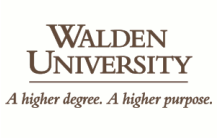

2019

A Constructivist Grounded Theory Study of Counselors' Preparedness to Counsel Refugees

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This is to certify that the doctoral dissertation by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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2019

Abstract

A Constructivist Grounded Theory Study of Counselors' Preparedness to Counsel Refugees

by

Shadin Atiyeh

MA, Eastern Michigan University, 2012

BA, University of Michigan, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education & Supervision

Walden University

November 2019

Abstract

A gap exists in the current literature on the training needs of professional counselors so they can meet the increasing demand for counseling services among refugee populations. The purpose of this constructivist, grounded theory study was to explore the perceptions of professional counselors related to their preparedness to demonstrate multicultural competence when counseling refugees. A constructivist grounded theory approach following Charmaz's principles guided the investigation into perceptions of professional counselors towards counseling with refugee clients. The author conducted a qualitative demographic form, individual interviews, and a focus group with professional counselors who had experience working with refugees. Sample included 21 licensed professional counselors who had experience working with at least one refugee client. Utilizing a thematic data analysis on the qualitative data, the main themes outlined in this comprehensive theory included contexts, challenges, competencies, and professional development. The study may contribute to positive social change through increasing access to mental health services for refugee populations who currently underuse the services.

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Dedication

I dedicate this dissertation to my village, Amar Al Hosn, Syria; which is more than just a place, but a community of people who care for each other across oceans, an embodiment of values of hospitality and honor, and a connection to history and traditions.

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I would like to thank my dissertation committee: Dr. Geneva Gray, Dr. Theodore Remley, and Dr. Fredricka Vyvlecka for their feedback, guidance, and mentorship.

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Chapter 1: Introduction to the Study

According to the American Counseling Association (ACA, 2014) Code of Ethics, counselors have an obligation to gain multicultural competence to work with diverse populations and to advocate for equitable access to mental health care among underserved populations. Refugee populations represent a diverse group facing barriers to accessing mental health care in many societies, including the United States (Edward & Hines-Martin, 2015). In this study, I explored how mental health counselors are providing services to refugees and how they perceive their preparedness to be effective in delivering services to their refugee clients.

In this chapter, I will offer an overview of the study. This overview will include a background to the study, problem and purpose statement, description of the nature of the study, limitations and delimitations, key definitions, and assumptions. I will conclude this chapter with a discussion on the potential significance of the study to the counseling profession.

Background of the Study

The United Nations High Commissioner for Refugees (UNHCR, 2016) defined a refugee as a person who flees his or her home country due to persecution based on race, religion, nationality, political opinion, or membership to a social group. There is currently an unprecedented global refugee crisis with 25.4 million refugees worldwide (UNHCR, 2016). Edward and Hines-Martin (2015) focused on the perspectives of healthcare providers and found that refugee populations face barriers to seeking and benefiting from counseling, including lack of counselors trained to work with refugees,

lack of bilingual counselors and trained interpreters, and social stigma against mental illness. Despite the growing global need for counseling services among refugees, counselor training programs often do not include orientation to immigrant issues in their counseling courses (Villalba, 2009). Information concerning historical migration patterns, relevant legal aspects of immigration to the United States, and common psychological concerns related to migration would be important for counselor trainees to be able to demonstrate competence with immigrant populations.

Counselors also face several challenges when counseling refugees, and current counselor preparation and supervision programs may not be designed to meet these challenges. The topic of this study was on the preparedness of counselors to counsel refugees effectively. In this study, I explored the experiences and perceptions of counselors towards counseling refugees and how their training prepared them for the experience. Because multicultural competence is a component of effectiveness and preparedness when counseling refugees, I also explored how these counselors understand and conceptualize multicultural competence with refugees.

Problem Statement

Despite higher rates of mental health symptoms among refugees than other immigrant groups, refugees tend to underuse mental health services (Tempany, 2009). Rates of traumatic stress and depression are higher among refugees than with other immigrant groups, while current Western treatment models may not be culturally appropriate with non-Western refugees (Tempany, 2009). The scarcity of multiculturally competent professionals is a barrier for refugees attempting to access mental healthcare

(Tempany, 2009). In addition to lack of multicultural competence among therapists, the linguistic barriers and social stigma make refugees an especially vulnerable group for untreated mental health issues (Edward & Hines-Martin, 2015). The perceived multicultural competence of the counselor is integral to immigrant clients' positive experiences in counseling (Rogers-Sirin, Melendez, Refano, & Zegarra, 2015). A lack of multicultural competence can lead to harmful therapeutic practices among vulnerable groups (Wendt, Gone, & Nagata, 2015). Therefore, counseling refugees competently may require knowledge and skills related to diverse cultural values, immigration issues, advocacy, and languages (Kuo & Arcuri, 2014).

Counselors have an ethical obligation to attain multicultural competence, and counselor educators have an ethical obligation to prepare graduates sufficiently to do so (ACA, 2014). However, counselor training programs often do not include information about immigrant and refugee issues in multicultural counseling courses (Villalba, 2009). This oversight in preparing counselors to work competently with immigrant clients may compromise counselors' ability to practice ethically. Part of this gap in cultural competence might involve a lack of knowledge of cultural traditions. Counselor education programs may prioritize gaining self-awareness of attitudes and beliefs while putting less emphasis on the knowledge of cultural traditions of ethnic groups (Barden, Sherrell, & Matthews, 2017). A research gap exists on the training needs of professional counselors to meet the demand for counseling services among refugees as an especially vulnerable group. To meet the mental health needs of this vulnerable population, counselors need an understanding of how to gain and demonstrate cultural competency

with refugees and the support and training that counselors need in their efforts to do so (Edward & Hines-Martin, 2015).

Purpose

Although the counseling profession has an ethical obligation to provide mental health services competently and equitably, more research is needed to adequately address the mental health needs of refugees. The purpose of this constructivist grounded theory study was to explore the perceptions of professional counselors related to their preparedness to demonstrate multicultural competence when counseling refugees. I highlighted the perceptions of counselors toward multicultural competence in counseling with refugees and their preparedness to demonstrate that competence when providing services with refugee clients. The results of the study may provide a deeper understanding of how counselors perceive potential barriers to competence when counseling refugees, which may inform educators and supervisors to better prepare counselors to serve this special population and related groups. The contribution to positive social change was through increasing access to mental health services for refugee populations who currently underuse the services.

Research Questions

How do professional counselors who work with refugees conceptualize multicultural competence?

How do professional counselors perceive their preparedness for demonstrating multicultural competence when counseling refugees?

Theoretical Foundation

The theoretical foundation of the study was the multicultural competency theory first developed by Sue, Arredondo, and McDavis (1992). Sue et al. presented a multicultural perspective in the counseling profession and defined multicultural competence. Sue et al.'s multicultural counseling competency model informed professionals in all roles of the counseling profession to be a more culturally inclusive and responsive, including counseling researchers, counselor educators, mental health counselors, and clinical supervisors. Sue et al. provided a framework to operationalize cross-cultural competency as having the required knowledge, skills, and awareness to perform those roles among diverse groups. Ratts, Singh, Nassar-McMillan, Butler, and McCullough (2016) updated this definition to include a social justice perspective and created a model that includes attitudes and beliefs, knowledge, skills, and action across the domains of interventions, relationships, client worldviews, and counselor self-awareness. Ratts et al. approached multicultural competence with an awareness of the need to include a broader concept of diversity, intersectionality of identities, and the role of counselors as social justice advocates. In this study, I explored how the updated multicultural competencies may relate to counselors' perceptions of their preparedness to counsel refugees.

Conceptual Framework

A constructivist grounded theory approach following Charmaz's (2017) principles guided the investigation into perceptions of professional counselors towards counseling with refugee clients. Because my goal in this study was to determine perceptions,

perspectives, and individual meanings, the constructivist approach served as an appropriate conceptual framework. Patton (2015) defined reality within the constructivist approach as consisting of individual perceptions, and it is important to understand those subjective perceptions as a way of coconstructing new knowledge. In this framework, reality is dynamic and constructed from perceptions, and knowledge is created within the interactions between people (Raskin, 2011). As this framework often guides counseling practice, supervision, and counselor education, it may be appropriate for investigation into these processes related to counseling refugees. Research provides a method to engage in critical inquiry that questions power and injustice (Charmaz, 2017). I chose this framework is to give voice to participants, gain multiple perspectives, and prioritize positive social change that promotes equity (see Charmaz, 2017). In Chapter 2, I will provide a more thorough explanation of how the conceptual framework guided the research process.

Nature of the Study

Based on the need to investigate perspectives and experiences to establish a deeper understanding of multicultural competence in counseling with refugee populations, a constructivist grounded theory approach was appropriate. The constructivist grounded theory approach was most appropriate for this study's exploration into participants' perceptions, meaning-making, and constructs (Patton, 2015). The nature of the study was a qualitative constructivist study guided by Lincoln and Guba's (2013) recommendations for quality in qualitative research and Charmaz's (2017) constructivist grounded theory methodology. In this study, I prioritized seeking out

diverse perspectives, triangulating data sources, immersing into the naturalistic environment, debriefing and member checking, and questioning assumptions. I explored perceptions related to counseling refugees and multicultural competency among counselors working with this population. In this study, I coconstructed knowledge through interactions with participants to arrive at a deeper understanding of multicultural competency and preparedness to provide mental health services to refugees in the United States. Qualitative thematic analysis is an appropriate data analysis strategy within this framework to gather patterns of meaning and themes from the qualitative data (Lincoln & Guba, 2013).

Definitions

Acculturative stress: Chronic stress associated with exposure to a new culture that has physiological and psychological implications, such as, depression, decreased cognitive abilities, and higher incidences of physical illness (Yakushko, Watson, & Thompson, 2008).

Asylum seeker: A person who flees his or her country due to persecution and applies for refugee status to stay in the current host country. A person who claims to be a refugee but their immigration status is not yet determined through legal proceedings (Watzlawik & Bresco De Luna, 2017).

Refugee: A person who flees his or her country due to persecution based on race, religion, nationality, political affiliation, or opinion (UNHCR, 2016).

Resettlement: A process of moving refugees to a different country to live there permanently as they are no longer able to return to their home (Marlowe, Bartley, & Hibitit, 2014).

Resiliency: A dynamic process of thriving after experiencing risk factors and traumatic events that typically make a person susceptible to distress and illness (Sleijpen, ter Hedie, Morren, Boeije, & Kleber, 2013).

Multicultural competence: A set of attitudes and beliefs, knowledge, skills, and actions in which the counselor understands privilege and acts to promote social justice (Ratts et al., 2016).

Unaccompanied refugee minors: A child under 18 years of age who flees the country without a parent or caregiver due to persecution (Keles, Friborg, Idsoe, Sirin, & Oppedal, 2018).

Assumptions, Limitations, Scope, and Delimitations

One of the main assumptions of the study was related to the choice of participants of professional counselors. I assumed that counselors are able to reflect on their training and their supervisory experience and how it has prepared them to work with refugee clients. This assumption was necessary so that the experiences and perceptions of professional counselors may inform counselor education and supervision practices. I also assumed that the participants were honest and reflective in their responses.

This study was limited in scope to the perceptions of professional counselors and did not include the perceptions of those from other mental health professions working with refugee populations or professional counselors who have not worked with a refugee

client. The research problem addressed in the study was how counselor training and supervision prepares counselors to work with refugee clients, which is why those counselors who can reflect both on their training and any experience working with refugees made up the participants of the study. Those with no experience may not be familiar with what type of training might be needed and may only speculate. The study was also limited in scope to the service providers and did not include the perceptions of refugees as consumers of those services. The study did not include client perspectives and experiences. Studying how clients view multicultural competence of their counselors is an important area of future research because counselors may not be accurate evaluators of their competence (Drinane, Owen, Adelson, & Rodolfa, 2016). It would be an important extension of this study in the future to compare counselor and refugee client perspectives and ratings of multicultural competence.

Significance of the Study

Lincoln and Guba (2013) defined the value of a study as its ability to advance positive social change. Through this investigation, I highlighted areas in which counselor educators and supervisors could better prepare counselors to provide mental health services to newly arrived refugees in the United States. Counselor educators and clinical supervisors can use these findings to guide their attempts to increase competence among counseling trainees. Increasing competence of counseling professionals would make counseling more accessible to refugees, currently an underserved group (Tempany, 2009). Outcomes from this study may illuminate the perceptions of counselors counseling refugees and contribute to the current body of knowledge about how

counselor educators and supervisors can better prepare counselors to provide culturally competent mental health services with refugee clients.

