Examing the Therapeutic Process with Refugee Youth

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UNIVERSITY OF MIAMI

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in Education

EXAMINING THE THERAPEUTIC PROCESS WITH REFUGEE YOUTH

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In an effort to make mental health services more accessible to and appropriate for refugee and immigrant youth, mental health practitioners are increasingly adopting community-based, comprehensive models of clinical practice that bridge therapy, case management, and advocacy. Though existing empirical evidence, however limited, suggests these programs are successful in improving outcomes and reducing symptoms for refugee children and adolescents, little is known about the specific tactics individual clinicians employ to guide the therapeutic process within these settings. To answer the question, “How do mental health clinicians supporting refugee clients approach clinical practice?” this study used grounded theory coding to thematically analyze semi-structured interviews previously conducted with five mental health clinicians working in community-based clinical practice with refugee youth. Results suggest that clinicians cultivate expansive, non-traditional therapeutic relationships with their clients and other actors as a means of bridging cultural difference and responding to clients’ complex needs. Particular strategies clinicians used to build these relationships were examined, and ethical dilemmas regarding establishing boundaries emerged. These findings provide a nuanced understanding of the mechanics of community practice and its personal impact on practitioners while at the same time underscoring the need for clinical training that better prepares professionals to work with diverse clients.
## TABLE OF CONTENTS

Chapter 1: Introduction .................................................................................................................. 1
  Purpose of the Present Study ....................................................................................................... 2
  Conceptual Framework .................................................................................................................. 2
  Researcher Positionality ................................................................................................................. 4
  Refugees in the United States ......................................................................................................... 6
Chapter 2: Literature Review ......................................................................................................... 9
  Prevalence of Mental Health Concerns Among Refugees .............................................................. 9
    Construction of Disorder in the Present Study ............................................................................. 9
  Disorder Prevalence ...................................................................................................................... 10
  Influences on Mental Health Outcomes for Refugees ................................................................. 11
    Acculturative Stress ..................................................................................................................... 12
    Discrimination-Related Stress .................................................................................................... 13
  Structural Barriers ....................................................................................................................... 13
  Utilization of Mental Health Services .......................................................................................... 14
  Clinical Profile of Refugee Youth .................................................................................................. 16
    Functional Impairment, Integration, and Mental Health Outcomes ............................................ 16
  Clinical Practice with Refugees ...................................................................................................... 19
    Complex Mental Health Needs of Refugee Populations ............................................................. 19
    Evidence-Based Practice and Practice-Based Evidence ............................................................ 20
    Multicultural Approaches .......................................................................................................... 24
    Social Justice Approaches .......................................................................................................... 29
  Contribution of the Present Study ................................................................................................. 31
Chapter 3: Methodology ................................................................................................................. 32
  Data Collection Procedures .......................................................................................................... 32
  Sample ........................................................................................................................................ 34
    Clinical Training and Professional Organizations ...................................................................... 34
    Participant Demographics .......................................................................................................... 34
    Professional Experience and Organizations .................................................................................. 34
    Client Demographics .................................................................................................................. 35
  Data Analysis ............................................................................................................................... 36
Chapter 4: Results ............................................................................................................................ 38
  Context of Complexity in Clients’ Lives ......................................................................................... 39
    Coping with Trauma .................................................................................................................... 39
    Acculturating to New Systems ..................................................................................................... 48
    Navigating Shifting Roles and Resources ................................................................................. 50
    Protective Factors and Resilience ............................................................................................... 56
  Relationships as Therapeutic Core ............................................................................................... 61
    Adjusting to Different Perceptions of Self, Others, and Community ........................................... 62
    Re-conceptualizing Therapy ........................................................................................................ 64
    Searching for Cultural Context ................................................................................................... 67
    Interpreters and the Therapeutic Relationship .......................................................................... 69
    Relationships as Protective Factors ........................................................................................... 71
  Addressing Therapists’ Personal and Professional Needs ............................................................. 74
  Relationships as Cause and Effect in Community Work ............................................................... 81
CHAPTER 1: INTRODUCTION

Since the initiation of its official resettlement program in 1980, the United States has accepted over two million refugees (Brown & Scribner, 2014) from increasingly diverse ethnic, racial, linguistic, socioeconomic, and educational backgrounds. The humanitarian focus of the program aims to provide safety for individuals fleeing imminent danger, many of whom have been exposed to violence, armed conflict, and intimidation prior to their arrival in the United States (Thomas, Thomas, Nafees, and Bhugra, 2004). As a result, many of those granted refugee status are at risk for psychological distress that may impact their overall quality of life as well as their ability to integrate into U.S. society. This risk is often exacerbated by stressors experienced during the resettlement period, during which refugees must overcome challenges related to acculturation, discrimination, and structural barriers to integration.

Though refugees use mental health services at significantly lower rates than the non-refugee population (Birman et al., 2008), those who do engage in services often face challenges to receiving effective services. These challenges include the complexity of symptoms refugees experience, the range of stressors present in refugees’ lives that may impede the treatment process, the limited availability of evidence-based practices that can inform clinicians’ treatment planning, and cultural and linguistic barriers to the therapeutic relationship. While researchers have begun accumulating practice-based evidence aimed at understanding how certain therapeutic techniques can be successfully adapted for work with refugee clients (Birman et al., 2005; Beehler et al., 2012), this evidence remains limited, providing little information on the particular impairments refugees face in their day-to-day lives or insight on how clinicians who have been
working successfully with refugee populations implement clinical decision-making tactics to help improve clients’ lives and relationships.

**Purpose of the Present Study**

By documenting current approaches to clinical community work with refugees, this study helps fill these gaps in our knowledge regarding clinicians’ experience providing mental health services to refugee clients. I explore the question: How do mental health clinicians supporting refugee clients approach clinical practice? In order to answer this question, I consider service providers’ perceptions of clients’ functional impairments and factors contributing to such impairments at various levels of analysis. Furthermore, I examine these clinicians’ conceptualizations of cultural competence in the clinical setting and their approaches to planning and guiding the therapeutic process.

**Conceptual Framework**

This analysis is informed by the ecological metaphor grounded in the field of community psychology. The ecological metaphor was introduced to community psychology in 1972 by Trickett, Kelly, and Todd and has since been adopted as a central value of the field. This perspective departs from traditional psychological approaches to assessment and treatment of mental health concerns by embodying a contextual approach to examining individuals’ lived experiences, exploring the impact of environmental factors on individuals and families. Unlike mainstream psychology, rather than blaming individuals for the problems they experience by attributing them to purely individual factors, such as motivation or IQ, the ecological metaphor posits that individual behavior
is shaped by interdependent variables interacting at multiple levels of analysis (Bronfenbrenner, 1977).

These levels of analysis include micro, meso, and macro layers (Bronfenbrenner, 1977). The micro level of analysis is that which is largely unique to the individual’s inner social circle and most immediately impacts her. Household and family dynamics could be considered as micro-level systems in which the individual is embedded. The meso level of analysis, meanwhile, comprises the interrelationship between various micro systems; these relationships impact micro-level variables and are impacted by larger structural (macro) variables. Schools, community health clinics, or community-based organizations may be considered meso-level settings. Finally, the macro level of analysis encompasses overarching structural factors, such as governmental policies and cultural norms, which are largely beyond the individual’s control but affect her indirectly through their manifestations at the micro level.

This model provides important insight into refugees’ experiences in the resettlement process, during which newcomers are forced to navigate two cultural systems, each with corresponding microsystems (Birman, 2011). In addition to those micro-, meso-, and macro-level factors experienced in the pre-migration and migration processes, upon arrival to the United States, refugees often must rapidly adjust to considerable changes in family dynamics and sense of personal identity; navigate new school and community settings; and learn to function within an entirely new system of laws, policies, and cultural norms, many of which may present significant barriers to successful integration (Weine et al., 2011; Brown & Scribner, 2014).
Many studies have focused on how factors at various levels of analysis, particularly the micro and meso levels, influence mental health outcomes for refugees (Ellis et al., 2008; Ellis et al., 2010; Fazel et al., 2012; Correa-Velez et al., 2015; Trentacosta et al., 2016). However, no known study has examined how clinicians support refugee clients in navigating these multi-level influences as part of the therapeutic process, despite increasing calls from scholars and practitioners for clinicians to expand the bounds of clinicians’ traditional “helping” roles to account for the impact of factors at different levels (Lewis, 2011; Ratts and Pedersen, 2014; Bemak and Chung, 2017). Chung, Bemak, Ortiz, and Sandoval-Perez (2008) have suggested that an approach that takes into account these various levels of influences is particularly important for work with immigrants and refugees, and other scholars note the importance of adopting an ecological approach to clinical practice, in particular, given the damaging effects of oppression on individual well-being (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2016). Thus, in its explicit consideration of clinician understandings of multi-level influences on refugee mental health and their related decision-making process vis-à-vis guiding the therapeutic relationship, this study contributes a new perspective to the literature on mental health care with refugee communities.

**Researcher Positionality**

In accordance with the principles of ethical research in Community Psychology and qualitative methodology at large, I would like to acknowledge my relationship with this topic. I am neither a mental health clinician nor from a refugee background myself. My interest in refugee communities in the United States stems from my larger interest in
promoting respect for all people and appreciation of the capacity of meaningful exposure to cultural diversity to enrich our lives, relationships, and society. I have had the opportunity to work with refugees and immigrants in a variety of capacities over the past seven years and have found that this exposure to different ways of thinking and living has taught me to think more critically and experience life more fully. At the same time, I have also learned more about some of the struggles and challenges these communities face as they integrate into U.S. society. As a mental health consumer myself, I am particularly interested in the ways in which such struggles affect communities’ psychological well-being and how community advocates and practitioners can help prevent and/or ease any suffering that results from this reality. I recognize that my own identity impacts my ability to represent both refugee communities and clinicians in my research and writing. As an immigrants’ rights advocate with a strengths-based approach to research and practice, I perceive and discuss refugee acculturation through a critical framework. At the same time, I recognize that my outsider relationship to the immigrant experience puts me at risk for misrepresenting my participants and their clients by constructing their experiences through my own worldview (Haarlammert, Birman, Oberoi & Moore, 2017). I hope that, by approaching this topic with a learning mindset, seeking feedback along the way, and acknowledging any findings as necessarily influenced by my own lived experiences, I have done justice to participants and their clients.
Refugees in the United States

Though the United States’s history of resettling refugees began with an *ad hoc* practice grounded in the promotion of U.S. foreign policy interests in the years following World War II, formal resettlement policy was not introduced until the Refugee Act of 1980, which shifted the underlying premise towards a humanitarian interest in protecting the most vulnerable individuals without attention to foreign policy aims (Anker, 1990). As a result of this expanded focus, refugee demographics since that time have become increasingly ethnically diverse: refugees arriving in the United States in fiscal year 2016 were speakers of 162 languages representing 78 countries of origin (Fix, Hooper, & Zong, 2017), chief among them “the Democratic Republic of Congo, Syria, Burma (Myanmar), Iraq, Somalia, Bhutan, Iran, Afghanistan, Ukraine, and Eritrea” (p. 5). These newcomer groups joined large established communities from Cuba, the former Soviet Union, and Vietnam. According to Capps et al. (2015), intragroup difference in certain characteristics, such as language and age, is also increasingly prevalent: co-national individuals from Somalia and Burma arriving between fiscal years 2004 and 2013, for example, spoke 31 and 61 distinct languages, respectively.

A significant portion of these refugees are children and adolescents. Martin and Yankay (2012) indicate that nearly 40% of the U.S. refugee population is under age eighteen (as cited in Sullivan and Simonson, 2016). However, youth as a proportion of the population varies by ethnic origin. Liberian and Somali populations, for example, had relatively high rates of arrivals under age fourteen for the period between 2002 and 2013, at 36% and 34% of the population, respectively, while Iranian and Cuban communities reported lower rates of 13% and 19%, respectively (Capps et al., 2015).
The high proportion of youth represented among newcomers is significant, as scholars and practitioners alike have noted that children and adolescents often face unique challenges during their resettlement experiences. These include difficulties in school transitions as a result of interrupted educational processes in their countries of origin or first asylum; identity-related challenges related to the acculturation process; and familial tension resulting from differential rates of acculturation between parents and children (Birman et al., 2005).

In addition to being characterized by considerable diversity on such factors as age and ethnic origin, refugee populations vary widely in terms of prior educational experiences, English language proficiency, and living conditions, among other factors (Fix et al., 2017). On these markers, refugees’ backgrounds may range, respectively, from illiteracy in one’s native language to college-educated or beyond; from zero English proficiency to training in professional English; and from decades of living in camp settings to mostly urban living. Intergroup differences in such experiences are high; for example, native-language literacy levels among Cubans and Iranians were near 100% between 2004 and 2013, as compared with levels below 25% among Somalis and Hmong (p. 6). Furthermore, the shift towards humanitarian-based claims has led to admission of individuals with higher rates of exposure to trauma, torture, and poverty that may impact their pathways towards integration.

This diversity has created challenges for receiving communities, who must learn how to accommodate a broad range of complex linguistic, educational, employment, social, and psychological needs (Barkdoll, Weber, Swart, & Phillips, 2012). These communities do so even though placements are increasingly to smaller towns that may
lack the infrastructure and experience to meet these needs. This overstretching of resources, in turn, has fueled rising opposition towards and discrimination against newcomers in many locales (Barkdull et al., 2012; Fix et al., 2017). Given already-high rates of perceived discrimination among individuals from certain refugee backgrounds (Ellis et al., 2010; Fazel, Reed, Panter-Brick, & Stein, 2012) and the established relationship between discrimination and mental health outcomes (Ellis, MacDonald, Lincoln, & Cabral, 2008; Ellis et al., 2010; & Fazel et al., 2012), particularly during the initial resettlement period (Danso, 2002), this rising anti-refugee sentiment may, in turn, impact newcomers’ integration prospects. This study helps contribute to a wider body of literature on how service providers can support refugee communities as they work to overcome these challenges to successful integration.
CHAPTER 2: LITERATURE REVIEW

Any study of clinical practice with refugee youth must be grounded in the existing theories and empirical findings related to this work. In this literature review, I first outline the findings on mental health issues among refugee communities, including their prevalence and factors contributing to their development. Next, I discuss refugee communities’ engagement in mental health services and the associated symptoms and functional impairments with which they present in these settings. I continue on to examine the current approaches to clinical practice with refugee youth, including the complex mental health needs that influence this practice; current findings in evidence-based practice and practice-based evidence; and approaches to cultural competence in multicultural and social justice practice. Finally, I analyze my study’s contribution to this literature.

Prevalence of Mental Health Concerns Among Refugees

Construction of Disorder in the Present Study

There is considerable debate in the psychological literature regarding the construction of mental health concerns and functional impairments as “disorders.” Though the biomedical concept of mental disorder as a chemical imbalance yielding consistent, diagnosable symptoms is central to the fields of psychology and psychiatry, many researchers and writers have expressed concerns of the over-emphasis in psychological sciences on the concept of disorder. These concerns stem from a variety of disciplines and philosophical perspectives, from positivistic concerns regarding the
validity of mental illness as a scientific claim (see Goddard, 2014); to multicultural concerns of the cross-cultural validity of certain causes of symptoms of “disorder” (Bemak & Chung, 2017), including the risk of pathologizing “normal responses to abnormal situations” (Ehntholt & Yule, 2006, p. 1199); to postcolonial concerns of the inherent power dynamics involved in the categorization of what qualifies as “disordered” or acceptable behavior (Montero, 2011). In the spirit of maintaining an ecological approach to the topic of clinical approaches to working with refugees, I will attempt to maintain a relatively loose concept of mental health concerns as contextually-driven functional impairments to adjustment rather than as “disorders” according to the more traditional constructions. However, to the extent that notions of disorder are entrenched within mainstream psychology and therefore have considerable influence on access to resources in clinical settings like those to be examined in this study (Ehntholt & Yule, 2006), and to the extent that the discourse of disorders may also prove useful in establishing the presence of mental health struggles experienced by refugee populations and, in the process, highlight environmental barriers to well-being, I find justification for outlining the literature on prevalence of mental “disorders” below.

**Disorder Prevalence**

Estimates of the prevalence of mental distress among refugee populations remain conflicting. In their article on well-being after trauma, Chan, Young, and Sharif (2016) discuss prevalence rates of mental disorder related to war trauma as portrayed in several earlier studies. One such study was Steel et al.’s (2009) meta-analytic examination of data collected internationally from over 64,000 refugees and conflict-affected populations of diverse ethnic origin. The authors estimated a prevalence rate of 30% for
posttraumatic stress disorder (PTSD) and 31% for major depressive disorder. However, due to methodological and sampling differences, these figures varied significantly in each individual study included in the meta-analysis: in their 2015 study of mental health among Iraqi communities, for example, Slewa-Younan, Uribe Guajardo, Heriseanu, and Hasan estimated a 75% prevalence of major depressive disorder and a PTSD prevalence ranging from 8% to 37% (as cited in Chan, Young, & Sharif, 2016, p. 292).

Though inconsistent, these estimates suggest that refugees suffer from mental health concerns at a significantly higher rate than the general public in the United States, which suffers from PTSD and depression at estimated rates of 3.5% and 6.6%, respectively (Lambert & Alhassoon, 2014). Refugee youth in particular are at least twice as likely as their U.S. counterparts to suffer from mental health issues in general, with an estimated 40% to 50% prevalence of “one or more mental disorders” (Sullivan & Simonson, 2016, p. 506). Of these disorders, PTSD accounts for an approximate 11%, a rate ten times higher than that estimated for U.S. children in general (Fazel, Wheeler, & Danesh, 2005, as cited in Sullivan & Simonson, 2016, p. 506).

**Influences on Mental Health Outcomes for Refugees**

Refugees’ resettlement journeys can be understood as existing within a “triple-trauma paradigm” in which they are at risk for traumatic exposures at three distinct phases of migration: prior to migration, during flight, and post-resettlement (Fazel & Stein, 2002). Prior to and during migration, refugees, by definition, have personally experienced or been in close proximity to traumatic events. In one 2004 study by Thomas et al., 86% of refugee youth sampled “had witnessed or experienced violence”
(as cited in Sullivan & Simonson, 2016), with an average number of violent incident exposures of 4.8. Such experiences of violence included rape, imprisonment, and forced hiding, among others. As cumulative trauma increases rates of psychological distress, this high rate of exposure poses considerable risks to youth (Sullivan & Simonson, 2016), who are also at-risk for inter-generational transference of trauma experienced by parents (Baker & Shalhoub-Kevorkian, 1999, as cited in Sullivan & Simonson, 2016).

There is a relative lack of emphasis in research and clinical practice on the effects of post-migration stressors on mental health outcomes for refugees (Ellis et al., 2008); however, those studies that have examined the impact of resettlement stress on refugees’ outcomes note that certain mental health issues are heavily influenced by the resettlement experience. This is true for both PTSD and depression, with the latter best predicted solely by resettlement stress as opposed to pre-migration traumatic exposure (Sack, Clarke, & Seeley, 1996, as cited in Ehntholt & Yule, 2006). Ellis and colleagues (2008) note that studies on stressors related to post-resettlement mental health outcomes focus on acculturative and identity stressors, including the role of perceived discrimination.

**Acculturative Stress**

Several factors contribute to stress during the acculturation process. According to Birman and colleagues (2005), refugee families experience a myriad of challenges during the resettlement period, including worries related to meeting basic needs such as housing, medical care, and employment, and those resulting from the integration process, such as linguistic and cultural shock, social isolation, and familial conflict. Of notable importance as a stressor related to family functioning is the development of an acculturation gap whereby children integrate faster into the host society, developing new
cultural identities that parents struggle to understand. This gap can lead to tension and disconnect between parents and youth, depriving individuals of a crucial protective factor that may otherwise help combat psychological distress (Trentacosta et al., 2016).

**Discrimination-Related Stress**

Another acculturative stressor that can impact refugee outcomes is discrimination, which may be expressed through host society reception, public rhetoric, and interpersonal experiences with members of the dominant culture. On an interpersonal level, refugees in general (and refugee youth in particular) are often targets of discrimination on the basis of multiple social identities, including race, religion, ethnicity, and socioeconomic status, putting them at significant risk for developing mental health concerns and/or exacerbating existing ones (Ellis et al, 2010; Fazel et al., 2012). Refugees must contend with discrimination and anti-immigrant sentiment on a cultural level, too, particularly since the presidential election of Donald Trump, whose ultra-nationalistic policy perspectives have marked a new era in resettlement-related discourse and practice alike with his threat-oriented characterization of immigrants and refugees and establishment of a historically low refugee ceiling (Pierce & Selee, 2017). As Bemak and Chung (2017) assert, xenophobic rhetoric of this sort “may contribute to hostility, exclusion, rejection, and subsequent refugee trauma” (p. 301).

