

Counselors' Reflections on Their Experiences in
Preparation to Counsel Adult Refugee Clients

Bethany Ann Lackey

Dissertation submitted to the faculty of the Virginia Polytechnic Institute and State University in
partial fulfillment of the requirements for the degree of

Doctor of Philosophy
In
Counselor Education

Nancy Bodenhorn, Chair
Cherie Edwards
Laura Farmer
Gerard Lawson
Laura Welfare

December 9, 2020
Blacksburg, VA

Keywords: counselors, refugees, counselor training, social justice, relational cultural, advocacy,
cultural humility, multicultural competence, trauma

Counselors' Reflections on Their Experiences in Preparation to Counsel Adult Refugee Clients

Bethany Ann Lackey

Abstract

Millions of people around the world have fled their home countries in search of refuge, and there is a great likelihood they experience traumatizing events in their journeys to safety. Refugees are screened for mental health issues in the resettlement process in the United States, and there is a large body of established research regarding refugee mental health needs and strengths. However, far less is known about counseling refugees, and even less so about counselors working with the population. This dissertation study sought counselors' reflections on their experiences, both personal and professional, they feel helped prepare them to see refugee clients. Four post-masters counselors participated in the video interviews. Participants were diverse (3 women, 4 ethnicities, counseling refugees from all areas of the world). Minimum criteria was having three adult refugee clients for a minimum of three sessions each. Four main themes emerged as result of analysis: 1) Trauma-informed, 2) Cultural competence and humility, 3) Counselor determination, and 4) Integration of Self. Participants specifically identified trauma-informed practices, cultural competence, and cultural humility as integral parts of necessary training for counselors to see this population. Counselors in this study found they were ill-prepared when they began seeing refugees and had to overcome obstacles to provide needed therapy. Results show a gap between what is known about refugees in academic literature and counselors' knowledge of the population which highlights the need for accessible curriculum and training on refugee issues as well as best practices for serving refugee clients. Implications for counselors, counselor educators, and future research are shared.

Counselors' Reflections on Their Experiences in Preparation to Counsel Adult Refugee Clients

Bethany Ann Lackey

General Audience Abstract

People who have refugee status often struggle to meet basic needs upon resettlement. They have experienced potentially traumatizing events in their journeys, and their mental health needs are not often met. While a great body of research on refugee mental health exists, far less is known about counseling refugees, and even less so about counselors working with the population. This dissertation study sought counselors' reflections on their experiences, both personal and professional, they feel helped prepare them to see refugee clients. Four counselors participated in the video interviews. Minimum criteria was having three adult refugee clients for a minimum of three sessions each. Four main themes emerged as result of analysis: 1) Trauma-informed, 2) Cultural competence and humility, 3) Counselor determination, and 4) Integration of Self. Counselors in this study found they were ill-prepared when they began seeing refugees and had to overcome obstacles to provide needed therapy. Results show a gap between what is known about refugees in academic literature and counselors' knowledge of the population which highlights the need for accessible curriculum and training on refugee issues as well as best practices for serving refugee clients. Implications for counselors, counselor educators, and future research are shared.

Acknowledgements

I am truly the luckiest woman to have such a vast support system. They cheered me on, held me up, and empowered me every day in this endeavor. I would have to write a second paper to acknowledge every person who consistently propelled me forward. I share this achievement with all of you.

My incredible husband, Jacob, you have always been my cheerleader and my biggest fan. Thank you for being my rock and my warmth. The goodness in you brings out the best in me. You make me want to achieve my dreams and pursue every passion.

Nicole, you are my person. You knew exactly when to ask how it was going, and when not to ask any questions and just bring coffee with a smile.

Holly, my writing partner, inspiration, and friend; this semicolon is for you.

Thank you to the rest of my extraordinary Family- Wyatt, Tay, Jen, Daley, Zack, Anna, Kalee, Michael, and all others who consistently checked in, baked me things, asked me how I am doing, and asked how to be helpful.

Thank you to my family on both sides who have always shown me incredible love and encouragement.

Christina and Brian, you two showed support and cheered me on the whole way. Thank you for always pumping me up and distracting me with games, as needed.

Hildy, you saw something special in me and were consistently there when I needed someone. I will never be able to thank you enough for the roles you have played in my life that helped get me where I am today. You are an inspiration.

To those at Roanoke Refugee Partnership- your work inspires me every day. How can so many people gather around one cause out of the kindness of their hearts? You all remind me of the incredible force for good that can be created just by stepping up.

Those who served on my committee- Gerard, Laura, Cherie, Laura, and especially Nancy- you knew I could do this, even when I was not certain. Thank you for helping me stay focused and igniting my passion for social justice.

To Brandy, Justin, and Okey, I am beyond grateful for the unending encouragement and support. No one knew what this process was like better than those going through it with me.

Ariann, my Diss Miss- you are another person I am not sure I would be here without. Our Tillerman Tuesdays gave me renewed energy, and your constant support got me through the long days.

Chanelle, you are a true change-maker and an inspiration. Your passion for this work gives me strength and fuels me as we move forward in our counseling journeys.

Thank you, everyone. I am overwhelmed with love and gratitude as I think about how you have changed my life.

“All we have to decide is what to do with the time that is given us.” - J.R.R. Tolkien

Table of Contents

Abstract.....	ii
General Audience Abstract.....	iii
Acknowledgements.....	iv
List of Figures.....	viii
List of Tables	ix
Chapter One: Introduction	1
Research Design	3
Definitions	4
Chapter Two: Literature Review	5
Defining Refugee Status	6
The Journey	6
Country of Origin and Country of Asylum	6
Resettlement in the United States.....	7
The Vetting Process.....	8
Mental Health Screening	10
Trauma Defined.....	11
Adverse Childhood Experiences.....	12
ACEs and Refugee Experiences.....	14
Prevalence of Mental Health Issues.....	15
Counselor Preparation	17
<i>Trauma-informed Counseling</i>	17
<i>Multicultural Counseling Competence (MCC)</i>	19
Relational-Cultural Framework.....	30
Counseling Study.....	32
Chapter Three: Methods	35
Role of the Researcher.....	35
Qualitative Research.....	37
Recruitment.....	38
Participants	39
Interview Method.....	41
Analysis of Data	41
<i>Coding Process</i>	42
Credibility and Trustworthiness	43
Institutional Review Board.....	45
Confidentiality and Data Storage	45
Informed Consent.....	45
Reflexive Journaling and Memoing	46

Chapter Four: Findings	47
Trauma-informed.....	47
Cultural Competence and Humility.....	50
Counselor Determination.....	53
Global Systems.....	53
National Systems.....	53
Local Systems.....	54
Overcoming Systemic Obstacles.....	55
Integration of Self.....	56
Conclusion.....	57
Chapter Five: Discussion	59
Trauma-informed.....	59
Cultural Competence and Humility.....	61
Competencies: Awareness, Knowledge, and Skills.....	62
Cultural Humility.....	63
Connectedness of Cultural Humility, Competence, and Trauma-Informed.....	64
Counselor Determination.....	65
Integration of Self.....	66
Underprepared.....	68
Participant Diversity.....	69
Implications for Counselors.....	69
Implications for Counselor Educators.....	71
Future Research.....	73
Limitations.....	75
Conclusion.....	76
References	78
Appendices	94
Appendix A.....	94
Appendix B.....	96
Appendix C.....	97
Appendix D.....	99
Appendix E.....	100
Appendix F.....	101
Appendix G.....	103
Appendix H.....	105

List of Figures

Figure 1 Stages of the Refugee Vetting Process for the United States9
Figure 2 Effects of ACEs Throughout the Lifespan15

List of Tables

Table 1 ACEs Lasting Effects Categorized	13
Table 2 SAMHSA’s Six Principles of Trauma-Informed Practice.....	18
Table 3 Risk Factors for Refugees Categorized by IS-WEL Factors	27
Table 4 MPM Phases and Skills to Utilize in Each Phase	29
Table 5 Participant Characteristics	40
Table 6 Stages of Coding: Open, Axial, and Selective	42
Table 7 Discussion Factors Integrated into SAMHSA’s Six Principles of Trauma-Informed Practice	60

Chapter One: Introduction

Over 70 million people worldwide are currently unable to return to their homes because of extreme, life-threatening issues such as war, famine, and persecution (United Nation High Commissioner on Refugees [UNHCR], 2019a). This forcible displacement of so many millions of people has aptly been designated The Refugee Crisis, as there has never before been so many people seeking refuge at once (International Rescue Committee, 2019). Many flee their homes and live in various types of temporary living situations, such as refugee camps, waiting to either be able to move back to their countries of origin or for approval to be resettled in another country. Getting resettled in the United States can be a long and arduous process, especially with the current regulations on resettlement becoming increasingly restricted, leaving some refugees waiting decades for admission. A prerequisite to gaining refugee status is proving that staying in the home country would mean death (UNHCR, 2019b).

Upon arrival in the United States, a mental health assessment is completed within the first 90 days, along with many other physical assessments. However, the guidelines for this mental health screening are broad and often result in an unstructured conversation about mental health issues (Shannon, et al., 2012) which could be one of the reasons mental health services is one of the largest unmet needs of refugees (de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009).

A great breadth of information and research regarding refugee mental health has been established which consistently shows high rates of post-traumatic stress disorder (PTSD), anxiety, and depression (Lindert et.al., 2009; Fazel, Wheeler, Danesh, 2005). Much of the research has been focused on trauma as many refugees endure traumatic experiences in their countries of origin, during flight from their homes, and again while in refugee camps awaiting a permanent placement (Bemak & Chung, 2017).

Adjustment is not simple or easy for refugees admitted to the United States and can be a traumatic experience in itself because of the pressures of acculturation and facing the stigma many people have about refugees (Bemak and Chung, 2017). Additional hardship often awaits people of color. Negative rhetoric regarding refugees is prevalent, and many face discrimination due to issues such as race, language, religion, and socioeconomic status (SES) (Ellis, et al., 2010).

There is a well-established need for refugee mental health services, although this is not a standard requirement for resettlement. Counselors who see refugee clients should be multiculturally competent, understanding the many cultural complexities of resettlement. They should also use trauma-informed practices given refugees' many exposures to traumatic stressors throughout their journeys (Bemak & Chung, 2017). Competencies for multiculturally competent counseling have long been established in the counseling field (Sue, Arrendondo, & McDavis, 1992), while the creation of trauma competencies have long been discussed, but have not yet been developed and adopted. The Council for Accreditation of Counseling and Related Educational Programs (CACREP), however, has standards for accredited counselor education programs to ensure counselors-in-training (CITs) receive necessary education in both trauma-informed counseling and multicultural counseling competence (CACREP, 2016). In many states, CACREP accreditation is not required for counseling programs, and so these standards may not apply to certain programs.

Most of the existing research on refugees concentrates solely on the negative experiences of refugees, which is obviously not in alignment with counseling best practices. However, this may change as more research on refugee mental health is published in counseling-specific journals, as counselor identity is rooted in client wellness and strengths-based practices (Mellin,

Hunt, & Nichols, 2011). There is currently little information on refugee mental health in counseling research in comparison to the vast amount across many other fields of study. There are many factors that contribute to positive outcomes from traumatic experiences refugees face, and counselors can use a strengths-based approach to help refugees create schemas that fit refugees' new lives in the U.S. (Chan, Young, & Sharif, 2016).

This dissertation will review literature relevant to refugee mental health and counselor preparation including preparation in trauma-informed and culturally-appropriate practices, and then show the need for the current research study. The purpose of the study was to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. This study is intended to help fill a gap in the literature by giving voice to counselors who see this population and highlighting what these counselors report needing to feel prepared. To meet this goal, the following research question guided the study: How do counselors who work with adult refugee clients reflect on their experiences in preparation for this work?

Research Design

This qualitative study was completed using a phenomenological approach. Licensed or license-eligible counselors who counseled at least three adult refugee clients for three or more sessions were interviewed. A homogenous purposive sample was utilized, as all participants were counselors and worked with refugee populations. Snowball sampling was also used to find additional participants by asking current participants to contact others who qualified for this study. Four participants were interviewed using a semi-structured interview protocol. The interviews were then transcribed, and the researcher identified themes that naturally emerged

across the participants' dialogue. Specific information on the research process is provided in chapter three.

Definitions

ACEs - Acronym for "Adverse Childhood Experiences." Early life events that were potentially traumatic (CDC, 2019c)

Asylum - a form of protection granted to a person by a host country to those seeking refuge (UNHCR, 2019e).

CACREP - Acronym for "The Council for Accreditation of Counseling and Related Educational Programs." CACREP is a major accrediting body for counseling degree programs (CACREP, 2019)

Complex trauma - a cumulative form of trauma experienced by those who have lived through recurrent exposure to traumatic stressors (Courtois, 2008)

Exile - Refugees in exile refers to those who have refugee status but are not yet resettled (Devictor and Do, 2016).

Multicultural Counseling Competence - An ongoing process of learning and refining knowledge, skills, and awareness for working with diverse populations (Sue, Arrendondo, & McDavis, 1992).

Refugee - a person who has been forced from their country of origin for fear of their lives and obtained official refugee status from the United Nations High Commissioner on Refugees (UNHCR, 2019c)

Trauma Informed Care - a paradigm utilized by many practitioners with a focus on empowering the survivor of trauma and understanding their context (Clark, Classen, Fourt, & Shetty, 2014).

Chapter Two: Literature Review

Images of those caught in the Refugee Crisis and seeking asylum have been in the worldwide media because of wars around the world razing cities and tearing countries apart, garnering worldwide attention (Yahya, 2018; Amos, 2018; Qiblawi, Pleitgen, & Otto, 2018). Many do not have homes to which they can return. Recent examples of mass forced migration include the 2017 mass genocide in Myanmar which displaced over one million Rohingya Muslims because of their religion (United Nations, 2019). A civil war broke out in Syria in 2011, which was a fast-growing country at that time. By the end of 2013, repression and violence were the norm and there were over two million Syrian refugees, many of whom were in Lebanon.

About two-thirds of all refugees come from Syria, Afghanistan, South Sudan, Myanmar, and Somalia, respectively (UNHCR, 2018c). Some refugee camps in Kenya hold hundreds of thousands of people because war and famine have driven them out of their homes (UNHCR, 2019d). The number of people unable to return home continues to grow every day, with many not knowing where they can be housed next, or how their basic needs will be met.

This uncertainty and long-term lack of stability during their journeys can greatly affect mental health. Post-traumatic stress disorder, depression, and anxiety are all well-founded in research on refugee mental health, and literature consistently calls for counselors to be adept in two main areas when counseling adult refugee clients: Trauma-informed practices and the importance of cultural considerations, i.e. multicultural counseling competence (MCC) (Bemak and Chung, 2017). These concepts, how they relate directly with refugee mental health, and current standards for counselor preparation in these areas are outlined in this chapter. This sets

the foundation for understanding the importance of studying counselors' views on their own preparation for seeing adult refugee clients.

Defining Refugee Status

There are differences in statuses between immigrants, migrants, asylum-seekers, and refugees, even though these terms are sometimes incorrectly used interchangeably. Immigrants are a broad category of people who make a conscious, unforced decision to move to another country to stay. Migrants are similar to immigrants except they move from place-to-place, often seeking better opportunities. Asylum-seekers are people who are forced to leave their homes due to persecution, violence, or fear for their lives, but they have not been granted refugee status and do not have the protections of that status. Refugees are those who have been forced to leave their homes and have been granted refugee status by the UNHCR or a government (International Rescue Committee, 2019). This proposed study focuses on the latter, people who have refugee status.

The Journey

Country of Origin and Country of Asylum

There are many events in the long journey to safety that could result in trauma, depression, and debilitating grief (Blackwell, 2005). Many refugees have faced horrific experiences such as torture and rape while in their country of origin and while fleeing home (Hollifield, Warner, & Westermeyer, 2011). A staggering number of people die before they leave to find refuge or die getting to safety, meaning many refugees have lost loved ones during their journey. In 2018, there was one death per 51 arrivals traveling by sea to safety in Europe

(UNHCR, 2019e). Most flee for a country of asylum in masses because war and its catastrophic effects have driven them out. In order to be considered for refugee status, a person must meet the criteria set by the UNHCR, which defines a refugee as:

Someone who has been forced to flee his or her country because of persecution, war or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. (UNHCR, 2019c)

When a person officially receives refugee status, they are eligible for the protections and resources of the refugee camp, such as schooling for children, food access, and having basic needs met. Approximately 40% of refugees live in camps, while the other 60% live in cities (often crowded apartments) or makeshift living spaces (UNHCR, 2019d). Refugee camps are often made up of tents and stations for food, water, schooling, and medical care (Médecins Sans Frontières, 1997; UNHCR 2019d). Many refugees live in camps for decades while waiting to be resettled in their new country. If refugees are not living in refugee camps, they still qualify for assistance and international protections while in individual accommodations (Médecins Sans Frontières, 1997). Devictor and Do (2016) used data from the UNHCR database to determine how long refugees in 2015 had been in exile and found the mean to 10.3 years and a median of four years. This median and average help inform many concerned parties, such as researchers, advocates, and policymakers about the existing need.

Resettlement in the United States

Refugees cannot apply to be resettled in a different country. The UNHCR identifies refugees who are most vulnerable and countries decide who to admit (UNHCR, 2019b), and the cap on the number of refugees resettled in the United States is set by the president before the new

fiscal year. Since the Refugee Act of 1980, which first set regulations and allowed a substantial amount of people to be resettled in the United States (Office of Refugee Resettlement, 2012), over 3 million refugees have been resettled in the country (U.S. Department of State Bureau of Population, Refugees, and Migration, 2019), almost 85,000 in the 2016/2017 fiscal year (Zong & Batalova, 2017). The most significant cut to this number came in 2019, when the cap on refugee resettlement in the United States was decreased to 30,000. In 2018, the cap was the lowest it had been since the Refugee Act of 1980 at 45,000 (Wroughton, 2018). This made 2018 the first year the United States did not lead the world in refugee resettlement (Radford & Conner, 2019). For the 2020 fiscal year, the cap has been set at 18,000 (Pompeo, 2019).