Advocating for social justice and positive social change is an aspect of ethical professional identity as counselors and counselor educators (Lee, 2007). Professional counselors risk losing perspective on the societal and group dynamics of wellness when they provide mental health services in individualized settings (Ali & Lees, 2012). However, a commitment to equity, justice, and beneficence is a part of counselors' professional ethics and identity (ACA, 2014). As health professionals, counselors must advocate for conditions that promote wellness within communities. Therefore, developing advocacy skills and a commitment to social justice is crucial to establishing cultural competence and ethical practice with refugee clients.

Wronka (2008) connected human rights to basic human needs, arguing for basic human needs and dignity to set the standards for establishment of human rights globally. Counseling professionals have a role in advocating for meeting human needs and upholding the values of human rights and social justice (ACA, 2014). Professionals working with marginalized groups can provide insight into their needs for those in power to make decisions that support those needs (Kabranian-Melkonian, 2015). Advocating for social justice and furthering positive social change is an aspect of maintaining the integrity of the counseling profession (Lee, 2007). These issues of limited access to mental health services among refugees are ethical and human rights issues that require further research to address.

Summary

In this chapter, I provided an overview of the background of the study, its problem and purpose statement, research question, and the theoretical and conceptual frameworks. I reviewed definitions of relevant terms, assumptions and limitations, and the potential significance of the results to the counseling profession. In the next chapter, I will provide an extensive literature review related to counseling refugee populations.

Chapter 2: Literature Review

An important professional issue in counseling is the development of multicultural competency for counselors, particularly when serving underserved populations like refugees. Globally, there has been the highest rate of displacement of people since World War II (Colucci, Valibhoy, Szwarc, Kaplan, & Minas, 2017). Government officials in the United States have accepted between 20,000 to 85,000 refugees annually within the last 10 years (U.S. Department of State, 2018). Refugees are resettled in 48 states, with Washington, California, Texas, Ohio, and New York being the top resettlement areas (U.S. Department of State, 2018). The Top 10 native languages spoken by refugees coming to the United States include Arabic, Nepali, Somali, Karen, Spanish, Swahili, Chaldean, Burmese, Armenian, and Farsi (U.S. Department of State, 2018). Counselors are currently facing a global humanitarian call to support the refugee and asylum-seeking populations (Baarnhielm, Laban, Schouler-Ocak, Rousseau, & Kirmayer, 2017). This call is based on an unprecedented number of displaced persons worldwide of 68.5 million (UNHCR, 2016). Health issues among displaced populations include untreated depression, traumatic stress, and anxiety (Berthold et al., 2014). Increasing access to counseling resources would reduce the incidence of mental health problems among refugee groups (Edward & Hines-Martin, 2015).

Conceptualizations of multicultural competency has evolved, which affects implications for counselor preparation. Ratts et al. (2016) revised the definition of multicultural competence to include a framework based on attitudes and beliefs, knowledge, skills, and action. Ratts et al. also incorporated social justice competencies

into a definition of multicultural competence. Barden et al. (2017) argued for two dimensions of multicultural competence, including only knowledge and awareness. These differing conceptualizations may indicate a dispute in the field about how to define and assess multicultural competency and how to best teach multicultural competency. Counselor educators in counselor training programs may prioritize gaining personal self-awareness of beliefs at the expense of gaining knowledge about clients' cultural backgrounds and worldviews (Barden et al., 2017). This oversight might have implications for counselors' preparedness to counsel refugee populations.

To provide effective counseling for refugees, counselors may require knowledge of cultural values, political immigration issues, advocacy skills, and languages (Kuo & Arcuri, 2014). A counselor's lack of multicultural competence in counseling relationship can lead to harmful therapeutic practices (Wendt et al., 2015). Deepening an understanding of what multicultural competence means for refugee populations may lead to greater access to mental health services among refugees who tend to underuse counseling (Edward & Hines-Martin, 2015). In addition to the lack of competent counseling professionals, there are often other barriers that limit access to counseling services among refugees, including language barriers, lack of transportation, fear of stigma, and financial limitations (Berthold et al., 2014).

Much of the research related to refugees' mental health needs relates to refugees in countries outside of the United States. Most of what is known related to multicultural competence with diverse groups is related to major racial/ethnic minorities in the United States such as African Americans, Hispanic Americans, Native Americans, and Asian

Americans. In this chapter, I will review what is currently known about multicultural competence in counseling, refugee mental health care, and the constructivist philosophy guiding this investigation on counselors' preparedness to counsel refugees in the United States.

Literature Search Strategy

In this section, I will highlight the literature review search strategy. I selected literature based on its relevance to the main concepts of the study. The relevant topics covered include counseling refugees, counselor preparation for multicultural competence, and constructivist grounded theory. The general search terms included *multicultural competence, refugees, counseling,* and *constructivist* approaches. More specifically I used a combinations of terms on these databases: Education Source, ERIC, CINAHL Plus, SocINDEX with Full Text, PsycINFO.

Search Terms:

Multicultural competency AND Refugees AND Counsel*

Training AND Refugees AND Counsel*

Supervis* AND Refugees AND Counsel*

Mental Health AND Refugees

Counsel* AND Refugees

Constructivist AND education AND counsel*

Refugees AND acculturation

Counselor education AND refugees

supervision AND refugees

cultural competence

*cultural competence AND counselor education

Through this literature review, I sought to describe the current professional knowledge about the mental health needs of refugees and barriers in seeking counseling, evidence-based approaches with refugees, the profession's past and current understanding of multicultural competency, and the current literature on how the counseling profession is preparing counselors to demonstrate multicultural competency with refugee populations.

Theoretical Foundation

The theoretical foundation for the study was the theory of multicultural competence. Multicultural competence is a complex concept that has been defined and measured in different ways throughout the history of the counseling profession (Wang, Hogge, & Sahai, 2016). Ratts et al. (2016) updated the original theory of multicultural competence from Sue et al. (1992) consisting of knowledge, skills, and awareness. The new conceptualization of multicultural competence theory is that it involves a dynamic process of attitudes and beliefs, knowledge, skills, and action in which the counselor understands privilege and acts to promote social justice. The concept of multicultural competence is relevant for various social service professions globally; however, the definition is not clear across professions or among researchers within the same profession (Portera, 2014). Collins and Arthur (2010) defined culture-infused counseling competence as a set of awareness of self and others and the ability to form a working alliance with clients of diverse backgrounds. Barden et al. (2017) suggested that it is

made up of awareness and knowledge. Multicultural competence skills are distinct from other more general competencies to practice therapy such as building an alliance with clients according to Drinane et al. (2016). Also, Oppedal and Toppelberg (2016) defined cultural competency as possessing knowledge and skills to understand communication, relational patterns, and values of a culture when discussing cultural competence more broadly among individuals crossing cultural boundaries. The updated theory of counseling professionals, Ratts et al. (2016), of a dynamic, complex set of factors leading to a set of skills, attitudes, actions, and knowledge was the guiding theory for this study.

Conceptual Framework

The conceptual framework guiding this study was that of constructivist grounded theory. Constructivist ground theory adds to the original grounded theory an inductive research process with the methods of coding, memo-writing, and theoretical sampling; it updated methodological techniques and added a critical framework of questioning the researcher's assumptions and process (Charmaz, 2017). Using constructivist grounded theory, researchers also prioritize reform and social change from a pragmatic philosophy and critical inquiry questioning power and injustice (Charmaz, 2017). The researcher must address reflexivity and positionality of his or her role in the study (Charmaz, 2017). Additionally, collaborative inquiry requires engagement and coconstruction (Kim, 2014). In constructivist approaches, perception is dynamic and dependable on context, and reality is made up of these individual dynamic understandings (Guiffrida, 2015). The philosophy can be applied to multiple contexts such as teaching, supervision, and research (Guiffrida, 2015). Grounded theory analysis and ethnographic-based

investigations inform interventions and approaches that are appropriate for refugee populations rather than imposing Western-based theories onto clients (Weine, 2011).

Key Concepts

In this section, I will discuss an overview of the key concepts discovered in the literature review. The main key concepts are related to counseling refugees and how counselors are trained to do so. I will discuss what is currently known in the literature about these key concepts.

Counseling Refugees

Distress and needs: The case for counseling for refugees. Migrants are at risk of traumatic experiences premigration, during transition, and postmigration in resettlement (Bemak & Chung, 2014). The refugee experience consists of many losses associated with war and exile (Al-Roubaiy, Owen-Pugh, & Weeler, 2013). Experiences of early childhood adversity also impacted the development of PTSD and depression in addition to war trauma and acculturation stressors (Molsa, Kuittinen, Tiilikainen, Honkasalo, & Punamaki, 2017). Loss of social and family networks pervade all aspects of the transition through death and forced migration (Bemak & Chung, 2014). Survivors also become cut off from indigenous healing practices and cultural supports (Bemak & Chung, 2014). Family roles shift both in war areas and in postresettlement in the host country (Hoffman, Robertson, & Tierney, 2017). Refugees are ethnically diverse and have diverse experiences and backgrounds; however, they all share an increased risk for trauma-related distress and underuse of services (Lambert & Alhassoon, 2015). There

are higher prevalence rates of PTSD and depressive disorders (Lambert & Alhassoon, 2015).

Premigration. Premigration refugees are likely to experience four different types of trauma: scarcity of food and shelter, torture, incarceration, and witnessing killing and injury (Bemak & Chung, 2014). The highest numbers of refugees arriving to the United States in 2018 originated from the Democratic Republic of Congo, Ukraine, Bhutan, and Burma (U.S. Department of State, 2018). They may face persecution in their countries of origin based on their religion, ethnic group, political affiliation, sexual orientation, and/or gender. Green (2013) described experiences working with a Congolese woman in South Africa. The client had witnessed and fled a war, in which she was particularly vulnerable as a woman. Compared to other immigrants, refugees have the additional difficulties of premigratory traumatic experiences, grief, and loss of self-determination (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008). For example, the client in Green's study had a higher socioeconomic status in her home country, and fleeing meant the loss of her home, community, family members, and status. Many immigrants often make a choice to migrate and prepare for that transition. However, refugees flee for their safety, without a choice and often without time to prepare, leaving behind valuables and important documents. This loss of self-determination continues in migration as host countries often do not offer the right to work, establish lawful presence, or study in their countries.

Flight and migration. Many refugees face hazards in the flight from their home country while fleeing under duress across dangerous routes. Fleeing might also mean leaving behind possessions and/or selling off assets to pay for the trip (Lambert &

Alhassoon, 2015). Women, children, and the elderly are especially vulnerable to gender-based violence, lack of employment and educational opportunities, and lack of sufficient healthcare (Lambert & Alhassoon, 2015). For example, the Congolese client who Green (2013) described had suffered physical and sexual assaults and was victimized due to her being a foreigner and refugee in South Africa.

After fleeing, the waiting process to obtain asylum in another country is also often a source of severe distress (Fazel, Garcia, & Stein, 2016). Immigration status and waiting for asylum or resettlement magnify traumatic stress symptoms that originate from premigration experiences (Nakeyar & Frewen, 2016). During this waiting time, refugees are often placed in refugee camps and become dependent on others for assistance or they live in large cities in informal working and living arrangements. The top refugee hosting countries in the world include Iran, Lebanon, Pakistan, Uganda, and Turkey (UNHCR, 2018). This waiting time can take years to pass various interviews, background checks, and health screenings before approval for permanent resettlement in a third country. Dependence on both the hospitality of host countries, which are often developing countries, and the approval for permanent resettlement by developed countries breeds a loss of self-determination and autonomy (Bemak & Chung, 2014). Of all the refugees who present themselves to the United Nations, only the most vulnerable with no hope of return home (about 1% of all refugees) are resettled in a third country permanently. Both pre and postmigration experiences contribute to psychosocial distress (Fazel et al., 2016).