**Structural Barriers**

As indicated above, several studies note the formidable challenges refugees face related to meeting basic social service needs, including securing affordable housing, stable employment with a decent wage, and adequate medical care (Ellis et al., 2008;
Trentacosta et al., 2016). In their critique of the “unfulfilled promises” (p. 103) of the U.S. resettlement system, Brown and Scribner (2014) detail how narrow definitions of self-sufficiency, insufficient resource allocations tied to stagnant funding, and lack of collaboration between refugee adjudicators abroad and resettlement providers domestically result in an inefficient and overburdened system unprepared to meet arriving refugees’ increasingly diverse needs. However, few studies have espoused as a primary aim the examination of how institutional policies and procedures impact mental health outcomes of refugee populations, particularly within a clinical setting. Indeed, in terms of outcomes, “[a]n individualized, biomedical focus by and large estranged from broader socio-cultural context has predominated” (Edge, Newbold, & McKeary, 2014, p. 34), except for a recent and expanding body of literature on the impact of interpersonal discrimination on refugee mental health (summarized above). In a rare, longitudinal ethnography of 73 refugee adolescents of Liberian and Burundian descent, Weine and colleagues (2011) document how institutional failures such as fixed funding rates unresponsive to cost of living in an area, ethnocentric definitions of family, and lack of policy response to high rates of secondary migration impacted adolescents’ and families’ overall well-being. This study did not specifically discuss implications of these institutional variables on refugee mental health or service provider approaches to working with impacted clients.

**Utilization of Mental Health Services**

Refugees are under-represented in the formal mental health treatment sector (Birman et al., 2008). Sullivan and Simonson (2016) attribute this underutilization of
services to a combination of three factors: the relative youth of the refugee population in
the United States, its symptom internalization, and its minority status. As noted by Bean,
Eurelings-Bontekoe, Mooijaart, and Spinhoven (2006), children in general are less likely
to engage in mental health services than are adults (as cited in Sullivan & Simonson,
2016, p. 507). Given that around 40% of the more than 21 million individuals worldwide
classified as refugees are youth under the age of 18 (Edwards, 2016; Ellis et al., 2013),
refugees as a whole are therefore also less likely to utilize mental health services than the
general population. Furthermore, this population is often characterized by internalizing
symptoms, or those which “are less noticeable or intrusive to others, thus reducing
likelihood of referral” (Sullivan & Simonson, 2016, p. 507). Finally, refugees are also at
risk for service underutilization due to their status as racial and/or ethnic minorities in the
United States, a country where racial and ethnic minorities face significant barriers to
engagement in formal mental health care.

Notably, this underutilization of mental health services among refugee
populations is not due to a lack of desire or perceived need. Indeed, in a 2006 Dutch
study comparing perception of need for community mental health services and
willingness to engage in services among refugee populations versus a control sample,
nearly 60% of the refugee respondents reported need for services, and 72% were willing
to engage in services were they available. These high rates of desired engagement
juxtaposed sharply against the respective 8% and 12% among the general Dutch
population (Bean et al., 2006, as cited in Sullivan & Simonson, 2016, p. 507). Similarly,
in a 2014 study of perceived effectiveness of mental health interventions among Iraqi
refugees in Australia, Slewa-Younan and colleagues found that psychotherapy was
among the top three activities favored as a potentially-helpful intervention, with over 70% of those refugees sampled affirming its plausible effectiveness.

Clinical Profile of Refugee Youth

Functional Impairment, Integration, and Mental Health Outcomes

The term *functional impairment* is used in the American Psychological Association’s Diagnostic and Statistical Manual of Mental Disorders (DSM), along with distress, as one of two primary criteria necessary to determine the clinical significance of a mental health concern (Üstün and Kennedy, 2009), or the impact of the disorder on the individual’s everyday life (Stein et al., 2010). Though there is some ambiguity surrounding the term *functional impairment* resulting from its lack of definition in the DSM(-IV), this term can be operationally understood as the experience of disability resulting from disorder. As contrasted with *symptoms* of mental health issues, such as problems with sleep, attention, or memory, which relate to or stem from internalized cognitive and/or emotional effects of disorder, *impairments* can be best understood as the external impact of this disorder in one’s social functioning and general quality of life understood holistically, including the individual’s interaction with his environment (Üstün and Kennedy, 2009). The functional experience of disability may entail everyday difficulties in functioning within academic, social/interpersonal, and occupational realms (Stein et al., 2010).

Clinician awareness of the functional impairments of mental health concerns is important, as such impairments can be “used to plan treatment, track clinical progress and predict treatment outcome” (Üstün and Kennedy, 2009, p. 83). Furthermore, for
refugees, functional outcomes may be particularly significant given the correlations between social support during the integration process and levels of psychological distress among certain refugee populations (Fazel et al., 2012; Trentacosta et al., 2012). As presence of such protective factors as sense of belonging in school and supportive relationships with parents are associated with better outcomes for youth in particular (Trentacosta et al., 2012), it stands to reason that improvement in functioning may lead to improvement in overall wellness and management of distress, insofar as improved functioning leads to better integration outcomes.

However, despite the significance of functional ability on potential outcomes, there is relatively little focus on such measures in either clinical or research settings (Greer, Kurian, & Trivedi, 2010). Few studies have sought explicitly to examine the clinical profiles of refugees, including both functional impairments and trauma histories (Betancourt et al., 2012), in their own right. Instead, the social burdens of mental health concerns are more often briefly listed as “other concerns” accompanying diagnostic profiles of disorder, rather than as functional impairments that characterize the experience of disability. In such a fashion, Ehntholt and Yule (2006) identified a combination of certain symptoms and functional impairments of mental health concerns as “additional psychological difficulties” coexisting with disorders such as PTSD and depression. Among these were “somatic complaints, sleep problems, conduct disorder, social withdrawal, attention problems, generalised fear, overdependency, restlessness and irritability, as well as difficulties in peer relationships” (p. 1199).

One notable exception to this lack of research was a 2012 study by Betancourt and colleagues, who analyzed quantitative data housed in the Core Data Set of the
National Child Traumatic Stress Network (NCTSN) to create a limited portrait of trauma history and functional impairments of refugee children and youth seeking treatment in NCTSN-affiliated centers across the country. This data included clinician evaluations, the Trauma History Profile, and symptoms of PTSD as expressed in the UCLA PTSD Reaction Index (UCLA PTSD-RI). Though significantly limited by challenges to the data set, including restricted ability to separate refugees from other immigrant groups within the data and limited availability of NCTSN measures in languages other than English and Spanish (thereby excluding a large portion of the already-limited refugee youth who access mental health services), the researchers were nevertheless able to surmise some probable trends. Notably, they identified traumatic loss, community and/or domestic violence, and forced displacement as the most common trauma exposures shared among their sample. These traumatic experiences often co-occurred with other traumatic exposures, including caregiver impairment and experiences of war or politically-motivated violence.

The researchers also outlined several trends related to those functional impairments with which refugee youth presented in the clinical setting. Like other groups with high rates of traumatic exposure, refugee youth presented with high incidence of behavioral problems at home, school, and/or in the community; academic problems related to school work and academic achievement; and attachment issues, characterized by a lack of trust and issues in caregiver relationships. Unlike similarly-exposed groups, however, there was a notable abstention from risk-taking behaviors among the sample, which was characterized by exceptionally low rates of engagement in crime, substance abuse, fleeing the home, and risky sexual behavior. However, given the
quantitative nature of the study and gaps in the data set, the contours of these functional impairments and risk-taking abstinences were not explored in much depth, leaving much room for further exploration regarding the specific manifestations of these behavioral, academic, and interpersonal difficulties, as well possible protective factors insulating youth from risk-taking behavior.

**Clinical Practice with Refugees**

**Complex Mental Health Needs of Refugee Populations**

As noted previously, refugees, by definition, have suffered exposure to traumatic experiences such as war, sexual violence, torture, loss of family and property, and imprisonment (Birman et al., 2005). Many refugee families have experienced repeated exposures over several decades, resulting in complex, cumulative trauma (Bronstein & Montgomery, 2011, cited in Sullivan & Simonson, 2016) that may be passed down from one generation to the next (Danieli, 1985, cited in Baker & Shalhoub-Kevorkian, 1999). This complex trauma may be compounded by resettlement stressors post-migration that further impact individuals’ mental health and cognitive development (Ellis et al., 2008; Beehler et al., 2012).

As a result, refugees may display a range of psychological challenges—such as post-traumatic stress disorder (PTSD), mood disorders, somatization, and traumatic grief (Betancourt et al., 2012)—and functional impairments, including behavioral and academic problems (Bronstein & Montgomery, 2011; Sullivan & Simonson, 2016) and attachment issues (Betancourt et al., 2012). Furthermore, due to barriers to accessing formal mental health treatment, refugees may only access treatment once symptoms have
become severe, heightening service complexity (Bemak & Chung, 2017). In recent years, scholars and practitioners have increasingly focused on the significant resilience that refugee communities display in the face of such challenges, noting that factors such as family cohesion and sense of belonging may help insulate individuals from developing mental health issues (Fazel et al., 2012; Masten & Narayan, 2012; Trentacosta et al., 2016). Even so, the severity and cumulative nature of many refugees’ exposure to risk factors have led counselors to develop treatment methods designed specifically to address these complex needs.

**Evidence-Based Practice and Practice-Based Evidence**

Due to its positivistic origins, the field of psychology relies heavily on “evidence-based practices” proven through randomized clinical trials to determine the effectiveness of particular techniques for improving mental health outcomes among specific populations (Birman et al., 2008). However, though research interest in the effectiveness of interventions geared towards refugees and immigrants has been growing in the past decade, relatively few such trials have been conducted with refugee and immigrant populations, and less so with refugee youth (Ehntholt & Yule, 2006; Beehler et al., 2012). Birman and colleagues (2008) note that this lack of research stems, in part, from ethical “concerns among service providers about denying services to a high need population for the sake of scientific rigor” (p. 122). Furthermore, the complex challenges of resettlement and considerable diversity among refugees may not lend themselves to development or testing of manualized programs specific to these populations, as these trials are conducted in highly-controlled settings with non-refugee participants who are less likely to have been impacted by complex trauma and acculturative stress. Indeed,
even trauma-oriented adaptations to traditional, manualized interventions, such as trauma-focused cognitive-behavioral therapy (TF-CBT), were designed to treat a single traumatic event and do not take into account the “complex trauma” that is pervasive in refugee communities. As a result, even if such trials were systematically administered with refugee populations, there remains considerable skepticism as to their ability to translate adequately to real-world practice (Birman et al., 2008; Beehler et al., 2012).

Thus, many researchers have advocated for the development of “practice-based evidence” that builds on “the accumulated wisdom of years of programming for varied refugee groups” (Birman et al., 2012, p. 123). In addition to harnessing non-randomized techniques such as “dose effect” and case studies to evaluate the use of traditional and adapted psychotherapeutic interventions with refugee populations in a variety of settings, such methods may be better able to illuminate how practitioners develop cultural competence in the face of considerable cultural and linguistic diversity, exercise “clinical judgment” (Beehler et al., 156) while attending to a range of complex variables, and confront the various factors that impact refugee wellness at multiple levels of analysis. Indeed, several smaller-scale studies have been able to assess effectiveness of treatments used in practice with immigrant and refugee youth. In a review of such treatments as employed in school settings, Sullivan and Simonson (2016) outline three primary approaches: trauma-oriented adaptations to traditional psychotherapeutic approaches (such as various forms of cognitive-behavioral therapy), group-based creative expression therapies, and multi-tiered interventions.

**Cognitive-behavioral therapy.** Sullivan & Simonson (2016) note that analyses of cognitive-behavioral therapy (CBT) techniques with refugees have consistently
confirmed their effectiveness in treating symptoms of PTSD; however, results related to treatment of symptoms of depression and anxiety have remained mixed. In a meta-analysis of 12 trauma-focused therapeutic interventions with refugee adults, Lambert and Alhassoon (2014) found large effect sizes confirming the effectiveness of trauma-focused adaptations of cognitive-behavioral therapy (CBT), narrative-exposure therapy (NET), and eye movement desensitization and reprocessing (EMDR) in reducing symptoms of both PTSD and depression. This finding is consistent with Fox et al.’s (2005) study confirming the reduction of depressive symptoms among Southeast Asian refugee adolescents through a CBT program facilitated by school personnel (cited in Sullivan & Simonson, 2016) but contrasts with an earlier study by Ehntholt et al. (2005, cited in Sullivan & Simonson, 2016), in which group-based CBT showed no changes to depression-related outcomes for war-exposed youth. The mixed results of these findings may reflect the different methods of implementation of the intervention (i.e., group-based or individual; clinician-led or led by school personnel) as well as the interplay of complex variables impacting both the school setting and refugee youth’s lives.

**Creative expression therapies.** Creative expression therapy (also called expressive arts intervention) involves the use of activities that “incorporate creative elements designed to provide individuals with outlets to express feelings and process emotions” (Sullivan & Simonson, 2016, p. 517). This may include elements of music, drama, writing, art, or dance. Creative expression therapy is a common approach to intervention with refugee youth given its ability to transcend stigma and linguistic difficulty, as well as its potential familiarity to refugees from certain cultures (Birman et al., 2005). However, despite being the most commonly-implemented approach, it also
has produced the least consistent empirical results (Sullivan & Simonson, 2016). In their review of school-based creative expression therapies, Sullivan and Simonson (2016) detail improved symptoms in some studies but not others, with one study actually demonstrating increased teacher-assessed behavioral impairments (Baker & Jones, 2007).

**Comprehensive or multi-tiered interventions.** Refugee populations’ low engagement with traditional mental health services and their complex needs have underscored the necessity for interventions that offer a more holistic approach to treatment. These programs complement traditional counseling services with other social services, such as “case management and tangible adjustment support” (Beehler et al., 2012, p. 156). In contrast to “singular” interventions, in multi-tiered approaches, intensity of services is scaled according to severity of client need (Sullivan & Simonson, 2016). According to Birman et al. (2008), who conducted a case study of the International Family Adult, and Child Enhancement Services (FACES) program, this type of intervention expands the role of the clinician beyond that typically associated with the therapeutic relationship. In addition to conducting TF-CBT as needed with clients, clinicians may engage in outreach, case management, and community consultation, including with cultural brokers, or staff members who are from refugee backgrounds themselves and serve to increase community engagement with services and clinician cultural competence. Service setting is also flexibly structured: clinicians may work from the traditional office environment, conduct home visits, or travel to schools, public parks, or any other location that fits within the purview of providing comprehensive services.
In their evaluation of the FACES program, the researchers found evidence of improvement in refugee youth’s outcomes over time but were unable to confirm that this improvement “was a function of the quantity of services received” (p. 129). Additionally, they noted that ethnic matching of clients with cultural brokers increased engagement and retention but did not impact clinical outcomes. These findings regarding the impact of comprehensive programs on immigrant youth outcomes were further confirmed in a 2012 study by Beehler et al., who demonstrated the effectiveness of a school-based, wraparound-style intervention in reducing symptoms of PTSD among immigrant students.

While these findings are promising, both in terms of their nascent empirical support for community-based services and their introduction of “practice-based evidence” as a viable if alternative means of assessing outcomes in challenging settings, they reflect a new approach to clinical research that merits further study. Notably, both Birman et al. (2008) and Beehler et al. (2012) assert the need for further research on clinicians’ decision-making processes and “clinical judgment” (Birman et al, 2008, p. 130) in determining both appropriate treatment plans and just service allocation. In its focus on examining clinicians’ approaches to facilitating wellness among refugee youth clients, my study fills a critical need in the emergent literature on “practice-based” approaches to community-oriented mental health services.

**Multicultural Approaches**

In addition to focusing on evidence-based practices and practice-based evidence, considerable literature has considered how cultural factors impact the therapeutic process, particularly in the case of clinicians and clients from different sociocultural backgrounds.
Growing awareness during the Civil Rights Movement in the 1950s and 1960s of the pervasive influence of culture, including racial and ethnic bias, in “helping” professions prompted the development of an entirely new paradigmatic approach to psychology: the multicultural tradition (Ratts and Pedersen, 2014). According to this paradigm, effective counselors recognize culture as an all-encompassing force responsible for constructing an individual’s worldview, including sense of meaning, purpose, behavior, beliefs and values (Chung and Bemak, 2002). Due to this role of culture as a starting point for understanding client thoughts, behaviors, and attitudes, Ratts and Pedersen (2014) assert that it is imperative for effective therapists “to view clients in context of their culture and environment” rather than using a “‘one size fits all’ approach” to intervention and treatment (p. 26). Indeed, the authors explain that an ineffective grasp of culture on the part of the counselor can not only decrease her potential to support the client towards improved outcomes by diminishing credibility with the client and investment in therapeutic techniques; it can also lead to interpretations that actively harm the client, such as misdiagnosis, early termination of therapy, conscious or unconscious imposition of the clinician’s own cultural views (Ridley, 1995, cited in Ratts & Pedersen, 2014), and diminished client agency.

**Development of clinician cultural competence.** Despite many critiques of the philosophical and practical implications of adopting a multicultural approach to psychology (as noted in Ratts & Pedersen, 2014), multiculturalism as a principle has largely been accepted within mainstream psychology, as reflected by the American Psychological Association’s 2002 adoption of the “Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists.”
(Constantine, Capodilupo, & Kindaichi, 2007). As discussed by Birman et al. (2005), several authors have developed frameworks for approaching service providers’ development of cultural competence, though few have conducted empirical research focusing on either the practical development of cultural competence among clinicians or its potential effectiveness in treatment outcomes for ethnic minority clients as a whole, and much less so for refugee clients (Birman et al., 2005).

Birman et al. (2005) reviewed several such frameworks, highlighting three predominant models of operationalizing cultural competence among mental health service providers. The first model, which has remained largely empirically-unexamined, focuses largely on training “mainstream” service providers in the cultural particularities of clients from ethnically-diverse backgrounds. In one rare study of this service provider training model, Miranda, Schoenbaum, Sherbourne, Duan, and Wells (cited in Birman et al., 2005) found that mental health service providers were more effective in improving outcomes for ethnic minority clients after undergoing a quality improvement training program including elements of cultural awareness; however, this study was not conducted specifically with refugee clients, nor was the cultural competence training portion assessed separately from the larger quality improvement effort.

The second model of cultural competence emphasizes matching clients with service providers from similar ethnic backgrounds “with respect to culture, ethnic or racial group, language, prior experience, or other factors” (Birman et al., 2005, p. 13). This process of “ethnic matching” has been the focus of more empirical interest. In one case study with refugee children at a community-based comprehensive care clinic including mental health components, ethnic matching was shown to promote better
outcomes in terms of engagement and retention of clients despite showing no significant influence on clients’ mental health outcomes (Birman et al., 2008), confirming prior studies associating ethnic matching with improved retention outcomes (Gong-Guy, Cravens, & Patterson, 1991 and Musser-Granski & Carrillo, 1997, as cited in Birman et al., 2008).

The third model outlined by Birman and colleagues (2005) involves the development of mental health programs designed to address the needs and cultural backgrounds of clients from specific (non-refugee) ethnic backgrounds. These programs, in addition to enjoying much respect from service providers in the resettlement community, have also been shown by Snowden (1998) to be effective in “increasing access and engagement” (Birman et al., 2005, p. 15) for particular cultural groups. However, no evidence of the effectiveness of refugee-specific ethnic clinics exists, nor has empirical research been conducted to examine ethnic-specific programs’ ability to influence clinical outcomes for minority populations at large.

**Operationalizing cultural competence.** In addition to those developmentally-oriented models discussed by Birman and colleagues (2005) and summarized above, other authors have focused on the practical operationalization of cultural competence. In their 2002 article on culture and empathy in cross-cultural counseling, Chung and Bemak (2002) acknowledge the importance of prior articles’ focus on concrete ways clinicians can communicate their understandings of clients’ cultural backgrounds, clarify the implications of these cultural understandings in clients’ lives, and express their own interest in learning about and appreciating clients’ lives. The authors emphasize the need for clinicians to first develop their own cultural self-awareness in order to truly appreciate
the role of clients’ own cultural backgrounds. Once this prerequisite has been met, clinicians can then expand their cultural competence further by embodying six additional dimensions of cultural empathy: acceptance of the role of family and community in clients’ lives, active incorporation of traditional healing practices that may be central to clients’ conceptualizations of mental health, development of sociopolitical and historical knowledge base as relates to client background, development of knowledge of potential factors impacting client adjustment, sensitivity towards issues of oppression that may impact clients from different ethnic backgrounds, and guidance towards empowerment through provision of information, resources, and services (p. 157-158).

