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Cross-Cultural Adaptation of Counseling Treatments for Refugee Clients: The Experiences of Mental Health Service Providers

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Abstract

This study examined the perceptions of mental health professionals through their experiences of adapting counseling treatments to meet the cultural needs of their refugee clients. For this interpretative phenomenological study, eleven licensed clinicians participated in in-depth, semi-structured interviews that utilized multicultural counseling and vicarious trauma theories. Results were presented in superordinate and subordinate themes. The results give context to the developmental process participants experienced and insight into the changes in clinical conceptualization and transformative professional identity which emerged from the challenges and areas of support they experienced during each stage of their professional progression. Suggestions for counseling psychologists, supervisors, mental health professionals, and academic trainers to use in their work included reflective examination of the influences and impact of clinicians' cultural identities on clients, as well the cultural influences on the mental health paradigms in academic training.

Keywords

refugee, counseling, cross-cultural adaptation, mental health, community, qualitative

1. Introduction

According to the United Nations High Commissioner of Refugees' (UNHCR) Global Trends report, the number of people in 2021 forcibly displaced from their homes by regional conflicts was over 89 million worldwide (UNHCR, 2022). Since the U.S. Congress passed the Refugee Act of 1980, close to 3.5 million refugees have been resettled throughout the United States (US Department of State, 2023). During the resettlement process, refugee populations face the hurdles of learning to adjust to an entirely

new environment while also experiencing possible symptoms of trauma, depression, anxiety, or other mental health issues caused by the conflict in their country of origin (Miller & Rasmussen, 2017). These mental health issues are further compounded by the stress caused by a lack of agency and resources, separation from family and other supports, and overwhelming acculturation pressures, making the demand for psychotherapeutic treatment extremely high (Kirmayer et al., 2011).

Research indicates that mental health (MH) professionals who use counseling interventions adapted to fit their clients' cultural needs are more effective in their treatment (Chowdhary et al., 2014; Hall et al., 2016; Smith & Trimble, 2016). Furthermore, the Ethical Principles of Psychologists and the Multicultural Guidelines established by the American Psychological Association (APA) emphasize the ethical importance of using culturally adapted treatments in working with clients from diverse backgrounds (APA, 2003; 2017). Given that most MH professionals who work with refugees resettled in the US have different cultural backgrounds than the clients they serve (Sonethavilay et al., 2011), the mandate of the APA's ethics code becomes especially relevant in the context of refugee mental health service provision.

Yet, for MH professionals providing counseling services to refugee clients in the US, the culturally appropriate treatments outlined by the APA's best-practice requirements are sparsely found in the literature (Smith & Trimble, 2016). Another challenge is that treatments may have been developed with a sample from a uniquely different cultural community than the providers are serving (Miller & Rasmussen, 2017). Despite this research gap, due to the pressing demand, MH professionals have provided and will continue to provide refugee groups with mental health services regardless of the lack of culturally appropriate treatment strategies or applicable adaptation frameworks (Kirmayer et al., 2011). Without research to draw on or adaptation frameworks that address the complexities of the refugee experience, service providers often need to adapt and provide treatment in an ad hoc manner.

This decision-making process and the effect it has on MH professionals has not yet been examined in depth. The clinical experience of MH professionals who have developed their personal heuristic approach for adapting treatments for refugees can provide essential information for other professionals who are either entering the field or mentoring others.

1.1.1 Refugee Mental Health

Research on refugee communities consistently indicates their high vulnerability to psychological distress and the subsequent symptoms of overwhelming sadness, frustration, anxiety, and emotional responses related to adversity (Alemi et al., 2014). Additional high rates of risk factors, such as social isolation, economic difficulties, substance abuse, and mental health stigma, contribute to the prevalence of mental health disorders in refugee communities (Giacoo, Laxhman, & Priebe, 2018). MH service providers working with refugee clients in the US must effectively navigate the complex layers of pre-migration and migration stress and trauma within the context of their clients' cultural histories as those histories interact with US socio-political dynamics (Kira & Tummala-Narra, 2015).

1.1.2 Multicultural Counseling

Throughout its development and implementation, the theory of multiculturalism has had as its underlying foundation that each person's unique cultural background profoundly influences their worldview and perspective of life. As such, any cultural value judgments placed by a therapist onto a client serve to invalidate several aspects of the client's experience, which is counter to the stated goal of psychotherapy (Sue & Sue, 2012). The potential to harm clients becomes an increased risk without appropriate cultural adaptations to treatment. For example, in 2004, the influx of well-meaning Western MH service providers to the regions hit by the Asian Tsunami led to clashes between local community beliefs and Western-derived mental health interventions. The clash resulted in a disregard for and erosion of local support systems, causing the psychological trauma suffered by the members of the tsunami-affected communities to be exasperated rather than alleviated (Wickramage, 2006).

Furthermore, providing refugee clients with mental health services that meet their cultural needs has been recognized as an essential aspect of social justice (Ibrahim & Heuer, 2016). Resettled refugees often face the effects of being the targets of overt and covert racism and oppression in direct social interactions, and neglect and disregard for their needs by societal resources institutions (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008; Fang et al., 2015). MH professionals are placed on the front lines of responsibility to help address the social inequalities refugee communities have traditionally encountered in the US (Kirmayer & Jarvis, 2019).

1.1.3 Cultural Adaptations

In order to address the cultural gap between clinicians and clients, adaptations of currently available treatment modalities are made to culturally fit refugee clients. Several meta-analyses have been conducted which support the contention that cultural adaptations of therapeutic interventions are more effective than non-adapted approaches (Chowdhary et al., 2014; Hall et al., 2016; Smith & Trimble, 2016). The strong research support for adaptations of EBTs, emphasized further by the APA's *Ethical principles* (APA 2003a) and *Multicultural guidelines* (APA 2003b), has led to primacy of the development and use of cultural adaptions in the efficacy of treatment.

There have been some efforts at developing general cross-cultural adaptation frameworks. Adaptation models have attempted to address the long-standing conflict between the cultural fit of adapted interventions and fidelity to the initial, evidence-based and research supported interventions. Cabassa and Bauman (2013) stipulate the identification of core functional elements of adaptations, which should be left intact, with adaptation focused on form or customization to local settings. Cabassa and Bauman (2013) also make distinctions between *surface adaptations*—which focus on the form or delivery of interventions, and *deep adaptations*—which focus on issues of cultural salience that may impact the content of the interventions. However, issues of selection and direction, core elements of interventions, and negotiating the conflict between fit and fidelity are likely to vary considerably from service provider to service provider. This is particularly true for MH professionals working with refugee clients, for whom unpredictable, fluctuating circumstances of the refugee process, clients' diverse cultural

backgrounds and complicated acculturation issues, and complex issues of stress and trauma (Miller & Rasmussen, 2017) provide another layer of complexity to treatment.