Postmigration/resettlement. Much of the current literature related to the resettlement of refugees focuses on traumatic experiences before migration, leaving out

the stressors involved after resettlement to a third country (Al-Roubaiy et al., 2013). Since 1975, there have been 3,411,132 refugees resettled to the United States (U.S. Department of State, 2018). Upon arrival to the United States, refugees are awarded legal status, work authorization, and eligibility for public benefits and other social services. Although having legal status, work authorization, and healthcare allow for integration into their new society, there are many obstacles to meaningful integration and inclusion in U.S. life for refugees. One distinction between refugees and other migrants is that while immigrants tend to arrive to the United States healthier than the native-born population and then develop illnesses over time, refugees tend to enter the country less healthy than the native-born population (Johnson-Agbakwu, Flynn, Asiedu, Hedberg, & Breitkopf, 2016). Also, the daily stressors of postmigration can be more distressing than war-related trauma experienced premigration (Goodkind et al., 2014). These daily stressors may include acclimating to new culture, language, and socioeconomic status as well as navigating new social systems to access public benefits and healthcare. Family dynamics may shift as males in the family may have difficulty finding work suited to their skills and profession and struggle to provide for their families (Al-Roubaiy et al., 2013). The focus of refugee services towards self-sufficiency as quickly as possible is a stark contrast from the country's policy of taking in the most vulnerable refugees and the refugees' years of experience having to depend on others for survival.

Discrimination, racism, and prejudice. Migration to various regions of the United States raises the likelihood that counselors will encounter clients of immigrant or refugee backgrounds who face discrimination and racism (Chung et al., 2008).

Discrimination and prejudice are risks to overall wellbeing affecting self-esteem, belonging, and self-determination (Edge, Newbold, & McKeary, 2014). Youth are particularly at risk of mental health distress due to bullying in schools while they are also less likely to use mental health services (Colucci et al., 2017). In many refugee cultures, job status and socioeconomic status are highly tied to identity, while prejudice prevents upward mobility and job placement (Vinokurov, Trickett, & Birman, 2017). The resettlement institution in the United States prioritizes employment and economic self-sufficiency as quickly as possible, which pressures refugees further at their most vulnerable time (Marlowe et al., 2014). For example, a refugee may arrive to the United States as a physician and would need to pass board exams, an English proficiency exam, and be accepted and pass medical residency before practicing medicine in the United States. Those who are willing to go through the process will need to work at entry-level employment in the meantime to support themselves, and many who may arrive at an older age may not be able to go through that process to practice their profession again. At the same time, there may be cultural barriers to accepting employment with less prestige that would be considered beneath their training and educational level (Vinokoruv et al., 2017). Refugees also face discrimination while trying to enter the job market in Western countries where their credentials are not accepted (Al-Roubaiy et al., 2013).

Acculturative stress. Even those refugees demonstrating resilience through reduced depressive symptoms 1 year after arrival to the United States still struggled with traumatic stress symptoms and acculturation difficulties (LeMaster et al., 2018). Chronic stress, such as acculturative stress, has physiological implications including increased risk

of disease, decreased cognitive abilities, and depression (Yakushko et al., 2008). Stress is a subjective experience, and counselors need to be able to work with immigrants' subjective experience of acculturation within its cultural context (Yakushko et al., 2008). Immigrants and refugees often experience acculturative stress on different levels while adjusting to the dominant culture and potentially to different socioeconomic status, language, and quality of life (Chung et al., 2008). Acculturation is more complex than a linear process from one culture to another (Johnson-Agbakwu et al., 2016). It involves a dynamic adaptation of at least two distinct cultural identities (Johnson-Agbakwu et al., 2016). Comorbid physical chronic conditions also exacerbate mental health and acculturation stressors (LeMaster et al., 2018). I stopped reviewing here due to time constraints. Please go through the rest of your chapter and look for the patterns I pointed out to you. I will now look at your Chapter 3.

The assimilation experience is influenced by social identity factors and the cultural distance between the two cultures (Marlowe et al., 2014). The effects of assimilation to U.S. culture on mental and physical health outcomes may vary by ethnicity and gender (Lincoln et al., 2016). The concept of identity among refugees and other migrants is influenced and affected by social concepts and legal definitions (Watzlawik & Bresco De Luna, 2017). For example, refugee women are often forced to adjust their parenting in the face of conflict post-migration and then in the face of a new culture and set of laws and policies post-resettlement (Hoffman et al., 2015). Acculturation style was associated with mental health outcomes (Nakash, Nagar, Shoshani, & Lurie, 2015). Berry (1990) described for acculturation styles across two

domains of connection to the host culture and heritage culture: 1) assimilation, no connection to heritage culture and full affinity for the host culture, 2) separation, strong connection to heritage culture and no participation in host culture, 3) marginalization, no connection to either heritage or host culture, and 4) integration, connection and involvement to both heritage and host culture. Often overlooked are the social factors contributing to acculturation style (Nakash et al., 2015). For example, a refugee may feel betrayed by their country of origin and desire to fully assimilate into the United States. However, prejudice and discriminatory policies may prevent that refugee from feeling fully welcomed and being able to participate in the new community, leading to marginalization. Assimilated refugees are more likely to experience depression in the United States (Nakash et al., 2015). Immigrants who are racial minorities in the United States may experience shock at the different racial dynamics and the prevalence race plays in identity in American culture (West-Olatunji, Frazier, Guy, Smith, Clay, & Breaux, 2007). For example, a refugee from an African country where their ethnicity, religion, or gender might have been primary in their identity and after arrival to the United States, they are labeled as Black/African American by others and a minority facing inequities foreign to them. Muslim women might second-guess their decision to wear a headscarf, African men might not be aware of how to protect themselves from police brutality, an educated woman with an accent may be assumed by others as unintelligent, and a child may be seen by teachers as uninterested when trying to demonstrate quiet compliance and obedience. Facilitating healthy acculturation requires counselor knowledge of both the host and home cultures (Oppedal & Toppelberg, 2016).

Barriers to Counseling

The availability of mental health services within refugee camps and communities is not meeting the need adequately, and there exists a large discrepancy between what is available and what is needed regarding mental health care (Ghumman, McCord, & Chang, 2016). Refugees and immigrants experience additional unique barriers to accessing mental health care as well as additional threats to wellness such as increased rates of poverty and experiences of discrimination (Edward & Hines-Martin, 2015). Regardless of cultural background, refugees commonly experience barriers related to transportation, language, loss of social networks, financial difficulties, and limited access to resources (Hauck, Lo, Maxwell, & Reynolds, 2014). Limited accessibility and social stigma are two factors contributing to the underutilization of services (Fazel et al., 2016). Refugees experience mobility differently than other immigrant groups (Bose, 2014). They lack choice in where they are placed and aren't often driven by family reunification or economic forces but by government policies (Bose, 2014). Transportation is a major barrier for refugees who lack a private vehicle, a driver's license, or the self-determination to choose where they live (Bose, 2014). Relying on public transportation and rides from others limits accessibility to economic and social services (Bose, 2014). Of the high percentage of people with psychological distress, a smaller percentage believed counseling would help; and of that group, an even smaller percentage participated in counseling (Ghumman et al., 2016). Ninety percent of migrant children in need of mental health service do not utilize them (Ellis, Miller, Baldwin, & Abdi, 2011). Barriers include language, lack of knowledge, stigma, and fear and mistrust (Ghumman

et al., 2016). There are also limited evidence-based treatments for trauma with refugee populations, such as refugee children (Schottelkorb, Doumas, & Garcia, 2012). More research is needed on how to conceptualize and build on resiliency factors with refugees (Sleijpen et al., 2013). Further research is needed on how to assess for wellness with refugee and other migrant populations (Strijik et al., 2010). The counseling profession needs innovative research strategies on how to implement culturally responsive community-based preventative approaches (Weine, 2011). Minority clients often do not have the space in counseling to communicate their distress (Moodley, 2009). Health systems need informal settings to facilitate relationship and community building (Edge et al., 2014). Innovative strategies and community engagement are ways that counselors can overcome these barriers (Ellis et al., 2011). A comprehensive treatment model should include education, psychotherapy, empowerment, traditional healing practices, and advocacy (Bemak & Chung, 2017). It is challenging for counselors to provide community-based interventions necessary to address post-migration stressors within the context of psychotherapy (Al-Roubaiy et al., 2013). Cultural barriers to seeking mental health counseling include shame about sharing personal or family concerns with those outside the family, a need to maintain a positive reputation within the community, and disbelief that talking about an issue would make it better. Refugees, who often have experienced oppression that bred mistrust of people in power, may have concerns related to privacy and safety in counseling (Ghumman, 2016). With varying educational levels and interrupted education due to conflict, refugees may also have a lack of knowledge of the availability and utility of counseling services (Ghumman, 2016).

Counseling Approaches

Counselors need to understand the diverse experiences in each of the three phases of migration: pre-migration, migration, and resettlement (Bemak & Chung, 2014). An integrative approach to help with refugee clients must include mental health education, empowerment, integrative healing practices, and advocacy for social justice and human rights (Chung et al., 2008). In addition, to be effective with refugee clients, counselors must be able to advocate, provide guidance, be accessible in different contexts, and have a deep understanding of cultural factors. Green (2013) concluded that therapists working with traumatized refugees should consider the present safety and stability of clients and work from a social justice perspective to advocate for and with clients. Effective counseling with refugees must also involve advocacy components and understanding of sociopolitical influences (Al-Roubaiy et al., 2013). Counselors should also utilize advocacy and holistic approaches attending to cultural understandings (Clarke & Borders, 2014). Culturally responsive approaches should also address the socio-political reality of refugees' post-resettlement and the role of racism in psychological distress (Green, 2013). Counselors must also advocate for refugees to be perceived by the greater society as having value and advocate for refugees to have access to basic needs (Goodkind et al., 2014).

Refugees need support to cope with the transition into the United States and the counseling field scan support them with integrated approaches (Clarke & Borders, 2014). Job satisfaction plays a significant role in psychological well-being (Salo & Birman, 2015). Career counseling and case management may be additional appropriate

interventions within this assimilation process (Keles et al., 2018). Counselors must also be skilled in utilizing a resiliency approach (Weine, 2011). Addressing resource hardships with refugees is key to reducing psychosocial distress (Ellis et al., 2013).

Counseling services also need to be integrated into existing service structures such as medical, school, and social service systems; therefore, counselors must be able to collaborate with other professionals and be present to the community (Ellis et al., 2011). Receiving social and mental health support in school settings post-resettlement can alleviate the effects of pre-migration traumatic experiences and improve academic outcomes among adolescents (Wong & Schweitzer, 2017). Schools provide a setting for youth to participate when considerations are made for confidentiality and appropriate space (Fazel et al., 2016). Therapy in schools facilitated self-esteem, autonomy, emotional regulation, and interpersonal skills (Fazel et al., 2016). Refugee students may benefit from support groups and additional orientation to the school settings (Lepore, 2015).

Facilitating cultural and religious resources in counseling promotes resiliencies in clients (Molsa et al., 2017). Assisting clients by facilitating adjustment to the host culture demands awareness and knowledge of self, society, and clients' cultural backgrounds (Keles et al., 2018). Coping strategies can be rooted in cultural and religious beliefs among refugee populations (Clarke & Borders, 2014). Potential treatments include, cognitive processing therapy, prolonged exposure, narrative exposure therapy, and eye movement desensitization and reprocessing (EMDR) (Ghumman et al., 2016). Telehealth may also be an option to increase accessibility, but there are concerns about

security and preferences for speaking to someone in person (Ghumman et al., 2016). Effective interventions need to increase refugees' social connection, self-esteem and sense of belonging to the greater society, and ability to navigate systems (Goodkind et al., 2014). Counselors must also consider and address social factors of mental health (Goodkind et al., 2014). Assessing for trauma symptoms and providing evidence-based treatments are crucial (Nakeyar & Frewen, 2016). To do so effectively, counselors must assess and understand how refugees conceptualize trauma and wellness (Savic, Chur-Hansen, Mahmood, & Moore, 2016). Service providers also need to be connected to the ethnic communities to understand these cultural conceptualizations and facilitate resources because coping, healing, and adjustment are part of a social process rather than just an individual mental health issue (Savic et al., 2016). Cultural competency requires flexibility in accepting individual conceptualizations and needs rather than knowledge of a set of generalized facts about a cultural group (Savic et al., 2016). Treatment length and approaches may need to vary based on racial/ethnic background and level of distress (Lockard, Hayes, Graceffo, & Locke, 2013). Racial/ethnic minorities may wait until they experience a higher level of distress before seeking counseling (Lockard et al., 2013). Counselors must be flexible in adapting their language and approaches for client preferences and needs (Aggarwal et al., 2016). Counselors who address cultural differences further encourage client's active treatment participation and engagement (Aggarwal et al., 2016). The profession tends to pathologize diverse cultures rather than address the sociopolitical factors causing distress so more flexibility in hearing and addressing clients' multiple identities and sociopolitical realities is required (Moodley,

2009). Counselors must be adept at providing a comprehensive culturally based assessment, questioning personal assumptions and biases, and challenging discriminatory policies through advocacy to address discrimination reactions among clients (Chung et al., 2008). Assessments may need to be adapted for use with refugee populations (Johnson-Agbakwu et al., 2016). Religiousness prevented mental health issues in the face of past traumas and present acculturation stressors, so counselors need to be adept at bringing in religious and cultural aspects of clients to promote resiliency (Molsa et al., 2017).