**Impact of interpreters.** Despite their potential to significantly impact the clinical setting, there is very little empirical literature available on the impact of interpreters in therapy (Miller, Martell, Pazdirek, Caruth, and Lopez, 2005; Lambert & Alhassoon, 2014), especially for refugee youth. In a meta-analysis of outcomes in trauma-informed therapy with adult refugees and one of the only known studies to assess for significance of interpreter use in a mental health setting, Lambert and Alhassoon (2014) noted “a nonsignificant difference between studies that used an interpreter and those that did not” (p. 33). This analysis confirmed d’Ardenne and colleagues’ prior findings that therapists influenced neither the outcomes nor the duration of sessions (2007, as cited in Lambert and Alhassoon, 2014). However, these findings have yet to be reconciled with those of Miller et al. (2005; cited in Kaczorowski, Williams, Smith, Fallah, Mendez, & Nelson-Gray, 2011), whose qualitative study indicated that clinicians perceived interpreters as an integral part of the therapeutic process, contributing
positively to this process as “cultural consultants” (p. 364), a concept similar to Ehnholt and Yule’s (2006) promotion of “interpreters as potential co-therapists” (p. 1206).

**Social Justice Approaches**

While the multicultural counseling tradition recognizes the need for counselors to acknowledge the roles culture and language play in the therapeutic relationship, many scholars and practitioners have argued that this approach does not adequately account for the psychological impact of institutional barriers to refugee integration and wellness (Crethar et al., 2008; Singh et al., 2010; Lewis, 2011). As a result, these advocates have worked to develop a social-justice-oriented approach that can help clients better negotiate stressors existing at multiple levels of analysis. Though this approach has been critiqued by some scholars for espousing paternalism and intolerance as well as remaining theoretically underdeveloped and practically infeasible (Hunsaker, 2011, cited in Ratts and Pedersen, 2014; Raskin, 2010), others have argued for social justice counseling as an ethical and practical imperative, noting that lack of attention to issues of social justice increases counselors’ risks of limiting their effectiveness at best and inflicting more harm on clients at worst (Ratts & Pedersen, 2014).

In terms of operationalizing social justice in counseling, Lewis (2011) argues that both a “comprehensive and clearly structured approach to professional practice” (p. 183) and an accompanying skill set, as outlined in Lewis, Lewis, Daniels, and D’Andrea’s (2011) Community Counseling Model, are necessary components in implementing social justice counseling. The Community Counseling Model compels practitioners to focus on both human (i.e., individual) and community development through the use of focused and broad-based strategies in each of these domains. In the human development domain,
focused strategies entail implementation of a “strengths-based and contextual” (Lewis, 2011, p. 185) approach to the traditional therapeutic relationship and conducting outreach focused on connecting the individual client to services, resources, and social support networks within the community. Human-development-oriented broad-based strategies, meanwhile, may entail preventive health promotion and wellness programs tailored to the larger population the counselor serves rather than the counselor’s individual clients. On the community level, focused strategies can be understood as those which intend to foster an improved “helping network” (p. 187) within the therapist’s own community through involvement in coalition building, community planning, and partnership-building, while broad-based strategies are those which extend beyond the context of service provision to advocate for larger political and social change.

While the Community Counseling Model provides theoretical insight on how counselors may integrate social justice principles into their work with clients, few empirical studies have examined counselors’ perceptions of social justice practice. In one study on doctoral counseling students’ perceptions of social justice training within their academic programs, Singh and colleagues (2010) note that participants’ social justice practice primarily involved self-examination of their own belief systems; adhering to feminist principles such as “minimizing the power differential between counselor and client, developing a collaborative therapeutic relationship, examining the multiple identities of clients, identifying the role of oppression and discrimination in clients’ presenting issues, and acknowledging the cultural context of clients’ lives” (p. 779); and seeking outside opportunities to educate themselves (particularly through external
conferences) on the impact of social issues on clients’ lives. However, the study did not provide specifics on how these practitioners operationalized these beliefs and values.

**Contribution of the Present Study**

The literature on refugee mental health emphasizes the many challenges refugees must overcome during the resettlement period. Though this literature outlines some of the general approaches clinicians have used to support refugee mental health and the settings most conducive to engagement with mental health services, there is little discussion of the specific ways in which clinicians conceptualize and enact cultural competence, build relationships with their clients across cultural boundaries, and help clients navigate the many competing influences in their lives, including systemic forces. By focusing on specific ways in which clinicians support refugee clients experiencing macro-level stressors, my study contributes to this literature gap.
CHAPTER 3: METHODOLOGY

This study conducted a thematic analysis of five pre-existing interviews with mental health clinicians working in community-based practice in Chicago with children and youth from refugee backgrounds. Qualitative interview data were collected in 2011 and 2012 as part of a project at the University of Illinois at Chicago (UIC) that was then being conducted by Dr. Dina Birman, my advisor for this current iteration of the project. The stated purpose of the study at that time was to identify the range of treatment outcomes that clinicians considered important in working with refugee children, focusing especially on how clinicians used standardized assessments to guide their work. However, the researchers also asked many questions about what this work looked like in general, including how the participants came to be involved in the work, how they interacted with clients across cultural difference, and the issues they were working through with their clients. These questions resulted in rich data on clinicians’ broader approaches to and perspectives on the work, which is where I focused my analyses.

Data Collection Procedures

After receiving approval from UIC’s Institutional Review Board (IRB) in February 2011 as well as administrators at the prospective recruitment sites, the initial researchers recruited participants via emails sent to clinical staff of two reputable, community-based organizations in the Chicago area. The recruitment email informed prospective participants that the study would consist of an in-person interview lasting 60-90 minutes at “the time and location of [their] choice” for the purpose of “learn[ing] from providers such as [them] about assessing clinical outcomes for refugee children and
youth.” The email also clarified that participation was completely voluntary and confidential and that volunteers would be compensated with a $15 gift card to a retailer of their choice. (See Appendix A for full email contents.) After agreeing to participate in the study, participants were asked to sign an informed consent document reiterating the voluntary nature of the study and informing participants that they were free to withdraw at any time.

Interviews were semi-structured and typically lasted one to two hours. They began with general questions about participants’ pathways to working with refugees, including whether they came from immigrant or refugee backgrounds themselves, how they became interested in work with refugees, whether they spoke any languages other than English, how long they had been working clinically with both refugees and non-refugees, and how well they felt their training had prepared them for this work. The interviewers then explored the role of culture in the therapeutic process, asking questions such as, “How do you address cultural issues in your work or think about bridging a cultural gap with the clients, if there is one? Were there differences between working with refugees and non-refugees? How are the clients and services different, and how are they similar?” The last segment of the interviews explored how participants worked with clients to set goals, track clients’ progress towards those goals, plan treatment and interventions, and measure outcomes, as well as how aptly they felt assessments captured clients’ progress. (See interview guide in Appendix B.)
Sample

Clinical Training and Professional Organizations

Inclusion criteria for the study stipulated that participants must have worked clinically with refugee clients for at least one year to be eligible to participate. All five participants worked at one of two professional organizations in Chicago. Two held graduate degrees in social work, two in counseling, and one in clinical psychology. One had also received supplemental training in art therapy, while several mentioned prior interest, training, or professional experience in working with trauma.

Participant Demographics

All five participants were women, none of whom came from refugee backgrounds themselves. However, one had one parent who immigrated to the United States from a Southeast Asian country at a young age, and another grew up partially in the United States and partially abroad. Four of the five participants were white, while one was multiracial.

Professional Experience and Organizations

Three participants had been working clinically with refugee clients for a range of 3-5 years, while the remaining two each had 11-13 years of clinical experience with refugee populations. Participants estimated that they had worked with anywhere from 40 to several hundred refugee clients throughout the course of their careers. While the interviewers did not collect data regarding how many cases participants worked at any given time, some participants alluded to managing large caseloads, including one who recalled working with 60 kids her first year on the job.
In addition to their work with refugee clients, four participants had worked to some extent with non-refugee clients, providing rich opportunities for comparisons of the two experiences. Length of work with non-refugee clients ranged from a few months to up to 10 years. One participant had only worked with refugees and thus had no basis on which to compare her experiences with clinical work with non-refugee clients. Total time as a clinician (i.e., working with both refugee and non-refugee clients) ranged from three years to nearly 20.

Participants conducted this work in settings highly similar to those described in the practice-based evidence literature on community-based programs (see Birman et al., 2008, and Beehler et al., 2012). These programs provided comprehensive care, pairing mental health services with case management, advocacy, and outreach, all of which were conducted to some degree by therapists themselves. Collaborative, team-based approaches characterized these settings, in which participants consulted regularly with other service providers working within the same communities (if not the same families).

**Client Demographics**

All participants worked primarily with children and youth with refugee status. However, as discussed in more detail in Chapter 4, this often included working to varying degrees with adults, including parents, older siblings, and other community members. Clients were from a wide range of countries, from African countries such as Liberia to Eastern Europe countries such as Bosnia to Southeast Asian countries such as Burma.
Data Analysis

Interviews were transcribed shortly after being completed. The initial researchers subsequently used Atlas.ti to begin coding for goals, treatment components, and outcomes. I began re-visiting the interview transcripts in 2018, restarting the coding process from scratch to reflect the broader focus of my analysis. Though this was not a grounded theory study because sampling was not theoretical, I loosely followed Charmaz’s (2014) and Strauss and Corbin’s (1990, 1998) guidelines on coding in grounded theory for my analysis. I began open coding on each transcription either line-by-line or incident-by-incident using Atlas.ti. Codes attempted to “stick closely to the data” (p. 116), inserting neutral gerunds to capture participants’ own actions within a statement when possible. (For example, the code “Recognizing client progress” denotes that participants were engaging in this process of recognition as they spoke in the interview.)

However, because a wide range of topics were covered in interviews--from goal-setting processes to client symptoms to perceptions of cultural competence to working with interpreters and beyond--it was often necessary for codes to provide additional context for the action. This was done by accompanying action codes with additional nouns or gerunds representing larger topics of conversation at the time of a particular passage. For example, rather than coding a passage merely by the participant’s action of “Comparing backgrounds and experiences” (which could have implied comparing the backgrounds and experiences of interpreters, colleagues, refugee clients from different countries, and so on), the expanded code “Refugee versus non-refugee clients/comparing backgrounds and experiences” bound the action of comparing to the larger context of
discussing work with refugee versus non-refugee clients. This is similar to Strauss and Corbin’s (1990, 1998) concept of axial coding, which aims to create “a dense texture of relationships around the ‘axis’ of a category” (Strauss, 1987, p. 64).

In all, this process yielded 406 codes. Codes that were related to one another were then categorized into 31 code groups, each of which contained anywhere from two to 40 individual codes. Code groups represented larger themes or topics in the data, such as building relationships, collaboration and advocacy, and cultural differences. (For a list of code groups and their associated codes, see Appendix C.) A number of these code groups emerged as highly interrelated, making them the most interesting themes to explore in the analysis. Each of these groups was then entered into its own network. Networks were hierarchical structures: the top of each network contained the name of the code group, to which each associated code was linked below with a line. Each code, meanwhile, was similarly linked to all of its correlated quotations, most of which had been renamed as brief phrases capturing the essence of the participant’s statement. (For an example of a network, see Appendix D.) These network views were used to examine the relationships among interdependent codes, placing participants’ own words at the forefront of the analysis process by keeping quotations accessible.
CHAPTER 4: RESULTS

Three key themes related to participants’ experiences with this work emerged from the data. The first was the overwhelming complexity of clients’ lives that provided the context for the clinicians' experiences. Clients were often managing extensive symptoms of trauma while also navigating the acculturation process, adapting to new systems and norms, and dealing with changes to their family structures. These stressors interacted with one another to create overwhelming stress to which therapists sometimes struggled to respond, particularly when their attempts to engage with clients had to be conveyed via an interpreter. Therapists had to learn to adapt to this complexity while at the same time working across cultural differences. Clients demonstrated more collectivist worldviews than did participants and had different visions for the healing process. Furthermore, it was necessary for participants to gain critical insight on the social, cultural, and political dimensions of clients’ countries of origin so that they could better understand the events and values that clients brought with them to the therapeutic space. Their efforts to overcome this complexity and these cultural differences in a way that was responsive to clients’ needs and their own led them to the second theme from the data: a focus on building strong relationships with multiple actors within the environment. Clinicians cultivated these relationships through actions that reflected value-laden principles. These principles focused on honoring clients’ strengths, agency, expertise, and privacy while also demonstrating willingness to learn, be vulnerable, and participate fully in clients’ lives. The final insight of this study, meanwhile, focused on the personal and ethical challenges this relationship-centric practice entailed. Because participants had not been trained to engage in community-based therapy that required
them to maintain intensive, fluid roles in clients’ lives, they struggled to develop boundaries in their work, which often led to distress and confusion.

**Context of Complexity in Clients’ Lives**

Nuanced understanding of participants’ approaches to working with clients across cultural difference would not be possible without first contextualizing the complexity of clients’ lives. In their discussions on building relationships with clients, setting therapeutic goals, and evaluating clients’ progress towards those goals, therapists provided rich detail of the many challenges clients faced in their quests for wellness as well as the resources they harnessed throughout the journey. While exposure to complex trauma and constant changes to family and household dynamics often led clients to experience severe physical and emotional symptoms in addition to impaired social functioning, participants also highlighted the resources and resilience many clients used to overcome these difficulties in inspiring ways.

**Coping with Trauma**

Experiences of trauma were pervasive—and often recurrent—among participants’ clients. In addition to experiencing trauma in their countries of origin (often on multiple occasions or for extended periods), many clients faced new traumatic exposures in their communities in the United States, particularly in schools systems plagued by violence and discriminatory policies.

*For a lot of the children that I’m working with, they have the past trauma of some of the violence or war-type traumas that they’ve witnessed or heard about in the*
past, and then they are kind of loading that on top of the traumas that you experience being a youth in Chicago and being a part of the Chicago public school district. [Participant 2]

Beyond helping clients to work through these prior traumas experienced both in the country of origin and in the United States, many participants spent a lot of time supporting clients for whom trauma was ongoing throughout the course of the therapy. One client spent at least a year being subjected to immigration-related court proceedings that required her to relive having been trafficked into the United States while at the same time living in fear of being found by the traffickers she escaped. Because of the preeminence of these concerns in the client’s daily life, helping the client cope with them dominated the therapeutic process for a substantial period of time, during which the focus was primarily on case management.

For the first year, it was a lot of case management—dealing with what she’s going through now, like she was going through this traumatizing court system with the FBI and confronting...I mean she fled the people who trafficked her here, and there’s ongoing fear that they were going to find her, and, you know, like, dealing with that reality. [Participant 1]

Other clients faced similar challenges coping with their prior traumas while also confronting systemic oppression. The below case of one teenage boy is emblematic of the multiple layers of stress clients bring with them to the therapeutic environment. Not only was this client struggling with severe post-traumatic stress disorder on top of family violence and conflict, furthermore, he was forced to navigate these tensions within
The issues we were working on with this youth were addressing some very severe post-traumatic stress disorder. Addressing family violence level, family conflict. Addressing law enforcement involvement [...] A teacher at the high school started a rumor about him that he had murdered people in his home country—that he had been a child soldier—which wasn't true. The layer after layer in terms of his interaction with the systems and the systems’ response to him and all that were just disastrous [...] I think what [the child soldier rumor] did for him was just alienate him from another space. He's starting high school; a nasty rumor has started about him by a faculty member. High school’s already grossly unsafe for him because he's being targeted by half of the gangs whose members go to the school. So, school becomes not just foreign but unsafe and dangerous [...] [The people at school] see him as dangerous, but that is dangerous for him, and he's all of a sudden stripped of his capacity to defend himself. When you've got very active post-traumatic stress disorder, your capacity to gauge what is safe and isn't safe is already impaired, and your fight, flight, or freeze response is going to be triggered. This youngster's response is fight, which in a high school gets you arrested. For this youngster, I think that he eventually dropped out of high school. I think he had earned half a credit in three years of slogging away at high school. [Participant 5]
**Trauma-related symptoms and behavior.** These experiences of trauma impacted clients’ present realities in multiple ways. Many times, they led to an array of physical and emotional symptoms that clients brought with them to the therapeutic environment. Often, these symptoms were the reasons clients had been referred to a clinician, while at other times, they surfaced throughout the course of therapy.

*The emotional is where those trauma related symptoms could come in. Someone is presenting as really depressed or anxious or angry or not able to control their mood or not sleeping or having nightmares or flashbacks or not able to concentrate in school [...] Some people have headaches or stomach aches all the time or difficulty concentrating/sleeping—that kind of thing. So that can come up a lot too. [Participant 4]*

Occasionally, symptoms became so severe that clients had to be hospitalized, putting them at risk for additional trauma that would further complicate the situation.

*I dealt with* some of the more intense cases where I worked with them more shorter-term, or a lot of them ended up moving or dropping out of services for whatever reason or being hospitalized. *[I remember]* one case in particular—a young girl, a teenage girl, who was pretty dissociative, so she would just check out. She would have a hard time breathing, sort of hyperventilating, shak[ing]. So, in that case, especially with intense trauma like that, the goal would be stabilization. Sometimes it would require medication or psychiatric care. In that case it did. She was hospitalized for a short time, which brings up another whole
slew of issues, another potential trauma and traumatizing experience.

[Participant 4]

The effects of this trauma on clients’ bodies and minds often expanded outwards, affecting their ability to function socially and academically. Some therapists reported clients who were afraid to leave the house or to go to school, while others commonly encountered issues with affect regulation, wherein clients experienced intense emotions that they struggled to contain. This could result in intense outbursts that left clients “crying one minute and yelling the next” (Participant 1). One participant saw such outbursts as a result not only of the intensity of clients’ emotions but also having to bear that intensity for such a prolonged period:

These people have been dealing with this trauma for so long that how it's manifested is so varied. So, I would say lots of times kids would appear to someone to be fine, and then everything kinda bubbles up, and [they] just completely melt down. [Participant 1]

Occasionally, clients’ attempts to manage these emotions devolved into violence. This was the case for one client, who confided in her clinician that she resorted to self-harm when her thoughts became too overwhelming: "Sometimes, I’ll get really upset, and when I get really upset, I try not to think about it, so I hit my head on the wall" (Participant 1). Other clients, meanwhile, dealt with this intensity in ways that were more passive but equally as concerning. One therapist recalled the challenge of working with a client whose attempts to self-regulate resulted in unusual behavior that the therapist wasn’t sure how to address:
We see different kinds of severities, like kids that are quieter. We might not know quite what is going on, which is sometimes even more frightening than kids that are right in your face with it all [...] The first girl I talked about [who was hospitalized for self-harm], her behavior really wasn't unusual. But this [other] girl, when she started menstruating, she didn't tell anybody. She would just lay whatever she was using to absorb the blood under her bed. That's unusual. So, things like that that are a little more concerning to me because I just don't quite understand. [Participant 3]

For other clients, years of chronic stress and exposure to complex trauma led to developmental delays that therapists worked to address.

We also find that kids—refugee kids—that we work with, developmentally, they're not...they seem a lot younger than their peers [...] I work with this seven- or eight-year-old boy [who] still throws temper tantrums like a three-year-old. That's just the way he deals with feeling upset. He just...he'll go at home, crawl under the bed, and bang his fists and head on the ground. I'm not sure if he ever kinda went through that stage [...] with his mother, and this is kinda trying to go with it again and see where...how far he can go and see how she will react and how he gets his way. [Participant 1]

While ascribing this child’s tantrums, in part, to a developmental stage lost due to family trauma in the country of origin, the therapist also recognized the role of current stressors in the client’s life. She noted that many refugee children are often forced to assume adult roles to help make ends meet for the family and posited that, to a certain
extent, this client engaged in infantile behavior as a means of insulating himself from losing more of his childhood to undue responsibility.

Once you kinda start to act like an adult, especially in families that really are single-parent or struggling, you get a lot more responsibility. These kids already have a lot of responsibility, but I think they are afraid of getting even more, [so they think.] “If I act really young, then maybe I can be a kid longer.” And also, I think missing out on a childhood... [Participant 1]

Some clients who had lost parts of their childhood, meanwhile, found themselves on the other end of the developmental spectrum. The same participant as above reflected on another client who had no choice but to take on adult roles from a very early age, noting that she seemed to mature quicker as a result. Though this maturity led to better functioning for the client, it also left her grieving the many aspects of childhood she felt she had missed.

