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Refugee Experiences of Counselling and Psychotherapy

by

Christopher William Marusiak

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Abstract

This study explored former refugee clients' perspectives of psychotherapy, namely their reasons for seeking counselling, conceptualization of their presenting problems, experiences in psychotherapy, and aspects of counselling that were considered helpful in facilitating therapeutic change. Eliciting client perspectives added a critical element to the ongoing discourse regarding helpful therapeutic processes among refugees, which has been largely dominated by theorists, researchers and practitioners rather than actual service utilizers. Four refugees (1 from Zimbabwe, 1 from Nigeria, and 2 from Bosnia-Herzegovina) participated in in-depth interviews in this qualitative interpretive inquiry. Refugees were recruited from settlement agencies and refugee treatment centres. The participants had diverse migration trajectories and experiences and had resided in Canada for a minimum of three years. Each had participated in long-term counselling which addressed issues relating specifically to their pre-migration or resettlement experiences.

Since interpretive inquiry is an emergent design, it appeared most effective to represent participants' interview disclosures and their ideas about counselling through detailed narratives and analysis of these narratives. Several themes emerged from this analysis and were grouped into four categories. Therapeutic Goals highlighted the importance of client-congruent treatment goals to assist in restabilizing the client's life through symptom relief as well as by addressing immediate concerns and life challenges. Therapeutic Tasks were the tasks perceived to be helpful in attaining these goals, which included looking at

the past, directive interventions including advocacy, advice and direct assistance with key life tasks, and developing confidence for the future. The importance of strong Therapeutic Relationships was emphasized by each participant, and was developed through mutual understanding, a positive interpersonal connection and sharing expertise to overcome challenges. Finally, a Counselling Setting which is both accessible and safe was reported as helpful. Clinical implications of this research included recommendations for organizations (including establishing the credibility of the program within the refugee community; fostering contacts within the community; maintaining continuity of care and providing easy access to the program) as well as recommendations for therapy (including the importance of addressing continuing resettlement/safety needs; providing a directive, needs-based approach; providing flexible treatment options; and communicating empathy).

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CHAPTER 1: INTRODUCTION

War, civil unrest, political persecution, and ethnic cleansings affect millions of lives worldwide (United Nations High Commissioner for Refugees [UNHCR], 2010). In 2010, an estimated 43.3 million people were forcibly displaced from their homes and homelands due to conflict and persecution (UNHCR). Of these, 10.5 million became refugees. As defined by the United Nations (1951), a refugee is an individual who is forced to leave his or her country of origin based on a "well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion" (p. 16). This definition has since been extended to include those individuals who are forced to leave their home country due to war or civil conflict (UNHCR, 2003).

In contrast to immigrants who relocate voluntarily based on the perceived opportunities afforded in Canada, refugees are forced to depart from their homeland (Berry & Kim, 1988; Gonsalves, 1992). If given the choice, most refugees would prefer to stay in their home country (Stein, 1986; Williams & Berry, 1991). Recent national population statistics indicate that approximately 1 of every 10 people immigrating to Canada claims refugee status, averaging approximately 25,000 individuals searching for sanctuary in Canada each year (Citizenship and Immigration Canada [CIC], 2010; Statistics Canada, 2011). These numbers represent between 6-10% of the world's refugees, with Canada ranking among the top 5 countries receiving new asylum-seekers in 2010 (UNHCR, 2011).

Due to conditions in their countries of origin as well as conditions of exodus, many of the refugees entering Canada will have endured significant premigration trauma, such as incarceration and forced participation in re-education camps, personal injury and torture, witnessing the torture and killing of others, and the often sudden or violent separation from family members (Arthur, Merali, & Djuraskovic, 2010; Johnson & Thompson, 2006; Mollica, 2006). Significant challenges continue after resettlement as refugees experience the added stressors of adapting to an alien culture, learning a new language, and the simultaneous loss of valued family and community support, employment, and financial resources (Arthur et al.; Bemak, Chung, & Pederson, 2003; Birman & Tran, 2008; Prendes-Lintel, 2001; Yakushko, Watson, & Thompson, 2008). While many refugees demonstrate incredible resiliency in overcoming these numerous premigration and resettlement obstacles (Beiser & Hou, 2001; Witmer & Culver, 2001), the experiences endured throughout the refugees' history can have a lasting psychological impact that may continue for years after resettlement (Beiser & Hou; Fenta, Hyman, & Noh, 2004; Lie, 2002; Murray, Davidson, & Schweitzer, 2010), and result in unique mental health needs (Bemak et al.; Palic & Elklit, 2011; Rousseau & Drapeau, 2004).

The ability of refugees to successfully rebuild their lives depends in part on the nature and quality of governmental and social policies, resettlement and support programs, and mental health care services (Bemak et al., 2003; Murray et al., 2010; Pernice, 1994). The appropriateness and effectiveness of these policies and programs, in turn, depends to a large extent on knowledge obtained through

research studies which may provide justifiable grounds on which to base policies and services (Mollica, Cui, McInnes, & Massagli, 2002; Pernice; Vasilevska, Madan, & Simich, 2010). Partially in response to these policy and program development needs, the number of refugee-related research articles has increased several fold over the last 25 years (Ingleby, 2005).

Unfortunately, much of the current refugee psychotherapy literature has ignored client insights and perspectives of counselling in favour of therapist outlooks (Kramer, 2005). For example, studies have focused primarily on alleviation of posttraumatic stress symptoms as the principal indicator of therapeutic success (Palic & Elklit, 2011; Offet-Gartner, 2005; Ponterotto & Casas, 1991), whereas refugees seeking counselling may expect resettlement stressors and needs to be addressed for intervention to be successful or helpful (Hwang, 2006; Sue & Sue, 2008; Summerfield, 1999). Also the majority of treatment and intervention strategies used with refugees have been generated from Western theories of mental health and healing (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008; Murray et al., 2010; Palic & Elklit; Ponterotto & Casas; Sue & Sue; Summerfield), which may be incompatible with refugees' beliefs, values, and worldviews (Atkinson & Lowe, 1995). Western approaches may not be consistent with the refugees' views regarding the causes of their current problems or challenges, or considered culturally appropriate ways of promoting healing. Similarly, existing treatment paradigms are based on assumptions that certain processes and interventions, such as re-telling the trauma story and changing one's beliefs about adverse life experiences, are particularly therapeutic

or beneficial, while it is currently unknown what refugees perceive as therapeutic or beneficial in counselling.

The lack of attention to refugee clients' perspectives is a serious omission as existing research has found that client perceptions of counselling are more accurate indicators of therapeutic effectiveness and outcome than therapist perspectives (Bachelor, 1991; Levitt, Butler, & Hill, 2006; Norcross, 2010). Similarly, client perceptions can inform the development of culturally sensitive treatments to assist refugees with their recovery, and contribute to the body of knowledge pertaining to effective psychotherapeutic processes (Gonsalves, 1992; Kramer, 2005). While it is becoming increasingly clear in mainstream research that client perspectives are essential to the development of effective programs and services (Heppner, Rosenberg, & Hedgespeth, 1992), the client's voice continues to remain silent in refugee research (Kramer).

Purpose of the Study and Overview

The purpose of this qualitative inquiry is to explore the experiences of an ethnically mixed sample of refugees who have previously sought counselling for problems related to their premigration and resettlement challenges. Specifically, this study will explore the refugees' perspectives regarding their reasons for seeking counselling and how they conceptualize their problems, how they experience counselling in general, and what aspects of counselling were helpful or beneficial in facilitating therapeutic change. Ultimately, it is hoped that this study will lead to a better understanding of how refugees perceive psychotherapy in

order to inform current treatment strategies and assist refugees with their recovery.

The remainder of the introduction section will review common refugee experiences spanning premigration through resettlement, as well as the mental health concerns that may arise out of these experiences. The literature review chapter that follows explores existing research in three main areas relevant to this study. First, current refugee treatment approaches will be described, including their underlying assumptions about processes and counselling techniques that promote client change and their effectiveness with various refugee populations. Second, refugee process research, or research addressing how therapy works, will be presented. This review will include a discussion of the helpful or therapeutic components of counselling as generated by refugee researchers, scholars, and practitioners, including conceptualizing the problem in a way that is congruent with client beliefs, employing interventions which are consistent with client expectations, and maintaining a positive therapeutic relationship. Third, mainstream research on the importance of incorporating client perspectives into counselling process research will be addressed to highlight the need to involve refugees in understanding counselling interventions employed among refugee populations. These three topics are subsequently integrated, leading to the statement of the problem and the research questions. The methods chapter outlines the research design and its philosophical and theoretical underpinnings, as well as the specific methods used to answer the research questions. The criteria for evaluating this study will also be presented. Chapters 4 and 5 will present

narratives of participants' experiences in counselling and emerging themes reflected in their stories. Finally, the discussion chapter will situate the findings of this study within existing literature and identify ways in which the research contributed to new discoveries on how to facilitate refugee well-being and adaptation during the resettlement process. Implications for psychologists, limitations of research findings, and considerations for future research will also be outlined.

The Refugee Career

To effectively work with culturally diverse groups, it is necessary to understand their unique historical, cultural, social, and political realities (Sue & Sue, 2008). In understanding the unique perspective of refugees, it is important to know both their cultural and ethnic heritage (Sue & Sue), as well as their status as political refugees, the conditions which resulted in their forced migration, conditions of exodus, and resettlement experiences (Bemak & Chung, 2008; Bemak, Chung, Bornemann, 1996; Hernandez, 1996). Berry used the term *refugee career* to describe the series of events faced by refugees who fled their homes in search for asylum (as cited in Prendes-Lintel, 2001). The refugee career consists of six stages, spanning from the situations leading to their forced displacement, to their eventual settlement and adaptation to the new country and culture. These stages include: (a) *Predeparture*, or the period of war, trauma, or political unrest from which the refugees are fleeing; (b) *Flight*, when the refugees leave their home and begin the journey to find asylum; (c) *First Asylum*, when the refugees first arrive at a place of asylum, usually a refugee camp; (d) *Claimant*,

when the refugees arrive at the country of potential resettlement and apply for refugee status; (e) *Settlement*, when the refugees are formally accepted to the new society, including the potential for citizenship; and (f) *Adaptation*, when the refugees make satisfactory adaptations and settle into routine lives (Prendes-Lintel).

Predeparture

Refugees entering Canada form a rich cultural mosaic representing diverse regions throughout the world. In 2010, South and Central America accounted for on average 18% of new Canadian refugees, Asia and the Pacific accounted for 27%, Africa and the Middle East accounted for 45%, Europe accounted for 5%, and the United States accounted for 4% (CIC, 2010). However, these percentages fluctuate from year to year reflecting changing global conditions, shifts in international crises and changing needs of the various geographical regions (CIC, 2010). For example, in 1996 following the war in Bosnia-Herzegovina, individuals from this country represented the largest refugee group entering Canada at 20% (CIC, 1996). In comparison, Africa and the Middle East represented the largest source region for refugees entering Canada in 2010 (CIC, 2010).

While refugees represent numerous countries with diverse cultures, religions, customs and beliefs, they share many common premigration experiences (Bemak et al., 2003). Trauma is defined as an event involving "threats to life or bodily integrity, or a close personal encounter with violence and death", which evokes feelings of "intense fear, helplessness, loss of control, and

threat of annihilation" (Herman, 1992, p. 33). During premigration and conditions of civil war, foreign occupation, political violence, and other social turmoil, refugees are repeatedly exposed to significant traumatic events including: personal injury, imprisonment and rape; and witnessing genocide, mass violence, and the execution or kidnapping of family members (Mollica, 2006; Mollica, Wyshak, & Lavelle, 1987; Regel & Berliner, 2007).

The use of torture is widespread across the globe (Baker, 1992; Engstrom & Okamura, 2004), in what has been described as a "modern epidemic" (Silove, Tarn, Bowles, & Reid, 1991, p. 481). Although there are international attempts to stop the use of torture (Amnesty International, 2011), it continues to be practiced in more than a third of the world's countries (Amnesty International; Engstrom & Okamura; Van Velsen, Gorst-Unsworth, & Turner, 1996). Refugees are one of the groups who are most likely to have suffered torture (Engstrom & Okamura); it is estimated that up to 35% of the world's refugees have been tortured (Baker, 1992; Kleijn, Hovens, & Rodenburg, 2001). Compared to all other forms of trauma, the effects of torture are particularly insidious, and negative mental health outcomes are typically more severe and long lasting (Jaranson et al., 2004; Lie, 2002; Silove et al., 1991; Van Velsen et al.). Several elements of torture may accentuate its impact on the mental health of the survivor: the abuse is deliberate, and the perpetrators use methods that maximize fear and debility in the victim; the trauma is inescapable, uncontrollable and repetitive; and feelings of guilt, anger, and humiliation tend to erode the victim's sense of security, integrity, and self worth (Silove, Steel, McGorry, Miles, & Drobny, 2002; Van Velsen et al.).

These events that lead up to forced departure can be characterized by an overriding factor of fear and helplessness (Westermeyer, 1990). Most refugees understand the difficult experiences likely to ensue following the escape from their homeland. Many are well-educated and have been successful professionals, businesspeople, or otherwise valued and respected contributors to their community. Most have highly valued social connections and friendships with strong family and extended family ties. Still, these individuals and families feel the need to flee rather than chance the alternatives of remaining in the chaotic conditions of their home countries (Westermeyer).

Flight

The flight phase is characterized by profound loss as refugees are forced to leave family, friends and possessions (Cravens & Bornemann, 1990), and uncertainty, as the refugees often do not know where they will go or what will happen next (Prendes-Lintel, 2001). The conditions which lead to their forced departure often continue through the period of exodus. Throughout this phase, refugees continue to endure many hardships such as deprivation of food and starvation, violence, abuse and rape, as well as the ongoing risk of capture, injury, and death (Arthur et al., 2010; Marsella, Bornemann, Ekblad, & Orely, 1994; Mollica, 2006). Forced exile also leads to isolation, loss of social support, and separation from nuclear and extended family systems (Nicholl & Thompson, 2004). While physical separation from family members and loss of social support is a characteristic of most immigrant families, the separation among refugee

families is more sudden, unpredictable and violent, with a much more uncertain outcome (Chambon, 1989).

First Asylum

The place of first asylum is most often the nearest refugee camp or settlement, which is operated by the UNHCR, the host government, or other non-governmental organizations (Clinton-Davis & Fassil, 1992; Prendes-Lintel, 2001). While refugee camps for some may truly be places of asylum (Cravens & Bornemann, 1990), for others, there are new problems to be overcome including insufficient water and food supplies, poor sanitation, overcrowding and inadequate shelter, limited medical resources, separation from family members, and continued violence (Clinton-Davis & Fassil; Cravens & Bornemann; Marsella et al., 1994). Serious physical health concerns including tuberculosis, malaria, skin lesions, measles, venereal diseases, cholera, meningitis, hepatitis, HIV and AIDS, leprosy, intestinal parasites, and anemia, are also widespread within many refugee camps (Bemak et al., 2003). Malnutrition is a particularly devastating problem in refugee camps (Leopold & Harrell-Bond, 1994), and is the highest cause of death among refugee children (Clinton-Davis & Fassil). Mental health concerns and social problems are also prevalent within refugee camps, with many individuals exhibiting self-destructive and violent behaviour, high rates of alcohol and drug abuse, and depression and anxiety (Clinton-Davis & Fassil; Cravens & Bornemann; Kamau et al., 2004).

A study by the UNHCR highlighted the desperate situation that many refugees in these camps find themselves in. These persons have no immediate

prospect of a solution to their plight. They cannot integrate into the local society or participate in the local economy and the persistent conflict and violence in their homeland precludes the possibility of repatriation (as cited in Clinton-Davis & Fassil, 1992). Unfortunately, it is in these settlements where the majority of refugees continue to live, with some refugees enduring life in a refugee camp for 7 to 17 years (UNHCR, 2010). In 2006, the world reached the highest numbers of internally displaced persons in global history, reaching 23.7 million (Executive Committee of the United Nations High Commissioner for Refugees, 2007).

Claimant

Refugee claimants, or asylum-seekers, are those individuals who request refugee protection upon or after their arrival in Canada (CIC, 2004). The refugee claimant process is lengthy and complicated, often taking two years for a permanent residency application to be completed (Lacroix, 2004; Rousseau et al., 2002). The results of these applications are not always successful; many refugee claimants (approximately 54%) are turned back to their home country where they face the possibility of imprisonment, torture, or death (UNHCR, 2005).

The claimant phase is characterized by intense uncertainty due to the very real possibility of deportation (Prendes-Lintel, 2001). Additionally, during the claimant process refugee claimants have limited access to employment, education, social welfare and health services, and are often separated from their immediate and extended families (Arthur et al., 2010; Lacroix, 2004; Mollica, 2006). This insecure asylum status has a significant impact on the mental health of refugees, and depression or other mental health concerns are not uncommon among

asylum-seekers (Heptinstall, Sethna, & Taylor, 2004; Kennedy & Rogers, 2009; Yakushko et al., 2008).

Settlement

During the claimant and settlement stages, the refugee is first introduced to the new culture and society of the host country (Prendes-Lintel, 2001). Many refugees face considerable challenges entering into mainstream Canadian society and effectively adapting to the world around them, even when compared to other immigrant classes (i.e., economic and family class; CIC, 2006). For example, the unemployment rate for refugees in Canada six months after arrival was 52%, compared to 31% for principal applicants of economic-class immigrants and 34% for family class immigrants. Three years after arrival, the gap in unemployment between refugees and other immigration categories narrowed, with refugees at 30% unemployment, and principal applicants of economic-class immigrants and family class immigrants at 13% and 21% unemployment, respectively. However, high unemployment rates three years after landing indicate that recent immigrants still face barriers to finding employment (CIC).

Refugees and other immigrants indicated that lack of job experience in Canada, language problems, and difficulties in transferability of foreign qualifications, were the primary reasons for the difficulty securing employment (Arthur et al., 2010; CIC, 2006), with 71% of refugees experiencing difficulties finding work (CIC). These challenges lead to underemployment or employment in fields outside of the refugees' training acquired in their country of origin (Guarnaccia, 1997; Ho, Rasheed, & Rasheed, 2004). The ultimate result of these

difficulties is downward mobility and a marginalized socio-economic position within mainstream society (Bemak et al., 2003; Clinton-Davis & Fassil, 1992; Hernandez, 1996; Reitz, 2001).

Refugees' premigration experiences may compound resettlement challenges. Tran (1993) observed that Vietnamese refugees who experienced more premigration trauma also experienced greater acculturative stress in terms of difficulties learning English, finding jobs, and otherwise navigating through the host society. This finding highlights the complex interaction between trauma and resettlement stressors. For example, it has been consistently observed that trauma interferes with the capacity and ability of survivors to function in social, occupational, and economic spheres (Engstrom & Okamura, 2004). Silove et al. (2002) found that refugees' recollections of distressing premigration events interfered with the acquisition of new work-related skills.

Specific challenges also occur as refugees begin to interact with a new and often alien culture. Upon settling in Canada, refugees face the challenging task of adjusting to a new cultural climate that is very different from their own in terms of beliefs, behavioural norms, social and familial structures, religious or spiritual beliefs, and communication styles and norms (Sue & Sue, 2008). Acculturation refers to the process of change that occurs along these various levels (i.e., language, beliefs, behavioural norms, social and familial structures, etc.) as individuals of one culture come in contact with another cultural group (Berry, 2001; 2006). The stress that can arise during this cultural transition process is referred to as acculturative stress (Donà & Berry, 1994), and can result in mental

health concerns (particularly anxiety and depression), feelings of marginality and alienation, and may underlie poor adaptation and problems in daily life (Berry, 1992; 2006). In addition to acculturative stress, refugees may experience cultural bereavement, or the grief that is produced by "massive social loss", such as that caused by forced resettlement and uprooting (Eisenbruch, 1991, p. 674).

The settlement phase is also associated with the loss of valued community and social support, and continued separation from nuclear and extended family systems (Nicholl & Thompson, 2004). This is especially significant as social and family supports are considered to be among the most important factors in restoring social functioning and moderating the effects of premigration trauma (Al-Issa, 1997b; Beiser & Hyman, 1997; Emmelkamp, Komproe, Van Ommeren, & Schagen et al., 2002; Lyons, 1991). Social alienation may be heightened by racism and discrimination experienced in the host society. Prejudice and discrimination may negatively affect employment opportunities and access to community services (Arthur et al., 2010), thereby aggravating the already difficult social and economic transitions faced by newcomers.

Language also plays an integral role in refugee adjustment (Beiser & Hou, 2001; Bemak & Chung, 2008). Lack of language competency is a major barrier to employment and educational opportunities, and may heighten the loss of social and economic status (Arthur et al., 2010). Additionally, lack of English language ability compromises access to community, mental health and other support services, and limits options to participate in other important aspects of civic life (Beiser & Hou, 2001). The actual process of learning a new language presents

additional difficulties. For example, challenges learning the official language may exacerbate emotional difficulties and result in feelings of inadequacy and low self-esteem, and serve as a catalyst for feelings of cultural identity loss (Bemak et al., 2003).

In 2010, approximately 59% of the refugee population living in Canada had some knowledge of at least one of the official languages, while 41% knew neither English nor French. In comparison, 91% of the economic-class immigrants (who are granted permanent residency status based in part on their English or French language abilities) had some knowledge of either English or French (CIC, 2010). Language acquisition can be a long-term process: approximately 8% of refugees still speak no English a decade after their arrival in Canada (Beiser & Hou, 2001).

Adaptation

Through the traumatic premigration and migration experiences to the challenges of resettlement and acculturation, refugees display remarkable resilience and ability to adapt (Beiser & Hou, 2001; Stein, 1986; Witmer & Culver, 2001). During resettlement, refugees generally show a common pattern of adjustment and are able over time to successfully adapt to the new culture and rebuild their lives (Djuraskovic & Arthur, 2009; Donà & Berry, 1994; Prendes-Lintel, 2001). Two primary factors appear to facilitate positive refugee adjustment. First, the amount of community support received by refugees is a strong determinant of refugee well-being (Emmelkamp et al, 2002; Simich, Beiser, & Mawani, 2003; Vasilevska et al., 2010). For example, Southeast Asian

refugees who were received in Canada by established communities of similar cultural background demonstrated significantly fewer mental health concerns when compared to individuals with no such community support (Beiser & Hyman, 1997). Conversely, the breakdown of social support and kinship ties is a significant risk factor for mental health problems among refugees (Fazel, Wheeler, & Danesh, 2005; Gorst-Unsworth, & Goldenberg, 1998; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). The second important factor appears to be family support. Because family relationships are important sources of support (Beiser & Hyman; Goodman, 2004), refugees who remain connected to their families during the refugee career have fewer mental health concerns (Al-Issa, 1997a; Vaslivska et al.). This is particularly true among refugee children and adolescents who are in formative stages of development (Goodman; Heptinstall et al., 2004; Tousignant, 1997).

Nevertheless, the experiences endured throughout the refugee career can have a lasting psychological impact that continues for years after resettlement (Beiser & Hou, 2001; Carswell, Blackburn, & Barker, 2011; Fenta, Hyman, & Noh, 2004; Lie, 2002; Mollica, 2006). In addition to the long-term sequelae of traumatic experiences, new losses may also occur during this stage. For example, refugees may learn of the traumatic death of a loved one in their home country, or experience continued racism and discrimination (Van Der Veer, 1995).

The refugee career is not the same for all people. Some refugees may not pass through all six stages, and differing combinations may occur. Similarly, the refugee career has no set time frame; it can range from days to years (Prendes-

Lintel, 2001). Most importantly, there is not a direct correlation between the experiences during the refugee career and mental health consequences. While it may be helpful for the clinician to understand the characteristic psychological experiences and social problems that accompany the refugee career, it is most important to understand an individual's perspective on his or her refugee experience and the meaning attributed to these events (Bemak et al., 2003; Prendes-Lintel).

Mental Health Concerns

The refugee experience is characterized by a breakdown of cultural, social, and familial structures, the systematic violation of human rights and exposure to trauma, and the burden of resettling in a foreign culture (Bemak et al., 2003; Clinton-Davis & Fassil, 1992; Farias, 1994; Murray et al., 2010; Palic & Elklit, 2011). The entire refugee career can be described as an enduring and cumulative process of traumatic and stressful life experiences (Van Der Veer, 1995). As a result of the continual and prolonged exposure to these events, refugees are often considered to be at increased risk for mental health concerns (Bemak et al., 2003; Cohon, 1981; W. L. Hinton, Tiet, Tran, & Chesney, 1997; Orley, 1994; Rousseau & Drapeau, 2004).

Most frequently, refugee problems are described in terms of posttraumatic stress disorder (PTSD; Bemak et al., 2003; Murray et al., 2010; Renner, Banninger-Huber, & Peltzer, 2011; Summerfield, 1999). According to the current Diagnostic and Statistical Manual of Mental Disorders fourth edition, text revision (DSM-IV-TR; American Psychiatric Association [APA], 2000) upon

which mental diagnoses in Canada are based, the diagnostic criteria for PTSD are: (a) the exposure to an event that involves threatened death, serious injury, or threat to the physical integrity of a person, or learning about the unexpected death or serious injury of a family member or other close associate; (b) a subjective response to that event that is marked by intense fear, helplessness, or horror; (c) characteristic symptoms resulting from exposure to the traumatic event including persistent re-experiencing of the traumatic event (such as intrusive recollections of the traumatic event and distressing dreams), persistent avoidance of reminders associated with the traumatic event and numbing of general responsiveness (such as efforts to avoid activities, places or people associated with the trauma, and restricted range of affect), and persistent symptoms of increased arousal (such as an exaggerated startle response, irritability and difficulty concentrating); (d) symptoms must be present for at least one month; and (e) symptoms must cause significant distress or impairment in social, occupational or other areas of functioning.

The traumatic events of the refugee career including personal injury, torture, and witnessing the effects of war, genocide, and mass violence (Mollica, 2006; Mollica et al., 1987), would certainly meet the first diagnostic criteria of PTSD. Some of the common symptoms among refugees from varying geographical regions include negative long-term effects on cognitions (i.e., concentration difficulties, impaired information processing and memory difficulties, lowered interest levels, feelings of hopelessness about the future, intrusive memories about the event, and hyper-arousal and hyper-vigilance),

emotions (i.e., depression, irritability, phobic disorders, stress, and anxiety), and behaviour (i.e., avoidance, startle reactions, lack of energy, alcohol or drug abuse, insomnia, sexual dysfunction, and nightmares; Asner-Self & Marotta, 2005; Bemak & Chung, 2008; Cervantes, Salgado de Snyder, & Padilla et al., 1989; Clinton-Davis & Fassil, 1992; Cohon, 1981; Diehl, Zea, & Espino, 1993; Fenta, Hyman, & Noh, 2004; Ferren, 1999; Gavagan & Martinez, 1997; Kinzie, 2001; Mollica et al., 1999; Portes, Kyle, & Eaton, 1992).

Numerous mental health concerns and varying presentations of PTSD have been described across various refugee groups in differing countries of resettlement (Arredondo et al., 1989; Birman & Tran, 2008; Clinton-Davis & Fassil, 1992; Stein, 1986). Epidemiological studies have indicated that rates of PTSD are typically 50% or higher among Central American, Southeast Asian, European, and African refugee groups (de Girolamo & McFarlane, 1996; Hollifield et al., 2002; Johnson & Thompson, 2006; Marsella, Friedman, & Spain, 1996). However, rates typically vary depending on the severity and chronicity of traumatic events encountered in the country of origin or during flight (Cervantes et al., 1989). Some highly traumatized groups such as Mein refugees from Laos (Laotian hill people) have reported rates as high as 93% (Marsella et al.).

It is important to note that the majority of research and clinical expertise which validates PTSD as a diagnostic construct was developed in Western industrialized nations (Friedman & Marsella, 1996). As such, the universality of PTSD and the appropriateness of applying this diagnosis to non-Western refugee cultures has been widely challenged (e.g., Chakraborty, 1991; Davidson, Murray

& Schweitzer, 2008). Cross-cultural studies have consistently indicated that culture mediates the experience and expression of emotion and distress, and how personal problems are conceptualized (Jenkins, 1996). Because of ethnocultural differences among some refugee groups, the clinical phenomenon of PTSD and how traumatic stress is experienced by an individual may differ significantly between groups (Davidson et al.; Friedman & Marsella, 1996; Kirmayer, 1996). Therefore, it is unclear whether the statistics on PTSD presented earlier accurately reflect the impact of refugees' premigration experiences on their personal functioning. In light of the complex nature of the refugee career, this diagnostic category may not fully capture the overall nature of refugees' presenting problems or mental health needs (Papadopoulos, 2007).

Another mental health outcome of the refugee career is that refugees who have survived war, repression, and other losses, may suffer from survivor's guilt. This intense guilt or self-recrimination for surviving the circumstances from which they escaped while family or friends remained in danger or died is associated with the feeling that they did not do enough to save those left behind. This may engender a very negative self-perception and the belief that they are unworthy of significant others' love and concern (Hernandez, 1996).

Given the complexity of refugee experiences, it has been argued that a PTSD diagnosis may not effectively encompass the wide range of posttraumatic reactions (Beltran, Llewellyn, & Silove, 2008). In addition to the possible experience of PTSD and survivor guilt, some refugees present with physical health complaints due to psychological stress stemming from premigration or

resettlement stressors. These somatic manifestations of psychological difficulties include abdominal pain, chest discomfort, dizziness, chronic back and joint pain, and fatigue (Arredondo, Orjuela, & Moore, 1989; Guerin, Guerin, Diiriye, & Yates, 2004; Liedl, Muller, Morina, Karl, et al., 2011; Orley, 1994). These somatic symptoms are often interpreted by refugees to equate with fatality or extreme disability, and often result in heightened distress (Otto et al., 2003).

Additionally, the impact of resettlement stressors during the first few years following arrival in the host society has been found to be related to other long-term psychological consequences (Al-Issa, 1997a; Bemak et al., 2003; Marsella et al., 1994). For example, loss of status and unemployment have a significant impact on the psychological well-being of refugees (Al-Issa, 1997b), and have consistently shown to be risk factors for anxiety disorders, substance abuse, and depression across refugee groups (Beiser & Hou, 2001; Beiser, Johnson, & Turner, 1993; Schwarzer, Jerusalem, & Hahn, 1994; Wickrama, Beiser, & Kaspar, 2002). Similarly, the lack of English language ability is a significant risk factor for psychological distress and depression among refugees during the resettlement process (Beiser & Hou, 2001; W. L. Hinton et al., 1997; Wickrama et al., 2002).

Although various mental health problems may emerge during the refugee career, the exact nature of the relationship between the refugee career and mental health is not always clear. Numerous variables such as the socio-economic status, cultural identity of the individual, and level of available social and community support interact in affecting the mental health status of the refugee (Al-Issa,

1997a; Beiser & Hou, 2001; Clinton-Davis & Fassil, 1992; Guarnaccia, 1997; Prendes-Lintel, 2001; Tran, 1993). The complexity of experiences along all stages of the refugee career may result in unique mental health needs (Davidson et al., 2008; Hollifield et al., 2002; Rousseau & Drapeau, 2004), which may lead refugees to seek help in the health care and mental health care systems (Hollifield et al.; Nicholl & Thompson, 2004).

CHAPTER 2: LITERATURE REVIEW

A wide range of psychotherapeutic techniques have been utilized in the treatment of refugees (Murray et al., 2010; Nicholl & Thompson, 2004; Palic & Elklit, 2011). This chapter reviews the most frequently employed mainstream therapies as applied to refugee populations. Each treatment will be briefly described along with specific cultural adaptations to treatment protocols, and studies assessing their effectiveness. Subsequently researcher efforts to better understand how these therapies work, or what it is about refugee therapy that makes it effective are described. This review will explore how refugees' presenting problems are conceptualized, the cultural appropriateness of treatment goals and strategies in relation to refugees' expectations and broader resettlement experiences, and the client-counsellor relationship. In the final section, it will be argued that existing studies of refugee counselling strategies fail to address critical aspects of the refugee experience and neglect refugee perspectives on mental health and healing. A qualitative approach to understanding refugees' treatment experiences is advocated to address this important void in the literature and to facilitate improved service delivery.

Conventional Treatment Approaches for Refugees

The majority of mainstream[1] counselling treatments for refugees presented in the literature have most frequently been employed to alleviate posttraumatic

[1] For the purposes of this paper, the terms *mainstream* and *conventional* therapy will be used to refer to Western psychotherapies, and the terms *traditional* and *indigenous* therapy will be used to refer to therapies indigenous to the client's cultural background.

stress symptoms. These therapies have included cognitive behaviour therapy, insight-oriented and psychodynamic approaches, psychosocial support and interventions, testimony therapy, narrative exposure therapy, and pharmacotherapy (see Murray et al., 2010; Palic & Elklit, 2011). Additionally, Bemak and colleagues (2003) proposed the Multi-Level Model of psychotherapy for refugees as a holistic treatment model designed specifically for refugee populations. These therapies, their cultural adaptations, and related findings on their therapeutic effectiveness with specific refugee groups are described below.

Cognitive Behaviour Therapy

Cognitive behaviour therapy (CBT) is the most widely used treatment method with refugees resettled in Western nations (Kinzie, 2001; Nicholl & Thompson, 2004), or at the very least, the most commonly evaluated treatment (Murray et al., 2010; Palic & Elklit, 2011). This is perhaps because the difficulties associated with posttraumatic reactions have shown to be highly amenable to CBT in mainstream research (Foa, 2000). In its broadest and most generic form, CBT is a form of psychotherapy which emphasizes the way people think and behave in order to help them overcome emotional problems. The basic premise of CBT is that the way a person thinks about or interprets an event affects how he or she feels and behaves in response to it. These thoughts and interpretations can either be "irrational" and maladaptive, or "rational" and adaptive, with irrational or maladaptive thoughts resulting in or perpetuating emotional and behavioural problems (Prochaska & Norcross, 2003). Therefore, changing maladaptive thoughts to more adaptive ones alleviates emotional and behavioural difficulties

and helps the individual more effectively cope in the world. Also essential to refugee psychotherapy, CBT assumes that fear is a reflexive response, which through pairing with other stimuli can come to be triggered by non-dangerous as well as dangerous situations (Foa).

As a treatment approach among refugees, the goals of CBT are to change maladaptive and irrational thoughts to become more adaptive, and weaken the learned fear response. This therapy typically occurs through two related processes. First, exposure to the traumatic event in a safe environment via imagery or re-telling the trauma story weakens the learned fear response. Clients are trained in relaxation techniques and then asked to imagine the trauma event while relaxing until the scene is no longer fear provoking, as after they have sought asylum, fear-triggering stimuli may no longer be adaptive. Clients are gradually exposed to increasingly traumatic events until the trauma memories and associated fears and anxieties are manageable. Second, it is essential that clients examine their beliefs regarding the traumatic event. Cognitive restructuring involves modifying the thinking processes and changing maladaptive thoughts to more adaptive ones. For example, leaving ones home country may be viewed as necessary for survival rather than an abandonment of social ties and his or her old way of life. Treatment also includes education concerning the interrelationships between events, thoughts and emotions, and the way that beliefs influence subsequent emotions and behaviour (Foa, 2000; Foa & Meadows, 1997). In nature, CBT is problem-oriented, with the focus of therapy on reducing problematic emotions or symptoms. As well, CBT tends to be directive, as the

therapist provides instructions to clients in terms of how to "fix" their concerns in a typically didactic relationship (Prochaska & Norcross, 2003).

Some theorists, researchers, and clinicians propose that the theoretical and practical components of CBT allow it to be transferable to the treatment of refugees (Regel & Berliner, 2007; Summerfield, 1995). The clinical expectations of refugee groups from non-Western cultures may include an unsymmetrical relationship, with the therapist taking on an active, "expert" role, providing guidance, advice, and a problem-centred approach to counselling (Kramer, 2005; Organista & Munoz, 1996 D. W. Sue, 1990; Sue & Zane, 1987). These expectations are congruent with the nature of CBT techniques (de Silva, 1985; Kleinman, 1980; Organista & Munoz). Similarly, the didactic style and psychoeducational aspects of CBT may lead clients to perceive therapy as a classroom experience, helping to alleviate the stigma associated with formal mental health services among refugee populations (Organista & Munoz). Finally, practices involved in CBT may resemble healing activities in clients' cultures of origin or religious frameworks. As one example, CBT relaxation procedures such as deep breathing and visualization are similar to meditative techniques found in several Eastern religions (De Silva, 1985; Hinton et al., 2004).

In contrast, the universality of these approaches has been challenged by many authors (Katz, 1985; Kinzie, 2001; Sue & Sue, 2008; Summerfield, 1995). The therapeutic significance attributed to emotional expression and cognitive change varies greatly across cultures (Summerfield, 1999), and such treatments may not be considered equally credible among refugee clients. For example,

among members of some refugee groups, avoidance of the traumatic experience may be a more culturally acceptable response rather than confronting traumatic emotions and memories (Kinzie, 2004). In addition, these treatments focus on changing client belief systems and helping clients to develop more "rational" ideas or appraisals of their situation. The emphasis on rational thinking that is central to cognitive therapies is not held across cultures (Katz, 1985). Correspondingly, the emphases on spirituality, intuition, and social connection found in many refugee groups (Fernando, 2005) is devalued or neglected in cognitive treatments (Nicholl & Thompson, 2004). Along a related vein, beliefs which are apparently irrational in one cultural or historical context may be completely rational given differing historical backgrounds or cultural beliefs. Finally, these therapies do not address factors external to the client such as loss of family and community support that are commonly experienced through the refugee career (Prochaska & Norcross, 2003). Instead treatment emphasizes changing the individual's thoughts and beliefs.

Insight Oriented Approaches

Insight-oriented approaches encompass a broad category of therapies (including psychoanalytic and psychodynamic therapy), which work towards an increased understanding of the source of the problematic thoughts and emotions. These paradigms assume that an individual's pattern of behaviour and emotion (both healthy and unhealthy) results from a complex interaction between factors such as motives, thoughts, and feelings that are often outside of the individual's awareness. By becoming more aware of these unconscious factors which

determine behaviours and emotions, an individual is better able to control his or her emotions and behaviour, and direct his or her life. Therapy which aims to gain insight into or understanding of one's underlying emotions, thoughts, or motivations leads to behavioural, emotional, and psychological change (Corey, 2001). Clients who obtain greater insight into themselves will be better adjusted individuals (Sue & Sue, 2008).

As applied to refugee populations, massive trauma experienced during the refugee career can be overwhelming and provoke extreme fright and helplessness. To cope with these distressing effects, an individual represses the memories of the trauma; however, these memories continue to exert unconscious pathological effects through symptoms such as recurrent nightmares, avoidance of intimacy, and somatic pain. During the counselling process with refugees, therapists help clients identify the triggering situations, events, or other reminders that cause re-experiencing of traumatic symptoms, and explore with clients their traumatic memories, beliefs about the traumatic experience, and how they have affected their lives (Drozdek, 1997; Fitzpatrick, 2002; Garland, Hume, & Majid, 2002; Varvin & Stiles, 1999). Through these activities, individuals can better understand the underlying causes of their emotional or behavioural problems, and through this insight individuals can better control their lives.