Counselor Preparation

Training counselors to work with refugees can be challenging. Counselors must be knowledgeable and competent in utilizing culturally responsive techniques and to be adaptable to client needs and contexts (Fondacaro & Harder, 2014). Although it is understood that counselors need to be culturally competent social justice advocates, it is less understood how to support trainees in learning and demonstrating those skills in real world contexts (Kuo & Arcuri, 2014). Many counseling programs focus on competency with U.S. based racial minorities rather than working with cultural groups from outside the U.S. (Yakushko, 2010). There also needs to be a more flexible understanding of the diagnostic process and including culture in that process (Yakushko, 2010). For example, being able to work with interpreters also requires additional skills not taught in master's level programs (Yakushko, 2010). Also; curiosity, humility, and the ability to collaborate are important qualities of successful therapists with limited English proficient clients (Yakushko, 2010). Professional development training on specific cultures is important to

further developing multicultural competency beyond master's training (Barden et al., 2017). Counseling programs may have a deficit in preparing counselors who are knowledgeable about their clients' worldview (Barden et al., 2017). A multicultural understanding of mental health is adjunctive to the dominant biological and universalist mental illness model (La Roche, Fuentes, & Hinton 2015). Many refugees also face discrimination and racism in host countries (Chung et al., 2008). In the United States, those from Latinx, Asian, and Middle Eastern backgrounds are constantly treated as foreigners and negative media can affect counselors' views of clients from these backgrounds (Chung et al., 2008).

Service-learning components within courses improved multicultural and social justice knowledge and skills (Midgett & Doumas, 2016). However, developing awareness seemed to take more time (Midgett & Doumas, 2016). Service-learning early in the program while students are developing their conceptualizations of the counseling profession may be more beneficial for students to gain social justice and multicultural competency skills (Midgett & Doumas, 2015). Students need applied experiences within the community to grow these skills (Midgett & Doumas, 2015). An exercise that promotes reflexivity on self and client related to multicultural issues allows students to develop multicultural competence (Mills-Powell & Worthington, 2007). A cultural immersion and social action project may useful in developing multicultural competence and social justice advocacy competence (Hipolito-Delgado, Cook, Avrus, & Bonham, 2011).

The leaders of the counseling profession need to make it more likely that refugee clients can find counselors who match their backgrounds, who can understand refugee experiences, promote mental health literacy among refugee communities, demonstrate respect, and assess for clients' understanding of mental health (Colucci et al., 2017). Further research is needed to support counselors in rising to the global challenge of refugee mental health (Knaevelsrud, Stammel, & Olff, 2017).

Multicultural Counseling Competence

Counselors must possess knowledge, awareness, and skills to be culturally competent as well as awareness and knowledge of sociopolitical issues affecting client populations (Sheely-Moore & Kooyman, 2011). Changing legislative and social policies deeply affect refugee populations (Robinson, 2013). Being effective with refugee clients requires complex and deep knowledge and awareness of refugees' context and the experiences of loss, migration, and trauma from that context (Bemak & Chung, 2017).

Counselor educators have a responsibility to train counselors to become advocates within a social justice orientation (Manis, 2012). Counselor educators demonstrating multicultural competence and social justice orientation when teaching and when managing their institutions are more effective in facilitating cultural competence in students (Zalaquett, Foley, Tillotson, Dinsmore, & Hof, 2008). Some effective techniques to development of cultural immersion, self-reflection, and skills have included writing assignments, experiential activities, and other teaching strategies (Sheely-Moore & Kooyman, 2011). Multicultural competence is too complex and important to limit to only one class (Celinska & Swazo, 2016). Mental health training programs need to have

larger diversity in faculty and student body to train counselors to be multiculturally competent social justice advocates (Esmiol, Knudson-Martin, & Delgado, 2012). Much of the training provided in master's counseling programs are geared toward white students working with non-white clients (Celinska & Swazo, 2016).

How to accurately assess competencies is an important area of inquiry for counseling profession (Kamen et al., 2010). A counselor's multicultural competence could be evaluated by the counselor's self-report, supervisor's rating, and client rating (Drinane et al., 2016). More research is needed related to client ratings of their counselors' multicultural competencies (Drinane et al., 2016). Part of multicultural competence is to develop awareness of privilege and biases, which must include an affective and personal response to racism and inequity rather than a solely cognitive understanding (Torino, 2015). Culturally responsive clinical supervision can facilitate multicultural competence in supervisees (Apostolidou & Schweitzer, 2017).

Clinical Supervision

Clinical supervision is a place to explore the legal and social influences on the therapeutic process (Apostolidou & Schweitzer, 2017). Those working with refugees often received little to no training to do so (Robinson, 2013). Maintaining a contextual lens on clients and therapeutic work often needs ongoing consultation, supervision, and reflective processes (Esmiol et al., 2012). Professional counselors may face challenges in obtaining and utilizing quality supervision (Bultsma, 2012). Their supervision in their workplaces may be heavily administrative and informal, focusing on documentation, immediate issues, and job performance (Bultsma, 2012).

Clinical supervision throughout the post-graduate experience is an opportunity for a long-term awareness-building developmental process required to build multicultural competence (Apostolidou & Schweitzer, 2017). Supervisory working alliance is a mediating factor between supervisory cultural competence and supervisee self-efficacy and satisfaction with supervision (Crockett & Hays, 2015). Supervision allows supervisees to evaluate biases, boundaries, and discuss political contexts (Apostolidou & Schweitzer, 2017). Counselors working with refugees are also at risk for vicarious trauma and burnout and often struggle to negotiate boundaries and power dynamics (Robinson, 2013). Therefore, counselors and their supervisors must also attend to the risk for vicarious trauma and burnout (Fondacaro & Harder, 2014). Supervisors need to be able to engage in political topics with supervisees who are working with this population (Apostolidou, 2016).

There is limited research on theories of multicultural supervision and the application of supervision to facilitate multicultural competence in supervisees (Tohidian & Quek, 2017). Some tools to facilitate social justice advocacy in supervisees include reflexive questioning, genograms, mapping, and focused conversations on power and privilege (Glosoff & Durham, 2010). Clinical supervisors should attend to various factors at the same time, attempting to build multicultural competence, social justice advocacy skills, preventing vicarious trauma, and facilitating ethical reasoning ability with complex cases.

Summary and Conclusions

The literature has highlighted the need for complex, multi-level interventions to promote the mental health of refugees in resettlement through addressing access to resources, educational needs, and experiences of trauma and loss. Those countries taking in those fleeing from their homes for fear of persecution need to respond to the physical and mental health needs of these refugees (Hunter, 2016). Prior research has established the psychological, educational, and resources needs, as well as the need for preventative mental health services. However, there remains a gap in how to train counselors to be culturally competent in addressing these needs and providing access to this underserved population. Further research is needed to adequately prepare mental health, school, college, and career counselors to work effectively with this population and promote their successful integration into the United States.

According to the research to date, the refugee population has an increased need for counseling services and additional unique barriers to seeking it. Counselors have an ethical mandate to work towards equity in access of services and to provide counseling in a way that culturally responsive. What we don't know is how counselor educators are preparing their graduates to overcome barriers with refugee clients and the experiences of pre-licensure counselors working with refugee clients. Our profession needs a grounded theory of preparedness to provide counseling for refugee clients. A detailed overview of the methodology to find out more about this topic will follow.

Chapter 3: Research Method

Introduction

Qualitative research can deepen understandings of barriers and approaches in mental health with refugees (Thikeo, Florin, & Ng, 2015). The purpose of this qualitative, constructivist, grounded theory study was to investigate the experiences and perceptions related to the preparedness of participants to demonstrate multicultural competence when counseling refugees. In this chapter, I will provide an overview of the research design, the role of the researcher in the investigation, the methodology of the study, and the steps to ensure trustworthiness of the study.

Research Design and Rationale

The research questions for this study were as follows: (1) How do professional counselors who work with refugees conceptualize multicultural competence? and (2) What are the experiences of professional counselors in relation to their preparedness to counsel refugees?" The central phenomenon of the study was how professional counselors describe multicultural competence and preparedness to demonstrate it with refugee clients. Historically the counseling profession has defined multicultural competence differently, but the current definition involves a set of attitudes and beliefs, knowledge, skills, and actions in which the counselor understands privilege and acts to promote social justice (Ratts et al., 2016). I used a constructivist, grounded theory approach to explore how counselors define multicultural competence and describe their preparedness to demonstrate it, especially in the context of working with refugee clients.

I also followed Lincoln and Guba's (2013) recommendations for quality constructivist research.

The choice of constructivist grounded theory was an appropriate fit to facilitate an investigation into the construct of multicultural competence and to build a theory that comes from those constructions. Charmaz (2006) established the constructivist grounded theory tradition to provide a framework for collecting and analyzing qualitative data. Both Charmaz (2006) and Lincoln and Guba's (2013) traditions prioritize seeking multiple perspectives and diverse types of data and promoting the voice of participants. Constructivist grounded theory will allow the researcher to coconstruct new theory from the data with participants (Charmaz, 2006).

Role of the Researcher

In constructivist grounded theory, it is difficult to separate the roles of participant and researcher and both are seen as coresearchers in the project (Charmaz, 2006). As the researcher exploring participants' constructs, I worked alongside my participants in the process of investigating the research questions. The participants and researcher are both changed by the interaction, and knowledge is coconstructed within the encounter (Lynch, 2008). Because this process is unavoidable, it is important to consider the potential power dynamics, biases, and ethical issues.

In obtaining informed consent, collecting data, analyzing, and presenting the data, I made sure to communicate to participants my desire to hear their genuine perspective and to prioritize that perspective above my predetermined assumptions. These biases and assumptions might be related to my own professional experiences working with refugee

clients in a nonprofit setting. After over 7 years working with refugees and supervising other professionals working with refugee clients in various programs, I have a conceptualization of effective practice from that experience. These potential biases were managed by confirming findings with participants and making sure that analytic conclusions were tied directly to data from participants. Constructivist approaches and grounded theory studies allow for a deeper understanding directly from a group rather than imposing researchers' beliefs and theories on the phenomenon (Botella & Beriain, 2010).

Methodology

I will outline the methodology of the study in this section. The methodology chosen follows a constructivist, grounded theory framework. In this section, I will outline the procedures for recruitment, data collection, and data analysis.

Participant Selection

The population of the study included licensed professional counselors. Participants graduated from a master's program in counseling and also worked with at least one refugee client. Participants self-identified as meeting the criteria when they voluntarily participated.

Theoretical sampling was the sampling strategy for this study. Theoretical sampling allows for reaching saturation to guide the sampling strategy (Charmaz, 2006). For example, I continued data collection and sought out participants intentionally to obtain diverse perspectives. Data collection ended when theoretical saturation was reached and similar ideas were presented in several interviews (see Allen, 2011). I used

theoretical saturation to seek heterogeneity in the sample, which will increase the transferability of the study (Robinson, 2014). Guest, Bunce, and Johnson (2006) argued that the data saturation should guide how many participants are included and found that six-12 in-depth interviews may lead to achieving data saturation.

Participants were identified through various counseling associations and groups. I used the CESNET listserv to inform counselor educators and supervisors about the study, so they may pass it on to their contacts and supervisees. I posted an invitation to participate on social networking sites for the National Board of Certified Counselors (NBCC), International Association of Counsellors (IAC), ACA, and groups for professional counselors. I also e-mailed an invitation to participate to a national network of resettlement agencies who may employ or collaborate with professional counselors providing services to refugees as well as other mental health services sites for refugees across the United States such as Women Refugee Commission, Survivors of Torture International, and De Novo Center for Justice and Healing. I also asked participants to share the invitation with other counselors who may qualify for the study.

Instrumentation

I used a demographic form, individual face-to-face intensive interviews, and a focus group with the same participants. I created and used a semistructured interview protocol (see Appendix A) and a semistructured focus group protocol (see Appendix B) including initial open-ended questions to guide the interviews and focus groups. Constructivist grounded theory guided the development of these protocols to include

open-ended questions related to participant perspectives and experiences. Content validity was established by connecting the questions directly to the research questions.

