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Examining the Process of the Development of Multicultural Counselling Competencies in Therapist-Trainees

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By

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Therapist Trainees

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ABSTRACT

Canada admits between 22,000 – 24,000 refugees each year (Beiser, 2005). Immigrants and visible minorities tend to underutilize mental health services. However, ensuring new settlers' physical and mental health is not only humane, but also crucial to enable them to achieve their social and economic potential in the host country. Fundamentally, the need for Multicultural Counselling Competencies (MCC) is due to diverging notions of mental health and healing between clients and therapists who are culturally different from each other. There is ample literature on Multicultural Counselling Competencies. However most of this body of research has been conducted using quantitative approaches. The present study is a qualitative analysis which aimed to answer the research question: *"What are therapist-trainees' experiences regarding their Multicultural Counselling Competencies (MCC) while providing therapy to first-generation, government assisted, refugee clients?"*. The sample for this study consisted of fourteen therapist-trainees who were doctoral level students in the Clinical Psychology program, Adult Track, at the University of Windsor. These therapist-trainees completed Critical Incident Journal (CIJ) entries after each session with their refugee clients. The therapist-trainees completed a total of 165 CIJ entries. These entries were analyzed using an adaptation of the Grounded Theory Method (GTM) as a guiding framework (Rennie, 2006). Three main themes emerged from the therapists CIJs: "Feeling the Need to Adapt", "Feeling a Sense of Increasing Cultural Self-Awareness" and "Building the Therapeutic Relationship is Important". In addition, developmental aspects of the therapists' experiences were identified. Implications for future training, practice and research are discussed.

DEDICATION

To my parents, whose love and support have inspired me and allowed me to reach my dreams.

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TABLE OF CONTENTS

List of Figures

Chapter I

Introduction

In 2006, two-thirds of the population growth in Canada was accounted for by international immigration (Statistics Canada, 2008). Hoping to revitalize an aging society, and seeking to provide skilled and unskilled labour, Canada admits between 220,000 – 240,000 newcomers each year (Beiser, 2005). Predictions made by Statistics Canada (2008) anticipate that around 2030, deaths will outnumber births due to low birth rates and aging; once this happens, immigration will be the only growth factor for Canada's population. In the 2006 census, 6.1 million people 15 years and older reported being born outside of Canada (first generation). This represents 23.9% of Canada's population (Statistics Canada, 2010). Each year, 10% of immigrants to Canada are refugees (Beiser, 2005).

Immigrants to Canada come from a myriad of different countries and decide to emigrate from their country of origin for numerous reasons. However, in most cases, immigrants arrive at the host country by choice, usually after a fair amount of planning, and have the freedom to return to their country of origin (Beiser, 2005). In contrast, refugees usually had to flee their countries of origin, possibly in a relatively short time for fear of being persecuted because of their race, religion, nationality, political opinion, or membership in a social or ethnic group (Gonsalves, 1992; United Nations High Commissioner for Refugees [UNHCR], 1951). Due to the fear of persecution, refugees are unable to return to their country of origin (UNHCR, 1951). At the UNHCR in 1951, Canada pledged to protect the persecuted and stateless and agreed to offer refugees the option of permanent resettlement (Citizenship and Immigration Canada [CIC], 2011). Refugees and victims of torture are a heterogeneous group; they are boys and girls,

women, and men with widely varying levels of education, socio-economic status, and

backgrounds (Fabri, 2001). Given the increasing number of refugees in need plus the

increasing torture practices around the globe, refugees immigrating to Canada are likely

to have been tortured or suffered trauma in the past (Gorman, 2001; Marotta, 2003).

Immigrants and visible minorities tend to underutilize mental health services. This

underutilization stems from several sources among members of visible minorities

including: lack of awareness regarding mental health, stigma for mental illness, feeling

misunderstood by mental health professionals, lack of accessibility, and language barriers

(Beiser, 2005; Bourget & Chenier, 2007; Bowen, 2001; Kuo, Kwantes, Towson &

Nanson, 2006; Simich, 2010). However, ensuring new settlers' physical and mental

health is not only humane, but also crucial to enable them to achieve their social and

economic potential in the host country (Beiser, 2005). Thus, in recent years, several

organizations (e.g., Canadian Mental Health Association [CMHA], Canadian Alliance on

Mental Health and Mental Illness, Mental Health Commission of Canada [MHCC]) have

placed increasing emphasis on the importance of mental health in immigrant and refugee

populations. As a result, it is reasonable to assert that most psychologists in Canada will

have opportunities to work with clients who are culturally different from themselves at

some point during their practice (CAMH & MHCC, 2012; Sue, Arredondo, & McDavies,

1992).

Although psychologists may have multiple opportunities to work with culturally

diverse clients, studies such as the one conducted by Heppner and O'Brien (1994) found

that a significant number of therapists and therapist trainees feel inadequately prepared

for working with culturally diverse clients. The importance of being culturally competent

is heightened by the fact that psychiatric misdiagnoses are more common for members of

visible minority groups than for members of the dominant group (Good, 1993; Ortiz, 2001; Paniagua, 2000; Pumariega, Rogers, & Rothe, 2008). Hence, *Multicultural Counselling Competencies* (MCC) are essential for mental health professionals planning to practice in Canada.

The MCC movement was prompted in the 1980s in the U.S. by minority clients' underutilization of mental health services, their tendency to terminate therapy prematurely, and an increased attention to the existence of culturally biased assessment (Sue, Bernier, Durran, Feinberg, Pedersen, Smith, & Vazquez-Nuttal, 1982). These findings signalled the inadequacy of mainstream counselling and mental health services for treating multicultural clients. Consequently, the American Psychological Association (APA) and the American Association for Counselling and Development (AACD) noted the serious lack of training programs for promoting the development of MCCs among therapist trainees (Sue et al., 1992). Meanwhile, the APA mandated the development of MCCs to be both an essential part of professional competencies and an ethical obligation of its members (APA, 2003).

It is noteworthy that when clients of minority groups were surveyed in terms of their satisfaction with counselling services, therapists' MCC explained a large amount of variance above and beyond their general competence (Fuertes & Brobst, 2002). Roysircar (2006) identified the components of MCC to include a therapist's self-awareness of his/her attitudes and world-views, his/her knowledge, recognition, and sensitivity to the client's world views and attitudes, his/her understanding of the effects of socio-political influences on clients, clients' racial and ethnic identity, acculturation, minority stress, and their coping with minority status. MCC also includes the therapist's ability to be culturally responsive and to transform mainstream interventions into multi-culturally

sensitive strategies, skills, and interactional proficiencies. MCC in essence "pertain to the

effective delivery of counselling service that includes a broad constellation of awareness

of counsellor attitudes and values, knowledge and skills." (Roysircar, 2006, p. 369). For

instance, MCC skills and knowledge can be demonstrated when a therapist can

differentiate whether a client's experiences are culturally or individually based. In other

words, the therapist can differentiate whether the client's struggle is rooted in the client's

cultural background as experienced in a Canadian context or if the issue has its roots in

the individual's psyche, independent of the client's cultural background (Constantine,

Miville, & Kindaichi, 2008). For instance, a common ritual in Mexican culture is to place

"ofrendas"[1] on Nov. 1st when "Day of the Dead" is celebrated. The belief is that deceased

relatives return from death to enjoy the food and drinks placed in the "ofrenda". Without

the cultural context, a clinician may misinterpret this cultural ritual and the associated

belief as a form of delusion. In order to avoid misdiagnoses and to provide better services

to clients from diverse cultures, MCC are critical for psychologists in Canada. Thus,

knowledge regarding the experiences and the learning process through which MCC are

developed are fundamental for psychology in Canada.

Statement of the Problem

In essence, psychotherapy involves an interaction between two people where one

of them has the aim of helping the other understand and resolve his or her issues

(Bateman, Brown, & Pedder, 2000). Often, regardless of shared culture and worldview, it

is very difficult to truly understand another person (Kottler & Carlson, 2005). The present

study focuses on the therapeutic encounter between a therapist trainee and a refugee

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[1] "Ofrendas" consist of flowers and favourite food and drink offerings for deceased
relatives.

client, each with a different ethnic background, different life experiences, and (possibly) different views on what constitutes mental health and healing (APA, 2003; Draguns, Gielen, & Fish, 2004).

Fundamentally, the need for MCC is due to diverging notions of mental health and healing between clients and therapists who are culturally different from each other. While there is ample literature on MCC, most of this body of research has been conducted using quantitative approaches. A number of quantitative studies have centred on therapists' and therapist-trainees' self-reports of their MCC. These studies have typically focused either on identifying the components of MCC through the development of self-report scales such as the Multicultural Counselling Inventory (MCI; Roysircar-Sodowsky, Taffe, Gutkin, & Wise, 1994), or on learning outcomes on attaining MCC as measured by therapists' self-reports also based on quantitative scales (e.g., Constantine, Fuertes, Roysircar, & Kindaichi, 2008). Scholars in this area have noted that qualitative research in MCC is lacking and seriously needed (Ponterroto, 1998). In the past few years, several qualitative studies on MCC have been published. These studies range from auto-ethnography (Kiselica, 1991), to reports of trainees' experiences in the field leading groups in the community (Burnham, Mantero, & Hooper, 2009; VanderGast, Post, & Kascsak-Miller, 2010), descriptions of trainees experiences in cultural immersion programs (Boyle, Nackerud, & Kilpatrick, 1999), and qualitative interviews and surveys regarding clinicians' perceptions of their MCC when working with clients who are culturally/ethnically different from themselves (Downing-Hansen, et al., 2006; Fuertes, Mueller, Chauhan, Walker, & Ladany, 2002; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003). However, little is known about the elements that influence the development of MCC, such as the self-reported experiences therapists go through while

providing therapy to first-generation, culturally diverse clients and the specific ways in which cultural competencies develop over time.