In the most comprehensive attempt to develop a framework for culturally responsive interventions specifically for refugee clients, Bemak and Chung (2017) outlined the Multiphase Model (MPM) of Psychotherapy, Counseling, Social Justice, and Human Rights. The MP model recognizes the impact of culture on refugee mental health and trauma, with a highlight of the differences between Western mental health concepts, and the cultural norms, beliefs, and values of refugee communities, and a recognition that these differences often result in negative experiences of clients attempting to access services. The MPM also emphasizes recognizing the potential cultural differences between MH service providers and their clients, such as individualistic vs. collectivistic values, indicating a focus on family or group treatments when possible. MPM identifies other potential cultural differences, including verbal and non-verbal communication, somatic and physical expressions of distress, knowledge of cultural stories, myths, and metaphors used in narrative treatment approaches, and a focus on the unique sociopolitical context of each client.

While the MPM addresses many of the gaps in previous adaptation frameworks, including and especially the role of social justice and human rights in the quality of life of resettled refugee communities, the broad systemic approach outlined by the MPM, which may serve as a useful template for agency-wide program development, only provides cursory mention of the specific counseling adaptations that is the focus of this study. Thus, MH service providers looking for strategies to overcome the challenges presented by the cultural adaptation process, and potential areas of support in developing their sense of professional self-efficacy, may not find sufficient resources in the MPM.

1.1.4 Experiences of Mental Health Services Providers

Much of the literature on the experience of MH service providers working with refugee clients has focused on vicarious trauma. Vicarious trauma has been defined as the “cumulative effect of identifying with clients’ trauma stories, which can profoundly and negatively impact service providers’ thoughts and emotions, memory systems and schemas, self-esteem, locus of control, sense of safety, and worldviews” (p. 744, Puvimanasinghe et al., 2015). In many cases, the refugee experience from home country to resettlement contains high degrees of life-threatening stressors, with the expected result that psychological trauma is a common presentation in refugee mental health settings (Rousseau, 2018). As with many forms of trauma-focused mental health work, service providers who work with refugees are impacted by their client’s narratives in ways beyond the scope of the treatment setting (Guhan & Liebling-Kalifani, 2011). Solutions to vicarious trauma effects have been outlined as increased supervision and self-care for providers (Puvimanasinghe et al., 2015), as well as a shifted focus on resiliency and vicarious post-traumatic growth rather than on traumatization (Barrington & Shakespeare-Finch, 2013).

While vicarious trauma, resiliency, and post-traumatic growth among refugee service providers and approaches to its management have now been extensively studied (Chan, Young, & Sharif, 2016), the

literature has not addressed MH service providers' experiences with adapting treatments using their clinical judgment in the place of evidence-supported frameworks to guide the adaptation process. This gap in the literature leaves an important element of service providers' experience unaddressed, one which can add to the established support prescriptions of supervision, self-care, and resiliency and growth.

1.2 Rationale

An examination of the process of culturally adapting available counseling treatments for their refugee clients through the lived experiences of MH service providers could facilitate an understanding of how providers are addressing the need to meet APA ethical and multicultural guidelines (APA, 2003; 2017) while also delivering effective services to their clients. The experiences of these MH professionals can provide essential information and insight for other professionals either entering the field or mentoring others through it. The results of this study address the current gap in the literature by providing an in-depth understanding of the clinical judgment that MH providers utilize in the cultural adaptation process. By understanding this process better, counseling psychologists who work with refugee clients can address the barriers to cultural adaptation and better meet their clients' cultural mental health needs.

1.3 Research Question

The following question was explored in this study: What are the experiences of MH service providers adapting counseling treatments for refugee clients living in the US?

2. Method

The theoretical frameworks for this phenomenological qualitative study include the constructionist-interpretivist epistemology, the multiculturalism theoretical perspective, Interpretive Phenomenological Analysis (IPA) methodology (Smith, 1999), and the methods of semi-structured interviews with participants. A constructivist epistemology guided the underlying principles of this research. Constructivism views the participant and the researcher as co-constructors and co-interpreters of the data, and of the research findings (Ponterotto, 2005). The theory of multicultural counseling, as developed by Sue and Sue (2012), also guided the current study in that the need for cultural adaptions of mental health treatments stems from the concept of multicultural counseling, and effective adaptations will therefore meet the requirements for cross-cultural competency as stipulated by Sue and Sue.

For this study, Interpretive Phenomenological Analysis (IPA) methods were employed as outlined by Smith, Flowers, and Larkin (2012). Smith and Osborn (2007) write of IPA as a two stage, or a double hermeneutic, process: "The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (p. 53). IPA utilizes both the participants' and the researcher's experiences and perspectives as interpretation tools to help identify essential components of the phenomenon being explored.

2.1 Participants

Purposive sampling was utilized to ensure all participants had both experienced the phenomenon (Ponterotto, 2005). For this study, sufficiency was reached at seven participants, but interviews were conducted with four additional participants to provide supportive rigor to the study's findings. Participants were recruited through various sources, including the lead researcher's professional network, faculty referrals at the University of Northern Colorado (UNCO), APA Division listservs, (Division 17: Counseling Psychology, Division 52: International Psychology, and Division 54: Trauma Psychology), and the International Association of Applied Psychology's (IAAP) Counseling Psychology Division 16 listserv. Once participants were contacted, snowball sampling (Polkinghorne, 2005) occurred through referrals from participants to their colleagues.

Inclusion criteria for this study were participants who have a master's degree or doctorate in Counseling, Clinical Psychology, or Clinical Social Work and a) had worked or were currently working providing mental health counseling services for at least one year with a case load of at least ten clients, and with b) at least two culturally distinct refugee communities. Exclusion criteria for the study were MH service providers who worked exclusively with clients from one cultural or ethnic group, including clinicians with refugee backgrounds who worked exclusively with clients from their own community.

The primary researchers four years of previous experience, from 2012 to 2016, providing mental health services to refugee and other displaced communities in both Afghanistan and South Sudan informed many parts of this study. Additionally, the primary researcher's two years of experience, from 2018 to 2020, providing counseling services for refugee clients at a non-profit mental health agency impacted the study's development and focus. These experiences were an essential influence in the interpretative analysis of this study (Smith, Flowers, & Larkin, 2012) and should be included in considerations of the validity of the findings (Morrow, 2005).