Recruitment, Participation, and Data Collection

I collected data through the interviews, focus group, and demographic forms. Each participant had the opportunity to contribute at three separate points in data collection, through completing a written demographic form, participating in a one-on-one interview, and participating in a focus group. To recruit these participants within a theoretical sampling, I used convenience sampling and snowball methods. On the demographic form (see Appendix C), I asked participants to provide contact information for an individual they know who would meet the criteria. I also requested their preferred times for a face-to-face interview.

The data collection procedures were as follows: recruitment outreach through social networking sites and e-mail listservs with a SurveyMonkey link to the informed consent form and demographic form to be completed online. A participant implies agreeing to participate by clicking the link to continue to the demographic form. I then contacted the participant by his or her preferred method to set up an interview time and conducted the intensive semistructured interview. Face-to-face or phone interviews and the focus group took place through Adobe Connect and conference calls. The individual interviews averaged about 30 minutes, and the focus group lasted for about 60 minutes. I protected the privacy of participants by not collecting names and maintaining the data on a password-protected laptop. I will maintain the data for 5 years. I used NVivo transcription service to do an initial automatic transcription of the interviews and focus

group meeting, and NVivo to organize the qualitative data. NVivo allows for conducting an inductive coding process and organizing the data into a hierarchy (Chandra & Shang, 2017). After initial coding of the data, I contacted the participants to host a follow-up focus group meeting in which I checked out the initial themes with participants and conducted a debriefing. As I asked participants to spend a considerable amount of their time participating in the research, I gave them a $15 Amazon gift card for their participation at the end of the individual interviews and explained that they may discontinue participation at any time and still receive the incentive.

Data Analysis Plan

Following Charmaz's (2006) constructivist grounded theory method, I analyzed the data simultaneously while collecting the data in two major phases: an initial coding procedure and a focused coding procedure. The initial coding process included line-by-line coding to describe the codes further and make comparisons. Focused coding involved pulling major codes into categories and those categories into themes to form a larger theory. The data analysis process was cooccurring with the data collection process to ensure that saturation guided the sampling strategy.

Trustworthiness

A key aspect of ensuring quality and trustworthiness is conducting qualitative research within a theoretical paradigm in a systematic way while maintaining data integrity, awareness of reflexivity and subjectivity, and clear communication of the results (Williams & Morrow, 2009). Criteria for ensuring rigor needs to flow from the research theory (Porter, 2007). I ensured trustworthiness of the study through following

Charmaz's (2006) constructivist grounded theory method and Lincoln and Guba's (2016) guidance for quality in qualitative research. Lincoln and Guba (2013) outlined four measures of trustworthiness in qualitative research: credibility, transferability, dependability, and confirmability. In this section, I will explain how I meet those measures with the methodology of this study.

Credibility

Morse (2015) presented strategies for ensuring credibility by discussing potential sources of bias, triangulating data, and conducting checks and audits of data. Lincoln and Guba (2013) also discussed the importance of triangulation of data to ensure credibility of the study. I obtained three different data points and methods with participants to ensure credibility of the data. Using Charmaz's (2006) guidance of connecting any analytic conclusions directly with raw data also improves the credibility of the study and its results. In my presentation of the results, I drew directly from the data to support my points.

Transferability

Seeking diverse perspectives and a heterogeneous sample increases the transferability of the study (Robinson, 2014). My sampling strategy allowed me to reach counselors across the country in various settings to make sure that the results may be transferable and relevant. Providing information about the context of the data collection process allows for transferability (Shenton, 2004). Through gaining contextual information of participants from a demographic form, I was able to provide sufficient information about the context of my study.

Dependability

Describing in detail the research methods so that others may replicate the work increases dependability (Shenton, 2004). In this methodology section, I describe the procedures and provided references to appendices of instruments so that others have sufficient information to replicate the study in the future.

Confirmability

Ensuring confirmability involves following a structured coding strategy and analysis process (Shenton, 2004). I followed a structured analysis process guided by Charmaz's (2017) method. I also incorporated member checks by conducting a focus group meeting and asking participants to confirm or dispute the themes identified.

Ethical Procedures

I obtained informed consent from participants by providing it at the demographic form and asking them to continue with the form if they agree to participate in the study. I also verbally reviewed informed consent at the beginning of the interview and focus group. I maintained the data on a password-protected laptop to which no one else has access. I obtained approval through institutional review board at Walden University for the study (Approval #: 02-13-19-0647540). During data collection, names were not used and any identifying information, such as cities or workplaces, were removed from transcripts. When a participant suggested other potential participants, his or her identity was also protected by not disclosing to potential participants who named them. Participants had the right to withdraw from participating at any time during the study and still receive the $15 incentive for their time.

Summary

In this chapter, I described the overall methodology of the study and the procedures guiding its implementation. I also discussed my plan for ensuring the trustworthiness of the study and ethical treatment of participants. In the next chapter, I will review the results of the study.

Chapter 4: Results

I have provided an overview of the study, a review of the literature related to the topics of the study, and an overview of the methodology and procedures. The main purpose of the study was to explore the perceptions of professional counselors related to their preparedness to demonstrate multicultural competence when counseling refugees. The research questions were (1) How do professional counselors who work with refugees conceptualize multicultural competence? and (2) What are the experiences of professional counselors in relation to their preparedness to counsel refugees? In this chapter, I will describe the setting of the study, relevant demographics of participants, data collection and analysis process, trustworthiness of the study, and overview of the results of the investigation.

Setting

Participant recruitment and data collection occurred remotely through e-mail, social networking sites, and phone or video chat. Participants self-selected and had experience working with refugees in many different settings and within diverse contexts. They participated in the study and engaged with me from within their own work settings. Initial recruitment was limited to prelicensure counselors and yielded three participants. Due to low number of responses, I included fully licensed and experienced counselors in the study. Those who declined to participate chose to do so when they discovered they were not eligible for the study because they had no experience working with refugees. Participants received invitations to participate through e-mail or posting on professional networking sites then followed a link to complete the demographic survey which 21

participants completed. I contacted them through their preferred method of contact to arrange an individual interview time and completed 16 individual interviews. I offered to interview participants in a face-to-face meeting through Adobe Connect video chat. Those who did not use the video chat due to unfamiliarity with the technology requested a phone interview instead. All participants were invited by e-mail to a focus group meeting held by video conference. Participants were invited to participate through video, phone, or chatbox, and five attended. One participant used phone only due to traveling at the time and another used phone only due to unfamiliarity with video method. All participants were also invited to respond to a write-up of the results through e-mail. Two participants provided a reaction through e-mail supporting the initial results. No adverse events occurred through the data collection process.

Demographics

Participants were diverse in their work settings and experiences with refugee clients as well as age, race/ethnicity, religion, number of years of experience, and educational backgrounds. Ages of participants ranged from 25-67. Nineteen participants were female, two were male. Reported religions included none, spiritual, Jewish, Muslim, Christian, Bahai, and agnostic. Reported race/ethnicities included Hispanic American, Afro-Latinx, European American, Asian American, Middle Eastern, African American, and mixed race. Participants' time working in the counseling profession ranged from 1 month to 24 years. Levels of education included graduates of master's programs, doctoral students and candidates, and doctoral-level counselors. Participants worked in K-12 schools, government, nonprofits, colleges and universities, community

mental health, substance abuse treatment programs, private practice, home-based counseling services, and inpatient units. Participants lived and worked in various states across the country, many of which represented current and historical top states for refugee resettlement including Texas, Michigan, Washington, New York, and Minnesota.

Data Collection

Data collection occurred at three main points: a demographic form, individual interviews, and a focus group meeting. Twenty-one participants completed the demographic form. Sixteen of those completed individual interviews, and five of those participants attended the focus group meeting. Two participants provided written feedback through e-mail after the focus group meeting.

The demographic form took a few minutes to complete and consisted of 10 questions. The individual interviews lasted on an average of about 30 minutes and consisted of at least nine questions, which were asked of each participant, with additional questions depending on the information shared in the interview. The focus group meeting lasted for about 60 minutes. In that meeting, I presented initial findings and asked for feedback from participants. I also asked several follow-up questions and asked for participants' initial impressions of the implications of the research. I provided this information by e-mail to all participants and invited them to respond with any reactions within 1 week.

The demographic form was available through SurveyMonkey, and the answers were exported to an Excel spreadsheet. The individual interviews and focus group meeting were audio-recorded and transcribed. Two participants also provided reactions

to initial results through e-mail on a Word document. The transcripts, survey responses, and participant reactions were imported into NVivo for data analysis.

One main variation to the initial plan that occurred was that the eligible participants were limited to pre-icensure counselors in the beginning of data collection. Initially, I was interested in obtaining an understanding of how prelicensure counselors' perceptions of preparedness to counsel refugees as they were closest to their basic master's level training and could reflect on it. However, this approach did not yield the number of participants required for the study, and the participant pool was expanded to include any professional counselor with experience working with refugees. Including experienced counselors as participants increased the diversity of the sample and yielded a more complete picture of how counselors engage with refugee clients in the United States. All participants provided a reflection on how their master's programs prepared them to work with refugees and what additional training they needed to complete after graduation to gain competence with the population. Those with years of experience were also able to illuminate a distinction between themselves and newer counselors in levels of confidence and how that influenced their work with refugees. For example, some experienced counselors said that newer counselors may be more rigid in their boundaries and less willing to take risks, may be more flexible in their approaches, and may self-disclose more often.

Another variation was offering phone interviews rather than using the video chat in the majority of cases. Many participants were challenged by the technology and preferred to use a telephone for their interviews instead of a video. This did not allow for

face-to-face interviews as planned in many cases. About three of the individual interviews were conducted through Adobe Connect and the rest through phone due to participant preference.

One unusual circumstance encountered in data collection was that one or two participants completed the demographic form and then declined to complete the individual interview due to having no experience in counseling refugees. Two participants who completed the demographic survey did not provide any contact information so I could not contact them for the individual interviews.

Data Analysis

I analyzed the data as they were collected. After each interview, I listened to the interview and reviewed/edited the automatic transcription. I conducted open coding of the transcripts and stopped recruiting participants as the ideas appeared to be repeated through interviews. After collecting the individual interviews, I conducted an axial coding of the transcriptions, pulling those codes into categories, which I organized into themes. I presented these categories and themes to participants by e-mail and within the focus groups for confirmation and asked follow-up questions to enrich my understanding of the data. Participants reported that they were impressed with the comprehensive findings and confirmed that they captured how counseling occurs with refugees. I conducted a selective coding of all the data collected after obtaining participant feedback and adjusted the categories and themes as needed.

Categories and themes emerged directly from the data. The main themes included contexts, challenges, competency, and professional development. These themes will be

described in greater detail in the Results section of this chapter. Main categories of the theme, contexts, included the work settings, reasons for doing this work, client reactions to counselors, and the rewards counselors gained from working with refugees. Categories of the theme, challenges, were barriers, complexity, and trauma. Barriers included limited training opportunities, counselor bias and assumptions, counselor rigidity, and language barriers. Complexity involved complex power dynamics between counselor and client; cultural intricacies with framing the therapeutic relationship, diagnosing problems, and the vastness of cultures and subcultures; and the need for holistic and integrative approaches that sometimes involves case management, understanding of family dynamics, career development, and psychoeducation. Participants identified that working with refugees involved working with multiple layers of trauma, potential risks for retraumatization, a heightened need for self-care, and an ability to recognize symptoms of traumatic distress. Competence to work with refugees included a set of dispositions, skills, and knowledge. Professional development involved the many ways that clinicians attained competence, including learning from clients, being exposed and involved within communities, consulting, and learning in formal courses.

All participants shared information that could be brought together in a holistic picture of competency to work with refugees despite the diversity of contexts and perspectives. There were no seriously discrepant cases or disputing data. What may have appeared initially as discrepant could be integrated into a greater conceptualization of the main themes. For example, some reported that their training prepared them to work with refugees as the basics of listening and empathy are the same for any client,

while others reported they needed additional training to work competently with refugees as there are complex cultural factors involved. I focused on the skills and dispositions reported to pull out what makes up competence with refugees rather than to focus on the sometimes "yes" or "no" answers participants provided when asked to reflect on what aspects of their training prepared them to work with refugees. There appeared to be some disagreement on whether or not working with refugee clients should be considered a specialization or advanced level of counseling. However, it was agreed among participants that counselors need to continuously develop their cultural competence, that working with refugees adds to their clinical skills, and that there are negative consequences to not developing cultural competence to work with refugee clients.