The divide between research and practice in psychology has been extensively noted in the literature (Garland, Plemmons, & Koontz, 2006; Tavris, 2003). Some authors such as Fensterheim and Raw (1996) highlight the need for researchers to listen to clinicians' experiences in the field. These authors suggest that research would benefit from clinicians' insights attained in the field. Following Fensterheim and Raw's (1996) suggestion, the current study aims to attend to and document the therapist-trainees' experiences and insights while providing therapy to culturally diverse refugee clients.

Research question

Through the analysis of post-therapy-session Critical Incident Journals written by the therapist-trainees participating in the Psychological Services and Research Centre (PSRC) practicum training with refugees at the University of Windsor, this study aimed to answer the following research question: *"What were therapist-trainees' experiences regarding their Multicultural Counselling Competencies while providing therapy to first-generation, government assisted, refugee clients?[2]"*
This question provided the framework and focus for the present study.

Chapter II. Review of the Literature

Three contextual issues need to be addressed in order to answer the stated research question: the macro-context (larger cultural context), previous research in MCC and training, and the micro-context (research context). The first topic pertains to the larger cultural context or macro-context. The macro-context includes cultural differences and

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[2] Please find more information on Government Assisted Refugee clients in the "Micro-Context" section of this document

similarities in the conceptualization of mental health and mental illness in diverse cultures. A discussion on the socio-political and economic forces that shape the conceptualization of mental health, mental illness, and healing which in turn influence the clinicians' and therapist-trainees' worldviews is also needed. The heart of the present study is the therapeutic encounter between therapist-trainees and refugee clients. Thus, the macro-context also comprises a discussion on refugee clients who are an integral part of this study's therapeutic dyad. The refugee clients' experiences, past and present challenges, and challenges for therapy will be discussed. Addressing the larger cultural contexts, the ethnic backgrounds, and diverse life experiences of both therapist-trainees' and refugee clients is critical to better understand the therapist-trainees' experiences and perceptions of the process (Henwood & Pidgeon, 2003).

The second topic pertains to previous research on common factors in psychotherapy and healing, MCC, and training programs. Addressing previous research will help strengthen the significance and implications of the present study by identifying gaps in the literature. Knowledge of previous research will also help deepen and strengthen the analysis and the emerging concepts. The objectives and significance of this study are also discussed in this section.

Finally, the third topic pertains to the micro-context or research context. Describing the research context is fundamental in order to better understand the therapist-trainees' perceptions, to provide the reader with a clearer, more accurate picture of the trainees' experiences and to strengthen this study's trustworthiness. Thus, this section describes the therapy practicum with refugee clients at the Psychological Services and Research Centre (PSRC) in the University of Windsor where the present study took place.

In addition, information about the therapeutic relationship in this context as well as

considerations on trauma, PTSD, and healing will be discussed.

Macro-Context: Healing the Soul[3] Across Cultures

Everything happens within a context. Therefore, in order to truly understand any

experience it must be viewed within the larger context (Corbin & Strauss, 2008). Context

includes *culture* which according to Cohen (2009) should be more broadly defined to

include differences in national origin, ethnic origin, religion (or lack thereof), Socio-

Economic Status (SES) level or social class, regional origin within a country and even

sexual preference or identity. According to Draguns, et al. (2004) human suffering and

methods to alleviate it are found in virtually all cultures across space and time. *Healing* as

a concept refers to the collection of varied techniques used to alleviate human suffering

by counteracting distress in the body, mind, and spirit (Draguns, et al. 2004). When it

comes to healing, each culture has a different view of its elements. For instance, diverse

cultures have different views and rationales for behaviours that are worthy of change, for

the activities or rituals that aid in this change, and for how the outcomes of change or

improvement are to be defined. Even cultures that appear to be alike may view a similar

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[3] The word soul was chosen because it points to a universal dimension of humanity. This is best expressed by Elkins (1995) "To know the soul, we must lay aside our rational ways of knowing and open ourselves to the world of reverence, feeling, and imagination-the world of I-Thou encounter, imagery, poetry, art, ritual, ceremony, and symbol. We meet the soul when we are stirred by a person or music, moved by a poem, struck by a painting, or touched by a ceremony or symbol. Soul is the empathic resonance that vibrates within us at such moments" (p. 83). This description of soul fits well in terms of addressing universal dimensions of pain, suffering, human connection, and healing. While the following sections strive to provide a culturally aware, unbiased perspective, most of the available research originates from a Western context. In many instances, even research developed in other countries is conducted by Western scholars (Rosenzweig, 1994; Summerfield, 2000). Thus the word "soul" used in this sub-title, which aims to convey the universal concept for healing, suffering, being emotionally moved, is not used throughout the document because "soul" is a term that is not used in Western scientific research.

undesirable situation quite differently, do different things to improve the situation, or

even do similar things but for very different reasons (Carpenter-Song, Chu, Drake,

Ritsema, Smith, & Alverson, 2010; Fish, 2004).

In many cases, therapy as defined by Canadian-American[4] standards may not be a

part of a client's cultural framework (Tribe, 2002, 2007). In fact, in many cultures, there

is no word for psychotherapy (Blackwell, 2005). Expressing pain through talking and

subsequent treatment through the exploration of inner conflicts and insight as healing

methods are fairly specific to Western societies and their conceptualization of the

individual (Bracken, Giller, & Summerfield, 1995). In other cultures, emotional

expression and healing may involve the use of dance, music, art, or other rituals such as

lighting candles or praying (Blackwell, 2005; Veer, 1998). These rituals may also include

the family and larger community (Tseng, 1999). Furthermore, in some cultures, mental

health issues are strongly stigmatized (Gorman, 2001; Tribe, 2002, 2007). For instance in

many Arabic cultures, mental illness is regarded as a failure of the family. In Arabic

cultures mental illness casts a negative light on the family as a group. Therefore seeking

treatment for mental issues is highly stigmatized and is only pursued as a last resort

(Meleis & LaFever, 1984). This is consistent with a hypothesis put forth by Tribe (1999)

who suggested that the high levels of somatisation among refugee clients may be related

to the clients' belief that physical pain is more acceptable than psychological pain. In

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[4] While there are many differences between Canadian and American health systems and policies, these countries constantly engage in comparisons with each other in this arena (Hussey, 2007). In general these countries have many similarities regarding their approaches to mental health care and share a concern regarding the mental health care and treatment of culturally diverse populations. Due to these similarities and because a lot of the research in the field of multicultural counselling comes from the United States the following discussion will refer to the Canadian-American context.

addition, the person may feel safer indicating a physical symptom than expressing pain, anguish, and fear.

The Therapist's Background: Contextualizing Psychotherapy in Canada

A first step in understanding MCC entails learning about psychotherapy in the Canadian-American context in which these competencies are applied. Thus, the historical, social, and political forces that have shaped psychotherapeutic practice and research in the last two decades need to be discussed. The importance of addressing context is reinforced by the discrepancy between what the research states regarding cultural sensitivity, such as adapting treatments and approaches for the individual clients, and the real-world practical demands resulting from financial and political pressure which call for treatment standardization and efficiency (Dana, 1998). Moreover, addressing context is important in order to provide thick description of the phenomenon at hand, which in turn strengthens this study's credibility (Lincoln & Guba, 2007). Practice demands and clients' needs in the field of mental health care seem to be going in opposite directions. For instance, a qualitative study investigating patient satisfaction with psychiatric care conducted by Johansson and Ecklund (2003) found that while practices are increasingly moving towards standardized, medical paradigms, patients seem to value the quality of the relationship and feeling understood by their therapist. This conflicting environment in which research calls for treatment individuation (Frank & Frank, 1991) but practice demands treatment standardization, is what psychology therapist-trainees, like the ones participating in this study, will eventually be faced with.

The influence of social, political, and economic forces on the practice of psychotherapy.

Discussing the influence of social, political, and economic forces is important for various reasons: (a) it sheds light on the mono-cultural view that permeates the field of psychology and psychological research in Canada and the U.S., (b) it helps understand the reasons why culturally diverse clients may be pathologized and/or misunderstood, and (c) it is part of providing thick description, which strengthens the credibility of this study. The socially constructed and contextual nature of psychological paradigms has been reflected by the revisions undergone in the Diagnostic and Statistical Manual of Mental Disorders (DSM)[5]. Consistent with the psychological framework of the time, in the original version, the DSM viewed pathology as an expression of neurotic conflict. Throughout subsequent revisions, however, it evolved toward a more biological perspective (Zur & Nordmarken, 2008). The current biological paradigm used in the understanding of mental illness has determined research, methodologies, training, interventions, treatment approaches, programs used and outcome measures assessing treatment success (Jennings, 1994). Psychology's evolution toward a biological paradigm may have been influenced by the fact that of the 170 panel members who contributed to the diagnostic criteria produced for the DSM-IV and DSM-IV-TR, 56% had one or more financial associations with pharmaceutical companies. Moreover, 100% of the members on the panels on "mood disorders" and "schizophrenia and other psychotic disorders" had financial ties to pharmaceutical companies (Cosgrove, Krimsky, Vijayaraghavan, & Schneider, 2006). These financial interests are noteworthy because despite contradictory

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[5] The DSM is the classification system of mental disorders used primarily in Canada and the United States.

evidence (Kirsch, Moore, Scoboria, & Nicholls, 2002) pharmacological interventions are part of standard treatments for both mood disorders (i.e., anxiety disorders, depression) and schizophrenia and other psychotic disorders (Cosgrove, et al., 2006). Other financial interests that shape the current psychological landscape are insurance companies' need for specificity in diagnoses and cost-effective treatments (Zur & Nordmarken, 2008).