I work with this girl who's 19. She’s very, very insightful. She was trafficked here, actually. She will sit here and talk about, "I missed my whole childhood. I was an adult since seven. It really sucks," and just talk about all the things she missed. And she actually acts more mature than she is but probably because of what she did have to do to survive at an early age. [Participant 1]

While many clients who had been exposed to trauma struggled with some level of symptoms or functional impairments, some did not. One participant highlighted the broad range of individuals’ responses to traumatic experiences, observing that a traumatic
exposure may lead to severe symptoms in one person, but another may seem relatively unfazed.

*When someone experiences trauma, a lot of people...one person can experience the same thing as someone else and just have a different response to it. And [this one client] seemed probably more resilient to it. I think all kids are resilient, though I never got the sense from him, as I often do from other kids, where it’s like, “Wow, he's really exhibiting a lot of trauma symptoms or trauma-related symptoms,” like a vacant look or...I just didn't get that from him. He was always sort of engaged.* [Participant 4]

**Effects of parental trauma.** In addition to the traumas kids faced first-hand, parents’ experiences of trauma also impacted kids’ ability to function. Even in instances where parents bore the brunt of the traumatic violence, the effects of this trauma on parents’ ability to attend to children’s needs hindered children’s own development. As a result, many clients struggled to form healthy attachments to the adults in their lives. While this struggle sometimes manifested for older adolescents as difficulty trusting those around them, for younger clients, it often led to problematic attention-seeking.

*I think it takes a long time for kids to feel, for one, that what happened to them is not going to happen again—that they're, like, safe and kind of gonna settle here. And I guess just, you know, because the parents really are the ones who experienced the war trauma or abuse or torture, whatever it was, they're also very traumatized, so they are less emotionally available to their children. So, the children often don't get the kind of care and attention that they need, and that’s*
really [...] that attention is like kids’ currency. That’s what they really thrive off of. That’s what they really need, and these kids, not to fault necessarily the parents, but they're not able to get it. So in that case, they either have the disinhibitive type of reactive attachment, so they want to attach to every caring adult that they can trust, or sometimes not [the ones they can] trust—just every adult. You see lots of kids that just they are just hugging you all the time and really just want your attention and just cry and cry when you have to leave, but then you'll take them to the park and you will see a nice adult with a dog and they will go try to get that adult to pick them up. [Participant 2]

**Therapy and the worsening of trauma symptoms.** The complex trauma clients were managing—both in terms of coping with memories of prior trauma and struggling to navigate current ones—and its effects on clients’ minds and bodies, combined with the other stressors influencing clients’ well-being, introduced a high degree of complexity into the therapeutic environment. At times, these symptoms worsened the more the clients delved into the trauma throughout the course of the therapy, further complicating the situation. One participant described confronting trauma in sessions as “peeling back layers and layers” of the client’s experience. Often, the more layers they pulled back, the more the “deeper parts of [the] trauma” were revealed, resulting in more symptoms as clients attempted to cope with the intense emotions this process evoked. This participant went on further to explain how these emotions, many of which had been repressed for a long time, sometimes led clients to return to “crisis mode.”
You know, they've kinda opened up this wound again, and managing it, because they didn’t really learn how the first time, other than just trying to forget and covering it up, and all these layers are so hard to kind of uncover with them, so we do see some people kinda going into kinda like crisis mode [Participant 1]

**Acculturating to New Systems**

Even as clients worked to cope with the effects of the trauma they and their families had experienced before, during, and after resettlement, they also had to tackle many pressing needs related to adjusting to their new lives in the United States, such as securing shelter and food. Often, the fundamental, life-sustaining nature of these needs meant they took precedence over psychoanalysis. As a result, participants typically delayed working through clients’ trauma therapeutically, devoting a lot of time and resources to supporting clients in a more case-management-oriented capacity until they achieved enough stability to be able to better concentrate on the more psychological aspects of their adjustment.

*I think that there's the trauma piece, thinking about the past history and the trauma, which I don't even think can be looked at until we deal with...it's a hierarchy really; we are dealing with essential survival needs. So, the first main goal would be finding safety and providing food, housing, shelter, and basic essentials for people who don't even have that. So, until they get that, it's like...it's like with asylum process—really, until they gain asylum and feel safe in this country, how can we even begin to talk about the trauma? So yes, I think that a lot*
of the overarching goals [at the beginning] are mainly focused on the acculturation. [Participant 4]

For kids, this acculturation process involved not only learning the new norms and values of the larger culture but also those particular to the school systems in which they spent much of their time. One participant saw this involvement with schools as an added pressure for youth, who were unable to choose their degree of engagement with the host culture to the same extent as could some adults. Furthermore, adjustment to schools was a multifaceted process with social, academic, and behavioral components, all of which required different underlying knowledge and skills. Because schools are driven by rigid but often implicit norms, students struggled to understand the unspoken rules; at the same time, because schools are also highly institutionalized, there was little margin for error for the students or flexibility in the schools’ responses to them. This paradox pushed clients to adjust quickly and quietly, adding more stress to their already-complicated lives.

If you are going to be in school, because our school system is so inflexible, some level of adjustment has to take place. It's different for adults where, especially for the large communities, there are ways in which I think you can take more time for the adjustment process and you can pick and choose what you are adjusting to. For kids, that adjustment would look at sort of the social adjustment to school, the academic adjustment to school, the adjustment to the school policies and expectations [...] I'm talking about, "Do you understand what behaviors are expected of you, and can you manage to pull that off? Not that that expectation is
fair or rational, but can you pull that off and know what those are? Are you learning what the non-verbal cues that teachers toss up constantly mean? Do you know how to keep yourself from getting yelled at or getting kicked out? Can you communicate effectively so that you can advocate for yourself in a high school setting? Defend yourself in an argument? Can you be the kid that says, ‘This kid did it,’ because you can effectively communicate?” and that happens.

[Participant 5]

Navigating Shifting Roles and Resources

If the stress inherent to adjusting to the norms of a new society and its institutions while also managing symptoms of complex trauma were not enough, clients’ home lives often presented further challenges. Many clients were learning to take on new roles and responsibilities within families whose underlying structures and values had changed dramatically. This negotiation took place within a larger context of constantly-fluctuating resources that left families struggling to stay afloat in their new homes.

Adjusting to unfamiliar family roles. For many refugee families, the resettlement period is the first time that they must learn to operate as an independent household. This learning period provokes a process of trying to establish certain roles in relation to other members of the household, including who is responsible for which tasks and how to negotiate one’s needs in relation to the needs of the larger group and each of its individual members. Since this sometimes involves learning to rely on caregivers who were not previously as familiar to this equation, many kids struggle to feel safety and
stability at home even as they struggle to feel safety and stability in the larger community.

Nothing feels safe, and not even their caregivers because even when they were, like, in a camp, their parents lots of times would go to work, so they would kind of be living with grandparents or someone [because] their parents would be trying to find money. And then they get here, and we work with a lot of kids [where] it’s really kind of the first time they are operating as a unit in a small place of their own again. [Participant 1]

As one participant observed, this renegotiation of family roles was occurring within a larger context requiring families to re-examine their cultural identity, values, and sense of self as part of the acculturation process. For some families who were already struggling to maintain cohesion prior to arrival in the United States, their attempts to maintain that cohesion became further challenged once their family life became embedded within unfamiliar structures. This led to a “tipping point” for some families, whose relationships with one another descended into chaos as a result.

I feel like with each community we worked with, we had a family. It felt like there was just a family that had been resettled that was already highly in conflict with each other coming here, [who had a lot of] just stuff that was going on. I guess I always wondered about families like that. Once you removed the sort of known roles that culture and life within your country of origin provide for you, it is just sort of the tipping point for families. Any of the structures that were helping hold
that family together had now been pulled away. Families would feel in some respects like there was free falling going on. [Participant 5]

Systems of support were often the most prominent structures that were pulled away from families during this acculturation process. Community members had factored into this family equation in many clients’ home countries, where child-rearing was a more communal task, and elders supported parents in advising and disciplining children. In the United States, parents not only had to learn to renegotiate their existing roles but to do so on their own without being able to turn to anyone for help in the ways they previously could.

Well, for example, with one family it was a single mom and eight kids, one of whom was an adult when they came, one of whom became an adult in six months—turned 18. Everybody else was little. The camp in that family provided structure in terms of elders in the community who could keep the boys accountable for their behavior—systems of discipline that would help the mom in terms of providing a role because she was a single parent. There were these boundaries set up that we all need and safety nets. So, even though the family was a mess and fighting, she had places to go for help. She knew the help she was going to get at those places, and it met her needs. I think for that family, typically what would happen then is that if the kids really weren't in line, weren't following the elders’ instructions, they'd be enlisted in the army. That was what would happen. Well, I don't see that as my role. So, we would have families, and again I think it is an issue not so much that the families were just a mess and never going
to be okay, but that they were a mess and we stripped away everything that was known and supportive of them, and we couldn't possibly rise to what their needs were. [Participant 5]

**Managing shifting expectations.** The home isn’t the only place that children had to adjust to new roles. While learning to adapt to household expectations that were different than in their home countries, participants’ clients were also learning to conform to new expectations in other settings—and learning to shift between these multiple personas as they moved between these settings. They learned to behave differently “in the home and in the school and in the community” (Participant 3). This was stressful to clients, who sometimes needed spaces where they could “just be themselves.”

*I think also really important is to have programs where kids can go and just—even if it’s just for two hours—just be themselves. They are constantly having to shift and change who they are, to adapt [...] They are trying to figure out a totally new world, and it is stressful.* [Participant 5]

**The acculturation gap.** In addition to navigating new roles in the home, clients were also confronting an acculturation gap between themselves and their parents. Parents often wanted to continue their traditional ways of life and expected their children to grow up embodying the values and behaviors they may have personified had they stayed in their home countries. Children, meanwhile, were adapting quickly to U.S. perspectives and behaviors and often pushed back on or grew discontent with parents’ expectations of them. As a result, ideological differences occurred that occasionally added another layer of conflict into the home.
Here's a case that is coming to mind—a mother who wants her nine-year-old daughter to stay home and take care of the younger kids and cook. [thinking,] 

‘That’s what nine-year-old girls do.’ She’s the oldest girl in the family. She has older brothers. This nine-year-old wants to just run around with her friends and hang out and go to people’s apartments—you know, wants to live her life. I think that this is an extreme case, but I think it really typifies the divide within the home that can potentially occur with the children probably acclimating more quickly, the parents maybe not even wanting to be here and wanting to carry on their traditions. The conflict in the home really affects all members of the family.

[Participant 4]

This acculturation gap extended to more logistical endeavors, as well, forcing children to take on adult roles that often served as undue stressors. Children typically learned English much quicker than their parents, particularly those kids who came from refugee camps, where they often had received English instruction. As such, out of necessity, they were often expected to help parents take care of household tasks, such as managing bills, sorting through mail, and interpreting conversations with service providers and school officials.

They oftentimes were put in roles where they have to take on much more, and if they are the ones learning English, then their parents don’t necessarily have those skills. They are put in this place where it could be a nine-year-old girl, but you are interpreting, you are looking through parents’ mail and pay stubs and trying to figure [things] out...so they are often put in these roles where they are being
adults, and they have experienced a lot and witnessed a lot in their lifetime that most kids have not. [Participant 2]

Household instability. Another stressor in clients’ lives resulted from constant changes to their household makeup. Given financial strain, many children’s parents or older siblings were working multiple jobs or long hours, meaning their presence in the home was often sporadic. This created household structures that were inconsistent, wherein kids struggled to adapt to different routines and the presence of different actors at different times, including people who would come into the home for extended periods of time and leave for other periods. This constant fluctuation made it more difficult for children to focus on coping with the many stressors in their lives and to develop a sense of security and comfort at home, especially if they were re-introduced to individuals who posed a threat to their safety or reminded them of prior traumatic experiences.

Occasionally, such circumstances influenced children’s progress in therapy, causing prior symptoms to flare up after children had made gains in overcoming them.

So, this one kid, he’s making great strides in group. I’ve worked with him for a year and a half. He’s just been doing so much better, but a month ago, for that whole month, he just started having temper tantrums like almost back to what it felt like when I first met him. I was like, "What is going on? What’s the deal?" and I found out that his dad, who lives in that neighborhood still and used to abuse him […] had come visiting the house a lot that month. Ohhh, it just kinda felt like, "Well maybe that’s what’s going on," and then kinda talking to him more about that and realizing that he just doesn’t know what to make of his dad and
how to deal with it. So, he was acting out in group because I think that group had become a safe place that he was used to—it was consistent, and all of the sudden, “I’m showing you, [Therapist], that I need your attention.” [Participant 1]

Just as the actors in the home were often inconsistent, so, too, were the resources available to families in constant flux. Changes to family income or to eligibility for public benefits could lead to household crisis, putting both physical and emotional strain on participants’ clients. These pressures impacted client behavior, including their ability to self-regulate and the ways they presented at and engaged with the therapeutic environment. One participant spoke of a client who, while experiencing hunger, lashed out physically at other clients. These clients, in turn, surely felt threatened in yet another space, furthering contributing to a cycle of stress and instability within the community.

Things might be pretty stable at home, and all the sudden, their food stamps are cut. And then they are hungry, and so they come to group, and they are in a pretty bad mood, and they start hitting their neighbor. [Participant 1]

Protective Factors and Resilience

While participants emphasized the ways in which a myriad of factors—including managing recurrent traumatic exposures and their accompanying symptoms, acculturating to new systems, and navigating shifting roles and resources both within and outside the home--created a cycle of overwhelming stress and instability in clients’ lives, they also highlighted the incredible resilience clients and their families harnessed to manage or overcome these stressors. Clients relied on multiple strengths and resources that helped them provide for their own basic needs, cope with their experiences,
contribute to their communities, and make meaning of their lives. For many, the first resource they made use of was their fervent desire for growth and wellness. This will to overcome their struggles enabled them to overcome any hesitations they might have had about therapy and allow participants into their lives because this presented a prospect for growth.

*When refugees come here, there might be a stigma to work with us, but their guard is kinda down, 'cause they're in this foreign place; they don't know anything; they do want help really bad; and once you can just establish trust, it's always a journey, but you can really start to work together.* [Participant 1]

One participant attributed this willingness to try new things to larger cultural values of openness, spontaneity, and creative expression that differentiated her refugee clients from U.S. clients. These values served as a resource for clients, who were able to engage in a wider range of therapeutic activities, thus expanding their possibilities for healing.

*Personality-wise, I think [my refugee clients] are just more open. As an expressive art therapist, it's so awesome. I don't know if they are going to do visual arts or sing or dance, but they'll do one of them. So, with refugees, I think that there is a joie de vivre. I found that in living with the Peace Corps [in West Africa], and I found that it keeps me alive in this work. That's what I think sets them apart from the non-refugee population—just really being able to tap into that creative and spontaneous piece within that I think is so key to healing. I think it's hard for us Americans to do that sort of thing. I begin or end a group with a*
song or dance or something. Really, mostly the refugee populations are more likely to take it. [Participant 4]

This therapist went on to explain how having a strong sense of community was also a strong asset for clients. She noted that non-refugee clients typically had more logistical resources at their disposal in terms of knowledge and support enabling them to meet their basic needs, particularly given ever-increasing cuts to resettlement funding and social benefits for refugees. However, on a more emotional and spiritual level, refugees’ strong connections to their communities and those “survivor” communities’ long histories of resilience in the face of trauma proved to be abundant sources for healing and growth.

The sense of community that comes in is a great, great resource. I mentioned that the non-refugees were more resourced. I was just talking about the logistical, practical aspects of living day to day, but as far as mental health resources, to just tap into life energy, I think that refugees just have a lot of that, just as survivors. That sets them apart too, I think—really being in touch with their strengths and being able to...maybe they are not always able to reflect on that, but as a clinician, being able to see that, to see that survivor strength and community aspect. Especially with the Burmese community, it strikes me. [Participant 4]

One story, in particular, typified how this determination to overcome could lead to remarkable psychosocial progress. The client entered therapy exhibiting overwhelming emotions that provoked major depression, disordered eating, self-mutilation, and regular fights with family members. However, her therapist noted that despite being “very, very symptomatic when she [first] came,” the client had “something
that was very persistent in her.” The therapist saw this intensity as a balancing act, wherein “the severity of her symptoms were kind of mirroring this inner core that was very strong” (Participant 3). Ultimately, this balance tipped in favor of resilience, allowing the client to successfully pursue her passion for helping others facing similar struggles.

To think about where she is now, she is very bright. She finished college. She's wanting to go in...she was the only person in her class that was interested in psychiatric nursing. She’s really come a long way and been able to say, “I’m not finished. I still have some of the struggles I had before, but not nearly what they were.” So, I think that she is somebody who is pretty incredible. [Participant 3]

Another rich case example illustrates how the issues of trauma, symptoms, functional impairments, acculturative stress, structural barriers, systemic oppression, family conflict, and resilience discussed in this section can interact within one client’s experience. The client in question was a minor who was one of five siblings. During a period of political turmoil, the youngest child and the parents were separated from the four older siblings; the parents and youngest sibling then ended up in the United States and were told there would be a two-year waiting period for the four oldest siblings, who were still in the home country, to be able to join them. During those two years, the older siblings were living with their aunt, who had to move them each month to a new house because they were being targeted by a political system. Once the older kids arrived in the United States, the parents suddenly went from being responsible for one two-year-old child to five children ages two to twelve. This led to overwhelming family stress,
including some concerning disciplinary behaviors by the father that the clinicians were worried may require a referral to child protective services.

The eldest client ended up becoming a client of one participant’s organization. The clinicians soon learned that he was having nightmares six nights a week that led to bedwetting, trouble eating, and high anxiety to the point that he was scared to go outside alone because he thought it was too dangerous. In addition to dealing with the traumas of family separation; threats to his physical safety; and the myriad psychological and developmental implications of persistent transient living, as well as the new family stressors introduced during the acculturation process, this minor was also coping with the loss of the aunt who had been his caretaker during those two years. Furthermore, when he went to school, he was then targeted by local gangs for membership, which led to renewed fears for his safety. His siblings and parents were also struggling with the effects of trauma, and his parents’ relationship was under strain, creating additional tension in the home that the client was struggling to manage on top of all his other stressors.

From the onset, this youth displayed a strong willingness to engage in therapy, especially play-based expressions. After two and a half years working with the organization, his depressive symptoms decreased, and though his relationship with his father still wasn’t perfect, he had learned to manage it in a way that was productive. The clinician noted that, at the end, “He was coming into therapy and didn't have a lot to discuss. He was really okay.”
Relationships as Therapeutic Core

This context of complexity was one of several critical influences that affected the way clinicians approached the therapeutic process, prompting them to rethink how to approach that process relative to their training. A cultural continuum between clients’ collectivist cultures of origin and the more individualistic U.S. culture intersected with this context, impacting the ways clients navigated the complexity of their lives and, in turn, the way therapists navigated their work with clients. Relationships emerged as a key aspect of this intersection for several reasons. First, clients’ cultural expectations placed networks of relationships at the center of how they processed the events in their lives and decided to respond to them. This compelled therapists to build relationships with multiple actors in clients’ lives, including their families and communities. Thus, relationships were important for meeting clients’ needs.

At the same time, relationships were also important in responding to therapists’ own needs. Relationships with colleagues, other service providers, community members, and clients’ families helped therapists to gain the knowledge, skills, and advocacy opportunities they needed to help clients adapt to the complex context of their lives and to mitigate cultural differences between clinicians and their clients. Furthermore, connections with colleagues who understood the challenges of this work provided crucial support to therapists attempting to manage the emotional toll it took on them. On both personal and professional levels, relationships became central to therapists’ ability to do this work.
**Adjusting to Different Perceptions of Self, Others, and Community**

One of the reasons that therapists in this study relied so heavily on building strong relationships with clients was because of the all-consuming role of relationships in clients’ lives. Participants in the study frequently noted that their clients, most of whom came from collectivist cultures, defined themselves in ways that differed substantially from more individualistic U.S. ways of thinking. Whereas the non-refugee clients with whom participants had previously worked conceptualized themselves as more independent individuals, participants’ refugee clients made much more fluid distinctions among *me, you,* and *us,* understanding themselves as extensions of their families and communities.

*Our participants’ sense of self is very much connected to the rest of their community and their family, whereas when working with other youth that weren't refugees, that connection really wasn't there. They didn’t have...unfortunately [my non-refugee clients] really didn’t have a lot of family or people that they really relied on to make decisions, but this is very communal: the refugee experience is very much...the boundaries are different.* [Participant 2]

Because clients’ worldviews differed so significantly from the more Western emphasis on the autonomous self, the traditional Western concept of individually-focused therapy did not always fit clients’ needs. Thus, clinicians realized that to make therapy relevant to these clients’ community-based identities, they would need to reconceptualize the work to make room for clients’ communities rather than attempting to define clients individually in ways that clients did not define themselves. In the case example below,
one participant explains how this concept of “working with the whole family” changed the ways in which she and one client interacted with one another.

