidentiality will be protected, as only you and I will have access to this folder. If you have any issues using this tool to upload your documents, please contact me with any questions. If you choose to schedule a face-to-face interview, you may submit these documents to me directly at the time of our interview.

**Scheduling the Interview:** Please email me at [zalaota@uncg.edu](mailto:zalaota@uncg.edu) with your preferences for the interview:

1. Provide a list of all possible proposed dates and times that you are available for an interview. I will make myself available on both weekdays and weekends in order to best accommodate your scheduling needs.
2. Indicate your preferences of the interview format: face-to-face, phone, or video-conference. A face-to-face interview is only possible if you are located in the state of North Carolina.
3. If you are able to complete a face-to-face interview, please list your preferred interview locations. Please note that the interview will need to occur in a quiet, limited distraction environment. I am also able to reserve a space at the University of North Carolina at Greensboro if this option is preferred.

**After the Interview:**

1. You will be sent a summary of the written analysis report (including the significant statements, themes and subthemes) for review. After reviewing this summary, please share any needed clarifications of your responses, verify whether

the summary accurately reflects your experiences, and share any additional missing information or reflections that were not captured by the summaries.

2. In a follow up email, you will be asked to send me your preferred physical mailing address, or email address for digital gift cards, to receive your \$40 gift card. You will indicate your preference for the gift card from the following options at this time: (a) Amazon (b) Visa (c) Target (d) Best Buy, (e) Apple Store & iTunes.

## APPENDIX D

### INFORMED CONSENT FORM

#### The University of North Carolina at Greensboro

#### Consent to Participate in Research

**Title of Research:** Counseling Refugees: Examining Mental Health Professionals' Learning Experiences and Recommendations for Effective Training

**Principal Investigator:** Zobaida Laota (zalaota@uncg.edu)

**Faculty Advisor:** Craig Cashwell (cscashwe@uncg.edu)

**Participation in research:**

You are invited to participate in a research study conducted by Zobaida Laota, a doctoral candidate in Counseling and Counselor Education at the University of North Carolina at Greensboro. This study, conducted under the direction of Dr. Craig Cashwell, will support knowledge in the counselor education field. Participation in this study is voluntary. If you chose to participate, you may still withdraw your consent at any time, without penalty or explanation. If you have any concerns about your rights, how you are being treated, concerns or complaints about this project or benefits or risks associated with being in this study, please contact the Office of Research Integrity at UNCG toll-free at (855)-251-2351.

**Purpose:**

The purpose of this study is to explore and better understand the preparation and training experiences of mental health professionals who have worked with refugee clients, and better understand how they describe the educational and learning experiences they had to prepare them to work with this population. This research is intended to take a preliminary step towards filling the gap in current literature on the training and preparation of mental health professionals to work with refugee populations. Experiences, reflections, and accounts of the process of learning how to work with refugees will be gathered. Participants will be asked to reflect on how their preparation experiences have prepared them to work with refugees. Both formal and informal educational experiences, as well as other learning experiences and factors, will be explored. This study aims to gather recommendations from mental health professionals based on their own experiences as to what is needed in the counseling curriculum and training practices to better prepare mental health professionals to work with refugees. Ultimately, this knowledge will serve to inform curriculum development, teaching practices, training, and preparation to work with a population with an immense need for access to culturally competent counseling services.

**Participants:**

To be eligible for this study, you must be a licensed mental health professional in the fields of counseling, psychology, clinical social work, or marriage and family therapy. You must have provided individual, face-to-face counseling services to refugee clients. This excludes individuals who have provided services to refugees outside of the context of direct counseling/therapy (such as referral specialists, resettlement employees, case managers, and nonprofit or government employees or volunteers who work with refugees outside of the scope of counseling). Finally, ideal participants are willing to reflect in-depth on training, learning, and educational experiences, as it pertains to their work as mental health professionals working with refugee populations.

**Procedures:**

Participants in this study will participate in an individual interview, approximately 45-90 minutes long. This interview will take place face-to-face, online, or over the phone depending on the participant's geography and presence. Participants will receive (a) an invitation to participate in the study with a brief description of the research and its goals, (b) a copy of the consent form to review (c) selection criteria for participants and instructions to confirm their eligibility to take part in the study, and (d) a copy of a demographic questionnaire to complete. To confirm eligibility, participants will be asked to: (a) provide information about their mental health practitioner license, (b) briefly describe their experience working with refugee clients, including extent of time and approximate number of clients the participant has worked with, and (c) provide a statement that indicates their ability and willingness to share in-depth reflections on their experiences of training, preparation, and overall learning to work with refugee populations. Eligible participants will then be contacted via phone or email communication to schedule an interview time and determine a preferred location. After the interview is scheduled, participants will be allowed additional time to ask questions about their participation in the study or the demographic questionnaire.