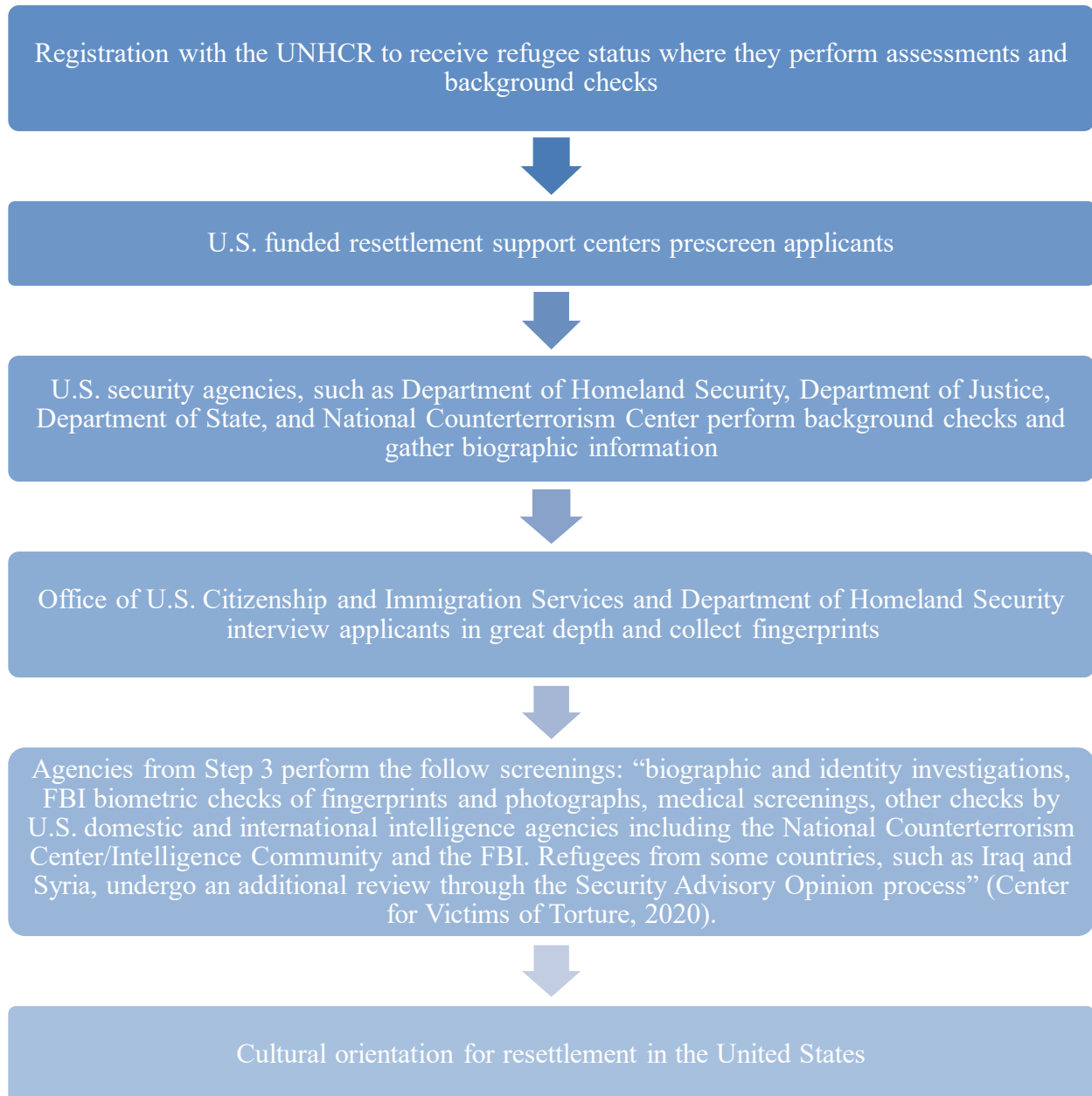
The Vetting Process

When a person or family is selected for resettlement in the United States, their journey may continue after extensive background checks and interviews conducted by the UNHCR, then the United States. Figure 1 (Center for Victims of Torture, 2020) abbreviates the many agencies involved in the vetting process one must go through in order to be resettled in the U.S.

There are many applications, interviews, security, and biometric checks that must take place through these agencies before the applicant is admissible to the U.S. The location of resettlement and the local resettlement agency are determined before refugees arrive. Within 90 days of arrival, the resettlement agency must enroll the children in school, find housing, and enroll the family in Medicaid and other assistance as necessary (National Immigration Forum, 2019). The adult(s) must also either have a job within this timeframe or be fully enrolled in English and cultural training programs. They must also complete a medical screening evaluation, generally through the Department of Health, and also includes a mental health

screening. This is usually the first interaction refugees have with the healthcare system in the United States (CDC, 2019a).

Figure 1
Stages of the Refugee Vetting Process for the United States



Mental Health Screening

Resettlement does not automatically mean life gets easier. The process of being displaced for fear of their lives, traveling to a makeshift living space, and moving to a country with a starkly different culture to try to assimilate is difficult and often fraught with potentially traumatic experiences that can greatly affect mental health long after the resettlement process is complete. Mental health screening for existing issues upon arrival is integral in connecting refugees with needed resources.

Creating a valid screening instrument for mental health issues for refugees has historically been very difficult considering the many cultures, literacy levels, and languages represented. The Refugee Health Screener 15 (RHS-15) (Appendix A) is now one of the main instruments utilized in this process, but before its development in 2012 through the Pathways to Wellness Project, there was no common screener used for mental health issues (Hollifield, et. al., 2012). The RHS-15 is a brief 15-item assessment designed to use simple questions and images to screen for post-traumatic stress disorder, depression, and anxiety. The vision of the Pathways to Wellness Project was three-fold: 1) Provide early mental health screening 2) Build capacity for refugee mental health 3) Design evidence-based, validated tools (Pathways to Wellness, 2011).

Hollifield et al (2012) developed the RHS-15 empirically by combining items from existing screeners for PTSD, depression, and anxiety that have shown transcultural validity. This initial assessment amalgamated of several instruments was then given to refugees at their public health visits. The data gathered were analyzed to select the best items to create the RHS-15. It has been validated across many cultures and languages since its release (Bosson et al. 2017; Hollifield et al, 2016; Kaltenbach, Härdtner, Hermenau, Schauer, & Elbert, 2017).

The RHS-15 or other methods for mental health screening are not specified as part of resettlement. It is unclear how many localities currently use the RHS-15, but it is widely utilized as it is the only valid instrument available to screen this population. Health Departments use screeners as a tool to connect refugees with the appropriate mental health services in the community. Having a common screener for mental health issues is particularly important and helpful for a population that has experienced many traumatic stressors which could result in post-traumatic stress disorder, depression, anxiety, and many other mental health issues.

Trauma Defined

The fifth edition of the Diagnostic and statistical manual of mental disorders (DSM-V), defines trauma as:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (American Psychiatric Association, 2013, p. 456)

Post-traumatic stress disorder (PTSD) is caused by experiencing or witnessing a dangerous or terrifying event (National Institute of Mental Health, 2019) and affects the parts of the brain involved in stress response: the amygdala, hippocampus, prefrontal cortex, mid-anterior cingulate cortex and the right inferior frontal gyrus. These areas in the brain can become hyper- or hypo-reactive to stress following the event(s), causing symptoms such as: hyperreactivity, night terrors, insomnia, hypervigilance, and higher stress responses among many other psychological, physical, and behavioral changes (Morey, Haswell, Hooper & Bellis, 2016).

Traumatic stressors/events affect people differently and can include one event or many. Trauma is not based on the event itself, but how the person experienced it. When there are multiple traumatic stressors that have accumulated over time, it is often referred to as complex trauma. This form of trauma is often seen in those who have experienced war, domestic, and child abuse, where people lived in fear and the stressors were reoccurring. This is also the case with those who have been through different types of traumatic events throughout their lives, which are differentially identified when experienced in childhood (Courtois, 2008). Refugees are at a great risk for complex trauma because of consistent exposure to stressors throughout their journeys (Ryan, Dooley, & Benson, 2008; Miller & Rasmussen, 2010).

Adverse Childhood Experiences

Half of the refugees in the world are children (UNHCR, 2019a) making it necessary to underscore the significance of Adverse Childhood Experiences (ACEs) when considering refugee mental health. Researchers first began looking at ACEs following a study by Vincent Felitti on obesity in 1985. Felitti conducted interviews with those who dropped out of programs despite progressing well, and he noticed a commonality. All dropouts had experienced negative childhood events. Expanding on this, Felitti, along with other researchers from Kaiser-Permanente and the Center for Disease Control began researching the links between adult outcomes and ACEs (Stevens, 2012).

Felitti and others (1998) constructed a survey using previously published surveys in seven different areas of ACEs: psychological abuse, physical abuse, sexual abuse, substance abuse in the home, mother treated violently, and criminal behavior in the household. The ACEs survey was sent to 13,494 adults who had recently gotten a medical examination at a large Health Maintenance Organization, and over 9,500 surveys were returned (70.5%). Researchers

first noticed over half of those who responded to the survey experienced one or more ACEs, and over one-quarter experienced two or more. The data from these surveys were compared to adult health issues in the categories seen in Table 1. Felitti and others found a strong dose-response relationship between ACE scores (the number of ACEs someone has experienced) and many risk factors and health issues. Cumulative effects were also found, meaning the higher the number of ACEs someone has experienced, the greater risk for negative outcomes in multiple categories (Felitti, et al. 1998).

Table 1
ACEs Lasting Effects Categorized

Category	Outcome
Injury	Traumatic Brain Injury Fractures Burns
Mental Health	Depression Anxiety Suicide PTSD
Maternal Health	Unintended pregnancy Pregnancy complications Fetal death
Infectious Disease	HIV STDs
Chronic Disease	Cancer Diabetes
Risky Behaviors	Alcohol and drug abuse Unsafe sex
Opportunities	Education Occupation Income

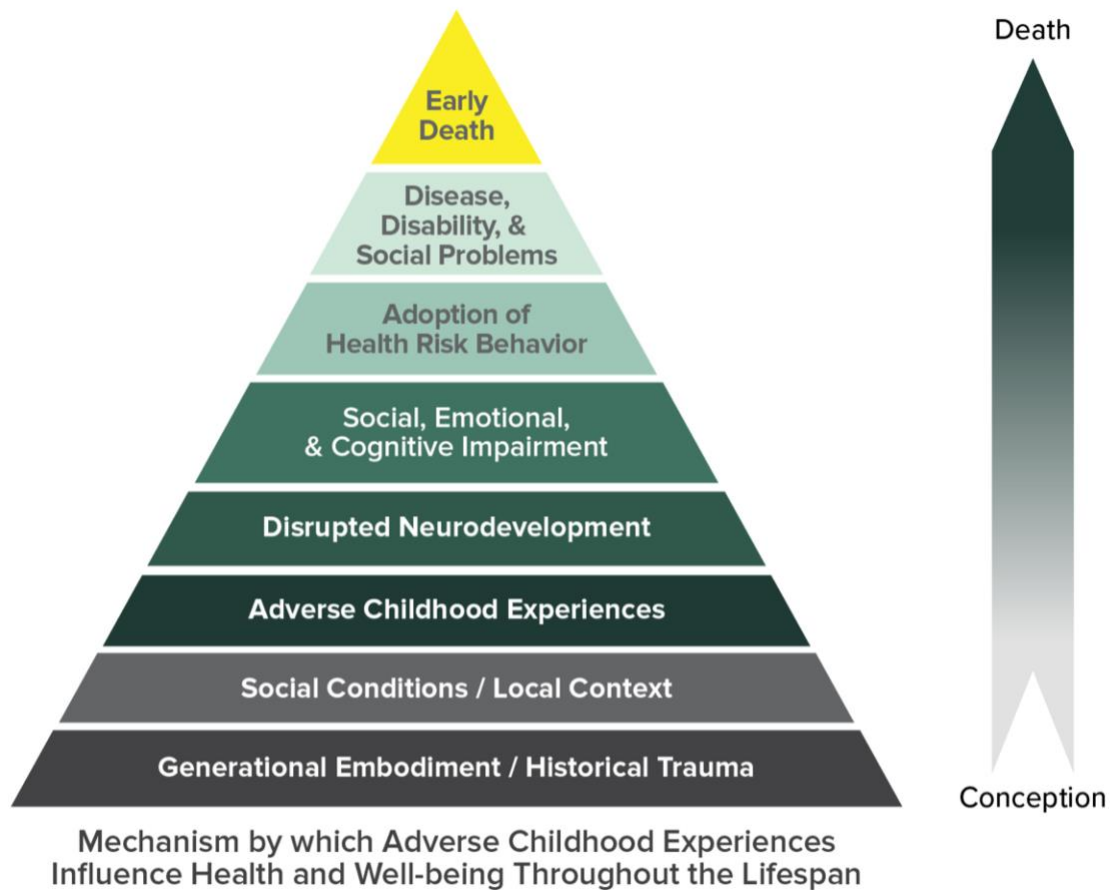
ACEs do not always mean negative outcomes, however. There are factors found to mitigate the effects of childhood exposure to ACEs. Researchers found these protective factors to be “concrete support for basic needs; nurturing parenting skills, stable family relationships, household rules and child monitoring, parental employment, parental education, adequate housing, access to health care and social services, and caring adults outside the family who can serve as role models or mentors” (CDC, 2019b).

ACEs and Refugee Experiences

While the proposed study focuses on adult refugees, ACEs are highly relevant when considering the mental health of this population even though there are no existing studies on ACEs and refugees. Over half of the world’s refugee population are children, meaning many have likely witnessed violence at some point in their journeys. Adult refugee clients’ journeys may have started in childhood or they may have supported children with high ACEs. Figure 2 (CDC, 2019c) shows how trauma experienced early in life may affect a person throughout their lifespan.

Many of the protective factors are difficult, if not impossible, for many refugees to provide their children given their circumstances of consistent instability. Lacking these protective factors put refugees at great risk for negative outcomes, making the full context of ACEs and refugee experiences important for counselors to consider when seeing refugee clients and practicing using a trauma-informed approach.

Figure 2
Effects of ACEs Throughout the Lifespan



Prevalence of Mental Health Issues

Many mental health issues are more prevalent in the refugee population in comparison to other populations due to their circumstances (Porter & Haslam, 2005). Lindert et al. (2009) performed a meta-analysis and systematic literature review to better understand the associations between gross national product (GNP) and the prevalence of depression and anxiety in first generation refugees and labor migrants, respectively. Labor migrants are those who move to another country specifically for work, also known as migrant workers. Researchers reviewed studies published between 1990 and 2007. The meta-analysis showed the mean weighted

prevalence of depression (44%) and anxiety (40%) of refugees to be twice as high as labor migrants (20% and 21%, respectively). Researchers then created subgroups for GNP in the country of origin and compared refugee and labor migrant groups. They found labor migrants moving to a country with a higher GNP show a lower prevalence of depression and anxiety, but there was no change in refugees. A possible implication is that labor migrants move for better opportunities, while refugees' immigration is forced (Lindert et al, 2009).

Fazel, Wheeler, and Danesh (2005) compared diagnoses prevalence in refugee populations to age-matched populations in the host countries through a systematic review which included 6,743 refugees who were resettled in Western countries. Researchers found refugees could be up to ten times more likely to have PTSD than age-matched populations in the United States. Steel (et al., 2009) performed a meta-analysis on the overall prevalence of trauma in refugees and calculated an unadjusted rate of 30.6% in the population.

It is difficult to make assumptions based on meta-analyses and the mean prevalence rate of diagnoses in this population because the mean does not tell the whole story. Meta-analyses of refugee diagnoses aggregate many cultures, places of resettlement, countries of origin, types of assessments for diagnoses, and studies with different statistical measures. Studies rarely acknowledge these many aspects as integral to the understanding of the population, but do acknowledge the large ranges of prevalence. One consistent finding throughout is that refugees are at a higher risk than other populations for mental health issues considering their context of survival. It is unknown how many refugees receive counseling services for these issues, but there are many counseling organizations across the country specific to refugee mental health. It is necessary counselors who see refugees as clients be prepared for that work (Bemak & Chung, 2017).

Counselor Preparation

Counselor preparedness for working with refugees goes beyond the therapeutic work done with many other culturally diverse populations considering their multifaceted and complex circumstances (Bemak, Chung, & Pedersen, 2003). Although there is great diversity within this population, there are unique stressors to the group as a whole given their forced migration, many traumatic stressors, and journeys to safety (Bemak & Chung, 2017; Miller, 1999; Murray, Davidson, & Schweitzer, 2010). Competence working with culturally diverse populations and trauma-informed counseling are both integral for counselors who have refugee clients (Bemak & Chung, 2017). Many counseling programs have integrated trauma-informed work and multicultural competence into their curricula thanks to the growing implementation of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) standards in counselor education programs.

Trauma-informed Counseling

Trauma has been listed throughout the CACREP standards since 2009 and regards the understanding of the impact “trauma-related events” have on clients. This language shifted for the 2016 CACREP standards and outline more specific areas in which counselors should be trauma-informed, and that they should be able to identify trauma in clients (CACREP, 2016). Specific competencies for trauma have not yet been adopted by the counseling field which would outline how to best implement the standards.

The term “trauma-informed” has been rising in popularity in the mental health field. Despite the title, being trauma-informed is different than having training in treating clients with trauma. It is a strengths-based paradigm counselors use when seeing clients that marries the knowledge of trauma with the context of the client. Counselors who are trauma-informed see

their clients are survivors, acknowledge their resilience, and empower them to heal (Clark, Classen, Fourt, & Shetty, 2014). Mental health research often references the Substance Abuse and Mental Health Services Administrations’ (SAMHSA) six principles of a trauma-informed approach (Table 2) which were created in an attempt to have a unified and broadly accepted framework for discussing and treating trauma (SAMHSA, 2014).

Table 2
SAMHSA’s Six Principles of Trauma-Informed Practice

Safety	Foster sense of safety in relationship and in physical space
Trustworthiness and Transparency	Build trust through honesty Being upfront about therapy and relationship
Peer Support	Build support systems Recognize trauma may affect more people in client’s system
Collaboration and Mutuality	Level out the power differences within relationship Include client in decisions
Empowerment, Voice, and Choice	Utilize a wellness and strengths-based approach Recognize power differences, current and historical Promote self-advocacy
Cultural, Historical, and Gender Issues	Consistently recognize stereotypes and biases Incorporate cultural healing practices - client to lead and share Broach historical trauma

Counselors seeing refugees should use a trauma-informed approach because refugees face potentially traumatic situations at many points in their journeys to asylum. Traumatic events that occur even before the migration process begins affects how well refugees resettle, postmigration (Bemak & Chung, 2014). Each stage of a refugees’ journey is fraught with events that could potentially lead to post-traumatic stress. A prerequisite to gaining refugee status is proof that staying in the home country would likely mean death, and fear of death in itself can be a traumatic experience (UNHCR, 2019c). In the flight process, refugees first experience the

trauma of leaving behind everything they know because they are running for their lives and the lives of their loved ones. They are exposed to potentially traumatic experiences in refugee camps or in exile, then many different stressors during their resettlement.

For refugees who are admitted to the United States for resettlement, adjustment is not simple or easy and can be a traumatic experience in itself (Bemak & Chung, 2017). Many stressors could lead to compounding traumatic experiences during the resettlement phase when refugees are becoming accustomed to the starkly different culture of the United States. Hence, trauma and cultural issues are inextricably intertwined for this population.

Multicultural Counseling Competence (MCC)

The need for both trauma-informed care and multicultural competence when working with the refugee population is well established in many fields, including medical (Crosby, 2013), psychiatry (Nickerson, et al., 2014), and social work (Ostrander, Melville, & Berthold, 2017). Practicing through a lens of multicultural competence has been an initiative of the counseling field for decades and continues to evolve. Diversity and multicultural competence have been interwoven into The American Counselors Association (ACA) code of ethics which states “Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process” (ACA, 2014, p. 4).