2.2 Data Collection

The researchers obtained IRB approval from the University of Northern Colorado (UNCO). Data collection was completed through one to one-and-a-half hour, in-depth, semi-structured interviews with each participant. Participants were instructed to de-identify all information regarding clients discussed during the interviews. When offered the option to provide a pseudonym of their choice or to use a participant number selected by the researcher, all participants chose the number option. These numbers are used in place of participants' names throughout the study. Interviews were conducted via Zoom at the participants' request due either to logistical challenges created by geographical distances or limitations to meeting in person due to the COVID-19 pandemic. Interviews were audio-recorded on a password-protected device for later transcription. Field notes were taken during interviews that consisted of behavioral observations of the participant during the interview, a description of the location of the interview, etc.

2.3 Data Analysis

Data was acquired through audio-taped interviews and field notes taken during and after the interviews.

Data analysis began as soon as the first data was available. Each interview was transcribed verbatim, read individually, and analyzed using an interpretative framework (Smith, Flowers, & Larkin, 2012). Following interview completion and transcription, the researcher explained to participants the nature of a member check, and if participants were interested, they provided their email address for the researcher to contact them. The researcher did not include identifiable information on the member checks to the best extent possible. The member checks were utilized to allow the participants to clarify their understandings and elaborate on their experiences if they were interested.

2.4 Trustworthiness

In this study, triangulation ensured credibility, which entailed utilizing transcriptions of each interview, field notes, and observational data during the interviews. Transferability was enhanced in this study through gathering data from semi-structured interviews, field notes, and behavioral notes observations. For dependability, this study utilized an audit trail, including a journal the researcher used to keep track chronologically of the research steps, changes, thoughts, and questions that came up throughout the research process. Peer checks, peer reviews, and participant member checks were also used to analyze the data. Peer-checks of data were used to help confirm results, which gave the researcher a different perspective on the data. The above steps helped to ensure the trustworthiness of the study.

3. Results

In-depth interviews were completed with eleven licensed MH service providers working with refugee clients. Ten participants were female, and one was male. The cultural backgrounds of participants fell into three categories: refugee backgrounds (two participants), immigrant backgrounds (six participants), and Caucasian American backgrounds (three participants).

3.1 Emerging Themes

Nine superordinate themes emerged from this study: 1) participants' cultural identities, 2) influences of academic training and internship, 3) experiential learning through trial-and-error, 4) vicarious trauma, 5) interpreters dynamics, 6) clients' strengths and resilience, 7) supervision and consultation support, 8) cultural adaptations of counseling approaches, and 9) counseling self-efficacy. Eight of the nine superordinate themes had associated subordinate themes. Direct quotes and examples provided by participants are included in the description of each theme to provide a better understanding of the phenomenon of MH service providers adapting counseling treatments for refugee clients.

3.1.1 Participants' Cultural Identities

This theme is defined as participants' own cultural backgrounds, ethnicities, and perspectives as they relate to their experiences of interacting with their clients' cultural needs. Three distinct subordinate categories emerged from this theme: 1) clinicians with refugee backgrounds, 2) clinicians with immigrant backgrounds, and 3) clinicians with Caucasian American backgrounds.

Having a Refugee Background. Participants who reported having gone through the refugee experience consistently highlighted their own backgrounds as the driving force in deciding to join the mental

health field and focus on providing services to refugee communities. In most cases, these participants provided services to their own communities and refugee communities from other countries or cultures of origin.

Participant 5 describes how the shared background with her clients helped to increase her capacity as a mental health provider for her community, "Because like my experience of feeling lonely, depressed, anxiety and like an outsider helped me to have all the emotions and words I need to put out there to engage my client." This increased engagement is a significant asset for service provision with refugee communities, as the cultural stigma associated with mental health services often presents barriers to accessing available support.

For Participant 6, she first decided she wanted to become a therapist, and then because of her bi-lingual abilities, she found a high need for services with members of her community:

> Yeah, I mean, it was, it's just like, I knew I wanted to do therapy, but it was kind of like navigating that path, you know, counseling as a profession. And then, I didn't even know that there's not even a word for [laughs] counseling in our language. So, like navigating kind of just the mental health system here and kind of where I could be the most helpful…

For Participant 6, her desire to work in the mental health field, combined with her cultural experiences, led her to ultimately start a private practice and specialize in working with people who share the same cultural identity.

Having an Immigrant Background. For this subordinate theme, participants who had immigrated to the US consistently expressed similarities in their experiences with their clients' stories of the resettlement process. For participants with immigrant backgrounds, the challenges of acculturating to the US and the stress caused by navigating the changing cultural expectations significantly influenced their identities. Participants expressed that the unique perspective developed from their immigration experience increased their empathy and understanding of their clients' challenges, giving them an increased sense of self-efficacy in working with refugee communities in ways that U.S. clinicians might not. As Participant 2 stated:

> I used to feel like I was on the outskirts as well, like I'm not a part of the community because I don't speak perfect English and I did not have all the shared memory, the upbringing my peers have… And now I'm on this journey of helping the refugees to be part of this community… they know that I understand how it feels like... to be a foreigner.

Participant 10 also described her challenges of being an immigrant and acculturating to the US:

> It is clear that I'm foreign born. So I actually, I came with my family to the United States not that long ago, relatively, twenty years ago. I had to start from scratch, zero… So literally, I knew zero English and I believe that my struggles were a combination of first, my lack of language, then the way I was thinking, you know, the structure of my mind, and I need analyze to express myself: this is who I am, this is how things are going. And that was like, it was even sometimes complicated in my native language. So I just really felt like a fish out of the water…

Participant 11 also emphasized this aspect of her immigrant background as it affected both her early career choices and her current passion for working with refugee communities:

> And I think growing up understanding the duality of trying to navigate two cultures simultaneously. I think every immigrant has very distinct stories, but I think even growing up that certainly was in the background thinking about adjustment, thinking about, you know, how to navigate language and jobs.

Having a Caucasian-American Background. Unlike participants with refugee or immigrant backgrounds, participants with Caucasian American backgrounds reported a process of cultural exploration which led them to work with refugee communities, rather than areas of shared experiences. For these participants, the interest in working with refugee communities often developed tangentially to other interests. Participant 8 describes her interest and experience working internationally as a starting point for her journey to working with refugee communities:

> I was a psychology major and also really interested in cultural anthropology though… but I'm just really interested in other cultures and learning about other populations. And I had a teacher in my undergrad, and he was actually a positive psychologist…He did a lot of work in [country] and... I was just so interested in what he was doing. And so I think that kind of got me on the track of international psychology and global mental health.