However, insight is a culture-bound value; it is not highly valued or esteemed among many refugee groups, and the related self-exploration is not considered to be an effective therapeutic exercise (Sue & Sue, 2008). On the contrary, refugees from some cultural groups believe that too much thinking about

something can cause problems in itself. Within this framework, avoidance of distressing thoughts is considered important for maintaining mental health and well-being, rather than a sign of pathology (Lum, 1982; Sue & Sue; Summerfield, 1999). As well, the belief that psychological and emotional problems are the result of factors internal to the individual ignores important social, familial, political, and cultural contexts which impact mental health outcomes. The assumption that behavioural and affective change results from a deepened understanding of one's internal thoughts, motivations, and emotions minimizes the very real environmental conditions which may be impacting the refugee's mental health. Such realities as the loss of family members, insecure asylum status, and downward mobility, are not intrapsychic in nature, and an increased understanding of one's emotional response to these situations will not change the environmental reality of the individual (Prochaska & Norcross, 2003). Failing to recognize the factors external to the client such as his or her social, political, familial, and economic contexts may reduce therapeutic effectiveness (Kinzie & Fleck, 1987; Mollica, 2006; Sue & Sue).

As one variation of insight therapy, Fischman and Ross (1990) and Jenkins (1991) described a treatment paradigm for survivors of torture where traumatic premigration experiences were discussed within the client's social and political environment. As one example, the authors highlighted the refugees' experience of guilt over surviving and not being able to save others, and shame over their helplessness. However, torture is specifically designed to distort normal psychological, social and emotional processes, and induce guilt and helplessness

in torture victims (Somnier & Genefke, 1986). Allowing clients to gain insight into their personal experiences as they relate to the nature and design of torture may enable them to transfer the burden of responsibility to the torturers and the repressive political system that supported its use. Unlike other forms of insight therapy which emphasize processes internal to the individual, these therapies highlight the social and political contexts of emotional distress, and may help to validate what was previously considered a "unique personal reality" (Fischman & Ross, p. 141).

Psychosocial Support and Interventions

Psychosocial interventions are a broad category of treatments, which include those techniques that aim to re-establish social connections or otherwise reintegrate clients into their desired social and occupational roles (Pejovic, Jovanovic, & Djurdjic, 1997). These techniques may involve connecting clients with financial, educational, and healthcare services and resources in the host society, and facilitating clients' social integration. In light of the negative psychological impact associated with adjustment challenges, pressing life needs, and loss of social connection and support (Al-Issa, 1997b; Beiser & Hou, 2001; Beiser et al., 1993; Schwarzer et al., 1994; Wickrama et al., 2002; Yakushko, Backhaus, Watson, Ngaruiya, & Gonzalez, 2008), the theoretical suitability of this approach to refugee populations is clear. Additionally, this approach may provide a suitable fit with a refugee's worldview. In relation to causal explanations, refugees consider the loss of family connections (Guerin et al., 2004), and resettlement challenges and life stressors (Kramer, 2005), to be

significant contributing factors to current emotional distress. In terms of culturally appropriate interventions, the focus on changing current situations rather than talking about personal feelings and traumatic memories may be a valued and credible therapeutic practice (Summerfield, 1999), that matches some traditional coping styles (Vey & Yukl, 1982).

Testimony Therapy

Testimony therapy is a brief form of individual psychotherapy developed specifically for working with survivors of state-sponsored violence or human rights violations (Van Dijk, Schoutrop, & Spinhoven, 2003; Weine, Kulnovic, Pavkovic, & Gibbons, 1998). This therapy was originally developed by Chilean psychologists who worked with former political prisoners and survivors of torture and other human rights violations committed under the Pinochet regime (Cienfuegos & Monelli, 1983). During this treatment program the client first provides a detailed biography including: his or her personal and family history; stories of how he or she was affected by trauma, war, and political oppression; his or her experiences of being a refugee including flight, first asylum and claimant stages; and the experiences of his or her current life such as resettlement challenges, continued stressors, and positive changes. These stories are collected in the client's first language, if necessary, with the aid of an interpreter. The narratives are tape-recorded, transcribed, and read back to the client with revisions being made as necessary until the client feels that the testimony is an accurate reflection of his or her life. Second, once the final version of the biography is constructed and approved by the client, it is typewritten and signed

by the client and therapist. This document is then distributed to human rights organizations, family members, historical archives, or advocacy groups as directed and consented to by the client. The purpose of this testimony is to provide a voice against the human rights violations and let others know of the social injustices that are committed. The entire process typically takes between three to six sessions.

While developed in a cross-cultural context, the process of change is attributed to distinctly Western models of healing and change. The working mechanisms are considered to involve catharsis, exposure, and the reintegration of fragmented traumatic memories (Van Dijk et al., 2003; Weine et al., 1998). Still, testimony therapy may be particularly relevant to the refugee experience for two reasons. First, because testimony therapy collects the trauma story as evidence of injustices, oppression, and human rights violations, it may be considered a culturally acceptable way to discuss traumatic events (Luebben, 2003; Lustig, Weine, Saxe, & Beardslee, 2004). Therefore, less stigma may be attached to testimony therapy compared to conventional talk therapies. Similarly, many refugee groups may be more comfortable talking about their symptoms by way of reporting their life story as opposed to simply listing symptoms out of context (Kagawa-Singer & Chung, 1994). Second, testimony therapy addresses the political element of the refugee's experience, by socially validating the refugees' experiences (Agger & Jensen, 1990; Cienfuegos & Monelli, 1983; Van Dijk et al.). The public testimony stands as a recognition or acknowledgment of injustices that are often denied by the offending political powers. Recording a testimony of

human rights violations so others can know of existing social injustices was described by Bosnian refugees as a strong motivation to attend therapy (Luebben).

Narrative Exposure Therapy

Narrative exposure therapy is a synthesis of testimony therapy and exposure therapy as employed in CBT (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Neuner, Schauer, Roth, & Elbert, 2002). Like testimony therapy, narrative exposure therapy involves the creation of a detailed biography of the client, with the final document being typewritten, signed, and distributed to family members, governmental organizations and human rights groups as directed by the client. During the revision and editing of the narratives, the document is read back to the client with the client clarifying and revising the biography as necessary. Through this revision procedure, clients are exposed to memories of traumatic life events in a safe and controlled environment. This continued exposure necessary to construct a detailed biography resembles exposure techniques. This exposure, however, is not aimed at one most traumatic event, but rather at all traumatic events that the refugee finds important in the context of his or her life story (Palic & Elklit, 2011).

As a synthesis of testimony therapy and CBT, narrative exposure therapy may share many of the same benefits of the two approaches (Neuner et al., 2002; Neuner et al., 2004). Because narrative exposure therapy collects biographies for the purpose of providing evidence of injustice, oppression, and human rights violations, less stigma may be attached to narrative exposure therapy compared to other mainstream therapies and it may be considered a culturally acceptable way

to discuss traumatic events. Similarly, the approach is brief and the communication styles and therapeutic approaches may match cultural expectations as discussed in relation to CBT. Like both CBT and testimony therapy, narrative exposure therapy is considered to work through the process of reconstructing autobiographic memories and habituation (a gradual reduction of anxiety upon repeated exposure to the distressing stimuli).

Narrative exposure therapy is also considered to significantly improve upon some elements of CBT. Exposure techniques have been found to be highly effective for treating PTSD in mainstream research conducted primarily among survivors of rape and motor vehicle accidents (Foa & Meadows, 1997). Typically these exposure exercises involve re-telling the memories of single traumatic events (Neuner et al., 2002). However, most refugees do not experience a single traumatic event, but rather they experience a series of traumatic events often prolonged over the span of many years (Clinton-Davis & Fassil, 1992; W. L. Hinton et al., 1997; Orley, 1994). While the therapeutic benefits associated with conventional exposure exercises may be difficult to achieve among refugee populations due to multiple traumas, utilizing the client's biography and narratives of the repeated traumas as the stimuli for exposure exercises may overcome this difficulty (Neuner et al., 2002, 2004). Combined together, these benefits or assets of narrative exposure therapy may be one reason that, in terms of accumulation of evidence, this therapy demonstrated one of the best documentations of effect in one review of treatments for traumatized refugees (Palic & Elklit, 2011).

Pharmacotherapy

Drug treatment has demonstrated limited success with refugee clients in reducing symptoms of PTSD and depression (DeMartino, Mollica, & Wilk, 1995; Kroll, Linde, Habenicht, Chan, et al., 1990; Lin & Shen, 1991; Smajkic et al., 2001). Medication noncompliance could be one a factor in pharmacotherapy's limited success among refugee populations (Kroll et al.; Lin & Shen; Smajkic et al.). Kroll et al. examined the antidepressant blood levels of 15 Hmong, 12 Cambodian, and 5 Laotian refugees diagnosed with depression with or without comorbid PTSD. Twenty-seven of these participants who reported that they were taking their medication regularly had no detectable or sub-therapeutic antidepressant blood levels, especially among the Hmong group. Non-compliance may be due in turn to cultural differences in the expectations of drug use and interpretations of side effects. For example, Smajkic et al. found that while antidepressants produced some change in symptom level, they also produce severe side effects such as nausea, headaches, dizziness, and dry mouth. These side effects may be interpreted by clients as a worsening of symptoms, and may lead to the discontinuation of drug use. Also, some refugee clients may not see the relevance of drug treatment in light of the external causes of their problems such as political violence and resettlement problems.

The Multi-Level Model of Psychotherapy for Refugees

Bemak and colleagues (1996, 2003) proposed the Multi-Level Model of psychotherapy (MLM) as a therapeutic intervention model for refugees. The MLM is a holistic psychoeducational model, which takes into account the

refugee's historical background, pre-migration and migration stressors, acculturation processes, and current resettlement stressors, in order to make the counselling environment more accessible to this population. This model consists of four phases: Level I: mental health education; Level II: individual, group, and/or family psychotherapy; Level III: cultural empowerment; and Level IV: integration of Western and indigenous healing methodologies. These levels are interrelated, and may be implemented concurrently or independently, and in any sequence depending on the client's needs (Bemak & Chung, 2008; Bemak et al., 1996).

Level I: Mental health education. Refugees, like other newcomers, are generally unfamiliar with conventional Western mental health services and are often unaware of what to expect during counselling (Bemak et al., 2003). Level I addresses this concern by educating clients about mainstream mental health services and the processes and outcomes of psychotherapy (Bemak et al.). Here, therapists provide clients with "mental health basics", such as information regarding client and therapist roles, the therapeutic process and counselling procedures, and expected outcomes (Bemak et al., p. 53). Informing the clients about the counselling process helps them become more comfortable with it, and leads to greater treatment gains (Aponte, 2004; Beutler & Clarkin, 1990; Orlinsky, Ronnestad, & Willutzki, 2004; Zwick & Attkisson, 1985).

Level II: Psychotherapy. Level II focuses on conventional Western individual, group, and family therapy interventions that may be relevant to the refugees' experiences. Bemak and colleagues (1996) emphasize that the

counsellor must incorporate the refugees' cultural worldviews into the assessment and intervention procedures in order to adapt treatment for refugee clients. It is critical that mental health professionals are knowledgeable about the various Western therapeutic modalities, as well as the cultural norms and values of the client. By utilizing this information, therapists can better understand how the interventions match the needs and worldview of the client and ensure that the treatment provided is culturally sensitive (Bemak, 2003). It is also important to work collaboratively with the client, and obtain feedback to facilitate understanding and ensure goodness of fit between the clients' expectations and the treatment plan.

Level III: Cultural empowerment. The experience of adapting to mainstream Canadian society results in considerable obstacles such as securing employment, finding suitable housing, learning English, and learning how to access various social services. The goal of Level III is to assist refugees in overcoming these obstacles inherent to the resettlement process (Bemak et al., 2003). Towards this end, the therapist acts as a "cultural systems information guide" with the ultimate goal of assisting the client to develop the skills to deal independently with host society systems (Bemak et al., 1996, p. 259). The mastery of these skills leads to a successful resettlement experience, which Bemak and colleagues (2003) term *cultural empowerment*.

Level IV: Indigenous healing. Indigenous healing involves the combination of conventional Western healing and psychotherapy methodologies with indigenous healing practices (Bemak et al., 1996, 2003). Bemak and

colleagues call for professional openness to non-Western, traditional forms of healing in order to enhance the psychotherapeutic process. They further suggest that therapists establish treatment partnerships with legitimate folk healers, indigenous workers, or religious leaders to provide refugees with a valuable combination of healing sources.

Level V: Addressing social justice and human rights issues. This component involves working with refugees to advocate for fair and equal treatment and access to opportunities and resources in the community (Chung, Bemak, Ortiz, & Sandoval-Perez, 2008). This level extends the therapist's role beyond the traditional counselling service provider to include areas such as social justice advocacy and network building.

Effectiveness of Culturally Appropriate Therapies with Refugees

Empirically validated treatment debate. There is a current debate in the field of counselling and psychotherapy regarding how to evaluate whether a specific counselling approach is effective for addressing a specific type of emotional distress or problem among a specific population (King, 1999). On the one hand, some researchers believe that in order to be considered a well-established empirically supported treatment, the treatment must demonstrate its efficacy through at least two good between-group design experiments or through a large series ($n>9$) of single-case design experiments, where the treatment is compared to a placebo or other already established treatment. Furthermore, these experiments must be conducted with manualized treatment protocols, utilizing a sample with clearly specified demographic characteristics, and carried out by at

least two different investigating teams (Hunsley, Dobson, Johnston, & Mikhail, 1999).

Cross-cultural researchers argue that these criteria for evaluating treatments do not take into account the language, cultural beliefs, life experiences, and worldviews of immigrant and refugee groups (Atkinson, Bui, & Mori, 2001; Coleman & Wampold, 2003; Hwang, 2006). For example, a manualized treatment protocol for PTSD would not permit the therapist to modify the treatment to account for contextual factors such as the clients' preferred language of therapy, expectations regarding types of treatments, or current resettlement stressors which may be exacerbating the clients' distress. As well, therapeutic efficacy as indicated through symptom improvement alone may not accurately reflect positive outcomes as other factors relevant to the refugees' mental health may not have been improved. In the mainstream PTSD studies that have been performed according to the above criteria, the samples have been predominantly Caucasian, middle-class, and English speaking (Atkinson et al., 2001; Summerfield, 1999). Since the cultural appropriateness of the assumptions and interventions found in mainstream treatments may vary greatly across cultures (Summerfield), the well-established empirically supported treatments for PTSD (e.g., CBT; Foa, 2000) may or may not be effective in reducing traumatization among refugees from non-Western cultures.

The majority of treatment studies evaluating refugee therapy models have not conformed to the above criteria for empirically validated treatments as researchers have opted instead to alter mainstream treatment protocols in order to

take into account the clients' language (Basoglu, Ekblad, Baarnhielm, Livanou, 2004; Cienfuegos & Monelli, 1983; Neuner et al., 2002, 2004; Otto et al., 2003; Schei & Dahl, 1999; Van Boemal & Rozee, 1992; Weine et al., 1998), resettlement experiences (Kinzie et al., 1988; Schei & Dahl; Van Boemal & Rozee), acculturation (Paunovic & Öst, 2001; Snodgrass et al., 1993), beliefs about the problem (Otto et al.), and treatment expectations (D. E. Hinton et al., 2004; Rosser, 1986). While these treatment modifications may preclude the treatment studies from meeting the criteria for empirically validated treatments (i.e., utilizing manualized treatment protocols), taking into account relevant cultural factors may increase therapeutic effectiveness.

Cultural adaptations. The cultural adaptations employed in refugee treatment studies are reviewed below. Program outcomes and results are reviewed in the subsequent section. Several studies incorporated culturally sensitive techniques into mainstream treatment protocols. For example, D. E. Hinton and colleagues (2004) assessed the effectiveness of a culturally adapted CBT program for Vietnamese refugees with PTSD and comorbid panic attacks. This treatment program reframed relaxation training as a form of mindfulness that is consistent with the Buddhist background of the refugees, and utilized culturally relevant visualizations of soothing images. Otto et al. (2003) conducted a CBT program for Cambodian refugees in a local Buddhist temple. These refugees often experienced emotional distress somatically, in terms of gastrointestinal complaints, dizziness and chest discomfort. Moreover, they equated these physical symptoms with extreme disability or fatality resulting in heightened

distress. In their treatment protocol, bodily symptoms and sensations that the refugees associated with disability or fatality were presented as culturally specific reactions to trauma rather than signs of fatality. Participants were taught self-care skills they could apply when distressed by symptoms related to traumatic reactions.

Kinzie et al. (1988), Schei and Dahl (1999), and Van Boemal and Rozee (1992) each incorporated resettlement needs into PTSD treatment protocols. For example, Schei and Dahl developed a therapy group designed to ameliorate distress among women who were displaced by war in the former Yugoslavia. Therapy consisted of group-based occupational activities that enabled the women to engage in socially meaningful activities such as quilt making, and foster social relationships. Importantly, women who were highly distressed reported fewer benefits from the program compared to women who were mildly or moderately distressed. The highly distressed refugee women may have needed additional strategies to address troubling life experiences and their impacts. Van Boemal and Rozee compared treatment outcomes for refugee women being treated for psychosomatic blindness (which involves impaired vision with no evident medical cause and an assumed psychological etiology) via a living skills group, a therapy group, and a no-treatment control group. The purpose of the living skills group was to teach the women survival skills necessary in the host society, such as how to use the telephone, use U.S. currency, and take public transportation. The therapy group encouraged the women to express their current feelings and recall memories of traumatic events. Women in the treatment groups

demonstrated significantly improved visual acuity and perceived emotional well-being compared to women in the control group, supporting a psychological cause for their blindness. Interestingly, there were no differences between the living skills and talk therapy groups in treatment gains. This suggests that the psychological stress underlying the blindness may have had dual causes of premigration trauma and difficulties navigating the host society, highlighting the importance of responding to resettlement needs in the treatment of refugees.

Rosser (1986) modified the way a CBT program was delivered in response to the cultural expectations and needs of a Cambodian client. This individual was a socially isolated refugee single mother who was experiencing difficulty accessing mainstream social supports and services. Previous research on this refugee group has suggested that the therapist should be the one who initiates action to remedy or improve the situation, due to expectations of a doctor-patient relationship. In response, the therapist took an active role in helping the client make changes in her life and initiated the steps to help connect her to other members of her ethnic community and to a local school for teenage mothers.

Other studies (e.g., Basoglu et al., 2004; Cienfuegos & Monelli, 1983; Otto et al., 2003; Van Boemal & Rozee, 1992) employed ethnically matched therapists to provide therapy. Utilizing an ethnically matched therapist is assumed to result in culturally sensitive and effective treatment as both client and practitioner share similar health worldviews owing to their similar cultural background, although this view has been challenged in some cross-cultural research (S. Sue, 1998). The fact that therapy was delivered by an ethnically

matched counsellor may have led to adaptations in the way the treatment was delivered to match the client's cultural expectations. These studies also provided therapy in the clients' first language. This may facilitate a greater understanding between client and therapist and allow the client to more easily communicate distressing emotions.

In a similar way, Paunovic and Öst (2000) and Snodgrass and colleagues (1993) utilized participants who were arguably highly acculturated based on their length of residence in the host society and second language abilities. For example, Snodgrass et al. assessed a CBT program with Vietnamese refugees living in the United States. The participants had lived in the United States for approximately 14 years, having left Vietnam at the average age of 6-years old. It can be argued that these individuals were relatively well-adapted to the mainstream culture, and possibly to Western mental health care practices. Due to the refugees' heightened acculturation to Western society, both clients and practitioners may share similar worldviews, and fewer cultural adaptations would be necessary. Participants were also reported to be fluent in English, and no language modifications were considered to be required to assist communication during therapy.

Hwang (2006) developed the Psychotherapy Adaptation and Modification Framework to provide a logical organizational scheme under which the various types of adaptations described above can be subsumed. This framework consists of six therapeutic domains that culture is presumed to affect, or areas where attention in therapy should be drawn. The first domain, *dynamic issues and cultural complexities* points individuals to the complexities involved in working

with diverse populations. There is a danger when trying to be culturally aware to use general strategies when treating diverse clientele, and skill is required to know when to generalize and when to flexibly individualize treatment based on the client's individual characteristics. This skill is referred to as *dynamic sizing* (S. Sue, 1998). As well, clients may align themselves with multiple identities and group memberships and may identify with certain memberships over others. Hays (2001) proposed the ADDRESSING framework to underscore these numerous memberships: (A) age and generational influences; (D) developmental disabilities; (D) acquired disabilities; (R) religion and spiritual orientation; (E) ethnicity; (S) socioeconomic status; (S) sexual orientation; (I) indigenous heritage; (N) national origin; and (G) gender. Hwang suggested that culturally competent therapists are aware of these dynamic issues and effectively adapt treatment based on the client's composite identity.

The second domain, *orientation*, highlights the importance of orienting clients to therapy, which can be especially important for individuals who have had little exposure to Western mental health models or treatment (Hwang, 2006). Similar to the MLM's mental health education, orienting clients to therapy may facilitate clients' comfort with treatment and help them but into the treatment approach. Orientation involves several important components including establishing culturally congruent goals early in therapy, outlining the structure of therapy, and framing the problem with a holistic approach (rather than with a medical model).

Third, *cultural beliefs* influence the treatment process in myriad ways. Becoming familiar with the client's cultural background enables the therapist to engage in culture bridging, or relating psychotherapeutic concepts to the client's cultural beliefs and practices (Hwang, 2006). Hwang suggested that, drawing links between therapy and the client's culture, as well as using culturally familiar terms may "increase feelings of comfort, give treatment more meaning, and increase treatment adherence" (p. 710). Becoming familiar with the client's cultural beliefs also increases the therapist's ability to link to indigenous healing practices as also outlined in the MLM.

The fourth domain addresses the client-therapist relationship. Building a strong therapeutic relationship requires an understanding of the client's cultural background, and perhaps more importantly, an understanding of one's own self-identity and how it influences one's interactions with and attitudes towards others (Hwang, 2006). Therapists may also build a positive therapeutic alliance by clearly addressing client and therapist roles and expectations for therapy, and by effectively engaging and interacting with the client in a culturally appropriate manner (Hwang).

Fifth, therapists should be aware of cultural differences in communication and the expression of distress (Hwang, 2006). Outlined in greater detail in the subsequent section *language and communication norms*, understanding cultural differences in the nuances of communication is an important component of bridging understanding and building a positive therapeutic relationship (D. W. Sue, 1990). Furthermore, cultural forces shape how individuals express distress

(APA, 2000), and awareness of these cultural differences in the expressions of distress can improve diagnostic accuracy and treatment planning (Hwang, 2006).

The final domain addresses cultural issues of salience (Hwang, 2006). To make therapy relevant to the client and improve overall treatment, therapists should address issues that are salient and important to the client. This would include conceptualizing the problem in a way that is congruent with the client's beliefs and worldview (Sue & Sue, 2008), employing healing processes or therapeutic tasks that are relevant to the client (Mollica, 2006), and targeting treatment goals that are consistent with the client's beliefs (Hwang, 2006). Taken together, each of the six domains becomes a focal point where cultural modifications may be applied, with specific modifications varying depending on the cultural and individual identity of the client.

Treatment effectiveness. The effectiveness of the refugee treatment programs described above has been assessed across diverse ethnic populations presenting with numerous symptoms and difficulties. Treatments have been evaluated among refugees from Cambodia (Hinton, Hofmann, Pollack, & Otto, 2009; Otto et al., 2003; Rosser, 1986; Van Boemal & Rosee, 1992), Vietnam (Hinton et al., 2004; Kinzie et al., 1988; Snodgrass et al., 1993), Bosnia and Serbia (Drozdek, 1997; Kruse, Joksimovic, Cavka, Wöller, & Schmitz, 2009; Neuner et al., 2002; Schei & Dahl, 1998; Weine et al., 2001), Turkey (Basoglu et al., 2004), Central America (Cienfuegos & Monelli, 1983; Fischman & Ross, 1990), Rwanda and Somalia (Neuner, Onyut, Ertl, Odenwald, et al., 2008), and Sudan (Neuner et al., 2004). At the time of therapy, these refugees were along

differing stages of the refugee career from individuals still living in a refugee camp (e.g., Neuner et al., 2004; Neuner et al., 2008) to 10-14 years post-settlement (e.g., Paunovic & Öst, 2000; Snodgrass et al.). These therapeutic outcomes were evaluated by therapist- or researcher-determined criteria and measured through standardized self-report questionnaires and symptom checklists (e.g., the Symptom Checklist-90-Revised [Derogatis, 1975] and the Harvard Trauma Questionnaire [Mollica et al., 1996]), as well as through clinician diagnosis.

Most treatments have shown some promise in improving symptoms of PTSD, as well as anxiety, depression, and general mental health (Murray et al., 2010; Palic & Elklit, 2011). However, even though treatment gains were made, many studies reported that very few refugees were PTSD free at the end of the treatment. As well, there is little known regarding the longevity of treatment effects as most studies were designed with relatively short follow-up periods (Palic & Elklit). This is significant as the challenges experienced by many traumatized refugees are highly chronic in nature and may result in symptom relapse. The most robust treatment effect sizes were found in the highly specialized culturally sensitive CBT for Southeast Asians (Hinton et al., 2004; Hinton et al., 2005; Hinton et al., 2009; Otto et al., 2003) and narrative exposure therapy (Neuner et al., 2004; Neuner et al., 2008; Neuner et al., 2010).

Bemak and colleagues' (1996, 2003) model of psychotherapy for refugees has received little attention in the literature. The individual levels of this model have received some support in refugee and mainstream research. For example,

Orlinsky and colleagues (2004) suggested that orientation procedures similar to Bemak et al.'s mental health education generally enhance treatment outcomes. These benefits are particularly evident among clients who are culturally unfamiliar with psychotherapy and therapists who are unfamiliar the culture of the client. Additionally, indigenous healing practices such as traditional death ceremonies with Kurdish and Iranian refugee families (Woodcock, 1995) and purification rituals with Ethiopian refugees (Schreiber, 1995), were found to result in a reduction of PTSD symptom severity as indicated by clinician diagnosis. However, as a comprehensive treatment program, the MLM has not yet been evaluated. Similarly, although studies have tested the effectiveness of various subtypes of cultural adaptations in treatment, Hwang's (2006) Psychotherapy Adaptation and Modification Framework has not been assessed as a whole in studies utilizing multiple treatment modifications with a specific cultural group.

Method of treatment evaluation. The evaluation of conventional treatment studies described earlier relied on standardized measures of PTSD that have been developed and normed using disproportionately Caucasian samples, or therapist evaluations of client distress using mainstream diagnostic systems. These may not capture refugees' emotional, physical, and behavioural experiences of distress either before or after the completion of therapy, challenging the research results. Rogler (1999) argues that different psychological experiences among members of refugee groups warrant the use of culture-specific measures that take into account their unique symptom manifestations. The application of standardized diagnostic systems and related measures to groups whose experiences do not conform to

Western illness concepts represents a major diagnostic error and methodological problem. Kleinman (1980) labelled this the *category fallacy* or the presumption that the parameters of a mental disorder will be similar across groups or cultures.

In addition to being culturally inappropriate, standardized measures of psychological distress may pathologize normal aspects of the refugee experience. For example, the statement "Never feeling close to people" is included in a commonly used symptom checklist to assess social withdrawal in response to experiencing a traumatic event (see Derogatis, 1975). For refugees, social distance or alienation may simply be a by-product of the breakdown of social networks due to the refugee experience (Prendes-Lintel, 2001). Even as some of refugees' posttraumatic symptoms are alleviated, they may not be any more socially integrated unless the treatment has focused on social integration. Similarly, any change in the statement "Never feeling close to people" (i.e., from very often to seldom) may not reflect a corresponding change in symptom severity. Still, such symptom questionnaires remain in wide use regardless of whether they reflect the refugees' experience or not (Summerfield, 1999).

A third critical issue with the use of standardized instruments to measure pre-post changes in refugee distress is the metaphorical non-equivalence of terms used to describe mental health across different language groups. Dunnigan, McNall, and Mortimer (1993) attempted to assess the mental health of Hmong refugees from Laos using a battery of standardized tests administered in English. Significant positive inter-item correlations were found among items assessing opposing poles of mental health, such as depressive affect and self-esteem. This

pattern of correlations suggested that participants did not understand the questionnaire items resulting in invalid responses. In a second wave of this study, the researchers hired bilingual experts to translate the standardized instruments into Hmong in an attempt to increase reliability and validity. The translators alerted the researchers to several items that could not be literally translated into the refugees' first language due to the lack of words with equivalent meanings. For example, some items assessing depression refer to the experience of being "downhearted". In the Hmong language, the body part most often implicated in depression is the liver rather than the heart. The term *nyuai siab* or "difficult liver" is used to describe an experience of distress similar to but different from depression.

Therapeutic Processes in Refugee Counselling and Psychotherapy

Overall, the vast majority of refugee psychotherapy research has focused on the effectiveness of various forms of psychotherapy. These outcome studies have demonstrated that culturally adapted treatment programs can be effective in treating refugees. Process research on the other hand, focuses on how therapy works and attempts to understand what it is about therapy that makes it effective (Hill, 1982). Little process research has endeavoured to describe how change is brought about in refugee psychotherapy. Still, several components of therapy have been highlighted throughout the refugee literature regarding how therapy brings about healing and change.

Cross-cultural theorists and practitioners have emphasized three important factors that facilitate therapeutic change (Fischer, Jome, & Atkinson, 1998; Sue &

Zane, 1987). First, therapists need to conceptualize client problems in a way that is consistent with the client's belief system. Second, therapists must utilize treatment approaches that are credible to the client and congruent with the healing strategies of his or her culture. Third, therapists must create a strong therapeutic relationship. Each of these three factors will be addressed below.

Problem Conceptualization

Culture has been described as a central perspective through which members of a particular society determine "how to view the world, how to experience it emotionally, and how to behave in it in relation to other people" (Helman, 1994, p. 2). As culture is a lens through which people perceive, experience, and interact with the world, it also plays a significant role in determining how they define normal and abnormal behaviour, and conceptualize, explain, and experience mental health problems (Belliard & Ramirez-Johnson, 2005).

Refugee problems, as seen by mainstream mental health professionals, have most frequently been framed in terms of symptoms that need to be alleviated (Summerfield, 1999). Unfortunately, this focus has been to the expense of other important factors which contribute to refugee mental health. As one example, Maslow's (1943) hierarchy of needs suggests that psychological or emotional concerns cannot be addressed if basic physiological, safety, and belonging needs remain pressing or unmet. Accordingly, researchers and practitioners have repeatedly stressed that addressing financial, resettlement, and social obstacles must be an integral component of the healing process if therapy is to be effective

(Bemak et al., 2003; Hernandez, 1996; Kinzie & Fleck, 1987; Murray et al., 2010; Pejovic et al., 1997). Focussing exclusively on alleviating PTSD, anxiety and/or depressive symptoms ignores other important dimensions of refugee mental health.

This mainstream conceptualization of refugee problems may also not be meaningful for refugee clients, who view their situational stressors as the problems that warrant attention rather than their symptoms. In one study of refugees in the Netherlands, Kramer (2005) found that clients related their current emotional, psychological, or somatic problems to external, concrete events, such as experiences of political persecution, resettlement challenges, and difficulties gaining refugee status in the Netherlands. In contrast, therapists attributed the clients' problems to individual or subjective factors such as psychological reactions to stressful events and the concept of PTSD, and subsequent therapy was directed towards ameliorating these symptoms. Similarly, Guerin and colleagues (2004) reported that many Somali refugees cited preoccupation with finding family members to be the cause of emotional distress and identified finding family members as the most salient problem they wished to address in therapy.

The focus on PTSD in the current body of literature appears to be driven by trauma researchers who consider refugees to be a traumatized group, rather than refugee researchers and practitioners who have observed high rates of PTSD among refugee participants or clients (Ingleby, 2005). Moreover, it remains to be seen if alleviating PTSD or other DSM-derived symptomatology is the central

objective of the refugees who are seeking treatment. Here, research and practice appear to be fundamentally theory-driven with little relevance being afforded to refugee perceptions and experiences.

Causal explanations of symptoms. Problem conceptualization becomes even more complicated as symptoms are often attributed to varying causes across refugee groups. Substantial differences between conventional Western and traditional non-Western explanatory systems have been consistently demonstrated in the literature (Fernando, 2005; Sussman, 2004). Reflecting Western values of autonomy and personal responsibility, conventional clinical practices are typically characterized by an individual-centred explanatory model (McNamee, 1996; White, 1993), which posits that symptoms or difficulties are attributable to an individual's motivations, values, feelings, goals, physical or genetic makeup, or psyche (Sue & Sue, 2008). This explanatory model underlies the conventional treatment modalities described earlier, supporting their emphasis on changing personal beliefs, behaviours or emotional processes.

As well, refugee problems are conceptualized in terms of PTSD, and are considered disordered reactions primarily in response to exposure to war and trauma. Other possible situational causes such as resettlement issues can be downplayed in therapy. However, the importance of an interpersonal or situational etiology is emphasized among many refugee groups. For example, Somali refugees cited preoccupation with finding family members to be the cause of emotional distress or somatic complaints rather than exposure to war and trauma (Guerin et al., 2004).

Other explanatory models may also be more salient to refugees. The belief that illness may be caused by supernatural or metaphysical factors and agents is one of the most widespread alternative explanatory models among refugee groups (Sussman, 2004), and has been reported among cultures and societies in Africa (e.g., Sussman, 1981), Asia (e.g., Kleinman, 1980), South and Central America (e.g., Ho et al., 2004), and Europe (e.g., Sussman, 2004). For example, one belief held by some Central American refugees is *spiritualism*, or the belief that the "visible world is surrounded by an invisible world inhabited by good and evil spirits who influence human behaviour" and can either protect or harm, and prevent or cause illness, including mental health problems (Ho et al., p. 153). Within this explanatory system, illnesses may result from numerous causes such as displeased ancestors or divine retribution for improper behaviour towards other people, such as leaving behind family members during flight from political violence (Sussman, 2004). Such beliefs may lead refugees to interpret trauma symptoms as the result of divine or spiritual intervention. Restoring emotional well-being may therefore involve spiritual processes such as rituals to appease spirits, rather than relying solely on the techniques used in conventional therapies (Arredondo & Perez, 2003; Fernando, 2005; Kleinman, 1980; Kramer, 2005; Nicholl & Thompson, 2004; Sue & Sue, 2008).

Cultural patterning of symptoms. Refugees' cultural backgrounds also play a significant role in shaping how psychological or emotional distress is manifested (APA, 2000). The interpersonal, societal, and ideological structures that are associated with culture provide a categorical framework and lexicon for

emotional experience, and regulate socially acceptable and unacceptable patterns of emotional expression (Kirmayer, 2001). While the internal (i.e., biological, neurological, or physical) stimuli associated with distress may be similar in each culture (Kleinman, 1980), the affective responses to and experience of the stimuli are markedly different (Kirmayer; Kleinman). The symptom manifestation takes on a culturally meaningful and culturally appropriate form (APA; Niem, 1989).

One of the most frequently reported differences between Western and non-Western patterns of symptom expression is the somatization of distress (Kirmayer, 2001; Orley, 1994). In many non-Western societies, individuals often do not complain of symptoms of anxiety, depression, or other "psychological" manifestations of emotional distress. Rather, the distress is presented somatically or as physical complaints such as chest discomfort, dizziness, chronic pain, gastrointestinal complaints, and fatigue (Arredondo et al., 1989; Guerin, et al., 2004; Kirmayer, Robbins, & Dworkind, 1993; Kroenke, Jackson, & Chamberlin, 1997; Murray et al., 2010; Orley; Simon, Von Korff, & Piccinelli, 1999). For example, D'Avanzon, Frye, and Froman (1994) found that Cambodian refugees' post-traumatic stress reactions were most often characterized by headaches, abdominal pain and nausea, and physical rather than emotional pain. Similarly, Van Boemal and Rozee (1992) discovered atypical manifestations of posttraumatic stress among Cambodian refugee women including psychosomatic blindness. These patterns of somatization may be due to the structures of expression imposed by the relevant cultural lexicon for emotional experience, as

well as the stigma associated with psychological disorders or cultural value placed on suppression of intense emotions (e.g., Kirmayer; Niem, 1989).

Definitions of mental health and symptom expression are fundamentally connected with diagnosis and assessment. Many of the Western-based methods of diagnosis are not culturally sensitive (Bemak et al., 2003; Prendes-Lintel, 2001), as they are based on Western conceptions of healthy and unhealthy behaviour, and Western experiences of symptom expression. As a result, utilizing these measures in cross-cultural applications often results in the frequent misdiagnosis, under-diagnosis and over-diagnosis of culturally different clients (Aponte, 2004). For example, Kirmayer (2001) found that the clients' style of clinical presentation significantly affected the clinicians' ability to recognize cases of anxiety and mood disorders. The more persistently a client somaticized their distress, the less likely the clinician was able to accurately diagnose the underlying disorder.

Client-congruent problem conceptualization. Conceptualizing the problem in a way that the client finds credible or acceptable is considered essential to successful treatment across psychotherapies and models of healing (Fischer et al., 1998; Frank & Frank, 1991; Mollica, 2006; Torrey, 1986). For example, Atkinson, Worthington, Dana, and Good (1991) demonstrated that clients' ratings of perceived similarity between their and their counsellors' attributions of symptom etiology successfully predicted increased ratings of counsellor credibility and satisfaction with the therapy received. Similarly, clients who received interpretations of symptoms that were similar to their explanatory models demonstrated a greater expectation to change as a result of counselling,

the tendency toward greater therapeutic change, and greater satisfaction with therapy (Claiborn, Ward, & Strong, 1981). Tracey (1988) found that similar causal explanations between clients and therapists were related to both client and therapist satisfaction with the first session, and fewer premature terminations after the first session. While these effects were demonstrated in mainstream and multicultural counselling services (Fischer et al., 1998), they are particularly relevant to refugee applications as well.

Healing Processes

The previous sections have highlighted that refugees may view their presenting problems differently than mental health professionals and express these problems in different ways. Problem conceptualization and symptom expression are fundamentally connected with treatment, and refugees' unique problem conceptualizations may shape their treatment expectations and desired treatment goals (Belliard & Ramirez-Johnson, 2005; Kagawa-Singer & Chung, 1994; Kirmayer, 2001; Mollica, 2006). For example, conventional treatment approaches typically work towards symptom improvement and self-actualization. As mentioned previously, many refugee groups may consider finding lost family members (Guerin et al., 2004) and dealing with immediate resettlement needs (Bemak & Chung, 2008; Bemak et al., 2003; Kramer, 2005) to be the most important goals to pursue. These differing perspectives suggest that refugees may prefer treatment goals that try to effect change in their family or resettlement situation rather than goals that emphasize self-change in terms of beliefs or behaviours (Bekker, Hentschel, & Fujita, 1996; Fernando, 2005; Kirmayer).

Problem conceptualization also plays a significant role regarding how problems should best be addressed in therapy (Sue & Sue, 2008; Sussman, 2004). For example, if a refugee perceives his or her current mental health problems to be the result of spiritual intervention or punishment due to leaving family members behind during flight from political violence, then appropriate therapy may involve a restorative ceremony to appease the spirits (Arredondo & Perez, 2003; Nicholl & Thompson, 2004; Sussman, 2004). Similarly, if illness is experienced somatically, then physical treatments are typically desired and requested (Kleinman, 1980).