The movement for diverse perspectives throughout the field was first set in motion in 1991 by the Association of Multicultural Counseling and Development. The counseling field had nothing in place to ensure counselors were getting the education they needed to be multiculturally competent. Counseling standards were soon created by the ACA (then, the American Association for Counseling and Development) to make multiculturalism a

foundational part of counselor training and necessary for accreditation (Sue, Arrendondo, & McDavis, 1992). Building further on these standards in 1992, multicultural counseling competencies were created and adopted, which specify how culturally competent counselors operate. These competencies break down multicultural counseling competence (MCC) into three categories: “awareness” is comprised of personal biases, privilege, and culture; “knowledge” is the understanding of others’ cultures; and “skills” encompasses the specific techniques used for diverse populations (Sue, Arrendondo, & McDavis, 1992). These categories for MCC apply well to seeing refugee clients and are outlined here with the addition of cultural humility.

Cultural Humility and Awareness. Counselor awareness in the context of MCC refers to the awareness and acknowledgment of the privileges and marginalization of self, of clients, and how those interact with each other. This acknowledgement requires counselors to be open to exploring their own worldviews and biases as well as the openness to exploring clients’ worldviews as well. Barden, Sharrell, and Matthews (2017) found that counselors feel more efficacious in their Awareness than they do in Knowledge and Skills. This study replicated a landmark 1999 study by Holcomb-McCoy and Myers which measured professional counselors’ self-perceived multicultural competence and found counselors did not feel prepared to see a diverse group of clients. Barden, Sherrell, and Matthews wanted to find counselors’ self-perceptions of multicultural competence over 15 years later.

The same assessment tool from the 1999 study was used, the *Multicultural Counseling Competence and Training Survey* (MCCTS), to collect data. This is a self-report survey containing 32 statements categorically assessing Knowledge, Awareness, and Skills. Researchers combined Knowledge and Skills as these two were found to measure the same factors. Participants (N=171) ranked themselves on a four-point Likert scale ranging from “not

competent” to “extremely competent.” Researchers found the overall perceived multicultural competence was between “somewhat competent” and “competent.” Counselors rated themselves higher in Awareness than Knowledge/Skills. This indicates counselors feel more efficacious about their own views of the world and less so about working with clients’ of diverse cultural backgrounds (Barden, Sharrell, Matthews, 2017).

It is important to note that many instruments used to measure MCC are self-report which could be quite different than actual awareness, knowledge, and skills of the counselor. An MCC self-report measure is relevant in showing how counselors feel about themselves, but could show inflated competence in comparison to their actual competence. Cartwright, Daniels, and Zhang (2008) compared actual competence to self-perceived competence in a group of counselor education students. Researchers had students complete a self-report survey on Knowledge, Skills, and Awareness (the MAKSS-CE-R), then submit a role-play video displaying their skills in MCC. Independent observers assessed these role-plays then compared these scores to the MAKSS-CE-R results. The mean self-report scores were significantly higher than the independent observer scores in all three areas of Awareness (55.87 vs. 32.56), Knowledge (49.63 vs. 29.22), and Skills (43.80 vs. 33.22), meaning students felt they were more multiculturally competent than independent observers. MCC self-report measures are not accurate assessments of actual MCC, but do offer insight by showing how counselors feel about their own work. Counselors feeling they are more competent in their own worldviews, but not feeling competent working with people from diverse backgrounds begs the question of what is missing.

When taken into context of counseling the refugee population, this may be especially relevant since refugees are resettled in the United States from all over the world. Having knowledge of every culture of every country of origin would be impossible, but also may be of

little relevance since refugees often have an amalgamation of many cultures and learn different languages in refugee camps. This highlights the salience of cultural humility, which refers to the “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client” (Hook, Davis, Owen & DeBlaere, 2017). Cultural humility diminishes the need for counselors to be completely competent in every culture or mixes of cultures that may be addressed with refugee clients. It marries Awareness, Knowledge, and Skills together well because it is a person-centered lens that calls for open discussion about culture as a relevant and consistent part of the client’s worldview. An important component of cultural humility is the counselor acknowledging their own privileges and blind spots which is done by gaining awareness of self. It requires the acceptance that one cannot know everything about a person and their many dimensions.

Counselors who are culturally humble are aware of their own identities and are open to the many cultural aspects of the other by openly discussing culture. It is important for counselors to broach this as it could affect the relationship and outcome. Owen and colleagues (2016) had clients (N=247) rate their counselors’ cultural humility, missed opportunities to discuss culture, and had them report their overall counseling outcomes. Researchers found an inverse relationship between missed opportunities for discussion about the client’s culture and client outcomes. That is, the more opportunities the counselor missed to broach culture and discuss with the client, the worse the reported outcomes by clients. Hook and colleagues (2016) surveyed over 2,000 racial/ethnic minority participants about microaggressions committed by their counselors, which includes avoidance of discussion concerning culture. Counselors who participants perceived as culturally humble tended to commit fewer microaggressions and participants reported better counseling outcomes associated with those counselors (Hook et al,

2016). Broaching cultural differences through cultural humility while also being strong in Awareness are critical components of MCC and leads to a stronger therapeutic alliance (Day-Vines et al., 2007).

Knowledge. It is critical that counselors understand the specialized needs, risk factors, and barriers to services refugees face. It is important to note MCC does not only include ethnicity and race, but the many different aspects that make up a whole person. There are many dimensions relevant to resettled refugees as a whole population, such as socioeconomic status (SES), religion, gender identity, and oppression. Counselors should have some understanding of the common hurdles and struggles refugees face (Bemak & Chung, 2017). Villalba (2009) suggests education on refugee issues and considerations for counselors be a standard part of counselor training because of the complex nature of their trauma and barriers they experience. In studies where students worked with refugee clients, their overall MCC increased (Kuo & Arcuri, 2014; Nilsson, Schale, & Khamphakdy-Brown, 2011). While counselors cannot fully understand all the complexities of the many cultures refugees represent, they should have a baseline knowledge of common experiences such as those indicated below (Bemak & Chung, 2017).

Discrimination. In the United States, hate crimes reached a 16-year high in 2018, according to the Federal Bureau of Investigation hate crime statistics. Crimes against Muslims rose 78% from 2014 to 2015 (Federal Bureau of Investigation, 2015), then another 56% in 2016 (Federal Bureau of Investigation, 2016). Negative rhetoric regarding Muslims became so prevalent in 2016, The United Nations urged the world not to automatically label refugees as terrorists, which refers to predominant stereotyping and labeling of Muslims as “radical Islamic terrorists.” Islam makes up the largest religion among current incoming refugee populations to

the United States, but the ratio of Muslim refugees to other religions admitted into the country decreased sharply in 2017 (Kishi, 2017).

Discrimination against refugees has been perpetuated in recent years, most visibly so with the 2016 Presidential Election cycle when then-candidate Donald Trump spoke out against refugees, saying “We have no idea who these people are, we are the worst when it comes to paperwork... This could be one of the great Trojan horses” and “We cannot let them into this country, period... If I win, they’re going back” (Trump, 2015). Even so, there have been no acts of terror committed by people of refugee status in the United States (Nowrasteh, 2016), and those who have committed serious crimes are not eligible for refugee status through the UNHCR from the beginning of the process (UNHCR, 1979, pp. 24-27, Section B.3).

Socioeconomic Status. Refugees arrive in the United States with very little even if they had much back home. Because of this, they start out living on government benefits (Office of the Assistant Secretary for Planning and Evaluation, 2012) and often live in poor communities. It is often the case refugees have jobs and degrees that no longer qualify them for the same positions in the U.S. which could explain why high SES and education in the country of origin are indicative of poor mental health in the country of resettlement (Porter & Haslam, 2005). Refugees, even from affluent backgrounds, often have to start over. Many start out at a deficit, as the U.S. is one of two countries that require refugees pay back transportation costs, such as plane tickets (International Organization for Migration, 2019; Wescott, 2015).

Understanding the culture of living in poverty in the United States is important for working with this population and is also a piece of multicultural competence. When people live in poverty, the issues they bring into the counseling office are likely to be near the bottom of Maslow’s Hierarchy of Needs (Maslow, 1968), struggling to meet physiological and safety

needs. Counseling students who believe poverty is the fault of the individual score low in MCC and high in color-blind racial attitudes (Bray and Balkin, 2013). Clark, Moe, and Hayes (2017) studied the relationship between MCC and poverty beliefs. They found the higher the MCC, the lower the biases about structural and individualist poverty.

Cultural Understanding of Counseling. Currently, there is no counseling or mental health education provided as a mandatory part of the resettlement process. When refugees make it to a counselor, it could be the first time they have heard of trauma and depression due to a cultural divide in the understanding and communication of such issues. This could explain why many refugees say they do not know the purpose of counseling (Bemak, Chung, & Pedersen, 2003). Mental health issues and counseling may look drastically different in other cultures. Some may only speak to family members or religious leaders about mental health issues. Having no previous knowledge of counseling before entering a counseling office creates one of the many cultural barriers to counseling services for this population (Bemak and Chung, 2017). Counselors' roles in helping clients navigate the purpose of this process is not isolated to the informed consent. Thorough explanation may be needed as well as check-ins regarding purpose of services.

Cultural idioms of distress (CID) also play a major role in treating refugee clients. CID are common phrases and indicators clients use to convey mental health issues based on their cultural understanding of the problem. A very common CID is "thinking too much" for ruminations and anxiety (Kaiser, et al., 2015). Some cultures may not have words for mental health issues as it may not be discussed. It is often the case refugees discuss mental health issues as their physical symptoms such as headaches, stomach aches, and other body pain (Bemak,

Chung, & Pedersen, 2003). Cultural concepts of distress was added to the DSM in the fifth edition to aid mental health providers in making these links.

Acculturation. It is important to understand the cultural identity issues caused by the expectations of acculturation. Shedding pieces of cultural identity and adopting the norms of the majority group is a pressure faced by those emigrating to the United States. This process comes with many benefits such as being less likely to be discriminated against because the person does not seem like an outsider once the majority norms have been accepted by the refugee (Berry, 1997). However, this often leads to alienation by their own communities (Bartlett, Mendenhall, & Ghaffar-Kucher, 2017). Acceptance by one community could mean ostracism by another.

Many refugees are from collectivist cultures where the norms are often much different than the individualistic culture of the United States. This must be taken into consideration by counselors working with adult refugees (Bemak & Chung, 2017). Acculturation of children can lead to contention within families that hold collectivist values. Some parents feel resistant to assimilating and do not want their children to lose parts of their culture (Wong, et al., 2011; Renzaho, Dhingra, & Georgou, 2017).

Skills. The Skills category of MCC is specifically how to practice counseling in a multiculturally competent way, and it is important that counselors are familiar with the relevant research regarding the population they are seeing (Sue, Arrendondo, & McDavis, 1992). Many counseling skills are applicable to counseling adult refugees, but this section focuses on skills relevant to counseling refugees, specifically, established in existing literature.

Wellness and Empowerment. Much of the research regarding refugee mental health focuses solely on limitations, barriers, and issues. Many counselors see counselor identity as rooted in wellness and empowering clients (Mellin, Hunt, & Nichols, 2011), making it important

to see clients through this lens. Blount and Acquaye (2017) focused specifically on refugee wellness in counseling by showing ways of supporting wellness using the Indivisible Self Model of Wellness (IS-Wel) created by Myers & Sweeney (2005). Blount and Acquaye created an approach using the five factors from the IS-Wel (Table 3) to show risk factors in each category specific to refugee issues.

Table 3
Risk Factors for Refugees Categorized by IS-WEL Factors

	Risk Factors
Coping Self	Drugs and alcohol PTSD
Physical Self	Unsafe water Lack of nutrition
Essential Self	Acculturation issues Stereotyping and microaggressions Barriers to self-care
Social Self	Limited access to family planning services Issues building support system
Creative Self	Barriers to employment Loss of control of life

Blount and Acquaye suggest counselors who see refugee clients use this model to understand some of the risk factors, but also use the IS-Wel to build a wellness plan with refugee clients. Other suggestions by the researchers are to collaborate with other professionals and diverse communities, promote healthy lifestyles while taking barriers into consideration, and teach health literacy. Counselors must build trust, instill hope, be respectfully curious, and help build support systems to empower clients (Blount and Acquaye, 2017).

Building a support system is critical for newly resettled refugees as isolation in their new environment could lead to hopelessness (Yako & Biswas, 2014). Connections to resources are

important, but reducing isolation and connecting to others to find a sense of belonging is critical to empowerment. The Center for Torture and Trauma Survivors created the Clubhouse Model specifically for this reason with a broader goal of community healing. This model works through a peer-led system that develops into an advocacy club or organization. Members lean on each other for support and also reach out to advocate for their community. Evaluations from this model show that programs are working well in decreasing isolation and helping members become better acclimated (Block, et al, 2018).

Modalities. The refugee population includes many different cultures, making it difficult to culturally validate instruments, assessments and methodologies for treatment (Murray, Davidson & Schweitzer, 2010). This lends itself to therapists using many different paradigms to treat the population. Literature reviews and meta-analyses show that many different treatments are helpful in treating symptoms of trauma and depression in refugee clients. Slobodin and Jong (2014) reviewed studies that had quantitative measures for evaluating efficacy of mental health treatment. They found many types of interventions were effective with participants reporting positive outcomes. Slobodin and Jong also stated the need for more “guiding frameworks” for working with this population. Many meta-analyses and literature reviews on mental health treatments, such as the Slobodin and Jong study, promote cognitive behavioral therapy because it produces measurable results. The limiting factor in many studies regarding treatment efficacy is the lack of data from many types of therapy, making these difficult to study and compare (Slobodin and Jong, 2014).

Research in this area also tends to focus on one type of treatment modality at a time, but given the extensive needs of the population upon resettlement, a more integrative approach may be most helpful. Mixing modalities allows counselors to flex to the personal needs of the client

while staying in the context of working with refugees (Bemak & Chung, 2017; Kira, 2015; Miller, 1999; Mitschke, et al. 2017). This is especially true when considering newly resettled refugees start out very low on the Hierarchy of Needs, struggling to have basic needs met (Lonn & Dantzler, 2017).

In counseling-specific literature, a commonly cited integrative approach was created by Bemak & Chung (2017). The Multiphase Model (MPM; the 2003 iteration is the Multilevel Model) considers all aspects of migration as well as stressors of resettlement through a lens of MCC. Bemak and Chung underscore the importance of counselors understanding the trauma of the refugee journey, resettlement, and cultural stressors before implementing this model. The MPM outlines five phases for counselors to follow with skills needed to implement and are abbreviated in *Table 4*.

Table 4
MPM Phases and Skills to Utilize in Each Phase

MPM Phase	Skills to Utilize
Mental Health Education	Explain counseling process and expectations involved
Individual, Group, and/or Family Psychotherapy	Consider verbal and nonverbal interactions through a cross-cultural lens Know the links between somatic/physical symptoms and mental health issues Be able to integrate other methodologies such as CBT, storytelling, imagery, and narrative therapy Consider sociopolitical background of clients Integrate groups and family to adhere to possible collectivistic cultural backgrounds
Cultural Empowerment	Include some case management to meet immediate needs Empower clients to advocate for selves to meet needs and also in cases of racism and discrimination
Indigenous Healing	Incorporate healing processes from home country that could be helpful to clients
Social Justice and Human Rights (not an isolated phase)	Advocate for clients Educate clients on rights Write legislators Educate colleagues on inequalities

Working with Interpreters. Language is one of the biggest barriers refugees must overcome to acclimate successfully in the United States (Bemak & Chung, 2017). It is important to find a professional interpreter, preferably one who has experience in mental health interpretation, which can be particularly difficult. An often overlooked skill on which many counselors are not trained is how to work with an interpreter. There is an etiquette to this, such as only speaking to the client, not telling the interpreter what to say to the client, and speaking in segments to allow the interpreter to interpret what the counselor has said to the client. Blackwell (2005) suggests speaking to the interpreter before and after the session to state the goals and clear up any issues. Hesitance to ask open questions and clarify misunderstandings due to having an interpreter is common, and could be barriers to building rapport (Westlake & Jones, 2018). Gartley and Due (2017) interviewed mental health service providers regarding interpretation and found there is a gap in training people to work with interpreters and that interpreters become a part of the therapeutic alliance. Overall, working with interpreters can be very beneficial for the relationship, as the interpreter likely understands the implications and cultural background of the client and can help the counselor (Blackwell, 2005).

Relational-Cultural Framework

Relational-Cultural Theory (RCT) was created and developed by Dr. Jean Baker Miller, Judith V. Jordan, Janet Surrey, and Irene Stiver and is grounded in feminism. Miller's book, "Toward a New Psychology of Women" was first published in 1976 and became the seminal writing that would evolve into RCT over the next decade in response to psychodynamic theory. (Jordan, 2017). RCT is not techniques-driven in practice, but a framework for interaction and conceptualization of others rooted in connection rather than individualism. The core belief is that people are driven toward connection with others and desire acceptance in these relationships

(Miller, 1986). This creates the goal of the RCT therapeutic process of creating and keeping “Mutually-Growth-Fostering Relationships” with mutual empathy. Every phase of flight for asylum-seekers regards connections and disconnections of relationships and increased possibility of experiencing trauma. Leaving others behind, becoming a part of new communities, and the choice to integrate are all pieces of the journey. Many refugees come from collectivist cultures to the United States, where individualism is valued. RCT addresses trauma in relational terms through Relational Resilience which is created through helping clients shift their paradigm and find hope. Reframing and creating meaning from past experiences promotes post-traumatic growth (Jordan, 2010).

RCT is helpful for working with many populations (Aguilar, 2010; Duffey & Haberstroh, 2014; Singh & Moss, 2016). It integrates multicultural competence with growth-fostering connections to others, which is a foundational part of trauma-informed practices (Kress, Haiyasoso, Zoldan, Headley, & Trepal, 2018). The main tenets of RCT make this a fitting lens for studying counselor preparation in these areas. Understanding culture and being open to learning more from the client is foundational in RCT. Miller developed this theory because of the inequality of perspectives in the mental health field, and it was originally a feminist premise (Jordan, 2010). As RCT continued to evolve, it became applicable to many underrepresented and diverse populations of clients. Those who are trained in RCT are educated to see through a culturally competent and humble lens. Each client is different and should be seen in a holistic way (Jordan, Hartling, & Walker, 2004).

Pathologizing clients is unfavorable in RCT because context is taken into full consideration as part of MCC (Duffey & Somody, 2011). This is especially important with refugee populations because each person who is resettled in the United States experiences the

trauma of displacement in a unique way. Their cultural backgrounds vary greatly, as do their complex journeys, and individual capacities for resilience. By approaching every client holistically, as is part of cultural humility, MCC, and RCT, counselors foster an environment of growing and mutual learning. This framework is helpful in conceptualizing this proposed research as the core tenets overlap the needs of refugees outlined in the research literature.