Participant 4 shared a similar experience in which her religious background informed a strong value in social justice:

> And I think for me a lot of things just didn't make sense as far as the imbalance and inequity and injustice across the world. And so I sort of started looking for something very early on that would help me feel like I was contributing to re-balancing, you know, some of the systems I guess.

Her values of systemic justice were then impacted when she traveled to East Africa and worked in a program that provided humanitarian support for people in the region. She described a transformational point in her journey towards working with refugee communities in the US: "That has given me a whole other perspective that I lean on a lot even in my clinical work."

3.1.2 Influences of Academic Training and Internship

This theme is defined as participants' experiences with academic training programs in counseling or social work. These academic experiences are then compared to their post-graduate, professional experiences with refugee clients, with their differences and similarities laying the groundwork for the adaptation process. All participants' academic training programs provided the foundation from which future cultural adaptations would be drawn. The subordinate themes which emerged from participants' experience in academic training were: 1) culture of academia, 2) cultural limitations in academic training, 3) areas of support in academic experiences, and 4) areas of personal growth.

Culture of Academia. In this subordinate theme, participants described a cultural dynamic unique to academic environments and distinct from their experiences in other areas of their lives. For participants with refugee and immigrant backgrounds, enrolling in their academic programs resulted in another

experience of cultural adjustment. Participant 3 recalled it as "A total culture shock" when she started her doctoral program, describing the culture of academia as, "It's totally different. It was quite a culture shock and I really had to slowly learn from that experience." Participant 1 reiterated this perspective through his own experiences in starting his academic counseling training:

> So you know that counseling is actually a unique language…Yeah, so actually counseling is a unique language and I use a second language to learn counseling language, so I don't have so much confidence to do to so [in the earlier stages of his experience].

For Participant 1, the challenges of adjusting to the academic culture, including experiences of discrimination, caused him to experience significant self-doubt in his abilities to acculturate. He recalled struggling with that doubt, saying, "It's more like a self-reflecting to say that, 'Okay, so then can I really provide the services in America?'"

Cultural Limitations in Academic Training. For this subordinate theme, participants described encountering un-adapted mental health paradigms during their schooling and experiencing the need for adaptations as limitations in their academic training. For example, Participant 5 pinpointed a specific area of her coursework in which cross-cultural applications had not been considered: "Or Erikson, right? How a child, the child development, and my question is: okay, is it the same with Asians or with Africans, right? With non-Americans? Because most of the research have been conducted on white... [populations]." As Participant 1 stated, "So when I was in… my master's program, I kept asking myself, 'That knowledge is wonderful, however how can I bring this back to my country?' Because lots of things is kind of not make sense."

For participants with Caucasian-American backgrounds, the adjustment process occurred primarily after they graduated from school. In her experience, Participant 4 recalled encountering what she described as limitations in flexibility: "I think early on I learned, as I think anybody who works with refugee populations learns at some point, that the models we learn in school just need to be more flexible."

Areas of Support in Academic Experiences. Participants also highlighted areas of support which were instrumental in their ability to navigate the challenges of their academic experiences. For Participant 4, these areas of support involved seeking out and connecting with other members of the school who had some understanding of the cultural issues involved with working cross-culturally:

> And I relied on my other students who also had a more like global perspective. And eventually I did find a faculty member who ended up being like my closest support, and to help me through things, and we did some international stuff together… but yeah, that ended up being really helpful.

This viewpoint was shared by Participant 8, who described her experiences of working in externship placements internationally as part of her school program as an instrumental part of her academic training. She recalled,

> I do think that it helped me kind of expand my view of what things could be. I think that what we

> learn in school is so black and white, like, this is how you do this intervention, this is what CBT looks like, or this is what this should look like. And seeing how it can be applied in a different context and how it doesn't have to be so black and white, and manualized.

Areas of Personal Growth. Through a combination of challenges and supports, participants described a process of learning and growth during their academic training. This growth would allow participants to develop the foundation of their professional, post-graduate careers working with refugee communities. Participant 3 explained her perspective of her academic training as an essential stage in the development of a solid base of counseling skills from which she later developed more flexibility:

> And I will say that, "Hey, there's nothing wrong with the training that you received on campus. Those are very basic and traditional, fundamental trainings that you need. And there are certain things that your supervisors on campus are telling you not to do. Um, those are very important because when you first started, you got to follow those rules before you can be more flexible."

The limitations in academic training experienced by many participants were also relayed as an inherent developmental step in their learning processes, which they later recognized as key elements to their skills and growth as effective mental health service providers for refugee communities. After the initial stages of the adaptation process, the following two superordinate themes emerged from participants' discussions of the challenges they experienced in the earlier stages of their professional careers. This stage was characterized by instability in participants' sense of professional self-efficacy.

3.1.3 Experiential Learning through Trial-and-Error

This theme is defined as participants' experiences of learning on the job to meet their clients' cultural needs through a process of experimenting with alternative approaches. The subordinate themes associated with experiential learning are: 1) feelings of low counseling self-efficacy, and 2) re-examination of professional boundaries.

Feelings of Low Counseling Self-Efficacy. Many participants recalled encountering significant differences between their academic training or the previous professional experiences and the cultural needs of their refugee clients. In some cases, these feelings of low self-efficacy were directed at themselves, as in the case of Participant 5, or at counseling intervention paradigms, as in the case of Participant 2:

> Because it's so easy for me to just go in and hear all the poor story and be like, 'Oh, your poor thing!' and then forget about all their strengths and then, you know, jump into, let me teach you this and that. You just need to learn how to do breathing. You know? It's so easy to just do that, but I've tried it, it doesn't work [laughs].

Participant 11 described the experience of encountering the initial lack of efficacy, stating, "It is a rude awakening when you come into the field and you realize your participants are not going to engage in that way." For Participant 11, adjusting to multiple waves of refugee groups, culturally distinct from each other in many ways, and navigating the unique cultural needs of each group, amplified the need to experiment. She said, "And so almost by trial-and-error… So figuring out, okay, what modalities make

the most sense? Who we were resettling and serving in 2011 is completely different from who we're serving today." An additional aspect of challenges with language barriers was also relayed by Participant 7: "… when I'm in therapy sessions, when they're not speaking the same language, you know, the therapy style is different the way we talk and say things is different. And so that's definitely made me pause."

For all participants, experiencing the gap between training/past experience and the cultural needs of their clients, and the resulting lack of confidence, led them to take active steps towards cultural adaptations of their counseling approaches. For many participants, these early experiences of low-counseling self-efficacy become key stages of their adaptation process and later professional confidence.