So it’s like when I'm working with one person, you're really working with the whole family and like five or six other people--community members [...] There’s one family I’m working with that’s Iraqi, and they have two teenage boys and three daughters who are all two years apart starting at [age] nine. Every time I speak to them, it’s always on speakerphone. Their sense of self is really connected to the family, and there's no boundaries in terms of, "This is this one girl’s individual issue," so I’ll need to talk to the family or one person or the parent about the way one is acting out. And they're just all in it. [Participant 2]

In some cases, this community-oriented sense of self extended beyond merely changing the ways therapists interacted with their clients—or the who of the exchange—to changing the nature of the therapeutic encounter itself—the how of the exchange. One therapist looking to carve out some one-on-one time for individual talk therapy with a recently-hospitalized client found herself having to quickly adapt to an entirely different sort of encounter when she ended up leading an on-the-fly therapeutic gathering.

It goes back to how to bridge the cultural gap too, because this girl didn't want to be alone with me. I mean, I thought she might want some time to talk alone about her family, but no; her family was her resource. She wanted me to be there with her family, with her whole community. Then it got to the point where I had met with her a few weeks in her home, and everybody in the building from the same community would come. I was checking in with the one girl I was there for, and
she was like, "Come back next week. Everybody can come." So it came to be like a community gathering, which is also therapeutic. It was just interesting.

[Participant 4]

Re-conceptualizing Therapy

Clients’ perceptions of therapy itself also tended to vary from the Western conceptualization emphasized in the therapists’ own upbringing and professional training. The idea that one would divulge personal secrets to a complete stranger was a foreign concept for many clients, and the idea that this would somehow be helpful to the divulger even more so. Furthermore, therapists, at times, had to confront clients’ stigma surrounding seeking psychological help. As such, they had to spend more time on the foundational tasks of building reciprocal, trusting relationships that would enable clients to feel comfortable opening up.

I mean, you can’t come here and think that you can just, you know, sit in a bare room and have them just open up. It's just not going to work. Aside from everything about stigma and all that, it’s just like…it’s really a very kinda Western thing. And that’s what people expect in our culture, that they're gonna come and just kind of unload on a person—that’s their job—but it’s not what [our clients] come to us thinking. [Participant 1]

In line with clients’ more collectivist constructions of self, these relationships transcended the client-therapist relationship, expanding to include a relationship among individual therapists, their professional organizations, and clients’ communities in the broader sense.
I think that’s the biggest service we do for folks is really meeting them where they are at and breaking down the boundaries of, "I’m only going to talk to you in this office," just being a part of what’s going on in their lives. Like [a particular group of] girls [...] we went to their graduation, eighth grade graduation. They saw us around the neighborhood; they say, “Hi,” to us even now when we are walking around. I think that really demonstrates to them that we are trusted in the community, whereas if it’s just this one person who they only see at school, I don’t know if they would be as willing to share certain things. [Participant 2]

For children, in particular, it was often even more difficult to conceptualize the Western idea of therapy. Adults may have had some familiarity with the concept of therapy as a professional endeavor or were able to equate therapy with other cathartic, mentoring relationships indigenous to their own cultures, such as those with religious figures or community elders. For kids still struggling to conceptualize and adapt to the world around them in general, however, it was often a challenge to understand participants’ roles in their lives. Adults’ comparison of clinical work to other therapeutic experiences and kids’ struggle to conceptualize therapeutic experiences in general led one participant to reconsider her own perceptions and assumptions about this work.

I think that the children, I just wonder what their perception of therapy is. [My colleague] and I have talked about this lately. How do they see us? And how to verbalize that is so much easier, I think, with the adults. To recognize that and be able to verbalize it and think, "Oh, you’re my therapist," or, “Oh, people tell me you’re my advisor. You’re like a mother to me," or, “You’re like my aunt," or
whatever. Just a constant letting them know...What is therapy anyway? That brings up an existential question for me in working with these populations in particular. It's like, yeah, in their cultures, they go to the priest or the wise old man or the Imam or whatever. So how to constantly redefine that. [Participant 4]

Clients’ unfamiliarity or discomfort with therapy as a clinical endeavor was, at times, exacerbated by the procedures at participants’ organizations. At one organization, the therapeutic process typically began with a screening conducted at the initial meeting to assess for physical and emotional health, substance abuse, and social and recovery goal[s]. While for some, the opportunity to share their stories actually made them feel more engaged in therapy, for many, the expectation that they would provide such intimate details of their lives with a stranger at the very first meeting made them even more reluctant to participate. To accommodate those for whom this was a stressful request, participants and their organizations devoted extra time to community outreach to increase presence in clients’ communities and build informal, social relationships with potential clients. Having an existing relationship with the client on which to draw during this screening process often served to diminish any tensions these initial meetings may create. Even so, for many, the process of “opening up” still unfolded in an incremental, extended fashion, with therapists only gleaning the full breadth of their personal histories after months of sessions.

The main part of the screening process, it's a preliminary assessment[...]That's where the story comes in and the connection, I think. It's a relationship builder. It's at the first meeting—I mean, ideally, if we are doing a screening. Again, they
may not be open to that, so we may need to engage them in outreach then for a while before they'll actually come in and sit down or even be able to tolerate or answer those questions. Some people cannot talk about that, but others do, and some of them just share limited information and a lot comes out a few months later. [Participant 3]

Searching for Cultural Context

Just as clients usually had a different conception of self, community, and therapy than did their therapists, so, too, did clients have a range of diverse values and experiences that informed their lives in their home countries, their migratory journeys, and their present realities. Many social, cultural, and political phenomena integral to clients’ personal histories—and, therefore, to the therapeutic environment—were beyond the scope of the therapists’ existing awareness. As a result, therapists had to invest more time learning about clients’ backgrounds and the ways they lived their lives before arriving in the United States so they could better understand the issues clients may be struggling with here post-arrival. Gaining this contextual knowledge was particularly relevant given the heightened role of community life in clients’ self-concept. These factors underscored the need to develop a strong relationship wherein clients felt comfortable to share relevant contextual information and invested in collaborating with the clinician to transcend any gaps in understanding that may otherwise impede therapeutic progress.

I think I've learned so much from participants. So, really just learning from them—that's part of what I mean by collaborative relationship. It's like, "Wow, I
really don't know about your experience and where you come from. Can you please share that with me? And how much do you want to share?” and allowing them to share just as much as they are comfortable with. Just trying to be sensitive to that, to those differences, and recognize them as differences, as well, and not devalue that or minimize that. Also, recognize the human connection about how we can work together. [Participant 4]

This need for context was particularly relevant for clients whose lives prior to arriving in the United States were drastically different than therapists’ own experiences, such as those who had lived in refugee camps. Whereas participants who had worked with U.S. clients may have been able to draw, to some degree, from shared cultural backgrounds or knowledge of issues affecting nearby communities, this was not the case for therapists working with clients from very low-income, international communities, where standards of living, cultural norms, and even the structures of daily life were often outside the scope of therapists’ familiarity. In these cases, participants relied heavily on clients sharing their stories with them so that they could understand what experiences and values had shaped them.

Well even just life in a refugee camp—what it was like. I mean, I've never really been to one. I have ideas. I've read about it. I've heard about it. But their direct experience about what it was like to actually live in a refugee camp...just sharing their experience. One of the most powerful tools we have [at our organization] is the relocation addendum, which is really [when] I ask them about their story from
the time they left their home country to the time they arrived here. I think that
that is just full of information. [Participant 4]

In many cases, therapists relied on family members--particularly parents--to
provide crucial information related to clients’ backgrounds. Oftentimes, children
couldn’t remember the early experiences that had influenced their development and
cognitive schema, such as what their lives were like before, during, or even after
migration. Working with parents helped participants to gain this information and the
insight it provided about the clients’ present behavior, underscoring the need for strong
relationships with multiple actors in the therapeutic environment.

I work with children and with adults, so oftentimes the children don’t remember
[their migratory journeys], or, you know, the reports are very different than the
adults. Ideally, working with the parents and children, we can get that
information. A lot of education and a lot of stuff comes up around that about
their migration. [Participant 4]

Interpreters and the Therapeutic Relationship

Also highlighting the need to build relationships with multiple parties, therapists
sometimes didn’t even realize that a cultural gap was preventing them from gaining full
insight on how clients’ experiences were affecting them until it was brought to their
attention through someone else, such as an interpreter. When engaging with therapists
who appreciated the value of collaborative relationships, interpreters were sometimes
able to serve as “co-therapists” with participants, helping to bring context to the situation.
One participant recalled how a particular interpreter with whom she worked regularly
critically enhanced the therapeutic process by providing much-needed insight into clients’ use of subliminal messaging that therapists may not be able to understand.

I prefer to have an interpreter in person, because they also kinda end up interpreting cultural things as well, like what’s kinda said in a tone of voice I wouldn't recognize because of the language. You know, like, for example, I work with this Kirundi interpreter, and she also kinda interprets, you know, “She’s saying this, but I want you to know that she's saying this like she's very angry. You should know that so that you can address that,” and that's really helpful because in my experience using the phone interpreter, we don't really get all of that. Um, also, people...some expressions are shown a little differently. Some are from that culture that I might not understand, like, you know, she's trying to not look angry, but I cant recognize that, and she's using this word instead of that word. [Participant 1]

Though interpreters often contributed to the therapeutic environment, at times, the introduction of another agent complicated relationships with clients. Trying to intercept messages through a third party was often stressful and frustrating for both clients and their therapists, especially if the conversation centered around clients’ immediate (and possibly urgent) needs. These exchanges added another layer to the already-overwhelming complexity of clients’ lives and the therapeutic process.

That relationship goes both ways for me and the person. We are both using the person someone who speaks both of our languages, but we don't speak the participant's language. I feel like it's the same thing for me, also, because I'm
learning how to get these messages from an interpreter, and I'm learning how to pick out what the interpreter is saying, trying to think about, "Okay, well, he's talking about this appointment to get food; does he mean his public aid?" So, it's very much like a dance that we're both trying to learn, how to decipher messages from an interpreter. [...] It's not just that [the client's] really overwhelmed; I get really overwhelmed trying to think about what's being said and accurately getting a message through or from the person who is speaking. [Participant 2]

**Relationships as Protective Factors**

Given the distinct cultural context informing clients’ behaviors, on certain occasions, misunderstandings occurred between participants and their clients or between clients and their new U.S. communities and institutions. These ranged from more moderate differences related to sense of privacy or gender roles to more serious situations with potential legal ramifications, such as domestic violence, corporal punishment, or negligence. The therapists in the study related how, in some cases, clients or their family members engaged in physical behavior that was seen as an appropriate disciplinary action in their countries but may fit definitions of physical abuse in the United States. This presented legal and ethical challenges to the clinicians, who understood that this behavior was informed by a different cultural perspective but also were concerned about it given that their own perspectives on discipline were informed by U.S. standards and laws. They worried about its effect on clients, its potential legal and child custody ramifications for parents, and its implications for therapists themselves as mandatory reporters of abuse.
Most clinicians in the study detailed taking extra care to thoroughly explain mandatory reporting requirements and U.S. norms around these issues to clients at the onset of the therapeutic relationship. In a few cases, however, therapists had to report clients or community members to child protective services. In other situations, the clients were referred to the therapists by child protective services. In still others, the clients were referred to protective services by another community institution (such as a child’s school) at some point during the therapeutic process. All such scenarios threatened the level of trust clinicians and their professional organizations had established or hoped to establish in the larger community. Community members whom therapists reported to protective services blamed them for the involvement of protective services in their lives. Those who were referred to therapists by other organizations, meanwhile, associated the therapists with the awful and stressful situation of having to defend their custody of their children. On many occasions, this trust became damaged to a point of disrepair.

At times, however, clinicians had built such strong relationships with clients that they were able to persevere even through such severe strain. One participant recalled how a colleague of hers who had established trust within the community was able to use this connection to overcome the community’s suspicions and still provide effective services. This colleague, who was from Kenya, was able to maintain a relationship with the Liberian refugee community even after local schools initiated a number of referrals to child protective services shortly after a family’s arrival in the United States. The participant implies that part of the reason this particular colleague was able to do this under such difficult circumstances was due to shared racial and/or ethnic ties related to a common African identity between her and the community involved. This suggests that
an inter-community relationship of sorts played a protective role in her ability to forge individual relationships with the community and its members—and also hints at the power of collaboration among colleagues in this work, as this colleague’s ability to build relationships with the community improved the credibility of the organization as a whole.

I think the introduction of child welfare really early meant that we probably somewhat unconsciously focused a lot on family dynamics. There are very few things that us more nervous than having to do a [child welfare] referral because we know what it will do to our reputation, because we know that [the welfare agency] won’t possibly be able to handle the case. We are stuck between a law that is important and the bomb of the effect that will go off in a community as a result of that referral. If the community is big enough, it's not a big deal, but if it is a tiny community, which is what has happened, it is. So I think it did change the nature of what we did with our families. We were always on our heels in terms of trying to find ways to be helpful. [My colleague from Kenya], frankly, had the greatest impact, and she came like three years too late to really be okay, but the Liberian girls really responded well to [her]. So I think that speaks to another layer of this work in terms of [her] being a Kenyan woman who was able to make a connection when we weren't. [Participant 5]

Conversely, when clinicians were unable to effectively establish or maintain relationships in this type of scenario, the effects were potentially catastrophic to the organization and the community. The same participant whose Kenyan colleague succeeded in building community connections outlined how she and the rest of her
colleagues were nearly unable to do so, which would have been detrimental to community members.

_Some of my biggest emergencies came within that community, and they were often families I didn't know, and I would have to come in at a moment when they didn't know me, didn't trust me, and I'd have to intervene in a really awful situation._

_With that, your reputation, which is a part of this work, just takes another hit. We just couldn't do it, and it was heartbreaking, frankly, because I think that the Liberian kids struggled because of that. We had a summer where the community itself threatened not to let any of their kids come to our summer camp, which is unheard-of. This is a program that 70 to 100 kids went through every summer._

_They did come._ [Participant 5]

**Addressing Therapists’ Personal and Professional Needs**

Relationships also served as a means to meet participants’ personal and professional needs. On a professional level, relationships with colleagues within their programs enabled participants to gain much-needed skills and insight they had not acquired from their clinical education. Meanwhile, relationships with service providers practicing other types of community work and with members of the larger host community also provided opportunities to engage in professional endeavors such as advocacy and psychoeducation that challenged the systems and norms detrimental to clients’ wellness. On a more personal level, relationships with colleagues who understood how overwhelming this work could be helped participants to cope with stress related to the intense and often taxing nature of their practice.
**Relationships as a network of care.** Just as clients saw networks of relationships as a means to understand and solve the problems in their lives, so, too, did clinicians rely on networks of relationships to gain the knowledge, skills, and opportunities they needed to best support clients in reaching their goals. They did so by adopting a collectivist model of care that recognized that clients’ healing required involvement from the whole community. Given the host community’s lack of awareness of clients’ backgrounds, the intensity of clients’ needs, the impact of systemic factors and discrimination on clients’ lives, and the gaps in clinicians’ training, effective service delivery was only possible if clinicians both 1) learned from those who knew more about clients’ experiences and/or how to conduct this work, and 2) taught others who had no idea how to meet clients’ needs or made assumptions about clients’ lives. Like the proverb, “It takes a village to raise a child,” suggests that no one alone can complete a task so complicated and important as educating a child, clinicians seemed to believe that no one clinician alone could heal a person; rather, it takes a community to do so.

To reflect this belief, clinicians not only developed extensive relationships with clients, their families, and their refugee communities but also relied heavily on relationships with colleagues. In many ways, they felt that their work was taking them into uncharted territory for which they had not been aptly prepared during their more traditional clinical training, as that training often failed to address work with international communities or those with intensive psychosocial needs. Consequently, most participants learned through their own experiences and those of their colleagues. Furthermore, given that staff members at their agencies were often working with the same clients as the therapists in complementary capacities—perhaps as case managers or
as other family members’ clinicians—-they were often able to seek insight from co-workers who were aware of clients’ particular situations or could provide additional context from a slightly different perspective.

*I mean the ideal for me as a clinician is to work side by side with a case manager or a mental health reporter who is also connected with the case. I think about literally three people sitting in triangle like this. [Gestures.] It bridges that gap—really the collaborative team effort we make in this program serves that purpose in just providing a comprehensive service for them. [Participant 4]*

In addition to collaborating with colleagues within their own organizations, several clinicians emphasized conducting broader advocacy by building relationships with service providers working with clients in other settings and professional fields. These relationships were seen as a means to provide more intensive support for clients, as well as an opportunity to challenge systems that were impeding clients’ ability to integrate and thrive in their new communities.

*The part that I think we took equally seriously was [...] trying to find ways to get the systems to move a little bit, to be more flexible, to be less rigid, to understand [...] You did a lot of this sort of both messaging but also kind of confronting systems to just be better and to be patient. Sometimes that was in advocacy with [child protective services]. A lot of times it was in working with schools. Sometimes it was rerouting around administration and going directly to the teacher and trying to build a relationship. [Participant 5]*
Services are great when we do collaborate very closely with doctors and hospitals and resettlement agencies and all of the needs and resources that are available. I think the ideal would be to have that as consolidated and comprehensive as possible. I think we do a pretty good job, actually, but there is more that can be done. [Participant 4]

This type of advocacy was considered particularly important in instances where clinicians felt that external agencies’ actions were detrimental to clients’ wellness. In some scenarios, participants felt that schools, hospitals, or child welfare departments were more interested in protecting their own institutions than in furthering clients’ well-being, leading these agencies to pressure vulnerable clients into actions that were contrary to their families’ needs or wishes. This was the case for one child who passed out at school, an instance the therapist believed was due to severe mental distress related to trauma. However, because the child struggled to explain the experience, the hospital labeled it a seizure and stated that she had epilepsy, prompting the school to respond with a seizure plan that, in the therapist’s view, curtailed the child’s rights.

*The school, and the hospital...I mean I guess she wouldn't have to fulfill those meds, but because she came back from the hospital, and they said, “We're going to give her these meds,” the school is pushing that she has that on hand at the nurse. The school was very proactive, and they invited all of us to come and make a seizure plan, and at first they wanted to even say that she couldn't play on the playground because what if she had a seizure and fell. She's had ONE, you know? And the family is involved and [child protective services] also, so [child services]*
is covering their back and making sure the family is following up with these
doctors. [Participant 1]

These relationships with other service providers also offered participants a chance
to engage in psychoeducational outreach. This involved building community awareness
of clients’ backgrounds, values, and the challenges they face throughout the acculturation
process, as well as supporting service providers in other sectors who may also be feeling
overwhelmed by this work. In doing so, participants felt they were helping to create
spaces where clients faced fewer barriers to adjustment and benefited from more
supportive and inclusive environments that could better help them navigate the myriad of
changes occurring in their lives.

One of the things that I think is much different about working with refugees is the
advocacy piece, so helping other people who are working with refugees—they’re
usually involved with other organizations. Really talking with them about what
it's like to be a refugee and doing more psychoeducation stuff and maybe in terms
of direct service with them. [Participant 3]

At times, this outreach extended beyond relationships with other service providers
and into the larger host community. One participant recalled engaging in advocacy not
just to improve services available to clients but to diminish the prejudices and
assumptions clients faced in their encounters with others. She remembered conversations
she had with acquaintances who, upon learning she worked with refugee youth, doubted
her clients’ potential to contribute to their communities. Despite being vexed by the
biases these comments exposed, she worked to challenge these preconceptions in hopes
of fostering a more accommodating, compassionate environment in which her clients could thrive.

_I worked in residential [treatment], and people would say, "Why do you work there? These kids aren't ever really going to be contributing members of society." That really used to make me angry, because I would think, “What do you mean by that? Are they going to have the life that you have? Probably not, but does that [mean] there's not a million different ways to live that are productive and have meaning?” [Participant 3]_

**Relationships as personal supports.** Collaboration with colleagues was important not only due to its potential to improve the service provision clients received but also to protect clinicians’ own well-being and morale. Many clients were experiencing intense symptoms and challenges related to both the severity of their pre-migration trauma, which was often very recent, as well as the multiple stressors inherent to the acculturation process. Clinicians often felt that they were the first--or sometimes only--line of defense available to assist clients throughout these struggles, as many clients did not have adequate support systems established within their new communities. As a result, there was a sense that the stakes were very high, particularly in cases where clients were engaging in self-harm. This left several therapists to comment on feeling scared, overwhelmed, or at a loss for what to do. One clinician expressed these sentiments related to the case of a client diagnosed with major depression, bulimia, and anorexia who had to be hospitalized after regular incidents of self-isolation and self-harm. The
client’s family did not want to hospitalize the client, so the clinician accompanied the client to the hospital herself or visited her at home in times of distress.