Counseling Study

Isawi (2016) conducted a dissertation study addressing the self-efficacy of mental health clinicians who were counseling traumatized asylum-seekers and refugees. This quantitative study explores ways self-efficacy is related to these professionals' perceptions of their own training in trauma, length of experience, caseload of traumatized clients, and secondary traumatic stress. Isawi also studied this relationship while controlling for mental health professionals' perceptions of their own secondary trauma. The following research questions were posed:

1. How are perceptions of trauma training, experience, percentage of traumatized clients, and secondary traumatic stress related to counselor self-efficacy among mental health professionals who work with refugee and asylum-seeking clients who have experienced trauma?
2. How are perceptions of trauma training, experience, and percentage of traumatized clients related to counselor self-efficacy after controlling for secondary traumatic stress?

The survey used by Isawi was created using the Secondary Traumatic Stress Scale (STSS) and the Counseling Self-Estimate Inventory (COSE), which measures self-efficacy. Demographic data, including licensure and training in the treatment of trauma, were also obtained. The inclusion criteria consisted of mental health professionals from the fields of psychiatry, social work, counseling, and psychology who work with refugees and asylum-seekers

who have experienced trauma. Isawi recruited participants by contacting agencies in the United States who specialize in refugee issues. The survey instrument was digitally sent to this purposefully chosen sample of professionals and 98 people who met the criteria completed it (Isawi, 2016). These professionals were marriage and family therapists (n=5), social workers (n=44), counselors (n=26), and psychologists (n=22).

Isawi utilized a correlational research design to find relationships between self-efficacy and the independent variables of trauma training perceptions, length of experience, caseload of traumatized clients, and secondary traumatic stress. A standard multiple regression was conducted to examine these relationships. Isawi then conducted a hierarchical multiple regression to control for the variance caused by secondary stress (Isawi, 2016).

Isawi found a positive correlation between affirmative perceptions of their own trauma training and self-efficacy when working with traumatized refugee populations. Many of these mental health professionals (40.8%) did not take any trauma-related courses in their master's or doctoral education, but the majority attended workshops about trauma post-master's degree with 53.1% attending more than five. The more experiences counselors had with refugee clients, the higher their self-efficacy. The results suggest mental health professionals working with refugees feel efficacious in their work and the more trauma training they have, the more efficacious they feel. Counselor self-efficacy and secondary traumatic stress were negatively correlated, indicating counselors with higher levels of secondary traumatic stress feel less efficacious (Isawi, 2016). A limitation of this study was the small sample size. The target sample size for this study was 200, but 98 participants completed the survey. The effect size of this study was not listed, and the small sample size could call generalizability into question.

This study focused only on the self-efficacy of mental health clinicians working with clients who experienced trauma but did not specifically include multicultural competence. MCC should also be taken into consideration as a part of assessing perceptions of effectiveness when working with this population. It is unknown whether counselors who have not worked with refugees feel they would be effective with the population. Many of the participants did not have training in their master's programs regarding trauma, and self-efficacy was higher for those with more experience working with refugees. These two factors taken into consideration together could mean there needs to be more training about trauma, in general, at the master's level and more experience working with diverse populations to better serve clients.

The proposed study is not a study of efficacy, but qualitatively explores counselors' own experiences and training to better understand the most salient pieces related to the treatment of adult refugee clients. There is a large amount of research regarding refugee mental health, but not much published about the refugees in counseling-specific journals. This is important because counselors hold a unique view of issues and have their own professional identity. Many counseling articles focus on mental health issues of the population and modalities of treatment, but very few focus on counselors providing the treatment. It is also the case that very little research focuses on mental health.

Chapter Three: Methods

The purpose of this qualitative study was to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. This chapter establishes and describes the methods used for this research study in order to answer the following question: How do counselors who work with adult refugee clients reflect on their experiences in preparation for this work?

Role of the Researcher

Being a sole researcher means one must have their own checks and balances, making it critical for the researcher to understand their own biases and where these are from. Enhancing self-awareness via thorough analysis of my own relationship to the research topic helps identify blind spots from the beginning of the research process. It is important I understand myself as a multicultural being and be aware of the lens through which I see the world and the research topic (Creswell & Poth, 2018).

The majority of my clinical work as a counselor has been with underserved populations, such as adults and adolescents in poverty. I have a strong counselor identity and work to resolve social injustices through any avenue I am able. When working as a counselor, I became more involved in my local community and organizations that are also social justice oriented. It was then I learned of the difficulties of our local refugee population, many of whom live in poverty. Funding of the local resettlement agency was being cut which would lead to even fewer services being offered. Myself and three others began building partnerships with local organizations to understand the problems going unresolved. We met with many refugee families who expressed great interest in more services as they worked toward self-sufficiency. The more we discussed this with others, the more we realized people wanted to volunteer, but there was no

conduit between volunteers and a community in need. We established a nonprofit to help bridge this gap.

Through my nonprofit work, I have heard many stories from counselors and other mental health practitioners who wish they had been better prepared to work with the population. I have also heard feedback from refugees and former refugees that spans from very positive experiences to discrimination from community organizations. There are agencies who have denied services to refugees due to the language barrier and the cost of interpreters in time, energy, and money. I have heard many stories from refugee families about the trauma and loss they have experienced, as well as the frustration with barriers to services. I saw the need for culturally competent and trauma-informed counselors before I knew it was established in research.

These stories have informed my research interests and have consistently highlighted biases I must keep in check as a researcher. I believe counselors must be culturally competent, trauma-informed, and strengths-based in order to be effective given how dynamic refugee populations are. I believe counselors hold a specific identity, grounded in the wellness and empowerment of clients (Mellin, Hunt, & Nichols, 2011) and should consistently reflect on their work to refine their skills. I am also aware of biases I hold regarding national and local systems that affect change negatively for refugee communities, strategically building and keeping barriers in place.

Another salient piece of this discussion is that I grew up in poverty and experienced many barriers to education and meeting basic needs. This was a major factor in shaping my drive toward social justice and how I view those in poverty. My empathy for those who struggle runs deep and pushes me to fully understand issues, then work toward solutions. I recognize this

background could also increase the bias I hold as a researcher because I see parts of myself in what I study.

It is important I acknowledge my privileges, and I believe it is important for others to do the same. As a white woman who grew up in a culturally homogenous locality, I recognize I am discussing a vulnerable population to which I do not belong. I approach this subject in every discussion from a place of humility, checking biases I may hold to prevent them from being a detriment to the study. It is integral to the validity of the qualitative research that the researcher be transparent about what biases exist, but also how to mitigate these. If the biases of the researcher are not explored and mitigated, it will be the voice of the researcher that comes through instead of participants' voices. I intend to continue this research with an ongoing process of checking my biases through measures outlined under "Credibility and Trustworthiness."

Qualitative Research

"That which is subtle becomes obvious when we look through the eyes of the qualitative researcher. The invisible becomes visible. Veneers of phenomenological representation are removed so that we may become acquainted with subjective understanding of the meaning of human interactions" (Constas, 1992).

Qualitative research will be the best method to answer the questions left open by the gaps in research, as it allows for a more in-depth understanding of issues. Qualitative research is difficult to define because it has many meanings and is represented in many different ways depending on the circumstances (Creswell & Poth, 2018; Merriam & Tisdell, 2016). It is a broad category of research housing many methods of inquiry which do not necessarily require measurement, making this ideal for the proposed study. Van Maanen (1979) described

qualitative research by stating it is made up of techniques that “come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world” (p. 520).

The qualitative methodology that fits well for understanding counselors’ experiences in preparation to see adult refugees is phenomenological research which seeks out meaning that is common among the participants to understand how they perceive their own experiences. The purpose is to understand the nature of the phenomenon through the eyes of those who have lived it (Creswell & Poth, 2018). Counselors participating in this study will reflect on their experiences of preparation through their own lenses. While information exists about recommendations for counselors working with refugees, there is no research which elicits the counselors’ views on their own preparation. A phenomenological approach allows the participants’ voices to be heard, which also aligns with the Relational-Cultural lens through which I conduct research. RCT and phenomenological research both require me to approach others’ stories to learn and not to project assumptions based on my own biases.

Recruitment

My involvement with many organizations who work with refugees in the local community and connections within the mental health community opened up many avenues for connecting with potential participants. Helping lead a nonprofit for local refugee populations has given me opportunities to create partnerships with organizations that have similar goals such as local counseling agencies who see refugees, the local resettlement agency, the Virginia director for resettlement for a national resettlement organization, counseling associations in Virginia, and the local social services office. I reached out to many contacts via email (Appendix B) which introduced me and outlined the purpose and benefit of the research. This email also included a

survey link for those in this pool interested in participation. The online survey and demographic questionnaire (Appendix C) asked qualifying questions to determine eligibility and capture demographic information. Those who were interested and eligible were then contacted to schedule a time for the online interview. Many of those who emailed or called back were directors or management positions who forwarded the study information to their employees.

Participants

The purpose of this study was to get a better understanding of counselors' experiences, both personal and educational, they feel best helped prepare them to see adult refugee clients. Purposive homogeneous sampling was utilized, as I identified and contacted a specific population to be interviewed for this study (Bernard, 2002). Snowball sampling was also leveraged by sending a follow-up email to participants (Appendix D) which allowed me to reach more counselors and increase the possibility of having a diverse sample (Atkinson & Flint, 2001).

I reached out to licensed and license-eligible counselors who work or previously worked with adult refugee clients to find participants (see "Recruitment Plan"). Other mental health providers were considered, but ultimately counselors have a specific wellness-focused identity and specific criteria for education. Other mental health clinicians may provide services differently than counselors. The wellness and strengths-based focus counselors bring as part of their identities is important for refugee clients. Requisites also included working with at least three refugees for three sessions each as this meant they had multiple experiences with the population from which they can draw in the interview process. Having a minimum number of refugee clients also helped ensure counselors are not using the experience of one refugee to extend to multiple people.

I contacted many qualified individuals across the country based on mutual connections and recommendations. All four resulting participants were licensed professional counselors in the state of Virginia and represent a wide variety of work settings and experiences with adult refugee clients. They are also ethnically different from one another and have a significant range of educational backgrounds as represented in Table 5 below. Two participants shared that their parents were immigrants, one was an immigrant herself, and three of the four participants spoke at least two languages, including English. Six people completed the initial qualifying questionnaire, and four of the six were interviewed. Of those not interviewed, one was an LMFT and one person dropped out of the process due to personal issues.

Table 5
Participant Characteristics

Participant	Age	Sex	Race/ Ethnicity	Work Setting	Counseling Degree and year	Training hours specific to refugee populations	Approx # of refugee clients > three sessions	Refugee populations counseled	Interview length in minutes
Theresa	63	F	Mexican- American	Non-profit	Masters, 2000	10	25	Central America, Mexico, Sudan	35
Sara	28	F	Lebanese	Private practice, Community Services Board	Masters, 2016	4	3	Algeria, Iraq, Syria	46
Luís	47	M	Multi-race, Hispanic	Community- based qualified health center	Masters, 2007	40	100	Many African countries, Asia, Middle East, and Central America	58
Mia	32	F	White, Caucasian	Private practice	Masters, 2014	0	30	Many African countries, Afghanistan	42

Interview Method

In-person interviews are my preferred way of interviewing participants in order to navigate body language and establish rapport. However, due to the current epidemic, social distancing guidelines are in place which restricted in-person meetings for health and safety purposes. Video conferences were utilized instead via password-protected Zoom Video Conferencing. This version of Zoom is compliant with Health Insurance Portability and Accountability Act (HIPAA) standards. Interviews were video and audio recorded for later analysis. When interviews began, I gave participants the informed consent form, discussed, and requested they give verbal consent to participation.

An interview protocol (Appendix E) was used to provide a structure and ensure consistency across interviews (Turner III, 2010). The interviews were semi-structured, so I was able to follow up to provoke elaboration and clarification on questions when necessary. I asked counselors to first draw on experiences counseling adult refugees, focusing on their own process instead of clients' experiences. This helped ground participants to internal focus (their own experiences) versus external (experiences of refugees). The interviews then shifted to counselors' thoughts and feelings about their preparation, development, and training.

After the interview concluded, I made sure participants had my contact information and the contact information for my dissertation chair for further inquiry. None of the participants asked to follow-up or asked to review their transcript.

Analysis of Data

The video and audio recordings of interviews were uploaded to my personal computer, and I had these transcribed through TranscribeMe, a service approved by my university that

guarantees confidentiality is maintained. I verified transcripts by listening to the audio recordings of the interviews and reading simultaneously. Before coding, I read through each transcript several times to understand context and refamiliarize myself with the interview. The interview transcripts are considered data for this study and were analyzed for salient themes using open, axial, and selective coding. See Table 6 (Corbin & Strauss, 1998). This coding process is common in Grounded Theory Methodology. However, I chose it for this study because it allows the researcher to look back at every step in the process. Each stage of coding builds on the last, leaving a blueprint for emergent themes. Because I am close to this subject matter in many ways, I found this particular coding method to be helpful in mitigating my own biases. I was able to look back through the information in stages to see how I came to conclusions. It was important to take every step I could to reduce my biases and highlight the common experiences of my participants to create a credible and trustworthy study.

Table 6
Stages of Coding: Open, Axial, and Selective

Open Coding	Open coding is the first step in the coding process. The researcher takes large chunks of data, such as interview transcripts, highlights meaningful pieces throughout, and gives tentative summarizing code.
Axial Coding	Next, in the axial coding phase, categories are formed from the open codes created to structure information to find similarities.
Selective Coding	Finally, selective coding requires the researcher to further refine and amalgamate the central ideas emerging.

Coding Process

The full process of analysis took place through Tetra Insights, a software program which allows the researcher to store, organize, and code interviews in one place. First, portions of relevant information from each transcript were identified. These included statements like “Just

because I'm Arab doesn't mean I have the same experience as a refugee. I was raised, thankfully, in a setting that wasn't subject to those things," which were then given open codes such as "Recognizing Privilege." A total of 155 statements were identified and coded in the four transcripts. Open codes were synthesized and overlapping codes were merged (e.g. "Medicaid Barriers" and "Insurance Issues") to easily see all open codes together, creating 33 open codes.

To create axial codes, I chose the process of color coding similar open codes to sort into categories. This allowed me to give groups of open codes one unifying axial code by looking at similar open codes together. When I was unsure about a code, I followed the path back through the open code to the transcript to understand full context again and adjusted accordingly. I continuously reviewed the developing codes and context as I analyzed transcripts. In total, I identified six axial codes: systemic obstacles, social justice mindset, going beyond, importance of self, trauma understanding, and cultural understanding. Axial codes were grouped again, and four themes emerged: 1) Trauma-informed, 2) Cultural competence and humility, 3) Counselor determination, and 4) Integration of Self. A table showing codes and synthesis of these data can be found in Appendix F.

Credibility and Trustworthiness

In quantitative measures, bias can be reduced through the use of instruments such as tests and questionnaires, moving toward the ideal situation of bias elimination by distancing the researcher from the participants. In qualitative methods, however, this bias is an inextricable part of research as the researcher is the instrument to collect data (Creswell, 2003). The many aspects the researcher personally brings with them guide the research as it is built, conducted, and interpreted. There must be a careful balance between what is implied by the participant and what is inferred by the researcher in order to reduce this bias and ensure the messages from

participants are not being skewed according to the researcher's opinions on the topic. The findings should be shaped by the language of the participants and not the biases of the researcher (Lincoln & Guba, 1985).

Increasing credibility and trustworthiness of a study does not mean eliminating bias in qualitative research, as this is impossible, but increasing transparency and reflexivity so the consumers of qualitative studies are made aware of the internal processes of the researcher (Kalu & Bwalya, 2017). The researcher must be aware of biases at every point in the research process, from the formation of questions to the interpretation of data, in order to produce research that is ethically sound. A foundational piece of qualitative research is being certain the participants' voices are heard and the researcher's biases are not the driving force.

Throughout the research process, I did many things to mitigate my own biases. In the process itself, I often looked back and forth between the details and the bigger picture so I did not get stuck on a certain idea that may not fit the emergent themes (Morse, et al, 2002). This can happen when a researcher becomes rooted in a bias and follows a theme they are hoping or expecting to emerge. Researchers must remain consistently open to emergent themes, even if there is excitement about the possibility of a theme before saturation has been reached (Morse, et al., 2002). Zooming out to see the overall picture consistently becomes important in being flexible and open. The coding method utilized was also very helpful in zooming in and out to see how the smaller details create the bigger picture. I was able to follow the path back to the original statement when more context was needed, or if I wanted to check to make sure it was more of the participants' voice than my own.

Institutional Review Board

This research study was reviewed and approved by the Virginia Tech IRB Institutional Review Board (Appendix G) which thoroughly examines research proposals for ethical appropriateness. Each part of the research process was also in accordance with the American Counseling Association Code of Ethics (2014). My research study was also approved by my dissertation committee before I moved forward into the interview process. These procedures help ensure the researcher is acting in the best interest of the participants and in an ethical manner.

Confidentiality and Data Storage

Confidentiality in this research study was ensured through many methods. All the information and data collected was digital and kept on my personal computer, which is password protected. In accordance with IRB suggestions, I kept data on a shared University Google Drive with my dissertation chair. Participants chose pseudonyms which had a keycode kept in a separate folder in the Drive. The pseudonym keycode was deleted 48 hours after each interview, which was the timespan in which a participant could ask to review their transcript. Any identifying information, including the audio recordings, were also deleted after verification of transcripts. These measures help maintain participant confidentiality.

Informed Consent

Participants were emailed an informed consent form (Appendix H) at least 24 hours before the interview began which gave participants time to review before giving their verbal consent. The informed consent is critical to ethical research, as it is a tangible representation of the participant's option to consent to being in the study (American Counseling Association, 2014). The informed consent outlines the purpose of the research, process, and ethical

considerations such as confidentiality and protection of information (Wester, 2011). It allows the participants to understand the procedures the researcher is taking and what the researcher intends to accomplish. I read over the informed consent during interviews and asked if participants had questions before beginning the interview. Interviews did not begin before verbal consent was given.

Reflexive Journaling and Memoing

The researcher is the instrument in qualitative research and brings with them a unique lens through which they see the world and different circumstances. I see the world through a social justice lens, and I understood the importance of checking my biases consistently throughout the process. I recognized counselors I interviewed had different opinions, techniques, and training than I do. This process called for me to put my assumptions aside to allow participants to speak freely and themes across experiences to naturally emerge without my personal influence. When I began the interview process, I started writing in my journal as a way to reflect on how I feel about the emergence of information and emotions, both in myself and in the participants. This was especially important given how close I am to the subject (Malacrida, 2007) and a cathartic way to process emotions. I journaled after each participant and read my journal regularly as a method of self-reflection, seeking out blind spots, mitigating assumptions, and maintaining boundaries (Mantzoukas, 2005). I spoke to my dissertation chair regularly, and it was helpful to have another person with whom I could discuss feelings and potential issues. I also wrote memos while analyzing data to highlight salient pieces of information, write questions to review, and take notes. These memos proved critical in both adding context for later consideration and checking biases, as this helped construct the blueprint for emergent themes.