Re-examination of Professional Boundaries. Many participants also recounted experiences of feeling the limitations of the professional boundaries they developed in their academic training or their previous counseling work. Some participants, such as Participant 9, described these as cultural norms for their client communities, saying, "And also one thing I've definitely learned working with this population is most of the refugee communities we work with are much more community based rather than individualized. Like we tend to be here in America." In other cases, the common trauma experiences and high distress levels caused by the acculturation process for refugee communities were the focal point of the re-assessment of professional boundaries. Participant 9 illustrated this dynamic as well:

> You know, also boundaries, personal boundaries and professional boundaries are extremely important. I think in particular, working with refugees because they need help… And if you care so much that you're going to get impacted by every single story and need and go above and beyond what's actually appropriate for your position. Um, number one, you can do some damage to your clients long term, but two, you can burn yourself out in a heartbeat… So I think boundaries are extremely important to reflect on when you get into this work.

In terms of cultural boundaries, Participant 3, who comes from an Asian immigrant background, described her process of adjusting her boundaries for academic culture, then working to adjust them back to a cultural comfort level appropriate for her refugee clients:

> Boundaries are seen totally different, you know, in collectivism cultures. So I had to relearn—obviously I came from a very collectivism culture and had to learn the American way to follow boundaries when I was in my training program and once I get it out I'll get out of the way of doing this and I realized, "Oh my God, like this is much more comfortable for me to do…"

In this case, because of the cultural overlap between herself and her clients, Participant 3 made the necessary adjustments to work with her clients effectively in terms of relational boundaries.

Participant 1 conceptualized the boundary negotiation process as a balancing dynamic between the ethical boundaries required by the profession and the need to be sensitive and flexible with his clients' cultural norms, stating, "And how to balance both of them. Is that the... [how to] be ethical and keep

the boundary at the same time, but flexible. I think that that's the big challenges for those who are working for this population."

3.1.4 Vicarious Trauma

Included in the definition of the refugee process are the experiences of hardship, physical and psychological trauma, and significant de-stabilization. As participants recalled their encounters with their clients' trauma, many experienced vicarious trauma symptoms or felt overwhelmed. The subordinate themes associated with vicarious trauma are: 1) experiences of vicarious trauma symptoms, and 2) experiences of stress, exhaustion, and overwhelm.

Experiences of Vicarious Trauma Symptoms. For Participant 5, who is herself a member of a refugee community and had her own experiences of trauma from going through the refugee and resettlement process, encounters with her clients' trauma were initially de-stabilizing. She recalled a training experience that had a significant impact on her:

> And one training, I got triggered. That was during my master's program. And I told myself, you know I can feel like my body like I'm shaky and then cold, sweaty, and then, okay a little shaky. So, okay, 'Hey, [participant] you are grounded, you are safe.' I remember those moments; you are going to remember forever.

She described learning to adjust to the consistent encounters with clients' trauma narratives, including seeking support for her own trauma, adjusting her professional boundaries, and focusing on client strengths.

The trauma experiences of refugee clients also had a significant impact on Participant 8. She described her perspective, "It can be really difficult work. Like you're hearing a lot of trauma stories and a lot of, you know, the worst things you could ever imagine to happen to another human being." For Participant 8, learning to share her experiences with colleagues and supervisors was an important tool for managing the vicarious trauma reactions, "Just sharing about, you know, my experiences, the good and the bad. That's it really."

Experiences of Stress, Exhaustion, and Professional Overwhelm. Some participants recalled the initial stages of low counseling self-efficacy as significant contributors to their professional stress and exhaustion. Participant 10 recalled her initial reaction to the trauma and stress she encountered with her clients as an element of burnout, saying, "And then thinking that for me handling that level of stress, that probably in the beginning, I was just also more running on the autopilot before I figured out that I'm able to handle that amount of pressure." Participant 4 outlined her own experiences with this process:

> You know, just like any other new clinician at the beginning, there's a lot of self-doubt, there's a lot of frustration with why am I not seeing more change in my clients, am I making enough of an impact? And because of that, I actually went through a period where I had lot of secondary trauma… And it was because I had these expectations that I should've been able to do more, quicker.

For Participant 8, beginning to experience her own counseling self-efficacy was a significant support in managing her overwhelm. She recalled,

> So seeing the smaller successes and the smaller changes, and regarding those as important as, you know, an overall reduction in symptoms. Because I don't see that, that often. This is complex trauma, years and years of trauma, and it doesn't always go away that quickly. And it's not always as neat and black and white as I might've hoped, you know?

She stated this gradual shift in her expectations for counseling outcomes was a perspective she gained as an important aspect of her professional developmental process.

3.1.5 Interpreter Dynamics

Given the diverse range of cultural backgrounds in refugee communities resettled in the US, clients often present with needs for language interpretation to access mental health support. This theme is defined as participants' experiences in working with an interpreter or a cultural navigator in session with their clients. The subordinate themes related to interpreter dynamics consisted of: 1) the role of the interpreter, and 2) effects of the interpreter on the dynamics of the session.

The Role of the Interpreter. Many participants reflected on the role of interpreters in providing mental health services for refugee clients. Participant 9 described interpreters as a "mouthpiece" for both the clinician and the client, and in order to maintain the therapeutic boundaries of the session, she would have interpreters focus solely on the language content. For other participants, the interpreter's role included cultural consultants, in which the interpreters also served as representatives of the client community and contributed helpful information about clients' experiences before, during, or after sessions. Participant 1 reflected on his process in developing a balance for the role of clinicians and navigators:

> Because navigators sometimes can seem like your co-therapy because they are language brokers, they are cultural brokers. So, they are really useful. I always want my navigator to be my... kind of like a co-therapy… I'm still looking for the balance about that, because they do not have the full mental health training. However, they are experts for language and culture for sure.

Participants' perspectives on the role of interpreters created a spectrum of participation ranging from translators to cultural representatives and experts, and several points of variation between those two ends. Regardless of each participant's perspective, interpreters were recognized as having a central role of importance in the efficacy of counseling services, which Participant 2 outlined straightforwardly, "Without them, no matter how good we are it's not gonna… what's the word? You know… they're like our arms and legs."

Effect of Interpreters on the Adaptation Process. Many participants recalled experiences in which the shift to working with interpreters in session required an adjustment in the counseling approach, which informed their adaptation process. Participant 4 outlined the effect of interpreters on her experience with adapting her counseling approach:

> And being able to consult a lot with our dynamic team, having the perspective of our navigators

> has helped so much and, you know, because it's easy for people who have the privilege of education to be thinking about things in a certain way and then people who are more practical and like in contact with the real things, you know, and not from an academic theoretical perspective but from a lived experience, is helpful.

For Participant 11, utilizing the interpreters to assess how clients were responding to her interventions helped her engage with the trial-and-error process more effectively and, in turn, led to experiences of success, progress toward treatment goals, and greater counseling self-efficacy.