Well she started out in a really scary place. I mean there were times when I was just feeling like, “Oh my gosh.” I just kind of hung in there with her, and there were times when I didn't know what the hell I was doing. [Participant 3]

In some cases, symptoms were so severe that they provoked frightening medical responses that therapists struggled to manage. This was the case for one Karen woman who had a strong, physical reaction to her therapist’s revelation that she would be leaving the agency. Learning that this relationship would soon be terminated prompted her to enter an immobilizing crisis mode. The intensity of this response underscores not only the overwhelming nature of the stress occurring in her life but also the crucial support that this therapeutic relationship provided in helping her to deal with this stress.

I told her that I was moving, and she had a lot of other stuff going on: her food stamps had been cut; she’s single mom; one of the older kids is gonna be in high school next year so won’t be available to help the younger kid after school...and she was just so stressed, and when I told her I was leaving on top of it, she had what probably a doctor would describe as a panic attack, but I don’t know that that’s what it was. She just like melted into her chair, and she would nod her head to a few of our questions. She was still kinda there, but her blood pressure went really low [...] I don’t know how to put a label on that, but yeah, it was very scary. And she said she has those all the time at home. [Participant 1]
Because their colleagues were often the only people who could truly understand the intense emotions and stress intrinsic to this role, participants often felt a strong sense of community at work, where their relationships with colleagues were able to address certain needs that family and friends who didn’t truly understand the work failed to fulfill.

We're like a family here, so that’s good. I think because we work together, we're the only ones who can really understand. So, yeah, it’s been a learning curve, too, that I can't find the support I seek from...as much as even like my husband or my best friends would want to be there for me, in the end they don’t do it. But because we do work as a team, it works here. [Participant 1]

**Relationships as Cause and Effect in Community Work**

The centrality of relationships to the therapeutic process served as both a cause and effect of the structure and setting of therapy. On the one hand, as outlined above, the cultural context in which this process was unfolding compelled a core focus on building strong relationships between therapists and their clients. This led to the use of a community model among participants’ professional organizations. As part of this model, therapists engaged in roles not typically associated with traditional clinical work. Beyond conducting individual, group, and family therapy sessions, participants also were involved in some combination of case management provision; arts-based therapeutic approaches; regular home, school, and other community-based visits; attendance at personal and community events; engagement in client advocacy and community outreach; and collaboration with other therapists and service providers. This holistic
The community and the community outreach and being out in the community—I think that's a service, I think, that's different in this program in particular. [It’s] great and really valuable, like really able to meet the participant where they are at. Like, literally going into the home and being able to integrate into their community, while they’re also integrating and acclimating to this country. It just makes it a much different experience than with non-refugees [...] It bridges that gap. Really the collaborative team effort we make in this program serves that purpose in just providing a comprehensive service for them. [Participant 4]

Therapists were often willing to engage in these unconventional roles even beyond what was expected of them as community-based clinicians, taking time out of their evenings and weekends to assist clients in crisis or witness personal milestones achieved by individuals who had long since left the clinical setting. This willingness was due, partially, to their understanding that they were, in some instances, the only support systems on which clients could rely. This was true either in general (such as for clients who did not have a healthy support network available in the United States at all) or under particular circumstances (as in the case of clients whose support systems would be unable or unwilling to aid client in particular tasks).

You know, if a woman is going to have a baby and is in this great time of need, I’m not going to provoke more anxiety and tell them to keep looking. I think we're just very aware of that, so...The same thing: I took a teenage girl to have an
abortion. She had to hide it from her dad, and she was raped, and it was...and there was no one else, 'cause no one in her community would have said that that was okay. And that was her decision, so... [Participant 1]

Just as the need for non-traditional therapeutic relationships precipitated the use of this community model, so, too, did the model itself reinforce the development of unconventional relationships. Participants in the study shared stories of relationships that traversed many years, places, and profound experiences, resulting in therapists being considered part of clients’ extended families. These relationships often evolved over time as clients’ needs changed. In several cases, clinicians maintained personal relationships with clients long after their clinical relationships ended, whether in a mentorship capacity or simply as a witness to clients’ next steps in life.

I'm still in touch with them in a different way. Like, for example, there's one woman who I started out with when she was thirteen. I started seeing her right when they came here. She was from Bosnia. I saw her weekly—sometimes more than that. She ended up dating an African-American boy, and her family kicked her out of the house. She ended up having a baby with him and living with his family. I remember she was living over an hour away, but she would still come. And when you talk about goals, the goals were: finish school, finish high school. They went from, “Let's just get you through high school,” then she had the baby, and I continued seeing her through the adjustment things with the relationship. I ended up referring her and the boy, who she ended up marrying, to this marriage counselor/colleague of mine. I just went to her graduation from nursing school. I
hadn't seen her for a couple years, and she just bawled and said that, "I would really like it if you could come." And her child is in the second grade or third grade in honors classes. So, the relationship kind of lasts even though it doesn't necessarily look the same. She'll still call when she needs something, but she's not doing weekly psychotherapy with a visit to the psychiatrist. [Participant 3]

**Relationship-Building: Values, Principles, and Actions**

After outlining the fundamental importance of relationships to community practice with their clients, participants then delved into the mechanics of building relationships across such wide cultural differences. They related a number of actions they took to partner with clients in co-constructing a therapeutic environment that highlighted clients’ knowledge; incorporated clients’ traditions; provided clients agency to influence the process; and acknowledged the role of therapists’ own backgrounds, values, and experiences. These actions--such as attending community events and assessing clients’ amenability to therapists’ personal skill sets--reflected value-laden principles shared by practitioners of this work, who used those principles to guide the specific actions they took to build relationships with clients. The larger values guiding therapists’ work with their clients were humility and flexibility; learning and reflection; collaboration and participation; respect and appreciation; and vulnerability and transparency. (See Table 1.) These values were often overlapping and interdependent, with multiple values informing any particular principle or action.

**Humility and flexibility.** Humility was one of the most fundamental values participants espoused, inspiring and interacting with several other values. This value had both professional and cultural dimensions. Professional humility entailed recognizing
clients as the experts in their own lives and not assuming that clinicians’ professional titles or training implied that they knew more than clients did about how to address clients’ problems. Professional humility also required cultural humility enabling participants to recognize and appreciate participants’ own perspectives on healing practices. As one participant stated, “I can have my own thoughts and feelings about what they're going to get out of therapy to no end, and that doesn't really matter. It's what they think and what they want and what they need” (Participant 4). On a practical level, therapists often demonstrated this humility through actions such as asking clients to share these perspectives and explaining the ways their own conceptions of healing may contribute to the therapeutic process while also acknowledging the limitations of their knowledge and skills. Creating a practice grounded in humility also required participants to embody the value of flexibility by demonstrating willingness not just to consider clients’ conceptions of healing but also to adapt their practice to better respond to clients’ needs, traditions, and values. Thus, actions such as partnering with clients to brainstorm how to incorporate their traditions as thoroughly as possible displayed both flexibility and humility.

*It’s really stepping into a home and letting people be the experts of their own identity and asking a lot of questions and asking them to teach you things that you don’t know—just being very transparent about what you do and don’t know and asking questions and letting people teach you. And also doing your best to ask specifically, if I’m in there to do therapy, to address a certain symptom—let’s say their child is acting out and doesn't listen—the first question would be, "How would you handle this if you weren’t in the U.S.?" or "How is your country used*
to handling this?" or "What does your culture usually do?" or "What is your healing process?" and how does that kind of work with what's realistic here in the States, and seeing what would work. [Participant 2]

Learning and reflection. Just as humility required participants to demonstrate flexibility, so, too, did both of these values depended on participants’ willingness to engage in learning and reflection. Adapting one’s practice to meet clients’ needs required practitioners working with refugees to first develop a sense of cultural self-awareness that enabled them to recognize the cultural particularities of life in the United States and how these particularities may look from an outsider’s perspective.

You had the differences in terms of the U.S. systems, their expectations of families and families coming into these systems, like child [protective services], in particular, with kids. You had this foreign body introduced into the lives of families, and you had to make decisions, it seems, on a weekly basis about how you were going to communicate this drastic change to families and how you were going to help families work within systems that were really different and made no sense—made no sense for good reason to them [and] make no sense to us in some respects. [Participant 5]

This self-awareness emerged from a larger practice of learning about clients’ cultures in relationship to their own and reflecting on information gleaned from their interactions with clients. This led therapists to redefine their understanding of their own lives, assumptions, and professional perspectives. One participant explained how her
relationships with clients yielded changes to her own worldviews, her behavior, and her perceived role in the therapeutic process.

*My perspective on cultural competency as it pertains to refugee communities is that I had a responsibility to join with the community as much as I could to understand their worldview. I had a responsibility from the ways that I physically interacted with folks to the ways that I conceptually explained things, I had a duty to change my behavior such that it wasn't...so our world views became somewhat closer to one another. [...] Adapting my behavior is a critical piece to that, then showing the community deep levels of respect for what is important and true for them by presence at community events. [Participant 5]*

**Table 1.**

*Values Applied to Relationship-Building in Community-Based Practice with Refugees*

<table>
<thead>
<tr>
<th>Values</th>
<th>Principles</th>
<th>Actions</th>
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| Collaboration & Participation | Attempting to diminish power differentials  
Building a reciprocal therapeutic relationship  
Engaging communities in planning their own healing and progress  
Participating in clients’ lives and communities  
Supporting communities on their own terms | Attending community events and meetings  
Listening to communities’ stories  
Consulting with community leaders  
Connecting communities with resources needed to build their strengths, talents, and skills |
| Humility & Flexibility | Acknowledging that one’s professional skills and perspectives on healing are culturally-located  
Adapting clinical practice to incorporate clients’ needs, | Admitting fault when necessary  
Brainstorming with clients how to incorporate their traditions into clinical practice |
<table>
<thead>
<tr>
<th>Traditions, and Values</th>
<th>Explicitly outlining therapist’s own perspective on healing, including the limitations of one’s knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assessing the client’s amenability to therapist’s skillset at the onset</td>
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<tr>
<td></td>
<td>Explaining the underlying norms and expectations informing U.S. systems</td>
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<tr>
<td></td>
<td>Following clients’ lead in situations that do not go as planned</td>
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<tr>
<th>Learning &amp; Reflection</th>
<th>Being curious about diverse healing practices</th>
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<tbody>
<tr>
<td></td>
<td>Constantly examining and redefining one’s assumptions about culture and therapy</td>
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<td></td>
<td>Developing cultural self-awareness</td>
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<td></td>
<td>Incorporating clients’ experiences into one’s own worldview</td>
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<td></td>
<td>Seeking to understand the history, values, and traditions of clients’ countries of origin</td>
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<td></td>
<td>Asking clients to teach about their experiences and countries of origin</td>
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<td></td>
<td>Reflecting on the norms and expectations of the therapist’s own culture</td>
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<td></td>
<td>Showing genuine interest in clients’ stories and perspectives</td>
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</tbody>
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<thead>
<tr>
<th>Respect &amp; Appreciation</th>
<th>Honoring the limits of clients’ willingness to share and engage</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Recognizing the perspectives and skills clients contribute to the community</td>
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<td></td>
<td>Valuing clients’ individuality</td>
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<td>Employing an assets-based approach to community empowerment</td>
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<td></td>
<td>Not pressing clients to extend themselves outside their comfort zones</td>
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<td></td>
<td>Beginning therapeutic encounters with a clean slate free from assumptions</td>
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<td></td>
<td>Identifying communities’ strengths, talents, and skills</td>
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</tbody>
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<tr>
<th>Vulnerability &amp; Transparency</th>
<th>Respecting clients’ need for personal connection with their therapist</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Trusting clients with one’s personal information</td>
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<tr>
<td></td>
<td>Making one’s perspectives and intentions explicit</td>
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<td>Disclosing about oneself</td>
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<td>Answering clients’ questions about one’s personal life</td>
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<td>Explaining the therapist’s perspective and goals regarding therapy</td>
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Just as humility inspired this learning and reflection process, so, too, was humility reinforced by it. This participant contrasted this cultural self-awareness and appreciation for traditional methods of healing with the cultural superiority often embodied by many U.S. Americans. She recognized the political undertones of this work, arguing that this self-awareness led to critical understandings of the ways that U.S. systems and values affected communities. She also emphasized the importance of understanding healing as an innately human, culturally-located phenomenon practiced in different ways by different communities for millennia. While acknowledging that she had a particular skill set that could potentially be added to participants’ own healing toolbox, she resisted the temptation to assume that her particular approach to growth was the approach rather than one approach. This perspective reflected a principle of refusing to engage in cultural superiority that was enacted by explicitly outlining her therapeutic approach to clients and assessing how receptive they were to it before expecting them to engage in the practice.

[Doing this work means] not being so American; not being so convinced...sort of that imperialist side that exists in American culture. "This is right; this is how it should be; this is what we do, and ‘Come on! What's wrong with you?’" That's a ridiculous stance. I think if you look at most people who have worked with refugee communities for a fair amount of time, you will find that they are sort of political radicals. [...] Communities and cultures have known how to heal themselves for millennia, so what I bring to the table is my own sense of what that means, but more what I bring [is what] it feels like to be in distress and how you want that to abate. So, my job is to find out the systems of healing that communities would
invoke when under distress and how amenable they were to the skill set that I had and what I know. [Participant 5]

Collaboration and participation. For this participant, collaboration was at the heart of the intersection between humility and learning. For her, programs that did not address the ways that power and discrimination had impacted clients’ realities or that attempted to artificially “empower” communities from the outside rather than supporting them on their terms as they empowered themselves from within were destined to fail. Rather, effective programs focused on building reciprocal therapeutic relationships and engaging communities in planning their own healing processes by attending community events and meetings, listening to communities’ stories, consulting with community leaders, and connecting them with resources. This conviction was informed by her own experience of failing to connect with a particular community due to not having adequately upheld this participatory mindset. In that situation, practicing humility, learning, and collaboration proved a means of not only building but also repairing relationships: the situation was ultimately mended thanks to her willingness to listen authentically and admit fault, as well as the community’s capacity to forgive.

I think that programs cannot look like colonial systems. I think that programs have to represent the communities that exist. I think that we have a responsibility on an administrative level to be partners with communities in cultivating their...not cultivating but supporting the talents and strengths and skills that exist within that community [...] to make sure that the community had the resources they needed to grow and develop. I think the agency itself has to be a
multinational, multilingual representation of the communities that they serve [...] I stepped in it with the Burundian community in an unimaginable way, and what that meant for me was to end up in a meeting with a bunch of elders being taken to task--it was fair--and listening to stories and making sure that I said that I messed up. Fortunately, most communities are pretty forgiving. [Participant 5]

**Respect and appreciation.** While underscoring the need to learn about cultural practices indigenous to clients’ societies, participants also warned against translating general cultural themes into assumptions about individual clients’ values or perspectives based solely on their ethnic origin. Therapists noted that all societies are composed of individuals with diverse personalities, skills, and opinions, emphasizing that developing cultural competence required not just understanding how clients may be influenced by larger norms within their societies but also recognizing that they may diverge from those norms. This meant learning about a client’s country of origin while also understanding that this knowledge does not make one culturally competent: “Just really letting kind of letting go of the idea that being culturally competent means, ‘I’m going to go and do all of my research about this country’” (Participant 2). Demonstrating respect for clients’ individuality necessitated beginning each encounter with new clients with a clean slate free of assumptions.

To illustrate this point, one participant recalled having very distinct experiences in her work with two different Liberian men. While one adhered to very traditional gender roles that the participant felt made it difficult for him to feel comfortable working with her based on her female identity, this was not an issue with the other.
It’s good to be mindful of those different qualities [shared by many within a society], but every person is different, ‘cause I’ve had another Liberian man that I did individual therapy with, and that wasn’t an issue. So, I think that really is the work of being culturally competent. You have these things in mind that you need to pay attention to, to see if they're problematic or challenging, but it's not...there are no set rules. Two people are still different even if they are from the same country. [Participant 2]

Just as honoring cultural traditions while still allowing room for diversity demonstrated participants’ values of respect and appreciation, so, too, did honoring the extent to which clients were or were not ready to participate in certain activities. Therapists noted that clients were not always willing or able to engage in certain conversations or practices, particularly when those practices centered around traumatic experiences or when they were still in the process of building a therapeutic relationship. Respecting clients’ right to share as much or as little as made them comfortable was crucial at this stage, as was respecting their right to refuse services entirely if so desired. Some clients refused services even despite having an intense history of traumatic exposures, to which participants responded by conducting community outreach, making themselves available in the event clients changed their minds.

When I hear of someone witnessing such intense, horrific trauma and I also hear them saying, "But I'm okay; I don't need therapy," or whatever, that's a concern, and I also have to honor that as their own experience and where they're at. So, say someone refuses services. I will, hopefully—I mean this was ideal when I was
working at the resettlement agency, too, because for a lot of people who refused services, I would still see them—develop a relationship even if I wasn’t meeting with them for therapy. That can happen outside, too, in the community. So, just really building a relationship and outreaching people and sort of always being open and saying, "Hey, we are here if you are ready and if you want to come meet with us." [Participant 4]

**Vulnerability and transparency.** In addition to asking clients to share about their backgrounds and traditions as a starting point for building the therapeutic relationship, therapists soon realized that they, too, would have to be willing to share about themselves if they wanted clients to trust them. They grappled with the ethical implications of sharing personal information given that this diverged from their clinical training. At the same time, they also recognized that developing a one-sided relationship did not fit into clients’ worldviews or comfort zones and would, therefore, prevent therapists from being able to contribute meaningfully to their progress. This willingness to be vulnerable and transparent was the first thing that came to mind for one participant when asked how she addresses cultural issues in her work:

*I’m really open, so I’m more willing to disclose information about myself if it helps build trust and our relationship and they see where I’m coming from [...] I think just in the beginning I’m just very transparent as much as I can be, and I make sure to try to make them feel comfortable that they...because I’m always bombard them with questions that they have the opportunity to bombard me with questions. [...] [They would ask things like,] “Are you married? How many
kids do you want to have?” stuff like that that my clinical training kinda told me, you know, "You don’t say that. You don’t talk about that stuff with participants."

but I saw how important it was and how intrusive I sounded to them, and if I was willing to trust them with that information, I found that they were much more willing to let me come into their lives. But, you know, I know not everyone would agree to do that. That was kind of...that was the way that I was able to mediate that—our cultural differences, I guess. [Participant 1]

Another participant saw this process of self-disclosure not just as a means of building trust with clients through transparency and vulnerability but also as a form of collaboration that helped to mitigate the power dynamic between herself and clients, particularly those who had been tortured, by allowing clients to participate in guiding the therapeutic exchange.

I think disclosing a little bit about myself is helpful [...] just sort of sharing that I've lived in West Africa or sharing about where my family has come from and just sort of normalizing their newness and acclimation here, showing genuine interest in them and what they want to share with me. So, I think, in a way, giving a little bit myself, sharing information and seeing if they have any questions and just trying to leave it open, making it really human so that the power...I think that oftentimes what comes up is the power dynamic, which I think is inevitable in the clinical relationship, especially if someone has been traumatized or tortured. It's really, really important to be aware of that and be as collaborative as possible.
So, defining my role in a way that doesn't really feed into that power, [that] hierarchical relationship, I think is key also [Participant 4]

Accentuating the relationship between vulnerability/transparency and collaboration/participation, for most participants, sharing about oneself occurred not only by answering questions within the therapeutic setting but also by participating in the larger community. Going into clients’ homes and “joining in” in their lives on a personal level rather than merely a professional one was a core practice in participants’ organizations. Bonding with clients over meals or at community get-togethers such as barbecues was a common occurrence that helped clients to acclimate to their new societies while also strengthening trust and connection with therapists. Asked how she bridges the cultural gap with clients, one participant responded:

Well, I think that it's kind of really basic. I mean, things like going into the community and working with [them] versus having them come in. I mean these are kind of the things that are rote now [...] going into the community, you know, sitting down and eating food with them. Doing less maybe interpretive work around that stuff than somebody who came into my private practice. I just kind of join in in a different way at the beginning, so going into the community, accompanying them, probably being more direct in terms of meeting needs or benefits or information or getting information. I do much more in that capacity than I would with somebody who wasn't getting used to a different place.