Chapter Four: Findings

The purpose of this qualitative study was to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. Participants were interviewed, and interview transcripts were analyzed and coded to find emergent themes. This study was framed by the following question: How do counselors who work with adult refugee clients reflect on their experiences in preparation for this work?

The findings of this research study are represented by the following four themes: 1) Trauma-informed 2) Cultural competence and humility 3) Counselor determination and 4) Integration of Self.

Trauma-informed

Theme definition: "Trauma-informed" describes the language participants used when discussing their clients and overt statements concerning the need for trauma-informed practice.

Participants discussed the presence of trauma experienced by refugees when recalling their impactful experiences counseling the population. As interviews shifted to training experiences, the importance of trauma training was consistently highlighted, and participants emphasized the need for services in alignment with trauma-informed practices.

Participants outlined ways they educate clients on the impacts of trauma, such as teaching about the physical effects of trauma in the body and brain. Theresa, who began her work with refugees as a nurse, uses her medical background and education to describe how trauma works in the body. Luís shows clients a model of a brain to show what areas are affected by trauma and how people could respond. Mia stated, "A lot of times it was just a matter of integrating what was going on in their body with the way they were navigating through the world. A lot of times

with refugees there is a stigma of counseling, so it would come out as migraines, as reactivity, as a lot of somatic symptoms that they just didn't even recognize as being linked to mental health.”

Sara and Luís both explicitly discussed the impact of ACEs on the refugee population. Sara connected this with the importance of counselors learning about the journey refugees must make in order to be resettled. Luís expressed he wish he had known about ACEs and the neurological effects of trauma earlier in his career. He stated, “it would have made my work potentially easier. Now, I can tell my client, ‘This is what’s happening. This is what trauma means.’ It’s not ‘what’s wrong with you.’ It’s ‘what *happened* to you.’”

Modalities of treating trauma specifically in refugee clients was important to participants. Mia described how many traditional therapies did not work for this population.

I found typical Cognitive Behavioral Therapy techniques do not work for someone who's gone through the level of trauma that a refugee has, because if they could change their thoughts, they would, and it has nothing to do with that. And so a lot of times it just wasn't effective, and I wasn't seeing change because their triggers were deeper. And so a lot of times it was just a matter of integrating what was going on in their body with the way they were navigating through the world.

Luís also described using a more flexible approach when working with refugee clients impacted by trauma:

Some people are very structured, especially CBT therapists are very structured and they already have a plan. ‘This is session number five. This is what we need to do.’ That does not exist for me in trauma treatment. I allow this space to become organic... Psychoanalysts also are very structured in the way they do therapy. So, everybody has

these evidence-based practices that are very ‘this is what works for everybody.’ I believe in evidence-based practices. I don’t believe in the formality and the structure of evidence-based practices.

Sara echoed Luís’ thoughts on cognitive behavioral therapy sometimes being a more rigid method. She also emphasized using the right modality at the right time according to current client needs:

Thinking about the bombing that happened in Beirut, a lot of counselors, including myself, were all really running to talk about PTSD and what trauma means, but people lost their homes. They don’t have a place to sleep at night. They’re not ready to use deep diaphragmatic breathing and mindfulness... That can be said about newer refugees who just moved here who are probably struggling more with the actual acculturation than the actual trauma.

All participants described themselves as strengths-based counselors, and resilience of refugees was discussed at many points through anecdotes and direct identification of resilience as a strength in the population. Sara said, “when someone who has refugee status does make it to counseling, it’s a big deal that they can get there physically, emotionally every day.” They also described ways they build rapport and how important trust is when processing traumatic experiences, especially with refugee clients. Luís described this well when talking about trauma-informed practices:

It starts at intake. My demeanor and presentation- I try to be jovial while being formal, and I try to extremely show empathy or sympathy. I dedicate a lot of time to the exploration of early events of trauma and developmental stages; events of trauma all the

way to globally. That requires for you to be patient in the process because sometimes people have not ever talked about this with anyone.

Sara and Mia also highlighted the importance of patience when working with refugee clients in order to establish safety. Sara commented on learning to slow her pace and adjust her expectations to create a safer space and stronger therapeutic alliance. She also realized this slower pace left more room for client education on mental health. The education component was a part of Theresa's process as well. She educates clients on the intersection of physical and mental health and described this understanding as lacking in United States culture.

Cultural Competence and Humility

Theme definition: "Cultural Competence and Humility" regards the way participants described their work with adult refugee clients and overt discussion of the need for these two elements in counselor training.

Cultural competence and cultural humility were both strong components in this study, mainly discussed in regard to understanding the context of the client. Within cultural competence, participants were adamant about researching the historical context of the places refugee clients were from. Luís stated he always starts clinical trainings with a "geography" and "history lesson" to help clinicians who will be working with refugees understand the importance of research. Mia described how research is helpful by stating, "OK, this person is 45. They went through this specific historical conflict. This is how they came here as a refugee and why they were awarded refugee status; just putting their life story in the context of history." Theresa also discussed historical context and added the need for "social and a political update on what's happening in those countries as currently as possible." Sara said much of the helpful research she found was about the three-stage refugee journey and the reality of refugee camps: "It's not a

five-star hotel in the middle of nowhere. It's a camp. It's a literal tent in the middle of nowhere. And it's not always a real transition. Sometimes it can take years."

Three participants described their masters-level Multicultural course in their counseling programs to be helpful when recalling important educational experiences. Conversely, the fourth explicitly described it as unhelpful because he feels this research "is always evolving and universities have not caught up." He added he has seen improvements, but many therapists and interns who work for him say "this is nothing like the textbook."

Counselors frequently discussed their privilege, which they recognized as they worked with refugee clients. Mia described leading a group activity that involved using sugar. After the activity, the sugar was washed off clients' hands. A woman commented, "people in the camp were starving and fighting over these resources, and we're just throwing them away." Mia recalled, "It cut me to my core... It revealed my privilege a lot; that I have the privilege to be able to look at sugar as something disposable. I've never been hungry ever, so I can look at something that is a food as also a healthcare product [as used in the activity] with little consequence." Theresa remarked on her recognition of privilege when talking about her experiences "being a minority in Zambia," and she said she learned a lot about herself that way.

Sara stated:

Recognizing my privilege, just because I'm Arab doesn't mean I have the same experience as a refugee. I was raised, thankfully, in a setting that wasn't subject to those things... I don't know the refugee experience. So, just because I have the language and the cultural background, that doesn't make me privy to what actually happens; what their trauma actually means.

Cultural humility was apparent throughout each interview, sometimes through direct language, stating its importance, and most often indirectly when participants discussed their experiences. Mia reflected on learning the difference between competence and humility, then specifically stated the need for cultural humility “not competency.” She defined this as “finding a way to communicate how to use unconditional positive regard, openness, and asking questions about culture in a humble way.” She also made it clear “it was never my client’s job to educate me.” Sara stated a similar sentiment and gave an example of cultural humility:

Any counselor, regardless of their background, if they are trauma informed and they care enough to learn and to humble themselves to learn that experience, I think that's a really good place to start. And you can still work with a client regardless of your cultural background, just like any other client. For example, if I have an LGBT client who comes to see me, even though I don't identify with that population, I can be an ally and I can humble myself to learn that experience and meet them where they are.

Multiple times, Sara pointed out the importance of putting assumptions and perceptions aside, even when the counselor may believe they understand, and “humbling yourself, wanting to learn, and meeting them where they are.” Theresa also discussed openness through her health-focused lens. Without judgement, she talks to clients about health practices that are normal in other cultures and societies that are considered abnormal in the United States.

A supervisor gave Luís a client with the assumption Luís would understand the client because he had once lived in a neighboring country. However, the country was completely culturally different. Luís described still being able to build rapport with the client who eventually told him, “It is impressive to me that you're the first person that has taken time to

understand me and learn from me who I am. Everybody else that has come and worked with me had already come up with all of these assumptions of who I am as a Korean woman.”

Counselor Determination

Theme definition: “Counselor Determination” is the strength and resolve participants consistently exhibited in their descriptions of overcoming barriers.

As participants reflected on their training and experiences, they told stories that involved obstacles for refugees in different systems and discussed the importance of going beyond a traditional counseling role to best serve this population. Mia stated, “I had no idea how much I would have to advocate for getting my clients what was already promised them.” Systems were discussed at three levels: global, national, and local.

Global Systems

There were many references to the global issues that cause people to flee and seek refuge and how difficult these situations were for clients. Luís reflected on this: “I am keenly aware that many of our policies around the world, our international policies, have caused a lot of human suffering. And a lot of those people ended up coming here to this country and looking for help.”

National Systems

Frustration with the healthcare system and insurance policies were apparent in interviews. Mia expressed the difficulties within the system, such as trying to get services covered, and stated the need for counselor education on the healthcare system regarding refugee mental health. Luís stated that billing insurance can be difficult because of the eclectic approach he uses with refugee clients. He is also mindful about diagnosis when considering cultural differences. Sara said, “They no longer have insurance after the first six months of being here on refugee status.

So they really have to fend for themselves.” She added other barriers such as transportation, finances, getting jobs, reapplying to services, and mental health stigma.

Luís commented on the United States individualistic culture as “single, individual personal culture.” He added the problem this can cause for refugees: “The majority of the clients that we work with have immigrated from other countries. They are collectives and groups, and their language is not about the I’s. It’s about the ‘We as a family. We as a tribe. Or we as a community.’ We don’t have that.” He also mentioned that many studies and assessments, such as the ACES study, are based on “middle-class America” and many issues that are normal for refugee populations may not show up as normal because of how assessments were normed.

Local Systems

Participants’ local systems were most commonly referenced. They discussed times others made assumptions about refugee clients and lacked understanding about the population. Mia recalled other counselors often labeling refugees as “resistant” instead of meeting clients where they were. Sara saw clinicians pushing refugee clients to discuss PTSD before they were ready. Mia recalled a time a client was discriminated against and racially profiled by a local government agency which ended in a traumatic circumstance for the client. Luís stated, “The majority of therapists who come out to work in community-based facilities- they have no idea what they’re about to face. I have interns that come here and quit within a week. They have to be transferred from the internship because the emotional process is so taxing and painful.”

Interpretation was also a consistent point for participants. Theresa made it clear she feels this is crucial to counselor education in preparation to see refugee and immigrant clients. Mia also stated the need for education on “practical ways to work with an interpreter,” starting with the basics such as “This is what an interpreter is. This is how to find one. This is how to use one”

up to more advanced concepts like “What are the limits of confidentiality when working with interpreters?” and “How am I supposed to interact with an interpreter as a counselor?” Sara expressed frustration with phone interpretation: “The phone interpreter is a great resource, but it's not therapeutic. It goes against therapy. It's really hard to build rapport. A lot of things get lost in translation. The tone of voice, the body language are a big part of therapy.”

Overcoming Systemic Obstacles

Counselors discussed the challenges above with an air of determination. They had many stories about pushing through the many obstacles refugees face in mental health as well as those counselors face when seeing refugee populations. The reason both Mia and Sara began counseling refugees is because there was a gap in care. Mia saw refugee mental health as an “untapped area of disparity in the community.” She added:

No one wanted to provide counseling. Especially at the time, which was right around the last election, when a lot of resources were being diverted from refugee services. You could just see in the volunteer groups, people were really struggling emotionally, physically. There was just a lot of hurt there. So I saw it as a way that I could serve in my field, in my community, in an area that was underserved.

Luís told a story of working with a refugee client whose son had been struggling with intellectual and behavioral issues, but other clinicians assumed what they were seeing was cultural difference. He helped the client advocate for a different level of care for the son, who had an intellectual disability. Theresa works with families in their homes, which helps overcome many barriers including childcare and transportation.

Mia worked to find creative solutions to insurance issues, and she researched tirelessly to find ways to get the cost of interpreter services covered. “I think for me, I have a little bit of a

rebellious streak in that. They would tell me that I couldn't do it, and I'm like, 'you've gotta be able to take that.' So a lot of internet searches like, 'there's gotta be a way to make this work!'"

Theresa reframed working with an interpreter. She described the role of an interpreter to be more than just relaying a message from one language to another. She stated interpreters were also "cultural brokers" who were bridges for people in many ways. Having this understanding of interpreters "improved the quality" of her work with clients. Being a multilingual counselor was Sara's creative solution to language barriers refugees face. She knew she wanted to use her first language as a tool to help clients, so she sought out opportunities to work with people who spoke the same language, so no interpreter would be needed. Similarly, Theresa, a Spanish speaker, found she could be very helpful to refugee clients and is an interpreter as well as a counselor in her community.

Integration of Self

Theme definition: "Integration of Self" describes participants' deep connectedness with adult refugee clients achieved through the incorporation of their own lives and experiences into their work.

Participants talked about pieces of themselves they have put into their counseling work with this population and how rewarding the work has been. They all found ways to relate to their refugee clients. Mia referenced motherhood as a connection with many clients through anecdotes of her work. When remembering a client's young son she said, "As a mom, I think back to that kid and I see my own son in him so much. Like, how little my son is, and he cries about so much. Add ten years, and that boy was my son." Mia also recalled a time a client saw her carrying her child around and the client began talking about carrying her own children. Mia described these experiences as bonding.

Experiences of living internationally were described as important in participants' identities and making them more prepared to see refugee clients. Each of these experiences were immersions into culture. Luís emphasized the difference between "traditional travel" and "cultural curiosity," as "let me get into their world and understand it." He described himself as "very curious about the world." Mia was an intern abroad and saw her work with refugees in the United States as "a way to be effective in serving the international and global community right here at home." All four participants shared personal experiences from being abroad and how that affects their work. Sara is from Lebanon, Theresa worked in Zambia as a counselor for the Peace Corps, Mia lived in Guatemala, and Luís lived in many countries while in the Navy and doing volunteer work.

Sara and Theresa identified working with clients from similar cultures to their own as being very helpful in therapeutic relationships. Sara referenced her knowledge of Lebanese culture multiple times, often pointing out instances in which her understanding of widely held beliefs (e.g. stigma, divorce, sexuality) helped her navigate situations with clients. They also identified using language as a connection. When Theresa reflected on using Spanish as a counselor, she talked about her mother speaking Spanish at home and this being an integral part of her.

Conclusion

Participants in this study reflected on their preparation to see adult refugee clients by discussing what they learned through experiences counseling them. What counselors learned and found important was often not in their preparation to see refugees, but self-taught and realized as they counseled the population. They used their basic counseling frameworks as

guidance and had to draw their own blueprints. The themes identified show what counselors found integral to their processes in learning to be counselors for refugees.

Chapter Five: Discussion

This phenomenological study explored participants' experiences, both personal and educational, they felt best helped prepare them to counsel adult refugee clients. Four counselors were interviewed, their interviews were transcribed and analyzed, then four themes emerged: 1) Trauma-informed, 2) Cultural humility and competence, 3) Counselor determination, and 4) Integration of Self. Chapter Five further develops these findings, establishes connections to existing literature for each theme, and discusses implications of the research. Limitations of this study are also outlined.

Trauma-informed

Bemak and Chung, leading researchers on refugee mental health in the counseling field, have underscored the necessity of using a trauma-informed approach throughout their work. Participants recalled techniques they used with refugee clients that are consistent with Bemak & Chung's Multiphase Model (MPM; 2017) such as linking physical symptoms to mental health and explaining the counseling process. The MPM also states the importance of diversifying modalities in seeing refugee clients, which was also expressed by participants as important. This psychoeducation component along with practicing patience and meeting clients where they are in their readiness to talk about their traumatic experiences are all recognized as necessary in trauma counseling (Peck, 2012, p.168).

The trauma-informed language in counselors' answers was directly in alignment with SAMHSA's Six Principles of Trauma-Informed Practice (SAMHSA, 2014). *Table 7* shows the integration of participants' interviews and these principles with an example of each from interviews.

Table 7*Discussion Factors Integrated into SAMHSA's Six Principles of Trauma-Informed Practice*

Principles	Factors Exhibited	Examples
Safety	Fostering sense of safety in relationship and in physical space	Luís using humor and working hard to build a relationship from the beginning
Trustworthiness and Transparency	Educating refugees on therapeutic process Recognizing the importance of establishing trust	Sara educating clients on purpose of counseling Mia spending intentional time connecting with clients
Peer Support	Knowing power of the community Discussing family trauma	Theresa acknowledging collectivist cultures and finding a community Luís dedicating time to explore family history
Collaboration and Mutuality	Meeting clients where they are Finding client needs	Sara consistently avoiding assumptions and considering Hierarchy of Needs
Empowerment, Voice, and Choice	Using strengths-based approach Empowering clients	Mia teaching her client to advocate for self Sara educating client on her rights
Cultural, Historical, and Gender Issues	Discussing trauma through cultural lens Understanding and educating self on cultural practices/norms Incorporating cultural practices	Mia researching history of country of origin Sara talking to clients about cultural differences regarding gender roles Theresa talking to clients about their cultural healing practices to integrate

Participants used trauma-informed language, discussed the traumatic experiences of their refugee clients, and discussed specific techniques that are well-established in trauma counseling literature. They also emphasized the importance of training counselors well in the subject of trauma. The way participants described the population and their own work with refugees using trauma-informed language reinforces the importance of trauma training in preparation to see refugee clients.

Cultural Competence and Humility

Cultural humility and cultural competence were grouped into one theme because many points discussed fit under both, even though they are different concepts. They were both discussed individually as well as combined in interviews, so many codes were overlapping. Coding these was a careful process to ensure they were truly both emergent themes. This required consistently following the coding process back to the beginning to check for bias (e.g. “Is this really cultural humility or just what I want to see here?”). For example, “Understanding Cultural Context” was a common code and could fall into either theme, Cultural Humility or Cultural Competence. However, the avenues to participants’ “understanding cultural context” were different. Some original statements were rooted in competence, such as online research, and some were rooted in humility, such as having the client educate the counselor on their culture. Mia showed both of these in one statement. She first identified cultural humility and used culturally humble language, then she exhibited cultural competence by highlighting the importance of doing her own research:

I wish I would've known more about the differences in culture, specifically. Part of that is about cultural sensitivity and being open to the specific client, but there was so much... It was never my client's job to educate me on what they had gone through, but I didn't know about some of the history of their country, and what they had gone through. I definitely had to play catch up in going back and reading a lot of Wikipedia to understand that background... and what they've experienced.

Many participant's statements contained several codes in the beginning that could be either humility or competence, but as grouping began and themes emerged, context became important to seek out the difference. Because many codes overlapped for the two concepts, they became separate concepts under one theme.