Trustworthiness

In this section, I will describe how I maintained trustworthiness of the study and its findings through the study methodology and procedures. I will address the credibility, transferability, dependability, and credibility of the study given the few adjustments made between the original plan and the final study.

Credibility

I ensured credibility through triangulating data by collecting them from participants at three different points through different methods. Although it proved difficult to conduct a focus group meeting with all 16 participants who provided an individual interview, I was able to maintain credibility through allowing them the opportunity to provide written feedback to the initial results. In the results section of the chapter, I present the main themes of the results with connections to the raw data.

Transferability

Through expanding the participant pool, I was able to increase transferability above expectations. The diverse heterogeneous sample increased the transferability of the study. I was able to reach counselors across the country in various settings and with different experiences through conducting the recruitment online. Participants were also able to participate through allowing video-chat and phone interviews. I was also able to describe the heterogeneity of participants and settings through gaining contextual information through the demographic form.

Dependability

I described the procedures of data collection and analysis, including adjustments I made and the reasons for the changes so that others have sufficient information to replicate the study as needed in the future to ensure dependability of the study. I also developed these procedures with consultation and oversight from my committee chair, which contributed to fidelity to the constructivist grounded theory modality outlined in Chapter 3.

Confirmability

I followed a structured analysis process guided by Charmaz's (2017) method to ensure confirmability of the study. I also incorporated member checks by allowing participants to confirm or dispute initial findings and provide additional feedback. Feedback from the participants confirmed and enriched the findings and potential implications of the study.

Results

In this section, I will provide a response to the two main research questions. This response is organized by the main themes discovered: contexts, challenges, competency, and professional development. Throughout this section, I will provide a description of these themes to the raw data supporting them.

Contexts

Part of the value of the study was obtaining a comprehensive picture of the diverse contexts in which counseling refugees occurs within the United States. Participants shared which settings they encountered refugee clients and the services they provided. They also shared what led them to these settings, the reactions they noticed from clients when being multiculturally competent, and the rewarding nature of the work counseling refugee clients.

Work settings. It is important to conceptualize the results with an understanding of the context. Throughout data collection, I gathered information from participants on their experience working with refugees and what led them to that work. Table 1 presents a list of work settings of participants, roles played, and services provided.

Table 1

Work Settings

Settings	Roles	Services
In-home counseling	Mental Health Counselor	Mental Health Evaluations
Practicum & Internship Sites	Counselor-in-Training	Case management, outpatient therapy, career counseling, social adjustment services
Summer camps	Facilitator	Youth programming
Government	Administrator	Trainings, resources, advocacy
Survivors of Torture Programs	Manager	Supervision, outpatient therapy, case management
University	Advisor	Career counseling, advising
Public Schools	School Counselor	Evaluation, education, counseling, advising, career counseling, crisis management, referrals to community resources, working with students and their parents
Private Practice	Counselor	Outpatient therapy
Nonprofit Agencies	Volunteer Counselor	Social adjustment services, career counseling, case management, resettlement services, outpatient therapy
Community/Cultural Organizations	Counselor	Social adjustment services, outpatient therapy
Community Mental Health	Counselor	Outpatient therapy, case management
Integrated Health Centers	Counselor	Outpatient therapy, case management

Reason. I found that there were two main reasons why counselors chose to work with refugees. One group of counselors did so to honor their immigrant histories. One participant discussed the desire to contribute to new immigrants having a better experience than the participant's mother did when she came as an asylum seeker and was detained. Another participant also shared having a motivation to help others by providing

the resources and guidance the participant did not receive as a child of immigrants and a first-generation college student:

> Growing up first generation my parents didn't always know everything about school, colleges, and what job opportunities. They always think just one way so I didn't know much about what was out there. If I could do it again, I wanted to know more about what's available and to have more options. I wanted to be that person, to show them what resources are out there and to help them learn about colleges and jobs.

An aspect of having this connection to immigrant histories was then having a motivation to help. One participant stated,

> I'm not sure how to explain it but I feel a very familial connection. We speak similar language, eat similar food, and share traditions. Because of that, I know I have a moral duty, me, more than anyone else, to help them.

Having a personal experience of what migration feels like also led to a motivation to help refugees and provided participants with the knowledge and ability to connect. As a participant described

> Because I myself came into the United States from another country and I had to learn the culture and learn the way of life, you know, I think it protects me and it gave me the insight on how to be able to reach these people to deal with them and what they were going through because I experienced it myself.

Another group of counselors described "falling into it" rather than seeking out work with refugees deliberately. Some lived in an area where a large refugee population

was being resettled. These participants also shared a belief in being able to work "with anyone who comes my way." One participant shared a saying that rang true: "Every fish that comes in your net is yours." This belief motivated them to gain the competence they needed. One participant stated, "I saw the gap in it for us professionally and thought this is the way in which we can use our skills." After doing working with refugees, they found that "it's up to me and I've got the highest order of our work." Those who found themselves working with refugees described how "it just stuck" and they enjoyed the work so then sought it out. I stopped reviewing here. Please go through the rest of your chapter and look for the patterns I pointed out to you. I will now look at your Chapter 5.

Rewards. Almost all participants spontaneously discussed the benefits of counseling refugees and what it gave them personally and professionally as counselors. Working with refugees was described as "the most rewarding and honorable population to work with," "empowering work," "fascinating and wonderful," and "eye-opening." The rewards included being able to sharpen skills and expand competency to work with clients, to gain a new perspective, and to see great progress in clients. This experience was humbling, positive, and fulfilling for participants. Refugee clients "bring a lot of interesting cultures and ideas" and it's a "privilege" to help guide them through their acculturation experience in the U.S.

Reactions. Participants shared ways they noticed their impact on clients and how they knew they were being competent in these contexts. Many shared how clients would talk more, open up, and laugh when they were able to be culturally competent with their clients. They also described a relaxed, comfortable, and warm reception from clients in

their body language and demeanor. Some participants said that their clients would deliberately seek them out as counselors and verbalized that they felt more comfortable with them as opposed to others. One participant described hearing from a client: "It's like you've lived my life." This statement meant that the counselor understood the client's background and communicated that understanding successfully.

Challenges. There were a number of challenges that participants shared spontaneously when discussing development and demonstration of multicultural competence with refugee clients. In Figure 1, there is an overview of the main challenges participants identified.

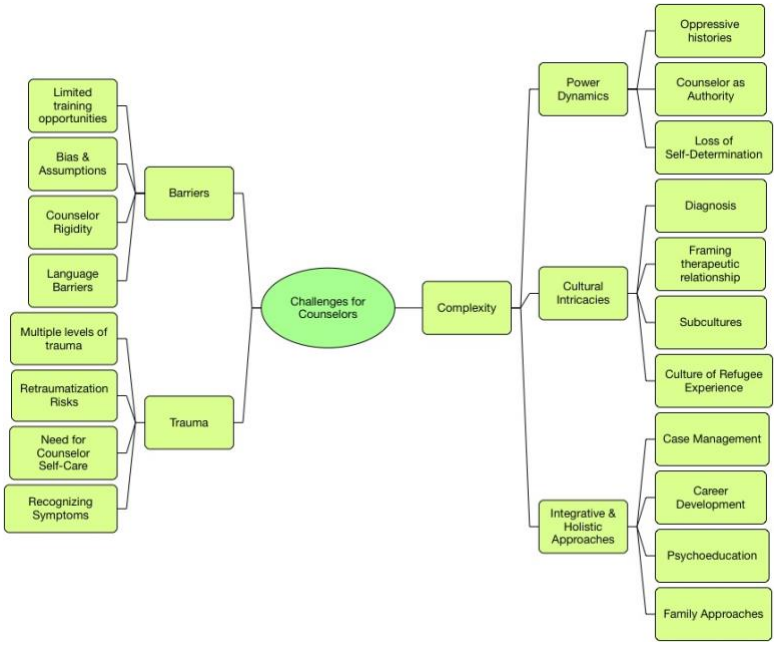


Figure 1. Challenges for Counselors

Barriers. Counselors focused on the barriers they faced when counseling refugee clients rather than the barriers refugees faced seeking services. The barriers counselors

identified included limited training opportunities, their own biases and assumptions, rigidity in counselors, and language barriers. This focus implied a belief in the responsibility of counselors to provide services regardless of challenges rather than refugees needing to change or adjust their approach to accessing services.

Limited training opportunities. Participants described limited training opportunities on refugee issues and explained that refugee and immigrant issues were not discussed in multicultural counseling courses in their training programs. Some counselors "kind of don't keep up with the news and what a refugee is specifically. Nobody really talks about it." There was a persistent belief throughout the interviews that one multicultural course was not enough and the cultural issues when working with refugees were very complex. Another participant discussed how the individual had courses on multicultural counseling and trauma but there was a connection between the two that was missed and more training was needed on understanding and treating trauma through a cultural lens. One participant described counselors as "starving for the cultural information."

Bias and assumptions. Participants were courageous in sharing ways they recognized that their own assumptions get in the way of connecting with clients. One participant stated: "We can sort of you know make a caricature of people out of different books that we are reading and then think that we were an expert on this person or culture," emphasizing the importance of engaging with clients as individuals and exposing oneself to cultures beyond just reading about them. Another participant expressed how they know when they're not being multiculturally competent: "I'll ask a

client a question and already have the answer in my head." A participant indicated that one of the dangers is losing a sense of humility when one has experience with and a knowledge base of the client's population. Another shared a similar experience: "I thought initially that I could listen to one story and one experience and that I initially assumed that it would be the same experience with a different client, and I have to kind of shock myself to kind of not assume." As people become more aware of cultural differences, there is "still a very ethnocentric view" in the helping professions. Refugees may come in assuming a bias against them:

> "They won't have trust that other counselors will understand them, especially when it comes to raising children or marital relationships, so they will hold back. I believe they are right in that many counselors don't understand these family relationships from the clients' culture."

Another participant also described how they hear from other counselors: "I don't know how to work with refugees. I don't know how to work with this kind of person."

Counselor rigidity. Many discussed the flexibility and fluidity needed to counsel refugees effectively and how rigidity in boundaries, approach, and understanding threatens development of the therapeutic relationship and its efficacy. Participants indicated that new counselors were at a greater risk of rigidity: "People tend to come out of school with this wonderful idea that they have to respect the therapeutic frame and they can't take chances and they can't do self-disclosure." Another participant agreed:

> So for example, for the new counselor self-disclosure would be, I don't know, where that stops and ends. And then on the other side of the spectrum playing

> dumb also takes confidence because sometimes new counselors think they have to counsel and really the biggest part of counseling is listening."

Another participant described how some counselors refused to engage in therapy with refugees because they believed they could not adjust or adapt their protocols and still be effective. This rigidity in treating clients prevents counselors from being able to build a therapeutic relationship, from being effective, and from being accessible to refugee populations. As a participant stated: "The theories and techniques that are very Western that we learned in school might not work."

Language barriers. A common barrier for those participants who were not bilingual was not being able to speak the language of clients. Limited availability of trained interpreters and lack of training in how to work with interpreters presented specific barriers. One participant mentioned that "even if I secure an interpreter, I am not sure they are conveying my message entirely accurately." This uncertainty leads to anxiety and avoidance of providing counseling to refugee clients.

Trauma. A challenge that participants shared involved the different ways trauma is involved in counseling refugees. The level of trauma and how counselors perceive it can serve as a barrier to working with refugees: "The other component that I think happens is that nobody wants to work with this trauma, now this is uppercase trauma." Some counselors, potentially more so new counselors, see the level of trauma refugees experience as being beyond their abilities and therefore avoid working with the population or with the trauma. While counselors are concerned about their own capacity to cope with the trauma that clients share. A participant said, "When they're worried

about their own skills, they're not going to be listening."

Multiple layers. Participants described trauma that refugees present as existing within multiple layers:

> So it's like it's just trauma after trauma after trauma and that's what I've learned it's like. Yeah, so when I when I get with them my first assumption used to be oh let's work with them on what they may have seen or what they may have done because of this genocide and yeah that's part of it but there's still much more that they had to deal with. So it's like kind of peeling back the layers."