There has been little consensus among researchers and practitioners regarding how problems should best be addressed in therapy, or which counselling interventions are helpful or therapeutic when treating refugees. Two interventions have been consistently highlighted among mental health professionals working with refugees. Specifically, mainstream refugee therapies have employed treatment strategies which underscore the clinical importance of re-telling the trauma story, and re-establishing social connections and addressing resettlement needs. These interventions have either been part of the mainstream treatment protocol, or incorporated into a modified treatment plan.

Re-telling the trauma story. The re-telling of the trauma story is a central therapeutic task common to the majority of treatment paradigms including CBT, insight-oriented approaches, testimony therapy, and narrative exposure therapy (Mollica, 2006). While conventional counselling approaches utilize the strategy of "talking through" one's problems to elicit emotional, psychological, and

behavioural change on an individual level (Summerfield, 1999), verbal and emotional expression is not highly valued by some refugee groups (Sue & Sue, 2008). For example, in speaking about Southeast Asian refugee cultures, Tung (1985) suggested that talking about feelings is equally as taboo as "parading in the nude in public". Some individuals within these cultures may consider the restraint of strong emotions to be a sign of maturity and wisdom (D. W. Sue, 1990), and individuals may be expected to conceal their "inner selves" and present a public front as a sign of respect for the other (Kagawa-Singer & Chung, 1994; Kirmayer, 2001). As such, the therapeutic significance of talk therapy varies greatly across cultures (Morris et al., 1993; Summerfield, 1999).

Due to these divergent cultural norms, considerable cultural differences exist in the willingness to tell the trauma story to others (Morris & Silove, 1992). Without cultural adaptations to treatment protocols, Western talking cures may prove to be somewhat unsuccessful in some refugee contexts (Boothby, 1992; S. Sue, 1998). In their longitudinal study of Cambodian refugees, Boehnlein et al (2004) suggested that avoidance of past traumatic events may be more therapeutic than actively discussing them in a therapeutic context. Comparatively, refugee clients from Southeast Asia (Kagawa-Singer & Chung, 1994) and the former Yugoslavia (Weine et al., 1998) were reported to be more comfortable talking about their problems in modified approaches which framed personal disclosures within the context of sharing their life story or in the process of recording their testimony of social injustices.

Re-telling the trauma story also emphasizes distinctly Western individual-centred values, as intervention strategies focus on processes within the individual and individual change and growth (Kramer, 2005; Fernando, 2005; Sue & Sue, 2008). For example, this therapeutic task highlights the change of an individual's beliefs, behaviours, or emotions. This focus minimizes the importance refugees may place on interpersonal relationships and factors such as the preoccupation with finding family members (Guerin et al., 2004). Similarly, the effectiveness of talk therapy may also be limited when refugees' life situations and resettlement needs warrant immediate attention. However, Mollica (2006) suggests that trauma stories can be shared in a way that fosters interpersonal connection in collectivist cultures, rather than self-focus or alienation.

Re-establishing social connections and addressing resettlement needs. The re-establishment of social connections and addressing resettlement needs have been highlighted by many researchers and practitioners as principal therapeutic tasks, and necessary elements required for successful therapy (e.g., Bemak & Chung, 2008; Pejovic et al., 1997). As such, researchers emphasize the importance of incorporating these social and resettlement considerations into a modified treatment program (Bemak et al., 2003; Hwang, 2006; Yakushko et al., 2008).

The emphasis on re-establishing social connections is not surprising as social and family supports are considered to be among the most important protective factors in promoting resiliency and moderating the effects of premigration trauma (Al-Issa, 1997b; Beiser & Hyman, 1997; Diehl et al., 1993;

Emmelkamp et al., 2002; Lyons, 1991). Many refugee groups as well may consider re-establishing social connections to be the most important goal to pursue during therapy (Bemak & Chung, 2008; Bemak et al., 2003; Guerin et al., 2004; Kinzie et al., 1988; Kramer, 2005; Rosser, 1986). The negative psychological impact of current resettlement stressors and pressing life needs is also well documented (Al-Issa, 1997b; Beiser & Hou, 2001; Beiser et al., 1993; Schwarzer et al., 1994; Wickrama et al., 2002). Therapeutically, these needs may take precedence over the resolution of psychological problems associated with premigration trauma (Arthur et al., 2010; Bemak et al., 2003; Hernandez, 1996; Kinzie & Fleck, 1987; Maslow, 1943). Through clinical observations of survivors of the war in the former Yugoslavia, Pejovic and colleagues (1997) indicated that therapy, whether CBT, pharmacotherapy, or family therapy, appeared to be ineffective if social elements such as concerns relating to current economic and living situations were not addressed during the therapeutic process. Similarly, Kinzie and Fleck (1987) found counselling to be ineffective if the therapist did not assist with the clients' pressing current social and financial concerns. In a similar fashion, the severity of PTSD symptoms in Southeast Asian and African refugees was found to significantly diminish once the refugee families obtained secure immigration status in the country of resettlement. This lessening of symptoms was independent of any psychological interventions received at the time (Oras, de Ezpeleta, & Ahmad, 2004).

Addressing social and resettlement needs may be an essential component of therapy; counselling has shown to be less effective if these needs are

overlooked in the therapeutic process (Looi & Drew, 1996; Pejovic et al., 1997). However, the relationship between psychological and emotional distress and psychosocial adaptation is complex. Addressing resettlement, social and adaptive factors alone while disregarding significant emotional difficulties may not lead to therapeutic change among those who are severely distressed (Schei & Dahl, 1999). Significant psychological distress inhibits psychosocial adaptation, and factors such as clinical depression and severe PTSD may require treatment before resettlement and psychosocial adaptation issues can be addressed (Silove, Manicavasagar, Coello, & Aroche, 2005). For this reason, Bemak and colleagues (2003) have emphasized the utilization of a treatment approach that holistically addresses the refugees' traumatic life experiences, acculturation and resettlement experiences, and social support and functioning. At the same time, they stress that any intervention used must be congruent with the clients' worldview and expectations of treatment.

Client-congruent treatment strategies. Employing therapeutic tasks and processes which are consistent with the needs and beliefs of the client is essential for successful therapy (Fischer et al., 1998; Frank & Frank, 1991; Torrey, 1986). Utilizing mutually acceptable tasks is an important component of a counsellor's perceived trustworthiness, and the development of a strong working alliance (Atkinson & Lowe, 1995; Egli, Shiota, Ben-Porath, & Butcher, 1991; Roysircar, Hubbell, & Gard, 2003; Sodowsky, 1991). In addition, a treatment that does not meet a client's expectations or is inconsistent with his or her worldview may affect the client's hope of change or belief that the therapy will work (Egli et al.).

The client's belief that therapy will work has been consistently demonstrated in the mainstream literature to be a key ingredient of a treatment's effectiveness (Bohart & Tallman, 2010; Lambert & Bergin, 1994). Perhaps for these reasons, interventions that are responsive to clients' culture, life experiences, and expectations significantly predict client ratings of satisfaction with therapy, perceived therapist credibility, and positive treatment outcome (Constantine, 2002; Roysircar et al., 2003; Sodowsky). Conversely, treatments which are not meaningful or credible to the client may result in the underutilization of non-adapted mainstream services (Arthur & Januszkowski, 2001; Atkinson & Lowe, 1995; Atkinson et al., 1991; Kramer, 2005).

It is an ongoing concern among cross-cultural scholars that refugee clients may not consider mainstream mental health services to be a viable solution to their emotional distress (Mollica, 2006; Sue & Sue, 2008). The credibility of mainstream services may be in question among refugees for several reasons. First, as indicated previously, mainstream approaches may not match client expectations in regards to problem conceptualization, treatment goals, and treatment processes. Second, refugees may be more likely to seek help from family members, and may have a reluctance to disclose their personal problems to individuals outside of the family context (Atkinson & Lowe, 1995; Green, 1999; Kleinman, 1980; Narikiyo, & Kameoka, 1992; Sue & Sue). Third, there is stigma attached to mental illness that may keep culturally diverse clients from seeking therapy (Narikiyo, & Kameoka; Silove et al., 1997). Similarly, conventional psychotherapy is highly stigmatized and considered by some refugee groups to be

reserved exclusively for “psychotic patients in mental hospitals” (Organista & Munoz, 1996, p. 259). Finally, because of the frequent somatization of psychological problems, clients may seek help from the medical sector instead of mental health professionals (Aponte, 2005; Kleinman, 2005; Narikiyo & Kameoka).

The Counsellor-Client Relationship

A strong therapeutic relationship is fundamental to positive treatment outcomes. This is equally as true in mainstream therapy (Horvath & Symonds, 1991; Norcross, 2010) as it is in cross-cultural and refugee psychotherapy (Fischer et al., 1998). Atkinson and colleagues (2001) suggested several cultural factors could affect the development and maintenance of a positive working relationship. These include the compatibility of beliefs concerning the conceptualization and treatment of the problem, and similarities in language and communication.

Problem conceptualization and treatment. As discussed previously, cultural differences between counsellor and client may result in a discrepancy between views regarding how problems are conceptualized, and how problems should most effectively be treated. Conceptualizing and treating the problem in a way that is consistent with client expectations and beliefs is essential to a strong counselling relationship (Egli et al., 1991; Looi & Drew, 1996; S. Sue, 1998). These shared attitudes and beliefs in terms of problem conceptualization and treatment have been consistently demonstrated to impact the therapeutic alliance and ultimately treatment effectiveness in immigrant and refugee settings

(Constantine, 2002; Kagawa-Singer & Chung, 1994; Pomales, Claiborn, & LaFromboise, 1986; S. Sue; Wade & Bernstein, 1991). Still, value differences in regards to worldview are frequently cited by counsellors as the primary cause of disagreement in the counselling relationship (Arthur & Januszkowski, 2001). Unfortunately, in much refugee psychotherapy, it is often the client who changes his or her worldview to match the view of the therapist (Kleinman, 1980; Kramer, 2005).

Language and communication norms. Psychotherapy is a form of communication that requires the accurate exchange of both verbal and nonverbal messages (D. W. Sue, 1990; Sue & Sue, 2008; Waxler-Morrison, 1990). Language similarity can have a significant impact on the therapeutic process and therapeutic effectiveness, as language similarity facilitates communication and the expression of emotion and distress (Collins & Arthur, 2005; D. W. Sue). Given the importance of language in organizing and assimilating traumatic memories and emotions (Pennebaker, 1995), language similarity may play an important role when expressing the experiences associated with the refugee career. This may be particularly relevant among refugee populations whose first language is not English due to the fact that when intense experiences are encountered, the emotions related to them tend to be encoded in the individuals' native language (Santiago-Irizarry, 2001).

Language dissimilarity may pose problems for understanding refugees' experiences and restrict the clients' ability to comfortably communicate. As one example, language dissimilarity may hinder the therapist from being able to

respond to code-switching among refugee populations. Santiago-Irizarry (2001) discussed the experiences of mental health professionals working with Latino immigrant and refugee populations who lived in New York for various lengths of time. Even clients who had resided in New York for over 10 years sometimes shifted back and forth between using English and words from their first language to express their experiences in psychotherapy groups.

Additionally, the many subtleties of nonverbal communication, including the use of personal space, facial expressions and body movements, and vocal cues, compound the possible misunderstandings that may arise during communication (Katz, 1985; D. W. Sue, 1990). For example, the large personal space comfortable for many Americans and Canadians (Jensen, 1985), may be interpreted as aloofness or coldness by Latin American and African refugees, as their cultures prescribe a much closer interpersonal stance (D. W. Sue). As well, the avoidance of eye contact is typically interpreted negatively by mainstream therapists, and is often attributed to negative traits such as shyness, depression, unassertiveness, dishonesty, or inattentiveness. Conversely, the avoidance of eye contact may be a sign of respect among some Asian and Latin American refugee groups (Baruth & Manning, 1991; D. W. Sue).

Language similarity is associated with increased treatment length, and may be associated with positive treatment outcomes among immigrant and refugee clients (S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Takeuchi, Sue, & Yeh, 1995). Several of the culturally adapted refugee treatments provided therapy in the clients' first language either through an ethnically matched counsellor or by

the assistance of an interpreter (Basoglu et al., 2004; Cienfuegos & Monelli, 1983; D'Ardenne, Cestari, Fakhoury, & Priebe, 2007; Neuner et al., 2002, 2004; Otto et al., 2003; Schei & Dahl, 1999; Schulz, Resick, Huber, & Griffin, 2006; Van Boemal & Rozee, 1992; Weine et al., 1998). This culturally sensitive modification may have accounted for the positive treatment outcomes, or been one of the factors that led therapy to be effective.

The Missing Voice of the Refugee

To be adequately portrayed, the counselling process must be viewed from three distinct viewpoints: that of the therapist, the client, and a detached observer (Llewelyn, 1988). The refugee research described above has focused almost exclusively on the perspectives of the therapists and researchers. Researchers, practitioners and scholars have dictated the goals of treatment, the mode of problem conceptualization and method of treatment, and hypothesized the processes through which these treatments are assumed to work. Throughout this discourse the perspectives of the refugee have remained noticeably absent (Kramer, 2005; Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001).

Background

The existing refugee research is not devoid of historical context and may be better understood within the larger body of psychotherapy research. Mainstream psychotherapy outcome research was originally spurred by Eysenck's (1952) controversial criticism that psychotherapy demonstrated to be no more effective than the simple passage of time. Over five decades of mainstream psychotherapy outcome studies have consistently allayed this charge and

empirically demonstrated the effectiveness of psychotherapy (Lambert & Bergin, 1994; Orlinsky et al., 2004; Wampold, 2010; Wampold et al., 1997). With the effectiveness of psychotherapy generally regarded as established, attention has shifted to investigating how therapy works and what ingredients contribute to therapeutic effectiveness (Hill & Corbett, 1993; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988).

Valuing the Client Perspective

Early efforts to address these questions typically centred on the therapist's view of therapy and assumed that "objective" measures of change were the most informative indicators of therapeutic process and outcome (Bohart & Tallman, 2010; Hill & Alexander, 1993; Llewelyn, 1988; Orlinsky et al., 2004). Like the refugee studies reviewed earlier, this mainstream research relied largely on the use of objective measures such as post-therapy questionnaires and self-report instruments, clinical observations, and the clinical perceptions of the therapist (Gallegos, 2005; Orlinsky et al.). In addition, while this research has led to many important advances in understanding psychotherapeutic processes, it has been largely theory-driven. Factors which facilitate therapeutic change were generated from within specific theoretical frameworks, while other ways of understanding the therapeutic process, such as the views and experiences of the client, were by and large ignored (Llewelyn).

Later efforts began to recognize that the client's perspective of therapeutic effectiveness is an essential dimension in understanding counselling process and outcome (Audet & Everall, 2010; Elliott & James, 1989; Levitt et al., 2006;

Llewelyn, 1988; Paulson, Truscott, & Stuart, 1999; Shine & Westacott, 2010; Viklund, Holmqvist, & Nelson, 2010;Wilcox-Matthew, Ottens, & Minor, 1997). Intuitively, the client's perceptions of therapy are important as client experience is the arena in which therapists and counsellors hope to effect change (Elliott & James; Foster, 2007). As Duncan and Miller (2000) assert, "it is the clients, not the therapists, who make treatment work. As a result, treatment should be organized around their resources, perceptions, experiences, and ideas" (p. 11). Developing a better understanding of what clients view to be helpful during therapy provides an important insight into the ingredients of psychotherapy which may be the most therapeutic (Bohart & Tallman, 2010; Gershefski, Arnkoff, Glass, & Elkin, 1996; Llewelyn; Shine & Westacott, 2010).

Furthermore, the client's perspective of therapy is a valuable source of information as a client's perception often differs from that of the therapist (Audet & Everall, 2010; Bachelor, 1991; Elliott & James, 1989; Gershefski et al., 1996; Llewelyn, 1988). For example, Llewelyn explored therapist and client perceptions of helpful and unhelpful events in therapy by collecting the perspectives of 40 therapist-client dyads after each session, and upon termination of therapy. She found that therapists most often reported cognitive and affective insight to be the most helpful event in counselling, reported both during therapy and after termination. Comparatively, clients most often reported reassurance and relief to be the most helpful therapeutic event during therapy, and valued problem-solving aspects of therapy most in retrospect. Significant differences also occurred for

awareness, and understanding, with therapists reporting these events to be more helpful than clients.

Other researchers have also suggested that clients emphasize to a greater extent the counselling relationship as a key component in therapy compared to counsellors (Halstead, Brooks Jr., Goldberg, & Fish, 1990; Lietaer, 1992; Marziali, 1984). Lietaer compared client and therapist reports of helpful and hindering aspects of therapy. Clients most frequently reported that relational attitudes were the most salient aspect of counselling, whereas therapists considered cathartic self-explorations to be the most helpful.

Client and therapist perceptions of therapy relate differently with therapeutic outcome, with client ratings correlating more strongly with outcome than therapist ratings (Bachelor, 1991; Elliott, Bohart, Watson, & Greenberg, 2011; Geller, Greenberg, & Watson, 2010; Halstead et al., 1990). Similarly, a counsellor's intentions during therapy may not match the client's reactions, and counsellors may not accurately perceive or interpret client reactions to therapy—particularly negative reactions (Hill, Helms, Spiegel, & Tichenor, 2001). Most alarming is the assertion that therapists appear to be poor judges of treatment efficacy or of the impact of a particular treatment in session (Geller et al.; Orlinsky et al., 2004). This is a significant observation as therapists may continue to provide a treatment that they believe to be effective, which in reality offers little therapeutic benefit. In this regard, clients provide a valid judgement of therapeutic impact and offer a valuable perspective into counselling processes.

Helpful and Hindering Aspects of Psychotherapy

Developing a greater understanding of client perceptions of helpful and hindering aspects of psychotherapy offers a valuable perspective into counselling processes and may provide important insights into the ingredients of psychotherapy. In a pioneering study, Elliott (1985) developed a taxonomy of helpful and unhelpful events in counselling as they may be perceived by the client. Pseudo-clients in mock counselling sessions were asked to identify and rate the most and least helpful counsellor interventions immediately following the session. Through cluster analysis, Elliott identified eight kinds of helpful events grouped into two "superclusters". The *Task* supercluster involved work directed toward the client's presenting problem, including adding a new perspective, clarifying the problem, problem solution or working to develop a course of action to solve the problem, and focusing attention on topics the client was avoiding. The *Interpersonal* supercluster consisted of events that were experienced as helpful interpersonal experiences, including understanding, reassurance, experiencing a positive interpersonal relationship, and feeling involved in the counselling process. Six types of unhelpful events were also identified, the most common being misperception, negative counsellor reaction, and unwanted responsibility.

In a later review, Elliott and James (1989) analyzed the existing research on client experiences of helpful events in counselling. Like Elliott's (1985) earlier study, Elliott and James proposed two broad categories of helpful therapeutic events. The task-oriented or problem solving category included tasks directed

toward the client's self-understanding and insight, and the therapist's encouragement of gradual extra-therapeutic practice. The relationship category involved interpersonal aspects of therapy, including facilitative characteristics of the therapist, a supportive relationship and unburdening of distress, and allowing client self-expression.

Subsequent researchers have reported results consistent with these early findings. Typically, these studies have underscored the client-perceived therapeutic significance of: (a) a positive counselling relationship, including an atmosphere of acceptance, warmth and empathy; (b) the opportunity for clients to talk about their problems; and (c) gaining insight into the problem and learning new ideas (Gershefski et al., 1996; Lietaer, 1992; Wilcox-Matthew et al., 1997). Other helpful aspects of therapy were specific counsellor interventions such as cognitive behavioral techniques, therapist feedback and advice, and answers to specific questions. These results have been demonstrated in client-centred psychotherapy (Lietaer) as well as CBT and interpersonal psychotherapy (which focuses on the relationship between problems in interpersonal relationships and emotional difficulties; Gershefski et al.). Of note, Gershefski and colleagues found that client perceptions of the most helpful aspects of treatment did not differ across the varying types of treatment. Clients reported that talking about their difficulties, developing insights, and having a helpful therapist were the most important aspects of treatment regardless of the type of therapy received.

Paulson and colleagues (1999) interviewed clients utilizing an open-ended probe: "what was helpful about counselling?" The opportunity to self-disclose

was rated by the clients to be the most helpful element of counselling. Furthermore, the role of the therapist's interpersonal style and a supportive, therapeutic relationship were also emphasized by clients as being particularly helpful in counselling. Additionally, clients reported that the ability to develop new perspectives, gain knowledge or insight, experience emotional relief, and develop personal resources as important components in the therapeutic process. Gallegos (2005) also utilized an open-ended interview format to explore client experiences of what contributes to symptom relief. Like previous studies, clients reported that therapist characteristics and a positive therapeutic relationship were important elements of therapy. Specifically, clients valued a therapist who was accommodating, knowledgeable, and attuned to their needs, as well as one who provided a safe, trusting, and supportive environment. In addition, clients found increased insight and awareness to be a helpful element in therapy.

Many of these studies (e.g., Elliott, 1985; Elliott & James, 1989; Gershefski et al., 1996; Lietaer, 1992; Wilcox-Matthew, 1997) utilized predetermined categorical systems based on the investigator's theoretical framework to encode client responses. As a result, these studies focused on what the researchers believed to be important elements of therapy, limiting the understanding of the counselling process to conceptual frameworks or worldviews consistent with those of the researcher (Paulson et al., 1999). Therefore, based on these studies, it remains unclear how clients perceive helpful events in counselling according to their own worldviews.

Later studies including Paulson and colleagues (1999) and Gallegos (2005) utilized open-ended questions and allowed clients to share their experience of counselling in a way that was more free from researcher-imposed constraints. It is likely that through these methods, client experiences were made clearer. However, these studies did not utilize a culturally diverse sample, and the results may not be applicable to refugee clients. For example, the therapeutic significance attributed to gaining insight may not be held across cultures, and self-disclosure may be experienced as distressing rather than helpful among some refugee groups where emotional restraint and directly addressing resettlement stressors may be a more appropriate therapeutic focus (Boehnlein et al., 2004; Sue & Sue, 2008; Summerfield, 1999).

Unfortunately, few studies have examined client perceptions of helpful aspects of therapy (or factors that facilitate therapeutic change) in a refugee sample. The reports of client experiences that are available in the literature were only included anecdotally in the studies cited. One case study described by Sveaass and Axelsen (1994) described the treatment of two refugee women attending therapy who had been imprisoned, tortured and raped. Following treatment, these women reported that the most useful aspect of therapy was talking about the detention, torture, and rape; or as one woman expressed, “to tell my story to somebody” (p. 27). This finding is especially significant as the clients identified themselves as coming from a culture where it is not usual to talk about personal problems or sexuality. This discrepancy between what some researchers (e.g., Morris & Silove, 1992; Summerfield, 1999; Tung, 1985) hypothesize as

helpful and what refugee clients report as helpful highlights the importance of better understanding refugees experiences of counselling. The question clearly remains: what do refugees perceive as helpful in counselling or psychotherapy?

Statement of the Problem

Due to current global conditions, unprecedented numbers of individuals are being displaced from their homes, many of whom are refugees seeking sanctuary outside of their homelands. Many of these refugees will have endured significant premigration trauma such as deprivation of food, loss of family members, incarceration, witnessing the torture and killing of other people, and personal injury and torture. Significant challenges continue after resettlement as refugees must often learn a new language, adapt to an alien culture, and deal with the loss of employment, limited financial resources, and loss of family and community support. While many refugees demonstrate incredible resiliency in overcoming these numerous obstacles, the experiences endured throughout the refugee career can have a lasting psychological impact and result in unique mental health needs (Beiser & Hou, 2001; Bemak et al., 2003; Boehnlein et al., 2004; Djuraskovic & Arthur, 2009; Fenta et al., 2004; Lie, 2002; Mollica, 2006; Yakusho et al., 2008).

Several models of therapy have been developed and utilized by mental health professionals in the treatment of refugees. Cross-cultural and refugee theorists and practitioners have highlighted that in order to provide effective counselling services, therapists need to conceptualize client problems in a way that is consistent with the clients' belief system, employ treatment strategies that

are congruent with the clients' expectations and beliefs, and create a strong therapeutic relationship (Fischer et al., 1998; Sue & Zane, 1987). Refugee problems as presented in the literature have most frequently been conceptualized as disordered responses to premigration war and trauma. Treatments have correspondingly targeted the alleviation of posttraumatic stress symptoms as the primary objective of therapy. Treatment strategies have typically been founded upon Western theories of mental health and healing, and have emphasized the clinical importance of re-telling the trauma story, re-establishing social connections, and addressing resettlement needs to facilitate therapeutic change.

These current understandings of problem conceptualization, treatment goals, and what contributes to therapeutic change in refugee psychotherapy have evolved through much dialogue and continuing discourse between researchers, practitioners and scholars. However, throughout this debate the voice of the client has been excluded (Kramer, 2005). The importance afforded to client perspectives in counselling has grown in mainstream research as researchers have recognized that client perceptions offer a valuable and necessary perspective into counselling processes (Llewelyn, 1988), and may provide important insights into the key ingredients of psychotherapy (Heppner, Rosenberg, & Hedgespeth, 1992). This is especially important as client perceptions often differ from those of the therapist (Bachelor, 1991; Elliott & James, 1989; Gershefski et al., 1996; Llewelyn). Still, the client's voice continues to remain silent in multicultural research (Pope-Davis et al., 2001) and research with refugees (Kramer, 2005).

The missing refugee perspective may result in a discrepancy between the worldview, beliefs, and expectations of refugee clients, and the services provided for them. Therapies may focus on symptom alleviation as the primary goal of treatment while refugees may favour an approach that addresses social relationships. Therapeutic approaches have conceptualized refugee problems as disordered responses to premigration war and trauma, while refugees may conceptualize their problems in terms of the breakdown of social relationships or the result of spiritual intervention. Treatments have highlighted the re-telling of the trauma story as an essential ingredient of therapy, while the therapeutic significance of this process may be in question among refugee clients. To date, no research has aimed to bring to light the valuable perspective of the refugee.

In order to better understand therapeutic processes with refugees, it is vital to understand how refugees perceive the counselling experience. The purpose of this study was to explore refugees' experiences and perceptions of the therapeutic process. The guiding research questions were: (a) Why do refugees seek counselling and how do they conceptualize their presenting problems? (b) What are refugees' experiences of counselling? (c) What do refugees identify as helpful in facilitating therapeutic change?

CHAPTER 3: METHODOLOGY

To better understand refugees' experiences of counselling, a qualitative research design was employed. Following the methodological framework of interpretive inquiry, participants were purposefully sampled through local settlement agencies and refugee counselling centres, data was collected through a series of in-depth interviews, and data was analyzed using a narrative approach. This chapter describes the methodological framework utilized in the current study and its philosophical underpinnings. Participant selection criteria and the recruitment strategy are also outlined, as well as data collection and data analysis procedures. The chapter concludes with standards for evaluating the study.

Research Foundations

The importance of acknowledging and understanding the client's lived experiences and meaning ascribed to these experiences has been increasingly recognized by counselling and psychotherapy researchers (Gallegos, 2005). Following this trend, the use of qualitative methodologies to investigate psychotherapeutic processes has been garnering increasing support, as the primary aim of qualitative research is to develop an understanding of individuals' experiences and meanings (McLeod, 2001). This focus of qualitative research is particularly germane to the current study as the experiences of refugees remain relatively unknown in the literature, and these experiences may provide a valuable wealth of information.

The methodologies through which researchers have attempted to understand client experiences in counselling have been nearly as diverse and

varied as the experiences which have been uncovered. Each methodological practice makes the object of study visible in a slightly different way; for example, quantitative studies result in group averages, phenomenological studies describe the "essence" of an experience, and narrative studies result in narrative texts (Denzin & Lincoln, 2005). As such, it is critical that the chosen methodology match the purpose of the study. Methodologically, this study can best be described as a basic qualitative inquiry (Merriam, 1998), which will be informed by the framework of interpretive inquiry (Ellis, 1998). This framework draws upon the theoretical perspective of hermeneutics and epistemological assumptions of constructionism. Each of these frameworks will be outlined below.

Constructionism

Constructionism is the view that all knowledge is constructed through the interactions of human beings as they engage in their social context (Crotty, 2003). In other words, humans are interpretive beings who actively construct their realities and endow meaning to events and experiences (Bruner, 1986; Chomsky, 1966). These meanings, however, are not constructed in a vacuum; rather, they are constructed against a backdrop of larger cultural, familial, historical, and social influences (Gergen, 1985). As a result of differing biographies, cultural backgrounds and unique life experiences, there are multiple realities and unique meanings that may be attributed to seemingly similar experiences. While individuals within or between cultural groups may share similar constructions and meanings, important differences may exist.

The underlying principles of constructionism are highly compatible with multicultural counselling and research practices. Like constructionism, multiculturalism accepts the legitimacy of multiple perspectives of reality. Additionally, both perspectives recognize that meaning can only be understood within a social context (D'Andrea, 2000). In terms of the current study, constructionist perspectives blend well as they value the multiple perspectives clients may have of the counselling process, and esteem each perspective as a legitimate form of knowledge. For example, since refugee clients may receive treatment from counsellors outside of their cultural groups, therapists and clients may have differing conceptualizations of the presenting problem or differing beliefs regarding legitimate interventions. The constructionist approach validates this possibility. As well, the constructionist approach validates the diversity which may exist among refugees regarding the reasons they seek help (e.g., trauma symptoms vs. family stressors) and how these differing perspectives may affect their counselling experiences.

Hermeneutics

Hermeneutic principles are firmly embedded in the epistemological principles of constructionism. Hermeneutics is the practice and theory of interpretation and understanding in human contexts (Moule, 2002), and works towards the uncovering of intended or expressed meaning in order to establish a co-understanding (McLeod, 2001). Hermeneutics as a social science emerged in the 17th century in the field of Biblical scholarship in an effort to interpret the meaning of scriptural texts (Crotty, 2003). The principal argument is as follows:

Any text is created within a socio-cultural-historical context. If the reader shares a similar background, it is presumed he or she would understand the text. However, interpretation becomes necessary when social, cultural, and historical/temporal differences exist between the reader and text (McLeod).

An individual's attempt to understand anything, whether Biblical text, verbal language, actions, or events, is built upon the framework of his or her culture or historical background and the associated norms, values, beliefs and traditions (Gadamer, 1989; McLeod, 2001). The product of one's history (i.e., his/her interests, beliefs, prejudices, values, etc.) comprises his or her *forestructure* (Packer & Addison, 1989), or the lens through which the individual perceives or interprets the world (Ellis, 1998). All initial acts of understanding or interpretation are influenced by this forestructure (Packer & Addison). The act of understanding occurs as one interacts with the text or subject of research, and represents a "coming together" of the historical understandings of the researcher and those of the researched (McLeod, 2001, p. 23). From this fusion develops a co-understanding or co-creation of meaning where the understanding of both interpreter and text are enriched and deepened (Gadamer, 1989).

In essence, the interaction between researcher and research situation is referred to as the *hermeneutic circle*, which is comprised of a forward and backward arc (Smith, 1991). When initially making sense of the research situation, participants, or set of data, researchers draw on their forestructure or existing preconceptions, preunderstandings, and beliefs. These attempts are referred to as *projection* and comprise the forward arc. *Evaluation*, or the

backward arc, entails re-examining the initial interpretation that resulted from projection. Through the process of evaluation, the researcher reconsiders the initial interpretation and endeavours to find contradictions, gaps, inconsistencies, or alternative explanations. Through this process, the researcher may discover inadequacies in his or her own pre-understandings, and his or her understanding is enriched and deepened (Ellis, 1998).

Each loop can represent a separate research activity such as data collection or interpretation, or alternatively, a consecutive effort to reinterpret one single event or set of data. However viewed, each loop represents the researcher's attempt to get closer to what he or she hopes to understand. What is learned from one loop influences the direction for the subsequent loop in the inquiry. For example, a new perspective may arise that was not considered before, and this new perspective may spur additional questions or shift initial interpretations. As the spiral of consecutive loops unfolds, the researcher gets closer to understanding the subject of research (Ellis, 1998).

In addition, a hermeneutic approach works holistically, through the constant movement between that which the researcher hopes to understand and the "web of meanings" within which it is lodged (Smith, 1993, p. 16). Individual parts cannot be understood independent of the whole, and the whole cannot be understood without reference to the individual parts (Ellis, 1998). In the current study, helpful aspects of counselling were interpreted within the larger context of general counselling processes, cultural variables, and the refugee career.

The principles of hermeneutics are central to cross-cultural research in general, and specifically to the current study. Most importantly, hermeneutics acknowledges that culture, ethnicity, and biographical experiences influence the forestructure of the researcher and participants, and recognizes that individuals make sense of events or experiences in terms of their cultural and historical worldviews (McLeod, 2001). Projection is seen as an unavoidable component of the research process. However, through deliberate evaluation, the co-understanding of researcher and participant can occur. My pre-understanding of the refugee experience is limited by my culture and historical contexts, namely a White, middle-class, North American male. Through genuine openness and interaction with the participants and their histories, it is hoped that some level of co-understanding was developed.

Interpretive Inquiry

The methodology of interpretive inquiry draws largely from the hermeneutic tradition and constructionist epistemology (Ellis, 1998). The overall objective of interpretive inquiry as a qualitative methodology is to discover or understand a phenomenon or process, as well as understand the perspectives of the individuals involved and how they make meaning of the situation (Merriam, 1998, 2002). While other qualitative methodologies share many of these same characteristics, these other methodologies incorporate additional aims or functions, such as theory building or providing an intensive case study of a single unit or system (Merriam, 1998).

Interpretive inquiry does not rely solely on one methodology. Typically, when utilizing this approach, data are collected through interviews or observations and analyzed inductively to identify recurring themes and patterns. These themes and patterns are then contextualized within and integrated into existing research and knowledge (Merriam, 2002). Researchers begin the inquiry process with an entry question, as well as openness, humility, and a genuine interest in the area of study. It is also recognized that researchers will be influenced somewhat by their forestructure or existing preconceptions and preunderstandings. From these first stages of the research project through to writing the final research account, the researcher engages in the hermeneutic cycle of projection and evaluation, interpreting the research data and evaluating the initial interpretations. Through this process, understandings and preconceptions evolve, new findings are uncovered, and new ways of seeing and representing the data emerge. This unfolding process enables the researcher to understand the question in a richer and more complete way (Ellis, 1998).

The Researcher

My research interests in survivors of political or social instability developed while I was a humanitarian worker in Romania shortly after their 1989 revolution. During this time, I established community support services in orphanages and children's hospitals and worked directly with children and adolescents with various difficulties and needs. At times I felt powerless as I tried to help infants crippled and deformed by lack of care, played with homeless children living in urine-drenched sewers, and tried to advocate for the needs of

children and adolescents to a system in need of reform. There I also witnessed the indomitable strength of the human spirit, and an inspiring hope that can flourish in even the most adverse circumstances.

Throughout my experiences I was deeply moved by both the atrocities of life and the hope of the people, and wanted to better understand the resiliency and change process among these individuals. This interest area merged later with my interest in psychology and psychotherapy. During my graduate training in counselling psychology, I began to pour over the research pertaining to psychotherapy among asylum seekers, refugees, internally displaced individuals and other survivors of state-sponsored violence or human rights violations. Through this review, I began to realize that very little attention was given to what these survivors thought. Researchers and scholars dictated what these individuals required in therapy, but little notice was given to what types of help these individuals wanted, or how they felt about the help they received. I wanted to better understand the experiences of these individuals as I believed that their voice is important to hear.

I entered this area of research as a White researcher studying multicultural issues in counselling and psychotherapy. I found it both alarming and disappointing that several authors have claimed that cross-cultural issues in psychotherapy research should fall within the exclusive domain of ethnic-minority researchers (Mio & Iwamasa, 1993; Parham, 1993). These calls come in response to the many difficulties that have arisen in cross-cultural research such as: researchers possessing the social bias of their own society; the frequent

portrayals of ethnic minorities as maladjusted, delinquent, or pathological; and exploitation of the group being researched solely for the benefit of the researcher (i.e., in obtaining research grants and promotions; D. W. Sue, 1993).

These issues are particularly salient in refugee psychotherapy research as participants may be slow to trust researchers and hesitant to engage in the research process based on past experiences of political oppression, institutionalized discrimination, and exploitation (Offet-Gartner, 2005; Pernice, 1994; Ponterotto & Casas, 1991; Silove et al., 2002; Spring et al., 2003). Some refugees believe that their responses to a research investigation may have a damaging effect on their personal safety or the well-being of their family, a belief that may continue for years after resettlement (Pernice; Silove et al.). As Pernice emphasized, even terms such as *investigator* may "conjure images of an investigation by the secret police, who are perceived not only as corrupt and exploitative but, first and foremost, as life-threatening" (p. 210). Furthermore, refugees may regard the research endeavour as a form of exploitation as the results of research do not benefit the day-to-day lives of the refugees or their community (Silove et al.; Spring et al.). It may be perceived that these research publications sit unused on a shelf, or serve solely the interests of the researchers. In the worst case scenario, research has further added to oppression, racism and social bias by confirming existing stereotypes and portraying refugees (along with other culturally diverse individuals) as maladjusted or pathological (Offet-Gartner; D. W. Sue, 1993), a frequent theme in much of the early (and even

current) refugee psychotherapy research (Al-Issa, 1997; Prendes-Lintel, 2001; Summerfield, 1999).

Issues of researcher credibility and trust become methodological concerns as they play an important role in the richness of the information collected, if that information can even be collected at all. While I do not agree with the simplistic (and in itself discriminatory) solution of banning White researchers from this area of study, it remains clear that my credibility and trustworthiness among research participants cannot be taken for granted, but must be carefully cultivated and nurtured. Throughout the course of study, special attention was paid to developing a strong research alliance (Silove et al., 2002; Spring et al., 2003). Time was spent learning the folkways of the refugee cultural groups that were included in the study, and understanding the tacit knowledge, social norms and patterns of respect in order to create a strong alliance (Morrow et al., 2001). Similarly, trust and a strong research alliance were developed within the research interview as personal and sensitive disclosures are handled in a culturally respectful manner (Mitchell & Radford, 1996; Morrow et al.). Uninterrupted listening and interested attention, while avoiding interpretations, judgments, or imposed worldview, are considered essential elements of a successful research interview (Beiser & Hyman, 1997; Hollway & Jefferson, 1997; Mitchell & Radford). Additional considerations included: (a) utilizing culturally appropriate and sensitive terms throughout the interviews and on all consent and information forms (e.g., utilizing the word *researcher* rather than *investigator*); (b) being as transparent as possible during the interviews in regards to the purpose of the study and how the research findings

will be used (e.g., answering all questions and using personal disclosure regarding why I am interested in their experiences); and (c) conducting the research in such a way that it will benefit refugee groups (e.g., conducting workshops for mental health professionals who work with refugees so that the findings of the study can inform current practices).