**Confidentiality:**

Every effort will be made to keep your information confidential. Interviews will be audio recorded and transcribed for the purpose of the study. These recordings will be kept in a secured, password protected location and will not be labeled with identifying information. After the interviews are transcribed, these recordings will be deleted. All identifying information will be removed from reporting in the study, and pseudonyms will be used to protect participants' information. Absolute confidentiality of data provided through the internet cannot be guaranteed due to the limited protections of internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing.

**Risks:**

Participants will be asked to reflect on their experiences working with refugee populations. Considering the potential trauma experiences and mental health needs of this population, it is possible that participants experience psychological reactions as they

recall some of their experiences of working with refugees. However, this study is interested in exploring experiences of learning and education in particular, so the likelihood for this risk is expected to be minimal. Participants are encouraged to only share information that they feel comfortable sharing during this interview. Information on secondary trauma and self-care strategies will be provided at the end of the interview for participants that would benefit from this material.

**Benefits:**

This study allows participants to share their experiences of learning and preparation to work with refugee populations, which may allow for positive reflections and/or recollections that increase the mental health professionals' continued development through the process of self-reflection. Furthermore, participation in this research will allow for important recommendations to be gathered that have the potential to influence the training of mental health professionals to work with diverse refugee populations.

**Compensation:**

To compensate you for your dedicated participation in this study, you will receive a \$40 gift card of your choice. This gift card will be mailed to your specified address at the end of the interview.

**If you agree to participate in this study, please acknowledge that you have read the informed consent and provide consent by signing below:**

**Printed name of participant:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_

**Signature of participant:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_

**Signature of principal investigator:**

**Date:**

\_\_\_\_\_

\_\_\_\_\_

## APPENDIX E

### INTERVIEW SCHEDULE

#### Semi-Structured Interview Questions

1. Describe your experiences of providing counseling to refugees.
  - a. How would you describe the context of the services you provided?
  - b. How has your experience of working with refugees changed over time, from your first client to your most recent client?
2. How did you learn how to effectively counsel refugees?
  - a. What has supported or facilitated your learning process?
  - b. What has hindered your learning process?
3. What has been most rewarding in working with refugees?
4. What has been most challenging in working with refugees?
5. What has helped you gain confidence in your work with refugees?
6. Describe the educational and training experiences that have prepared you to work with refugees.
  - a. How has your formal education and training contributed to your learning process? This may include, but is not limited to, training in graduate coursework, educational opportunities, practicums and/or internships, and clinical supervision experiences.
  - b. How has your informal training or other learning experiences prepared or not prepared you for work with this population? This may include, but is not limited to, self-directed learning, prior work/volunteer experiences, societal or environmental influences, informal mentorship, etc.
7. In what ways has your own personal identity or culture influenced your experiences of preparation to work with refugees?
8. Based on your experiences working with refugees, what could have better prepared you to work with this population?
  - a. How can graduate training programs better prepare future mental health professionals to work with refugees?
9. How do you know that your work with refugees has been effective?
10. What additional learning, training, and support do you need to further your learning process?
  - a. Based on your experience of preparation and training, what recommendations would you provide to a mental health professional who is seeking training to work with refugees?