These layers may exist within what clients don't say and one participant described being able to hear what is not said. Knowing what has occurred globally that led refugees to the United States is incredibly important, but also is not enough to replace being able to be attuned to a client's individual experience. As one participant stated: "The trauma that you know that someone experiences from one country because of the specific political events that are happening in that country may be different from another client." These traumatic experiences happen in phases: "talking about any trauma they may have experience in their country of origin, talking about any trauma they have experienced during their journey to the United States, and then once they arrive to the United States what are they experiencing now."

Re-traumatization. The existence of multiple layers of traumatic experiences means that clients are "traumatized at least three times where they're actually settled where they go because of the way it's done." Not knowing or recognizing the risks for re-traumatization throughout the process of obtaining refugee status and resettlement in

the U.S. can lead to challenges in counseling clients. The counselor must be careful to be sensitive to the client's challenges in resettlement because of the strong risk for re-traumatization. There might be a challenge in counselors developing a rapport with clients as one participant described: "Sometimes it takes a while for them to reveal what's deeper and under the surface because I think many of them had had very hard life experiences."

Self-care. One participant described the work of counseling refugee clients as requiring "a lot of self-care because there are going to be times when regardless of how much we want to help in a more concrete way, we just can't." Working with refugees often involves working within a system that does not adequately address refugees' health needs and meeting up with the limitations of one's role as a mental health care provider. While participants described the rewards of counseling refugees, there were also many challenges that leave counselors susceptible to burnout and secondary traumatic stress.

Symptomology. Another challenge involves the difficulty in connecting the mental health profession's view of trauma with the client's definition and conceptualization of trauma. One participant described having to break down the conceptualization: "When clients are with me, they'll talk if we put it in terms of symptoms and we really have to like stop looking at mental health as like this piece over here that's separate from health." A strict and narrow definition of trauma will not be useful in treating refugees. Participants described clients' aversion to being diagnosed as mentally ill but needing counselors to normalize traumatic stress and to treat symptoms rather than illness.

Complexity. Each participant said that working with refugees can be very complex. What they shared could be grouped into three areas of complexity: power dynamics, cultural intricacies, and integrative holistic approaches.

Power dynamics. Participants discussed ways that refugees' experiences with oppressive societies and the social structures they encountered in resettlement contributed to complex power dynamics in counseling. For example, refugees may have adapted ways of "being pushy, not obeying the rules" or "posturing" or "a lot of times they find that they want to please." Participants understood these behaviors as survival skills developed to cope with oppressive societies. The counselor is also "seen as an authority figure," which can lead to complex power dynamics in counseling. A participant explained: "They see us as part of an established structure, especially because I work for a refugee resettlement agency," and another warned: "I think that's something that's important to recognize when you're working with the refugees and they left particularly oppressive countries. Sometimes even though you're working for them and their attorney, you may be viewed as someone that could possibly be oppositional or we might be viewed as a part of the government.

Cultural intricacies. All participants shared the importance of recognizing cultural diversity among refugee clients and how it can be challenging to manage cultural differences. These cultural differences inform so many different aspects of counseling. For one example, participants described how culture influences relational boundaries: **"**like boundaries with our refugee and humanitarian immigrants. It's different. You if they bring you something, you know, a gift. It's like it's different than an American born client

bringing you something. There is a story and a background."

Culture also influences diagnosis and assessment: "But I found that it was critical to me to learn how you pick up on schizophrenia. How do you pick up on bipolar disorder or borderline personality disorder in another culture?" Participants stated the word "different" often when describing culture. For example, it is important to know about cultures within the U.S. and different countries. It is also important to know about the cultures of different groups within various countries. There are subgroups within subgroups of cultures which makes cultural awareness complex. Adding to that complexity is the understanding that migration and acculturation processes further complicate culture and that individual clients can have very individualized experiences and attitudes within a culture.

Integrative and holistic approaches. Another layer of complexity when working with refugees in the need to "integrate approaches and ideas." As refugees often come from cultures in which mental health is not separated from general health and wellness, counselors need to know how to respond to various needs with diverse approaches. One participant described different "doorways" to working on mental health which could include helping someone acculturate and learn English. The diverse settings and services outlined in Table 1 highlight how refugees may approach counselors in different ways and for different services.

Competency

One of the main questions of this study was how counselors perceive multicultural competency to work with refugees. Three main themes arose as making up competency when working with refugee clients.

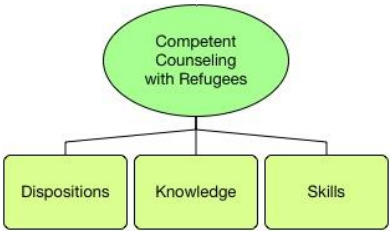


Figure 2. Competency

Dispositions. Dispositions that participants described included humor, openness, humility, flexibility, curiosity, courage, sensitivity, empathy, lifelong learner, patience, authenticity, and accepting. Openness involved being "open-minded enough to learn from clients," "being open to connecting with someone and being willing to step outside of whatever you think counseling is so that you can truly support and empower clients," and a "willingness to explore alternative ways of healing." For example, one participant shared: "I was willing to be more permissive with some of my boundaries as we navigated our relationship." This level of openness requires having "courage to fail and to acknowledge that you don't understand." This disposition means "being able to accept people as they are and being open to helping them and being nonjudgmental."

Knowledge. Participants shared what information would be necessary to work with refugees. Important areas of knowledge include social systems, cultural values and traditions, how culture frames mental health and helping, cultural considerations for diagnosis, self-knowledge of personal cultural beliefs and biases, being aware of holidays

and important dates, immigrant issues, and local policies, global issues or "what's going on in the world that led to refugees to come to the U.S.," the grief process, and the acculturation process. There may need to be specific focused training for counselors to gain the knowledge base identified by participants. One participant suggested, "I think that the potential to make the experience in multicultural courses more focused on refugees or possibly offer an elective for people who are interested in this work and do a deep dive in some of the issues, challenges, and ways to be most effective." Others described learning intentionally about the background of clients as they come in, seeking information about their country of origin, religious beliefs, important holidays, and specific words from their primary language. Knowing the services that are available and how the social systems operate is also important to being able to refer clients to resources they need and help them navigate obstacles. One participant advised that "not working with refugees is not an option, all counselors need to seek out what they need to know."

Skills. This statement highlighted the importance of having the skill of finding out new information, assessing what needs to be known, and actively seeking out that knowledge. Other skills that participants described as important are listed and connected to the raw data in Table 2.

Table 2

Skills and examples

Skills	Quotations from Participant Interviews
navigating fluid boundaries	And for a lot of the people that I've worked with from different cultures people seem to be able to smell if you are the kind of person who is going to keep them at arm's length
asking questions	I think for me playing dumb is the best therapeutic tool that I have because that allows me to competently work with people from the same culture and it can be completely different experiences you know kind of relearned again.

	cultural competency is knowing that you don't know very much and finding out from them and inviting them to try and explain.
Advocating	I would like to add that our work may not have always begun as a way to voice social advocacy, but it eventually turns into that when we see the struggles and disparities these communities face. Unless we grew up in similar settings as those that a refugee may have, we would not have first-hand knowledge. But once we see the struggles for ourselves, I believe that as helping professionals, we become almost a political voice and hopefully a force. as counselors we have an ethical duty to do civic engagement. And so like speak for me about political advocacy as well and how you know political advocacy for our clients like how do you how do we do that.
demonstrating a welcoming and warm demeanor	provide a safe and secure environment, be welcoming and warm And I just try to be really soft in my approach like even the way I enter the room I'll just I'll practically tiptoe into the room.
exhibiting emotional intelligence	pick up on when things are weird or when things are frigid or when things may be you know one thing maybe miscommunication and you really got to be open to pick that up the ability to listen you setting the tone to understand create trust non-verbal skills Being able to share the different options without giving my own opinion on what they should do.
hearing trauma	providing trauma informed care, and that the trauma may look very different than what we believe trauma is but really allowing the refugees to hear their stories and to release some of that pain they may be carrying with them. And so you do have to be prepared to hear some of the things you hear. And to and to look for things you don't hear.
connecting clients to community	So finding communities to connect them with so that we can really provide community care I don't think it's enough to have 50 minutes a week to reach out to community resources that kind of really link up together to see how you can help the families around. We do the best we can to make sure they are aware of resources available for financial help.
providing psychoeducation	psycho education is needed to help them navigate We've had to reframe it. As classes or teaching or life skills, coping with stress. those kinds of instructional kind of courses to kind of get their buy-in.

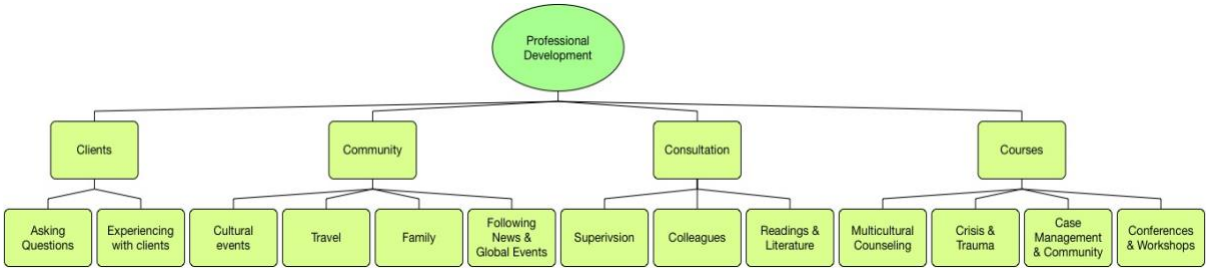
facilitating acculturation	Counselors then have a duty to help them reconcile emotions and their experience with grief and loss I saw my role as being sort of an ambassador to teach them how to survive in the U.S in the healthiest and happiest way that they could. And there are there are stages of acculturation but meeting that client where they are and understanding that they're going to be in shock at first and then generally leading them through that path of getting us getting acculturated to living in an America you know takes time.
working with interpreters	how to work with an interpreter
broaching topics	Depending on the culture I have to keep that in mind when I ask the question. I tend to change the wording of questions because saying mental health or suicide or homicide it's I feel like it has a different meaning and different cultures
translating cultural information between two different cultures	I also translate it to my culture. What I'm saying though in my culture this like this what do you think. What does it mean to you. I do a lot of negotiable you know negotiating across culture. And and the other thing that I'm doing constantly is redefining. For instance there's no such thing. There's just now becoming such a thing as PTSD in the somali community. Yeah because they're just now getting educated into it. And what I call it is grief and sadness and memories that keep coming back for them. When I say I think a lot you're thinking a lot aren't you. That means depression that's how they describe depression. Learning how to reframe it.
honoring cultural backgrounds	to honor and to understand the culture in as much as I can, coming from my point of view and and to understand how the relationships work as well as how they give, to helping individual communities. definitely honor whatever they say to you. Definitely honor and I learned this working in the schools there was often this well I have to tell you you know I've said this many times I have to tell you I know that you're trying to help us to get your child's behavior under control but I have to tell you we don't use that kind of discipline here. I can't tell you how many times. Now you do need to know that we don't use that discipline here and to be really you know to be honest and again very respectful of what they are trying to say. meet people where they are at, understand some of the obstacles they’re coming in to helping them understand some of the cultural norms while accepting theirs, and not pre-judging them. Listening and hearing them out even if I don’t agree with their perspective.

assessing symptoms	And when I talk about the symptomology they understand that and oftentimes the initial clients will come in and I will say I bet you're thinking a lot. I wonder you know I'm I'm thinking that you might have these memories come back and back and back. Oh yes. I wake up screaming. I'm thinking that you cannot you you have difficulty sleeping and thinking you're having headaches checking in and acknowledging the feeling, the situation and translating it into an acceptable form for them
utilizing flexible approaches	Well I don't do the exact Protocol because I connect the situation and I allow them to translate it for me. meeting their physical needs, meet the basic needs a good listener, and just try something different. multicultural competency means you need to be able to learn other cultures and be able to apply it to different situations, and be able to be relatable. Addressing family needs If you're helping families because you've got to think of that refugee not as an individual but for a family.
collaborating with an interdisciplinary team	researching sources for your client and then your clients might not want that traditional individual counseling We work with other places that donate

Professional Development

Figure 3 highlights findings related to how counselors obtain the dispositions, knowledge, and skills needed to demonstrate competency with refugee clients.

Figure 3. Sources of Professional Development



Clients. Many participants shared how they learned from their clients and that their competency increased with each client they counseled. One participant shared how she experienced new religions and cultures through her encounters with clients, such as going to the mosque with a client. Others talked about how hearing client stories

enriched their understandings of different cultures and countries. Another way to learn was to intentionally seek out readings and information about a country or culture because a client from that culture came to them for counseling.