Language

Language is a critical element throughout all stages of a qualitative inquiry (Guba & Lincoln, 1994). Language enables the researcher to engage in dialogue with the participant, textually represent the participants' stories, and disseminate the research findings to others. From a hermeneutic perspective, language plays a pivotal role in human understanding as language provides the structure and lexicon for understanding and interpretation, and is the medium through which understanding can occur between individuals (Gadamer, 1989; Gallagher, 1992). The importance of language is particularly evident in multicultural research where the researcher and participant may have different first languages (Pernice, 1994), and therefore a different lexicon with which to construct and express their experiences. Special consideration was given to the language used by the participants so that the interpretations remain true to their experiences and intended meaning. Towards this end, the language utilized by participants must be understood from within the context of their cultural background and personal histories. The use of an interpreter was offered to each participant in the interview process to facilitate this understanding as will be described in the interview section.

Participant Selection and Recruitment

Data was collected from an ethnically mixed sample of four adult refugees with varying refugee trajectories and refugee career experiences. Consistent with qualitative research designs, participants were selected through purposive sampling procedures to select information-rich cases from which the most could be learned (Merriam, 1998). Participants were selected based on three additional criteria: (a) a refugee with a minimum of two years of residence in Canada; (b) attendance in personal counselling or psychotherapy (as opposed to settlement, career, or educational counselling) relating to experiences endured through the refugee career; and (c) no greater than five years following termination of counselling.

Selection Criteria

Minimum length of residence in Canada. The first few years following immigration are typically devoted to the refugees' settlement and integration into the host society (Prendes-Lintel, 2001). This period is often a time of heightened psychological distress due to pressing resettlement needs such as finding housing, accessing healthcare services, and so on (Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, 1988). In order to allow for these initial settlement processes to occur and allow for at least a minimal level of stability among participants, a minimum of two years tenure in the host society was determined as a prerequisite for participation in the study. This criterion was not considered to have a negative impact on the study as many refugees typically do not seek out counselling services until this initial resettlement period has

passed (Bemak et al., 2003). As well, refugees often continue to experience recurring resettlement stressors and ongoing psychological difficulties even after achieving some level of initial stability (Beiser & Hou, 2001; Fenta et al., 2004), and may utilize counselling services as long as 14 years post-settlement or longer (e.g., Paunovic & Öst, 2000; Snodgrass et al., 1993). Participants were not excluded based on maximum length of residence in Canada as multiple historical perspectives are desired to address varying stages of resettlement and acculturation. The participants included in the study had been in Canada for varying lengths of time, ranging from approximately three years to eleven years. Each participant expressed in their own way that they felt settled in Canada, and had achieved some degree of stability and normalcy in their lives.

Attendance in personal counselling. A second inclusion criterion was attendance in personal counselling or psychotherapy relating to experiences endured through the refugee career. Personal counselling is differentiated from settlement, career or educational counselling in its focus on mental health concerns. For example, the primary goal of settlement counselling is to help recent immigrants adapt and settle in their new community. This is achieved predominantly by providing information about existing resources and providing referrals to government and community agencies and various support services. While providing information and referrals to help refugees adapt to their host community may also occur during the course of personal counselling, this is neither the sole objective nor exclusive type of "intervention" used.

Additionally, it was required that participants be attending counselling for issues relating to their refugee career experiences. As indicated previously, refugees may conceptualize their problems in numerous ways, and may seek counselling services for a variety of reasons. Here, it was important that researcher-imposed constraints were not placed on the participants' reasons for seeking counselling. As one example, limiting participation to individuals seeking treatment for PTSD related symptoms would miss the perspectives of refugees who view their mental health concerns in other ways, such as those individuals who may cite finding family members as the most salient problem to be addressed in therapy, or who view dealing with continuing resettlement stressors as their major presenting problem. Refugees seeking counselling for difficulties clearly unrelated to the refugee career (e.g., an individual seeking counselling following the death of a spouse 10 years after their immigration to Canada) were excluded from the study.

Other important considerations were the total number of counselling sessions attended and the reason for termination (e.g., premature termination or therapeutically indicated). It is recognized that an individual who attended one counselling session may have different experiences than an individual who attended weekly for one year. Similarly, an individual who prematurely terminates due to dissatisfaction with the services may have differing perspectives than an individual who "successfully" worked through his or her difficulties. The average number of counselling sessions in mainstream research is 8-12 (Gladding, 2004), or one session per week over 2-3 months. Culturally different clients have

been found to drop out of counselling prematurely or before completion more frequently than clients from the dominant group (Sue & Sue, 2008; S. Sue, Zane, & Young, 1994). As well, S. Sue (1998) found that immigrant and refugee clients who received therapy from a counsellor who speaks their language or is from their culture attend more sessions compared to those who receive therapy from counsellors from the dominant group. In order to participate in this study, participants had to have attended a minimum of 5 sessions of counselling. This minimum number of sessions will take into account some people who have prematurely terminated as well as those who have continued until their difficulties are resolved.

The actual average number of sessions is unknown in this study as participants were unable to recall the exact number of sessions received. However, the length of time in therapy was considered to be long-term for each participant, ranging from approximately two years to seven years. The frequency of sessions also varied between participants, but typically had the pattern of weekly to biweekly meetings at the onset of counselling (for a year or longer), with the remaining time (up to several years) meeting as needed or intermittently.

Length of time following termination. Length of time following counselling was also an important consideration. Because participants were going to be asked to reflect on their experiences in counselling, it was desired that these experiences are fresh in mind. In some ways, it was perceived to be ideal that participants be interviewed as shortly following the termination of therapy as possible, so they could recollect in rich detail their experiences and perceptions.

However, pragmatic considerations were also important, relating to the practical challenges of finding refugees shortly following their termination of therapy. Attempting to balance these considerations, participants were excluded from the study if they completed counselling more than five years prior to the first interview.

It was not anticipated that discussing the counselling process, whether 5 years or one month following counselling would in any way be detrimental to the participants (e.g., result in retraumatization). Mainstream research has consistently indicated that clients often find it helpful to discuss and comment on the therapy process (Shilts, Rambo, & Hernandez, 1997). In some cases, clients reported that research interviews were more therapeutic than the counselling itself (Gale, Odell, & Nagireddy, 1995).

Country of origin and English language fluency. Country of origin was not included as a selection criterion as a diverse ethnic sample was desired for the study and multiple cultural perspectives could create a richer understanding of the research question. The demographic composition of the sample in the current study included one participant from Zimbabwe, one Bosnian and one Serbian participant from Bosnia-Herzegovina, and one participant from Nigeria.

As well, participants were not excluded from the study based on their English language abilities. Selecting only participants who fluently speak English overlooks those refugees who attend counselling with a same-language therapist or through the aid of a translator. This would also overlook issues of language barriers that non-English proficient refugees may have experienced when

receiving counselling from an English speaking therapist. Such language barriers may affect what refugees perceive as helpful or hindering in the counselling process. Similarly, limiting the research conversations to English restricts the participants' ability to freely communicate in their first language, the language in which the refugees' experiences and emotions are most likely to be encoded (Dunnigan et al., 1993; Kleinman, 1980). As it was anticipated that participants may have varying degrees of English fluency, interpreters were available for use during the research interviews.

Recruitment Procedures

Participants were recruited through local settlement agencies and refugee counselling centres. Centre counsellors provided potential study participants with a verbal and written description of the research project (see Appendix A) as well as the researcher's contact information. Utilizing counsellors in this way to inform potential research participants about the study may help recruit individuals shortly after the termination of therapy. As well, communication of the study by people who the refugees perceive as credible may facilitate their interest or participation in the research (Pernice, 1994). Additionally, participants were recruited through advertisements placed in local settlement agencies and refugee counselling centres, as well as by word of mouth.

Participants who wished to be involved in the study were asked to contact the researcher either by telephone or email, or alternatively to leave their name with a pre-determined staff member from the agency or counselling centre. These staff members completed a confidentiality agreement (see Appendix B) to ensure

that the identities of the interested participants were not disclosed. The researcher maintained regular contact with the staff members who were the main contact points for the study to obtain the names and contact information of those individuals who were interested in the study. The researcher initiated contact with these potential participants by phone.

Following participant or researcher-initiated contact, potential research participants were informed again about the nature of the study and any questions relating to the study were answered. If the participant agreed to take part in the study, he or she was screened according to the study's inclusion criteria, offered the services of an interpreter, and scheduled for the initial interview according to his or her convenience. Interviews were conducted at the centre through which the participant was contacted as several authors have emphasized the importance of conducting research in a setting that is familiar to the refugee (Pernice, 1994).

Participants were given a small remuneration of $25.00 for their involvement in the interview process. This compensation was offered based on the significant financial difficulties that many refugees face, and the possibility that participating in the research interviews may take time away from gainful employment. Also, this remuneration may help to cover transportation costs to and from the interviews. This amount was selected so that it offers appropriate compensation for their time and effort without being perceived as a significant incentive for participation.

Participant Introductions

Four refugees participated in this research study. There was significant diversity among the experiences of the refugees in several ways: (a) a few of the refugee participants were members of the persecuted group in their countries of origin, whereas others where members of the local majority group or group holding power; (b) a few of the refugees' premigration experiences were characterized by being surrounded by organized violence in the form of war, whereas other participants were subjected to or threatened with individualized violence or harm; (c) some sought counselling primarily for being pre-occupied with fears or worries related to pre-migration events, whereas others sought counselling for assistance in dealing with resettlement stressors or a combination of the two; (d) some sought help for themselves, while one sought help primarily for her son; and (e) the regions of the world the refugees came from reflected patterns of refugee migration to Canada during their years of arrival, and the shift in source countries of refugees over time from European nations to African countries. Each participant is briefly introduced in the paragraphs below.

Mercy is a 31-year-old refugee woman who fled to Canada from Nigeria to escape a second and potentially fatal circumcision being required of her upon her marriage. She almost bled to death in the first circumcision she received earlier in her life. She is a single mother of a baby boy. Mercy arrived in Canada approximately three years prior to the research interview. She began counselling after living in Canada for nearly one year with the hopes of overcoming her constant fear and anxiety that the people from her village in Nigeria would find

her and persecute her here, as well as for help with resettlement. She attended therapy bi-weekly for approximately 1 year, with monthly follow-up visits over the following year. Her last meeting with her psychologist was approximately 6 months prior to the research interview. At the time of the research interview, Mercy was working in a retail position, had completed high school diploma, and felt she was establishing a good life in Canada. She had developed a feeling of safety and was able to separate herself from her pre-migration experiences. Mercy felt therapy was a helpful part of this process.

Arijana is a 49-year-old Bosnian woman who moved to Canada with her husband and son in 1996 to flee the violence targeting her cultural group in Sarajevo. She met with a psychologist upon the recommendation of a friend to address symptoms of depression after living in Canada for over a year. Arijana attributed her depression to past traumas in Sarajevo, loss of social and economic status, and worries about the wellbeing of family members and significant others who were left behind in Sarajevo. She met with her counsellor nearly every week for approximately one year and then sporadically for several years. Her last meeting with her psychologist was approximately 4 years prior to the research interview. She discontinued therapy after meeting her treatment goals of reducing her depressive symptoms and feeling more settled in Canada. For Arijana, feeling more settled includes developing social connections and friendships, gaining confidence in the language, and working towards greater financial stability. She received a college degree and is working in an administrative position. She

currently lives in Canada with her husband and two children, and considers her family to be well-settled in Canada.

Florence is a 38-year-old woman of Dutch descent from Zimbabwe. She left Zimbabwe in 2000 to the United Arab Emirates during a period when many White Zimbabweans were leaving due to political unrest and the illegal seizure of many White-owned properties. From there she moved to Canada in 2002 while her parents remained in the Middle East. Florence met with a counsellor to receive assistance with the refugee claimant process during her first year in Canada, which she found to be a highly distressing and nerve-racking experience. She met with her psychologist for approximately 4 years, meeting at varying frequencies throughout that period to deal with her application, the refugee hearings, and other tasks associated with her claim, from weekly to once every several months. Her last meeting was approximately one year prior to the research interview. Florence received final approval of her application in 2007 and discontinued counselling at the time when she felt equipped to proceed with her case with the refugee board. At the time of the research interview, she had applied to university to continue her education in the area of sociology, shifting away from her pre-migration training in the biological sciences.

Natasha is a 45-year-old woman from Bosnia and Herzegovina. She lived in Sarajevo with her husband and infant son when it came under siege in 1992. She left with her son to a neighbouring city after one year, with the hope of raising him in a safer environment. However, her husband was forced to stay behind. After one year with no contact, and no knowledge of his safety or

survival, they were suddenly reunited and they fled as a family to Croatia for a year and a half. After wrestling with the difficult decision of where to live, they decided to move to Canada where they hoped they could establish a better life for their family. They arrived together as a family in Canada in the winter of 1996. Natasha decided to meet with a psychologist in 1999 to learn how to help her son with behavioural problems he was experiencing that related to their pre-migration experiences. For example, her son was found to be telling frequent lies about non-existent family members having died. Natasha met with her counsellor until 2003, approximately four years prior to the research interview. They met twice a month for six months, and then intermittently or as needed if any additional concerns arose. Therapy was discontinued when Natasha felt that she developed a better understanding of her son's problems and their relationship to her and her husband's attempt to cope with their pre-migration and post-migration stressors, and learned concrete strategies for responding to his behaviour. While in Canada, Natasha completed a Master's degree in sociology and is working in the health care industry.

The interviews with the four refugee participants occurred between October 2006 and April 2010. The writing of this final dissertation was delayed due to unforeseen life circumstances of the researcher.

Data Collection Procedures

Qualitative interviews are considered to be one of the most powerful tools for understanding human experiences and individuals' perceptions of those experiences (Fontana & Frey, 1994). As the central goal of this research is to

better understand refugee experiences, meanings and interpretations, data was collected primarily through participant interviews. In conjunction with the in-depth interviews, a research journal was also maintained throughout the course of the study to track the research process and record the evolving understandings of the researcher.

In-Depth Interviews

Within the hermeneutic tradition, interviews require an interactive engagement between the researcher and participant (Weinsheimer & Marshall, 1989). More than merely asking questions and receiving responses, the overall goal of the interview is to create an open dialogue within which the participant is able to authentically discuss his or her experiences and meanings. For this purpose, establishing rapport was of the utmost importance during these interviews, and it was anticipated that openness, humility, and genuine interest would facilitate the sharing of personally meaningful information (Ellis, 1998; Hollway & Jefferson, 1997). In addition, it is also essential to not limit the participants' responses to predetermined categories and concepts (Paulson et al., 1999). Therefore, open-ended guiding interview questions were used to elicit thick or in-depth descriptions of the participants' experiences, perspectives and interpretations without constraining their responses. Ultimately, the purpose of the interview was to create a natural conversation which facilitated deep reflection and authentic discussion of the refugee participants' counselling experiences.

The interview process. In accordance with the Canadian Code of Ethics for Psychologists (CPA, 2000) and the tri-council code of research ethics (Canadian

Institutes of Health Research [CIHR], Natural Sciences and Engineering Research Council of Canada [NSERC], Social Sciences and Humanities Research Council of Canada [SSHRC], 1998), all participants were informed of the nature and intent of the study, as well as their rights as participants and potential risks of the study (see the "Respectful Research Practices" section below). The contents of the informed consent form were verbally explained to each participant at the onset of the study (see Appendix C). Written consent was obtained from each participant.

Following appropriate informed-consent procedures and after addressing any participant questions regarding the purpose or process of the study, the interview process began. Interviews were approximately 60 to 90 minutes in length. With the participant's permission, each interview was audio recorded. Each interview was later transcribed verbatim by the researcher, and subsequently reviewed along with the audio version to ensure the accuracy of the text.

Interviews began with a conversation aimed at gathering the participant's biographical information and explore the participant's cultural frameworks and cultural experiences. An accurate description of these concepts is essential in understanding refugee counselling experiences (Arredondo et al., 1989; Bemak & Chung, 2008), and these concepts structured the context through which the participants' experiences of counselling may be better understood. As well, demographic information was collected including age, country of origin, first language, years of residence in Canada, family composition, and education and employment information. During the course of the interview, the specific research questions were also addressed including: (a) Why do refugees seek counselling

and how do they conceptualize their presenting problems? (b) What are refugees' experiences of counselling? (c) What factors do refugees identify as helpful in facilitating therapeutic change?

Possible conversational entry points and guiding questions to address the research topics are outlined below. A few of the questions have been adapted from the interview protocol for counselling refugees developed by Johnson, Hardt, and Kleinman (1995). The specific questions adapted from this protocol assess what problems most concern refugees and what types of treatments they may see as helpful (spiritual interventions, cultural rituals, social support, etc.). These questions highlighted differences between counsellors' and refugee clients' preferred focus of therapy, expectations for counselling, and appraisal of counselling interventions. These questions did not represent a structured interview schedule that was strictly followed during the interview. Rather, they were intended to function as possible options for exploring the research questions, and were utilized during the interview as probes to initiate conversations. As indicated previously, the goal of the interview was to invite participants to share their experiences and tell their stories, rather than communicate information within a question-answer format.

Background questions:

- I'd like to get to know a little bit about you. Can you please tell me a bit about yourself (e.g., country of origin, first language, length of time in Canada, number of other family members in Canada, current age, age at migration, education and employment)?

- Tell me about your experience of leaving your home country and coming to Canada (e.g., premigration circumstances, conditions of exodus, etc.).
- What are some challenges you have faced in your life in Canada (e.g., learning a new language, getting a job, feeling lonely, etc.)?
- What life events or challenges concerned you the most?

Refugees' experience of counselling:

- What are the challenges (or life events) that made you go see a counsellor?
- How did you think counselling might help you?
- What changes did you think might happen after counselling was over (e.g., self-change, change in personal circumstances)?
- Tell me about your experience in counselling.
- Do you think that the counsellor understood your problem? Why or why not?
- Did the counsellor see the problem in the same way you saw it?
- How did you see your problem?
- How did the counsellor try to help you?
- What kind of treatment did you think would be best for your problem?
- What did you find helpful about meeting with the counsellor (e.g., relationship with the counsellor, specific actions taken, connection to other services, etc.)?
- Was there anything he or she did that didn't help?

- Is there something you wanted the counsellor to do for you that he or she didn't do? Tell me about that?
- Is there anyone else you went to for help with this problem (e.g., in your church, community, family, etc.)? If so, tell me about what they did.

Interpreters. Culturally specific ideas may not have English language equivalents and participants may not be able to freely express the complexities of their experiences if they are restricted to speaking only English (Dunnigan et al., 1993). As articulation of a second language develops more slowly than comprehension, this difficulty in expression may be present despite the participants' ability to comprehend the questions asked (Sue & Sue, 2008). Similarly, participants may switch back and forth between using English and words from their first language to express their stories (Santiago-Irizarry, 2001), limiting the researcher's ability to understand important elements of their counselling experiences. For these reasons, regardless of their proficiency in spoken English, all participants were given the option of having an interpreter present during the interview. However, each participant declined the use of an interpreter and elected to conduct the interviews in English. As is suggested from some of their interview disclosures presented in the following chapters, it appears that this choice may have reflected a desire for integration or rehearsal/practice of English skills.

Research Journal

The researcher is the primary instrument for data collection and analysis. As Merriam (1998) highlighted, all data are mediated through the researcher rather than through an inanimate inventory, questionnaire or data analysis program. Given the researcher's integral role in the process of collecting and analyzing data and otherwise constructing knowledge, it is essential that the researcher continues to be aware of his or her existing preconceptions, understandings and beliefs, and how these factors interact with and mediate the research process.

Recognizing the importance of acknowledging the researcher within the context of the study, a journal was kept throughout the course of this research. The journal commenced with an account of pre-understandings, ideas and comments prior to data collection (McLeod, 2001). These pre-understandings are important to document as they may influence the initial research process. Journaling continued throughout the course of study to reflect on the research process, keep a record of insights gained, note curiosities and questions, log possible interpretations and re-interpretations, discern possible patterns of the work in progress, record the decision-making processes through which the data are analyzed, and note the rationale for research decisions (van Manen, 1990). In this way, it was hoped that the research journal captured the personal dimensions of the meaning-making process as they occurred during the study (McLeod), and allow others to make well-informed judgements as to the methodological rigor of the study (Lincoln & Guba, 1985).

It is also recognized in the hermeneutic tradition that each interview and stage of data analysis will affect the researcher, shifting his or her understandings and ultimately influencing the course of research. Comments, reflections and reactions regarding this interaction between the researcher and the researched were also recorded (Clandinin & Connelly, 1998), documenting the personal impact of the research process and highlighting changes in understandings and interpretations as they evolved through the study.

Data Analysis

In qualitative studies, data collection and data analysis are not mutually exclusive processes (Merriam, 1998). Data analysis began while the interviewing was still underway and continued as an on-going process throughout the study. In this fashion, the cycle of data collection and analysis followed the hermeneutic circle (Ellis, 1998). For example, the initial interview and data analysis were informed by the researcher's preunderstandings as they have been informed through the research literature as well as clinical and life experiences. While little research has addressed the experiences of refugees in counselling, previous research and theoretical works suggest that possible zones of interest may include such factors as how participants conceptualize their problems, the perceived acceptability or utility of re-telling the trauma story, or the importance of the therapeutic relationship. These sensitizing themes, as well as those concepts reflected in the current research questions, represented possible areas of inquiry. However, in accordance with the hermeneutic circle, these initial conceptions

were evaluated throughout the research process in light of current interview data and analysis.

Through immersion in the data and the careful and detailed reading and re-reading of the interview transcripts, the researcher searched for general impressions, familiar concepts, differences and contradictions, new ideas, and other areas which may extend current understandings. Through this process, new perspectives arose, unexpected findings were uncovered, and new topics were broached. Also during this process, the researcher's interpretations, conceptualizations and understandings were questioned to search for gaps, inconsistencies and inadequacies, and alternative interpretations were actively sought out (Ellis, 1998; Guba & Lincoln, 1994).

As anticipated, the researcher's understanding of the research question evolved throughout the process of the study, and each interview and analysis influenced and directed the next step in the inquiry. New perspectives and understandings were explored in greater depth in subsequent interviews, re-reading of the transcripts, and re-explorations of the data. The study remained open to the uncovering of new information as it arose through the research project, and the research process remained flexible to further explore newly uncovered areas of interest or alternative interpretations of the data. How to best represent the participants' descriptions of their counselling experiences was identified through this evolving process of data analysis and uncovering the salient ideas in the data. Basic qualitative inquiry allows for such flexibility in

representation of the data based on the type of data that emerges from the participants' interview disclosures (Merriam, 1998).

In the end, narrative analysis and analysis of narratives (Pokinghorne, 1995) were used to present the participants' experiences of counselling. Polkinghorne (1995) defined a narrative as a story describing a chronological sequence of events detailing a central plot, having a clear beginning, middle, and end point. Narratives allow for participants' experiences to be presented in their unique cultural contexts, bound by the historical time periods in which the life events described occurred, and shaped by participants' own temporal recollections. Furthermore, they provide the opportunity to illustrate the evolution in research participants' self-understandings, mental health status, and life circumstances over time (Polkinghorne, 1995) in the course of their own settlement process. Presenting the data as narratives that link together their pre and post migration experiences along with their experiences of counselling allows the reader to see the connectedness across stories and how these experiences situate themselves within the broader context of the refugees' lives.

In the present study, the narratives for the participants began with their pre-migration circumstances and their conditions of exodus from their home countries. The midpoint of the stories was the refugees' arrival in Canada and the presenting problems and concerns that led them to seek help through counselling. The nature of their counselling experiences are thoroughly described according to their own accounts and recollections, and the end point of the narratives reflect

the changes that participants expressed were achieved through their help-seeking behaviours.

Narratives are also a fitting approach in the present study as they are an ideal method for better understanding the lives of individuals who have been marginalized, or whose voices have not been widely heard (Johnson-Bailey, 2004), and have also began to find favour in refugee research as a means to "illuminate the actual experience of displacement" (Kokanovic & Stone, 2010, p. 352).

Once the narratives were written, feedback was solicited from the participants to ensure the accuracy of information and request input about any desired modifications. Following the final approval of the narratives, an analysis of narratives was conducted to identify recurring patterns or themes that were common among participants as reflected in their stories and interviews (Polkinghore, 1995). This involves a cross-participant analysis of the stories and transcripts to detect shared experiences and variables related to the counselling process, relationship, or outcome that are particularly meaningful. Repeating ideas were presented thematically to highlight similarities in experience and presented with supporting quotes (Merriam, 2002). Theme labels were generated that took refugees' own language or terminology for describing their counselling experiences into account.

Respectful Research Practices

Respect for research participants is paramount (McLeod, 2001). As a minimum requirement, this research was submitted for ethical review and ethical

guidelines were fulfilled during the course of study. As well, respect was given to each participant regarding her preferences to interact in her first language. Therefore, the option to have an interpreter present during the interview was offered to each participant. Additionally, respect was given to the participants' right to voluntary participation, anonymity and confidentiality. Participants were assured that staff members of settlement agencies or counselling centres they were recruited from would not be informed about whether or not they took part in this study. They were also given the opportunity to withdraw from the study at any time without any questions or follow-up contacts. Each participant was informed how the information shared during the interviews may be used and presented, and how the study may be used in the future to be of benefit to the refugee community (e.g., conducting workshops for mental health professionals who work with refugees). Pseudonyms were used when transcribing and reporting the interviews, and no identifiable information is included in the dissertation. Finally, the participants' voices were honoured and respected in this study.

The main ethical consideration in the study was the possible harm to the participant due to the potentially sensitive nature of the interview topic and the distress which may arise following the interview. Precautions were taken to help ensure minimal risk to the participants as a result of their participation in the study. While participants were not asked directly to recount or disclose traumatic experiences, these topics did arise on occasion during the flow of the research conversation. However, the participants did not report emotional distress at any time. Participants were each debriefed after the interview. As it was possible for

painful issues to resurface due to the sensitive nature of the research, a list of accessible and culturally sensitive counselling services and other supports was prepared prior to the interviews, though none of the participants required these services.

Recording and Handling Data

Following each interview, an audio-file copy of the interview was saved to the hard drive of a password-protected computer. The researcher then transcribed each audio-file verbatim. To protect confidentiality, pseudonyms were used and all identifying information was removed from the transcripts. To protect third parties, all identifying third-party information was altered. All documentation including compact discs and transcripts was securely stored in a locked filing cabinet in the researcher's office and all computer files were stored on the researcher's password-protected computer. The study transcripts will be kept for a period of 5 years, as per the University of Alberta, Faculty of Graduate Studies and Research guidelines.

Evaluating the Study

While the need to critically evaluate the quality or value of a qualitative research study is well recognized (Ellis, 1998; Guba & Lincoln, 1994), little consensus exists regarding the criteria with which to evaluate qualitative research (McLeod, 2001). Standards pertaining to methodological rigor as described by Lincoln and Guba (1985), and the practical contribution of the research (Ellis; McLeod, 2001) were considered particularly germane to the current study.

Methodological Considerations

Trustworthiness refers to the rigor of the study and the extent to which the findings of an inquiry are "worth paying attention to" (Lincoln & Guba, 1985, p. 290). For the findings of this research to be trusted, this study must demonstrate that it will be conducted in a methodologically rigorous and systematic manner (Merriam, 2002). Four standards which assess the methodological rigor of qualitative research studies will be discussed here and applied to the current study: credibility, transferability, dependability, and confirmability (Lincoln & Guba).

Credibility. Credibility is the extent to which the findings of the study are congruent with reality (Merriam, 2002). As the current study assumes multiple, constructed realities, credibility relates to the researcher's interpretation of participant experiences and assesses the degree to which the research findings adequately fit or represent the "reality" experienced by the participant (Lincoln & Guba, 1985).

To help support the credibility of the current study, several strategies were employed. Member checks, where the researcher's interpretations and conclusions are reviewed and assessed by the participants, are considered the most crucial technique for establishing credibility (Lincoln & Guba, 1985). Once initial interviews and preliminary data analysis was complete, tentative results were provided for the participants' review to assess whether the emerging findings were described in the way that the participant intended. These tentative results were in the form of themes and narrative text. Participants were given the

opportunity to modify, further explain or retract any comments made during the interviews. Additionally, member checking occurred informally throughout the course of the study as part of the ongoing research conversations (Merriam, 2002). An additional peer review process was also employed to assess whether the emerging findings and interpretations are plausible given the raw data (Merriam). Through the review process, supervisory committee members probed the researcher's biases and reviewed the researcher's interpretations to determine if they are supported by the research data and decision-making processes logged in the research journal (Lincoln & Guba).

Transferability. It is hoped that the results of this study will be of some use not only to those individuals who participated in the study, but to other refugee counselling centres and health care providers as well. While a different research study may produce slightly different results owing to differing biographies and unique cultural and social contexts, if done properly, the findings of this study will have some degree of transferability to other sites and other refugees. Such transferability was increased by providing thick or detailed descriptions of the research setting and participant characteristics to help the reader judge the typicality of the data in the following chapters (McLeod, 2001). Similarly, a detailed description of the participants' experiences helped enable the results of the current study to transfer to other settings and individuals (Lincoln & Guba, 1985). A detailed account of the methods and procedures, as well as decision points and rationale of thematic interpretations were recorded throughout the study (Merriam, 2002). With a thick description and detailed account of the

research participants, settings and processes, well-informed judgements of transferability may be possible on part of the potential consumers or readers of the study (Lincoln & Guba).

Dependability. Dependability is closely linked to the concept of replicability or repeatability found in the natural sciences (Lincoln & Guba, 1985). However, as the context of research and the object of study are continually changing, an identical set of research conditions can never be met twice, thereby limiting any study's replication or consistency across repeated inquiries. The concept of dependability emphasizes the need for the researcher to account for factors of instability or the ever-changing context within which research occurs, and describe how the particular context influenced the course of the study (Lincoln & Guba). To shore up dependability claims in the current study, the research drew upon an inquiry audit wherein a reviewer examined the process by which the research occurred to determine its acceptability. While an external reviewer has been recommended by some researchers (e.g., Lincoln & Guba), cross-cultural and refugee researchers (e.g., Pernice, 1998) have suggested that the more people involved in a refugee study, the less likely a refugee may participate in the study. Therefore, the review or audit was performed by the dissertation supervisor. For the purpose of this review or audit, the research journal was particularly useful as it explicates the research processes and rationale for research decisions. In addition to reviewing the research process, the auditor reviewed the product of the study in terms of its "accuracy". Here, the auditor

verified that all findings and interpretations were justifiable given the research data.

Confirmability. Based on the principles of constructivism and hermeneutics, the current study assumed that the researcher brings a unique perspective to the study. Throughout the study, the researcher's theoretical orientation, assumptions, values, beliefs, and preconceptions were made explicit. By way of the research journal, the researcher's perspective was reflected upon in an attempt to recognize the role these perspectives play in understanding the participants' experiences. This disclosure and reflection will aid readers to interpret and better understand the findings of the study (McLeod, 2001).

Researcher perspectives aside, confirmable results are those results which can be confirmed or corroborated by others external to the study. An audit trail, or "residue of records" stemming from the study was maintained throughout the research process (Lincoln & Guba, 1985, p. 319). This audit trail consisted of: (a) raw data; (b) products of data analysis, including working hypotheses, the structure of possible categories, themes, narratives, or other interpretations; and (c) process notes including the research journal, methodological notes, and decision making rationales. Through this audit trail, the researcher's decision making processes can be assessed and help ensure the results are consistent with the data collected, as well as the context wherein the data was collected and analyzed. In addition, examples from the data are provided in this final dissertation to enable the reader to verify that the interpretations accurately represent the participants' experience (McLeod, 2001).

Contribution of the Study

In addition to the standards of methodological rigor discussed previously, several guidelines for evaluation were used to assess the current study. Specifically, this study was assessed in terms of its ability to enhance the audiences' understanding of refugees' counselling experiences and contribute to the existing body of knowledge in this area (Ellis, 1998; McLeod, 2001).

In order to enhance understanding, the current study must present a plausible and coherent account of refugee experiences (Ellis, 1998; McLeod, 2001; Packer & Addison, 1989). The research setting, participants, and refugees' experiences of counselling are described comprehensively in the following chapters in order to accurately and clearly represent the subject matter. As well, this research situated the data analyses and interpretations within existing relevant literature, and the linkages which exist between this work and the previous work of others in the field (Mitchell & Cody, 1993). Through the hermeneutic cycle, the current study attempted to build upon previous work, and this previous literature was critically evaluated with regards to how well it fits in light of the current data, or whether there are gaps, inconsistencies and inadequacies. Through this process, the results of the current study were considered to be plausible, coherent, and fit with what is currently known, and therefore able to contribute to the existing literature and clarify or expand the readers understanding of the subject matter.

Additionally, consistent with the hermeneutic approach it is important to question if the researcher's knowledge and understanding has been transformed

through the research process (Ellis). In addition to the insights gained as recorded in the discussion section, the researcher's own practice as a psychologist became richer and more complete. This has been true not only with ethnically different clients, but true for all clients. A heightened respect for and awareness of another's worldview, as well as the adoption of a holistic treatment approach have been impactful lessons to be carried into the future.

This study will also continue to be evaluated in terms of its utility in influencing current practices and creating new possibilities for the research participants, other refugees seeking counselling, and refugee mental health programs in general (Ellis, 1998; Packer & Addison, 1989). Often, refugees do not see the benefit of research studies in their community or in their day-to-day lives (Silove et al., 2002). Many researchers have questioned the all-too-common occurrence of simply describing the travails of refugee populations without working to change the systemic and political inequalities that lie at their root (Offet-Gartner, 2005; Silove et al.; Pettifor, 2005). It is hoped that the results of this study will inform policy and work to improve counselling practices with refugees. It is the intention of the researcher to present the completed study to local mental health professionals who work with refugees, as well as at conferences where policy makers can have access to the study results. Their feedback will be an important indicator of the study's utility in addressing counselling processes and practices with refugees.

The next chapter provides the narratives of each refugee participant in this research, describing their migration trajectories and counselling experiences. The

chapter that follows pulls together common elements of their experiences that illuminate reasons for help-seeking, conceptualizations of counselling, and aspects of the counselling process and relationship that were perceived to contribute to effectiveness in helping them to achieve their treatment goals.

CHAPTER 4: PARTICIPANT STORIES

Four refugees participated in this study. They arrived in Canada from across the globe, each with their own unique stories and experiences. These individuals came to counselling with specific reasons for seeking therapy and with their own needs for healing, but several similarities in their experiences emerged. This chapter introduces the participants, their refugee careers, the reasons they sought help, and their experiences and stories of counselling. This chapter also shares significant therapeutic events as they occurred in counselling. The themes which represent the participants' collective experiences of counselling are presented in the subsequent chapter.

Mercy

Mercy is a 31-year-old woman and single mother of a little baby boy. She has lived in Canada for three years, and is currently working in a retail position in a Canadian city. Before moving to Canada, Mercy lived in Nigeria with her mother and five sisters. Her father had passed away when she was fifteen. In describing her reason for leaving, she simply said, "A lot of things was happened to me, so that is why I decided I have to move. If I don't move, there will be problems...". Mercy's problems started several years before her actual departure from her country of origin. She shared the following story:

> Because my father is a chief in my country, so they circumcise me when I was six years old and gave me this belt mark on my face, that I'm married to somebody. That is where the problems started from... Because when I

was six years old, my mother told me I circumcised, I almost bleed to death.

So, after a long time, my father passed away. So this man came to my village, that he is going to marry me. It was a long time ago that my father gave me—he is going to collect a prize now from my father. Now, he's going to take me home. From there he get married to me and take me to a palace, so he have a lot of wives—I think it's six wives. So I said, "There are six wives, what am I going to do here?" So, for me, it's just like, I'm a piece of paper over there. So that is where my problems started from...

The problem is, to stay is the problem. He told me because to marry to a king, you have to circumcise again. It's just like to make… renew your body, that's now you are a new woman; there is no man who makes you before, we make you new. He told me I have to circumcise again. So, I can't do that. Again, again, I said, "No, I can't. I can't do that!" Because my mom told me the first time I almost bleed to death, so I can't do that. So my life is already over. My mom was crying a lot, there's nothing she can do for me. She's a woman, she can't do anything, so I have to abide to the law. My father's family, they said there's nothing they can do, my father's already passed away. So I have to do what I have to do, so I was crying. If I didn't agree, so they are going to set on fire me for the voodoo. That's like the voodoo that they do in Africa. They'd fire me for that.

Although filled with fear, Mercy said her only choice was to go to the palace with the king. She explained her circumstance matter-of-factly, saying, “So already he’s paid my bride price, I’m now a wife to him.” Once at the palace, he took Mercy to his first wife to teach her “how to do things in the palace—the greeting, how to put on their clothes and the bead and everything.” Mercy continued her story:

> So I was there for a good three months. This woman told me that, the main thing, if I don’t leave, there will be a problem. I have to circumcise again or there will be a problem... So what am I going to do? I don’t know anybody. I can’t go to my parents’ house anymore. What am I going to do now? She said I should not worry, that she is going to help me.
>
> So there’s a day when there is a big celebration—when all the chiefs come to the palace to celebrate... so that is, they accompany somebody, so that day there would be a lot of crowd in the palace, so that is the day I left.

Mercy was helped along the way by friends as well as strangers to leave Nigeria. She flew from Lagos, Nigeria to a large Canadian city, to meet with a man from Ghana. It was pre-arranged that he would help her get to the city where she currently resides. When Mercy did arrive, she had only $250 to her name. She described that time in her life as filled with great worry and fear. This fear continued even after moving to Canada, as she felt like her old life in Africa could still reach her here. As she described:

> I was scared of people, yeah, because this man I was married to is a really tough man. I don't know, maybe he will send somebody to monitor me, and do me harm. I don't know, so I was so scared. Maybe they kill me, or can knock me in the street. A lot of things, I was so afraid. I wouldn't talk to people, meet with people, I was so scared.

These symptoms would likely be described as manifestations of anxiety or posttraumatic stress when viewed from a clinician's lens. Mercy described her symptoms as feeling "You are going to die now, or you don't know where you are coming from." Mercy was also worried about her family that she left in Nigeria, and her thoughts were frequently turned towards them. She said:

> And I was thinking about mostly my mom, because my dad passed away for a long time, but my mom and my sisters all… because I know my mom was sick then, before I left Nigeria, so I don't know how the situation might be after I left. The man I had to get married to is a very tough man, so I was thinking about that, and if my mother if able to handle a situation and everything.

After reaching her planned destination city in Canada, Mercy met with an immigration lawyer to assist with the refugee claimant process. During each meeting, Mercy would complain to her lawyer, saying "I don't know what to do. Just like when I'm sleeping in the night, I normally get up in the night, start crying, just like somebody's going to take my heart away from me." Her lawyer, clearly seeing Mercy's distress, recommended that she meet with a psychologist. Mercy recalled, "So, my lawyer saw my situation, that I needed counselling, so

that is why he gave me Anna's phone number and address, so I made contact with her." This first contact was after living in Canada a little less than one year.

It was relief from symptoms that initially motivated Mercy to meet with Anna, a psychologist working in a centre specifically founded to address the varied needs of immigrants and refugees. Mercy was entirely unsure of what to expect from counselling or from her psychologist. She recalled, "I was thinking we were going to discuss things like maybe from my country." Although she was unsure of what to expect from counselling, she was absolutely certain of the fear that she felt before meeting with Anna. In describing her feelings when first meeting with her counsellor, Mercy recalled:

> It's about fear. I was thinking maybe she's discovered things about my country or take me back to Africa... yes, that was what I was thinking of. First I was so afraid. I was shaking, crying. I thought maybe it's going to take me back to my country, I don't know. Yes, the first meeting was very hard, it was very hard.