Competencies: Awareness, Knowledge, and Skills

Exploration of counselors' perceptions of their preparation to see refugee clients showed a direct alignment with the three categories of MCC: Awareness, Knowledge, and Skills (Sue, Arrendondo, & McDavis, 1992). Participants showed their Awareness through their discussions on their privilege, which they recognized through their work with refugees. Their own cultural experiences enhanced their abilities to work with refugees, but participants made it clear they needed to separate their own experiences from expectations about clients. They told stories of finding their own blind spots when working with refugee clients and what those times taught them about themselves.

The Knowledge component was exhibited many times throughout interviews, most commonly as participants discussed the amount of online research they did to better understand what they were seeing with clients. This included research on places clients lived, languages they spoke, common cultural practices, and the history of the events that caused them to flee their countries of origin. Some participants had first-hand knowledge of their refugee clients' cultures because of places they have lived. Seeking out more information about culture became helpful in diagnosing, building rapport, and contextualizing their clients' experiences.

Participants discussed modalities and techniques (Skills) specific to their work with refugees. They referred to ways in which they were trained, but stressed that their approach for refugees had to be different than other populations. Integrative modalities were commonly cited as most helpful because, as previously established (Bemak & Chung, 2017; Kira, 2015; Miller, 1999; Mitschke, et al. 2017), it allows for flexibility which participants stated is necessary for refugee clients. CBT was promoted in the literature as effective (Slobodin and Jong, 2014), but participants called CBT too rigid for the needs of the population. They explained this to be

especially true early in resettlement, as clients are working on meeting basic needs, and early in the therapeutic relationship while building safety and rapport.

Cultural Humility

When reading and writing about the existing literature on refugee mental health, I added cultural humility as an important component in the discussion of this population, even though it is not as common as competency in published work on refugee mental health. I did this because I see cultural humility as integral to discussions on client care for any population, but especially refugee populations because of their cultural dynamics. I was surprised when cultural humility was consistently discussed or alluded to by participants because of the lack of established research. As more information about cultural humility emerged, I considered the possibility of confirmation bias. I went back to the practices that mitigate my own bias. I began zooming out by following the theme back to the context in the interviews and looking at those with an open mind about themes. Even still, the best fit for some parts of discussions on culture and cultural understanding was rooted in cultural humility, not just MCC.

While the Knowledgeable counselor says, “I have done my research to better understand you,” the culturally humble counselor adds, “and I am still not the expert on you or your experiences.” The main tenet of cultural humility is being open to the pieces of client culture that are most salient to them (Hook, Davis, Owen & DeBlaere, 2017). Participants were adamant about being open to the experiences of their refugee clients in order to learn from them. Research counselors did outside of therapy helped add context, but being present as clients discussed their cultures helped the counselors understand their individual experiences was important to them.

Connectedness of Cultural Humility, Competence, and Trauma-Informed

It was apparent during analysis that cultural humility, multicultural competence, and trauma-informed practices are intertwined, particularly for this population. One could easily replace “cultural identity” with “trauma” in the following definition of cultural humility: “the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client” (Hook, Davis, Owen & DeBlaere, 2017). Being other-oriented in trauma-informed practice means meeting clients where they are and not making assumptions about their experiences.

I noticed this intersection during analysis as some codes consistently described all three topics. For example, I initially used the open codes “Meeting People Where They Are” and “Do Not Make Assumptions” to describe phrases about the high level of importance of researching culture (cultural competence), being open to the whole person and their beliefs (cultural humility), and refraining from assuming PTSD and needed treatment because of refugee status (trauma-informed). I re-coded to be more specific after noticing the overlap in meaning in order to have greater validity in the next stage of coding.

I believe this interconnectedness highlights the salience of these three in counseling refugees because the counselor-client relationship can be very fragile. Trauma and culture must be discussed only as the client is ready and willing to share their story in order to preserve and reinforce safety in the relationship. Discussions about both trauma and culture are integral to care for refugee clients and highly sensitive topics for this population, which is why these codes came up so often in transcript analysis.

Counselor Determination

The underlying message in interviews was that working with refugee clients was difficult work, but the participants talked about it as work they loved. The determination in their stories and their voices was consistent throughout. Participants did not talk about clients as if they were the problem, but talked about the systems that create the issues refugees face. They kept pushing to help their clients by learning more about their cultures, researching the history of conflict in their countries of origin, and working in creative ways to ensure their clients could continue receiving services. It was difficult for counselors to push through to learn what was necessary in order to be effective with adult refugee clients, but they were determined. They all leaned on their basic counseling skills, knowledge of trauma, cultural competence and humility, which eventually allowed them to understand what worked best in therapy for their refugee clients.

Participants consistently pushed beyond their previous duties as counselors working with other client populations. Their work also involved educating others and pushing back against systems that created obstacles. The last phase of Bemak and Chung's Multiphase Model (MPM) is Social Justice and Human Rights, which explains the need for counselors to go beyond what some may consider their normal counseling roles by writing legislators, advocating in their communities, and educating colleagues (Bemak & Chung, 2017). Participants all identified with the advocacy component, often explaining it as beyond what many counselors expect because of the high level of client need. The advocacy they described was grounded less in higher level advocacy, such as pushing for national policy change, and more in direct, local advocacy to eliminate barriers to obtaining and maintaining needed services.

Integration of Self

It was quickly evident in interviews that participants felt very deeply about their refugee clients. They put much of themselves into their work, and their experiences fit well in the Relational Cultural Framework described in chapter one. At its core, RCT is about the innate human need to connect with others (Miller, 1986), and in interviews, participants all told client stories with emotion and discussed the need to connect with their clients to build rapport. It is necessary in RCT to establish a safe environment through authenticity which allows for a relationship with mutual empathy. RCT posits empathy is not solely about the counselor's empathy toward the client, but also the client meeting this empathy with empathy in return (Jordan, 2017). The relationship plays a crucial part in the therapeutic process. Participants' stories and examples were not based in treatment of the client but in the relationship they established together. They discussed the importance of taking time to understand the client wholly so the client saw they cared about them.

Participants cared about their clients and gave examples of themselves being authentic, which is a component of RCT that eventually allows the client to feel safe enough to be their authentic selves as well (Jordan, 2017). A level of openness and vulnerability is necessary on the part of the counselor. Three participants became tearful during interviews when discussing experiences with their clients, displaying a deep connection and investment they had in their clients' processes. Mutual growth, empathy, and learning are essential to RCT and were integral in the findings of this study.

An underlying message throughout interviews was the power of client stories. Many clients had been through traumatic events and struggled with complex trauma which was impactful to counselors in interviews. Counselors are trained to deeply engage with clients, and when client stories are consistently rooted in traumatic experiences, this deep engagement can

result in the counselor having their own trauma response, known as vicarious trauma (McCann & Pearlman, 1990). Examples of these empathic counselor-client engagements include “listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments” and counselors with personal trauma histories are more vulnerable to vicarious trauma (Pearlman & Mac Ian, 1995, p. 558). Symptoms of vicarious trauma can mirror PTSD, and profoundly impact counselors' mental health, altering “cognitive schemas and imagery system of memory” (McCann & Pearlman, 1990, p. 132). Trippany, Kress, and Wilcoxon (2004) discussed the prevention of vicarious trauma and emphasized the importance of caseload size, peer supervision, agency responsibility in counselor support, education and training on trauma, personal coping mechanisms, and counselor spirituality.

Just as counselors can be negatively impacted, they can also be profoundly positively impacted by refugees' experiences. Participants all had stories of empowerment and wonder at their clients' abilities to overcome traumatic experiences. Mia told a client story which she said was “the most traumatic” and “unfair” she had witnessed. She described this experience for herself as eventually being “positive because I was able to walk with her and witness the strength that she had as a parent... she was just such an example to me of resiliency and internal motivation. It gave me hope for people who otherwise seem to be victimized in so many ways by various systems.”

Hernández, Engstrom, and Gangsei (2010) used a resilience framework, called “vicarious resilience,” in their approach to understanding counselors and their exposure to clients' trauma. Vicarious resilience is “a term for the positive meaning-making, growth, and transformations in the therapist's experience resulting from exposure to clients' resilience in the course of

therapeutic processes addressing trauma recovery” (Hernández, Engstrom, & Gangsei, 2010). This framework adds to the existing narrative of vicarious trauma by focusing on how client resilience can build counselor resilience as well. Vicarious trauma is an essential element in discussion about working with refugees as is the positive impact, vicarious resilience.

Underprepared

When asked what they wished they knew before counseling adult refugees, participants discussed the core aspects of counseling the population, such as an understanding of trauma, cultural differences, barriers to services, working with an interpreter, and the extent of advocacy needed. When they were asked how they learned these things, they told stories of how they learned while doing the work. They were often surprised in the beginning, so they adjusted their expectations accordingly, and did their own research to be better counselors for their refugee clients. These factors together suggest participants were not well-prepared to see refugee clients.

The difficulty Luís described when talking about counselors quitting soon after starting is a testament to this underpreparedness. Participants all showed great determination to overcome obstacles, and this determination was necessary, in part, because counselors are not prepared to see the population and meet their needs in therapy. It is important to consider how better preparation could have played a key role in lessening the frustration of the process. They all encountered new systems and barriers they had not seen before. There are many important considerations and expectations counselors could learn beforehand to mitigate the stark adjustment and be better prepared to counsel refugees.

Participant Diversity

A significant observation is that the four counselors who chose to participate in this study are diverse in comparison to the general population of counselors in the United States who are mostly White and female. Only one participant was White and female, and even then, she had incredibly rich cultural experiences. The difference in the general population and participants begs the question, “who is drawn to working with refugee clients?” It may be the case counselors who are passionate about this work have similar qualities, such as increased empathy due to their own diversity and/or cultural experiences. Their exposure to other cultures played a part in why they chose to work with refugee clients, and this may be the case for other counselors as well.

Implications for Counselors

Many implications for counselors arose as a result of this study. First is the importance of seeking out information about refugees and their common experiences. The journey from their countries of origin all the way to the United States is fraught with many difficulties and potential for complex trauma. Understanding the basics, including common barriers and incredible resilience of refugees, provides a framework to build on in a therapeutic relationship.

The counselor can begin to fill in the framework with information more specific to the client by researching the conflicts in their country of origin and aspects of culture in that area at the time the client was there. Cultural humility requires the counselor to hold the information they have learned while not making assumptions about the client’s experiences. They must remain open to the client’s own needs and timing. It is most important that the counselor meet the client where they are by allowing the journey to unfold as the client is ready. Educating clients on mental health and the purpose of counseling is a good starting point.

Counselors should be flexible in their approach to counseling refugees and refrain from holding expectations about immediate needs. Having the understanding of refugee experiences may make it tempting for counselors to want to broach complex trauma or culture early in therapy, but this could be harmful to the client and the therapeutic relationship.

Counselors should not operate from a place of sympathy or create a hierarchy based on the difficulties many refugees have faced. Refugees are considered a vulnerable population in the United States, but counselors must not see refugees as “less-than.” It is imperative counselors be open to seeking out their blind spots and recognizing their privilege. Counselors can integrate themselves to develop empathy, establish rapport, create connection, and work toward mutuality in the relationship.

It is often necessary for counselors to go beyond the scope of traditional counseling work to work with adult refugee clients because of the level of client need. This often includes advocating for clients in various systems and educating self on the common needs of clients outside of therapy. The work this requires makes self-care even more important to prevent burnout and vicarious trauma. Vicarious trauma can be harmful, so counselors should be aware of signs they are being negatively impacted by their work with clients with complex trauma and seek their own counseling.

This study also shows that counselors working with refugees would benefit from learning to work with interpreters. Counselors should be able to hire an interpreter and work with them appropriately within the counseling relationship. The role of the interpreter is more complex than having another speaker in the room. The interpreter is a person who can be helpful beyond simply relaying messages between the counselor and client. Gaining this understanding will bolster the therapeutic relationship as clients often see the interpreter as an ally.

Overall, the goal of the counselor should be to build a therapeutic alliance that is grounded in safety. Achieving this with adult refugee clients means the commitment on the part of the counselor to work to understand self and the client as a whole through research, patience, and advocacy.

Implications for Counselor Educators

Many of the implications of this study for counselor educators mirror those for counselors since counselor educators can teach these missing pieces as a part of their curricula. Counselor education programs can better prepare counselors to see refugees by teaching the basic information about common refugee experiences. Each refugee client is unique, but there are commonalities that define criteria for having refugee status and common obstacles refugees face, such as language barriers. Counselor education programs should teach counselors-in-training (CITs) how to appropriately work with interpreters and have them practice these skills in order to be prepared to work with refugees as well as the many other populations to which this is applicable.

Counselor educators can also teach CITs how to access resources, such as information about refugees and academic research on refugee mental health. This basic knowledge will lay the groundwork for CITs who work with refugees in the future. They should learn to balance information from their own research with the client's process, meeting clients where they are. Being open to the client was an important part of the discussion along with building awareness of self. Seeking out blind spots and acknowledging privilege should also be taught as an ongoing practice in counselor education and is vital in preparation to see refugees.

It is important to teach cultural humility and cultural competency as their own concepts, as they are uniquely vital in counseling. They can be discussed as complementary to one

another, but two different ideas: “I can get some context on my own through research, and I am still not the expert on my clients’ experiences.” Future studies in counselor education on refugee mental health should integrate cultural humility. It is integral in working with refugee clients and was an emergent theme in this research, but it is not regularly cited as its own concept in the literature.

CITs should understand the effects of trauma, how to educate clients on this appropriately, and utilize a trauma-informed approach. CITs can be better prepared to work with refugee populations by learning to recognize the signs of vicarious trauma within themselves. Vicarious trauma is often a cumulative effect of practicing trauma-therapy with many clients. While self-care is part of the solution, the expectations workplaces have for counselors, such as large caseloads, can be too great. Counselor educators should empower CITs to find workplaces that are a good fit and then advocate for themselves if the workplace is too demanding. Counseling refugees can be difficult work, but CITs should understand the positive aspects and the existing need in the population, working from a strengths-based approach. Trauma education should also include resilience, post-traumatic growth, and vicarious resilience.

The counselor’s role as an advocate is especially important when working with vulnerable populations. Advocacy is a part of the counselor identity and this is fostered in counselor education programs. Further, CITs should know *how* to advocate for clients and be empowered to be assertive. Teaching CITs about insurance, common barriers, and how to talk about insurance issues would be very helpful. CITs should also be empowered to advocate for themselves when they are not receiving the supervision, training, or resources they need when working with clients.

Counselor educators ensure counselors have the skills required to meet the mental health needs of the population. To do this, they wear many different hats. They are gatekeepers, teachers, consultants, and supervisors. They are also researchers, seeking to fill gaps in understanding in order to make better counselors, which in turn, helps clients. There is a large gap in understanding regarding counseling refugees, and this study sought to help fill it. This dissertation research also highlighted the work that still needs to be done.

Future Research

Common throughout each of the themes was the necessity of educating oneself through client experiences and/or stitching together previous knowledge and applying through a construct of cultural humility and trauma-informed practices. The information gleaned from interviews paralleled much of the information found in existing research on refugee mental health. However, participants learned this information through experiences counseling clients instead of curriculum, academic research, or specific trainings in preparation. While almost all had continuing education hours related to refugee issues, no one named these when identifying ways they learned the salient aspects of counseling the population. They described their cultural experiences as being integral to their work, but also their need for more awareness, knowledge, and skills specific to refugee populations. This implies there is a gap between the existing body of academic research and counselor knowledge of serving refugee populations. A curriculum or training model specific to counseling refugees would bridge the gap between existing academic research and counselors in practice. Surveying mental health professionals about subjects to include could prove beneficial in creating a comprehensive training model.

Much of the research about refugees is from the perspectives of researchers and clinicians. Refugee clients' voices are rarely heard in academic literature. Researching

counseling from the perspective of refugees would be helpful in understanding the therapeutic relationship and providing insight into their experiences of the issues so often outlined. The relationship according to refugee clients may look very different than what counselors believe it to be. This could lend itself to studying perceived effectiveness by both the counselor and client to learn strengths and short-comings of different modalities.

Another point-of-view rarely heard is that of the interpreter. Interpreters play a key role in therapy with refugee and immigrant clients, but little is known about the triadic relationship that is established or what can affect its efficacy. It is often impossible to keep the same interpreter for each session with clients. How does a new interpreter affect the counseling relationship, even if it is well-established? A study about the therapeutic alliance that includes interpreters would help us understand the dynamic relationships that occur and how these affect relationships.

Many of the systemic barriers refugees face are at the national and local levels. The policies implemented in government are always fluctuating and up for debate. Research on CITs understanding and confidence in advocating at various levels of government could show why many counselors do not engage in policy reform. Examples of this could be policy advocacy regarding transportation, fair housing, or integrating better mental health support into the resettlement process. More broadly, research into how counselors perceive themselves as advocates in their roles with clients would be beneficial. This could give counselor educators insight into better ways of empowering counselors to create larger systems changes and have a greater voice in decisions being made at all levels.

In a similar vein, determination exhibited in participants proved to be incredibly helpful to them in counseling refugees. They used their curiosity and value of social justice to find ways

to solve issues. This implies the need for further research into how counselor educators can best promote resilience and determination in CITs. The integration of a resilience framework into curriculum would help counselors acknowledge and prepare for the difficulties of counseling work and also be empowered enough to believe they will succeed.

CACREP standards on MCC and trauma education have changed significantly over time. Counselors' competency in these areas is likely to vary based on when counselors earned their degrees and the amount of specific continuing education they have sought out. Research on the differences in understanding and practice based on generations of CACREP requirements and graduation years could be very helpful to our field.

It is evident by studies such as the one by Kuo and Arcuri (2014) that working with clients from other cultures increases MCC. However, our field is lacking how this work affects other scales, such as empathy and social justice drive. Continuing to learn the full effects of working with culturally diverse clients would lead to an understanding of how to better equip counselors to work with immigrants and refugees and fill clinical gaps in care.

Limitations

Qualitative studies are limited in that they are not generalizable to the population as a whole. The participants in this study are not representative of all counselors who see refugees. This study is meant to help inform future work in the counseling field while also providing insight about working with adult refugee clients. Additionally, with qualitative research, the researcher is the instrument being used in the process. This inherently means there is bias as the researcher is using a personal lens to view each of the interviews in order to find themes. I remained aware of my biases throughout analysis and utilized many helpful techniques in mitigating bias. Even still, it is possible that my biases impacted the research.

The COVID-19 pandemic has greatly impacted many people, including counselors, as anxiety, depression, and suicidal ideation have increased significantly in comparison to 2019 (Czeisler et al., 2020). Counselors are coping with the increased demand for services in tandem with their own needs, both mental and physical. Many are also homeschooling their children and negotiating working hours to help balance. This may be one of the causes for the low response to my requests for participants. The number of participants for this study was lower than expected due to response rate and an obvious limitation to this study. Very few counselors responded at all, and most who did were not able to be interviewed. The pandemic also impacted the method of interviews, which were initially slated to be in-person. All interviews needed to be conducted virtually due to the safety risk and restrictions. This may have excluded some who have internet accessibility issues or do not have a personal computer.