As evidenced above, the DSM and the practice of psychology are inevitably linked to the social context and have been shaped by socio-political and economic forces. Bio-medical categories and diagnoses serve as criteria through which resources such as financial or professional support are allocated (Watters, 2001). The mechanisms for resource allocation are relevant to this study as they may place the clinician in a dilemma when it comes to working with refugees or other complex individuals (see Fensterheim & Raw, 1996). This dilemma is whether to frame refugee clients' issues following a more complex perspective emphasizing a range of social, political, and economic concerns, which may result in the denial of financial or professional support; or to view refugee clients as traumatized victims (thus pathologizing them) in order to enhance their claim for asylum and mobilize financial and professional supports (Ong, 1995; Watters, 2001). This is a dilemma therapist-trainees may face at various points during their work with refugee clients. For instance, when thinking about their case conceptualization or if they are required to write a report supporting the provision of social and financial supports for their clients, fitting the refugee clients' experiences to the dominant classification system may provide a more tangible benefit (i.e., attaining refugee status or permanent resident status); Although it may not be the best course of action in terms of the person's deep inner experience (Ong, 1995; Watters, 2001).

The influence of cultural aspects on the practice of psychotherapy in Canada.

While the emphasis on diagnosis, standardized treatments, and recovery is useful in treatment accountability and in advancing scientific knowledge, there is a high price to pay, namely the dehumanization of mental health care. Both visible minority clients (see Ortiz, 2001; pp. 19-20) and clients who are members of the dominant culture (see Jennings, 1994) pay the price of this dehumanization as they are viewed more as "diagnoses to be treated" than as people. Watters (2001) and Ong (1995) state that refugees are rarely given the chance to articulate their experiences and identify their priorities regarding service provision in their own terms. In general, refugees' experiences are made to fit into the biomedical illness categories (Good, 1993; Watters, 2001), resulting in the pathologizing and stigmatizing of refugee survivors' traumatic experiences (Watters, 2001).

This is not to say scientific advancement and the categorizing of mental illness is not beneficial. However, it is important to consider that these advancements have resulted from an environment of political stability and economic prosperity (lacking in many other countries) and are based on implicit notions of the person built on a Western value system and ontology (Bracken, Giller, & Summerfield, 1995; Kirmayer, 2007; Rosenzweig, 1994). In this context, the understanding of the person focuses on individualism. In this view, each individual has the right to pursue his or her private goals autonomously. Value is attributed to the development of a person's inner sense of self and how this sense of self is congruent with strong self-direction (Kirmayer, 2007). The Canadian-American emphasis on individualism stands in stark contrast to other cultures' collectivistic beliefs which value the self as embedded and connected to the larger community and, in some cases, to nature and to the spirit world (see Comas-Diaz, 2006; Kottler, Carlson, &

Keeney, 2004; Nussbaum, 2003). The discrepancy between collectivistic and individualistic worldviews is only one aspect of the differences therapist-trainees may encounter when working with their culturally diverse clients.

The Client's Background: Contextualizing the Refugee Experience

There are three main immigrant categories in Canada, namely, skilled worker or investor, family class or caregivers, and refugees (Citizenship and Immigration Canada, (CIC) 2013). The skilled worker category includes people who want to settle and work in Canada who are qualified in a skilled trade or who recently graduated from a Canadian University and/or have Canadian work experience. This category also includes investors, entrepreneurs, and self-employed people. The second immigrant category, family class or caregivers, is destined for family members and live-in caregivers of Canadian citizens or permanent residents. The third immigrant category, refugees, is reserved for people who fled their country of origin due to a well-founded fear of persecution (CIC, 2013). There are two sub-categories within the refugee category: asylum seekers and resettled refugees. Asylum seekers are people who fled their country of origin, arrived in Canada, and began their refugee claim from within the country. In contrast, resettled refugees are people who apply from outside Canada. These people are granted refugee status before arriving in Canada. Resettled refugees are typically in need of initial assistance in order to settle in their new country. Initial assistance is provided either by the federal government (Government Assisted Refugees, GARs), the province of Quebec, or private sponsors (CIC, 2012). In the present study, therapist-trainees provide therapy to GARs referred by the Multicultural Council of Windsor-Essex County (MCCWE). Unlike other immigrant categories, refugees can't go back to their country of origin for fear of persecution.

"There's no greater sorrow on earth than the loss of one's native land" - These words were said by Euripides in 431B.C. and are the words used by the United Nations High Commission on Refugees (UNHCR, 2008) to broadly describe the plight refugees face. As a group, refugees are heterogeneous and diverse. It is therefore not appropriate to make generalizations regarding their cultural backgrounds or coping mechanisms (Fabri, 2001; Tribe, 1999). However, there are many common challenges most refugees face. Some of these challenges originate from their past experiences (i.e., torture and trauma); other challenges stem from present situation (i.e., settling in the host country and becoming acculturated; Bemak & Chung, 2004; Summerfield, 2000; Watters, 2001).

Refugee clients' past experiences.

It is estimated that 5 – 35% of the world's refugees have undergone torture (Baker, Wuest, & Noerager-Stern, 1992). This number is difficult to ascertain because the victims are often reluctant to talk about their experiences due to diverse reasons such as fear of legal consequences, fear of retaliation on the part of their torturers, and fear of endangering family members who may still be in the country of origin (Baker, et al., 1992). Torture is defined as the deliberate and systematic infliction of physical or psychological pain and suffering by at least one person to another. At times, torture is inflicted by people in positions of power or even by the authorities (Center for Victims of Torture, 2005). An important component of torture is that the torturer has complete physical control of the victim (Nightingale, 1990). There are various means of torture and these may include: beatings, mutilations, asphyxiation, submersion, electric shock, rape, humiliation and threats, witnessing to the torture or murder of others, denial of food, medical care, or sanitary surroundings (Center for Victims of Torture, 2005). Survivors of torture may feel a sense of blame, shame, or guilt. They may not want to revisit these

feelings, especially if it entails talking to strange people in a foreign culture, such as is encouraged in the counselling context (Gorman, 2001). Moreover, when a person has survived torture, many of his or her symptoms (i.e., emotional numbing, hyper-vigilance, social withdrawal, grief) may have been useful ways of coping in previous life-threatening situations, but are maladaptive in the current place of resettlement (Gorman, 2001).

Refugee clients' present challenges.

Settling in a new country is a challenging endeavour for any newcomer. However, unlike other immigrants who emigrated on their own volition, planned the immigration for some time, and typically have financial and educational resources, refugees might have been forced to hastily leave their country and it is likely they don't have adequate financial resources (Beiser, 2005). Thus, settling in the host country is, frequently, a more daunting task for refugees. The initial years in the host country are crucial, and typically refugees are concerned with fulfilling their basic needs, such as finding employment and housing (Bemak & Chung, 2004). Current life stressors for refugees are related to becoming established in a new and different culture and may include: changes in socioeconomic status, psychological and practical adjustments, acculturation difficulties, loneliness, uncertainty about the future, fears of being sent back to their country of origin, racism, separation from their friends and family, threats to their family, poverty, stereotyping, marginalization, unemployment, low aspirations to succeed, and survivor's guilt (Beiser, 2005; Gonsalves, 1992; Miller, 1999; Pernice & Brooke, 1996; Roysircar, 2004; Silove, Steel, McGorry, & Mohan, 1998; Tribe, 2002). Current life stressors can be extremely distressing for refugees. It is not surprising that these populations are at increased risk for suffering from depression and anxiety (Pernice & Brooke, 1996). In

fact, many times it is due to these stressors, as opposed to pre-migration traumatic

experiences, that refugees decide to seek professional help (Beiser, 1999; Canadian task

force on mental health issues, 1988 Richman, 1998; Summerfield, 2000; Watters, 2001).

The Therapeutic Encounter: General Considerations

The idea of talking to a stranger about their difficulties may seem like an alien and

culturally discordant concept for refugee clients. Furthermore, many refugees may have

difficulty trusting other people, especially if they were tortured or forced into exile as a

result of their beliefs or backgrounds or if they were denounced by people they knew and

trusted (Fabri, 2001). As a result they may not see the world as a safe place (Gorman,

2001) and may be anxious about their personal information being revealed to a stranger

(Tribe, 2002). Summerfield (2000) suggests that another difficulty refugee clients may

face in building a relationship with the therapist is that the refugee client may view the

therapist as someone who has everything that he or she has lost, such as a place in

society, a voice, a family, status, and money (Summerfield, 2000). Thus, the process of

building the therapeutic alliance may be slow (Tribe, 2002, 2007).