Mercy felt that her counsellor did much to build trust and help her through that first session. What was helpful to Mercy seemed to be a combination of the therapist's approach, as well as the therapist's demeanour. Of her counsellor, Mercy said, "She's nice. She's so kind... She told me, 'Mercy, it's okay. I'm here to help you... She told me not to cry, nothing's going to happen to me." Anna walked Mercy through the forms and paperwork, "So the form it's there, okay. So everything go in the file." They spoke for a few more minutes, although Mercy could not recall what they talked about. As Mercy felt more calm, they delved

into counselling. “So after about ten, fifteen minutes, we started talking again things that happened to me in Africa.”

A language barrier existed during the early sessions of counselling, as English was Mercy’s second language and Anna only spoke English and French. Mercy laughed to herself as she admitted, “Before I come for meeting, my English, it was real bad. It was really, really… when I say bad, it was really bad.” At first, Mercy thought that an interpreter may be helpful, so in her words:

> So I ask her if there is somebody who can really speak my language, who can translate my language. She said, “No, Mercy, no, I can understand you...” Yeah. She said, “Yeah, I can understand you.”
>
> So, that’s when we started talking… There’s some people maybe when you talk, it doesn’t understand you. They talk slowly so you can understand what she’s talking about, just like Anna.

In Mercy’s experience, the language barriers never became an obstacle to therapy. In fact, Mercy felt that the act of trying to understand her did much to build the therapeutic relationship and was perceived as therapeutic in and of itself. She expressed:

> I know that Anna speak English for me... My English is so bad, but she’s trying to understand my situation and language; I don’t speak English very well, she’s still trying to understand me. She was always try to understand it, to understand the situation and how I feel. So, talking to me, that really made me a woman. I don’t feel like I’m lower and I’m inferior.

One of the first things discussed in counselling were the experiences that Mercy had been through in Nigeria. She recalled, “That was the first thing we discussed about on the first day we met.” It was difficult at times for Mercy to share that story. When looking back on counselling, Mercy remembered that it was “sad to talk about it”. However, she added that it was “releasing” as well, and felt “a little better” afterwards. She continued:

> Because when I have a problem with me, I’m dying inside, so I believe, I don’t know who’s going to help me... so when I release my problems with somebody, I’m finding help in that.

Mercy also felt a great relief from being taught directly how to “deal with” her fears. First, Anna taught her deep breathing exercises, which Mercy found to be very helpful. As Mercy recalled:

> It was so scary... I didn’t know there was any way to deal with fear. So then sometimes she told me if I have a fear or something to think, “I have to breathe, stay tight, take a deep breath, so the fear will go away.”
>
> So, I started doing that and it really helped me. I’m afraid, so if I’m start to afraid, that’s what I’m going to do. Yes, that helped me... She taught me a lot.

Dealing with these fears also involved other direct instructions. Mercy recalled the following interaction with her therapist:

> I was so afraid to go outside. One day, when I was going to school, just from school to home, from school to home. Anna said, “Mercy, you have

> to move outside, take a walk maybe five or ten minutes or fifteen minutes."
>
> I walk around the street, I come back home, I said, "No, I can't do that."
>
> She said, "No Mercy, you're staying inside too much. We have to go out; it's not good to stay inside. You have to walk around the street." How many...? Before I do that, I was so scared, I can go stay five minutes outside, run inside again.

Little by little, Mercy's counsellor helped her to leave her home and become more active in life. With this activity, fears decreased.

Mercy also felt that counselling helped her to see things differently. Early on, she was "worried... so afraid to come out". Mercy felt that these fears were based on believing somebody on the street might "recognize me or thinks he'll take me back." Through counselling, Mercy began to see that her current fears were based on past experiences. With that insight, she felt a shift in her emotions. In describing this process, she explained:

> It helped a lot. Just like sometimes when I'm thinking, when I see a black person, I was so afraid, I don't know if he recognize me. And just like, everything goes out of my mind. But I'm okay, telling myself "I'm okay... Yeah, that I'm okay, and that I shouldn't be afraid."
>
> Well, there are times that they shouldn't be afraid, because Anna told me as far as in here in Canada, nothing is going to happen to me, so I should not be afraid of anything. I'm okay with people. I'm not too much

> more afraid of what is going to happen to me. I'm believing that. Not afraid anymore. She told me that man is not coming to this country and don't be afraid of anybody, so you have to stand your right.

Symptom relief was also found by getting in touch with parts of herself that had been forgotten. Mercy recalled that she had a passion for singing. During their conversations, Anna asked Mercy about things that she used to enjoy in life. Mercy recounted, "So she started talking to me, things about my passion... So I started singing like Christian music, like my traditional music. My singing, make myself feel happy." Singing became a powerful tool in reducing fears.

During that period, Mercy was also facing numerous life challenges, including difficulties learning English, difficulties finding work, and problems with resettlement. There were also times during Mercy's first few years in Canada when money was very tight. During particularly difficult times, Mercy could not afford basic life necessities such as food. To address these challenges, Mercy's counsellor liaised with a social worker who was able to help. Mercy described:

> I was having a social worker, and Anna helped me with that. They called me and they said, "Do you still have food?" If I have food, I say, "Yes." If I have, so it's okay. If I don't, let us meet tomorrow anytime so we can go back to the food bank, take some food there.

Mercy's counsellor also took a direct and hands-on approach to address the other challenges as well. For example, Mercy's counsellor helped her get in contact with an English as a Second Language program. She recalled that experience:

> Anna is the one that put me to school... in an English school. Anna took me to one lady that she's the head of the school, just like she's the lady that take everybody there. So she's talking to the lady, so I fill out a form and everything. So they told me if I can start the same day, I say yes. So I started there at one o'clock already.

Mercy's therapist also connected her with a school where she could continue her education. At first, Mercy did not believe that a thing such as going to school would be possible, as education was out of reach in her home country. She explained:

> The thing in my country—People that go to school in my country, they have a lot of money. Like a poor family, you can't, because your parents cannot afford the school fees... And if you have like a baby girl in my country, so you cannot go to school. So I'm like, someone like me, mm-mm, no ways....

Again, her counsellor liaised with the school to help Mercy with the process of starting school and completing the required forms and applications for school and funding. There was a bright smile on her face as she thought back to those first prospects of going to school and recalled, "It's just like, oh, my God, we're talking about the school! Oh my god!" In fact, of all the assistance which her counsellor gave, Mercy felt the most important was helping her attend school. With gratitude, Mercy said, "I'm very lucky for that."

Specific advice and encouragement was helpful during her process of dealing with immigration. Mercy recounted one occasion when she was afraid

before going to an immigration hearing because she was unsure of what was going to happen. Recalling a meeting with her counsellor prior to this hearing, Mercy said:

> A week before that day, so we had to sit down and talk if I have anything to discuss with her—if there's anything I didn't understand. So I discussed with Anna. So really, we talked together and Anna asked me if I'm still afraid. I said that I'm still afraid, but it's not like before, but now I'm okay. But even when she will ask me if I don't have anybody who is going to go with me on the day of my hearing, she will go there with me if I'm afraid, or I'm in fear.

Anna did not go with Mercy to the hearing, but Mercy expressed gratitude for the fact that she had offered to attend. This offer also built positive feelings towards the counsellor. Speaking of this event, Mercy said, "So Anna is really nice, you know. Really."

Summarizing this assistance with basic life challenges, Mercy said:

> So, Anna put me in a situation where I can easily do things for my life. I should not worry... I believe and do things to my life. When I finish my school, I go to work, so that's something. So that is a good life, yeah... After I met with Anna, so everything started improving and I was okay.

Through counselling and the opportunities it provided, Mercy began to see possibilities that she could not have imagined before. With those possibilities before her, Mercy also grew in courage. Of the role of counselling in this process, Mercy said, "Anna gave me the courage… And of course, you can't depend on

somebody, really. You have to work for yourself and to get something from that." Through counselling and the assistance of the counsellor, Mercy said, "I started changing, started working, got my money and everything worked right. I always thought when I started working (I worked for about seven months), that makes me super. It does."

Much of what Mercy experienced as helpful in counselling addressed reconnecting socially. She felt very alone when first in Canada. She shared the following thoughts and fears that she felt at that time:

> What am I going to do? I'm here in Canada, I don't know anybody. So it was so tough. How am I going to cope with people, how am I going to cope in this country? Oh, I was thinking a lot of things to my head.

The reconnection experienced in counselling occurred in several different ways. For example, Anna connected Mercy with a women's group where she met with other women who have experienced similar life events. Mercy felt that hearing other women share their stories was not only was it helpful to hear, but it also made it easier to share her own story. She explained, "It's easier because you can share yours too. Sometimes, when things happen to some people, I really share my story. So, look at what's happened to me."

Reconnection also occurred naturally as part of schooling and work. Mercy was somewhat shy at first and nervous to meet with new people. She recalled, "Anna asked me if I'm going to mix with my people that I met. I told her no, I don't want to." With time and encouragement, Mercy began to meet new people and feel more connected and "less alone".

Mercy also found it helpful simply to talk about her current social situation. Her thoughts were often drawn towards her mother and family in her country. She said of these thoughts and feelings, “Yeah, it was fear, because the most that I was thinking was my mom, and my life.” Mercy often spoke with her counsellor about these fears and worries. She recalled:

> Anytime that I went there, she and I will discuss like brothers and sisters. Life. I won’t get in contact with my mom. There’s no contact with my mom, so Anna told me that maybe one day I will see somebody from my country, or I’ll maybe get in contact with—to call my mom. I should not be worried, I’ll be fine. I said, okay... It felt good. Super, yeah.

Mercy did speak with her mom again. She shared with me her memory of that conversation:

> So I speak to my mom, I say, “I’m in Canada.”
>
> “Canada? What country is that?”
>
> “I’m in Canada, mom. I’m so afraid of this place, it’s too cold.”
>
> She said, “Are you okay?”
>
> “Yes, I’m okay.”
>
> “Are you sure you’re okay?”
>
> Then I say, “Yes, I’m okay. A lot of people help to me. I’m okay.”

As Mercy retold her experiences of counselling, so much of what she said related to the relationship that she had with Anna, her counsellor. In describing Anna, Mercy said:

> Well, I find Anna is a nice person, you know. She's very nice, but she was nice to me. And that all those things she taught me... So that is just what saved my life, my entire life. I like everybody I met in Canada, both my doctor, my lawyer, Anna, my social worker. A lot of help they gave to me, and I didn't expect that at all. It's a very big help, a lot of help.

Mercy noted that the encouragement that she received from her counsellor was very helpful in moving forward to achieve her goals. Mercy explained that she lacked confidence at times, but the encouragement from her counsellor helped her to continue trying. She related the following account:

> I don't know how to read or write anything, and Anna say, "Mercy, you can do it when you start from somewhere. You've got to start from somewhere."
>
> I think my English is bad. Anna said, "So Mercy—yeah, your English is okay. There are people there who, kind of, speak like this."
>
> There's so many hard things... Are you sure I'm going to do that? Just like somebody say, encouraging, "Mercy, you can do it! Don't be afraid!"

Mercy greatly valued her counsellor's advice. Mercy compared the impact of the different people in her life; the "bad people" and the "right people." She felt

that the good advice that she received in counselling helped to rebuild her life and go “on the right side of things.” She continued:

> You know there’s things that totally happened to me in this life and we meet with bad people, and it will lead you to the bad side of it. Everything gets worse to worse to worse to worse. So you’re trying to find advice, when the advice is bad, you go on the wrong side. We meet with the good people, all their advice and everything went fine. Anna had nice words. Really, I’m looking for to meet the right people so that everything goes the right way of my life.

Although not a quality of the counsellor, counselling would not have been possible unless it was at a location which was easy to access. Mercy transferred buses several times as she crossed the city in a 45 minute bus ride to attend counselling. Without access through public transportation, Mercy could not have met with her counsellor. She noted that the counselling centre even helped with bus fare. She said, “I’m really happy... they even gave me a coupon to take a bus. Even my transport. It really surprised me, you know.”

Mercy began meeting with Anna approximately six months after arriving in Canada. She met with Anna weekly to bi-weekly for approximately 1 year, with monthly follow-up visits over the following year. She last met with her counsellor approximately 6 months before the research interview. Looking back, Mercy felt that Anna was instrumental in helping her not only to remove symptoms, but re-establish her life in Canada as well. Mercy now has a child and a job. She no longer has panic attacks. As she noted:

> Life feels… life is okay now. That's one thing I say now, I can never go back to my country... I'm so scared to go there now. But here in Canada, I believe I'm safe. I really am safe, but it's bad there in Africa. A lot of things happened to me, but when I came to Canada, everything worked fine with me. I don't blame God for anything. But now my life today, I thank God for everything... it is a good life.

Arijana

Arijana is a 49-year-old Bosnian woman who currently resides in Canada with her husband and two children. She was living in Sarajevo with her husband and young son when war erupted in Bosnia and Herzegovina. They lived for over a year in Sarajevo when it came under siege by Serbian forces. It was said of the Siege of Sarajevo during the International Criminal Tribunal for the former Yugoslavia (2003) that not since World War II had an army "conducted a campaign of unrelenting violence against the inhabitants of a European city so as to reduce them to a state of medieval deprivation in which they were in constant fear of death" (p. 5). The prosecution continued that during the siege, "there was nowhere safe for a Sarajevan, not at home, at school, in a hospital, from deliberate attack." (p. 5). Arijana simply said of the siege that "it was a very traumatic story." She continued:

> I never saw anybody dying or nobody attacked me directly. I mean, my life was in peril all the time when I was in Sarajevo, but I didn't escape from under the knife or something like a lot of people from Bosnia. But

> nevertheless, it was really hard experience. A very hard experience, the war.

Arijana and her family escaped to the Czech Republic where they lived for approximately one year in a refugee camp. She said very little of this time, except that it was "very hard... very traumatic." From there, they moved to Prague for just over two years before deciding to move to Canada. She was unsure of what to expect of life in Canada, but that it would be better than "life back in the Czech Republic." She added, "I didn't expect anything big, just normal life."

Once in Canada, Arijana "tried to establish a normal life again." From Sarajevo to the Czech Republic to Canada, Arijana said it was difficult and disheartening to have to "start again and again from scratch." She added that the first few years in Canada were particularly difficult, and a "normal life" seemed to be slightly out of reach. In her words:

> It couldn't be normal at the beginning because I was really burdened, not only myself, but whole family and friends. Everybody was very burdened with what was still happening back home and with some fears and expectations here and there. I tried to establish normal life again, and obviously that I expected too much from myself at the beginning. Obviously even expecting normal life from the beginning, it was too much, and it was—yeah, it was wrong.

She related three main burdens at that time which seemed to keep her from a "normal life." First, events which happened prior to coming to Canada were taking an emotional toll, and were part of the overall burden. She simply said of

this connection between past traumas and current emotion, “So probably I had more time to think about things that happened in Bosnia, and it was one of the things of the depression.” Second, even though life was safer here, she felt “degraded” by loss of social and economic status. As well, her challenges learning English were particularly demoralizing as language fluency was an important part of her career success and personal identity. She said:

> My background back home is as a writer. I worked for 11 years. I had kind of, kind of a reputation and people know me. From that level, when I came here, I came to the level that I'm afraid to take the phone; actually to respond to the phone. So if somebody tries to tell me something in English, I wasn't able to understand…And from very intellectual, and you come here and they try to teach you how to flush the toilet. I don't know.
>
> You are newcomer and so they treat everybody the same. So I didn't expect anything else, but you know inside it was really hard to accept some things. So it was kind of one big degradation. You could imagine that—so it was pretty, pretty depressing.

Third, there was the “ongoing worry of Bosnia” which continued to occupy her mind. The thoughts of Arijana throughout the war were always on Bosnia and on her friends and family members that remained there. She said:

> And on top of all that, it was really hard because it was still the worry of Bosnia. And all my family and friends and my husband's family, they were all there. We were constantly under the pressure of the worries, of

> the concerns... What if? So sometimes we didn't even know if they survived or not.

Arijana felt that these challenges combined “just piled up and piled up” and became difficult to manage. She described the feeling as “mostly like restlessness” but also felt “anxious,” “lost,” and “depressed.” Arijana shared, “I was pretty depressed at the beginning and pretty lost... I complained, I think, to one of my ESL teachers at school, and I told her that my mood is going up and down.” The ESL teacher, who was also a “trusted friend” recommended that she meet with a psychologist at a local counselling centre.

This referral from a trusted friend did much to build initial trust and help with the transition into counselling. As Arijana recalled, “Because I already had a very good relation with my teacher who actually recommended the counselling, I didn't have any problem to fit in from the beginning.” The location itself was also familiar to Arijana, and that familiarity helped to make that initial visit to the counsellor easier.

Arijana met with Sonya, a psychologist originally from Russia who has expertise in working with refugees. Their meetings started just over one year after arriving in Canada and they met nearly every week for approximately one year. They continued to meet sporadically for several years after that, sometimes with many months between meetings.

When asked what she was looking for in counselling, Arijana responded, “I don't know. I'm not sure exactly... Just somebody to help me, to tell me what to do—how to help myself.” She described feeling “stuck” in her emotions; with a

desire to change but lacking the knowledge of how to change. She thought, in addition to getting advice, that perhaps talking about her problems would help. Arijana said that she wanted "just somebody to hear to me, because obviously I had a need to tell my story to somebody. Yeah, and so I did." She continued:

> I tried to explain not only my feelings about the war and all that, but my regular, everyday problems in the family here, settling down here, et cetera, which was really nice when you have somebody to talk to. Actually, every time after I met Sonya I would feel much better.

Arijana reported a feeling of "relief" that came with the telling of her story. However, Arijana also emphasized the importance of desire in this process. She said:

> So if you are there because somebody told you to go and you are not interested to find a cure for your problem, so nobody could help you. Even a team 100 psychologists cannot help you. So if you are sitting there and just telling, "Yes, uh-huh. Yes, yes, uh-huh." I mean, it's really so just wasting of time.
>
> But if you really want to tell your story, to be helped, as I had actually experienced... you can. You leave Sonya's room kind of relieved, at least a little bit. Although there're terrible traumas in their lives and actually nobody could erase that. Nothing could erase that, but they feel a little bit more comfortable with their lives and a little bit more at ease. Yeah, like "aaaaah." I feel a little bit better.

Arijana related that she “was really open to her, like to the doctor or somebody close.” As she told her story and felt the accompanying relief, Arijana also received advice as she had hoped for. She highlighted the importance to her that the advice which she received “felt right” or in some way resonated with her own ideas.

One specific piece of advice that Arijana remembered was the use of relaxation strategies to help reduce feelings of anxiety and tension. She recalled feeling “very, very tense all the time—like a cat ready to jump.” She described these symptoms to her counsellor during one session, “So Sonya taught me some breathing techniques which helped at that time. I remember in the bus a couple of times I would try to practice... and that breathing helped me.”

Sonya also helped with challenges of “everyday life”. For example, Arijana recounted challenges that her son was having with the other children at school. Sonya provided her with practical advice on how to deal with this situation. As she recalled:

> Then my son, he had some, not problems, but some kids he didn't get along at school... Poor boy was suffering and having nightmares because of whoever was there... At that time, we didn't know how to deal with that. Now I know to go to the teacher and tell her what is happening, but at that time we didn't know that.

Arijana emphasized the importance of her relationship with Sonya as a critical component of the healing process. She described Sonya as “more than a counsellor.” She related how the ongoing meetings with Sonya became a

meaningful part of her day, and how a meaningful friendship was forged between them. She described the experience as follows:

> Counselling was relaxing and calming, and I was kind of—it was a habit. I mean, it became a habit to go to her when we would have a lunch break at school. And since it's pretty close, it's a five minute walk, so I would take my lunch and she would have hers, and we would sit as friends in her office talking and eating and crying. So it was really good experience for me.

Arijana noted that the characteristics and interactional style of the counsellor helped to build the relationship quickly at the onset of counselling. In describing the elements which helped to build the relationship, Arijana said:

> I don't know, actually. How could I explain that? I saw somebody who tried to help me. And Sonya, since she was very open, very friendly, very gregarious from the first moment, so somehow I opened to her immediately.

Even though she felt "open" at the onset, the development of a positive working alliance was not without its challenges. Especially during the early sessions, Arijana and Sonya had to overcome the language barrier that existed between them. Arijana's husband spoke English before coming to Canada and her son quickly picked up English at school, but Arijana continued to have difficulties expressing herself in English. Arijana recalled an experience at the beginning of counselling that illustrated the challenges in communicating. She related:

> At the beginning, it was really hard to express myself because it was my beginning in learning English... I remembered the episode when I talked to her on the phone for the first time from the counsellor office, and she tried to describe where her office was.
>
> I said, “Oh, well, that's okay. It's not fair.”
>
> I had no sounds from the other side. I said, “Oh, sorry, it's not *far*. It's not far away.”

Although it was difficult at times to understand one another, Arijana reported that the process itself of trying to understand each other helped to establish a positive relationship. She said:

> Yeah, it was pretty hard, but somehow we established—from the beginning we established very nice relation and cooperation, actually, and she tried to understand me. She speaks Russian as well, and it's close to my language—they are both Slavic languages. So a little bit, I mean, mostly in English, but a little bit in that mixed language: Bosnian, Russian. We somehow managed to understand each other... It was pretty bad at the beginning because of the language and all that, but somehow I managed to tell what I wanted and even more.

Not only did this process of communicating and building a mutual understanding help to build a positive counselling relationship, but Arijana also recalled that it was of itself therapeutic. She explained, “I told my story to somebody and I practiced English at that time. So I proved myself. I prove that I

could do something in that new scary language I was just getting familiar with." By proving this to herself, Arijana felt that she "grew in confidence."

Three qualities were highlighted by Arijana as particularly descriptive of the counsellor-client relationship. First, safety and trust were a foundation upon which the relationship was established. Arijana expressed that she always felt "safe" in counselling—that she could talk about the most difficult of topics and know that she would "be ok". These feelings of safety and trust were developed, as noted already, even before the first session as the therapist was referred by a trusted friend. These feelings were also built during their conversations by the way in which the counsellor approached the problem. Arijana shared the following of Sonya's approach:

> I noticed with Sonya, that she would never go directly and say, "Okay, now tell me what is your main problem."…But step by step... and always very alert and very conscious of the fact that the people she was talking with and she's talking to had a deep trauma somewhere in their life. So she would approach the trauma step by step. She would always say, "Oh, if you are comfortable of telling me so, or if you want to tell so, or if you don't feel too, I don't know, painful to say something."

Second, Arijana felt understood by her therapist. It was difficult for Arijana to describe how the feeling of understanding was developed during the counselling sessions. However, it appeared that it was developed in one way through a process of listening and responding. When asked what helped to build understanding, Arijana responded, "I don't know... Sonya is a good listener, a

very good listener. She just listened. She just listened and probably at the right moment she would tell something that sounded right to me at that moment."

The third quality with which Arijana described the therapist-client relationship was one of "being with" her. Arijana reported that this quality of therapy was very important to her in terms of developing a meaningful human connection as well as helpful in achieving her treatment goals. She described her experience with her counsellor as follows:

> I understand that it's your job, that in the next couple of hours you are going to have several other clients... But for me, it would be really, how could I say... offensive, if I were to pour out my guts and she were to look at her watch and say, "Time's up. It's over." I knew, I mean approximately, about how much time we could spend together, but I never had the impression that she was watching her watch or that she's rushing me or she's trying to throw me out because another client is waiting... I don't know how many clients after me and before me, but in the moment she was with me, I had impression that she is completely dedicated and she's completely focused on me and my case and my story….it was my impression from the first moment that she was really interested in what she's doing with me. It's not just a routine for her.
>
> Although I never thought that I'm the only client, I'm her favourite client or something. She gave me that impression, that she's completely into my case when she spend the time with me...So I think it was really

> good to have somebody, how could I say, objective or neutral in this case to tell what you feel... So it helped me that she was being there with me.

The proximity of counselling services to Arijana's place of work was also helpful in the overall counselling process as it allowed her to access the services. Hers was a 5 minute walk from school to Sonya's office. Arijana recalled that were it not for the proximity of services, "otherwise, I couldn't come." She explained:

> I had a small child at the kindergarten and after school I would go straight to pick him up. I lived at that time on the west side of the city, so probably I wouldn't have another opportunity to go downtown. At that time I didn't have car. I had to take the bus, so probably I wouldn't have a lot of chance to come and see her otherwise.

Once there, the comfortable and relaxing atmosphere of Sonya's office added to the overall positive experience of counselling. Of the setting, Arijana said, "Even the atmosphere in her office was kind of relaxing and so in her voice, really steady and really calm. And a package of tissues that I used profoundly."

There, Arijana and Sonya met over a span of several years. Their last meeting was approximately 4 years ago. With work, Arijana and her family were able to build again a "normal life." She said, "It took at least four or five years until I finally settled here and started feeling like home." For Arijana, "feeling like home" consisted of gaining confidence in the language, becoming financially "settled" and developing meaningful friendships and social relationships. Since her own counselling experiences, Arijana has wanted to help other refugees and

newcomers to Canada. She volunteers at a local organization helping other refugees to rebuild their lives in Canada.

Florence

Florence came to Canada "looking for a country." She lived in Zimbabwe with her parents, Dutch descendants from South Africa. She spoke little of her life in Africa, except that in the year 2000 her family joined the exodus of other White Zimbabweans who were leaving due to political unrest and the illegal seizure of many White-owned properties. Florence left with her parents to the United Arab Emirates. From there, Florence decided to move to Canada where she felt that she would have "more opportunities" to establish a good quality of life. She arrived in Canada in 2002 at 28 years old while her parents remained in the Middle East.

While she did experience difficulties in her home country, Florence shared that her greatest challenges occurred during her prolonged five-year claimant process. During this time, she felt "constant uncertainty and aloneness," and had a constant "fear of deportation." As she described, "You go to sleep at night, you scared. You wake up in the morning, you scared... People plan things two months ahead. You don't join in because you don't know if you will be here for two months ahead." In her frustration she exclaimed, "Deport me or keep me, but make a decision!" During this period, Florence described her life as being "on hold":

> You kind of just live, you know. It's basically like I've been in jail for five years. The only difference is my jail was an entire city. Well, you know, I'm sitting here; I don't know what to do. The people at immigration are

> just like: “Well, you know, there's a delay in paperwork and blah, blah, blah and blah, blah, blah.” So the years drag on...You can't really do anything. You can't go to school because, you know, you don't really have the rights. And if you go to school, then you're an international student because you don't have permanent residence. I really wanted to at least go to school, but then how do I apply? The minute that you talk about a student visa, you are talking about three, four times the cost.

As well, Florence had to find her way through a “maze”-like process of immigration. She was quick to point out the magnitude of this process, saying, “This is life altering... It was a constant, constant battle to figure out what to do, what is going to screw me the least. Because believe me, there was consequences no matter what you do.” In describing these experiences, she said:

> Believe me, even with advice from immigration, you still don't know what to do because you call today and tell them that you talked to somebody, they give you this advice. You wait until tomorrow, 4:00, you call again, you ask the same question, you get totally different advice. You screwed. You go to your Member of Parliament, they call Ottawa, you get a third opinion. Very difficult. You get as many opinions as you can, and then try and analyze out of all the opinions what is at least similar and then go on that. That’s all I could do.

Florence recalled a deep feeling of aloneness throughout this period. Describing her experiences, and others in her position, she said, “They don't want to make friends because everybody wants to know stuff, and they can't answer

that, so they become very isolated. They live with constant fear and they are very, very careful with what they say and to whom." She elaborated:

> To start to make friends, you have to be able to tell somebody stuff, and when you don't have answers to those stuff... what do you say? How do you make friends? When your life is up in the air, you can't make friends. You can't connect with people. It's very exhausting because, on top of that, you had to work. You had to fight immigration. You had to find information. You had to fight with lawyers. You had to fight with legal aid. Plus then work to pay your bills. So then forget friends, social life. Non-existent.

Florence also spoke of significant challenges finding meaningful employment. She could not obtain work in her field of study because her qualifications were not recognized in Canada. Work which she did find would not last long. She recounted that life was "constantly changing." She continued:

> Like losing jobs—because, oh, yeah, you would be fired because of cultural difference. Yeah, but I mean, what do you do?…
>
> It's like I was talking to somebody and he was like, "Oh, you know, you should actually have gone and complained. They can't just fire you because of a cultural difference."
>
> And I was like, "Yeah, you know what..."… If you're fighting so hard with immigration and for money and lawyers and legal aid and all this stuff—being fired from a job, you don't have the energy to fight that. You just don't have the energy.

Florence first sought out the assistance of a counsellor for help with the paperwork required as part of the immigration process. She was referred by her immigration lawyer to Linda, a psychologist with considerable experience working with refugees. Florence recounted, “She needed to write letters and stuff, and she did. She did an assessment every time I saw her, and she would write a letter that was sent in to the lawyer and to immigration.”

At that time, counselling was not something that Florence was interested in. Her sole expectation from Linda was “Lots of advice. How do I deal with this question? How do I fill in this form? I need a letter; can you write a letter?” Florence explained:

> Imagine if you're in a different country, you don't have an income, you don't know from day to day where you sleeping, you don't know from day to day whether you're being deported or not. You think you're going to be interested in counselling?

Florence used the metaphor of an ocean to represent the “deeper levels” of an individual, as well as the underlying “trauma and things” that may otherwise be the focus of counselling. She shared, “Life was like a thunderstorm, so you can't go down to the ocean before the thunderstorm that you have to fight the whole time”. She emphasized, “Right now, you’re just surviving.”

From the initial letters and assessments, Florence began to ask for other help in “figuring out” the system of immigration. Of the process of immigration, she said, “There's always this maze of red tape. You don't know what you have to do and you're in a constant battle. It's a constant battle of do I do this or do I do

this?" She emphasized the importance of these decisions in her life, because "very, very early on when I got there, everything was so brittle. One person said the wrong thing and things could blow up sky high."

One of the challenges that Florence experienced was how to sift through the often contradictory advice that she would receive from numerous individuals. Florence asked Linda for specific advice in this regard as she valued her counsellor's opinion and trusted her advice. She said, "Sometimes we would talk about it... These are the options or this is the stuff I gathered. I have these options. What do you guys think? Do I trust this advice?" While Linda's advice was just one in a long list of varying opinions, Florence felt that her advice was taken into special consideration over the others. Helpful advice also included how to effectively present information to immigration. As Florence described:

> Even some of the reports that I had to send in to immigration I would send to her and she would look over it and she would say, "Okay... how do you want to put this stronger so that it can punch?"…Because the only way that you could get through stuff is to make stuff up higher—the impact must be way bigger. So sometimes I would email her documents before I would send it off. Linda would read through it, and would say, "Okay, there's a better way to formulate it."…
>
> Because I mean, like, I speak English fine, but it is still my second language, so I didn't have the wide vocabulary to explain things really well. I just have, you know, the normal, everyday vocabulary. So they would put it into more punching words for me. Really punch, yeah. So, we

did all of that. Like, I would send, then I would read, then I would be like, "No, no, no, this is not what I want to say," or, "Oh, this is really good." And if there was stuff that I didn't want to have it, I would mark it and send it back. It went on like that.

Other times, counselling was used as a sounding board where ideas could be "bounced" around. Florence shared one example when she was "getting a lawyer and trying to apply for legal aid." She said, "I've got a problem. This lawyer didn't work out, now I have to get another lawyer." This was a concern for Florence as she was unsure if her decision to find a new lawyer would impact her eligibility for income support. She wondered, "What do I say to income support? What do you not say to income support?" She found these conversations invaluable where she "could bounce things off this person. And by bouncing it off, at least I could clear my head a bit because you're in a head space of fighting the whole time."

While initial contact with a counsellor was motivated by a desire for assistance with the immigration process, counselling branched out from there to address other areas as well. She explained, "A lot of these things that you have to write to immigration, or talk to in the hearings, or talk about to lawyers—a lot of that opens a lot of thoughts and things." She said of these thoughts, "Some things I've never looked at, and some things I have looked at somewhere in my life, but I kind of put it back in again... Close the door off." However, these thoughts and memories would be stirred up again during the processes of immigration: "But off you sleep and everything comes up to the surface."

Florence began to use counselling with Linda as an opportunity to address these stirring thoughts and memories from the past. However, she noted that these discussions of past events did not have an underlying purpose to "fix them" or "heal from them." Rather she felt that these discussions had the purpose of better understanding "behaviours that might have been altered due to historic events." Florence recalled:

> I mean, we talked about things as in the past, but we didn't get to deep levels. There was no fixing. If we were to talk about something, it was kind of very briefly what happened and maybe some possibilities of why it may lead me to where I am... I would ask her sometimes: "Well, why do I do this or why do I do this?" So we did talk about a few things, but I mean, more in the sense of understanding.

While Florence found these discussions "helpful" and "insightful," she found that they were not always able to delve down to the "deeper levels." Florence shared, "that was one of the big problems that we ran into—there was too much to unpack... After unpacking all the daily issues, there's not time for deep levels." She shared that, "Honestly, at times I wanted to do more work things—analyzing why am I doing this, or analyzing why am I doing this or what's there." However, time stood as an obstacle to this as she added, "But I can't get to the work things until I have unpacked all the garbage on top." She continued:

> But there's not enough time that Linda was giving me to get to that levels. Because then she would tell me, "You know, in counselling, normally I

> don't listen to what you did every day for the last three weeks. You pretty much walk in and we immediately jump to the deeper stuff." And I was like, "I can't do that. I just—I can't." Yeah, I literally had to unpack that to—because I had so much going on that there's no way I can get to a deeper level unless I can get rid of the stuff that's on top.

As the daily struggles experienced by Florence accounted for a significant portion of her daily energy, these daily struggles also accounted for a significant portion of her counselling experience as well. She said that, "we talked about some stuff, but I'd say the majority of things we looked at was just daily stuff because I had so many problems that would come and go, come and go. Just to keep up with that was a task." Other "daily problems" addressed in counselling related to challenges that Florence experienced in social relationships. As one specific example, Florence experienced difficulties handling various social interactions wherein people would ask questions about her accent and where she is from. As she described:

> I have discovered, Canadians are very nosey. They don't respect people's privacy. So everybody always asks questions. So I ended up not wanting friends because I don't need to tell them all the stuff that they ask. You know, what do I say to people asking me about my accent? Because, hell, I've never lived in a country where it is so important for people to know why you have an accent…You're dealing with basically essentially running away from that country, you don't want to go and talk about it. So for somebody that might be having this exotic idea: Oh, you're from

> another place! But you're running away from another place, why would you want to talk about it? So that was one of the main things that I was dealing with, was everybody was just kind of pushing me back towards this, towards Africa, and I don't want to talk about it because I'm trying to get away from it... I was fighting so hard to get away from it, why would I want to be reminded of where I come from?

These troublesome exchanges occurred repeatedly, sometimes several times a day, and became a source of considerable frustration for Florence. She said, “Well, imagine -- how many people do you talk to in a week? Imagine if each of that people said: Oh, you got an accent. Where's your accent from? Where are you from? What are you doing in Canada?” Florence wanted practical solutions to help her deal with these situations. Florence said that her counsellor helped her to “come up with things for you to say.” She continued:

> That's one of the things that we would discuss. We would literally practice it. Okay, you say this and I say this. I still remember she would write sentences for me on a piece of paper, and she was like: “Okay, if somebody asks you this question, here is an answer. Go and memorize it.” We would literally do that, and, yeah, I started using it on people. Because I don't have to talk about that. I just say: “Well, I have a Dutch heritage. How's the weather?” So that would at least satisfy them why I have an accent, and they change the topic. It worked... I still use it.

Other repeating challenges involved work-related issues. The professional qualifications that Florence had acquired previously were not recognized in

Canada, and she found herself floundering from job to job. This led to a growing resentment and frustration with life. Linda recognized this and said in one meeting with Florence, "You have to analyze why are you not doing that good—what do we have to change, right?"

Together, Florence and Linda assessed the situation and developed strategies to change it, discussing "How can I do this better? How can I communicate better? How can I handle conflict better? Why do you want to change this and how should we change it?" Florence valued this practical approach, and although it did not address the greater problem of unrecognized professional qualifications, she felt that it was helpful in "fixing the day-to-day problems" that occurred in her workplace. She knew that new training would have to wait until her immigration status was secured.

Within her experiences and challenges of the claimant process, Florence expressed that her connection with Linda was of great importance, perhaps even "the most important thing" in therapy. She described the value of this connection and consistency:

> I think the most important thing was the constancy because I have had so much change in my life that nothing was the same. You know, nothing—I had nothing that was the same. Even people in the community that was helping me, there was not constancy to that. Like, I would get help for six months from this organization, then they would withdraw. Then I would have to go to this place and they would help me maybe once, twice. Then I

had to go to somebody else. So not even in that respect constancy. So the only thing that didn't constantly change was this woman.

It was the only thing, and I think that's one of the reasons why she kept staying with me... Because why would I want to -- I've already built up a rapport with you. Why the hell would I start and do that with somebody else again? Because if it was constantly changing again, it's like you start all over again with somebody else, and that I already had to do. Every time—like losing jobs.

Like this woman—out of everybody, this woman has maybe done the most for me, in a sense, because she was the most consistent. Not that she did the most as in, oh, she did this whole heap of work for me. It was more because other people might have been able to do the same for me if they stuck with me for the four years, but they didn't. So she was the only person that stuck with me... The fact that she stuck with me is why she did the most, not that she did the most as in she did more things for me.

A degree of initial trust, as well as an initial feeling of mutual understanding, was attributed to Linda's expertise and past experience in working with other refugees. She said of Linda, "I was not her first person that was going through this. She's dealt with people in another city before... that have also gone through this." With this experience, Florence felt that Linda, "knew the constant uncertainty, she knew the constant agony that you are in because she has been through it with somebody else."

Trust increased as Florence felt that Linda was truly trying to help her. Florence shared one example of a particularly trust-building experience:

> Strictly speaking, she totally bended the rules for me, because strictly speaking, I think the max that she could see somebody is maybe three months, seven visits, that's it. And she saw me for several years. So I think that kind of helped with the fact that she bended the rules and said: "No, I'm keeping this person."…Because they would sometimes (I think once in two weeks) they would sit together to discuss their caseloads... I'm sure that even her superiors would tell her to let me go... But she stood up for me every time. She was like: No, she have to keep this person. She's not letting go of this person.

This experience also helped to demonstrate authentic understanding between the therapist and client. Through this experience, Florence felt that Linda truly recognized and understood her challenges. In recalling what she felt following these events, Florence shared:

> She recognized I'm extremely isolated, even though I was living right in the middle of the city. She recognized I was extremely isolated and she recognized that everything was uncertain plus a lot of change. She recognized that she can't let me go because I had so little out there that I could rely on.