## APPENDIX F

### RESOURCES TO MINIMIZE RISK

#### Resources for Secondary Trauma, Self-Care, and Emotional Health

- **United Nations Human Rights Office of the High Commissioner: *Manual on Human Rights Monitoring. Chapter 12: Trauma and Self-Care.*** This 40-page resource reviews important concepts associated with working with trauma survivors and vicarious trauma. Various strategies for practicing self-care while working with trauma survivors is provided. Information for recognizing signs of vicarious trauma, acute stress, chronic stress, and burn-out is detailed. This resource also includes strategies to build resilience and cope with the potential effects of working with traumatized individuals. Stress management and self-care suggestions are listed and explained. In Annex I of this chapter is an outline for creating a stress management plan to cope with symptoms of vicarious trauma. In Annex II of this chapter is a list of additional online resources, including secondary trauma and burnout self-assessment tools, for further information and suggestions for support. This resource can be found at the following link: <https://www.ohchr.org/Documents/Publications/Chapter12-MHRM.pdf>
- **The Headington Institute.** The Headington Institute is an organization that provides access to psychological and spiritual support to humanitarian workers and emergency responders across the world. The website offers resources on resilience, stress and burnout, and vicarious trauma. Examples of these resources include self-assessments for measuring burnout and vicarious trauma, tools for emotional health, online stress and resilience courses, and handouts with information and guidance on vicarious trauma and coping strategies. These resources can be find on the organization’s website: <http://headington-institute.org/>.
- **The Vicarious Trauma Toolkit.** This toolkit, available on the Office of Justice Programs governmental website, provides a variety of tools for service providers working with victims of trauma. One of the resources included in this toolkit is a course on vicarious trauma and resilience designed for mental health professionals who work with trauma survivors. This 64-page course document includes information on self-care, compassion fatigue, symptoms of burnout, strategies to prevent burnout, descriptions of important concepts related to vicarious trauma, and information on developing vicarious resilience and practicing trauma stewardship. This course provides important information to help mental health professionals develop effective self-care plans to protect their emotional health and wellbeing when working with trauma and crisis. This document can be found at the following link: [https://vtt.ovc.ojp.gov/ojpasset/Documents/VT\\_VT\\_and\\_Resilience\\_Training-508.pdf](https://vtt.ovc.ojp.gov/ojpasset/Documents/VT_VT_and_Resilience_Training-508.pdf)

## APPENDIX G

### INDEPENDENT BRACKETING SUMMARY

I stumbled upon this research topic through what I believe was divine intervention. This wasn't the dissertation I had intended to complete, and I have no prior experience providing direct counseling to refugees and have received no training in my graduate programs to prepare me for this work. Yet after graduating from my master's program, becoming licensed as an LPCA, and beginning my doctoral studies, I began receiving an influx of requests for services for individuals and families from refugee backgrounds in the local community. These requests came through personal and professional contacts, community members and leaders, and members of my mosque. My responses to these requests were the same: *I'm in the midst of a full time doctoral program that I'm still adjusting to, my clinical internships here limit me from being able to take on clients that don't directly come through the sites that I'm contracted with, and I'm not practicing independently at this time. I'm not specialized or trained to work with refugees, but I wonder if there are others in the area that might be. Can I help you get that individual/family connected to the services they need?* I began my process of compiling a resource list that I could share with those that reached out to me. In my efforts to identify resources and connect individuals with services, I faced significant barriers and came to realize just how limited services were. Although I knew at a cognitive level that mental health services for refugees were limited, I still found myself shocked and heartbroken that I couldn't connect the individuals who were reaching out to me to the counseling that they needed, especially in a state where the number of refugees resettled is extensive. Nonprofit organizations and refugee agencies often couldn't provide direct mental health services or were significantly constrained by the number of clients they could see. Private practice practitioners who I called shared that they didn't feel they had the competency or training to work with refugees or that they didn't have access to interpreters that they could use. Mental health agencies were similarly limited by access to interpreters or a shortage of practitioners who felt they could effectively work with these refugee families. A few individuals that I helped connect to clinics and practitioners who have experience working with refugees were able to get access to what they needed. However, I found that for many others who got connected to services, would share with me that *it's not working*, that they felt their cultures or religions (predominately Muslim) were misunderstood, or that they didn't feel comfortable with the process. I found myself stuck, and empathized at a deep, personal level with weight that these refugees must feel. I found myself asking questions that ultimately led me to this research: *why is it that I'm assumed to be prepared and competent to work with refugee as a new clinician with no prior experience in this area? Why is it that of the many clinicians in the area, so many of them also feel like they wouldn't know how to serve this population? What would I need to learn how to work with refugees, and how can other clinicians similarly get what they need to feel like they can say "yes" to referrals of refugee clients?* The process that led me to this research was emotional and

personal and I felt a responsibility to begin understanding how I can contribute to filling this need that was put into my perspective. I came into this research with an open mind and with curiosity. I wanted to learn, and help others learn. I came into this research very aware of the barriers that existed and aware of some of the challenges practitioners I consulted with cited as being barriers to their ability to work with refugees. I was curious if the participants that I would be interviewing had faced the same challenges, and more interested in learning how they navigated them.