The literature review details the many derogatory factors refugees face that have been prevalent in the U.S. in the last few years. The current administration's negative rhetoric about refugees has been in the news often, along with the frequent rule changes regarding refugee resettlement. Several participants brought this up briefly which shows it is on the minds of people who work with the population. Participants' beliefs about the current political climate and potential negativity toward refugees may have affected their feelings toward the study topic.

Conclusion

Chapter five fully developed the findings from this study utilizing existing literature as a framework. Themes were described in further detail and implications of the study for counselors and counselor educators were provided. Lastly, limitations of this study were outlined.

There is a vast body of academic knowledge on refugee mental health, but very little is known about counselors' experiences in learning to see refugee clients. The purpose of this

study was to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. The study was guided by the research question: How do counselors who work with adult refugee clients reflect on their experiences in preparation for this work?

I found counselors described their work with refugees as very special to them, and they were inclined to invest in the relationships, creating mutuality. They also reflected on many things they discovered about working with the population they wish they had known beforehand. Participants built on their existing counseling skills by learning through their clients and seeking out many other resources. Even though they discussed their preparation as minimal, their determination was evident. Counselors showed incredible resilience and used their passion to advocate for their clients to receive needed services and eliminate barriers to counseling.

References

- Aguilar, J. V. (2010). Boys don't cry, a movie review: Implications for counseling persons who are transgendered. *Journal of Creativity in Mental Health*, 5(4), 440-446.
doi:10.1080/15401383.2010.527819
- American Counseling Association. (2014). *ACA code of ethics*. Alexandria, VA: Author.
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>
- Amos, D. (2018). *100 Iranians Remain Stranded in Austria Awaiting Asylum In The U.S.* NPR. <https://www.npr.org/sections/parallels/2018/03/31/593703589/100-iranians-remain-stranded-in-austria-awaiting-asylum-in-the-u-s>
- Atkinson, R., & Flint, J. (2001). Accessing hidden and hard-to-reach populations: Snowball research strategies. *Social research update*, 33(1), 1-4.
- Barden, S. M., Sherrell, R. S., & Matthews, J. J. (2017). A national survey on multicultural competence for professional counselors: A replication study. *Journal of Counseling & Development*, 95(2), 203-212.
- Bartlett, L., Mendenhall, M., & Ghaffar-Kucher, A. (2017). Culture in acculturation: Refugee youth's schooling experiences in international schools in new york city. *International Journal of Intercultural Relations : IJIR*, 60, 109.
- Bemak, F., & Chung, R. C. (2017). Refugee trauma: Culturally responsive counseling interventions. *Journal of Counseling & Development*, 95(3), 299-308.
doi:10.1002/jcad.12144
- Bemak, F., & Chung, R. C.-Y. (2014). Immigrants and refugees. In F. T. L. Leong (Ed.), *APA handbook of multicultural psychology: Vol. 1. Theory and research* (pp. 503–517). Washington, DC: American Psychological Association.

- Bemak, F., Chung, R. C., & Pedersen, P. (2003). *Counseling refugees: A psychosocial approach to innovative multicultural interventions*. Westport, Conn: Greenwood Press.
- Bernard, H. R. (2002). *Research methods in anthropology: Qualitative and quantitative approaches* (3rd ed.). Walnut Creek, CA: Alta Mira Press.
- Berry, J. W. (1997). Immigration, acculturation, and adaptation. *Applied psychology, 46*(1), 5-34.
- Blackwell, D. (2005). *Counselling and psychotherapy with refugees*. London, Philadelphia;: J.Kingsley Publishers.
- Block, A. M., Aizenman, L., Saad, A., Harrison, S., Sloan, A., Vecchio, S., & Wilson, V. (2018). Peer support groups: Evaluating a culturally grounded, strengths-based approach for work with refugees. *Advances in Social Work, 18*(3), 930-948.
- Blount, A. J., & Acquaye, H. E. (2018). Promoting Wellness in Refugee Populations. *Journal of Counseling & Development, 96*(4), 461–472. <https://doi-org.ezproxy.lib.vt.edu/10.1002/jcad.12227>
- Bosson, R., Schlaudt, V. A., Williams, M. T., Carrico, R. M., Peña, A., Ramirez, J. A., & Kanter, J. (2017). Evaluating mental health in Cuban refugees: The role of the Refugee Health Screener-15. *Journal of Refugee & Global Health, 1*(1), 4.
- Bray, S., & Balkin, R. S. (2013). Master's-level students' beliefs concerning the causes of poverty, implicit racial attitudes, and multicultural competency. *Journal of Professional Counseling, Practice, Theory, & Research, 40*(2), 33.
- Cartwright, B. Y., Daniels, J., & Zhang, S. (2008). Assessing multicultural competence: Perceived versus demonstrated performance. *Journal of Counseling & Development, 86*(3), 318-322.

CDC (2019a). *Immigrant and refugee health: mental health screening guidelines*. Center for Disease Control.

<https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/mental-health-screening-guidelines.html>

CDC (2019b). *Risk and protective factors*. Center for Disease Control.

<https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html>

CDC (2019c). *CDC-Kaiser ACE Study: the ACE Pyramid*. Center for Disease Control.

<https://www.cdc.gov/violenceprevention/childabuseandneglect/cestudy/about.html>

Center for Victims of Torture (2020). *Refugee Vetting Process*.

<http://rejecttorture.cvt.org/cms/assets/uploads/2017/02/2016-Vetting-Process-postcard.png>

Chan, K. J., Young, M. Y., & Sharif, N. (2016). Well-being after trauma: A review of posttraumatic growth among refugees. *Canadian Psychology/Psychologie Canadienne*, 57(4), 291-299. doi:10.1037/cap0000065

Clark, C., Classen, C. C., Fourt, A., & Shetty, M. (2014). *Treating the trauma survivor: An essential guide to trauma-informed care*. Routledge.

Clark, M., Moe, J., & Hays, D. G. (2017). The Relationship Between Counselors' Multicultural Counseling Competence and Poverty Beliefs. *Counselor Education & Supervision*, 56(4), 259–273. <https://doi-org.ezproxy.lib.vt.edu/10.1002/ceas.12084>

Constas, M. A. (1992). Qualitative analysis as a public event: The documentation of category development procedures. *American Educational Research Journal*, 29(2), 253-266.

Council for Accreditation of Counseling and Related Educational Programs [CACREP] (2016). *2016 standards*. Alexandria, VA: Author.

Council for Accreditation of Counseling and Related Educational Programs [CACREP] (2019).

About CACREP. <https://www.cacrep.org/about-cacrep/>

Courtois, C. A. (2008). Complex trauma, complex reactions: Assessment and treatment.

Creswell, J. W. (2003). *Research Design: Qualitative, quantitative, and mixed methods*.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (pp. 181-223) Thousand Oaks.

Crosby, S. S. (2013). Primary care management of Non-English-speaking refugees who have experienced trauma: A clinical review. *Jama*, *310*(5), 519-528.

doi:10.1001/jama.2013.8788

Czeisler, M. É., Lane, R. I., Petrosky, E., Wiley, J. F., Christensen, A., Njai, R., ... & Czeisler, C. A. (2020). Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020. *Morbidity and Mortality Weekly Report*, *69*(32), 1049.

Day-Vines, N., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling and Development : JCD*, *85*(4), 401-409.

De Anstiss, H., Ziaian, T., Procter, N., Warland, J., & Baghurst, P. (2009). Help-seeking for mental health problems in young refugees: A review of the literature with implications for policy, practice, and research. *Transcultural psychiatry*, *46*(4), 584-607.

Devictor, X., & Do, Q. T. (2016). *How many years have refugees been in exile?*. The World Bank.

- Duffey, T., & Haberstroh, S. (2014). Developmental relational counseling: Applications for counseling men. *Journal of Counseling & Development, 92*(1), 104-113.
doi:10.1002/j.1556-6676.2014.00136.x
- Duffey, T., & Somody, C. (2011). The role of relational-cultural theory in mental health counseling. *Journal of Mental Health Counseling, 33*(3), 223-242.
- Ellis, B. H., MacDonald, H. Z., Klunk-Gillis, J., Lincoln, A., Strunin, L., & Cabral, H. J. (2010). Discrimination and mental health among Somali refugee adolescents: The role of acculturation and gender. *American Journal of Orthopsychiatry, 80*(4), 564-575.
<http://dx.doi.org/10.1111/j.1939-0025.2010.01061.x>
- Ellis, MacDonald, Lincoln, & Cabral, 2008;
- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet, (9467)*.
Retrieved from
<http://search.ebscohost.com.ezproxy.lib.vt.edu/login.aspx?direct=true&db=edsbig&AN=edsbig.A134831774&site=eds-live&scope=site>
- Federal Bureau of Investigation (2015). *Special status report: hate crimes in the United States*. [PDF] <https://www.documentcloud.org/documents/3110202-SPECIAL-STATUS-REPORT-v5-9-16-16.html>
- Federal Bureau of Investigation (2016). *2016 Hate Crime Statistics*. <https://ucr.fbi.gov/hate-crime/2016/tables/table-1>
- Felitti, V. J., Anda, R. F., Nordenberg, D., & Williamson, D. F. (1998). Adverse childhood experiences and health outcomes in adults: The Ace study. *Journal of Family and Consumer Sciences, 90*(3), 31.

- Frontières, M. S. (1997). Refugee health. *An approach to emergency situations*.
- Gartley, T., & Due, C. (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. <https://doi.org/10.1111/ap.12181>
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 18(1), 59-82.
[doi:10.1177/1525822X05279903](https://doi.org/10.1177/1525822X05279903)
- Hernández, P., Engstrom, D., & Gangsei, D. (2010). Exploring the impact of trauma on therapists: Vicarious resilience and related concepts in training. *Journal of Systemic Therapies*, 29(1), 67-83.
- Hollifield, M., Verbillis-Kolp, S., Farmer, B., Toolson, E. C., Woldehaimanot, T., Yamazaki, J., ... & SooHoo, J. (2013). The Refugee Health Screener-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General hospital psychiatry*, 35(2), 202-209.
- Hollifield, M., Warner, T. D., & Westermeyer, J. (2011). Is torture reliably assessed and a valid indicator of poor mental health?. *The Journal of nervous and mental disease*, 199(1), 3-10.
- Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. American Psychological Association.
- Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural humility and racial microaggressions in counseling. *Journal of Counseling Psychology*, 63(3), 269.

International Organization for Migration (2019). *Refugee travel loans*.

<https://www.iom.int/countries/united-states-america#rtl>

International Rescue Committee (2019). *Millions on the move: refugee crisis*. International

Rescue Committee. <https://www.rescue.org/topic/refugee->

[crisis?ms=gs_ppc_dynamicrefugee_mc_191018&initialms=gs_ppc_dynamicrefugee_mc_191018&gclid=Cj0KCQIA4NTxBRDxARIsAHyp6gCRPnyrSe9djyw50BLFLgVcKdIH](https://www.rescue.org/topic/refugee-crisis?ms=gs_ppc_dynamicrefugee_mc_191018&initialms=gs_ppc_dynamicrefugee_mc_191018&gclid=Cj0KCQIA4NTxBRDxARIsAHyp6gCRPnyrSe9djyw50BLFLgVcKdIH)

[_191018&gclid=Cj0KCQIA4NTxBRDxARIsAHyp6gCRPnyrSe9djyw50BLFLgVcKdIH](https://www.rescue.org/topic/refugee-crisis?ms=gs_ppc_dynamicrefugee_mc_191018&gclid=Cj0KCQIA4NTxBRDxARIsAHyp6gCRPnyrSe9djyw50BLFLgVcKdIH)

[O9DR4c8AVL27OVq10yjanTsmKpQaAsHVEALw_wcB](https://www.rescue.org/topic/refugee-crisis?ms=gs_ppc_dynamicrefugee_mc_191018&gclid=Cj0KCQIA4NTxBRDxARIsAHyp6gCRPnyrSe9djyw50BLFLgVcKdIH)

Isawi, D. (2016). Factors influencing counselor self-efficacy of mental health professionals working with refugees and asylum-seekers (Unpublished dissertation). The University of North Carolina at Charlotte, Charlotte.

Jordan, J. V. (2010). Relational-cultural therapy. *Handbook of counseling women*, 63-73.

Jordan, J. V. (2017). Relational–Cultural theory: The power of connection to transform our lives.

The Journal of Humanistic Counseling, 56(3), 228-243. doi:10.1002/johc.12055

Jordan, J. V., Hartling, L. M., & Walker, M. (Eds.). (2004). *The complexity of connection:*

Writings from the Stone Center's Jean Baker Miller training institute. Guilford Press.

Kaiser, B. N., Haroz, E. E., Kohrt, B. A., Bolton, P. A., Bass, J. K., & Hinton, D. E. (2015).

“Thinking too much”: A systematic review of a common idiom of distress. *Social Science*

& Medicine, 147, 170-183.

Kaltenbach, E., Härdtner, E., Hermenau, K., Schauer, M., & Elbert, T. (2017). Efficient

identification of mental health problems in refugees in Germany: the Refugee Health

Screener. *European Journal of Psychotraumatology*, 8(sup2), 1389205.

- Kalu, F. A., & Bwalya, J. C. (2017). What makes qualitative research good research? An exploratory analysis of critical elements. *International Journal of Social Science Research*, 5(2), 43-56.
- Kira, I. A., & Tummala-Narra, P. (2015). Psychotherapy with refugees: Emerging paradigm. *Journal of Loss and Trauma*, 20(5), 449-467.
- Kishi, K. (2017). *Most refugees who enter the U.S. as religious minorities are Christians*. Pew Research Center. <http://www.pewresearch.org/fact-tank/2017/02/07/most-refugees-who-enter-the-u-s-as-religious-minorities-are-christians/>
- Kress, V. E., Haiyasoso, M., Zoldan, C. A., Headley, J. A., & Trepal, H. (2018). The use of Relational-Cultural theory in counseling clients who have traumatic stress disorders. *Journal of Counseling & Development*, 96(1), 106-114. doi:10.1002/jcad.12182
- 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. doi:10.1177/0011000013491610
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage Publs.
- Lindert J, Ehrenstein OS, Priebe S, Mielck A, & Brähler E. (2009). Depression and anxiety in labor migrants and refugees -- a systematic review and meta-analysis. *Social Science & Medicine*, 69(2), 246–257. <https://doi-org.ezproxy.lib.vt.edu/10.1016/j.socscimed.2009.04.032>
- 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.
- Malacrida, C. (2007). Reflexive journaling on emotional research topics: Ethical issues for team researchers. *Qualitative health research*, 17(10), 1329-1339.

- Mantzoukas, S. (2005). The inclusion of bias in reflective and reflexive research: A necessary prerequisite for securing validity. *Journal of Research in Nursing*, 10, 279–295.
doi:10.1177/174498710501000305
- Maslow, Abraham H. *Toward a Psychology of Being*, 2nd ed. New York: Van Nostrand Reinhold, 1968.
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, 3(1), 131-149.
- Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor Professional Identity: Findings and Implications for Counseling and Interprofessional Collaboration. *Journal of Counseling & Development*, 89(2), 140–147. <https://doi-org.ezproxy.lib.vt.edu/10.1002/j.1556-6678.2011.tb00071.x>
- Mellin, E. A., Hunt, B., & Nichols, L. M. (2011). Counselor professional identity: Findings and implications for counseling and interprofessional collaboration. *Journal of Counseling & Development*, 89(2), 140-147.
- Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research a guide to design and implementation*.
- Miller, J. B. (1986). *Toward a new psychology of women* (2nd ed.). Boston: Beacon Press.
- Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy*, 29(4), 283-306.
- Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social science & medicine*, 70(1), 7-16.

- Mitschke, D. B., Praetorius, R. T., Kelly, D. R., Small, E., & Kim, Y. K. (2017). Listening to refugees: How traditional mental health interventions may miss the mark. *International social work, 60*(3), 588-600.
- Morey, R. A., Haswell, C. C., Hooper, S. R., & De Bellis, M. D. (2016). Amygdala, hippocampus, and ventral medial prefrontal cortex volumes differ in maltreated youth with and without chronic posttraumatic stress disorder. *Neuropsychopharmacology, 41*(3), 791-801.
- Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International journal of qualitative methods, 1*(2), 13-22.
- Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry, 80*(4), 576.
- National Immigration Forum. (2019). *Fact sheet: U.S. refugee resettlement*. National Immigration Forum. <https://immigrationforum.org/article/fact-sheet-u-s-refugee-resettlement/>
- National Institute of Mental Health (2019). *Post-Traumatic Stress Disorder*. <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>
- Nickerson, A., Liddell, B. J., Maccallum, F., Steel, Z., Silove, D., & Bryant, R. A. (2014). Posttraumatic stress disorder and prolonged grief in refugees exposed to trauma and loss. *BMC Psychiatry, 14*(1), 106-106. doi:10.1186/1471-244X-14-106
- 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 and Development* : JCD, 89(4), 413-422.

Retrieved from <http://login.ezproxy.lib.vt.edu/login?url=https://search-proquest-com.ezproxy.lib.vt.edu/docview/896482668?accountid=14826>

Nowrasteh, A. (2016). *Terrorism and Immigration: A Risk Analysis*. The Cato Institute.

<https://www.cato.org/publications/policy-analysis/terrorism-immigration-risk-analysis>

Office of Refugee Resettlement (ORR) (2012). *The Refugee Act*.

<https://www.acf.hhs.gov/orr/resource/the-refugee-act>

Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services (2012). *Overview of immigrants eligibility for SNAP, TANF, Medicaid, and CHIP*. <https://aspe.hhs.gov/basic-report/overview-immigrants-eligibility-snap-tanf-medicaid-and-chip>

Ostrander, J., Melville, A., & Berthold, S. M. (2017). Working with refugees in the U.S.:

Trauma-informed and structurally competent social work approaches. *Advances in Social Work, 18*(1), 66-79. doi:10.18060/21282

Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Natacha Foo Kune. (2016).

Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research & Practice, 47*(1), 30-37.