However, the development of a positive relationship was not without its challenges, and some interactions impaired trust and frustrated therapeutic progress in the session. Highlighting the importance of honesty and transparency

in therapeutic communication, Florence recalled the following negative or hindering experiences in therapy:

> Oh, I think if you discover that they are not as honest, then that kind of—I mean, sometimes she would tell me, “Well, you know, I only have this time because I'm expecting a new client, or somebody else.” And you would go outside and there would be nobody waiting... or I remember one time I had to send in papers. I had a deadline for all this refugee papers that had to be in. I was stressed to the max. Then I got to her and she was like, “Well, I only have an hour for you.” So I was sitting there, panicking, trying to get everything done in this little time. She was very relaxed. I mean, a few times in the hour, it's like why is she so relaxed? If she only has this little time and she knows how much we have to get through, why is she so relaxed? But I don't have time to think about it because I just have to finish. And then at the end she was like, “No, we can do another half an hour or you can stay for another hour. I don't have somebody right now.” And when I walked away, it was like she is talking bullshit with me
>
> So times like that I would get really pissed off because then I would be like: Why didn't you just tell me that because then I could have at least relaxed a bit because I could have known that you have the time. But instead, she waited to the very end and then she would be like, “Oh, we have a little bit more time.” So it's things like that. So you would wonder.

Florence did not bring these concerns up with her counsellor. Rather, she chose to “overlook” them. While they were frustrating during the session, Florence did not feel that they hindered the overall counselling process. She said that Linda “did many good things for me” that “I knew she wanted to help me.”

Overall, Florence found counselling to be very helpful. She felt that her initial goal of finding help with the claimant process was met, as well as subsequent goals of dealing with day-to-day challenges. She appreciated a directive approach, as well as the connection that she experienced with her counsellor. She met with Linda for approximately 4 years during her claimant process. She discontinued therapy once she felt “more in control” of life and no longer required assistance with her immigration application.

Florence received final approval of her application one year ago. At the time of the research interview, Florence said, “It's only now that I'm kind of starting to get a life again.” She has applied to university to continue her education in sociology. She feels “more settled” in her home city. She is beginning to meet with others on a social level, but still has few friends. Still, she feels as though life is “coming along.”

Natasha

Natasha is a 45-year-old woman from Bosnia and Herzegovina. Natasha lived in Sarajevo with her husband and infant son in what she described as an “ordinary, middle-class life”. Natasha was an artistic director in a performing arts theatre and her husband was a businessman. They had loving family connections and many close friends. Natasha described her life as follows:

> And so life was kind of basically normal. We had our careers. We got married and we had a baby. Everything was very planned. And then the war broke in 1992. The city of Sarajevo where I was coming from was under siege for a number of years.

After nearly one year, Natasha was able to escape with her child to the Bosnian city Banja Luka, but her husband was forced to stay behind. She recalled, "He could not leave, so we were separated with absolutely no communication. I did not know is he alive or not, like, absolutely nothing." With civilian deaths during the siege numbering approximately 10,000 and wounded over 50,000, the fear of her husband's death was "very real" for Natasha.

After waiting for one year in Banja Luka, Natasha's husband "suddenly arrived." She shed tears of joy as they were reunited as a family. However, still not entirely safe from the war, Natasha and her family fled to neighbouring Croatia. Solemnly Natasha declared, "We were refugees."

Natasha said of her experience as a refugee in Croatia, "We were never in refugee camp, but we had refugee status." She said that this status kept them from being fully able to rebuild their lives. Natasha shared:

> We managed to work, but it was not really fine; you still have that status. You can't really build life because Croatia was also close to the war. I mean, they had their chunk of war. There it was fine, but still it was really difficult politically.

Together, Natasha and her husband discussed what options they had for their future. They felt that Europe was not an option as it is "difficult to integrate"

and that in Europe "you can't get really a status." She explained, "You are a refugee. Many countries, they did not have a policy that you keep refugees and you give them a status—so Germany expelled all the refugees, for instance." The decision to move to Canada was a difficult one that was not made quickly. Natasha shared:

> We waited for a year and a half. I have to say I was quite against it. My husband was pushing it. I could not imagine living in different culture. Language was a very important part of our work and our professions. I was an artistic director. You express yourself through language, and so it was difficult to imagine that, you know, I can do this in some foreign language, so I resisted…But was really politically hot. I could not imagine my son being raised in such a divided society where every blood cell is counted. Are you a Croat or a Muslim or a Serb or what? I mean, it was difficult for me, but I did not want Daniel to be raised in that environment, so that was the final decision.

After making that difficult decision, Natasha and her family applied to immigrate to Canada. However, the process was a slow one. Natasha described, "It took us, I think, a year and a half to process everything." As well, it was not always clear if their application would be successful. She continued, "I think we were refused twice or something, and then finally the third attempt was successful, so we arrived."

Natasha and her family arrived in Canada in the winter of 1996. Once in Canada, Natasha and her family were faced with a different set of problems. She described:

> We were completely isolated, not knowing what to do in a foreign country and the land around you. No communication, no nothing. We decided to leave on our own, but it means having nothing. I mean, we arrived with $200. That's what we had. Like, two bags. So we did not have any money, and you are not eligible for any kind of assistance; no welfare, nothing.
>
> The first year was terrible. We were literally starving. And then the economy was not as it is right now, so we could not really find jobs and it was difficult. If you could find something, they were very hard jobs, so it was tough.
>
> It was tough just adjusting to hitting the bottom of society—being nobody, not knowing anybody, doing very basic labour jobs. Yeah, it's a difficult situation to accept. And so I think first three years were extremely difficult.

This period of adjustment was difficult for the entire family. Natasha and her husband tried to cope with life by "turning everything into a really rough joke." She recalled:

> Because everything around us was a joke. I mean, you know, I was an art director, now I am scrubbing toilets. I have to see that as a joke, because if somebody tells me this is reality, I will kill myself, right? So I have to turn in some kind of a joke. I have to distance myself from that, and I have to

> see myself like Monty Python or something, right? This is not reality. This is just me being, you know... So I guess between my husband and me, it was that kind of constant joking about our situation. This is the way we are surviving. We just don't know how to do it differently.

During this time, Natasha felt that her son was their "reason for living." They arrived in Canada when Daniel was five, and she described him at that time as a "very happy boy, very happy." Her face lit up when she spoke about him:

> In all this experience he was so happy all the time. And so, usually my husband said, "We did not give life to him—he gave life to us, really." You know, in all these depressing situations, we have this cheerful boy who is always happy and makes you laugh.

However, after living in Canada approximately two years, Natasha began to be concerned and worried about her son. She said, "And it was I think two years after we arrived, he started to lie. Lied to the point that I got scared. I felt it's not life-threatening, but they were serious; serious for his health, serious for his well-being." The seriousness and the frequency of the stories began to be alarming. She recalled:

> The amount of stories that he was producing... And in my mind, being seven, it's kind of a little bit late. Usually kids are doing it when they are four, five—you know when they imagine their friends and monsters and stuff. Being seven and being in Grade 2, I was just surprised. And the seriousness of these stories, and I just got scared. I did not know what to do...I mean, there were stories about telling teacher that he had two sisters

that were killed in the war and how it was difficult for him and his family and giving all the details.

So I come and she says, “I am so sorry for your daughters.”

And I am like, “What daughters?”

“Well, the daughters that were killed in the war.”

I said “I never had daughters.”

Being concerned for her son, and not knowing how to help, Natasha and her husband decided to talk with a counsellor. Natasha shared her perspective:

It's that sense of huge responsibility that you develop as a war survivor... War is something that you cannot control. You can't do nothing, and you are responsible for a child. So it's a huge conflict between: I have to do something for you, but I can't. So for me, it was very important that he is okay. So I was looking for that.

Natasha related that she was unsure of exactly what a psychologist would do to help Daniel be “okay”; however, she was sure that if someone had the expertise, then he or she would know what to do. She shared, “For me, it was not really an issue who she is or where she is from. For me it was important that this is what she specialized in.” She highlighted that finding an expert can be “very difficult.” She continued:

The fact is that it's very difficult to find a person that you would trust on that level... I think it's a very difficult field, but again, I mean, there are many difficult fields. I don't think it is the most difficult... I guess it has to be a specialization. What I am looking for is a person, again, who is

> knowledgeable enough. And how to define that expertise I don't know... If you have such a huge event in your life, it is very difficult to make a distinction between the impact of that huge event and your natural aging. My mom was a depressed woman all her life, and so do I have any of that or is it the war? So you know, that kind of helped to sort it out, because you don't really—you really don't know what caused what, you know? What is the real impact?

It was for this reason that Natasha sought out therapy at a counselling centre specific to refugee and immigrant issues. Natasha said, "The whole environment of the counselling centre is about immigrants and immigrant issues, so for me—and I guess for many other people—it would be a natural setting." Natasha met with Maria, an Eastern European psychologist with nearly 20 years experience working with "refugees and immigrant issues." Maria met with Natasha individually as well as together on a few occasions with her husband. Maria also met with Daniel alone to better assess his situation.

Natasha felt an "instant connection" with Maria. She discussed how having a counsellor with a similar background can help initially to build a connection of mutual understanding. She said, "I think that the fact that she has an accent and she is an immigrant, I think that helped because then at least in back of your mind you think, well, she understands how it is, right? She knows." Natasha also noted that other similarities with the counsellor helped to quickly foster a feeling of mutual trust and understanding at the onset of therapy. She continued,

“Maria was a woman, and it always helps woman to woman. I am not sure how my husband felt, but he did not complain, so I don't know.”

Upon this initial and “immediate” foundation of trust, early interactions served to foster a positive working relationship and meaningful connection with the therapist. She explained that, “you build that through conversation,” noting that demonstrating understanding in the conversation, as well as participating in a meaningful “level of exchange” were crucial in this regard. She continued:

> So that person is knowledgeable and that person can really have a conversation with you (and person I am saying counsellor or psychologist), on that level, that I know that he or she knows what I am talking about. Not a banal conversation in terms of "so, how are you feeling today? How may I help you?" But something a little bit higher level of exchange; that we can really explore and analyze. I guess that could be still helpful, but it is very difficult to find such a person...

While one level of exchange can serve to increase trust and connection with her therapist, other interactions could easily weaken the relationship. Natasha explained, “I know that I could be easily, really disconnected if I see that a person is really not engaged in that conversation.” For her, being “engaged in the conversation” means being responsive in the conversation. She exclaimed, “Do something! I mean, I am not saying we have to slice it up, but I expect to help me to analyze that, but I don't think that could be helpful with questions like ‘can you tell me more.’” She continued:

> It is very easy to be put off if I see that response is not on a level that I am expecting, if it's too banal, or if you can see the person does not know what to say because the thing that you are saying are too difficult or too foreign or too exotic. Maybe people are learning in school, like "Tell me more about that," or, "How would you feel about that?" That does not help, you know. I know that it's in a way leading the conversation, but at the same time I feel it's, like, you don't know what to say, basically. This is why you are asking me: "So, tell me more."
>
> It's kind of, you know, are they scheduled questions that I am just—are you really involved in this conversation? Do you know what I am talking about or are you just saying because this is what you supposed to say? It is a deeper level and more engagement with expertise, really, and ability to analyze what is going on and not letting me talk for two hours. I mean, I could talk forever. But I can talk with my friend also, and so what is the difference?

Natasha also explained how some counselling processes may take away from trust. Specifically, she felt that the forms and questionnaires which are completed at the beginning of counselling (e.g., informed consent and intake forms) may detract from trust as they take away from the "natural" process of communication. She explained:

> If you want to build a communication or a trust, how do you start the conversation? In many cultures you ask about you and your family. "Do you have family? What about your ..." You know? And so it's more

> building trust based on conversation... At the counselling centre that I went to, they start with papers. Sign this, sign that, go through the questionnaire. Especially for people in crisis, that's something that is really distracting.

Still, knowing that Maria was an expert in the field and feeling satisfied with the "level of conversation," Natasha felt comfortable in counselling, and confident that her goals in counselling could be met. In order to achieve those goals, Natasha had a specific expectation of receiving advice in therapy. She explained her reasons for seeking counselling as follows:

> I wanted to know what is going on, and I guess that's my personality. I like to know. I don't like to live in denial. Just tell me! So I wanted to know what was going on. I was terribly afraid that something is wrong with Daniel or with us... So I was really scared.
>
> You don't know what to do. You try to tell him, you try to talk to him, but then I was getting really upset and starting to scream and yell every time: "You can't do this! Blah, blah, blah!" And I did not like that. I did not like that part of me getting angry and screaming because I did not feel it was helpful. At the same time, I did not know what else to do. What do you do? So I really needed somebody to tell me what to do.

Counselling started with a brief review of experiences in Bosnia. Natasha recalled, "We talked about that. We talked about that because we had to explain the sources of our despair." However, she added that it was not necessary to go into great detail saying, "It was very brief. Not many details. We were refugees

from Bosnia. We experienced war. We are survivors. We were refugees. It was quite difficult at times for us." With that basic understanding, Maria asked, "What is your coping strategy? How do you survive?"

After describing their coping strategy, the explanation that Maria provided both "surprised" Natasha, and also "made sense." Maria linked the coping strategies of Natasha and her husband (i.e., using rough humour) to the challenges that her son was experiencing. She recalled the experience:

> It was helpful but surprising, very much. And the reason, what she discovered—I mean what she told us—is that... we use lots of very rough humour among the two of us, which is part of our mentality and culture. And then she reflected on that and she said that it's too rough on Daniel and that he is trying to cope, and because he is not able to come to that level, because these jokes are too sophisticated, but rough, then he is trying to balance them with his fantasies, his stories.

Natasha was "grateful" for the insight saying, "She helped us reflect on our own behaviour as parents and as survivors." She added that she had never considered that before and felt Maria's expertise helped them to better understand their situation. Summarizing the insight gained in therapy, Natasha simply said, "It really made sense." She further described:

> I mean, some people, they fight. Some people, they beat each other. You know, people find different coping—some people divorce. That was for us. And I did not think that that's hurtful for Daniel at all before she talked to us. He just sees that something is going on, very rough, very

> sophisticated, and he is trying to keep up—and then I think, "Of course! He is seven. He can't understand."
>
> So that helped us really to reflect on our behaviour and change and start to soften the communication, I guess. So this is something that helped me, you know, to start thinking of how we behave and how we talk to each other.

After gaining insight into the dynamics of her family, Natasha said, "Then I was looking for very practical skills. So what can I do? What can we do to help him?" The psychologist recommended several strategies to use concurrently. In addition to recommending various ways to "change your coping strategies among the two of you, especially when he is present," Maria also recommended specific strategies to help their son to better cope. Natasha said that she "really appreciated" a direct and practical approach in counselling. She recounted that in counselling, "We talked about how we can redirect his fantasies, and so she had some suggestions in terms of what practically you can do right now..." Natasha shared one practical strategy which they found to be helpful:

> We tried to explain to him that whenever he has these thoughts, that he can use either pictures or stories or something. And very quickly, actually, he started to do that. He started to draw like crazy. We had tons of cartoons. Like he was drawing these cartoons like all these little boxes, you know, with bubbles and people were talking about, you know, all these characters. And then he started to write stories, so slowly and gradually we kind of redirect these fantasies into something that's more

> appropriate, and then—I mean, he was still—he could come up with stories, but it was less and less, and I think took us two to three years to finally completely redirect him and keep the real life out of it.

They also discussed effective parenting strategies to use when their son was found lying. Before counselling, Natasha said that she "would get very upset." She explained that, "His stories were so real that you could not see when he was lying. We were completely lost... Which of course scared me, and then I would get upset and start to scream and yell." Maria taught Natasha more effective strategies to use in those moments, which Natasha found to be "quite helpful." She shared:

> We discussed that we have to have some rules that whenever he tells the truth, then whatever the truth is, nobody will get upset and there will be no consequences. We just talk about that. But, when he has more information than necessary, then we have a problem, and then consequences will kick in.

Natasha highlighted that even though counselling was helpful and, as she said, "very effective," it was also important that services be affordable. Affordability was related to her ability to access services, as well as her expectations of the health care system. She explained:

> Coming from the culture where all the health services are for free, you have that concept that health services should be for free. $150 is a lot of money for counselling, at least from my perspective. For me it is still difficult to understand that education and health care is not for free. So

> every time I have to pay dentist, I just—I am really upset. I guess it's a matter of perspective... I buy a pair of shoes the same amount and I don't have a problem with that. So I guess that perspective depends where you are coming from.

The overall atmosphere of Maria's office, which Natasha described as "comfortable and relaxing," added to her positive experience of counselling. Natasha felt that there was an important difference between the settings of clinical services in Canada compared to her home country. She described Serbian clinical services as, "very medicalized in terms of it's a hospital or it's a medicentre. It's very white. It's very like doctor's office. They all wear white coats... It's very bright, no nice colours." Natasha felt that this setting communicated that, "basically you are sick. You are sick. There's not that kind of softness and sympathizing. It's very clinical, medical, sterile, and not appealing at all."

She contrasted that to the counselling services that she experienced in Canada. She said:

> Here, that was one of the surprises that you create environment where it's soft, and the lights are not bright, and they are very careful how they pick the colours of the walls and what kind of decorations, and the chairs are soft, and so it's completely different. I mean, I saw that in the movies, but I never experienced that. I think it's completely different than Croatia, Eastern European. So that was nice. I liked that.

She added that she is unsure if she would utilize services that were "medicalized" in nature, saying, "If that happened in Serbia, I am not sure that I would look for counselling." She continued:

> It's difficult to say what I would do, but I see what is helpful here is this different environment that psychologists work. I think this is something that is a huge benefit, that you don't feel that you are visiting a doctor and that you are sick, that you have a conversation about an issue. And the whole environment speaks to that, so I like that... It's much more friendly and more comfortable... Probably Serbia has changed that in the meantime, but that was the approach at the time, white coat kind of thing. So if the same would be here, I would not like it. I probably would not go.

Natasha met with Maria from early 1999 until approximately 2003. They met "semi-regularly" (i.e., approximately twice a month) for six months, and then intermittently or "as needed" if any additional concerns arose. Looking back on the counselling experience, Natasha found it to be very positive. She related:

> I think it was good. I think it was helpful. I was glad that we went and that we were told what was going on. If I know what is going on, then I can deal with that, right? Other many people like to be in denial, but I am not such a person. So it helped me really to understand what is going on and what to do about it.

Natasha described how her experiences of war and migration to Canada redefined who she was as a person. As life settled, Natasha was able to create a "new identity." Speaking of herself and her husband, Natasha said:

> We both changed. I think when you experience changes you really can't... I could not stay the same in terms of my profession. Everything changed around me so much, and of course I change as a result. So I could not see myself... Art was my background. I just could not see myself being involved in art anymore. Like, who cares? It was very important part of my life before, but I lived in a sheltered life, so being an artistic director was the most important thing.
>
> But then coming here and going, and war and refugee experience and then being here, wherever I was, you just, like, "Art? What art?" So I changed completely my perspective, and then I developed interests in sociology. And because of all these human experiences around me, it was just, "Wow", you know? So then I switched. And my husband did the same thing with his profession. He did masters in anthropology. We did masters at the same time, and now he is in anthropology.

Natasha is currently living in Canada with her husband and son. Although it was "very, very hard," she shared that "somehow we managed to find our ways." She described her "new life" in Canada as follows:

> Now I think it's a different place, that's for sure. I think we managed to survive and to integrate as much as we could, I think. It's not a perfect place for us, but it's a good place. It's good in terms of finally finding who you knew you are, being comfortable with your new identity, with your new being and your new work, profession, friends, neighbourhood. So I guess I would say we are settled now, I would say.

CHAPTER 5: EMERGING THEMES

This chapter presents the themes which arose during the interviews with Mercy, Arijana, Florence and Natasha. These themes reflect the reasons these individuals sought counselling, encapsulate what their experiences were in counselling, and identify what they found to be helpful in facilitating therapeutic change. A description of each theme is provided, along with excerpts from the participants' responses which support thematic content. Themes were organized into four general categories: Therapeutic Goals, Therapeutic Tasks, Therapeutic Relationship, and Counselling Setting. These four categories, as well as their accompanying themes are outlined below in Table 1.

Table 1

Categories and Themes

Categories	Themes
Therapeutic Goals	Surviving the Storm
Therapeutic Tasks	Looking at the Past
	Directive Interventions
	Empowerment and Confidence for the Future
Therapeutic Relationship	Therapist's Ability to Understand
	Being There: A Positive Connection
	Giving
Counselling Setting	Accessibility
	A Safe and Sympathizing Environment

Therapeutic Goals

The first general category, *Therapeutic Goals*, represented the various reasons for which the participants sought out counselling. The goals of therapy appeared to be unique to each individual and reflected their varied experiences, whether they were the conditions that led to migration or conditions of exodus/resettlement. However, for the participants interviewed in this study, the goals of therapy could be summarized as help "surviving the storm."

Surviving the Storm

This theme reflected the destabilizing effects of the participants premigration and resettlement experiences, as well as the assistance which the participants sought out in restabilizing their lives. For example, Florence described her resettlement experience to be like a "thunderstorm," and when first seeking help, she desired assistance with her claimant process and other resettlement challenges. Natasha felt "scared," "overwhelmed," and "did not know what to do to help my son," and subsequently required help with parenting. Mercy and Arijana were both experiencing significant emotional distress and desired much needed symptom relief. Although varied and diverse, a common thread connected their reasons for seeking counselling—a thread which both Florence and Natasha both termed as "surviving."

Life at the time that Florence first attended counselling "was like a thunderstorm." Her storm was in the form of resettlement challenges and struggling just to meet her basic needs. She recalled, "Every day was a struggle, it was like life was falling apart... everything was fragile... there was constant

uncertainty and aloneness... there was always the fear of deportation." Florence desired meeting with a counsellor to help "calm the storm...but not in the sense of traditional counselling." Without an income, without knowing from day to day where she would sleep, and without even knowing if she would be allowed to stay in the country, Florence said, "I mean, if you are fighting just for your basic needs, you are not thinking of counselling." She described this metaphorically:

> Imagine you're standing on a piece of ice in the middle of the ocean, but a broken piece of ice that's not attached to land anymore. You're not standing on something solid. Your concentration is going to be to keep that balance. Because that piece of ice that you stand on, that can tip at any moment and you don't know when that moment will be... When you are standing on that piece of ice, there's too many other things to deal with than to actually talk about serious things. You have so much more just to cope with your everyday life that while you are standing on this little piece of ice, you can't go into this other stuff. Because it's just about survival.

In order to survive and regain balance in her life, Florence did not want what she deemed as "traditional counselling" where a psychologist and client "talk about all your problems... and try to fix behaviours." Rather, she contacted a counsellor desiring, "Lots of advice," and practical solutions to specific problems such as, "How do I deal with this question? How do I fill in this form? I need a letter; can you write a letter?" Although Florence recognized past trauma in her life, it was the daily struggles that often took the greatest priority during counselling sessions. She continued, "If you are dealing with so much, you cannot

go into traditional counselling. You have to deal with the daily stuff... the survival stuff."

Later in therapy, her desire for help evolved to include assistance with other challenges that impacted her, including interpersonal problems and job loss. Florence explained that in her counselling experience, "The majority of things we looked at was just daily stuff because I had so many problems that would come and go, come and go. Just to keep up with that was a task... It was so hard just dealing with daily stuff." Again, Florence desired practical solutions to these daily problems, with survival being found by "figuring out solutions" or "help with different problems." She concluded, "Just keep that balance. The rest, forget it."

Natasha described her storm as follows:

> Well, it's very emotional... It's something that we don't know why we had to go through and it's just—it was too much... and then you have that child that you really want to protect and you can't, so it's really emotional. It's really emotional.

Like Florence, Natasha recognized the past trauma in her life, but felt there were greater and more pressing priorities. She continued, "At that time, as many refugees, you have too many things to do that you just can't focus on that. It's impossible. You are just doing things in order to survive." For her, survival was focused on the well-being of her son. She explained, "It's not you that you're worried about. You're worried about other people. You're worried about your child, about your family." However, Natasha expressed a feeling of powerlessness in this regard. She shared, "War is something that you cannot control. You can't

do nothing, and you are responsible for a child. So it's a huge conflict between: I have to do something for you, but I can't." As such, Natasha sought out professional help to learn how to help her son, summarizing her goal in counselling as, "I wanted to know what to do about it."

For Natasha, the greatest priority was her son's "well-being... that he is ok." This was her storm. She recognized that there were other concerns in her life, other potential topics of counselling, but her core concern was for her son. She shared, "Thinking back, I think that I probably should have asked for counselling also, but I could not see that then. I was so worried for my son. But, I think that probably I was a good candidate for counselling for me." Although a good candidate for counselling, Natasha explained her reasons for limiting her counselling to parenting concerns repeating, "You can't focus on yourself. You do things just to survive."

Mercy's and Arijana's storms were internal ones. In describing their symptoms, Mercy said, "My head was so crazy, like somebody's going to take my heart away from me," while Arijana said, "I was quite depressed, especially at the beginning... I felt lost. I started doubting everything... I felt anxious all the time." Both found their symptoms to be quite debilitating. Mercy shared, "It was so hard. I was so scared. My head was so crazy... I couldn't go outside, I was so scared... I wouldn't talk to people, meet with people, I was so scared... it felt like you are going to die now." Arijana said, "My mood was so up and down... It was hard for things to be normal. I wanted a normal life, but it couldn't be normal at the beginning because I was really burdened."

Before being able to achieve a "normal life" or feel settled in Canada, Arijana wanted relief from her disabling symptoms. Arijana felt that her symptoms resulted from the cumulative effect of her experiences in Bosnia, challenges of resettlement, and worry about loved ones still in Bosnia. After experiencing such events in one's life, Arijana shared that, "Nothing could erase that," but felt that with counselling, "They feel a little bit more comfortable with their lives and a little bit more at ease... It can help you to have some kind of a normal life again." Here she linked symptom relief with the ability to achieve a normal life.

Like Arijana, Mercy desired relief from her symptoms as well. Speaking of her fear and other symptoms, Mercy shared, "I didn't know what to do. I just wanted it to go away... It was so scary. The fear, it was really bad... I could not be happy in my life." Mercy was unsure of how her counsellor would help, but said, "I believe she can help me... she can help me with the fear. She can help bring my life in a good place."

Therapeutic Tasks

The general category of *Therapeutic Tasks* involved work that was done in counselling to address the client's presenting problem. In other words, this category addressed what was helpful for the participants in addressing their treatment goals. The therapeutic tasks consisted of four basic themes: *Looking at the Past*, *Directive Interventions*, and *Empowerment and Confidence for the Future*.

Looking at the Past

The first theme, *Looking at the Past*, reflected the desire that participants had to talk about past experiences, whether in their countries of origin or during the resettlement process. While each participant emphasized the importance of talking about their past experiences to some degree, differences existed in the way they found this review of the past to be helpful.

Two participants, Mercy and Arijana, both described benefits in counselling simply from sharing their stories. Arijana recalled a specific desire, and even an expectation of therapy, to "share my story with someone." When asked what was perceived as helpful in counselling, she shared that one of the helpful components was that, "I told my story to somebody." Along with the telling of her unique narrative, came an accompanying feeling of emotional release. As she described it, after telling her story, that "I feel like I breathe easier now."

Mercy also spoke of the benefits that came from sharing her story. She shared, "Taking someone through my life, a part of my life story, it helps a lot." One of the first things discussed in her meetings with a counsellor were her experiences she had been through in Nigeria, and although they did specific work later in therapy to address symptoms directly (e.g., relaxation exercises), Mercy felt that talking about her experiences helped her to feel "a little better." She explained, "When I have a problem with me, I'm dying inside... so when I release my problems with somebody, I'm finding help in that."

Looking at the past was also helpful in therapy as it assisted participants to better understand the relationship between past experiences and current behaviour or symptoms. Florence explained it as follows:

> You can't change your behaviour unless you understand why it's there, and only then can you actually start on changing it. Why am I doing "X", "Y" and "Z"? And unless you can understand why you do "X", "Y" and "Z", how can you change it?

Natasha also emphasized the important connection between insight or self-understanding and the ability to change. She said that through counselling, "I could make the connection with previous experiences and experiences we were going through. I did not say my son started to lie because of the war in 1992, but I could see the connection." This increase of insight or understanding was described as empowering, as it helped her to be able to change behavioural patterns and develop more effective coping strategies. She explained:

> I did not know what can I do. I wanted to know what to do about it... and I guess we have to get to the point that we at least knew what was the partial cause of his behaviour... that point we can start addressing our behaviour.

By seeing how she was affected by the past, Mercy was also able to separate the past from the present, and anchor herself in the safety of her new home country. Mercy's past experiences while living in Africa resulted in significant fear. This fear persisted not only while living in Nigeria, but continued even after moving to Canada. She shared, "Even when I was in Canada, I was so afraid to go outside." As Mercy discussed her experiences of the past, their effect

on her began to lessen. Through counselling, Mercy began to see that her current fears were based on past experiences. In describing this process, she explained that she was, "Afraid from old experiences, but those experiences can't effect here." She continued, "I was so scared then... I don't be afraid here. What am I afraid for? Now, I see, I'm not afraid anymore." With this, Mercy was able to anchor herself in the here and now, or in a place of relative safety.

Within this form of "looking at the past", or looking at the past to develop self-understanding or awareness, some participants related that there was little need to delve too deeply into those past experiences. In speaking of disclosing past events in therapy, Natasha recalled that "we did not go into much detail" and only shared enough information to establish a basic foundation of understanding. In a similar way, Florence emphasized that minimal information was discussed in this regard. Relating to disclosure of past events, Florence noted, "We did get into it a bit... but not anything serious. It was very briefly happened, but that's about it. That's to the max we would get into stuff."

Directive Interventions

While it was helpful for the participants to look at past experiences and traumas, it was not always seen as the most pressing task of therapy. Participants each noted current demands and specific challenges that would arise in their day-to-day lives for which they sought assistance. Florence described it as the "everyday stuff—how to just survive." To address these current demands, participants each noted their desire for directive interventions, which included advice, advocacy, and direct support in key life tasks.

Directive interventions may have been required in part because participants did not know how to improve their situation on their own. For example, Mercy said, “I didn’t know how to deal with fear then, until my counsellor told me how to deal with fear.” In a similar way, Natasha admitted that, “I did not know what else to do... So I really needed somebody to tell me what to do.” As well, Florence could not navigate through the claimant process and immigration system successfully on her own and wanted “advice” from her counsellor and specific help with forms and paperwork, saying “It’s very difficult; you don’t know what to do... I could not do those things on my own. How do you know what to do?”

Advice. All participants recalled the benefit of a practical approach, or an approach which specifically focused on solutions or strategies to deal with a particular challenge. One way in which this was achieved was through advice. Of the three participants who reported treatment expectations prior to therapy, both Natasha and Arijana wanted somebody “to tell me what to do,” and Florence wanted “lots of advice,” echoing the common desire and expectation in therapy to receive advice.

Florence described the benefits of receiving practical advice “that really worked.” One of her challenges was how to deal with the constant questions that people would ask her. She didn’t want to talk about the problem; she wanted to “do something about it.” She asked, “What do I tell these people? They don’t need to know. How do I deal with them?” She shared, “It was good when she said, ’We’ll come up with things for you to say.’” Equipped with the things to

say, Florence was able to improve her interpersonal challenges. She shared, “I still have that, still. You talk to somebody on the phone: Oh, you have an accent. You meet somebody: Oh, you have an accent. I still use it.”

After gaining insight into her family dynamics, Natasha then desired a solution to the problem. She said that while it was helpful to know the “partial cause of his behaviour” it was not enough. She explained, “I guess we have got to that point that at least I knew the partial cause of his behaviour. So that was helpful. So I guess I wanted to know what to do about that.” Natasha did receive specific advice regarding parenting and learned practical strategies to implement change. She felt that the combined effect of (a) understanding “what is going on” and (b) knowing “what to do about it” was what made counselling “very effective.” She continued, “It was important that he was ok. That was one thing. And then I was really relieved when she said, ‘it’s fine, you just have to do these things.’”

To be effective, it was important that the advice given in some way matched the clients’ worldview. When asked how the advice she received was helpful, Arijana responded, “In every moment she had an appropriate advice. I don't know how to explain it more. The advice just sounded right.” Natasha described this in similar terms as she said that her counsellor’s advice “made sense.” Like Arijana, Natasha experienced the advice as something that resonated with her beliefs and ideas. She shared, “When we had a conversation with her and I think everything really made sense, what she said. And then she helped us reflect on our own behaviour as parents and as survivors, I guess. And she gave us

some suggestions of what to do, so that really made sense, what she said. So I think it worked for us for that particular issue, definitely."

To be effective, Natasha also felt that the advice had to be needed. Speaking of receiving advice, Natasha explained, "As an adult, you hate that. You feel like why does everybody have to tell me what to do... It's a clash of: I want help and I don't want to be helped." She felt that the advice was necessary for her because she felt that she could not resolve the problem on her own. She shared, "At the same time, I did not know what else to do. What do you do? So I really needed somebody to tell me what to do."

In addition to advice, some clients were taught specific techniques to manage their symptoms. Arijana reported experiencing significant anxiety and tension. With her psychologist, she learned relaxation strategies that helped to reduce these symptoms. In describing this process she said, "Some of her advices I really remember, she taught me breathing techniques which would help me a lot when I would be tense." Mercy also reported benefits from deep breathing exercises in order to deal with fear or anxiety, saying that, "They really helped me."

Advocacy and Direct Support. Within a new and relatively unknown system, everyday problems often involved challenges such as accessing financial assistance, accessing education, dealing with problems that arose at school, or even what to do if there was no food on the table. Arijana shared that when dealing with these problems, "As a newcomer, you don't know what to do." As

such, someone who is knowledgeable in the system may be necessary to provide help.

As one example of this, the everyday problems that Florence experienced were centred on the process of resettlement or claimant procedures. Her counsellor took a direct and hands-on approach to help her through those processes by assisting with paperwork. For example, Florence shared:

> Here, immigration is so closed off. It seemed like they don't want to help you. So instead, you have to run around to other sources to find information. So I would go to my counsellor and say: Look, what do I do? Or, Look, I have this form. I don't know how to fill this out. What do I do?

Like Natasha, Florence needed help because she did "not know what to do."

Mercy described a similar hands-on approach which her counsellor took to address her challenges. For example, Mercy's therapist liaised with an English language program to address language problems. Mercy recalled:

> So how I am speaking English? It wasn't good. So my counsellor said, "Mercy, do you want to go to school?"
>
> I said, "Yes."
>
> "So okay, the English school here, if you want to go, there's a lady. So let me take you to her."
>
> So after our discussion, she took me to see her. I started the school right away. We filled out the form, and that is where I jumped in the class.

Mercy felt that this help with school "changed my life." She shared, "The very best thing she did to me is really put me to school. I'm very lucky for that."

The metaphor of a journey is one that is fitting for the experiences of these participants. They leave their home countries and journey thousands of miles. Once here they navigate through a foreign and often confusing system. Through this journey, the counsellor was described by some to be like a trusted guide. Although the specific problems for which they sought help varied between participants, following treatment, participants cited good advice, advocacy and direct support as helpful to overall treatment success.

The relationship between looking at the past and seeking specific help for pressing immediate concerns appeared to be rather pragmatic in nature. Discussing past trauma was not reported by these participants to be avoided due to the intensity of the emotion or avoidance of self-disclosure. Rather, immediate concerns took priority, and discussions of past trauma had to wait. As Florence shared: "that was one of the big problems that we ran into—there was too much to unpack... After unpacking all the daily issues, there's not time for deep levels." Again speaking metaphorically, Florence explained:

> Let's imagine a garbage can. Say you have the garbage can, and there's lots of stuff on top. So before you can get to the junk that's down below, you have to unpack all the stuff that's been going on. So by the time that you have unpacked all these daily issues you've been struggling with to get to the deeper-lying issues, time is up.

Empowerment and Confidence for the Future

Much of the initial counselling work with Mercy addressed reducing feelings of fear and establishing feelings of safety in her life. Once Mercy believed she was safe, she had one very important question: "But what is going to really happen to me?" Each participant cited, in some way, this focus on the future. This focus looked beyond the impact of past events to a place of creating a new start. This focus looked beyond symptom reduction to a place of bringing in positive life experiences. This focus looked beyond present survival to a place of living life and thriving. This focus was reported by each participant to be an important component of counselling. The final theme of *Empowerment for the Future* reflects a therapeutic focus which looks to a rebuilding of one's life.

Participants all described the challenges involved in re-establishing their lives in Canada. For Florence, professional qualifications acquired previously were not recognized in Canada. For Natasha and Arijana, prestigious positions were replaced by mundane, menial, or even degrading tasks. Mercy had challenges learning a new language and adjusting to a country very different from her own. Each counsellor took a different approach in addressing these challenges, but it had the consistent effect of gaining confidence and self-worth, and building a positive future.

Mercy termed a positive future as "a good life." To find this good life, Mercy said, "I have to look for job, I have to work." Her counsellor liaised with various agencies to help Mercy receive an education and help find employment in the community. Of all the help she received, or of "everything good she did to

me" Mercy felt that the most important was "really to put me to school." Now that she went to school and found a job, Mercy said, "It make me feel like a woman, you know. I just doing it for myself. I don't depend on somebody."

The counsellor's encouragement was important in helping Mercy to achieve her goals. Although she lacked confidence in her own abilities at times, Mercy felt as though her counsellor's support and encouragement carried her through. She shared, "M'hmm, she was very encouraging. She said, 'Mercy, you can do it!'" Her therapist's encouragement helped Mercy to see "Yeah, I can do these things... I think that really, everything can work out fine."

Arijana felt "demoralized" and "degraded" from the loss of social and economic status. Reflecting on her thoughts at that time, Arijana stated: "I started doubting myself and my capacity to do something and my abilities." Throughout counselling, these doubts shifted. She said:

> So I cannot say that I completely cured or somebody else completely cured all my problems. It's not possible, of course. But at that time it was really, really helpful and kind of eye-opening and kind of helped me to gain, again, my self-confidence.

Empowerment, as experienced by Natasha, came from her increased understanding of how to help her son. Recognizing there was a problem but not knowing how to help, left her with a feeling of "powerlessness." By learning ways in which to help her son, she was able to shift from a position of powerlessness to empowerment. She shared, "I wanted to know what to do about

it... and I think from my perspective, knowledge always gives me a sense of power."

Empowerment also came for Natasha as she was able to step out of "the bottom of society" and redefine who she was as a person. While she made this transition, counselling was a place where Natasha could "explore... a new identity." However, she noted that the point of crisis was not an appropriate time to make significant life changes. As time passed and life stabilized, problems often resolved themselves. She said, "This was the most serious moment when we asked for help. After that, things looked much more in order." It was at that point where she felt she could make progress in creating a new identity. Arijana also highlighted the importance of timing in this regard. She recommended that during the early and most challenging years of resettlement, "is not the time to think about major life changes. Postpone all that for the time when you feel better." With this advice, Arijana indicated that "life would improve" and "things would work themselves out."

Arijana found that in counselling she could practice the task of integrating into a new society. For example, in addition to therapeutically telling her story to someone, she valued the added component of practicing English at the same time. She shared how this opportunity for rehearsal for real life in Canada helped her develop confidence:

> I told my story to somebody and I practiced English at that time. So I proved myself. I prove that I could do something in that new scary language I was just getting familiar with... I am prone to doubting what I

am doing always... but I grew in confidence. So now it's not a big problem.