3.1.6 Clients' Strengths and Resilience

This theme is defined as participants' recognition and conceptualization of their clients' personal and cultural strengths, and how those strengths impacted participants' perspectives of their own professional efficacy. As Participant 1 stated, "So, lots of [clients] that just can find their solution… they always can find their solution and find a way to survive." In some cases, recognition of these abilities resulted from clients' success stories as described by Participant 3,

> Another thing I have observed to help me to feel more confident, is that when you see your clients that came to this country the same year as you did with nothing, you know, nothing in their hands. Um, just nothing really… but now, right now they bought their own house, their family lived together. Kids go to college, you know, have stable jobs. They speak English and they have like two cars for the family… Look at their lives, my goodness. It's amazing the progress they have made.

In other cases, participants increased awareness of clients' strengths resulted from clients' self-report of their cultural supports. Participant 2 recalled an experience working with one of her Karenni clients and said the discussion turned to shared experiences of adjusting to cultural norms in the US, "But he [client] was very proud of his community. He was proud that when he needed help with English or money or whatever, he could reach out to his community [of other resettled Karenni refugees in the area]." Participant 2 cited this experience as a pivotal shift in her perception of her clients' understanding of their own strengths.

Participant 7 summarized a dynamic she had encountered several times in her career, in which conceptualizations of refugee communities tended to focus almost exclusively on the vulnerabilities of the community members. She stated she had learned to address this perception with her interns by highlighting their clients' strengths, stating,

> I think that's been very important to me that in addition to talking about the vulnerabilities, just the kinds of growth that happens and the profound amount of strength that anyone needs, anyone has to come here and build again. I try and remind myself to just make sure that I get that across. Cause I think there might be a tendency to only think of refugees as a vulnerable population. Which yes, there are vulnerabilities and there's also, there's just tremendous strength…

3.1.7 Supervision and Consultation Support

This theme is defined as participants' experiences receiving clinical supervision or colleague

consultation during their adaptation process. The subordinate themes related to supervision and consultation support are: 1) supervisor's understanding and knowledge of the unique experiences of working with refugee clients, and 2) validation from colleagues of the challenges involved with providing mental health services to refugee communities.

Supervisor's Understanding and Knowledge of Unique Experiences of Working with Refugee Clients. Participants described their experiences of working with refugee clients as distinct from their other experiences providing mental health support to non-refugee client populations. For these areas of cross-cultural counseling, many participants identified their supervisors' understanding of those unique cultural experiences as key aspects in normalizing their experiences in navigating cross-cultural dynamics. Participant 3 listed her supervisor as a significant support for her experimenting with different counseling approaches with her clients.

My supervisor was very supportive, and she was, she had been working with the population… So, there are many things I wasn't sure what to do and I'll go ask her and then realizing, "Oh, I guess there are different ways to do this rather than the way that, or traditionally that were taught, like being trained on campus, you know, in the academic setting." …They provided me a huge space of flexibility to try different things as long as it's maintained in a professional boundary.

For Participant 3, her supervisor provided a structure for maintaining professional boundaries with which she could explore and develop her own framework to adapt counseling approaches to meet her clients' cultural needs.

Participant 1 described a key factor in his supervision experience was the opportunity to have questions and concerns answered with practical information:

> And those answers, very specific, concrete, and very practical. Just that, I had several different supervisors, and lots of times, unfortunately didn't get very concrete... solutions, and sometimes I need that to have the anchor, to let me know what should I do, yeah.

In Participant 1's experiences, his past supervisors didn't have direct experience with refugee communities to address his specific questions, leaving him to return to a trial-and-error approach without additional support. For many participants, support from culturally experienced supervisors was listed, in Participant 1's terms, as anchor points amidst the otherwise overwhelming and de-stabilizing challenges of adjusting their counseling approaches.

Validation of Challenges from Colleagues. In addition to supervision, several participants listed consulting with other peers who had experience working with refugee clients and were navigating similar challenges as key sources of support. Participant 8 defined her experience working with other MH professionals in her agency as, "A kind of bubble" in which understanding and validation were foundational norms rather than potential areas for advocacy.

Participant 4 also identified her colleagues at the refugee MH agency she interned and currently works as a significant support network for her learning process and professional development:

> I think having a lot of people I trust that I could process it with, like whether that was peers and

> colleagues, you know, other students or interns that I process my experience with and who could offer me perspective and… you know, process. I think that that has really helped so that I am not holding anything too personally, but I'm able to kind of get it out into the ether and examine it and then reabsorb it. You know, in a way that's useful and growth oriented rather than holding me back.

Similarly, Participant 3, who cited nine years of professional experience working with refugee communities, recalled her experiences first joining the field as somewhat isolating for her in terms of a lack of available consultation from colleagues. When asked about what she felt might have been helpful to her in looking back at her initial challenges, she stated,

> Maybe more peer support and people like telling you that this is just going to be that hard. You will get there and you'll be able to help them and things like that. That probably would've been very supportive.

With the groundwork laid from the previous themes of clinicians' own cultural backgrounds, their experiences of academic training, and the challenges and supports of the early stages of their professional development, participants' experiences with the cultural adaptation of counseling approaches emerged as the next theme.

3.1.8 Cultural Adaptations of Counseling Approaches

This theme is defined as participants' experiences of adapting their academic training to fit the cultural needs of their clients. The subordinate themes associated with the adaptation process are: 1) changes in counseling identity, and 2) changes in therapeutic conceptualization.

Changes in Therapeutic Conceptualization. Participants relayed experiences in which their conceptualizations of therapeutic and counseling approaches shifted significantly due to the challenges and supportive processes they underwent in the early stages of their professional careers. Participant 7 described her change in perspective: "But I did notice that the way I did therapy changed… And I've noticed that with my other supervisees who have worked with refugees, they also have noticed how they're… just their way of doing therapy changes." Using the term Western models for therapy, Participant 1, who also identifies as an Asian immigrant:

> For Western mind I will let them know to say that it is okay to feel sad, you're miserable and feel angry, feel guilty. Then, it can be okay to have this kind of feeling. On the Eastern side I say that if you don't feel that to one, that's just okay too.

This view of a Westernized approach was also endorsed by Participant 4. She stated,

> You know, we can expect change to happen in our lives. And some cultures there is less expectation around change. You know, things have been this way for so many generations. Why should we hope for anything to be different? And you know, Western conceptualization we might think of as like learned helplessness.

In this case, Participant 4, who identified as a Caucasian American, discussed her perception of her clients' cultural norms of acceptance versus more Western views of empowerment and change and how

she needed to adjust to those cultural differences.