Tribe (1999) suggests that although as a group, refugees may share similar

experiences, therapists need to be aware that each client is a unique individual with

distinct experiences, beliefs, and histories, and they might interpret and cope with life

events differently. The therapist trainee must understand that the client comes from a

different culture and may have different ways of describing, or even, experiencing

psychological symptoms. For instance, it is well-documented that people from some

Asian cultures tend to describe depression using bodily symptoms (Roysircar, 2004).

Working with refugee clients may be a daunting task for therapist-trainees in Canada due

to: difficulties with language, linguistic nuances, cultural differences in coping and

processing hardship, the refugees' potentially traumatizing past experiences, and the

challenges of acculturation. In addition, these factors interact with the fact that such

adverse life experiences are sometimes difficult to imagine for people raised in a country,

such as Canada, where peace has existed for more than a century (Constantine et al.,

2008; Minister of Public Works and Government Services Canada, 2009; Summerfield,

2000).

<div align="center">**Previous Research: Therapy, Healing, and MCC**</div>

Healing the Soul Across Cultures: Common Factors in Therapy and Healing

In part due to Western ethnocentric bias in research and partly due to the vast

number of healing practices around the world, detailing the specific modes of healing in

different cultures is beyond the scope of this study. However there are some common

factors in healing found cross-culturally. Several commonalities have been identified

when studying healing practices cross-culturally. For instance, these practices are usually

aimed at restoring physical and psychological well-being and attaining spiritual serenity

(Draguns, et al., 2004). Other commonalities are associated with the relationship between

the client and healer as well as their specific individual characteristics. These

commonalities include, sharing a common world view, the personal qualities of the

healer, the client's expectations and sense of mastery, the quality of the relationship

established by the healer and client, and a ritual or intervention designed to relieve the

client's distress (Fischer, Jome, & Atkinson, 1998; Torrey, 1986). Other commonalities

are associated with the healing process itself which include: a) the cultivation of hope, b)

encouragement of the client's revelation of his or her wishes, conflicts, or desires in a

safe, non-judgmental, and accepting environment, c) the activation of social supports, and

d) the encouragement of culturally accepted coping (Frank, 1961; Kleinman & Sung,

1979; Torrey, 1986; Tseng, 1999). An example of healing rituals that embody these

characteristics are the cult to the Zar and Ho'oponopono. The cult to the Zar is practiced

in Sudan, Ethiopia, Libya, Tunisia, Egypt, Arabia, and in some tribes of West Africa

(Grotberg, 1990). Zar ceremonies are mainly a female ritual and aim to restore balance

by allowing the afflicted woman to express hidden wishes and desires without facing

judgment (Tseng, 1999; Grotberg, 1990).   Another example of a healing ritual that

encourages self-disclosure, activates social supports, and leads to culturally sensitive

conflict resolution is the practice of Ho'oponopono in Hawaii (Tseng, 1999). This ritual

performed by a "Kahuna" (healer), aims to settle arguments, assuage hurt feelings, and

restore harmonious relationships within a family (Hurdle, 2002; Phillips, 2012).

When working with culturally diverse clients, therapists can create a culturally

sensitive "healing space". This healing space is consistent with allowing the client to

reveal wishes, desires, or conflicts in a non-judgmental, safe, and accepting environment.

This healing space aims to help the client in developing culturally sensitive courses of

action or coping patterns, helping the client access or create social supports, and most

importantly, instilling a sense of hope (Frank & Frank, 1991; Fulton, 2005; Tseng, 1999).

Healing the culturally diverse soul in the Canadian-American context.

It has been found that there is a strong association between the therapists'

multicultural competencies and their general competence and empathy as rated by clients

of diverse backgrounds (Roysircar, Gard, Hubbell, & Ortega, 2005). In particular, a

significant amount of variance in the clients' satisfaction with therapy has been found to

be explained by the therapist's general competence (Fuertes & Brobst, 2002). Hence,

having general counselling competencies is essential in order to develop Multicultural

Counselling Competencies (Fuertes, Bartolomeo, & Nichols, 2001; Sodowsky, Taffe,

Gutkin, & Wise, 1994). Therefore, in order to fully understand the development of

MCCs, it is necessary to first consider the general definition and goals of psychotherapy.

        In this study and in this context, psychotherapy will be defined as a system. This

system is made up of a therapist who ideally is non-judgmental, empathic, respectful,

warm, gives unconditional positive regard, and has the ability to inspire hope in the client

(Jennings et al., 2008; Rogers, 1961; Wampold, 2001). The system also includes a client

who is looking for relief, and the interpersonal relationship between client and therapist.

This relationship takes place in a semi-structured series of time-limited contacts, where

interventions are individualized for the client's particular difficulty and context. The

therapeutic relationship and interventions result in changes in the client's emotional state,

beliefs, attitudes, and behaviours, which in turn, may result in the amelioration of his or

her suffering (Frank & Frank, 1991; Wampold, 2001). Psychotherapy as a healing method

depends on using explicit talk about the client's thoughts, feelings, emotions, and

interpersonal relationships; it is through this self-reflection that healing takes place

(Kirmayer, 2007). The therapeutic process offers clients opportunities for catharsis,

opportunities for the learning and practicing of new behaviours, and provides clients' a

rationale for change. Treatment structures and strategies are characterized by the use of

techniques or rituals, the exploration of emotional issues and of the client's "inner world",

and an adherence to one or more psychotherapeutic theories by the therapist (Grencavage

& Norcross, 1990; Goldfried, 1980; Wampold, 2001). These factors are common in both

multicultural and mainstream therapy (Roysircar, 2009).

Multicultural Counselling Competencies (MCC)

        Regardless of the method and theoretical framework, all psychotherapies pursue

the common goals of creating conditions that are conducive to healing and growth

(Bateman et al., 2000). When working with culturally diverse clients it is fundamental that both the therapeutic approach and the changes that arise from therapy take into account and are congruent with the client's context, core values, beliefs, and goals– these qualities have been found to be important components of MCCs (Kirmayer, 2007; Mirsalimi, 2010; Roysircar & Gill, 2010). The main components of MCC include therapists' self-awareness, cultural awareness, knowledge, and skills (Roysircar, 2006). Therapists' self awareness and cultural awareness refer to the therapists' awareness of how his/her cultural background shapes his/her perceptions and worldview as well as the awareness of how this can influence the therapy process. Therapists cultural knowledge refers to the therapist's understanding of the client's worldview and attitudes as well as the therapists' cultural awareness and sensitivity to the contextual issues that might affect the client such as racism, acculturative stress, legal issues, and coping with minority status. Finally, MCC skills refer to the therapist's ability to be culturally responsive and to transform mainstream interventions into multi-culturally sensitive strategies, skills, and interactional proficiencies (Roysircar, 2006; Sodowsky, 1991).

MCCs are not only essential to understand multicultural clients but play a fundamental role in client outcome. For instance, a study of white therapist – black client dyads, found that therapists who had training in MCC demonstrated strong multicultural skills (Fuertes, Mueller, Chauhan, Walker, & Landany, 2002). These skills included being sensitive and direct when referring to issues pertaining to race, conveying a sense of openness, and showing acceptance of the historic effects of racism, while being aware of not overestimating these factors. In terms of the relationship, the therapists with higher MCC reported better rapport, increased intimacy, increased disclosure by the clients, and overall increased client participation. On the other hand, the lack of MCC negatively

impacts clients' therapy outcomes as well as therapeutic relationship. For instance, a

study by Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittain-Powell, et al. (2002)

showed that clients from the non-dominant group reported therapist's MCC as critical.

These clients limited the amount of material they discussed depending on their

perceptions of their counsellors' abilities and approaches. Various studies show that

culturally diverse clients, especially those coming from oppressed groups, often perceive

suggestions or advice given by therapists from the dominant group as dominant, hostile,

manipulative, and ill-intentioned (LaFromboise, 1992; Roysircar, 2006; Sodowsky,

1991). In contrast, Fuertes, et al. (2002) found that therapists who received multicultural

training identified positive client outcomes marked by appreciable gains for the clients

such as reduced depression, reduced anxiety, and a reduced number of panic attacks.

Training and practice in Multicultural Counselling Competencies.

Attention to culture as a variable in clinical practice and the recommendation to

include cultural diversity training in doctoral programs and through continuing education

workshops were first mentioned at the Vail Conference of 1973 (Korman, 1974). Since

1980, with the creation of the Board of Ethnic Minority Affairs (BEMA), the APA has

strived to promote scientific study of the influence of culture, race, and ethnicity on

individuals' behaviour as well as on clinical practice (APA, 2003). Since 1986, the

American Psychological Association (APA) incorporated multicultural education into its

accreditation requirements (Constantine, et al., 2008). While a consensus has been

reached regarding the importance of multicultural competence in psychological training,

guidance and direction on how to incorporate multicultural competence into training

programs is not yet clear. In addition, the specific components of the best multicultural

training practices are still unclear and understudied (Miville, et al., 2009). Hills and

Strozier (1992) reported that almost 90% of graduate programs in psychology offered at least one course in MCC. Across studies, therapists who had multicultural training through a workshop or a semester-long class reported higher levels of multicultural competence than those who did not receive multicultural training (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). Moreover, therapists who participated in multicultural education that was grounded within a theoretical framework reported higher MCC than therapists who participated in programs that were not grounded in theory (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006).