Therapeutic Relationship

The third general category of helpful therapeutic elements pertained to therapist characteristics which the participants reported were facilitative to the overall counselling process. The establishment of a positive working relationship between the therapist and client was seen by each participant as an essential component of counselling. This may be especially true for refugee clients due to their vulnerable positions. Natasha shared her opinion of the importance of trust when counselling refugees saying, "Refugees are for first few years, you are scared" and clients may see the therapist "as a threatening Canadian." This was true of Mercy who was afraid to meet with the counsellor at first because "something bad might happen—that maybe my counsellor's going to take me back to my country." Natasha continued by sharing what she felt to be one of "the most important things" in successful therapy: "You have to build a good relationship." This category labelled *Therapeutic Relationship* contained elements which were viewed by participants to "build a good relationship." It was comprised of three basic themes, including: *Therapist's Ability to Understand*; *Being There: A Positive Connection*; and *Giving.*

Therapist's Ability to Understand

Clients appeared to be acutely aware and perceptive of numerous characteristics and behaviours of the therapist. Florence said, "Believe me, as much as you on that side is analyzing the person on this side, this person is

analyzing you just as much." One characteristic that participants were perceptive of, and which they deemed as important in creating a positive therapeutic foundation was the counsellor's perceived ability to understand the client. Although not stated explicitly, this could be stated as the question: "Will this counsellor be able to understand me?" Participants did not want to feel as though they were "foreign" or "exotic," but rather they wanted to be understood by the therapist. This theme reflects the clients' perception of being understood by their counsellor. It also reflects the efforts through which the therapist attempted to understand the client, or the feeling, as Arijana expressed, that the "counsellor was trying to understand me."

Certain elements created a sense of "understanding potential," or a feeling that the therapist has the potential to understand or empathize with the client. One such element was the background of the therapist. Natasha discussed how having a counsellor with a similar background of being an immigrant in Canada helped to build an initial connection of mutual understanding even though they did not come from the same country or share similar experiences. She said, "I think that the fact that she has an accent and she is an immigrant, I think that helped because then at least in back of your mind you think, well, she understands how it is, right?... You know, it's that kind of an immediate connection. You know how it is. Like, I don't need to explain you everything. So I think that helped a lot."

The perceived clinical experience of the therapist can also create the feeling of understanding potential. Florence felt that her counsellor's past experience in working with other refugees helped her therapist to develop a

heightened ability to understand and empathize with her experience. Florence felt that because her counsellor had “been through this with somebody else,” that her counsellor would be better able to understand or empathize with “the constant uncertainty” and “the constant agony” that Florence was feeling.

In a related way, Natasha also noted that expertise was one foundation upon which she could build a counselling relationship. Natasha said that a therapist “has to have expertise in that area, real interest and some kind of a better understanding.” She felt that this expertise or understanding could be acquired in various ways, including “whether you are involved with the community closer, or you are coming from the community, or you have some kind of a common ground of understanding.” It is interesting to note that the groundwork for this understanding potential was laid even before deep interactions with the therapist began. The commonality in background (i.e., being an immigrant) was perceived by Natasha “immediately after meeting” her counsellor, while the therapist’s expertise was being evaluated “even before” their first meeting.

Believing that they could be understood by their psychologist was important for clients in establishing a therapeutic relationship early in the counselling sessions. Actually being understood continued to be an important therapeutic element during the duration of counselling and was cited as helpful by each participant. Understanding was communicated in several different ways between the participants. As one example, the counsellor demonstrated to Florence authentic understanding by the way in which she responded to Florence’s challenges. As she had exceeded the recommended number of sessions

that her organization provides, Florence said that her counsellor was requested to close her file. However the counsellor would not close the file and continued seeing Florence for several years. Florence expressed the significance of this event saying, “She totally bended the rules for me... She recognized that she can’t let me go because I had so little out there to rely on... She recognized how it was. ” Feeling that she recognized and responded appropriately to her situation built a feeling of “being understood” between Florence and her counsellor.

Understanding was communicated to Arijana by the way in which her counsellor responded to her during the course of their conversations. Arijana had some difficulty articulating her observations of this process. Speaking of what was helpful in counselling, she said, “It helped that she understands—she knew what I was saying.” When asked what helped her to actually feel that she was understood in counselling, Arijana said, “She just listened and probably at the right moment she would tell something that sounded right to me at that moment.” Natasha also highlighted the importance of a counsellor’s responses in building a feeling of mutual understanding. She expressed that in counselling she expected a conversation “on that level that I know that he or she knows what I am talking about,” thereby linking the level of exchange with the feeling of being understood.

Two participants had difficulties overcoming the language differences which existed between themselves and their counsellor. However, these communication difficulties did not appear to hinder therapy, but rather helped to build a strong therapeutic alliance. For example, although it was difficult at times

to understand one another, Arijana shared the therapeutic significance of trying to understand. She said, “From the beginning we established very nice relation and cooperation, actually, and she tried to understand me.” The process itself of trying to understand each other fostered a feeling of “cooperation” and communicated to Arijana that her story and experience was “important and valued.”

Mercy’s experience suggested that the act of trying to understand was more significant to her in developing a positive relationship with her counsellor than the actual amount of information understood. She acknowledged that “we didn’t understand everything.” Notwithstanding the fact that not every word was understood during therapy, Mercy felt that her counsellor always *tried* to understand her story and how she felt. She shared, “I don’t speak English very well, she’s still trying to understand me. She was always try to understand it, to understand the situation and how I feel.” Mercy highlighted that this act of trying to understand was very important to her. Like Arijana, Mercy shared that this act of understanding communicated her value and worth saying, “Talking to me, that really made me a woman.”

Being There: A Positive Connection

A second element of the therapeutic relationship which was cited by participants as a helpful component of therapy was the feeling of connection with their counsellor. Each participant in turn, and in their own way, spoke to this feeling of connection in therapy: Arijana described her psychologist as, “a friend” and “more than a counsellor;” Mercy said that her counsellor was “there for me;” Florence felt that her therapist was “a constant” in her life; and Natasha said that

she had “a good connection” with her counsellor. This theme describes the connection felt by the participants, as well as the way in which they perceived that connection to be built up during the course of therapy.

The groundwork for the creation of a positive human connection was laid for Arijana even before meeting with her therapist. She was referred to the counsellor by a trusted friend, and felt that this referral helped to get counselling quickly off on the right foot. She said, “Someone that I trusted commended me to counselling, so it was easier for me to fit in... I felt more comfortable.” In finding it easier to fit in and feeling more comfortable, Arijana said, “it helped to make a good relationship.”

Safety was an important precursor to building a connection for Mercy. Upon first meeting her psychologist, Mercy said, “First I was so afraid. I was shaking, crying... Yes, the first meeting was very hard...” Nevertheless, from that frightened and tearful beginning a “good relationship” was forged in which her therapist, “was there for me... and was so good to me.” When asked what helped to work through the fear and build an initial connection with her therapist, Mercy said, “It’s so easy to talk to her... She was so nice to me... Any time I have to come today, I was so happy to meet with her.”

Connection was described by Natasha as a sense of the therapist “being involved” with the client. She shared that connection, “is about being involved... I mean really being involved in the conversation.” She believed that this feeling was developed by the nature of the interaction with the client, or the level of involvement in the conversation. Speaking of connection, Natasha said, “You

build that through conversation, but because you open up your heart and your mind, you don't want to be put off." Being "put off," from Natasha's perspective could occur from a general passivity in responding or appearing disengaged in the conversation. She said, "I could be easily, really disconnected if I see that a person is really not engaged in that conversation...if I see that response is not on a level that I am expecting... or if you can see the person does not know what to say." Natasha shared the following conversation that she had with her friend which illustrates this type of negative counselling exchange:

> My friend told me the other day, she said, "I am not talking to this person anymore." She opened up, she said something, and you know, the person just switched to something completely different. And she was like, "But I just said something very important to me. Why did not you pick up on that?"

Natasha felt that through this interaction, the therapist demonstrated to her friend that "you're not really there."

One interaction which is commonplace early in the counselling setting is the completion of required paperwork such as informed consent and intake forms. Natasha felt that completing these forms immediately in the first session may not create a positive first impression, and in some way detract from the therapeutic relationship. She explained that completing paperwork early on in the first meeting may communicate a negative message: "Papers? People think papers are more important than me? Here I am in tears, you know, shakes, crisis, I need your help, I need to talk, and you just throw the papers at me?" Natasha recommended

that, if possible, paperwork “could be postponed for later” as she felt that it may “take away from the relationship.”

On the other hand, positive interactions led to an increase in the human connection. Arijana felt a connection with her counsellor from the “first moment,” saying, “Since she was very open, very friendly, very gregarious from the first moment, so somehow I opened to her immediately.” Arijana described her connection with the therapist as follows: “I had impression that she is completely dedicated and she's completely focused on me and my case and my story.” Emphasizing the therapeutic value that connection provides, Arijana said, “It helped me. Just the fact that somebody listened to me and showed interest in my problems helped me after that... So it helped me that she was being there with me.”

Amid her challenges during resettlement, the connection with her counsellor was seen by Florence to be an anchor that helped promote her stability and endurance in facing difficulties. As Florence described, “The only constant thing that I had was this person. Nothing else in my life was constant, nothing. Not jobs, not immigration, not lawyers, not work, not nothing. Nothing was constant... She was the only person that stuck with me.” Speaking of the value of this anchor, Florence simply stated, “That kept me sane.”

One other element of a positive connection appeared to be the therapist’s ability to equalize the power differential between therapist and client, or make it an equal status relationship. Natasha noted the significance of this by comparing therapists and clients: “You have this huge power. You have your profession,

your expertise, your environment that you are comfortable with. I don't have any of these. This is a foreign environment for me, so I don't have power... you have to be aware of that, and try to minimize it." She shared that this was done through the qualities of the relationship, in her therapist's "demeanour and attitude." Mercy's experience of counselling portrayed a similar effect wherein certain qualities of the relationship served to equalize the power differential. She recognized that her counsellor was "trying to understand my situation and language" and in this act of trying to listen and understand, Mercy shared, "I don't feel like I'm lower and I'm inferior."

Giving

The final theme related to an attribute of the therapist of being giving: Bringing specialized knowledge to counselling and sharing this expertise with clients and active problem-solving skills to directly help and support them in overcoming their unique life difficulties. With this giving, clients are better able to get through a situation that they would not be able to get through alone. This theme not only reflects the ways in which therapists were perceived as giving, but also the way in which this was perceived as important in strengthening the therapeutic relationship. Therapist giving seemed to facilitate the research participants' hope in the effectiveness counselling process.

Within the theme *Understanding: Trying to Understand Me*, a question was posed towards the therapist: Can you understand me? A similar question was posed here by Natasha: "Can you help me?" In order to help, Natasha said the therapist needed to be "knowledgeable enough" to know how to help. She said

that a psychologist "needs to have an expertise, a specialization... For me it was important that this is what she specialized in." Without this knowledge, Natasha asked, "How else will she help me?" Because "it can be difficult to find such a person," Natasha desired to meet with a therapist from a counselling centre specific to refugees and immigrants. She said, "The whole environment of the counselling centre is about immigrants and immigrant issues, so for me... it would be a natural setting." She shared that before meeting with her therapist, "I believed she could help me."

While the belief that her counsellor could help her prompted Natasha in seeking out help, it was the glue that kept the therapeutic relationship together for Florence. During the course of counselling, there were times when Florence felt "irritated" because she felt that her counsellor was "not being totally honest with me." In the face of this threat to the integrity of their relationship, the perception that her psychologist was trying to help, as well as the recognition of the help that she had already received, did much to maintain the relationship. Florence shared that she chose to "overlook it... she did many good things for me... out of everyone, she did the most... I knew she wanted to help me."

In a similar way, Mercy shared that the perception that her therapist was there to help her made it easier to work through the fear that she felt at the beginning of their meetings. She recalled one brief but particularly poignant moment that she felt was helpful in moving past the fear of counselling: "After we met, she told me, 'Mercy, it's okay. I'm here to help you...' I really feel that." Later, when reflecting on the overall experience of counselling, helpfulness

appeared to be a central component of what Mercy felt as relationship building: "...All those things she taught me... So that is just what saved my life, my entire life... A lot of help they gave to me, and I didn't expect that at all. It's a very big help, a lot of help... She was so good to me."

Like the others, the perceived helpfulness of the therapist, or the giving of help, was important to Arijana in building a positive therapeutic relationship. When asked what factors combined to build the relationship between her and her counsellor, Arijana answered, "I don't know, actually. How could I explain that? I saw somebody who tried to help me."

Counselling Setting

The final general category did not address helpful therapeutic elements, per se, but rather was comprised of contextual elements wherein the therapy occurred. Although contextual in nature and not necessarily the sources of healing, these elements were still deemed to be significant by the participants as they either enabled counselling to occur (as seen in the theme of *Accessibility*) or added to the overall healing environment of the therapeutic setting (as seen in the theme of *A Safe and Sympathizing Environment*).

Accessibility

This theme is comprised of various factors which helped to make counselling accessible, or within reach to attend. The accessibility of the counsellor was reported by each participant to be an important factor in their counselling experience. If not for the ease of access, each individual reported that they could not have attended counselling.

The accessibility of the counsellor, or ease of access, meant something different for each person. One element of accessibility was related to the location of services. For Mercy, this meant a location close to a bus route where she could travel independently between the counsellor and her home. She said, “It’s not that close to my home... it may take me sometimes 45 minutes to get there for the bus. I don’t think about that. I could go.” The proximity of services to her workplace, or an office in a “central location” was important for Arijana to meet with a counsellor. Otherwise, Arijana would have been unable to fit counselling into an already busy schedule.

Flexibility in scheduling appointments also made counselling more accessible for some clients. Arijana appreciated that her counsellor “was really flexible,” even meeting during her lunch hour. These lunch hour appointments allowed Arijana to meet for counselling as they were the only time in her day which she had to meet. Related to flexibility in scheduling appointments, was the time allowed for each appointment. Florence recommended that counsellors “extend their time.” She explained that, “that was one of the big problems that we ran into, was the short time.” When trying to get through the “mountain of problems you’ve been struggling with,” Florence felt that one hour “is too little to do everything you need to do.” There were times that she wanted “to do a little bit more” in counselling or address other topics, but time constraints did not allow for it.

The financial cost of counselling was another area related to the accessibility of services. Mercy was able to attend counselling because she was

provided with financial assistance with the bus fare and also received subsidized services. She commented that without subsidized services, she would have been unable to afford counselling, saying, “No, I didn’t pay for that... I couldn’t pay for that... They even gave me a coupon to take a bus.” She added, “I didn’t expect that. In my country, you don’t see something like that... you have to pay a lot of money for that.” Florence also received subsidized (no cost) services. She shared that given her financial status at the time of counselling she would have been otherwise unable to access counselling at its full cost. Given the challenges of “finding good work” and “making little money,” Florence asked rhetorically, “You think you can pay for that?”

Natasha also stated that counselling services had to be affordable. She said, “I have an income now, but then?... $150 is a lot of money. It is cost... But her services were for free.” For Natasha, affordability was related to not only the actual fees for service, but also the expectations of the healthcare system. She said, “Coming from a culture where all the health services are for free, you have that concept that health services should be for free.”

A Safe and Sympathizing Environment

This theme related to the environmental features, or the physical setting of the counsellor’s office. An atmosphere which in some way adds to feelings of safety and warmth was reported by three participants to be helpful in therapy, and contributed to the overall experience of counselling. A comfortable and relaxing atmosphere, which entailed offices with comfortable furniture, soft lighting, home-like decorations, and use of warm colours, added to the positive

experiences of both Natasha and Arijana. Such a setting, created an environment which Arijana called “relaxing” and Natasha called “friendly,” “comfortable” and “relaxing.”

Natasha felt that this “soft and sympathizing environment” is a “huge benefit” for clients because “you don’t feel that you are visiting a doctor and that you are sick.” Rather, she felt “more open” within this setting, and that she could “really have a conversation about an issue.” She speculated that within a more “sterile” environment, she “probably would not go” to counselling.

The location of her counsellor’s office was familiar to Arijana, making the initial visit to the counsellor easier. She said, “A very good friend of mine already worked at the counselling centre, and I was familiar with the place. So it was like going somewhere where you already know somebody... not some unknown place.” A known place, or a familiar setting, was related to feeling “more comfortable” going to counselling, which had the potential of being an “intimidating” experience.

The location of the counsellor’s office was familiar for Mercy as well due to its positioning within a larger centre devoted to immigrant and refugee needs. Speaking of her counsellor’s office she said, “You already there for other services... One door is employment, another door is education counsellor and then it is my counsellor. So that helps.” She noted that she felt more “comfortable” within that familiar setting, and it had the added advantage of centralizing many of the services that she was accessing. In a related way, Natasha recommended that, “You want to create something that is close to where immigrants naturally

gather. If the psychologist is very far away, people won't want to go there.” The refugee participants’ views about therapeutic goals, tasks, relationships, and the counselling environment are situated within existing literature in the discussion chapter that follows.

CHAPTER 6: DISCUSSION

The purpose of this study was to explore refugees' experiences of counselling or psychotherapy. The research captured each participant's perspective on why she sought counselling, experiences in counselling, and what aspects of the counselling were found to be particularly helpful or beneficial. As with other qualitative studies, the experiences presented in this study are unique to the participants who were interviewed. However, their stories and the themes emerging from them are reflected in and supported by the literature. This chapter situates the research findings within existing literature on the counselling process and on working with refugees and immigrants in a helping role. It subsequently provides suggestions and implications for therapists, provides a study evaluation, describes the limitations of the research, and outlines directions for future research.

The present study reflects the work of Bordin (1996) who suggested that a good working relationship contains three important elements: (a) agreement on the goals of therapy; (b) agreement on the tasks needed to achieve these goals; and (c) the development of an interpersonal bond. These areas are also consistent with existing research on cross-cultural counselling, which highlights the importance of relevant therapeutic goals (e.g., Nelson-Jones, 2002), belief in the methods being employed or culturally-relevant interventions (e.g., Sue & Zane, 1987), and the therapeutic relationship (e.g., Qureshi & Collazos, 2011) as central to positive therapy outcomes.

The themes presented in this study also had considerable overlap with a list of cross-culturally valid features of effective treatment for PTSD (Draguns, 1996; see Table 2). These "universal components" of effective treatment were considered to be "valid regardless of social context and geographical locale" (Draguns, p. 465) and were generated as a synthesis of mainstream therapy effectiveness research (e.g., Lambert & Bergin, 1994) and interventions for PTSD among refugees (e.g., van de Veer, 1995). The present study also had an added category of C*ounselling Setting*, which has received less research attention, with the exception of the importance of accessible services among refugees as well as other minority groups (e.g., Arthur et al., 2010; Parron, 1982).

Table 2

Comparison of Study Themes and Universal Components of Effective Treatment for PTSD

Study Themes	Universal Components of Effective Treatment for PTSD (Draguns, 1996)
Surviving the Storm	Focus on presenting complaints or current distress
Looking at the Past	Help clients make sense of the traumatic event in the context of their lives
Directive Interventions	Use specific and possibly directive techniques
Empowerment for the Future	Strengthen the client's sense of competence, autonomy and self-worth
Human Connection	Experience and communicate empathy readily
Therapist's Ability to Understand	Experience and communicate empathy readily
Giving	-
Accessibility	-
Safe and Sympathizing Environment	-
-	Intervene immediately or promptly after the traumatic event
-	Deal with any guilt and self-blame early and directly
-	Deal with any object losses early and directly

Therapeutic Goals

This theme relates directly with the first research question posed earlier, namely why refugees seek counselling. The reasons for seeking therapy were summarized by one participant succinctly and vividly by the description "surviving the storm." Each participant spoke of this common desire to survive the storm which included two main facets: removal of distressing symptoms and addressing immediate resettlement needs. Participants did not appear to be unaware of the fact that there were other underlying concerns that may be of clinical significance. Rather, their goals in therapy were pragmatic in nature with basic needs and debilitating symptoms trumping the other potential targets of therapy. Other therapeutic goals or objectives would simply have to wait until after the storm. These findings are consistent with others (e.g., Fernando, 2005; Kirmayer, 2005) which suggest that refugees may prefer treatment goals that directly address pressing immediate needs rather than intra-personal change or analysis.

Maintaining a collaborative approach where both therapist and client endorse and value treatment goals is an important element in successful treatment (Bordin, 1996; Norcross, 2010). This is observed within a cross-cultural context as well, where problems related to the perceived irrelevance of treatment are reported to be one of the largest predictors of premature termination (Stevens et al., 2006) as well as underutilization of psychological services among minority clients (Nelson-Jones, 2002). For this reason, it is important that therapists openly

discuss treatment goals with the client and establish commonly agreed-upon goals early in the treatment process (Hwang, 2006; Sue & Sue, 2008).

One mechanism through which this may operate may be the building of a positive therapeutic relationship. By addressing the goals brought in to therapy, therapists are ultimately communicating their understanding of the client's needs and concerns. This type of positive engagement early in treatment process is related to positive therapeutic outcomes (Tsang, Bogo, & Lee, 2011). Another mechanism may be through the client's expectancy of positive therapeutic change, which is considered to be an important factor common across various treatment modalities (Battino, 2006).

Among refugee clients, focusing treatment on the removal of distressing symptoms has been associated with improved functioning, a hopeful or optimistic outlook, and satisfaction with therapy (Draguns, 1996; Mollica, 2006). Refugee clients may even expect the therapist to be active and take the lead in reducing symptoms (Kinzie, 2004). If a therapist fails to focus on the presenting complaints or current distress, clients may be "frustrated by what may appear to them to be a rudderless therapy—diffuse, erratic, and without any apparent direction" (Draguns, p. 466).

The majority of mainstream counselling approaches for refugees target the alleviation of posttraumatic stress symptoms (Murray et al., 2010). There has been an increasing call for the need to adopt a more holistic approach which frames refugees' challenges within the resettlement environment (Papadopoulos, 2007) and the necessity of addressing the challenges of resettlement alongside mental

health needs (Carswell et al., 2011). These reforms have been largely heralded by clinicians and researchers. The present study is significant as it relates to this movement, as it adds the voice of the refugee client. These individuals indicated the desire for both symptom relief and assistance with immediate circumstances or challenges of resettlement. Their view was a holistic one, where mental health cannot be understood outside of the immediate context or life circumstance.

These results also highlight another concept worthy of mention. The participants interviewed in this study appeared to be working actively towards an improved overall well-being for themselves and their families, which included mental health as well as overall adaptation. They were working towards what one participant termed "a good life." For these individuals, they needed help to overcome certain obstacles that stood in their way of that goal. Sometimes these obstacles were symptom-related, and sometimes they were environmental in nature, but they were similar insofar as they kept the individuals from reaching their good life. Counselling was a search for assistance within an area where these individuals felt that they could not succeed themselves. This is consistent with the view of refugees as active survivors in a new environment, rather than passive victims of trauma (Birman & Tran, 2008; Vasilevska et al., 2010). Services based upon this view of the individual may facilitate the individual's efforts towards well-being by providing them with resources to address immediate demands (Ryan, Dooley & Benson, 2008; Vasilevska et al.) or addressing environmental or policy-related obstacles which are beyond their ability to control (Chung & Bemak, 2012; Chung et al., 2008; Khamphakdy-Brown et al., 2006).

Therapeutic Tasks

The therapeutic tasks reflect the means through which counsellors attempted to address the therapeutic goals. It is a widely held belief that outcomes for clients are better when they "believe in their therapists and in the methods being employed" (Sue & Zane, 1987, p. 40). This is significant as a disjunction may occur between refugees' mental health needs and the services provided for them (Murray et al., 2010). The experiences participants shared in the current study highlighted three general areas of treatment including: looking at the past, directive interventions, and empowerment for the future.

The first area related to the sharing of the trauma story. One "universal component" of effective intervention for PTSD is to help clients make sense of the traumatic event in the context of their lives (Draguns, 1996, p. 465). This may be one of the reasons that a common ingredient among most refugee treatment programs involves the telling of the trauma story (Murray et al., 2010; Kinzie, 2004). Sharing the trauma story was perceived as helpful in the current study as well. As one participant described it, she had the "need to share my story with someone." Although participants did not report receiving any formal mental health diagnosis, and PTSD was not their presenting problem, nevertheless story-telling appeared from their perspectives to have tremendous therapeutic benefit.

There were important differences between participants in terms of how this sharing was accomplished as well as what elements were deemed as helpful. For example, some participants reported symptom relief simply by re-telling their trauma story. This re-telling appeared to be done in some depth and detail. Other

participants shared their trauma story only insofar as it was necessary to better understand their present challenges. They felt little need or desire to look in depth into the trauma, but experienced benefits from better understanding the effect it had on their lives.

This finding is significant in that it adds the clients' perspective to the current researcher/practitioner-dominated discourse. Several of the conventional treatment approaches for refugees emphasize the importance of an in-depth re-telling of or exposure to traumatic memories. For example, cognitive behavioural therapies involve exposure to traumatic events via imagery or re-telling the trauma story (D'Ardenne et al., 2007; Otto et al., 2003) and narrative exposure therapy emphasizes the importance of an in-depth sharing and re-telling of traumatic events within the context of the client's life story (Neuner et al., 2002; Neuner et al., 2004; Van Dijk et al., 2003). These models are based on the assumption that a very detailed exposure to the premigration trauma is a prerequisite for healing. However, clients' perspectives of therapy often differ from therapists' perspectives (Gershefski et al., 1996). In the present study, it was highlighted that the effective sharing of the traumatic events can be accomplished by superficially discussing the trauma; just enough to allow for a basic framework of understanding. This may be a more acceptable or palatable approach among individuals who are reluctant to tell the trauma story to others.

There may be some individuals who find avoidance of the trauma to be desirable, or feel overwhelmed by sharing it (Morris & Silove, 1992). Of some significance, specific cultural groups which have been historically avoidant of

actively discussing past traumatic events within a therapeutic context (e.g., Cambodian refugees; Boehnlein et al., 2004) were not represented in this study. Because of the considerable difference that exists between clients and their relationship with trauma, the best clinical practice may be to follow the client's lead (Hwang, 2006; Kinzie, 2004) and discuss past traumas, if at all, in a mode respectful of the client's expectations and desires.

The second area is related to another universal component of effective treatment of trauma in the use of specific and possibly directive techniques. Two participants in this study stated this as "somebody to tell me what to do." These findings are consistent with the findings of a recent focus group, where a family support worker expressed that "African families want you to tell them what to do" and may be dissatisfied with therapy if it was "all talk, no advice" (Codrington et al., 2011, p. 135).

Considering the unique position of many refugees may shed some light on this finding. Many refugees have had their lives and regular coping-skills overtaxed by events over which they had no control (Carswell et al., 2011; Mollica, 2006). Within such an environment, efforts to produce change may have little or no effect, especially if the individual is unsure of how to create change or if the situation is outside of his or her ability to change. The lack of direct assistance and advice may promote learned helplessness (Seligman & Maier, 1967), which potentially develops under conditions where attempts to avoid harm do not result in diminished harm. In other words, if repeated attempts to improve one's situation are unsuccessful, learned helplessness may ensue. Direct

assistance and advice may be necessary at times in order to help the individual overcome their challenges and create effective change (Sue & Sue, 2008). This counters the frequently cited belief that advice-giving may foster a non-therapeutic dependency or impede self-sufficiency (Anderson & Handelsman, 2010). The participants interviewed in the present study clearly expressed their desire for advice, as well as the therapeutic benefits of receiving advice. Upon their reflections of therapy, no mention of dependency or impaired self-sufficiency was reported by the participants.

The types of interventions that are described in this section can be framed within the Multi-Level Model of psychotherapy with refugees (Bemak et al., 1996; 2003), specifically levels 2, 3 and 5. Level 2 of the MLM focuses on Western therapy interventions to aid in symptom reduction (Bemak et al., 1996; 2003). Such approaches were evident in the participants' narratives of their counselling experiences and deemed as helpful by the participants. For example, clients who experienced anxiety-related symptoms found interventions like relaxation and deep breathing to be very helpful in reducing and ultimately controlling the symptoms. In like manner, relaxation exercises have been found to be effective in reducing symptoms in several refugee treatment studies (e.g., De Silva, 1985; Hinton et al., 2004; Otto et al., 2003). Other interventions consistent with Western models of therapy were also discussed by the participants as being helpful in counselling. Increased physical activity was recommended to one participant and was seen by the participant to have a positive effect. Augmenting a bio-feedback-based CBT treatment program with physical activity was seen to

increase treatment effect sizes and result in higher rates of clinical improvement compared to a wait-list control group and CBT-only group (Liedl et al., 2011).

Some of the directive interventions that participants described their counsellors employing fit into the category of cultural empowerment as outlined in level 3 of the MLM. Here, the psychologists functioned in a mode similar to a "cultural systems information guide" wherein they assisted the client with information relevant to successful resettlement and how to resolve associated challenges (Bemak et al., 1996, p. 225). For example, the counsellors assisted the participants with various activities such as completing paperwork for refugee claims, helping navigate through the confusing processes of immigration, and providing instruction regarding how to address concerns within the public school system. Counsellors appeared to not only understand the life experiences that placed clients at additional risk for mental illness (Hwang, 2006), they also acted on that understanding to facilitate change.

The final level of the MLM involves addressing social justice and human rights issues (Chung et al., 2008). Chung and colleagues (2008) suggest that many psychologists may operate from the assumption that being effective therapists involves being "good listeners who are respectful, caring, and all accepting" (p. 314). While their intentions may be good, such an assumption may unintentionally result in negative and culturally biased practices as it potentially "affirms, reinforces, and perpetuates the injustices that mark the existing status quo" (Chung et al., p 315). Instead, they promote working with clients to obtain fair and equal treatment and access to opportunities in the community.

Participants noted several such interventions, including: helping access educational and employment opportunities in the community; acting as a liaison with other services to help meet basic needs (e.g., accessing the food bank); and advocating within the mental health agency to increase the number of sessions beyond the recommended limit.

Overall, it was a combination of different types of directive interventions that was perceived as therapeutic: those focusing on symptoms and those focusing on the root causes of the symptoms or obstacles to resettlement. By overcoming symptoms, participants were able to feel more settled and safe in their lives. By overcoming obstacles inherent to the resettlement process, clients develop the skills necessary to survive and gain "cultural mastery and empowerment" (Bemak et al., 1996, p. 225). This process was observed in the present study where therapists began in a very "hands-on" and directive manner, including liaising with various organizations to assist with educational and employment goals or helping to access the food bank. Consistent with the MLM (Bemak et al., 1996, 2003) it was necessary for some therapists to function in the capacity of the cultural systems information guide over a prolonged period of time. For one participant, this continued over the course of several years. Although therapists were directive at the onset, the ultimate result was client empowerment; the enabling ability to function in the new culture and environment. This was seen in each participant as each one felt successful in establishing a new life in Canada.

The third therapeutic task, refugee empowerment, is an important tool in helping refugees truly adapt to their new lives (Khamphakdy-Brown et al., 2006;

Soliman & Miah, 2011). Empowerment is related to another of Draguns' (1996) universal components, namely strengthening the client's sense of competence, autonomy, and self-worth. Empowerment may be defined as "helping individuals achieve greater control over the resources that affect their lives" (Miller & Rasco, 2004, p. 46). Participants reported greater control as they were able to manage symptoms and better deal with life stressors. Developing oneself through work and education was also seen as empowering, or enhancing competence, autonomy and self-worth. One participant expressed that working and going to school, "made me feel like a woman." The importance of work and education as elements of empowerment is supported by other studies (e.g., Keddie, 2011).

Increasing emphasis is being placed on healing models which promote positive change, shifting the focus away from stress-related trauma and mental illness (Murray et al., 2011; Papadopoulos, 2007). These interventions assist clients to "regain a sense of control over their lives" (Ehntholt & Yule, 2006, p. 1202), and build resiliency (Khamphakdy-Brown et al., 2006; Vasilevska et al., 2010). This shift reflects the developing field of positive psychology, which has been an increasingly growing movement in mainstream psychology over the past decade (Seligman, Steen, Park, & Peterson, 2005). After surveying a century of accomplishments in psychology, past president of the American Psychological Association, Martin Seligman (2008) observed:

> Psychology and psychiatry had done reasonably well with mental illness: suffering, victims, depression, anger, substance abuse, and anxiety. But they had done very poorly with mental health: positive emotion,

> engagement, purpose, positive relationships, and positive accomplishment. And it was clear that mental health was not the mere absence of mental illness (p. 4).

He suggested that people desire well-being "above and beyond the relief of their suffering" (Seligman, p. 5) and encouraged actively addressing well-being in the building of mental health. Based upon positive psychology, positive psychotherapy differs from standard psychotherapeutic interventions by increasing positive emotion, engagement and meaning in life, rather than directly targeting specific negative symptoms (Seligman, Rashid, Parks, 2006).

Participants in the present study shared this perspective, desiring well-being above and beyond the relief of their suffering. Negative symptoms and life challenges impeded their ability to achieve this, but once the storm had settled, each looked beyond survival to a place of well-being. This principle is reflected in the question that one participant asked after reducing fears and establishing safety in her life: "But what is going to really happen to me?" She desired a "good life," which was more than symptom relief, encompassing work, education, social relationships and a positive family life.

Timing appeared to be an important consideration in relation to the therapeutic tasks. During the first few years of resettlement, many refugees are attempting to meet their basic needs such as housing and employment. Safety and security are paramount during this period, and challenges which arise during resettlement, whether they are financial, vocational, educational or immigrational,

must be addressed before delving into intra-psychic concerns (Bemak et al., 1996).

For example, one participant first met with her psychologist during the claimant phase of her immigration, during which time she was experiencing great uncertainty, fear and distress, as well as many of the common challenges associated with this period including limited employment and education, and considerable financial hardship (Heptinstall et al., 2004; Lacroix, 2004; Prendes-Lintel, 2001). The fear of deportation was also very real for her as approximately 54% of refugee claimants are turned back to their home country (UNHCR, 2005). During this time in her life of instability and uncertainty, she valued an approach which dealt directly with her specific resettlement challenges, especially those challenges for which she felt that she lacked the resources or ability to successfully navigate. Another participant met with her psychologist during what would be considered the resettlement phase of her migration. She reported challenges associated with language competency, separation from extended family systems, and downward social and economic mobility—challenges which have been cited by numerous authors as common to that phase (e.g., Bemak et al., 2003; Nicholl & Thompson, 2004; Prendes-Lintel). She benefited from an approached which addressed the psychological impacts of these challenges, namely depression.

There is a vital importance in maintaining a flexible approach to therapy among refugees (Codrington, Iqbal, & Segal, 2011) and providing a client-congruent treatment approach. Within this approach, appreciating the client's

culture, exploring client expectations, and openly negotiating treatment goals, is paramount (Hwang, 2006; Kinzie, 2004; Mollica, 2006). Providing a client-congruent treatment approach may have a two-fold effect based on a common-factors approach, including: (a) increasing the client's expectation of benefit; and (b) improving the therapeutic relationship (Smith, Rodriguez, & Bernal, 2011).

In mainstream research, clients who felt more understood by their therapist showed more improvement over the course of therapy (Lafferty, Beutler, & Crago, 1989). Client-congruent treatment approaches are one way of expressing that understanding through action. Of interest, the fact that a therapist attempts to align therapy with client culture may matter more than the specific procedures used to make the alignment (Smith, 2010).

Therapeutic Relationship

There is a general agreement among therapists and researchers alike that a positive relationship between client and therapist is essential to therapeutic success across therapeutic orientations as well as client populations (Horvath & Symonds, 1991; Norcross, 2010; Orlinsky, Grawe, & Parks, 1994; Fischer et al., 1998). Moreover, it is considered essential to effective intercultural psychotherapy (Hwang, 2006; Paris et al., 2005; Qureshi & Collazos, 2011). Numerous variables are considered important in contributing to a positive therapeutic alliance including: therapist personality traits and attributes such as emotional adjustment and relationship skills (e.g., Lafferty et al., 1989; Beutler et al., 2004); client personality traits and attributes such as self-criticism, attachment patterns, ego strength and readiness to change (e.g., Clarkin & Levy, 2004;

Whelton, Paulson, & Marusiak, 2007); extra-therapeutic variables including setting and client social support (Gifford, 1988; Clarkin & Levy); and in-therapy experiences (Horvath & Luborsky, 1993). The current study focuses primarily on in-therapy factors which the clients perceived as alliance-building and, in turn, helpful in therapy. This is significant as in-therapy experiences are considered to be the most powerful predictors of therapeutic effectiveness of all the therapist-related variables (e.g., theoretical orientation, and therapist personality traits; Beutler et al; Lafferty et al.).

There appears to be a window of opportunity during the early sessions of therapy in which to establish a positive therapeutic relationship (Bachelor & Horvath, 1999; Mohl et al., 1991). The present study suggested that the development of a strong working alliance may even precede the first appointment. For example, one participant noted that the recommendation of a particular therapist by a trusted friend did much to lay a foundation of initial trust in the therapeutic relationship. Other participants noted that the location of therapist within a specialized centre, or a clinician's prior experience in working with refugees had a similar effect of enhancing trust, even before meeting with the therapist. This finding supports the call by other researchers and practitioners who suggest that it is beneficial to situate mental health services in immigration and settlement agencies (e.g., Arthur et al., 2010).

In a related vein, there has been an increasing push for inter-professional collaboration and service environments where psychologists work in conjunction with other professionals in a holistic and integrated manner. A recent guide to

providing effective refugee mental health services observed that when helping refugees and supporting their emotional well-being, "often the most important thing that we can do is bring different experts together" (Vasilevska et al., 2010, p. 5). In this way, focus can be given to meet the clients' health care needs and life challenges simultaneously. It has been suggested that psychologists working in isolation without a network of other professionals or contacts linked to refugee agencies may be unlikely to be approached for help by refugee clients or to keep them in their care (Arthur et al., 2010). An important contribution of the current study is the addition of the refugee's voice to this discussion. From the perspectives presented in this study, refugees did perceive it as helpful to access mental health services which were housed within a larger settlement agency. They also noted the importance of referrals from trusted sources. The mechanism through which they perceived both of these elements to work is enhancing the credibility of, and trust in, the therapist.

Mainstream research on the working alliance suggests that a client's judgements of, or responses to the therapist during the early phases of counselling may be influenced by several factors including the external features of the therapist (e.g., attractiveness), contextual information (e.g., perceived expertness), and the client's past experiences in similar relationships (Horvath & Luborsky, 1993; LaCrosse, 1980). These factors appeared to be relevant to the current participants as well. For example, external features of the therapist (including status as immigrant) and contextual information (including recommendation by a friend, situation within a specialized counselling centre, and perceived expertness

due to the therapist's past experience) were reported to be helpful in establishing early trust in the therapist.

These factors may relate to the ascribed status or the ascribed credibility of the therapist, or the position that the therapist is assigned by others. Sue and Zane (1987) have suggested that the ascribed credibility of the therapist may relate to utilization of therapy among minority clients, with low ascribed credibility as one reason for underutilization of therapy. Achieved credibility, on the other hand, refers more directly to the therapist's skills, or those in-therapy experiences which enhance the alliance. Freud (1913) described this aspect of the therapeutic relationship as the client's "belief in his [analyst's] communications and explanations" (as cited in Horvath & Luborsky, 1993). Frank (1959) observed:

> Expectancy of benefit from treatment in itself may have enduring and profound effects on his (the patient's) physical and mental state. It seems plausible, furthermore, that the successful effects of all forms of psychotherapy depend in part on their ability to foster such attitudes in the patient (p. 36).