Community. Exposure and participation in community was another avenue for gaining competency. Participants valued highly what was learned through immersion and exposure. These immersive experiences included attending local cultural events, traveling to foreign countries, learning from family members and histories, and following news and global events.

Consultation. Another area of professional development that participants discussed often included learning from colleagues. This type of peer consultation came up more often in interviews than learning from supervision. Participants valued consulting with colleagues on cases, processing challenges and difficulties, and learning about colleagues' cultures.

Courses. Almost all participants mentioned the multicultural counseling course in their masters' programs as contributing to their ability to work with refugees. It gave them some exposure to understanding their own cultural beliefs and those of other people. Many also discussed attending workshops and topic-specific trainings post-graduation. Participants highlighted the importance of the basic skills and power of empathy learned in masters' programs and how they gained more specific information about cultures and approaches through trainings.

Summary

Through the study, I answered the two main research questions. Competency to work with refugees involves dispositions/attitudes, knowledge, and skills. Dispositions included flexibility, openness, curiosity, sensitivity, courage, kindness, patience, and authenticity. Knowledge involved knowledge of immigrant issues, cultural groups, counselor biases and cultural values, current global events, available local services, and the resettlement process. Skills included: advocacy, emotional intelligence, providing trauma-informed care, connecting communities, providing psychoeducation, broaching difficult topics, working with interpreters, cultural interpretation, and strong listening skills. Competency was developed through learning from clients, consultation with colleagues and supervisors, graduate courses, readings, trainings, and exploration into communities. In the following chapter, I will provide a discussion of the interpretation and potential implications of these results for counselor education and supervision and future research.

Chapter 5: Discussion

Through a constructivist grounded theory approach, I intended to explore the perceptions of professional counselors related to their preparedness to demonstrate multicultural competence when counseling refugees. This approach allowed me to explore perspectives, conceptualizations, and experiences and pull from these a larger theory of multicultural competence when working with refugee populations. To maintain the trustworthiness of the study, I followed Lincoln and Guba's (2013) recommendations for quality in qualitative research and Charmaz's (2017) constructivist grounded theory methodology.

The understanding of multicultural competence that arose from the study included a set of dispositions, knowledge areas, and skills. Dispositions included flexibility, openness, curiosity, sensitivity, courage, kindness, patience, and authenticity. Knowledge areas involved knowledge of immigrant issues, cultural groups, biases and cultural values, current global events, available local services, and the resettlement process. Skills included advocacy, emotional intelligence, trauma-informed care, connecting communities, providing psychoeducation, broaching difficult topics, how to work with interpreters, interpreting and translating concepts from one culture to another, and strong listening skills. Competency was developed through consultation, engagement with the community, courses, through learning from clients. The context for this work involves many different settings and despite the challenges (or because of them) the work is very rewarding in many ways. Many felt that additional knowledge

and skills were needed beyond basic training but that it is required of all counselors to gain them and to become competent in working with refugees.

Interpretation

In many ways, the theory constructed from this research confirms and extends existing knowledge described in Chapter 2. In this section, I will describe how the findings fit in with the larger body of knowledge and existing theories.

Counseling Refugees

The findings confirmed what the literature presents as the challenges refugees face in their journeys. Counselors who have multicultural competence to work with refugees have a comprehensive understanding of the complexity involved in refugee trauma, migration, navigation of social systems, and acculturation processes as well as the effects of prejudice and racism on their clients. Counselors have an ethical imperative to address these challenges and overcome the barriers they pose to receiving services. Counseling refugees often looks different than the traditional counseling process taught in graduate programs and the findings add to the diverse contexts in which helping occurs.

Counselor Preparation

The findings also confirmed the many ways that traditional counselor preparation may fall short in preparing counselors to provide services in the adaptive and flexible way needed when working with refugees. I found that a broader definition of culture, more information about immigrant issues, and global perspectives are needed in counselor preparation programs. The findings add to the understanding of how

counselors are compensating for the limitations of their training. Learning from clients and peer consultation were two main ways that participants shared how they learned to work with refugee clients. These forms of learning are often missing from the literature on counselor preparation. Barden et al. (2017) found that counseling training programs tend to focus on developing self-awareness in counselors, often at the expense of developing knowledge and skills. Learning from clients and colleagues, postgraduation may be a way that counselors are making up for this deficit in practice. The findings confirmed the need for supervision to monitor the risk for vicarious trauma and burnout, facilitate discussion of political topics, and to develop ethical reasoning and social justice advocacy skills (see Apostolidou, 2016; Fondacaro & Harder, 2014; Glosoff & Durham, 2010).

Theoretical Framework

The findings illustrated the ways that the multicultural counseling competency theory outlined by Ratts et al. (2016) applies within the context of counseling refugees. The ways that counselors who work with refugees conceptualize multicultural competency included main ideas shared by Ratts et al. such as attitudes, knowledge, skills, and the importance of advocacy. Counselors emphasized skills such as listening, advocating, and learning as well as having a general attitude of openness, curiosity, and flexibility. Multicultural competency also meant having a commitment to lifelong learning, ethical practice, and social justice. The findings enriched and described how many of the concepts purported by Ratts et al. appear in practice when counseling

refugees. It also confirmed that the conceptualization presented by Ratts et al. is comprehensive and reflective of what is occurring in practice.

The grounded theory developed through the study involves a diverse and complex understanding of competent counseling with refugee populations. Counselor educators may focus their training on facilitating a set of skills, knowledge, and dispositions in future counselors. Counselor educators and leaders may use the following table to organize their understanding of competent services for refugees.

Table 3

How I Work with Refugees

Know how to:	**Understand:**	**Demonstrate:**
Navigate boundaries	Social Systems & Service Structures	Humility
Ask Questions	Cultural values & traditions	Flexibility
Advocate	Personal beliefs and biases	Curiosity
Hear traumatic histories	Local policies	Courage
Facilitate acculturation	Global issues	Sensitivity
Work with Interpreters	Grief	Empathy
Honor cultural backgrounds	Immigration process	Patience
Integrate therapeutic approaches	Acculturation Processes	Authenticity
Collaborate with service providers	Cultural views of mental health & diagnosis	Warmth & Welcome

Limitations

A main limitation of the study was that it did not include certain crucial perspectives among participants. Participants did not include refugees, supervisors/counselor educators, and the international community. The missing perspectives among participants, included refugees, supervisors, and international community. One limitation is that all the participants in the study lived and practiced in the United States. Refugees are engaged in counseling around the world and conceptualization of multicultural competency as well as the path to developing it may differ across boundaries. Counselors may also be limited in their ability to understand how their refugee clients perceive them, especially because of the power dynamics involved in the counseling relationship. Counselor educators and supervisors play a role in facilitating the development of multicultural competence in counselors so their perspective could also add to the study.

Recommendations

The recommendations for future research come directly from the strengths and limitations of the study. Future researchers should target the perspectives of counselors working in countries besides the United States for a fuller and more diverse picture of multicultural competence and developing it. Participants noted the missing perspective of refugees in the results. Future research should be a replicated study investigating how refugees conceptualize multicultural competence and perceive counselors' preparedness to counsel them. The supervision process was only mentioned once or twice when participants were asked to reflect on how their training had prepared them to work with

refugees. Further research is needed to explore further the role of supervision in preparing counselors to demonstrate multicultural competence. A replication of this study with clinical supervisors investigating how they conceptualize multicultural competence to work with refugees and their supervisees' preparedness to do so would add to the findings. Bringing together the three perspectives: counselors, refugees, and supervisors could lead to a greater understanding of multicultural competence and preparedness when counseling refugees.

Many participants struggled to answer the question "How did you know when you were being multiculturally competent?" Further research into understanding how counselors self-assess and self-monitor their own competence, particularly multicultural competence, is needed. As the findings may inform the creation of a list of competencies when working with refugees, future quantitative research could contribute to the development and evaluation of an assessment tool that helps counselors assess strengths and weaknesses in their approaches when counseling refugees.

Implications

Participants were invited to share how they perceive the potential implications of the results. Many emphasized the need for a list of competencies that can inform their own self-assessment and ways they can improve their competency to work with refugees. The list can also inform training and education of future counselors and other health professionals or frontline staff who provide services to refugee clients. Participants also discussed the importance of training more professionals as the availability of multiculturally competent counselors is limited. Participants highlighted a limitation to

the current concept of culture and how counselors learn multicultural competency. One participant stated that the multicultural competency class in graduate programs often use broad categories of cultural identity, often presented as African American, Asian American, and Hispanic American. However, the migrant experience contributes to cultural identity and is missing from this course. These broad categories also do not capture the many subcultures throughout the world. Responding to the importance of the work, another participant stated, "The most helpful thing from your findings so far is that the work is being done at all, that this topic has finally come to the forefront, that refugees no longer have to live in the shadows, as such they contribute to this country and we to them."

Social Change

This statement highlights the feelings of invisibility and isolation that many counselors who work with refugees may carry. I highlighted the needs of refugees for counseling as well as the needs of the counselors who are providing the services. Counselor educators and supervisors have an ethical obligation to prepare and support counselors for this important work of meeting the mental health needs of refugees (ACA, 2014). The findings may inform ways that counselor educators can incorporate refugee experiences into the classroom, address self-care needs among counselors, and connect counselors to a larger community of care for refugee clients. Increasing the number of trained professionals increases the accessibility of services for refugees.

Theoretical Implications

I found that it can be useful to explore what multicultural competency may look like across different contexts. The conceptualization described by Ratts et al. (2016) appeared to encompass the theory attained in this study. However, the study's' findings illustrated exactly what skills, attitudes, actions, and knowledge is needed to work with refugee populations. The set of competencies puts the theory to work in practice and makes it relevant for providers and educators.

Practice

The set of competencies is important for counselors to be able to do self-assessment and self-monitoring. The ways that counselors may be monitoring their own efficacy now is if their clients open up and talk more and if their clients are coming back. There may need to be more research to explore if these factors are actually linked to positive therapeutic outcomes. Another implication of the study is that it highlighted the importance of peer consultation and learning from clients. There could be more research to explore effective ways of learning by these two methods. It also implies the need for counselors to engage in monitoring of each other and to share consultation and critiques when needed to develop multicultural competency in peers.

Conclusion

The purpose of the study was to explore how counselors perceive their preparedness to counsel refugee clients and how they conceptualize multicultural competence when doing so. The findings add to the current body of literature on counseling refugees and multicultural competency by illustrating what competency to

work with refugees looks like in practice and how counselors have developed the skills, dispositions, and knowledge base to be effective with refugee clients. This information can guide training and education of future counselors so that refugees have access to culturally competent and effective counseling services. Future research can further expand on this study to include the perspectives of refugees and educators/supervisors. Although the literature and the study's findings point to the complexity and challenges involved when counseling refugees, all participants emphasized the ethical imperative that all counselors gain competency to work with refugees as well as the power of the basic skills of listening and empathy when helping refugees. Therefore, counselors are able and obligated to contribute to the health and wellness of refugees through providing integrated and holistic approaches.

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Appendix A: Interview Protocol

Describe your experience working with refugees.

What led you to working with refugees?

What about your training or supervision prepared you for this work?

What are your perceptions of the needs of refugees in counseling?

What does multicultural competency to work with refugees mean to you?

Probe: Give me an example of a time when you demonstrated multicultural competency with a refugee client.

Probe: How did you know?

What would you say about the experience to another counselor who has never counseled refugees?

What else would you like to share about your perspectives on counseling refugees?

When might you be available to participate in a 60-90 minute focus group meeting on this topic?

Appendix B: Focus Group Protocol

Researcher sets ground rules and expectations for how the group will run.

Researcher describes initial aggregate findings without providing any individual responses.

What about how I have interpreted these findings would you correct?

What would you like to add to these findings?

What perspectives, if any, might be missing from these findings?

How do you see potential significance of these findings to the profession?

Appendix C: Demographic Form

Participant Name:	
Age:	
Gender:	
Preferred Pronouns:	
Race/Ethnicity	
Religious/Spiritual Background:	
How many months of experience post-master's graduation do you have in counseling?	
Describe your work setting in which you did so.	
Describe your educational experience.	
Please offer a time you would be available for a 30-45 minute interview (include time zone) and how would you like to be contacted. Please provide the name and contact information of another individual you know who may be eligible for the study.	
If you would like a copy of the final results, please provide an email address for that purpose:	