   Training models for MCC.

   There are a variety of training models for Multicultural Counselling Competency (MCC). While culturally sensitive practicum and supervision are emphasized, few training programs actually include them in the curriculum and the focus has typically been placed on didactic learning (Abreu, Chung, & Atkinson, 2000). The didactic training models of MCC include: the traditional approach, the workshop design, the separate course model, the interdisciplinary model, and the integrated program. The traditional approach assumes that no changes to the theory or interventions are needed when working with multicultural clients. The workshop model works under the same assumption, except trainees are encouraged to attend diversity workshops that are not part of the core curriculum. The separate course model includes one or two didactic courses that focus on issues relevant to working with minority populations such as clients' socio-political history, the role of culture in the development of the self, self-awareness of cultural biases, and counselling techniques suitable for different cultural groups. The interdisciplinary model encourages trainees to take courses that are relevant to multicultural understanding from disciplines such as sociology, anthropology, and

linguistics. Finally, the integrated program model integrates multiculturalism into the

entire coursework of a training program and is viewed as the ideal approach (Copeland,

1982; LaFromboise & Foster, 1992; Ridley, et al, 1994). According to Dickson and

Jepsen (2007) there are three instructional strategies for multicultural training: (a)

traditional strategies which include didactic lectures, reading and research assignments,

and objective impersonal discussion, (b) exposure strategies which include activities that

encourage contact with people from diverse backgrounds, and (c) participatory strategies

which include role-plays, counselling simulations, candid class discussions of reactions to

course assignments and activities, as well as the processing of resulting emotions. When

talking about experiential learning it is important to make a distinction between in-class

active learning strategies and immersion programs. In-class active learning strategies

include activities such as role-play and other simulation exercises (Arthur & Achenbach,

2002). In contrast, immersion programs encourage trainees to have real-life contact with

people from a cultural group different from their own (Canfield, Low, & Hovestadt,

2009). Both types of experiential learning share the goals of raising awareness of

multicultural issues, challenging trainees' personal frameworks about cultural diversity,

and helping trainees in their development of cultural empathy (Pope-Davis et al., 1997).

Regardless of the teaching method employed, the goals of MCC training are to increase

trainees' awareness, knowledge and skills (Roysircar, 2003).

Research shows that the three components of MCC (awareness, knowledge, and

skills) are not taught and learned equally. Trainees consistently show lower levels of

skills acquisition as compared to knowledge and awareness (D'andrea, Daniels, & Heck,

1991; Priester, et al., 2008; Smith & Ng, 2009). This discrepancy may be a result of the

emphasis training programs place on the acquisition of knowledge and awareness through

teaching focused on didactic learning. For instance, an analysis of 64 syllabi on

Multicultural Competency Training (MCT) revealed that across training programs the

most frequently used teaching strategies included: journal writing (56%), cultural self-

examination paper (42%), reaction paper to a book or film (35%), attend a cultural event

in which the trainee was a minority person (34%), class presentation on a specific cultural

group or issue (33%), interview a member of a different cultural group (31%; Priester, et

al., 2008). It is important to note that none of the above described approaches and

programs integrated actual therapeutic work with culturally diverse clients, as is done in

the clinical psychology training program on which the current study is based. The lack of

integration of actual therapeutic work with clients is echoed in research findings where

MCC skill development is not emphasized throughout graduate counselling training

programs (Priester, et al., 2008). One of the only exceptions is a study based on trainees'

experiences in a pre-doctoral internship program where trainees had the opportunity to

work with people who were culturally different from themselves. In this case, an increase

in MCC skills and knowledge was noted but there was no significant increase in trainees'

awareness (Manese, Wu, & Nepomuceno, 2001). The discrepancy between MCC

awareness and knowledge and skills was also evident in a study that surveyed therapists

with an average 20 years experience conducted by Downing-Hansen, et al. (2006). In this

study, 80% of the therapists surveyed rated the following as often or very often used: a)

show respect for clients' worldview; b) avoid idealizing racial/ethnic groups; c) take

responsibility for transcending their own negative racial/ethnic cultural conditioning; d)

evaluate when their assumptions values and biases were negatively impacting treatment;

e) establish rapport and convey empathy in racially/ethnically sensitive ways, f) recognize

stereotyping, prejudice, and discrimination on institutional and societal levels, and g)

consider the impact of race/ethnicity on psychological disorders. All these elements can

be considered to be in the realms of awareness and knowledge. However, 42% of the

therapists surveyed rarely or never implemented a professional development plan to

improve their multicultural competence, 39% rarely or never sought culture-specific case

consultation, and 27% rarely or never referred a client to a more culturally qualified

provider. In addition, the therapists surveyed did not take time to do any of the following

recommended activities: prepare cultural formulations, make culture-specific diagnoses,

use translators when a client was not proficient in English, integrate indigenous resources

into treatment, integrate relevant multicultural resources into treatment, actively seek

feedback on their multicultural competence, use racially/ethnically sensitive data-

gathering techniques, and negotiate appropriate languages for treatment. All these

activities can be considered to be in the skills dimension of MCC.

Some researchers hypothesize that therapist-trainees are not given enough time to

master counselling skills (May & Kahnweiler, 2000). While trainees are encouraged to

become familiar with the prescribed behaviours, they are not given enough time to

practice and develop genuine skills (May & Kahnweiler, 2000; see Anderson ACT*

theory, 1982). Previous research suggests that practice is fundamental for effective

learning of counselling skills (O'Toole, 1979; Roysircar & Gill, 2010). The importance of

practice and experience in skills acquisition has been echoed in the literature. For

instance, trainees in a didactic course indicated that working with culturally diverse

clients would be one of the most beneficial experiences in developing MCC (Tomlinson-

Clarke, 2000). In this same study, trainees mentioned that direct experience with

members of culturally diverse groups enrolled in the class was conducive to greater MCC.

Diaz-Lazaro and Cohen (2001) conducted a study where graduate students were

encouraged to identify a culturally different group in which to seek immersion experiences. Results suggest that cross-cultural contact is a significant factor in the development of MCC. While cross-cultural contact is valued, actual contact with culturally diverse clients is usually postponed until trainees reach internship because academic programs typically place more emphasis on the theoretical aspects of MCC than on skills acquisition through practice (see Speight, Thomas, Kennel, & Anderson, 1995).

Gaps in the Literature

The present study aims to address three main gaps in the literature. First, the lack of knowledge regarding the therapist-trainees' experiences in developing MCC (awareness, knowledge and skills) through providing therapy to clients from diverse cultures. Although previous research suggests that experientially based multicultural training is beneficial to therapist-trainees in acquiring MCC (Roysircar & Gill, 2010), thus far the experiential and developmental process of MCC has not yet been studied in the existing MCC training literature. It is therefore logical to further research and explore the process underlying the development of MCC in therapist-trainees through experiential means, such as through providing actual therapy to culturally diverse clients. Previous experiential research on the development of MCC has been based on trainees' experiences with culturally diverse people in a variety of settings but not in an actual therapeutic relationship (See Boyle, et al., 1999; Burnham, et al., 2009; Downing-Hansen, et al., 2006; Fuertes, et al., 2002; Knox, et al., 2003; VanderGast, et al., 2010). In addition, the research on MCC has been carried out mainly through quantitative, positivistic and post-positivistic approaches (Ponterotto, 2005). Until recently, previous research on the development of multicultural counselling skills has mainly focused on therapists' quantitative self-reports (Ponterotto, Rieger, Barrett, & Sparks, 1994;

Worthington, Soth-McNett, & Moreno, 2007). More recent studies have asked clients to rate their therapists' multicultural counselling skills (Fuertes & Brobst, 2002; Fuertes et al., 2006). However, the therapists' insights (taken from the therapists' point of view) throughout the experiential process of providing therapy to a client who is culturally different from themselves has not been qualitatively examined in detail in the current multicultural counselling literature. As a result, trainees' or clinicians' lived experiences are rarely documented.

This study aims to fill a second gap in the literature, namely the temporal aspects of the development of MCC in therapist-trainees. The few qualitative studies that use data obtained at various points in time analyse the data as a whole (see West-Olatunji, Goodman, Mehta, & Templeton, 2011). The temporal aspects of the analysis are not explicitly addressed. Examining temporal or session-to-session aspects of the trainees' development of MCC will address this second gap in the literature.

Finally, the third gap in the literature is presenting the therapist-trainees' experiences in a rich and meaningful way that will be useful for both novice and experienced clinicians. As noted above, in 2003 the APA developed a set of guidelines that set the basis for culturally sensitive education, training, research, and practice in psychology. Although these guidelines provide rich information and strategies on ways to strengthen psychologists' cultural sensitivity and competence, the authors recognize that this document is not exhaustive (APA, 2003). Specific practical considerations pertaining to the provision of therapy to culturally diverse populations are not within the scope of the APA's guidelines. Moreover, studies suggest that guidelines and codes are least influential on the development of MCC (Allison et al., 1994; Fensterheim & Raw, 1996). This is not to say APA guidelines lack value. However, the way they are presented is not

conducive to effective memorization, recall, and application (Mandler, 1984). A

potentially more effective medium for both clinicians and researchers to find relevance

and application of research findings is through therapists' lived experiences, their stories,

of providing therapy to culturally diverse clients. Previous research has shown that

stories are the primary mental model on which human beings structure, give meaning, and

understand experiences (Bruner, 2003; Crossley, 2000). In addition, people tend to

remember stories better than information delivered through any other means (Haven,

2007). Qualitative researcher Brene Brown (2010) explained how qualitative research, at

its core, is about collecting stories (in the form of interviews, journals, etc.). In fact, she

called these stories "data with a soul".