<https://doi-org.ezproxy.lib.vt.edu/10.1037/pro0000046>

Pathways to Wellness (2011). *Integrating refugee health and well-being: creating pathways for refugee survivors to heal*.

https://cls.unc.edu/files/2015/06/RHS15_Packet_PathwaysToWellness.pdf

- Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional psychology: research and practice*, 26(6), 558.
- Peck, B. (2012). Treating Adult Trauma Survivors. In L. L. Levers (Ed.), *Trauma counseling: theories and interventions* (p. 168). Springer Publishing Company.
- Pompeo, Michael (2019). *Presidential determination on refugee admissions for fiscal year 2020*.
<https://www.state.gov/presidential-determination-on-refugee-admissions-for-fiscal-year-2020/>
- Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *Jama*, 294(5), 602-612.
- Qiblawi, T., Pleitgen, F., & Otto, C. (2018) “Children swap basement hideouts for rooftop playgrounds after escaping war”CNN. Retrieved from:
<https://www.cnn.com/2018/04/05/middleeast/voices-from-eastern-ghouta-intl/index.html>
- Radford, J., & Conner, P., (2019). *Canada now leads the world in refugee resettlement, surpassing the U.S.* Pew Research Center. <https://www.pewresearch.org/fact-tank/2019/06/19/canada-now-leads-the-world-in-refugee-resettlement-surpassing-the-u-s/>
- Renzaho, A. M., Dhingra, N., & Georgeou, N. (2017). Youth as contested sites of culture: The intergenerational acculturation gap amongst new migrant communities—Parental and young adult perspectives. *PloS one*, 12(2).
- Ryan, D., Dooley, B., & Benson, C. (2008). Theoretical perspectives on post-migration adaptation and psychological well-being among refugees: Towards a resource-based model. *Journal of Refugee Studies*, 21(1), 1-18.

- SAMHSA (2014). *Concept of Trauma and Guidance for a Trauma-Informed Approach*. Substance Abuse and Mental Health Services.
<https://store.samhsa.gov/system/files/sma14-4884.pdf>
- Shannon, P., Im, H., Becher, E., Simmelink, J., Wieling, E., & O'Fallon, A. (2012). Screening for war trauma, torture, and mental health symptoms among newly arrived refugees: A national survey of U.S. refugee health coordinators. *Journal of Immigrant & Refugee Studies*, 10(4), 380-394. doi:10.1080/15562948.2012.674324
- Singh, A. A., & Moss, L. (2016). Using Relational-Cultural theory in LGBTQQ counseling: Addressing heterosexism and enhancing relational competencies. *Journal of Counseling & Development*, 94(4), 398-404. doi:10.1002/jcad.12098
- Slobodin, O., & de Jong, J. T. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy?. *International Journal of Social Psychiatry*, 61(1), 17-26.
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. *Journal of American Medical Association*, 302(5), 537-549.
- Stevens, J. E. (2012). The Adverse Childhood Experiences Study—the largest, most important public health study you never heard of—began in an obesity clinic. *ACES Too High News*, 3.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research techniques*. Thousand Oaks, CA: Sage publications.

- Sue, D. W., Arrendondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477-486. doi:10.1002/j.1556-6676.1992.tb01642.x
- Trippany, R. L., Kress, V. E. W., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & development, 82*(1), 31-37.
- Trump, Donald, television interview by Belvedere, Matthew. *CNBC News*. 2015, November 11. <https://www.cnn.com/2015/11/16/donald-trump-we-should-attack-terrorist-oil-bank-resources.html>
- Turner III, D. W. (2010). Qualitative interview design: A practical guide for novice investigators. *The qualitative report, 15*(3), 754.
- U.S. Department of State Bureau of Population, Refugees, and Migration, 2019. *Refugee admissions*. <https://www.state.gov/j/prm/releases/statistics/>
- United Nations High Commissioner on Refugees (1979). "Handbook on Procedures and Criteria for Determining Refugee Status under the 1951 Convention and the 1967 Protocol relating to the Status of Refugees." pp. 24-27, Section B.3
- United Nations High Commissioner on Refugees (2019a). *Figures at a glance*. UNHCR. <https://www.unhcr.org/ph/figures-at-a-glance>
- United Nations High Commissioner on Refugees (2019b). *Resettlement in the United States*. UNHCR. <https://www.unhcr.org/en-us/resettlement-in-the-united-states.html>
- United Nations High Commissioner on Refugees (2019c). *What is a refugee?* UNHCR. <https://www.unrefugees.org/refugee-facts/what-is-a-refugee/>

United Nations High Commissioner on Refugees (2019d). *Refugee facts*.

UNHCR. <https://www.unrefugees.org/refugee-facts/camps/>

United Nations High Commissioner on Refugees (2019e). *Desperate journeys*.

UNHCR. <https://www.unhcr.org/desperatejourneys/>

United Nations (2019). *Genocide threat for Myanmar's Rohingya greater than ever,*

investigators warn Human Rights Council. <https://news.un.org/en/story/2019/09/1046442>

Van Maanen, J. (1979). Reclaiming qualitative methods for organizational research: A preface.

Administrative science quarterly, 24(4), 520-526.

Villalba, J. A. (2009). Addressing immigrant and refugee issues in multicultural counselor

education. *Journal of Professional Counseling, Practice, Theory, & Research*, 37(1), 1.

Wescott, L. (2015). *A brief history of refugees paying back the U.S. government for their travel*.

News Week. <http://www.newsweek.com/brief-history-refugees-paying-back-us-government-their-travel-403241>.

Wester, K. L. (2011). Publishing ethical research: A step-by-step overview. *Journal of*

Counseling & Development, 89(3), 301-307.

Westlake, D., & Jones, R. K. (2018). Breaking Down Language Barriers: A Practice-Near Study of Social Work Using Interpreters. *British Journal of Social Work*, 48(5), 1388–1408.

<https://doi-org.ezproxy.lib.vt.edu/10.1093/bjsw/bcx073>

Wong, Y. J., Tran, K. K., Schwing, A. E., Cao, L. H., Ho, P. P., & Nguyen, Q. (2011).

Vietnamese american immigrant parents: A pilot parenting intervention. *The Family Journal*, 19(3), 314-321. doi:10.1177/1066480711406697

Wroughton, L. (2018). *U.S. to sharply limit refugee flows to 30,000 in 2019*. Reuters.

<https://www.reuters.com/article/us-usa-immigration-pompeo-idUSKCN1LX2HS>

Yahya, M. (2018). *Syrian refugees: The people who want four things before they go home*. BBC.

<https://www.cnn.com/2018/04/05/middleeast/voices-from-eastern-ghouta-intl/index.html>

Yako, R. M., & Biswas, B. (2014). "We came to this country for the future of our children. We have no future": Acculturative stress among Iraqi refugees in the United States.

International Journal of Intercultural Relations, 38, 133-141.

Zong, J., & Batalova, J. (2017). *Refugees and asylees in the United States*. Migration Policy

Institute. <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states-6>

Appendices

Appendix A

REFUGEE HEALTH SCREENER-15 (RHS-15)
 Pathways to Wellness Integrating Refugee Health and Well-being
 Creating pathways for refugee survivors to heal
 ENGLISH VERSION

Instructions: Using the scale beside each symptom, please indicate the degree to which the symptom has been bothersome to you over the past month. Place a mark in the appropriate column. If the symptom has not been bothersome to you during the past month, circle "NOT AT ALL."



SYMPTOMS	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Muscle, bone, joint pains	0	1	2	3	4
2. Feeling down, sad, or blue most of the time	0	1	2	3	4
3. Too much thinking or too many thoughts	0	1	2	3	4
4. Feeling helpless	0	1	2	3	4
5. Suddenly scared for no reason	0	1	2	3	4
6. Faintness, dizziness, or weakness	0	1	2	3	4
7. Nervousness or shakiness inside	0	1	2	3	4
8. Feeling restless, can't sit still	0	1	2	3	4
9. Crying easily	0	1	2	3	4

The following symptoms may be related to traumatic experiences during war and migration. How much in the past month have you:

Appendix B

Invitation to Participate

Dear (potential participant),

My name is Bethany Lackey, and I am a doctoral candidate at Virginia Tech and a licensed professional counselor. I am also the director for Roanoke Refugee Partnership, a nonprofit serving families of refugee status. I am reaching out to you because, as part of my dissertation, I am interviewing counselors who work or have previously worked with adult refugee clients. Counselors eligible for this study should have counseled at least three refugee clients for a minimum of three sessions each. The purpose of the study is to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. This will help fill some of the gaps in research within our field, and more importantly, increase our knowledge of the experiences counselors find important in order to counsel adult refugee clients. Ideally, this will lead to better research-informed practices for counselor education so that this population receives appropriate services.

The interview will take place virtually and will take about one hour. I understand the value of your time, and would greatly appreciate your participation. The interview will be recorded and transcribed, and a pseudonym will be used in place of your name to ensure your confidentiality is kept. If you are interested in being a part of this study, please fill out the short survey linked below regarding criteria to participate and demographic information. This survey will only take about ten minutes. If criteria is met, I will contact you via email to set up a time for the interview.

If you have questions, please reach out to me via email - lackey@vt.edu You may also contact my dissertation chair, Dr. Nancy Bodenhorn - nanboden@vt.edu

[Qualtrics link here]

Thank you for your consideration,

Bethany Lackey, LPC
Doctoral Candidate
Virginia Tech

Appendix C

Inclusion Criteria and Demographic Information

Thank you for your interest in participating in this research study on counselors experiences with counseling adult refugee clients. This survey will take 5-10 minutes to complete. The purpose is to verify eligibility of participants and to capture demographic information. If you are eligible to participate in the study, I will contact you by phone or email, depending on your preference, to set up an interview. The purpose of my study is to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients.

Criteria to participate include 1) being a post-master's level counselor 2) who has counseled at least three adult refugee clients 3) for a minimum of three sessions each. Information gathered through this study will help increase knowledge of the experiences counselors find important in order to work with adult refugee clients.

If you have questions, please contact me: Bethany Lackey lackey@vt.edu

You may also contact my dissertation chair: Dr. Nancy Bodenhorn nanboden@vt.edu

1) Please indicate your profession: _____

2) Please indicate your licensure status: _____

3) Please indicate your work setting (e.g. private practice, community services board, hospital, etc.): _____

4) When did you graduate with your most recent counseling degree? _____

5) Did you take a course on counseling the refugee population? _____

6) Approximately how many hours of continuing education have you received specific to refugee populations? _____

7) Please indicate the number of years you have worked with clients of refugee status:

8) How many clients of refugee status have you counseled in your practice? _____

9) What populations of refugees have you counseled?

10) Thinking of the three adult (18+) refugee clients you saw for the longest period of time, what is the approximate number of sessions you had with each? Please include the ages of these clients.

_____ sessions age of client _____

_____ sessions age of client _____
_____ sessions age of client _____

Demographics information

1. Gender: _____

2. Age: _____

3. Highest degree earned
 1. Bachelor's degree
 2. Master's degree
 3. Doctoral degree

4. Race/Ethnicity: _____

Contact Information

Name: _____

Pronoun: _____

Phone: _____

Email: _____

What is your preferred method of contact?

1. Phone
2. Email

What other information would you like to share at this time?

Appendix D
Snowball Sampling Request

Subject line: "Seeking Additional Counselors Who See Refugee Clients"

[Participant name], I am seeking additional counselors to participate in my research study in order for it to move forward. As a reminder, the criteria for participation is 1) being a post-master's level counselor 2) who has counseled at least three adult refugee clients 3) for a minimum of three sessions each.

If you know counselors who may fit these criteria, please forward them the following message:

My name is Bethany Lackey, and I am a doctoral candidate at Virginia Tech and a licensed professional counselor. I am also the director for Roanoke Refugee Partnership, a nonprofit serving families of refugee status. I am reaching out to you because, as part of my dissertation, I am interviewing counselors who work or have previously worked with adult refugee clients. Counselors eligible for this research study (IRB# 20-246) should have counseled at least three refugee clients for a minimum of three sessions each. The purpose of the study is to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. This will help fill some of the gaps in research within our field, and more importantly, increase our knowledge of the experiences counselors find important in order to counsel adult refugee clients. Ideally, this will lead to better research-informed practices for counselor education so that this population receives appropriate services.

The interview will take place virtually and will take about one hour. I understand the value of your time, and would greatly appreciate your participation. The interview will be recorded and transcribed, and a pseudonym will be used in place of your name to ensure your confidentiality is kept. If you are interested in being a part of this study, please fill out the short survey linked below regarding criteria to participate. This survey will only take about ten minutes. If criteria are met, I will contact you via email to set up a time for the interview.

If you have questions, please reach out to me via email - lackey@vt.edu You may also contact my dissertation chair, Dr. Nancy Bodenhorn - nanboden@vt.edu

[Qualtrics link here]

Thank you for your consideration,

Bethany Lackey, LPC
Doctoral Candidate
Virginia Tech

Appendix E
Interview Protocol

The purpose of the study is to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. The result of this will help me build on what we know as a field about preparing counselors to work with this population.

1. First, I want to know about you as a counselor. Tell me about why you became a counselor and your counseling style.
2. How did you start counseling adult refugee clients?
3. Please describe two positive experiences you have had while counseling adult refugee clients.
4. What do you wish you would have known before seeing adult refugee clients?
 - a. How did you learn [reiterate aspects participant wishes they knew]?
 - b. What impact did learning these things have on your sessions with clients?
5. What courses and trainings did you take that were more relevant to this work than other courses?
6. Again, think of positive experiences and challenges. What personal development and experiences were helpful in preparing you to counsel adult refugee clients?
7. If you were designing a curriculum in counseling adult refugees, what is one thing you would include?
8. What have I forgotten to ask you?

Appendix F
Coding Process Table

Open Codes	Axial Codes	Selective Codes (Themes)		
Discussing client trauma	Trauma understanding	Trauma-informed		
Trauma-informed language				
Client empowerment				
Client resilience				
Physical health education				
Do not pressure clients				
Refraining from assuming PTSD and needed treatment				
Stated need trauma training				
Mental health education				
Self education				Cultural understanding
Stated need for cultural humility				
Stated need for cultural competence				
Recognizing Privilege				
High level of importance of researching culture				
Being open to the whole person and their beliefs				
Understanding cultural context				
Global outlook	Social justice mindset	Counselor determination		
Social justice passion				
Advocacy in community				Going beyond
Pushing through obstacles in care				
Getting creative				
Not ready to see refugees				

Need for interpreters/Interpreter issues	Systemic obstacles	
Gap in care		
Medicaid barriers/Insurance issues		
Systems frustration		
Care for client	Importance of self	Integration of self
Empathy		
Cultural experiences		
Relationship investment		
Humor		
Curiosity		
Counselor self		

Appendix G
IRB Approval Letter



**Division of Scholarly Integrity and
Research Compliance**
Institutional Review Board
North End Center, Suite 4120 (MC 0497)
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-3732
irb@vt.edu
<http://www.research.vt.edu/sirc/hrpp>

MEMORANDUM

DATE: May 27, 2020
TO: Nancy E Bodenhorn, Bethany Ann Lackey
FROM: Virginia Tech Institutional Review Board (FWA00000572, expires October 29, 2024)
PROTOCOL TITLE: Counselors' Reflections on Their Experiences in Preparation to Counsel Adult Refugee Clients
IRB NUMBER: 20-246

Effective May 27, 2020, the Virginia Tech Human Research Protection Program (HRPP) and Institutional Review Board (IRB) determined that this protocol meets the criteria for exemption from IRB review under 45 CFR 46.104(d) category(ies) 2(ii).

Ongoing IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities impact the exempt determination, please submit a new request to the IRB for a determination.

This exempt determination does not apply to any collaborating institution(s). The Virginia Tech HRPP and IRB cannot provide an exemption that overrides the jurisdiction of a local IRB or other institutional mechanism for determining exemptions.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<https://secure.research.vt.edu/external/irb/responsibilities.htm>

(Please review responsibilities before beginning your research.)

PROTOCOL INFORMATION:

Determined As: **Exempt, under 45 CFR 46.104(d) category(ies) 2(ii)**
Protocol Determination Date: **May 27, 2020**

ASSOCIATED FUNDING:

The table on the following page indicates whether grant proposals are related to this protocol, and which of the listed proposals, if any, have been compared to this protocol, if required.

Invent the Future

SPECIAL INSTRUCTIONS:

*** The Virginia Tech IRB/HRPP has requested that research involving person-to-person contact or gatherings of human research participants be paused as soon as possible. The duration of the pause is unknown, but to reduce disruption to the extent possible, we will be reassessing daily. Although we continue to issue approval notices, Virginia Tech guidance should be followed. Please visit <https://www.research.vt.edu/covid-19-updates-impacts.html> for updates.

Date*	OSP Number	Sponsor	Grant Comparison Conducted?

* Date this proposal number was compared, assessed as not requiring comparison, or comparison information was revised.

Appendix H

Informed Consent

Virginia Polytechnic Institute and State University
Informed Consent for Participants in Research Projects Involving Human Subjects

Title: *Counselors' Experiences of Their Preparation for Working with Adult Refugee Clients*

Investigator: Bethany Lackey, LPC lackey@vt.edu 276-224-2647

Advisor/Dissertation Chair: Nancy Bodenhorn, Ph.D nanboden@vt.edu 540-231-8180

I. Purpose of this Research

The purpose of this study is to better understand counselors' experiences, both personal and educational, they feel best helped prepare them to counsel adult refugee clients. The results of this study will be used in my dissertation as well as publications directly associated with this research study.

II. Procedures

Following the initial inclusion and demographic questionnaire, approximately eight counselors will participate in an interview that will be about one hour. The interview will be audio and video recorded then transcribed so the investigator may review the interview as part of the research process. You may review your transcript in order to verify its content and make any clarification. This may be done up to one week after transcripts are available, and you will be notified via email regarding availability.

III. Risks

The risk involved in the study is minimal. Participants may feel emotional discomfort during the interview while discussing prior experiences. If you do feel discomfort, you may share this with the researcher. You may also choose to discontinue the interview at any time with no penalty.

IV. Benefits

This research regarding counselors' experiences of their training to work with refugee clients will help fill gaps in counseling literature and counselor education practice. It could potentially add to the knowledge we have of experiences counselors find important in order to counsel adult refugee clients. It may also be beneficial to participants by eliciting positive emotions related to their practice with refugee clients.

V. Confidentiality

Your confidentiality as a participant is very important in the research process. You will be assigned a pseudonym, and all other potentially identifying information will be removed to protect your anonymity in the analysis and publication process. The interview recording and transcript will be password-protected. The recordings and transcripts may be audited by the Virginia Tech Institutional Review Board (VT IRB) and the investigator's dissertation committee. In cases of suspected child abuse or if the participant is at risk of harming self or others, confidentiality cannot be maintained.

VI. Compensation

There will be no compensation for your participation in this study.

VII. Freedom to Withdraw

As a participant, you may withdraw at any time from this study, as your participation is voluntary. You also have the right to choose which questions you feel comfortable answering during the interview.

VIII. Questions of Concerns

If you have any questions or concerns, please feel free to contact the researcher, Bethany Lackey, with the contact information above. This research has been reviewed and approved by the Virginia Tech Institutional Review Board (IRB). You may communicate with them at 540-231-3732 or irb@vt.edu if:

- You have questions about your rights as a research subject
- Your questions, concerns, or complaints are not being answered by the researcher
- You cannot reach the researcher
- You want to talk to someone besides the researcher to provide feedback about this research

If you would like to contact the VT IRB regarding your rights in this study, you may do so by phone or email: 540-231-3732 / irb@vt.edu.

IX. Statement of Consent

I have read and understand the information in this document, and my questions have been answered. I consent to voluntary participation in this research study.

Participant printed name

Participant signature

Date