Changes in Professional Counseling Identity. In addition to changes in conceptualizations of therapeutic approaches, many participants also iterated the impact that working with refugee communities had on themselves, directly, in terms of their perceptions of their own professional identities. Participant 2 described a change in her perception as: "The biggest distinguisher is when I work with refugee clients, I really feel like I'm working with the community. It's not just one individual or one family. I feel like I'm really part of this community."

Participant 9 discussed the changes in her counseling identity as one that grew to incorporate a wide range of roles, and that often started with exploring her clients' conceptualization of her as a therapist:

> So someone from Burma, I may not even use the words, 'mental health' or 'therapist.' I might just describe what I do. So I might say "I'm someone who you can meet with regularly and develop a relationship with, and I can help you with how you're feeling. So if you're sad or worried or can't sleep or remembering things that might've been scary, or...." …And so I might present it like that and then ask them how they feel about working with someone here in America. And honestly, most of them are like, please, it just helped me cause I offer them an interpreter too. And they recognize that they might benefit. So that's how I start.

3.1.9 Counseling Self-Efficacy

This theme is defined as the development of a secure professional identity associated with working with refugee communities after having initially experienced self-doubt, feelings of low self-efficacy, and overwhelm during the early stages of the adaptation process. The subordinate themes of counseling self-efficacy are: 1) recognizing failure as a learning process instead of a barrier, 2) increased therapeutic flexibility, and 3) confidence in therapeutic abilities.

Recognizing Failure as a Learning Process. Several participants identified perceptions of challenges during sessions contributing to a sense of failure; however, perception of those experiences shifted toward being essential to their learning process. Participant 5 discussed this shift in perception.

> What helped me I think first to go through the emotion of pain, disappointment, you have to fail, but either you fail forward successfully or backwards, it's your choice. And, you know, like I... so my choice is to fail successfully, you know, to learn from my mistakes. So, reflect like with, from whatever client, whatever, what I learned from it, you know, what worked, what didn't work.

Participant 11 analogized experiences of therapeutic failures with clients as a developmental difficulty in adjusting to the cultural complexities of clients' unique experiences. She stated, "You still need to learn, of course you still need to evolve, but if you can sit with, you can sit comfortably with complexity, I think that that's a good indicator that you found your footing, you found your grounding."

Increased Therapeutic Flexibility. Participants also described a consistent theme of increased flexibility in their ability to work therapeutically with clients. When asked about differences he noticed between

his earlier work experiences and his current approach to working with refugee clients, Participant 1 said, "I feel much more flexible, and I feel more comfortable what's my boundary about." Participants also identified flexibility as a natural product of the cultural adaptation process and of learning to adjust to clients' cultural needs. Participant 8 described arriving at this perspective as a part of letting go of expectations for how mental health service provision is "supposed to" look. She described her view as,

> I think that just being flexible and open-minded is the best approach that you can take. So really giving up on the idea that it's going to go the way that you expect it to go, or you want it to go. That, I think, is the key to being able to do this work effectively, or to not go crazy trying to do this work.

Confidence in Therapeutic Abilities. Participants described consistent experiences of confidence in their abilities to work effectively with their refugee clients. As Participant 3 said, "But then after doing this job for a couple of years and all the things that I learn, these things kind of start coming together in your head. And, you have that." For Participant 11, developing confidence in her therapeutic abilities did not imply that struggles with clients' cultural dynamics or with clients' diverse range of presenting concerns no longer occurred. Instead, she recognized an increased comfort with those challenges as an important step in her sense of self-efficacy. However, she also clarified that her increased confidence did not imply she felt her developmental process was complete: "…I don't think that I've arrived, but I will say I am more comfortable with the work. Like I don't have the same anxieties that I remember having in grad school."

Participant 1 defined his developmental process as learning to work more comfortably with interpreters, expanding his role as a therapist to include aspects of case management, and becoming more flexible in the application of traditional models for therapy. He described his current perception of his counseling abilities as,

> However, somehow, I just know that I feel much more comfortable working with this population. Or in this style, of the style of counseling or therapy model; like, interpreting and working more closely with the case management combined with the skill training and the traditional psychotherapy.

Similar to Participant 11, Participant 1 felt his learning process was a continual one, and that he was always exploring new ways to enhance his work, stating, "…even today I feel much more comfortable and confident to use this approach. At the same time, I still continue to pressure myself: where's the boundary? And where is it ethical?"

4. Discussion

The experiences of clinicians culturally adapting counseling treatments for refugee clients involved many areas of challenges and supports throughout their academic training, and post-graduate work experiences, which followed a developmental trajectory from feelings of low counseling-self-efficacy in the early stages of the process, to feelings of more stable professional identities in later stages. The

present study explored those experiences of MH service providers and found nine superordinate themes: 1) participants' cultural identities, 2) influences of academic training and internship, 3) experiential learning through trial-and-error, 4) vicarious trauma, 5) interpreters dynamics, 6) clients' strengths and resilience, 7) supervision and consultation support, 8) cultural adaptations of counseling approaches, and 9) counseling self-efficacy. Eight of the nine subordinate themes had associated subordinate themes.

The literature on counseling self-efficacy draws a direct and predictive relationship between clinicians' sense of self-efficacy and their knowledge of evidence-based practices (Schiele et al., 2014). The lack of evidence-based resources and higher use of trial-and-error approaches may result in higher perceived failures and perceptions of reduced quality of services when working with refugee clients, further decreasing perceived self-efficacy (Schiele et al., 2014). Low counseling self-efficacy has also been linked to experiences of vicarious trauma, and the stress, exhaustion, and overwhelm from professional burnout, which further impacts self-efficacy in a cyclical pattern (Isawi & Post, 2020).

Participants' experiences of vicarious trauma, stress and exhaustion are extensively documented in the literature of clinicians working with clients with high rates of complex trauma, as found in refugee communities (Kim, 2017; Puvimanasinghe et al., 2015; Sui & Padmanabhanunni, 2016). One aspect of participants' experiences involved the activation of symptoms from their own histories of trauma, as in the case of participants with refugee backgrounds themselves. For MH service providers working with refugee clients, due to the high prevalence rates of trauma in those communities (Mellor et al., 2021), the risk factor for vicarious trauma experiences increases (Sui & Padmanabhanunni, 2016).

Through the range of perceptions of the interpreters' role in sessions, the literature also highlights the impact of interpreters on the outcome and cultural adaptation process of services in cross-cultural MH service provision (Fenng & Denov, 2021). In this area, participants discussed the central role of interpreters as supports in their progression towards providing more effective services. Here, interpreters were utilized as a resource to increase clinicians' cultural knowledge and awareness, served as a significant element in participants' experiences of treatment success with their clients, and therefore contributed significantly to their counseling self-efficacy.