Objectives of the Study

This study aims to answer the research question: *"What are therapists-trainees'*

experiences regarding their Multicultural Counselling Competencies (MCC) while

providing therapy to first-generation, government assisted, refugee clients?" by

qualitatively analysing the therapist trainees' post therapy session critical incident

journals (CIJ)[6]. This will provide a rich description of the therapist-trainees'

developmental process in attaining MCC while providing therapy to culturally diverse,

first generation, refugee clients. In addition, this study aims to offer an innovative

approach to explicitly analyse the developmental processes inherent in the trainees' post

therapy session critical incident journals.

Consistent with the research question and aims, the present study has three main

objectives: first, it aims to explore and provide rich descriptions of the therapist-trainees'

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[6] Please refer to the "Inquiry Mechanisms" section in the Methodology chapter of this
document for more information on the Critical Incident Journal.

perceptions, experiences, and reflections whilst providing therapy to refugee clients. Once the first objective is fulfilled, such that themes are clearly identified, the descriptive model is stable, and saturation is reached, the second objective is to describe the therapist-trainees' developmental process in acquiring MCC. Finally, this study intends to describe the methodological procedure involved in analysing qualitative data while integrating change and process.

Significance and Implications of the Study

The present study intends to explore therapist-trainees' lived experiences and development of MCC while participating in a training practicum with refugee clients. In addition, by analysing the post-session Critical Incident Journals (CIJ), the present study aims to add to the body of knowledge on training and/or therapy practices grounded in the therapist-trainees' experiences while providing therapy to refugee clients. Using therapists' journals to further understand the therapists' subjective experiences in the provision of services to refugee clients will provide depth of information that is free from theory-driven quantitative measures and pre-conceptions. Documenting therapist-trainees' lived experiences will advance the understanding of their developmental learning process while working with first-generation, culturally diverse refugee clients. Further knowledge of therapist-trainees' perceptions and difficulties will help fine-tune the themes that are taught in MCC courses to better fit the trainees' actual experiences in providing therapy to culturally diverse clients. An implication for MCC training is that this new knowledge will provide a starting point for the advancement of evidence based training practices in the instruction of MCC.

Many experienced counsellors are part of a generation of professionals who didn't receive multicultural training (Ridley, Mendoza, & Kanitz, 1994). This study will be

significant for clinical practice, both for experienced clinicians and therapist-trainees.

Learning about therapists-trainees' experiences and struggles will shed light on elements

that even experienced therapists should be aware of when providing therapy to multi-

national, first-generation clients. Considering the power of stories to provide meaningful,

memorable learning, it is reasonable to anticipate that a qualitative exploration of

therapists' insights and experiences will enhance the perceived relevance and

memorability of MCC for practitioners.

Finally, the methodological significance of this study is that the analytical

strategies applied to explore the developmental aspects of the therapists' experiences will

be useful to other investigators doing similar process research.

Micro-context

Practicum and Training at the University of Windsor

Previous research has found that courses that emphasize knowledge of other

cultures and self-awareness do not necessarily translate into culturally competent skills

(Priester et al., 2008). The clinical training program at the University of Windsor uses the

three strategies proposed by Dickson and Jepsen (2007) in combination. In the didactic

Multicultural Issues in Clinical Practice class which all students take in their second year

in the program, class lectures and reading assignments are combined with open class

discussions and processing of emotions through critical incident journal writings. In their

fourth or fifth year, some of these students, typically those in the Adult Clinical Track of

the clinical program, participate in a practicum offered at the Psychological Services and

Research Centre within the university.

These therapist-trainees learn MCC through experiential means as they have the

opportunity to work directly with refugee clients. Research suggests that practicum

training allows trainees to develop competence in case conceptualization and interpersonal interactions relevant for psychotherapy such as systematic behavioural observation, interviewing, psychotherapy, research application skills, psychological assessment skills, inter-professional collaborations, inclusion of individual and cultural differences, ethics, development of leadership skills, and supervision skills (Galassi & Brooks, 1992; Hatcher & Lassiter, 2007). Another important component of the practicum experience is supervision by a trained and well-qualified supervisor (Hatcher & Lassiter, 2007). The importance of such a program is highlighted in a study by Dickson & Jepsen (2007), which found that students who perceived higher levels of integration of multicultural issues throughout the curriculum and in supervision also reported higher levels in their self-perceived multicultural competence. Other studies have found a positive relationship between therapists' self-perceived multicultural competence and clients' ratings of therapist expertness, attractiveness, trustworthiness, empathy, and working alliance (Constantine, 2002; Fuertes, et al., 2006). Dickson and Jepsen (2007) also found that practicum experiences with clients from diverse backgrounds provide opportunities for students to increase their awareness and confidence when working with multicultural issues. The implication is that learning MCC through diverse multicultural training experiences can increase students' self-perceived multicultural competencies and their ability to work with culturally diverse clients (Burnham, et al., 2009).

The Multicultural Counselling and Psychotherapy Practicum with Refugees course was established and began in the Fall of 2007 at the University of Windsor. It is a two-semester long, in-house training that begins with a 7-week didactic component on clinical and cultural issues related to refugees. This is followed by 17-20 weeks of individual counselling conducted by the trainees with refugee clients referred by the

Multicultural Council of Windsor Essex (MCCWE). When needed, language interpretation for counselling is provided by professionally trained interpreters or language aids. Language interpretation services are arranged and paid for by the referring agency, the MCCWE. This therapy practicum course includes weekly group supervision that involves reviewing trainees' videotaped therapy sessions. The therapist-trainees use a variety of therapeutic interventions in working with their refugee clients. Allowing the therapist-trainees to adopt flexible counselling interventions is congruent with previous research which suggests a strong therapeutic relationship is a more important predictor of positive client outcome than the theoretical modality of therapy interventions chosen (Wampold et al., 1997).

Research setting.

This study takes place at the Psychological Services and Research Centre (PSRC) at the University of Windsor. Therapist-trainees provide weekly 1.5 hours long therapy to the refugee clients, in most cases with the aid of a qualified language interpreter. The trainees' therapy sessions and interactions with their clients are supervised by Dr. Ben Kuo, who is an instructor and an active researcher in the field of multicultural counselling and cross cultural psychology. Outside of this multicultural practicum, but within the larger Psychological Services and Research Practicum, the therapist-trainees also provide therapy for non-refugee clients referred from the Student Counselling Centre (SCC) at the University of Windsor. Supervision with an integrative psychotherapy framework is provided for the therapist-trainees in their work with clients referred from the SCC.

The Clients: Government Assisted Refugees

While the refugee clients' data will not be directly used in the present study, they are an integral part of the project. It is these clients and the therapy experience they

provide in working with their therapists that makes this study possible. The clients are

Government Assisted Refugees (GARs) referred by the Multicultural Council of Windsor

Essex County (MCCWE). These clients receive regular, weekly therapy from the

therapist-trainees. The total number of GARs that arrived in Windsor, Ontario during

2009 was 306. The main five countries of origin of GARs were Somalia (30%),

Democratic Republic of Congo (18%), Iraq (12%), Myanmar (10%), and Ethiopia (9%).

GARs face a number of challenges in seeking out community services, including

language barriers, different cultural perceptions, service barriers, and financial

difficulties. The multicultural council has identified that emotional and mental health

needs are among the most pressing concerns for GARs (Multicultural Council of

Windsor-Essex County, 2011). The variability in client attrition and in the number of

clients per therapist is an asset for the present study. This variability allows for temporal

differences to be attributed to therapists' experience and training as opposed to the on-

going therapy process with only one client. Refugee clients seen by the therapist-trainees

come from different cultural and national backgrounds. However, they all have in

common their status as GARs, being first generation in Canada, and being cared for and

served by the MCCWE, the referral agency. The MCCWE is a non-profit organization

that has been serving the community, especially immigrants and refugees since 1973. The

MCCWE helps community members gain access to services and it aids newcomers in

settlement and adaptation in Canada. In addition, the MCCWE provides support to

newcomers in their acculturation process, helping them to find employment and to access

second language training. The MCCWE refers GARs for therapy at the Psychological

Services and Research Centre (PSRC) at the University of Windsor. Refugee clients

referred for treatment face diverse issues, including previous untreated chronic health

issues, physical and emotional traumas, PTSD, depression, marital conflicts, parent-child conflicts, adjustment difficulties in Canada, etc. At times, GARs are illiterate in their own native language, which makes learning English and accessing job opportunities more difficult. In addition GARs face acculturative stress and cultural adjustment difficulties. Due to all of these factors, this population is deeply in need of culturally sensitive psychological services provided by the current practicum.

Context of the Therapeutic Encounter at the PSRC Multicultural Practicum

MCC: moving beyond therapeutic techniques.