[Participant 3]
This practice of extensive, personal engagement was particularly useful in enabling children to feel safe throughout the process of building the relationship, as initials outings typically unfolded in the presence of community members with whom clients felt comfortable. Because of its communal nature, this engagement not only benefited relationships with individual clients but also helped therapists build presence in the larger community. Therapists often became known to community members even before they enrolled in services at therapists’ professional organizations. Building relationships with communities in addition to individuals increased therapists’ reputability to prospective clients, thereby providing a positive starting point for future therapeutic endeavors.

*With the children, we usually start by taking them for outings, like recreational socialization outings with people that they might feel comfortable [with], so like siblings or with other people at their school. And that is how we engage them. We do home visits. We take them on outings so they know who we are, so they don’t see us as strangers. We really have a presence with these neighborhoods and these communities [...] more often than not, the children just think, "Oh, there's that older girl that's always with so-and-so," and they start saying, “Hi,” to us before they even know who we are or what we do. So just having that presence is part of building the relationship, so it’s not just building a relationship with individual or with the family—it’s really building a relationship within the community, with other people in the community, just so they can see that we are trusted.* [Participant 2]
Engaging with clients in multiple settings provided a wealth of insight on clients’ lives, thus furthering participants’ opportunities to engage in learning and reflection. Seeing clients in their homes, especially, shed new light on their experiences and struggles. Though an important professional endeavor, conducting such visits was emotionally taxing for therapists personally, as it forced them to confront the often harsh realities of life as a refugee in the United States.

*Getting the opportunity to be in someone's home gives you so much more information as well as builds a relationship with them. It's hard, too; it takes a lot of time, and it's very difficult to do [...] a lot of the refugees we work with, unfortunately, live in pretty horrible conditions. It takes a lot out of you to go, but it gives you soooo much more information than if they can come here and kind of present their best. [Participant 1]*

**Finding the Line: Navigating Boundaries in Relationship Building**

As outlined above, relationships became a fundamental force central to helping clients fully engage with their communities in ways that would enable them to navigate the multiple stressors in their lives, confront their trauma, and harness their resilience and resources. Relationships also helped therapists to build their professional capabilities, manage the stress of the work, and find further meaning and growth in their lives. At the same time, however, these relationships presented a challenge to participants in their own right, as participants often felt unprepared to deal with the unconventional nature of these bonds. Though the circumstances of clients’ lives necessitated the implementation of unorthodox, community-based modes of practice, this departure from traditional
methods—including an extended length of service—also entailed a departure from traditional training surrounding ethics and boundaries, leaving clients with unanswered questions about the extent to which they were justified in blurring the lines between the professional and the personal.

*It was hard for my team, and it was hard for me in some respects, to feel like we could just, and this is absolutely clinically contraindicated, but be okay with moving on to the next phase of life. The attachment that develops in work with refugee communities on the part of the workers is profound[...] I think in some respects, and I'm just being honest, that the length of service has as much to do with...a sense of our role that is not defined by Western clinical work, and I don't know if that is a proper sense of the role or an improper sense. [Participant 5]*

In their work with non-Western clients, clinicians were compelled to alter their Western conceptions of therapy in order to create spaces where clients would feel safe, acknowledged, and connected. These spaces demanded significant emotional investment on the part of therapists, who shared clients’ intense joys, sorrows, milestones, and achievements with them, often over the course of numerous years. They went into clients’ homes and communities, built relationships with their families and mentors, and, in the process, questioned their own notions of self and community. As a result, a profound attachment developed that made it difficult to bound the relationship in the ways that would be expected of them according to Western professional standards. However, they often felt pressure to do so as a result of their training and upbringing, which created a sense of unease.
It’s really hard for me because my training has taught me—and my culture has taught me—that your clinical relationships are clinical, and that’s it. And then there’s this...it’s just not the reality of who I’m working with. And it’s really hard to find your boundary. That’s something everyone here really struggles with, and I really struggle with, because when you work with people who...a lot of them have seemingly endless needs, and [...] I could let them in as much as I wanted. I have to kind of decide for myself. [Participant 1]

This struggle to bound the relationship occurred both during the course of therapy and as therapy neared its end. Participants often felt conflicted not just by how to negotiate the confines of the relationship while therapy was ongoing but also how to terminate the relationship in a way that honored its importance in therapists’ and clients’ lives. Some participants even implied that terminating the relationship altogether in tandem with terminating therapy would be morally questionable given the level of experiences shared and the extent of therapists’ presence in clients’ lives.

*When you're in someone’s home every week at least once a week, and you go to their graduation, and you go with someone to the hospital when they are going to deliver their baby, I mean, like, I’m not just going to say, "Okay, bye, we’re done," even though that’s kind of what I feel I’ve been told to do. [Participant 1]*

At the same time, clinicians also recognized that these Western notions of boundaries were created for a reason even as they struggled to adapt them to this not-quite-Western situation. One participant acknowledged that she felt deeply connected to certain clients but understood that providing the opportunity for closure in the
relationship may be in the clients’ best interest. In that context, she struggled to balance her own needs with her obligations to her clients.

> It’s been very hard to figure out what a healthy relationship—non-clinical relationship—will look like. Also, finding what’s best for them, separating that from what I want. I love some of these people, so what I want is to...I like that I feel needed, and that feels great. But it’s also important to be able to say goodbye, to give some people that...I don’t know. It’s hard to figure out. [Participant 1]

This issue of boundaries was further complicated by the communal approach to the work, wherein therapists worked not just with individual clients but with members of their families and communities, including other clinicians who were working within the same network of individuals in different ways. In these scenarios, the clinicians struggled to navigate the complexity of these relationships and the confines of confidentiality across them, particularly if they felt pulled in different directions by different members of the network.

> Confidentiality is...there are boundaries to confidentiality. You have this layer of community expectations that is often very different to the boundaries of confidentiality. I think you can step over that line without even knowing that you’ve done it in work with international communities [...] So, I think, in terms of those boundaries, it's like everything else in this work: it's on a moment-to-moment basis, understanding where you are at with that particular case. "What is the relationship with your parents?" if you are working with an adolescent. What are the boundaries there in terms of the clinical work with that adolescent? What
are the laws in terms of what you can and can't reveal? What's the role of your work to that family as well?

We had a particular family--we had families like this--where we were working with either every member of the family, or the family was there. Chaos constantly going on, and people were getting drawn in places where others were trying to work in different ways. The case would get really messy because we hadn't minded our boundaries.

[Participant 5]

This was especially conflicting if these situations were impacted by ethical issues such as violence in the home, as clinicians had to contemplate the intersections of these multidirectional relationships in tandem with their moral and legal obligations as mandatory reporters of abuse.

I think the other place where sort of inappropriateness could come into play was the area around domestic violence. Domestic violence I think for me as a program manager [is] the hardest area to step in and understand. What in the world we were going to do and how we were going to operate when we had been sort of aligned with community and all of a sudden we were having to take sudden, quick, swift, decisive actions and closing of relationships. It was a mess. It would typically put the agency into kind of a tail spin for a couple of days.

[Participant 5]
Working through interpreters often added an additional dimension to these boundaries, as this was another relationship that clinicians cultivated—sometimes ineffectively. At times, interpreters also extended outside their traditional roles, inserting themselves into the clinical aspects of the exchange if they felt compelled to advocate for clients. Because interpreters were often from clients’ own communities, confidentiality was an issue to consider; furthermore, poor relationships with interpreters could complicate the dynamics among individual therapists, clients, professional organizations as a whole, and communities.

*I think it's another piece, another layer to this brokering. So there are lots of different types to these challenges. Some of it was just pure personality clashes between interpreter and clinician or clinician and interpreter when the interpreter went all sorts of directions [...] Often the interpreters would come to us and say, "This person is completely mishandling this case," from the perspective of culture, and so we would have to go and broker that issue. Tricky sometimes because interpreters were taken from their community [...] Then interpreters get very involved in the lives of our folks as well. So it was just another sphere, part of what makes the work rich but also sometimes tricky.*

[Participant 5]

Blurred boundaries were not just a product of the mechanics of community-oriented therapy; they influenced those mechanics, as well, occasionally affecting participants’ ability to fully engage clients. In working with kids, for example, one participant found that the closeness of the relationship instilled in clients a desire to
please the therapist, whom the clients conceived of as their friend. As such, when it came
time to conduct assessments of clients’ progress, they sometimes withheld important
clinical information because they weren’t sure what that information might mean for that
friendship.

They also start to become savvy too, like "I don’t want to endorse that," you
know, "I want you to think that I’m a good kid, and if I say that..." ‘Cause I think
our relationship gets pretty muddy. Even though kids see me as their friend, I
think that’s just the best way they...I’m this person that comes and visits them, and
sometimes we play together, and sometimes we talk about things, but I’m kind of
like their friend. So, after a while, kids will start to be like, "I don’t want to tell
you that I’m feeling sad,” ‘cause, I don't know, they are wondering what that
might mean. [Participant 1]

Findings Synthesized

Therapists in this study were operating within a context of high complexity that
permeated the therapeutic environment, shaping clients’ goals and needs. This
complexity dictated the roles therapists undertook and the issues they addressed with
clients in therapy. At the same time, this complexity intersected with a cultural
continuum that separated clients’ collectivist backgrounds from therapists’ own
individualistic worldviews. Clients’ values and expectations differed tremendously from
therapists’ own perspectives as well as their professional training, resulting in a gap
between the ways therapists conceived and conducted therapy and clients’ needs within a
therapeutic exchange. Making progress in the therapeutic relationship required therapists
to learn to bridge that cultural gap while also responding to the intensity of clients’ lives.

(For a visual representation of these results, see Image 2 in Appendix E.)

Relationships emerged as the central way to do so. Developing relationships with multiple actors, including clients’ families, communities, and the service providers working with them in other settings, enabled therapists to respond to clients’ collectivist worldviews, which placed family and community at the center of their lives and made individualistic, traditional modes of therapy incongruent with their needs. Furthermore, constructing a holistic model of care characterized by networks of relationships with their own colleagues and members of the community provided therapists with critical insight, skills, and advocacy opportunities that were crucial in addressing the myriad of stressors in clients’ lives.

At the same time, since the nature of this work differed drastically from the more traditional therapeutic approach in which participants had been trained, they struggled to navigate the amorphous boundaries of these relationships. Relationships often lasted many years, during which time therapists shared some of clients’ most pivotal life moments. As a result, they became emotionally invested in the work on an intimate level and sometimes struggled to separate their own needs from clients’ therapeutic progress. Knowing where and how to draw lines in the relationship became a critical but often unanswered question that they pondered regularly in their work.
CHAPTER 5: DISCUSSION AND CONCLUSIONS

This study examined how clinicians working with refugee youth guided the therapeutic process with their clients, focusing on how clients’ mental health struggles manifested in their daily lives and how clinicians worked with them to overcome challenges situated at various ecological levels of analysis. The results indicate that participants’ clients led complex lives in which issues of trauma, acculturative stress, and systemic injustices interacted to create intensive needs and symptoms that could not be adequately addressed using traditional modalities of clinical practice. Moreover, clients’ collectivist values and non-Western conceptions of healing further compelled therapists to diverge from the individualized, talk-centric practices associated with rigid relational boundaries. Instead, participants embodied values of humility, openness, and vulnerability to cultivate unique relationships whose broad dimensions blended the personal and professional spheres. These relationships were a critical tool enabling participants to respond to clients’ needs and build on their existing strengths in ways not feasible in traditional practice. However, the novelty of these exchanges also created internal tension for therapists, who often felt the amorphous boundaries of the relationships left them in uncharted ethical territory that their education and training had not prepared them to navigate.
Complexity in Practice with Refugees

These results reinforce the emphasis within the practice-based evidence literature on the complex nature of service provision with refugees. Participants highlighted the ubiquitous impact of trauma among their clients, emphasizing that traumatic exposures were often recurrent and took place both in clients’ home countries and in the United States. These experiences often were a product of systemic discrimination within school or legal systems and were exacerbated by parents’ own traumas. These findings were consistent with well-established findings related to trauma, which highlight how refugee communities typically exhibit high incidences of exposure that is often cumulative in nature (Sullivan & Simonson, 2016); occurs at multiple points throughout the pre-flight, flight, and post-resettlement periods (Fazel & Stein, 2002); can stem from racist and xenophobic norms (Bemak & Chung, 2017); and is passed down intergenerationally (Trentacosta et al., 2016). However, participants also acknowledged that, as a result of both the intensity of their trauma and cultural norms around disclosing sensitive personal information, clients often take several months to share their trauma histories with therapists. This challenges the notion that short-term, evidence-based practice—the “gold standard” in the psychological intervention literature—can be a sufficient response to this population’s needs, lending empirical support to the suspicions of several researchers of refugee mental health (Birman et al., 2008; Beehler et al., 2012).

The findings also provided a more detailed picture of how incidences of trauma translated into functional impairments, or the manifestations of mental health concerns on an individual’s larger social functioning (Üstün and Kennedy, 2009), and physical and emotional symptoms. Though prior studies have identified trauma’s link to attachment
disorders, diminished behavioral and academic performance, and a wide range of mood
disorders and somatic symptoms (Bronstein & Montgomery, 2011; Betancourt et al.,
2012; Sullivan & Simonson, 2016), these studies examined such impairments tangentially
without providing significant insight on their implications on the therapeutic
environment. Participants in this study, however, provided detailed imagery of the extent
of clients’ symptoms and impaired behavior, demonstrating how these challenges
impacted clients’ physical health and interpersonal relationships.

In terms of acculturation’s impact on refugee mental health, participants’
experiences were well-aligned with existing scholarly thought. They outlined clients’
struggles to negotiate new roles in family and society and to shift seamlessly among these
roles, emphasizing how these challenges were further heightened by an acculturation gap
that created tension between parents and youth. Such acculturative stressors have long
been documented in the refugee mental health literature (Birman et al., 2005; Bemak &
Chung, 2017). These stressors exacerbated clients’ more primary concerns of how to
meet their basic needs within a context of dwindling resources and social supports and
led clinicians to dedicate significant portions of time to case management. These
concerns are consistent with findings on how the “unfulfilled promises” (Brown &
Scribner, 2014, p. 103) of the resettlement system lead many refugees to stress about
similar needs (Ellis et al., 2008; Trentacosta et al, 2016) and how community-based
programs attempt to incorporate those needs into their holistic models of care (Birman et
al., 2008).
Practical Contours of Community Practice

The results also contribute a more nuanced understanding of what community-based programs with refugee clients look like in practice. The primacy of relationships emerged as central to this picture. The need for practitioners working with diverse populations to broaden the boundaries of their relationships to include a wider range of actors has been documented to some extent in practice-based evidence on community-based approaches to working with refugees (Birman et al., 2008); theoretical conceptions of social justice practice with refugees (Bemak & Chung, 2017); and empirical studies of counseling students’ perceptions of social justice practice (Singh et al., 2010). However, this study is the first known, empirical analysis grounded in clinical experience with refugee clients to provide in-depth insight on how clinicians operationalize their values and beliefs to build, maintain, and maximize relationships across complexity and cultural difference.

Birman et al. (2008) note that the increasing ethnic, linguistic, and socioeconomic diversity of refugee populations underscores the need for clinical programs that “provide culturally and linguistically competent services to a wide range of groups simultaneously,” calling for “the development of generalized principles of ‘multicultural competence,’ or an approach that attends to specific cultural perspectives, needs, and circumstances, but can be used across diverse cultural groups” (p. 123). Participants in this study outlined well-defined, value-laden perspectives on engaging with diverse populations without alluding to tailoring these tactics for specific ethnic groups, suggesting that practitioners have already developed such principles for themselves. These principles, such as engaging communities in planning their own healing and taking
an assets-based approach to community empowerment, were rooted in larger values of respect, agency, and social justice. (See Table 1 on pages 87-88.)

Most of these values and principles mirror those within the existing theoretical literature on social justice counseling and cultural competence, particularly those in Chung and Bemak’s (2002) article on cultural empathy in cross-cultural counseling; Chung and colleagues’ (2008) paper on social justice counseling with immigrants and refugees; and Lewis’s (2011) discussion of operationalizing social justice practice within the Community Counseling Model. The empirical nature of this study’s analysis lends credibility to the effectiveness of these theorists’ models for working with refugee clients.

Furthermore, these values paralleled those espoused by doctoral students in Singh and colleagues’ (2010) empirical analysis of perceptions of social justice training in counseling psychology programs around the country. Participants in that study expressed frustration that “theoretical orientation in client conceptualization and treatment in their clinical training did not consistently reflect how to integrate living social justice principles with regard to clinical practice” (p. 784). The rich descriptions provided by participants in the present study serve as a starting point for envisioning clinical application of these principles.

Values were so deeply embedded in this work that one participant noted that most providers working with refugees were “sort of political radicals,” a viewpoint that mirrors Chung and colleagues’ (2008, p. 314) assertions that social justice practice with immigrants “requires significant flexibility and sometimes taking what many persons would consider to be highly controversial positions by not strictly abiding by laws that conflict with the cultural worldviews, values, beliefs, and practices of different immigrant
populations.” The political undertones of this work suggest that it is not just training that is crucial to success as a counselor working with refugees but also personality and worldview. Indeed, participants’ professed values and practices fit squarely and seamlessly within theories of social justice counseling, suggesting that clinical work with refugees is an inherently political endeavor. This has important implications for recruitment of clinical staff, as focusing especially on hiring staff whose values are a clear “fit” with these principles may lead to increased effectiveness for the organization.

**Personal Impact on Clinicians**

The data also provide new understanding of how engaging in non-traditional practice impacts clinicians’ own lives and well-being. Clients were not the only ones who often felt overwhelmed by the complexity of their lives; clinicians, too, noted feeling scared by the intensity of clients’ needs and helpless to support them. Some mentioned that confronting the realities of systemic injustices in clients’ homes and schools was emotionally taxing for them, while most admitted to feeling conflicted about their ethical obligations to clients. On the one hand, participants recognized that these were not typical therapeutic relationships and thus should not be bound by standard ethics guidelines, which were not written with community-based practice in mind. They grew to love some of their clients almost as family after witnessing their milestones, sharing their sorrows, and reveling in their progress over the course of many years. After such a long period of serving as a constant, reliable support in clients’ lives, it felt almost unethical to some to terminate the relationship all together once it came time to terminate therapy, as such abrupt changes had the potential to negatively impact clients’ progress.
On the other hand, however, participants recognized that the traditional code of ethics was created for the important purpose of giving clients space to pursue closure and protecting them from potential abuses of power. Thus, participants felt compelled to walk an ill-defined line between over-engaging with clients and closing them out, both of which had the potential to be detrimental.

The fact that these emotional and ethical struggles were shared by the participants in the study conveys that they are not isolated incidents of distress particular to individual therapists but rather that this is the nature of the work itself. This has important implications for clinical training, suggesting that educational institutions and professional organizations should better prepare clinicians for ethical community-based practice and for managing the emotional toll of this work. The therapeutic modalities clinicians employed were responsive to clients’ needs and reflective of their worldviews, reflecting a high degree of the cultural competence so heavily emphasized in clinical training. However, these modalities were also very different from the ways that participants were trained to conduct therapy, and participants were, therefore, left to figure out both the practical and philosophical contours of their practice on their own. This disconnect between the theory of cultural competence in training programs and the reality of cultural competence in practice underscores the need for institutions to re-examine their conceptualization of cultural competence, assessing the degree to which it may manifest differently in different contexts and adapting training accordingly.
Limitations of the Study

One limitation of the present study is the small sample, which included just five participants from two professional organizations in the same city. Though participants had a wealth of experience working clinically with refugee youth that enabled them to provide rich insight on this work, without representation of a broader range of experiences, it is difficult to discern whether these insights reflect larger trends in community-based practice with refugees or are unique to participants, their organizations, and/or the geographic area. Furthermore, the interviews were collected more than five years ago and therefore may not reflect the most updated thinking in practitioner circles. This is particularly so given that the interview questions were tailored to the initial study’s more specific aim to assess clinicians’ perceptions of treatment outcomes. Though these questions were broadly focused and included extensive examination of approaches to clinical work more generally, thus inspiring ample detail on the present research question, the opportunity to design questions that focused more intentionally on aspects of relationship-building would likely have led to an even more nuanced understanding of the topic. Even so, given the prior lack of literature on the practical dimensions of community-based practice, the results serve as an important starting point on which future studies could build by examining issues of complexity, relationships, and boundaries with a larger, more diverse sample.