As participants discussed experiences of support in their professional developmental process, the theme of clients' strengths and areas of resilience was consistently endorsed. Complimentary to the extensive literature on vicarious trauma, research has also paid substantial attention to resiliency factors for clients who have experienced significant trauma in their lives (Blount & Acquaye 2017), indicating the literature supports the strengths and resiliency-based approaches endorsed by participants of the current study. Liu et al., (2020) investigated the direct experiences of newly arrived refugees' perception of their own areas of resiliency. Furthermore, in their study on Nepali Bhutanese refugees' experiences of resilience, Spatrisano et al. (2020) outline a model of resilience which includes clients' cultural supports, such as community and spirituality, navigation and negotiation of resources, and exposure to adversity as central components of refugee survival experiences. Several participants relayed

acknowledgment of these areas of their clients' stories as a key shift in their conceptualization of clients, resulting in a reduction in stress caused by feelings of high need and responsibility for the clients' wellbeing, and therefore also a reduction in exhaustion and overwhelm.

Research on supervision styles provides support for participants' experiences, with findings indicating a direct connection between satisfaction with supervision and trainees' sense of self-efficacy (Fernando & Hulse-Killacky, 2005). This connection may be further moderated by supervisors' MCC competency, especially when trainees work cross-culturally (Crockett & Hays, 2014). For many participants, their peers and colleagues also contributed significantly to the normalization, validation, and contextualization of their cross-cultural experiences, though research efforts have not yet examined this aspect of MH providers working with refugee communities.

The literature also indicates supervisors can be a pivotal and influential source of support in mitigating the impact of vicarious trauma for counselors working with refugee clients (Long, 2020). Participants described their supervisors as instrumental in their attempts to adjust their cultural awareness, boundaries, and clinical adaptations, which allowed them to develop more effective approaches to working with clients, enhancing their work-satisfaction and increasing their professional self-efficacy.

Recent research on MCC supervision also emphasizes the importance of including social justice in supervision models. In their study, Dollarhide and colleagues (2020) outline a model of MCC supervision in which intentional and purposeful explorations of the social justice aspects of their clients' experiences are incorporated into the supervision relationship. Given refugee communities are frequently faced with challenges of low access to resources, discrimination, and cultural segregation resulting from the lack of support in local and national societal systems (van der Boor et al., 2020), the social justice model of MCC aligns with the perspectives shared by participants.

Advancements in research continue to find support for the centrality of cultural frames of experience on presentations of mental health related symptoms (Faregh et al., 2019; Jarvis & Kirmayer, 2021; Vance et al., 2017), especially in conditions of acculturation which are core aspects of the refugee resettlement process (Mellor et al., 2021). With these cultural frames continuing to gain prominence in mental health conceptualizations and treatment approaches, participants' experiences of trial-and-error approaches to adaptation further reinforce the need for evidence-based adaptation frameworks specific to refugee cultural dynamics. Recent literature reviews continue to support the clinical utility of cultural adaptations (Degnan et al., 2019; Naseh et al., 2019; Turini et al., 2019), indicating participants' trajectory through the cultural adaptation process toward greater counseling self-efficacy is aligned with research findings.

As many clinicians resorted to teleconference software platforms to maintain treatment with their clients during the global COVID-19 pandemic, the need for cultural adaptations utilizing technological resources has become especially highlighted. A recent study on cultural adaptations using internet-related formats with resettled refugee communities in Germany (Spanhel et al., 2019) has relevance to some of the adaptation challenges involved with the COVID-19 mandated restrictions of

the 2020-2021 year. Adaptation research in the modern era is therefore more likely to include these digital formats as part of standard practice in working with clients, with applications for refugee communities as well.

As participants discussed their developmental trajectories from experiences of inefficacy to more confident professional identities, flexibility was identified as a prominent theme related to their experienced increase in counseling self-efficacy. Flexibility has been identified in the literature as a component of vicarious resilience (Puvimanasinghe et al., 2015), indicating participants' descriptions of increased flexibility may also be a factor in reducing stress related to their experiences of vicarious trauma when working with their refugee clients.

The findings of Isawi and Post's study (2019), which directly examines self-efficacy in counselors working with refugee clients, also support the role of self-efficacy in reducing vicarious trauma experiences. Other research has indicated that reduced vicarious trauma is related to an increased focus on clients' strengths (Roberts et al., 2018). Participants' descriptions of confidence in counseling abilities developed in later stages of their development process may directly connect to reduced stress and overwhelm from earlier stages. With research findings supporting the inverse relationship between stress experienced by counseling trainees and counseling self-efficacy (Lanin et al., 2019), participants' developmental experiences working with refugee clients also match other elements of counseling training stages.

4.1 Limitations and Implications for Future Research

A limitation of this study is that data provided by participants conveyed experiences of their clients' unique stories and perspectives and the experiences of the interpreters with which they worked. Through sharing their understanding of these client and interpreter stories, participants expressed great empathy and gratitude for the opportunity to be a part of their clients' lives and for the support they received from interpreters. However, these experiences only provide a second-hand understanding of the direct, lived experiences of people from refugee communities, whether clients or professional interpreters. Though the scope of this study was limited to the perspective of MH service providers, the experiences and perspectives of people directly undergoing the refugee process are an important topic with a great deal of urgency. Exploring these experiences further necessitates the inclusion of refugee voices. While second-hand accounts from service providers are compelling, it is recommended that the direct perspectives of people experiencing forced displacement and acculturation stress be included in the conversation for future studies.

4.2 Conclusion

The clinicians interviewed for this study offered suggestions for current or future trainees considering a career in mental health service provision for refugee communities. Recommendations included deliberate inclusion of refugee and immigrant client experiences in course material, a reflective examination of the influence of cultural identities on academic and professional cultural experiences, and program level support and understanding of the unique cultural challenges of minority students'

experiences in the academic environment. When discussing how her work with refugee communities fits into the field, Participant 4 advocated for profession-wide changes to increase the inclusion of the refugee experience in counseling psychology. In discussing the need for recognition of refugee communities' unique experiences, and clinicians who are navigating the path from academic training to cultural adaptations and counseling self-efficacy, Participant 4 stated definitively,

But valuing it for what it is; this perfectly fits within our field of psychology. This is something that we should be doing as a field, supporting people with just these incredible lists of trauma in their lives, and adaptations and adjustment. Like we as a field have an absolute responsibility and I think that we need to start seeing it that way versus seeing it as some novelty area of interest.

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