This study's primary focus is studying the development of MCC in therapist-trainees while working with refugee clients. Thus, in the present investigation, the therapist-trainees will engage in an integrative psychotherapy[7] approach in their work with clients. This is consistent with this study's focus on the actual development of MCCs and not on the proven effectiveness of any particular therapeutic approach. Therapists' application of an integrative psychotherapy approach is also consistent with the current state of research regarding the compared effectiveness of different psychotherapeutic techniques. Research has shown that therapy is generally effective (Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold, 2001). However, the exact mechanisms through which therapy works and any significant differences between therapeutic approaches are yet to be determined (Germer, Siegel, & Fulton, 2005; Luborsky et. al., 1975; Smith et al., 1980; Wampold, 2001; Wampold, et al., 1997). Reynolds (1983) explained: "the client is probably more in need of "being with" than in "being done to", more in need of

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[7] Integrative psychotherapy approaches incorporate aspects of several therapeutic orientations with the ultimate aim of making psychotherapy more effective (Castonguay, Reid, Halperin, & Goldfried, 2003

sharing than receiving, more in need of telling their life stories to truly listening ears, than themselves listening to our sage, but perhaps uninformed advice." (p. 2).

Chapter III. Methodology

The present study focused on the practicum experience of therapist-trainees in a multicultural practicum course. This study entails performing a secondary data analysis using data obtained as part of a larger research project. The larger project, led by Dr. Ben Kuo, examined quantitative pre-post differences in therapist-trainees' Multicultural Counseling Competencies (MCC) and the quantitative differences between a purely didactic course and a practicum course. It is noteworthy that I have closely collaborated with Dr. Kuo, in the development of the larger project, participating in the selection of measures, research design, the application for the Research Ethics Board (REB) approval (I am listed as the Co-Investigator), and the data collection process, which began in Fall 2010. I continue to be involved in the collection and management of the data, including the aspects of the larger project that will not be part of the current study. However, in the following section only the procedures relevant to this dissertation will be described. This chapter is divided in three main sections. The first section describes the research design and rationale. The second section explains the procedures followed to establish trustworthiness. Finally, the third section describes the methodological procedures including a description of the participants and the inquiry mechanisms used.

Research Design and Rationale

Overview of the research design.

As mentioned above, this study consists of a secondary data analysis of 14 therapists' post-session Critical Incident Journals (CIJ). This study spans over three academic school years for three cohorts of therapist-trainees participating in the

Multicultural Practicum at the Psychological Services and Research Centre (PSRC).

During the course, the therapist-trainees spend the first seven weeks learning about

clinical and cultural issues related to working with refugee clients in therapy. The actual

data collection, in the form of weekly post-therapy session CIJ, takes place for a period of

about 5-6 months (or 17-20 weeks) for each cohort. In this study, after each session with

their client, the participating therapist-trainees complete a CIJ. Journal entries are

numbered consecutively regardless of client changes (i.e., when a client decides to

terminate their therapy, therapists usually start working with another client).

Rationale for the research design.

As a group, the therapist-trainees share the same training environment[8]. This

shared learning and therapy background ensures that the participants in the study have

similar clinical training experiences before and during this multicultural practicum. While

working with refugee clients and non-refugee clients at the same time under different

modes of supervision will likely influence therapist-trainees' learning with the respective

groups of clients, the experience of working with diverse client populations may have

several advantages. The first advantage is that trainees' reflections will be based on a

range of experiences, which will allow them to provide more in-depth and insightful

feedback. This will help explore in depth issues pertaining to the relevance of

Multicultural Counselling Competencies, which has been debated (see Patterson, 2004).

The second advantage is that working with a variety of clients from different backgrounds

more closely resembles the type of environment these trainees will likely have in their

future practice. In real-life clinical practice they will likely be working with clients from

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[8] The training environment at the PSRC and the client characteristics are described in the
"Micro-context" section of this document (p. 29).

many different backgrounds. Thus, this setting provides a more realistic environment for the therapist-trainees. The third advantage is that the therapists are trained in an integrative therapy approach in order to work with both refugee clients and non-refugee clients. The relevance of trainees using an integrative framework can be linked to previous research which shows that effective counselling is not only a matter of knowledge, practice, skills and techniques (Wampold et al., 1997). Various researchers state that the therapist's abilities to show caring and concern for the client and to build a good therapeutic relationship are fundamental components of effective counselling (see Patterson, 2004). The freedom to use diverse therapeutic approaches may allow trainees to focus more on their actual process and experiences with the clients rather than on the application of specific therapeutic orientations or techniques. Thus, when asked to complete their CIJ after each session, the therapist-trainees' journals may provide a more accurate reflection of their experiences with their refugee clients rather than recalling the implementation of particular therapy techniques or skills. In completing the CIJ the therapist-trainees are asked to focus on their experiences with their refugee clients. As such, their journals are expected to be a more accurate reflection of their experience treating their refugee clients and not of their general therapy experiences.

Rationale for the use of Critical Incident Journals.

The present research study uses the CIJ to collect qualitative data from the participants. Critical Incident Journals have been useful as a research tool across various disciplines and studies (Butterfield, Borgen, Amundson, & Maglio, 2005). The CIJ focuses on observable behaviours, situations, or encounters that occur in a naturalistic setting (Collins & Pieterse, 2007; Roysircar, 2003). Critical Incident Journals have two components: the first is the involvement of an observable real life situation and the

second is the involvement of a reflective examination of said situation (Collins &

Pieterse, 2007). Focusing on actual incidents encourages participants to ground their

responses and perceptions on the actual events transpired during the session. In addition,

concentrating on specific incidents may facilitate research participants' recall as well as

aid participants in identifying their affective, cognitive, and behavioural reactions to the

event in depth and in detail (Butterfield et al., 2005; Collins & Pieterse, 2007). Focusing

on therapist-trainees actions may lead to further understanding of the multiple meanings

behind these actions. These "layers of meaning" could include: explanations,

assumptions, and intentions for their actions, as well as statements about the effects or

consequences of these actions (Charmaz, 1995). The CIJ technique encourages reflective

learning because it involves personal experience, reflection, and transformation of

knowledge and meaning (Collins & Pieterse, 2007).

Critical Incident Journals have been used previously in MCC research. Collins and

Pieterse (2007) suggest that keeping a CIJ increases therapist-trainees' attention,

understanding, and insight into how race and culture influence counselling and

supervision. Self-awareness and self-reflection have been postulated as integral

components of MCC (Coleman, 2006). Self-reflection can further the therapist-trainees'

awareness and knowledge of their own race or culture of origin (Roysircar, 2003). Which

in turn may aid therapist trainees to understand and become sensitive to the client's

culture and worldview (Neville, Heppner, Louie, Thompson, 1996). Some authors have

strived to raise therapist-trainees' awareness through self-reflection by encouraging their

students to write CIJ (Roysircar, 2003). In a cross sectional study, Coleman (2006) used

a CIJ at the end of a multicultural counselling training course and asked therapist-trainees

to describe one incident they believed influenced their development of MCC. The trainees

were able to choose any of their training experiences (course work, practicum, supervision, etc.) in order to write this journal. The trainees' responses were analyzed using cluster analysis and the results showed that trainees especially valued having the opportunity to interact and build relationships with peers from diverse racial and ethnic backgrounds. This finding, namely valuing the interaction with others from diverse cultures, is consistent with the activity of interest in this study – providing therapy to culturally diverse refugee clients.

The present study's research design requires therapist-trainees to complete a CIJ after each session with their refugee clients. The importance of this activity resides in the fact that completing a CIJ after each session reflects the therapists' immediate experience and captures the reflective process involved in providing therapy to the refugee client. In contrast to an interview conducted at the end of the practicum in which therapist-trainees provide retrospective reflections, these journals are completed as the therapists are immersed in the experience and may better reflect their developmental process. The value of this data collection method is that it will document process and change in the development of MCC in the trainees. Completing CIJ after each session with their client also allows for the therapist-trainees' insights and reflections to be free of potential influences that could arise as a result of the dialogic interaction inherent in semi-structured interviews (Ponterotto, 2005). While in qualitative inquiry this influence is not typically considered a problem, I wanted to ensure that the therapist-trainees' process was not unduly influenced by me (a first generation immigrant who may have a lot in common both with the therapist-trainees and with the refugee clients).

Rationale for the sampling strategy.

The sampling strategy was a convenience sample of 14 trainees enrolled in the Multicultural Practicum with Refugees at the PSRC in the University of Windsor (Kemper, Stringfield, & Teddlie, 2003). These 14 therapist-trainees were enrolled in the Multicultural Counselling and Psychotherapy Practicum with Refugees (02-46-715) course over a three-year period, from 2010-2011, 2011-2012, and 2012-2013 academic years. This study spanned over a three-year period because only 4 to 5 students are allowed to enroll in this course per year. These trainees are providing therapy to refugee clients. Therapist-trainees have between 6 and 19 journal entries for an average of 9 completed Critical Incident Journal (CIJ) entries each. Therapist-trainees submitted a total of 165 CIJ entries. It is important to note that in contrast to quantitative research, which requires a large sample to strengthen validity, qualitative research attains its credibility and trustworthiness from in-depth description, participant feedback, and researcher reflexivity. A qualitative analysis is concluded once saturation is reached. Saturation is attained when further analysis of the data shows that no new categories or properties emerge. Saturation can be recognized because the analysis is stable, the categories are reasonably well-developed and their properties, dimensions, and variations are identified (Creswell, et al., 2007; Corbin & Strauss, 2008; Rennie, et al., 2006). Some authors suggest that saturation is typically reached after analysing 6 to 10 protocols (Rennie, et al., 1988; 2006). However, in this case in order to capture the therapist-trainees' experiences more fully the totality of the sample will be included in the analysis.