I am a Sudanese American, Muslim woman. I am a black, African woman, and Arabic was my first fluent language. My family immigrated from Sudan to the United States in my childhood, and became naturalized as citizens five years later. The circumstances around our immigration were certainly not traumatic. I remember, sometimes with surprising clarity, my own experiences of adjusting to culture and language in elementary school. My process of adaptation as a child and adjustment to school was difficult. I also watched my parents navigate the new culture and language barriers. My process of identity development continues even now in my adulthood as I try to hold on to the beautiful parts of my original culture while also knowing that my culture is now a blend of the many experiences I've had and the cultures I've been exposed to. I have lived my life in three continents throughout my life, and identify as a Third-Culture-Kid (TCK) because of my experiences. I have always been able to travel back to the places I called "home" across these continents, unlike refugees. I belong in many places and not quite fully in any place at the same time. I know many others that identify as TCKs, immigrants, or refugees feel the same. I have travelled extensively throughout my childhood, adolescence, and early adulthood. These experiences have shaped my worldview significantly. I am immensely and positively influenced by the cultural identities I hold, and see my experiences and cultural perspectives as a privilege. As a visibly identifiable Muslim and black woman living in the United States, however, I have experienced significant microaggressions, discrimination, and encounters of both racism and Islamophobia. I am not immune to racial and religious trauma and the impacts of social injustice. I am aware of how my worldview and experiences influence how I view refugees and my strong views that graduate education is not preparing counselors to work with diversity and intersectionality. Going into the interview process, however, I know that I'll be able to focus instead on learning from these professionals how they navigated their own process of developing multicultural competence to work with refugees. I know that I do expect that they will share experiences far beyond what was learned in graduate school, because of my personal experiences as well as the literature reviews I have conducted in this year. I'm excited to see what they will share, and hope to learn from them how I might even navigate my own learning moving forward.

I am a counselor, and have had the privilege of working with clients of diverse worldviews and cultural identities. However, the majority of clients that I have worked with in the settings where I have been employed or completed internships are culturally different than me. For me, working with clients who are culturally different is my norm, because I am usually the one in the counseling room who is not of the majority culture. Not learning to work with clients who were culturally different than me was never an

option. I'm so thankful for that. Choosing not to work with any group should never be an option, but I find myself frustrated that for some people it is, and that they may choose it because it's easier. Similarly, I am a religious minority in the United States, and have engaged significantly in spiritually integrated counseling particularly when working with grief. As a clinician in my early stages of development, I was more comfortable working with clients who were of different religious identities than my own because my training and access to clients in my work settings was often focused on those who were culturally different than me, and prepared me to better serve those of the majority culture. As I heard participants share their experiences of counseling refugees, some from my own original culture and birthplace, I found myself reflecting on how I have come to feel so unprepared to meet the needs of the culture that once my home. I also found myself reflecting on my own training at the master's level. I found immense value in my multicultural counseling course and the infusion of multiculturalism in some of my coursework. I identified who the participant who shared that his social justice oriented program influenced his framework and considered how my own experiences at the master's level both in graduate coursework and in my clinical practicums and internships have infused *advocate* into my counselor identity and multicultural framework. I reflected on how despite the influential mentorship, guidance, and supervision I received prepared me to be a multicultural competent counselor (especially when considered with my own personal life experience and worldview), the books, research articles, trainings, continuing education, and additional resources I had access too still treated multicultural topics as auxiliary add-ons. I related to the lack of cultural infusion in my training as a doctoral student, and found myself reflecting on what I needed not just to continue my own development as a clinician, but also to help me prepare the supervisees and students that I teach.

While my interview process inspired much reflection on my own culture, training, and experiences in the mental health field, I have found that I have been able to focus on the words and experiences of these participants because of my genuine curiosity and intentional efforts towards objectivity. As I reflect on the end of the research journey, I know that I have been deeply inspired by the participants who I have interviewed. In the brief time spent with them, I found that their presence and way of being embodied cultural humility and felt gratitude that they had taken the initiative to help meet the needs of refugees in the United States by self-directing their own learning experiences. I have had moments in these interviews of being extremely humbled by participants' reflections. By learning about their experiences of learning, I am also learning in ways that I never expected. I found myself making connections to my own experiences at times, both in hearing about these participants' experiences and in hearing their reflections on the needs of refugees. I walked into this research feeling unprepared to provide services to refugees, I leave this experience with more confidence, commitment, and belief in my ability to work with this population and learn along the way. I look forward to my own professional development, as I begin my clinical work with refugees for the first time.