This belief or trust in the therapist was fostered in several ways. The participants appeared to actively assess the client-therapist relationship and process many contextual cues that informed them of the status of this relationship (e.g., can you help me? and can you understand me?). As one participant stated: "Believe me, as much as you on that side is analyzing the person on this side, this person is analyzing you just as much." This may be one reason why, when adapting or modifying therapy in a cross-cultural context, Hwang (2006)

recommended that “therapists should be professional and present themselves as expert authority figures” (p. 708) and otherwise actively work towards building a strong therapeutic relationship.

In successful therapy, the client must perceive the therapeutic tasks as relevant and efficacious (Bordin, 1994). Pfeiffer (1996) emphasized that cross-cultural counselling is particularly susceptible to a clash occurring if an incompatibility exists between the expectations of client and therapist (as cited in Draguns, 2002). For example, if a client seeks advice and direction while the therapist expects the client to find a solution to his or her problems, then a client may question the effectiveness of therapy, and the working relationship, or trust in the therapist may falter. There was a predominating expectation of advice reported by each participant in the study. As the therapist met that expectation, a building of trust was reported.

By observing and experiencing firsthand the benefits of treatment, trust is fostered and developed further. While the quality of the relationship during early sessions is consistently correlated with long-term treatment benefits (Bachelor, 1991; Beutler et al., 2004), there is also evidence that early symptom alleviation can do much to improve the therapeutic alliance (Tang & DeRubeis, 1999). As early interventions, whether viewed as advice or otherwise, are perceived to be beneficial by alleviating symptoms, then trust in therapy increases. Trust within this context can be defined as the client’s perception of the therapist as an effective and trustworthy helper.

Upon this foundation of trust, understanding and empathy can develop within a relationship (Dilts, 1983). While definitions and use of the term *empathy* have varied (see Ridley & Udipi, 2002; Duan & Hill, 1996), Roger's (1980) definition of empathy captures the essence as it was demonstrated in the current study:

> It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that he or she is experiencing. It means temporarily living in the other's life, moving about in it delicately without making judgements. (p. 142)

The experience of empathy is an essential component of therapy both within and across cultures (Draguns, 1996; Qureshi, & Collazos, 2011). Indeed, the participants interviewed in the current study did not want to be misunderstood or seen as "foreign" or "exotic," but rather wanted to be understood by their therapists in the development of an authentic human relationship. However, counselling across a cultural divide poses unique challenges in the development of empathy (Steward et al., 2000), and understanding or empathizing accurately can be particularly challenging within this setting. The concept of cultural empathy can be considered a specialized or specific form of empathy and is defined as the ability to understand accurately the experiences of clients from other cultures. It also includes the ability of counsellors to communicate their understanding to the clients (Ridley & Lingle, 1996). The current study

highlighted several elements which were perceived as important by refugee clients in building empathy during their counselling experiences.

One aspect relevant to the development of empathy or understanding was conceptualized in this study as the therapist's "understanding potential." Understanding potential is the ability or the potential ability of the therapist to accurately understand the client as perceived by the client him or herself. This may be understood as a question asked inwardly by the client, "Does this counsellor have the ability to understand me?"

Several components may impact this perception, including: whether or not the therapist has experienced challenges or sufferings similar to the client (e.g., Draguns, 1996); whether or not the therapist can identify with the culture of the client (e.g., Ridley & Lingle, 1996); and whether or not the therapist can sufficiently understand the language nuances of the client (e.g., Ridley & Udipi, 2002). This may be one reason that cross cultural psychotherapy research has demonstrated a consistent trend in which many ethnic minority persons prefer therapists of their own ethnicity (Zane et al., 2004). This trend may reflect a belief that a therapist of their own ethnicity may be more able to understand them, or have a greater understanding potential. In a similar way, a mother seeking parenting advice in counselling may say of a young unmarried therapist, "How can this counsellor understand me? She doesn't even have kids!"

While participants in the present study did not report a preference for a therapist of their own ethnicity as seen in the current research trend, they did highlight the importance of having a therapist that understands their experience.

Overall, various elements which were seen to enhance the therapist's ability to understand the client, were cited as helpful to the therapeutic process. For example, a therapist who is him or herself an immigrant was reported by one participant to form a perception that "You know how it is. I don't need to explain you everything," and resulted in an "immediate connection." Understanding potential was also fostered by one therapist's prior experience working with refugees. This participant felt that the therapist "knew the constant uncertainty, she knew the constant agony that you are in because she has been through it with somebody else."

Another aspect which was important in building empathy in the relationship was an effective demonstration of understanding on the part of the therapist. It is not enough for a counsellor to understand his or her client; a client needs to know that they are understood. It has been suggested that a counsellor may possess all of the skills of cultural empathy and still fail to help the client if he or she fails to demonstrate genuine concern about the welfare of the client or accurate understanding of the client's experience (Ridley & Udipi, 2002). In other words, it is perceived understanding more than understanding itself which serves a therapeutic purpose.

Ridley and Lingle (1996) identified a variety of responses which may communicate accurate understanding, including: verbally describing to the client the counsellor's understanding of the client's experience; expressing interest in the client's cultural values; affirming the client's cultural experience; clarifying language and other modes of communication; and communicating a desire to help

the client. Refugee perspectives provided in the current study suggested similar elements. For example, clinicians communicated their desire to help the client in a nonverbal way by extending their help to a point beyond what was expected by the client (e.g., assisting with bus fare, meeting over a lunch hour, or meeting over the allotted number of sessions).

Communicating an understanding of experience is more than parroting the words of the client. It involves a process of "responding selectively to core messages" (Egan, 2010, p. 89) which may involve understanding a message that goes beyond a client's words. How responses were given in therapy helped to communicate this understanding. As one participant described this experience, the therapist "just listened and probably at the right moment would tell something that sounded right to me at that moment." Moreover, participants clearly felt understood when the advice which was given by the therapist was consistent with their beliefs and worldviews. In the participant's words, the advice "makes sense" or "just sounded right."

Genuine interest in the participants was also communicated readily in the experiences of counselling related in the present study. One participant said that she "had the impression" that her counsellor was "completely focused on me and my case and my story." As was seen in the therapist's desire to help the client, the therapist's interest in the client was communicated predominantly nonverbally.

Language differences can become barriers to counselling when individuals misconstrue what was said or subtle nuances of speech are overlooked. Language differences which were observed in two of the accounts presented previously

were seen to, in some respects, create misunderstanding between the therapist and client. Indeed, not every word was understood. However, language differences were not seen to weaken the therapeutic alliance or impede empathy. In fact, it was the act of trying to understand, more than the actual amount of information understood, which was seen as relationship-building for the refugees interviewed here. These counselling experiences suggest that trying to understand may communicate an important and empowering message to clients: that "my story is worth understanding."

There was also an aspect of the research findings related to language differences between the counsellor and client that contributed to a new discovery. Some participants in this research study perceived the language barrier to be an opportunity for them to learn how to function in the host society where English was the dominant language. Paired with their counsellors' empathic and understanding stance, they expressed that it was a chance for them to safely practice and improve their English skills, which then facilitated their better integration into the surrounding society and community. Previous research on counselling refugees has mainly been conducted by researchers imposing their own perspectives on the study and not soliciting refugees own perspectives on counselling. This study's attempts to solicit refugees' own viewpoints suggested that language differences between therapists and clients are not always perceived as "barriers" and may instead be perceived as opportunities. This finding has important implications for counsellors' decision-making process related to the use of interpreters in counselling with refugees. It appears important for counsellors to

not assume that clients want interpretation and to instead elicit and follow the client's own preference.

While it is agreed that the quality of the counselling relationship is related to treatment outcomes, there has been some debate as to whether the relationship is healing in and of itself (e.g., Bordin, 1994), or whether the relationship is necessary as a "glue" which binds the client and therapist together in order to complete the therapeutic activities of counselling (e.g., Luborsky, 1976). For the refugees who participated in the present study, the relationship with their counsellors was unmistakably reported as both a glue, as well as healing or therapeutic. Reflecting the relationship as a glue, were the experiences of some clients who noted that a strong therapeutic relationship helped to maintain participation in therapy even during events which could have potentially threatened the therapeutic alliance such as perceived dishonesty.

For other clients, this relationship with their therapist was the only real relationship they had in Canada during the early years of resettlement. Considering the social isolation experienced by many refugees (Simich et al., 2003; Vasilevska et al., 2010), the potentially therapeutic nature of the counselling relationship is all the more salient and profound. Participants also echoed the observation that "being listened to and understood" can have powerful therapeutic effects (Kinzie, 2004, p. 272). Titchener (1909) who coined the term empathy, defined it as a "process of humanizing objects." There is some significance of this notion in the current study as the experiencing of what could be described as empathy was seen by some to have a "humanizing" effect, or as

one participant stated, “that really made me a woman... I don’t feel like I’m lower and I’m inferior.”

Counselling Setting

Also among the factors considered to play a role in the therapeutic process is the healing setting of counselling (Nasar & Devlin, 2011; Frank & Frank, 2004). The category of Counselling Setting addressed two factors related to the physical attributes of the counselling environment, which were reported by clients to be helpful in their therapy: the accessibility of counselling services, and the atmosphere of the counselling room. While accessibility of services may not be healing in and of itself, it may certainly impact a client’s ability to undertake therapy. A 1982 President’s Commission on Mental Health (Parron, 1982) outlined accessibility as one of the major obstacles facing minority groups in utilizing and benefiting from mental health services. Two barriers to accessibility were outlined in the present study, including barriers due to financial constraints and barriers due to limited transportation.

The marginalized socio-economic position in which many refugees find themselves (Reitz, 2001), may preclude many individuals from seeking counselling services. For some individuals, when faced with a limited budget, psychotherapy does not make it on the list of necessities (Prins et al., 2011). This barrier is not unique to minority or refugee populations as many individuals from varying groups and with varying reasons for referral cite affordability as a main reason to not utilize mental health services, even if those services have been recommended (Mancebo et al., 2011; Marques et al., 2010; Wei et al., 2005).

Issues of affordability may have to do more with the assigned value of therapy rather than the absolute cost of treatment. For example, one participant said, “I guess it's a matter of perspective... I buy a pair of shoes the same amount and I don't have a problem with that. So I guess that perspective depends where you are coming from.” Furthermore, an expectation of universal health care was reported by one participant to deter her from accessing out-of-pocket mental health services. However, the relationship between affordability and service utilization remains unclear, as Canadians with lower incomes visit specialists at a lower rate than those with moderate or high incomes despite the existence of universal health care (Dunlop, Coyte, & McIsaac, 2000). This disparity persists even after statistically adjusting for differences in health need.

The geographic availability of health care services may also impact the accessibility of counselling services to clients (Wei et al., 2005). Some services are less accessible to those who have limited transportation capabilities. A centralized location as well as proximity to public transportation, were two geographical considerations reported in the current study to be relevant to the accessibility of services.

More than accessibility to services, the setting of counselling also reflected the bridge between environmental and clinical psychology, suggesting that the atmosphere of the counselling room can influence a client’s perception of, and participation in, therapy. Roberta Feldman, an architect and psychologist has suggested, “The creation of the built environment isn't just about form. It's not just there for our visual pleasure, but has an enormous influence on the occupants”

(cited in Pressly & Heesacker, 2001, p. 148). Early studies in environmental psychology have demonstrated that the aesthetic conditions or designs of a room can impact an individual's perception of another person (Maslow & Mintz, 1956; Campbell, 1979), reported feelings of comfort (Campbell), as well as levels of communication (Sommer, 1969). With these effects of interior design on human interaction and behaviour, the implications for creating a positive counselling atmosphere are intriguing.

Indeed, mental health professionals and researchers alike have acknowledged that the aesthetic conditions of the counselling setting can have some impact on treatment process as well as therapeutic outcome (Frank & Frank, 2004; Gross, Sasson, Zarhy, & Zohar, 1998; Miwa & Hanyu, 2006; Nasar & Devlin, 2011). The present study reflects two possible mechanisms that have been presented in the literature, through which this therapeutic effect may occur.

First, the counselling setting may impact a client's perception of therapist credibility (Nasar & Devlin, 2011), which in so doing increases a client's expectation of therapeutic benefit (Frank & Frank, 2004). Therapist credibility can be influenced by a number of environmental and design variables, including the display of awards and credentials (Seigal, 1980), the softness and personalization of the office (Nasar & Devlin), the neatness and order of the office (Gosling et al., 2002), and the formality of office decor (Amira & Abramowitz, 1979). Each of these environmental/design factors have been suggested to communicate to the client that the therapist is an effective and trustworthy helper (Nasar & Devlin).

Dorn (1984) suggested that fostering a belief in the therapist's credibility may be influenced by a number of variables, including the client's perception of the therapist's specialized training and the client's perception of the therapist's reputation in the community. These two factors may be relevant in the present study. For example, one participant reported that her therapist was perceived as a specialist in refugee-related issues due to the fact that she practiced out of a centre which deals specifically with refugees and immigrants. Location within a centre such as this speaks to the specialization of the therapist, as well as the specialized services which may be available there. Location within a specialized centre may also create a ready-made perception of positive reputation within the community.

Second, a healing setting is one that creates an environment of safety (Frank & Frank, 2004). The physical environment and design of the therapist's office can have an influence on a client's perceptions of safety (Nasar & Devlin, 2011). Personalization, or the display of personal items (McElroy, Morrow, & Ackerman, 1983), home-like decorations (Gifford, 1988; Miwa & Hanyu, 2006), a "soft" room (e.g., one with plants, pictures, a decorative rug, and a padded armchair; Chaikin, Derlega, & Miller, 1976), room colour (Pressly & Heesacker, 2001), and muted lighting (Miwa & Hanyu) have each been suggested to add to the perceived safety of a room, as well as positive therapeutic effects.

These aspects of environmental design are mirrored in the present study, where the physical characteristics of a welcoming atmosphere were described by participants as: soft, nice room colour, dim lighting, nice decorations and soft chairs. Such a room was described in the current study to be comfortable,

relaxing, sympathizing and friendly. This again mirrors other studies wherein participants have described pleasant rooms as: comfortable (Morrow & McElroy, 1981; Gifford, 1988; Nasar & Devlin, 2011), welcoming/inviting (Morrow & McElroy, 1981; Nasar & Devlin), and relaxing (Flynn, 1988).

This healing environment as outlined above was contrasted by one participant to a more "medicalized" environment, which was described as "very clinical", "medical", and "sterile", and consisted of bright lights, white walls and staff wearing white coats. She described this environment as creating a perception that "you are sick". Within this type of setting, the participant questioned if she would have attended counselling at all. Nasar and Devlin (2011) suggest that the clients' impressions of the therapist and therapy which are generated from the atmosphere or environment of the therapist's office may affect the likelihood that the clients would want to undertake counselling or continue in it.

Nasar and Devlin (2011) continue that client perceptions generated from the therapists' office also affect the communications that take place within the office. Dim lighting (incandescent lamps, as opposed to overhead fluorescent lighting) has been suggested to facilitate a client's self-disclosure during counselling and increase speaking time. (Miwa & Hanyu, 2006; Chaikin et al., 1976). A possible mechanism is that dim lighting induced pleasant and relaxed feelings as well as favourable impressions of the counsellor, which may have resulted in increased self-disclosure and speaking time. With this impact of environment on self-disclosure, the description of a positive environment as "sympathetic" is insightful.

Summary

Consistent with the research literature, participants described struggles overcoming not only the long-term effects of pre-migration experiences, but the additional language, educational, vocational, and economic challenges associated with resettlement. Treatment was considered to be most helpful when it addressed each of these points of concern, but immediate stressors and challenges trumped various intra-psychic concerns in terms of therapeutic importance. Various approaches were deemed to be helpful, but participants appreciated a directive and solution-oriented approach. Also consistent with research literature, participants highlighted the importance of the therapeutic relationship, which was cultivated through understanding and the experience of a human connection.

There were several new discoveries in this research about counselling refugees. First, the refugee clients interviewed in this study sought out counselling services to address both symptom relief as well as addressing the circumstances directly affecting their lives. In this way they were active agents, engaged in an effort to remove the most salient obstacle from their path of healing and resettlement.

Second, while participants did find sharing their trauma story to be helpful in therapy, these results highlighted some of the complexities of this practice. For example, an in-depth review of the trauma was not always deemed as necessary by the client, although it was not avoided either. Rather, it appeared that they approached this problem pragmatically, by going into as much detail as necessary to be effective. Third, participants appreciated a directive approach that included

advice, advocacy, direct assistance with life tasks, and other interventions (e.g., relaxation exercises). Participants noted the need for directive interventions as they did not always have the knowledge or resources to effectively address their challenges alone. Fourth, participants noted a desire in therapy for services which foster empowerment and resilience in addition to other therapeutic tasks, with an ultimate focus on well-being.

Fifth, participants emphasized the importance of being understood by their counsellor, and appeared to actively appraise their counsellors' ability to understand. Finally, participants valued accessible services, including the situation of mental health services within immigration or settlement agencies, and centralized services accessible by public transportation. The implications of these findings for counselling refugees will be outlined in the following section.

Implications for Treatment

The experiences and perspectives outlined in this study and supported by previous research offer some insights pertaining to the counselling process for refugees. A summary of these implications for treatment is provided in Table 3 below. It is clear that counsellors need to establish the credibility or trustworthiness of the mental health program they are working in within the refugee community. The success of a cross-cultural treatment program depends upon the reputation of that program within the community it is serving (Kinzie, 2004). Establishing contacts at various agencies or related services, including ESL programs or immigration lawyers may ease the transition of referrals. Liaising directly with these agencies may also assist counsellors in establishing early

credibility. As well, locating therapists within a setting or agency where refugees naturally gather may improve the clients' familiarity with the program, as well as the program's credibility (Arthur et al., 2010).

Maintaining a continuity of services also appears to be important for working with refugees. The counsellor's familiarity with local services will be critical in this regard. Maintaining working relationships with other agencies, or when possible, housing multiple services within the same location may help to maintain continuity of services. Locating all services within a single setting may help to provide a more comprehensive service with minimal disruption (Kinzie, 2004). When possible, certain situations may be better suited for a long-term treatment model rather than a short-term approach, and imposing a limit on the number of sessions may be unrealistic and potentially harmful to the client as it may leave them being abandoned perhaps as in previous trauma experiences (Kinzie). Providing services which are consistent and predictable may help reduce any additional stress caused by vacillation in services in a population that has already experienced so much stress (Vasilevska et al., 2010).

Another recommendation emerging from this study is to provide services which are easy to access for refugees. This may include free services as well as a central location and proximity to public transportation. This may also include going to where the refugees live in situations where neighbourhoods are poorly serviced by public transportation (Vasilevska et al., 2010). Accessible services may also include embedding the counselling program within a broader agency which is addressing other refugee needs (e.g., resettlement or educational needs).

Accessibility may also be enhanced through a streamlined referral process between the referring agency and counselling provider. For example, this could include linking settlement workers with mental health service providers including mental health consultation if needed, or fostering strategic partnerships between agencies (Arthur et al., 2010; Vasilevska et al.). Finally, especially within agencies which offer many programs, clients may not know how professional roles are divided, or "who is supposed to take care of their specific needs" (Vasilevska et al., p. 26).

Addressing the continuing challenges of resettlement, as well as the ongoing challenges which may exist pertaining to housing, food, and other basic needs can facilitate effective therapy with refugees. The psychologist should be prepared to address various areas of concern and should have a working knowledge of regional services and processes. Working relationships with other organizations such as settlement agencies would also be beneficial in this regard as a way of bringing experts together in the work of helping refugees (Vaileyska et al., 2010).

In terms of interventions, psychologists should provide directive interventions as appropriate to support refugees' recovery process and adaptation to their new environment and to prevent the experience of learned helplessness. Specifically targeting distressing symptoms has been associated with an accelerated pace of therapeutic change and satisfaction with psychotherapy among refugee clients (Dragus, 1996). A needs-based approach which targeted specific areas of concern (whether removal of symptoms or addressing

resettlement needs) was cited as helpful by each participant in the present study. This may include a very hands-on approach involving liaising with other organizations or guiding through various processes, like the process of preparing for a refugee claim hearing, connecting to ESL classes, or job finding.

Flexibility of treatment options is also an issue (Codrington et al., 2011). Treatment may include, but would obviously not be limited to, relaxation exercises, various cognitive-behavioural strategies, and sharing in the trauma story. Alternative treatment modalities may also include, "visual art therapy, drumming, choral singing, leisure activities and social gatherings" (Vasilevska et al., 2010, p. 24). Sharing in the trauma story may range from a brief description of the trauma to an in-depth sharing of the experience—as according to the participants in this study, in-depth processing of pre-migration traumatic events was not necessary for successful adaptation in the new environment. Flexible treatment options may also include, in some situations, extending session length beyond the typical 50 minute counselling session. Within this flexibility, however, treatment goals should openly be addressed and reassessed as required. The theoretical and technical flexibility of the therapist, along with the effective modification and adaptability of treatment is essential in providing effective services to refugee populations (Hwang, 2006; Murray et al., 2010; Palic & Elklit, 2011; Sue & Sue, 2008).

Communication of empathy in the treatment process appears to be essential. The experience of empathy is an essential component of therapy, within and across cultural boundaries (Fischer et al., 1998). A substantial proportion of

therapy failures within a cross-cultural context are presumably traceable to breakdowns of empathy (Draguns, 1996). Conversely, there may be "no better therapy" than the sharing of experience and bringing "two people of markedly different backgrounds and experiences closer" (Kinzie, 2004, p. 272).

As empathy is expressed and perceived differently across cultures (Ridley & Udipi, 2002), it is not possible to create a simple "to-do" list or formulaic pattern through which to build empathy in a counselling setting. However, some basic foundational elements would include: valuing and trying to understand the client and his or her story; incorporating the information received in counselling (individual as well as cultural) into the counselling sessions; responding to core messages; and exploring cultural, resettlement, and situational issues. Counsellors may also modify their style of conveying empathy to better match the client. When it comes to cultural empathy, Marshall McLuhan's (1964) phrase seems to apply, that the "medium is the message."

Table 3

Implications for Treatment

Area of Focus	Recommendations
Structural Considerations	Establish credibility of the program within refugee community
	Foster contacts within the community
	Maintain continuity of care
	Provide easy access to the program
Therapeutic Considerations	Address continuing resettlement/safety needs
	Provide a directive, needs-based approach
	Provide flexible treatment options
	Communicate empathy

Study Limitations

This study was exploratory in nature and was designed to be an in-depth study of a particular phenomenon as experienced by the participants involved. As such, this study may not generalize across other situations or circumstances. In addition, the findings of this study should be viewed in light of additional limitations which are outlined below.

As outlined in the methods section, participants were recruited primarily through counsellors at various counselling centres. It is possible that counsellors recommended those individuals who had positive counselling experiences or who experienced a positive therapeutic relationship. They certainly selected

individuals who they believed to be well-functioning and who they considered to be at low risk of harm. This selection bias may filter out those individuals who experienced a more negative therapy experience, or for whom therapy was less effective. While much can be learned by exploring positive and helpful experiences of counselling, much too can be learned from hindering experiences.

In a related way, this sample was comprised of volunteers who may differ from the general population of refugees who have attended counselling. As a result, this study may only reflect the experiences and perspectives of clients who had a relatively successful experience of counselling. Those individuals who ended counselling prematurely or otherwise had negative experiences of counselling may not have volunteered to participate in this study. As premature termination has historically been a problem among this population, negative counselling experiences may provide invaluable insight. However, few negative counselling experiences were generated from these interviews.

Each participant in the present study was involved in rather long-term therapy—some attended therapy over the course of several years. Long-term therapy may have different treatment emphases compared to more short-term counselling. For example, empowerment may not be as important a therapeutic task in short-term therapy compared to long-term therapy. As well, experiences following several years of therapy likely differ from short-term therapy (i.e., 10-12 sessions). However, researchers and practitioners have highlighted the benefits of a long-term treatment approach with refugees rather than a short-term model (e.g., Kinzie, 2004), therefore this study would speak to such treatment

approaches. As well, because participants were recruited from community counselling agencies, their length of treatment may reflect what is done in the community and thereby increase ecological validity.

Another limitation of this study is the absence of male participants. This is of vital significance as women may respond more positively than men to Western-style counselling (Sue & Sundberg, 1996) and those aspects of therapy which were reported to be helpful by women may not hold the same significance for men. In a similar way, men may report differing goals for attending therapy and may find other aspects of the therapeutic relationship to be important. Two men were recommended to the study, but each denied participation as they had other pressing responsibilities, such as work.

It is important to make note of three points in evaluating this gender restriction in participation. First, existing research consistently suggests that the majority of utilizers of psychological services are female (Burgess, Pirkis, Slade, Johnston, & Meadows, 2009; Levinson & Ifrah, 2010; Mackenzie, Reynolds, Cairney, Streiner, & Sareen, 2012). As such, the female perspective is an important one. Second, refugees have been found to underutilize counselling services due to discrepancies in their worldviews or the perceived cultural insensitivity of the counsellors, and the stigma attached to seeking help or having mental health problems in their cultures (Arthur et al., 2010; Kramer, 2005; Sue & Sue, 2008). This stigma may also be related to why it was very difficult to obtain participants for this study. Even some females who were referred into the study were unwilling to share their experiences with someone other than their

counsellor, and declined participation. Third, the fact that the male researcher was able to recruit 4 female participants into the study, despite the difficult nature of their experiences, attests to the integrity of this research study and the researcher's ability to build a safe interview environment for the participants to share their perspectives. The difficulty in obtaining participants for this study sheds light on the reasons why counselling research on refugees has primarily been researcher-based rather than based on refugees' own voices and experiences. The voices and perspectives that were heard in this study expanded our understanding of the nature of effective counselling with this population.

One of the challenge accessing participants appeared to be related to concerns about the retraumatization of refugees by having to recount their counselling experience with a researcher. Building trust among the counsellors and administrators of the various counselling centres approached for help with recruitment was essential to gaining access to the participants. A common reservation noted in early meetings with counsellors or administrators was their concern of the potential negative impact the research interviews would have on the participants, namely retraumatization. Some centres were willing to open their doors to the researcher while other centres denied access outright. The most effective means of overcoming this challenge was meeting individually with administrators and attending team meetings with the centre's psychologists. It is interesting to note that the actual participants in the study had no concerns of retraumatization, possibly suggesting that "at-risk" individuals were filtered out during the selection process, or that the retelling of certain aspects of one's

experience within a safe environment may be helpful rather than harmful, as the research participants indicated. The discrepancy between counsellors' thoughts about refugee participation in research and refugees' own thoughts seems to further support the need to conduct research on this population to uncover refugees' unique perspectives and take these into account in the healing process.

Finally, many cultural groups were not represented in this sample. Therefore, the experiences noted by the participants in this study may not generalize to refugees from other areas. In a related way, recent research on various ethnic groups has demonstrated a greater ethnic-specific focus, with each group "beginning to more clearly define its own concerns and needs" and a growing trend in research to "focus research efforts on these needs" (Zane et al., 2004, p. 797). The study may not be powerful in elucidating any culture-specific factors of treatment. However, the factors which were outlined in the present study may serve as a framework upon which various culture-specific factors may be understood.

Even though there was not a wide range of cultures represented in the study, there was significant diversity among the experiences of the sample in several ways: (a) a few of the refugee participants where members of the persecuted group in their countries of origin, whereas others where members of the local majority group or group holding power; (b) a few of the refugees' premigration experiences were characterized by being surrounded by organized violence in the form of war, whereas other participants were subjected to or threatened with individualized violence or harm; (c) some sought counselling

primarily for being preoccupied with fears or worries related to premigration events, whereas others sought counselling for assistance in dealing with resettlement stressors or a combination of the two; (d) some sought help for themselves, while one sought help primarily for her son; and (e) the regions of the world the refugees came from reflected patterns of refugee migration to Canada during their years of arrival, and the shift in source countries of refugees over time to African countries. The results may therefore have some relevance for other situations or groups even if they do not address culture-specific elements of counselling refugees.

Design Limitations

One methodological limitation of this study addressed the validity of the participant's verbal reports. While each participant last met with their therapist between 6 months to one year before the research interview, the first counselling sessions were up to seven years prior to the research interview. It is possible that details from those early sessions have been since forgotten, or that recall of the early sessions has been altered over time. The recall of experiences always contains a certain degree of construction (Rennie, 1992), and this study is no exception. Related to the challenges of verbal reports, participants may have edited their experiences of counselling for other reasons as well. As one example, participants may have been apprehensive to share negative counselling experiences in order to "protect" the therapist with whom they feel an allegiance. It is also important to consider the social context wherein experiences of counselling were discussed as this social context may influence the participant's

representation of the experience (Rennie, 1992). The interviewer's cultural background and gender (White male) may have had some impact on the participants and their willingness to disclose information.

A second methodological limitation was related to the language of the interviews. Each interview was conducted in English although English was the second language for each participant. Interpreters were offered, but participants denied stating that they preferred to conduct the interviews in English. Still, it is possible that subtleties in the communication were missed due to language barriers. Of note, participants did not report verbal misunderstandings following the interviews, and they also reported that working with their counsellors without the assistance of interpreters was helpful. Therefore, there may be a parallel between their experiences as counselling clients and their experiences as research participants.

Considerations for Future Research

Towards the better understanding of refugee needs during resettlement, there is an increasing recognition of the need to employ qualitative and emic approaches (Murray et al., 2010). This study serves as an introduction to the area of understanding refugee experiences in psychotherapy, and several important research directions branch out from here. As one example, each category or theme in this study could be expanded upon and developed in greater detail and depth. A more focused study in each of these areas could provide a more complete understanding of the mechanisms and processes involved therein. One interesting application of this would be to explore in-session processes, whether based on

rater's observations of in-session events (e.g., Higham et al., 2012) or video-assisted recall (e.g., Larsen & Stege, 2012). Concepts outlined in the present study such as *understanding potential* can also be explored in greater depth and detail. For example, what are some of the factors which are perceived to cultivate a feeling of mutual understanding?

Other questions which may be important to address include hindering experiences of counselling, or the experiences of individuals who may feel marginalized by mental health services or otherwise feel that the services provided do not meet their needs. This may be particularly salient among individuals who terminate therapy prematurely. As premature termination is a consistent challenge among immigrant and refugee clients (Sue & Sue, 2008), the perceptions and opinions of those individuals may provide important insights into how to better link the services provided to the clients accessing them. Discussions with community members in general addressing barriers to treatment and how to modify or adapt treatment programs to make them more accessible may also be helpful in this regard (Hwang, 2006).

The limitations inherent to this study could also be addressed in future research. It would be interesting to explore refugee experiences of counselling across a larger sample. There are several variations of this idea, from a simple increase in sample size to exploring experiences within a particular refugee group. As noted previously, there is an increasing trend in multicultural research to explore ethnic-specific factors (Zane et al., 2004). An in-depth exploration into any one refugee group may be informative, especially as shared community

experiences and cultural values may be linked more clearly to the services needed for their healing and integration. Such insights into culture-specific factors may help service providers to culturally adapt treatment and provide a basic framework for such adaptations (e.g., Hwang, 2006).

As well, many cultural groups were not represented in this sample, and may differ in terms of their therapeutic goals, what was found to be helpful, or what makes a successful therapeutic relationship. Clearly, further research is needed across a wider cross-section of cultural groups. Between-group comparisons may be helpful in demonstrating various manifestations of common themes. For example, the theme of surviving the storm or understanding may be present across groups, but the various storms or modes of building understanding may differ considerably between groups.

Other limitations could be addressed as well. For example, men were also not represented in this sample, and their experiences and insights would be a valuable addition to the literature as their experiences of counselling may differ from their female cohort (Sue & Sundberg, 1996). As well, all participants in the current study experienced rather long term therapy with no distinct apparent theoretical orientation. While the information collected here is significant in that it may represent what is common practice in the community and therein maximize ecological validity, several questions remain unanswered. For example, what are the experiences of clients receiving distinctly CBT or NET treatments? These experiences may provide useful information in successfully adapting or modifying various treatment approaches.

Some interesting and unexpected questions arose during the study. For example, it was interesting to note the unanimous desire of participants to conduct the interviews in English even through English was their second language and some language difficulties were observed during some of the interviews. This may reflect the symbolic importance of language during the resettlement process as a distinct and separate entity from the functional importance of language during resettlement. Future research may help to explore this distinction as it relates to both resettlement as well as within a counselling context.

Conclusion

The impetus for this study was to give voice to the perspectives of refugees who have attended counselling or psychotherapy, with the hope of better understanding the therapeutic process among refugee clients. This study was significant as it added the voice of the refugee client to the discourse which has been largely dominated by theorists, researchers and practitioners. The guiding research questions were: (a) Why do refugees seek counselling and how do they conceptualize their presenting problems? (b) What are refugees' experiences of counselling? (c) What do refugees identify as helpful in facilitating therapeutic change? Four refugees from Zimbabwe, Bosnia-Herzegovina and Nigeria participated in the study, sharing their unique experiences and personal insights. The experiences shared by these individuals do not represent the counselling experiences of all refugees who have attended therapy. However, these experiences do offer a framework for researchers, psychologists, and other helping professionals to elicit further reflection, discussion, and future research.

Results have highlighted four important factors, namely: (a) client-congruent treatment goals which address both symptom relief as well as the circumstances and contexts of the refugees lives; (b) therapeutic tasks which may include looking at the past, directive interventions including advocacy, advice, and direct assistance with key life tasks; (c) a strong therapeutic relationship based on a mutual understanding and positive connection; and (d) a counselling environment which is both accessible and safe. It is hoped that the addition of the refugees' perspectives as a supplement to what is already presented in the literature will result in new insights into the key ingredients of psychotherapy with this population. Through these insights, this study may inform current treatment strategies and enable practitioners to better match the needs of their refugee clients and assist refugees with their recovery.

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Appendix A: Study Description / Advertisement

REFUGEE STUDY

Refugees deal with many challenges in their lives before and after moving to Canada. Sometimes it is hard to handle these challenges without some help. Chris Marusiak is doing a study to learn about the reasons refugees go to a counsellor for help, and how they feel about the help they are given. Chris is a student at the University of Alberta and is working with Dr. Noorfarah Merali. His study will help counsellors try to meet the needs of refugees who come to them for help.

Chris wants to talk with refugees who went to see a counsellor about challenges before or after coming to Canada. If you agree to be in the study, you will talk with Chris about:

(1) Your reasons for going to see a counsellor
(2) What kind of help you wanted from the counsellor
(3) Whether the counselling helped you

Someone who speaks your language can be there to help you talk with him if you need it.

The meeting will take one and a half hours. It will be at a time that works best for you. Everything you talk about will be private.

You can be in this study if:

(1) You have seen a counsellor in the last 6 months
(2) You are at least 18 years old
(3) You have been living in Canada for 2 years or more.

If you would like to be part of this study, please tell _____ at _____ (agency). This person will write down your name and phone number and tell the researcher that you want to talk to him. When Chris phones you, he will ask you some more questions and answer any questions that you have. Then, he will arrange a time and place to talk with you. If you would like to phone Chris yourself, please call at 492-8963.

Appendix B: Staff Confidentiality Agreement

Confidentiality Agreement

I, _____, the staff member at _____ (agency) have been asked by the researcher, Chris Marusiak to record the names of those individuals that may be interested in being a participant in his doctoral research at the University of Alberta, Department of Educational Psychology entitled: Refugee Experiences of Counselling and Psychotherapy.

I agree to:

1. Keep the names and contact information of all participants who express interest in or sign up for the research confidential, and not discuss or share the information in any form with anyone other than the researcher, Chris.

2. Destroy the list of potential research participants' names and contact information after the information has been transmitted to Chris.

Name of Staff Member: _____ Name of Agency: _____
(please print)

Signature of Staff Member: _____ Date: _____

Signature of Researcher: _____ Date: _____

Appendix C: Informed Consent Form

Agreement to Participate

This study is about the reasons refugees go to a counsellor for help, and how they feel about the help they are given. This study is being done by Christopher Marusiak. He is a student at the University of Alberta working with Dr. Noorfarah Merali. His study will help counsellors try to meet the needs of refugees who come to them for help. If I sign this form, I know these things about this study:

1. Chris will talk to me in English. Someone who speaks my language can be there to help me talk with Chris if I need it. This person will promise not to tell anyone my name or what I said.

2. I know that if I am in this study, I will be asked to talk about challenges in my life before or after moving to Canada and my reasons for going to a counsellor. I will also be asked to talk about what kind of help I wanted from the counsellor, and if the counselling was helpful for me. I will meet with Chris for about one and a half hours.

3. Chris will phone me to arrange another time to meet to talk to me again to make sure he understands my story. He may ask a few more questions to check that the information is right. I will have a chance to add or change anything that we talked about in the first meeting. This second meeting will take about one and a half hours too.

4. I know that my meetings with Chris will be recorded on a tape. After the talk is over, Chris will listen to the tape and type out what I said on paper. Everything I say to Chris will be private. He will take out my name and put a made-up name on the tape and paper so nobody will know that the words I said are mine. The typed paper and tape will be kept in a locked filing cabinet in Chris' office at the University.

5. Talking about why I went for counselling might make me feel stress or worries. If this happens, I know I can get some free help if I tell Chris what is going on.

6. I know that it is up to me whether I want to be in this study or not. Even if I sign this form, I can stop being in the study at any time without any questions or problems.

7. Chris may give lectures or write papers about what he learned in this study to help counsellors try to meet the needs of refugees who come to them for help. Some of my words may be used in the lectures or papers. Nobody will know that the words are mine because he will not use my real name.

8. I understand that I will receive $25 for being in the study.

9. I understand that if I have any questions or concerns, or want to know what Chris learned from this study, I can leave a message for him at the University of Alberta at (780) 492-3746 or send an email to marusiak@ualbera.ca. I can also call Chris's supervisor, Dr. Noorfarah Merali at the University of Alberta at (780) 492-1158.

10. This study has gone through the University of Alberta committee that makes sure that research is done properly and that people who take part in the study are treated right.

This committee is called the Faculties of Education and Extension Research Ethics Board. If I have any concerns about how this study is being done or about my rights as a person taking part in it, I can call the head of the committee, at (780) 492-3751.

Name: _____
(please print)

Signature: _____ Date: _____

Signature of Researcher: _____ Date: _____

Appendix D: Interpreter Confidentiality Agreement

Confidentiality Agreement

I, _____, the interpreter, have been hired by the researcher, Chris Marusiak, to accurately translate interviews he is conducting for the purpose of his doctoral research at the University of Alberta, Department of Educational Psychology entitled: Refugee Experiences of Counselling and Psychotherapy.

I agree to:

1. Keep all research information confidential by not discussing or sharing the research information in any form with anyone other than the researcher, Chris.

2. Inform Chris if there were important aspects of the interview that could not be properly translated.

3. Inform Chris if there were any culture-specific signs that participants were emotionally distressed during the interviews that the researcher may not have been aware of or that may need attention.

Name of Interpreter: _____
(please print)

Signature of Interpreter: _____ Date: _____

Signature of Researcher: _____ Date: _____