Conclusions and Implications for Future Studies

This study answers the question, “How do mental health clinicians supporting refugee clients approach clinical practice?” Clinicians enact personal values as
therapeutic strategies that enable them to build expansive, multi-party relationships that bridge cultural difference and situational complexity despite at times creating ethical uncertainty. These results contribute new insight on how clients’ mental health challenges present themselves in their everyday lives; the practical dimensions of relationship-building in community-based practice with refugees; and the political nature of this social justice work. At the same time, they also underscore the need for mental health training programs to better address ethics in non-traditional treatment modalities and to re-examine the contours of cultural competence in different settings of practice. Future studies can build on this research by examining its core themes with a bigger, more diverse sample; exploring the connection between political views and engagement in this work; analyzing how clinicians’ ideas of cultural competence change over time; and investigating the extent to which relationship-building is different or similar when therapists work with clients whose cultural perspectives and knowledge more closely match their own.
REFERENCES


APPENDIX A: RECRUITMENT EMAIL

Recruitment Email

Dear [name],

I am part of a research team from the University of Illinois at Chicago that is interested in speaking with you. I’m writing to invite you to participate in a research study designed to learn about your work with refugee youth and children. As a service provider, you are in the unique position to understand the particular challenges and strategies in working with refugee youth. The purpose of this study is to learn from providers such as you about assessing clinical outcomes for refugee children and youth. We would like to learn from you about your experiences assessing treatment success when working with refugee youth, whether you’ve had experiences using standardized measures, and/or how you may use clinical judgment and intuition in determining when treatment goals have been achieved. We hope to use the knowledge we gain from you and other providers we interview to inform the development of clinical outcome measures that can be used with refugee clients.

The [program name] program and [organization name] is one of the most respected and longest standing refugee mental health programs in the country. I believe that your work represents best practices in this field, which is why I am interested in talking with you. One aim of this work is to be able to document for the field the effectiveness of the creative and comprehensive services provided by refugee mental health clinicians, such as the ones on [staff name] staff.

What we are asking is to conduct a 1-1.5 hour long interview with you at the time and location of your choice. To thank you for your time we are offering you a $15 gift certificate to Borders or an alternative store of your choice. We will work with you to schedule a convenient time and location for the interview if you choose to participate.

In order to be eligible for the study, entitled “Clinicians’ Perceptions of Clinical Outcomes for Refugee Youth” you need to have worked with refugee children as a mental health provider for at least 1 year. Your participation is voluntary, and we will keep your decision confidential; we will not communicate it to any member of the staff at [organization name].

If you agree to participate or would like to learn more about the study, please reply to this email or call my number listed below within 1 week. I look forward to working with you to learn more about the work that you do.

Thank you for your time.

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Text for Recruitment Email, Clinicians’ Perceptions of Clinical Outcomes for Refugee Youth, Version #2, [3/29/2010], Page 1 of 1
APPENDIX B: INTERVIEW GUIDE

Thank you for agreeing to meet with us today. As you know from the previous forms, we are interested in talking to you about your experience working with refugees. Before we begin, do you have any questions about the consent forms or the general goals of this interview today?

To start off, we have a few questions about your background.

Clinician Information and Pathways to the Work

1) Do you come from a refugee/immigrant background yourself? (Y/N)
2) Gender _________
3) Language(s) Spoken __________________________
4) Degree type ____________________
5) Number of years as a clinician ___________
6) Number of years working in refugee mental health ___________
7) Approximate number of refugee clients served in lifetime _________
8) How did you become interested in clinical work with refugees? What brought you to this work?
9) What experiences or training have you had that you feel prepared you for this work?
   a) Have you worked with non-refugee clients? If so, what are some of the differences between that work and the work that you do now? Explain some of the ways in which the clients and services were different. In what ways were they similar?

Role of Culture

10) How do you address cultural issues in your work?
   a) How do you think about bridging the cultural gap with your clients, when relevant?
   b) How do you handle language differences, when relevant?
Goals and Outcomes

11) As you think about your current work with refugee children, how do you conceptualize the goals of treatment? Can you give a few examples of the types of goals set in treatment?

12) As you think about your current work, what kinds of services do you provide, and what do you feel is most helpful to the children you serve? What are some different kinds of interventions/services you use in your work? Why do you think they are effective?

13) Have you had experience using standardized assessments with your refugee clients? Which ones? What kind were they (client self report, clinician report, parent report, teacher report, other)? What was your experience with these assessments? Did you feel they accurately reflected client functioning or symptoms? Why or why not?

14) As you think about your current work, how do you determine when the goals of treatment have been reached? Can you think about some examples of cases where you felt that you’ve reached your goals? How did you know that the client had improved? Did you believe that the client improved as a result of services received? How could you tell?

   a) Can you think about some examples of cases where you felt that you did not reach your goals? Did you still feel that there was some improvement for the client? In what way?

15) In addition to the cases you’ve discussed, were there any other very unusual cases that either improved a great deal, or not at all?

16) If you were to design a way to assess clinical improvement for these clients, what kinds of things would it include?

17) What are your feelings about using standardized assessments? If negative, what could be done to improve them? Are there any circumstances under which you would use such assessments in your work?
APPENDIX C: CODE GROUPS

The number of instances each code was applied is indicated in parentheses.

Acculturation
Acculturation process (11)
Acculturative stress (13)
Changes to family roles (3)
Cultural gap (5)
Dealing with home stressors (6)
Discrimination (2)
Navigating multiple stressors (9)
Re-traumatization (4)

Assessments
Assessment/informal self-assessment (1)
Assessment/measuring therapeutic relationship (2)
Assessments/and self-image (4)
Assessments/as expanding one's perspective (5)
Assessments/as helpful (12)
Assessments/as stressful (1)
Assessments/as tests (2)
Assessments/as their own language (1)
Assessments/assessment user (2)
Assessments/client adaptation to (3)
Assessments/client perspectives on (7)
Assessments/client perspectives on/kids v parents (4)
Assessments/comparing (1)
Assessments/family input (1)
Assessments/having to interpret language (7)
Assessments/imagining alternatives or solutions (10)
Assessments/limitations (25)
Assessments/limitations/arbitrary (1)
Assessments/limitations/client difficulty conceptualizing (2)
Assessments/limitations/defining client narrowly (1)
Assessments/limitations/demonstrating what we already know (1)
Assessments/limitations/don't match client self-report (2)
Assessments/limitations/don't reflect clients' symptoms (4)
Assessments/limitations/make assumptions (2)
Assessments/limitations/not designed for refugee clients (1)
Assessments/limitations/not developmentally appropriate (1)
Assessments/measures (3)
Assessments/potential for (2)
Assessments/recognizing importance of (5)
Assessments/role of language ability (4)
Assessments/role of therapeutic environment (1)
Assessments/should include (13)
Assessments/surprising (1)
Assessments/tracking change (1)
Assessments/trying to adapt (3)
Assessments/trying to identify why they don't work (3)
Assessments/type (7)
Assessments/vs screenings (3)
Assessments/wording of (8)
Informal assessment (1)

Body
Focus on the body (4)
Mind-body connection (1)
Trouble being in one's body (4)

Boundaries
Boundaries (9)
Boundaries/and cultural difference (2)
Boundaries/breaking down traditional therapeutic boundaries (3)
Boundaries/establishing boundaries (4)
Boundaries/questioning oneself (1)
Boundaries/struggling to define (9)

**Building Relationships**
- Acknowledging challenges to investing in therapy (3)
- Asking clients to be teachers (5)
- Asking questions (5)
- Avoiding assumptions (2)
- Being transparent about one's knowledge (2)
- Building relationship (10)
- Building relationship/asking clients questions (3)
- Building relationship/before beginning therapeutic work (5)
- Building relationship/bonding activities (3)
- Building relationship/client evaluation of therapist (1)
- Building relationship/in familiar settings (1)
- Building relationship/on community level (2)
- Building relationship/outside therapy (1)
- Building relationship/presence in community (8)
- Building relationship/struggling with engagement (2)
- Building relationship/through screening (1)
- Building relationship/time to open up (1)
- Building relationships/being transparent (3)
- Building relationships/clients and case manager (1)
- Building relationships/creating comfort (1)
- Building relationships/helping clients see their strength (1)
- Building relationships/letting clients ask questions (1)
- Building relationships/mitigating power differentials (1)

Building relationships/navigating ethnic tension (1)
- Building relationships/on clients' terms (6)
- Building relationships/recognizing clients' strengths (1)
- Building relationships/recognizing cultural differences (1)
- Building relationships/sharing about oneself (7)
- Building relationships/through non-traditional activities (4)
- Distrusting therapist (4)
- Expertise/letting clients be the experts (1)
- Expertise/not being the expert (1)
- Intentions/Being transparent about one's intentions (4)
- Learning from clients/realizing impact of one's actions (1)
- Learning from clients/role in effectiveness of treatment (1)
- Meeting in the middle (5)
- Opening up (2)
- Opening up/being ready to (2)
- Opening up/learning when to ask questions (1)
- Realizing how one-sided the relationship is (1)
- Treating each client individually (3)

**Case Management**
- Case management (5)
- Case management/as therapeutic (1)
- Case management/coming to terms with this role (1)
- Case management/importance of (3)
- Case quantity (7)
- Connecting clients to resources (1)
- Therapy versus case management (2)

**Collaboration & Advocacy**
- Advocating for clients (4)
- Advocating for clients/working with other service providers (2)
- Collaboration/among colleagues (4)
Collaboration/among service providers (2)
Collaboration/between therapist and client (1)
Collaboration/with parents (4)
Community members comparing clients to themselves (1)
Psychoeducation (3)
Schools/role in treatment plan (2)
Schools/working with (2)

Community Model
Community model (4)
Community model/appreciating (4)
Community model/diverging from (4)
Engaging in non-traditional roles (9)
Not having enough time to do more of what works (1)
Prioritizing client well-being over personal time (1)
Role fluidity (1)

Comparing Refugee & Non-refugee Clients
Refugee vs. non-refugee/comparing backgrounds and experiences (12)
Refugee vs. non-refugee/comparing engagement (4)
Refugee vs. non-refugee/comparing needs (7)
Refugee vs. non-refugee/comparing progress (2)
Refugee vs. non-refugee/comparing relationships (7)
Refugee vs. non-refugee/comparing resources (3)
Refugee vs. non-refugee/comparing role of trauma (3)
Refugee vs. non-refugee/comparing therapeutic process (12)
Refugee vs. non-refugee/comparing therapist's background knowledge (1)

Cultural Competence
Cultural background/providing clients with context about US (4)
Cultural competence (7)
Cultural competence/asking for cultural insight (2)
Cultural competence/background knowledge (4)
Cultural competence/starting over with each family (3)
Cultural humility (1)

Cultural Differences
Client conceptualizations of therapy (7)
Contrasting/Western perspectives of therapy versus client perspectives (1)
Corporal punishment (1)
Cultural differences (11)
Cultural differences/at odds with US (8)
Cultural differences/awareness of (3)
Cultural differences/being at an impasse (3)
Cultural differences/evaluating different values (5)
Cultural differences/impact of disagreements (7)
Cultural differences/individual vs. communal (4)
Cultural differences/justifying (1)
Cultural differences/manifestations (1)
Cultural differences/negotiating possibilities (1)
Cultural differences/openness to alternative therapies (2)
Cultural differences/perceptions of therapy (1)
Cultural differences/reacting to (2)
Cultural differences/self-monitoring for bias (5)
Cultural differences/struggling to navigate (7)
Cultural differences/trying to identify (8)
Cultural differences/values (8)
Navigating cultural differences (10)
Navigating cultural differences/establishing priorities (2)
Development
Ability to just be a kid (6)
Adultification (8)
Adultification/by staff members (1)
Adultification/of siblings (1)
Adultification/trying to act like an adult (1)
Developmental stage (2)
Language development (1)

Functional Impairments
Attention as currency (2)
Functional impairment/in new settings (2)
Functional impairments/acting out (2)
Functional impairments/affect regulation (11)
Functional impairments/age differences (1)
Functional impairments/as cry for help (1)
Functional impairments/as protective measure (1)
Functional impairments/attachment (4)
Functional impairments/attention-seeking (2)
Functional impairments/delayed development (3)
Functional impairments/multiple settings (2)
Functional impairments/onset (5)
Functional impairments/self-harm (1)
Functional impairments/source (13)
Functional impairments/struggling to understand (1)
Functional impairments/trust (4)
Functional impairments/vs. normal kid behavior (2)
Functional impairments/working to resolve (6)

Goals
Goals (48)

Goals/ability to regulate (2)
Goals/being realistic (1)
Goals/broad (5)
Goals/client recognizing progress (1)
Goals/describing (13)
Goals/functioning as goal (3)
Goals/moving on as the goal (3)
Goals/not having goals for client (1)
Goals/parent relationship (4)
Goals/relationship as goal (3)
Goals/tracking (11)
Goals/ways to work towards (2)
Trying to build self-reliance (1)

Goal Setting
Goals/goal setting (33)
Goals/goal setting/and symptoms (2)
Goals/goal setting/and trauma history (2)
Goals/goal setting/challenges (4)
Goals/goal setting/changes over time (6)
Goals/goal setting/collaboration (1)
Goals/goal setting/external influence (1)
Goals/goal setting/ideals (2)
Goals/goal setting/struggling to articulate (3)
Goals/goal setting/through interpreter (1)
Goals/goal setting/tied to screening (2)

Grief & Loss
Coming to terms - trying to accept (1)
Coping/trying to cope (1)
Grief (2)
Loss (1)
Lost childhood (3)
Lost childhood/mourning lost childhood (2)

Interpreters
Interpreters/as co-therapists (1)
Interpreters/asking questions to make sure client understands (2)
Interpreters/caring for their trauma (1)
Interpreters/challenges (1)
Interpreters/choosing phone or in-person (6)
Interpreters/client perceptions of (1)
Interpreters/client preferences (2)
Interpreters/contextualizing interpretation (1)
Interpreters/cost of (1)
Interpreters/cultural brokers (4)
Interpreters/deciphering messages through (2)
Interpreters/in-person versus phone (3)
Interpreters/interpreting concept of therapy (1)
Interpreters/kids as interpreters (6)
Interpreters/less needed for kids (3)
Interpreters/not cutting out important information (1)
Interpreters/relationship with (1)
Interpreters/sensory overload (2)
Interpreters/speaking clearly or repeating (3)
Interpreters/using in therapeutic way (1)
Interpreters/when they're needed (2)

Maintaining Relationships
Relationships/becoming part of the family (2)
Relationships/changing over time (3)
Relationships/clinical vs. personal (4)
Relationships/depth of relationships (2)
Relationships/fluid roles in relationship (1)
Therapeutic relationship/wanting to please therapist (1)

Need for Therapy
Comparing/needs of different clients (3)
Need for services (3)
Needs/changing over time (4)
Therapy as preventing future stress (2)
Therapy/as enriching but not essential (1)

Organizational Structure & Norms
Comparing/adult v child caseload (4)
Comparing/resettlement staff v therapists (3)
Organizational structure (7)
Organizational structure/challenges (1)
Team as a family (1)
Team as a family/no one else understands (2)

Parents
Collaboration/with parents (4)
Parents (8)
Parents/educating parents (5)
Parents/Impact of parental trauma (2)
Parents/involvement in child's therapy (3)
Parents/need for their own therapy (1)
Parents/not around (4)

Pathway to the Work
“It's just a dream” (1)
Pathway to the work/chance (2)
Pathway to the work/interest in diversity (2)
Pathway to the work/interest in international populations (6)
Pathway to the work/interest in trauma (3)
Pathway to the work/international experiences (5)
Pathway to the work/joining of the personal and professional (1)
Pathway to the work/moral reasons (4)
Pathway to the work/origin of interest (5)
Pathway to the work/role of education (6)
Pathway to the work/role of internship (3)
Pathway to the work/role of skills and background (12)
Pathway to the work/sense of purpose or fit (4)
Transitioning from intern to full-time employee (2)

Resilience
Admiring clients’ "joie de vivre" (2)
Protective factors/education (4)
Recognizing client dimensionality (1)
Recognizing client strength (1)
Resilience (1)
Structure of Therapy
- Age differences (6)
- Terminating therapy (1)
- Therapeutic model/home visits (6)
- Therapeutic process/consistency (1)
- Therapy as never finished (3)
- Time in therapy (10)
- Transitioning out of therapy/reason (2)
- Transitioning out of therapy/when to start (3)
- Working with the whole family (5)

Symptoms
- Comparing/symptom expression (4)
- Depression (1)
- Foreseeing future symptoms or issues (2)
- Hospitalization (2)
- Medication (1)
- Self-harm (1)
- Symptoms (10)
- Symptoms/and labeling disorder (4)
- Symptoms/somatic (10)
- Symptoms/starting to appear (4)
- Violence (3)
- Violence/gravitating towards (2)

Therapeutic Progress
- Admiring client's progress (2)
- Client achievements (1)
- Defending clients' progress (2)
- Evaluating behavior (2)
- Evaluating behavior/considering context (3)
- Goals/client recognizing progress (1)
- Moving forward by going back (1)
- Past and present (3)
- Progress as non-linear (1)
- Progress/and art (3)
- Progress/as maintaining current state (1)
- Progress/manifestations of (1)
- Progress/standing up for oneself (1)
- Recognizing clients' progress (6)

Therapist Challenges & Reactions
- Being out of therapist's comfort zone (1)
- Being scared/as the therapist (5)
- Being the only person someone has (2)
- Challenges of the work (4)
- Crisis mode (5)
- Doing the work personally, not just professionally (1)
- Existentialism (1)
- Feeling overwhelmed (2)
- Not knowing what to do (3)
- Processing the work (3)
- Putting self in client's shoes (2)
- Reacting to one's own actions (2)
- Separating client versus personal needs (1)
- Therapist protecting self (1)
- Therapist support system (1)

Therapist Identity
- Therapist identity/and education (1)
- Therapist identity/and therapeutic process (2)
- Therapist identity/and therapeutic relationship (1)

Therapist Training
- Learning from experience (4)
- Navigating clinical training versus reality (6)
- Navigating clinical training versus reality/acknowledging different opinions (1)
- Training for the work/source (5)
- Utility of language background (1)

Trauma
- Complex trauma (13)
- Complex trauma/digging deeper (2)
- Complex trauma/normalizing (4)
- Complex trauma/relationship to functional impairments (5)
- Complex trauma/type or source (2)
Complex trauma/waiting to process (1)
Complex trauma/working with clients (8)
Peeling back layers (2)
Power dynamics/and trauma history (1)
Trauma/dissociating (3)
Trauma/flooding (2)
Trauma/not considering its role (1)
Trauma/relating traumatic experiences (4)

Treatment Planning
Planning/treatment plans don't fit clients' needs (3)
Planning/treatment plans/client reactions to (1)
Planning/treatment plans/don't reflect clients' reality (3)
Planning/use of treatment plans (3)
Planning/usefulness of treatment plans (8)
Therapeutic decisions/ideal v reality (4)
Treatment/short vs long term (1)
Working to identify emotions (1)

Type of Therapy
Comparing/individual versus group (4)
Drawing/art (4)
Focus on the body (4)
Group therapy (3)
Group therapy/client reactions (2)
Group therapy/structure (5)
Play therapy (2)
Role play (1)

Type of therapy/group (1)
Type of therapy/individual (1)

No Code Group
Adapting to new settings (6)
Being ignorant about refugees prior to the work (1)
Child protective services (3)
Client perceptions of therapist (4)
Comparing relationships/boys v. girls (1)
Comparing/clients to other kids (5)
Family engagement in therapy/impact on length (3)
Family history (1)
Gender roles (2)
Having two homes (1)
Identifying self narrative (1)
Identity versus self narrative (1)
Intensity of client's emotions (1)
Interclient relations (1)
Interclient relationships (1)
Language barriers/to expressing psychological self (2)
Learned behavior (1)
Normalizing clients’ experiences (1)
Outcomes/role of client education (1)
Systems over-protecting client (2)
Positive reinforcement (1)
Prior therapeutic background of client (1)
Prioritizing client autonomy (1)
Refusing services (2)
Screening/for background information (3)
Self-image (2)
Sense of safety (4)
Therapist conceptualization of therapy (2)
Trafficking (2)
Transitioning out as the therapist (4)
APPENDIX D: EXAMPLE OF A NETWORK VIEW

Image 1. Example of a network view. This image conveys how code groups were separated into interrelated codes and quotations during the data analysis process.
Image 2. Influences on the therapeutic environment with refugee clients. This image illustrates how the context of complexity permeates the therapeutic environment, which includes numerous actors operating within a cultural continuum. The amorphous boundaries of the therapeutic relationship encompass the actors, cultural continuum, and context of complexity; thus, the relationship serves as the central tool guiding the therapeutic process.