Rationale for the analytic approach.

There are a variety of qualitative analytic approaches that can be used in health research and psychology research. These include phenomenology, discourse analysis,

grounded theory, narrative research, case studies, and participatory action research,

among others (Creswell, Hanson, Clark, & Morales, 2007; Hill, Knox, Thompson, Nutt

Williams, & Hess, 2005; Starks & Trinidad, 2007). The appropriate choice of an analytic

approach is fundamental for qualitative research because it has to be congruent with the

research question, the researcher's philosophical position, and the study's target audience

in order to ensure that the results will be useful and well received in the field (Starks &

Trinidad, 2007).

In the present investigation, the objectives of the research and this researcher's

philosophical position calls for an analytic approach located midway between

phenomenology and grounded theory. The first objective (describing the participant's

experiences) is consistent with phenomenology while the second and third objectives (to

describe process and change) are more in line with Grounded Theory Methods (GTM). In

searching for a method that could provide a foundation on which to base this study, the

most appropriate data analysis method was Rennie's adaptation of GTM. Dr. David L.

Rennie is recently deceased, but was a full-time academic at York University in Ontario,

Canada, and had practiced qualitative research in the field of psychology for about 30

years (Rennie, 1996). This data analysis method that has been well-articulated in terms of

its philosophical stance, its procedures, and has shown promise in previous research[9].

Consistent with the descriptive goal of this study, Rennie & Fergus (2006) stated that an

alternative goal of Rennie's adaptation of GTM is to develop a grounded understanding

of the phenomenon at hand.

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[9] A description of the method can be found on p. 51 in the section entitled "Analytical
Strategy", in addition, a more in depth description of the analytical procedure planned for
the current study can be found in Appendix C.

Establishing Trustworthiness

The most common standards for establishing trustworthiness in qualitative research have been delineated by Guba and Lincoln (1989; 1994; 2007). There are some common criteria for ensuring trustworthiness across qualitative methodologies. However, it is important to note that the specific means of establishing trustworthiness vary depending on the project. The means for establishing trustworthiness and rigour are closely tied to the philosophical framework under which the particular investigation is being conducted (Morrow, 2005). Thus, it is important to adapt the procedures aimed at establishing trustworthiness to the specific project. In the following section I will detail the specific procedures I implemented in order to ensure rigour and trustworthiness. I was guided by five general interconnected criteria suggested by Guba and Lincoln (1989; 1994; 2007): credibility, confirmability, dependability, transferability, and authenticity.

     Credibility.

Originally, the credibility criterion was developed as a parallel to the post-positivistic paradigm's internal validity criterion (Lincoln & Guba, 2007). The credibility criterion aims to ensure that the phenomenon under study is being presented accurately, that the findings are congruent with reality (Shelton, 2004). Consistent with Shelton's (2004), Morrow's (2005), and Lincoln and Guba's (2007) suggestions, several techniques that aim to strengthen the credibility of this study were implemented. Choosing a well-established research and analytical method strengthens credibility. Thus, I adopted Dr. David L. Rennie's well-established and well-articulated analytical method, which is consistent with the philosophical stance, objectives, and framework of the current study. Ensuring the researcher is familiar and immersed within the context of the organization where the investigation takes place also strengthens credibility. In this case I am very

familiar with the context of the study because, like the therapist-trainees, I am also a

student at the University of Windsor psychology program. My familiarity with the

Psychological Services and Research Centre (PSRC) where the study was conducted

increased after I finished analyzing the data because, like the therapist-trainees, I

participated in the Practicum Training with Refugees. Thus, when writing the results I

had a more in-depth, felt sense of the therapist-trainees' context and experiences as they

completed their Critical Incident Journals (CIJ). A third technique employed to establish

credibility was negative case analysis. Common themes emerge from the data and portray

perceptions and experiences shared the participants. Negative cases pertain to

participants' perceptions or experiences that differ from the more commonly shared views

(Morrow, 2005) or expectations of the researcher (K. Calderwood, personal

communication, June 17, 2014). Negative cases add richness and depth to the analysis

and aid in accounting for all experiences involved in a phenomenon. Credibility is also

established by providing thick descriptions of the phenomenon under study. This was

accomplished by thoroughly describing the therapist-trainees' micro and macro contexts

and by providing excerpts from the CIJ, which illustrated the therapist-trainees'

experiences and further described the categories that emerged. A fifth technique

employed to ensure credibility was peer debriefing. This project went through several

instances of peer debriefing. The first peer debriefing took place during a lab meeting

within my research lab. This meeting was about two hours long. I presented my findings

to Dr. Kuo and five research lab members. They provided thoughtful comments, mostly

talking about how the findings resonated with them. The second thorough peer debriefing

took place with Dr. Kimberly Calderwood who specializes in qualitative research. This

meeting lasted almost four hours. Dr. Calderwood helped me reflect on the findings, this

led to a deeper understanding and to linking the original categories with each other in a more cohesive manner through another analytical iteration. After this meeting Dr. Calderwood and I met a couple of times for in-depth discussions, debate, and clarification of the findings. Finally, throughout the process I discussed my findings with my peers who have experience with qualitative research. Their feedback and questions also helped me attain more clarity and reflect on my findings[10]. In addition to outside scrutiny via peer debriefing, I also engaged in "internal scrutiny" through reflexivity. Reflexivity involves the researcher engaging in introspection and deepening awareness regarding his or her insights into the data as well as into any biases or expectations he or she may have. Additionally, throughout the process I recorded my own reflections and I strived to remain aware of my own biases and expectations in order to keep the results from being unduly influenced. In addition I explicitly set forth my own background, qualifications, and experiences in a cultural review before I began the analysis to ensure I was aware of where and how my background influenced my analysis[11]. Additionally, I reviewed previous research findings and related them to my project's results.

   Confirmability.

Lincoln and Guba (2007) liken the confirmability criterion to "objectivity" or "neutrality" in post-positivistic frameworks. It is important to note that all research, both quantitative and qualitative, is susceptible to researcher bias (Morrow, 2005). The confirmability criterion aims to ensure that the findings presented truly reflect the experiences and ideas of the participants (Shenton, 2004). The issue of confirmability is approached and managed differently depending on the underlying research paradigm. The

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[10] See Appendix E for more details about the issues discussed during those meetings.
[11] This document can be provided upon request.

present study embraces a constructivist paradigm. Thus, in this study the researcher is viewed as a co-constructor of meaning and integral to the interpretation of the data. As such, making my assumptions, previous experiences and biases explicit (through my cultural review) strengthened confirmability (Morrow, 2005). This increased awareness of my own position as a researcher was accomplished in several ways including memo-writing, reflexivity,[12] and peer debriefing (described above). Moreover, during the peer-debriefings with Dr. Calderwood my assumptions and preconceptions were challenged, this increased my awareness of my own position as a researcher and further strengthened this study's credibility.

Dependability.

The dependability criterion is analog to the criterion of reliability in post-positivistic frameworks (Lincoln & Guba, 2007). Detailing the research process so that future researchers can repeat the work strengthens dependability. It is important to note that within constructivist paradigms data, results and interpretations are contextually driven, such that knowledge is constructed differently depending on the context. Thus, even if the investigation is reproduced it doesn't mean the results will be the same. Two trustworthy investigations may offer inconsistent results (Morrow, 2005). Inconsistencies can be explained by acknowledging that varying results may just reflect different realities and that deeper understandings can be gained by exploring the reasons behind the variations in the results (Shenton, 2004). Thus, different findings can enhance and deepen previous findings. In the present project, dependability was strengthened by: thoroughly describing the research process (including a thick description of the participants), maintaining theoretical memos, and engaging in reflexivity throughout the process.

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[12] See Appendix C for a detailed description of the analytical procedure.

Transferability.

The transferability criterion is somewhat parallel to the criterion of generalizability in post-positivistic frameworks (Lincoln & Guba, 2007). Transferability is not about the author/researcher telling the reader that the findings can be generalized to the readers' context. Rather, the author provides sufficient information that allows the readers to make their own judgment about whether the findings are related to and can be applied to their own situations and experiences (Calderwood, personal communication, June 17, 2014; Shenton, 2004). In order to ensure transferability, I provide rich descriptions of the therapist-trainees' experiences that include contextual information on the research setting, the data collection methods, the time periods over which data was collected, and of the therapists' experiences as described by them in their CIJ.

Authenticity.

Lincoln and Guba (2007) developed the criterion of authenticity as a unique criterion for qualitative research. This criterion refers to the research's potential to foster change or to be of use in relation to the phenomenon under study. Aiming to ensure balance or fairness in describing the participants' perspectives, such that differing experiences and interpretations are given equal chance of expression, strengthens authenticity. I believe my own cultural and professional background is beneficial to ensuring that differing experiences are considered equally. The reason for my background being an asset resides in my wider worldview, which encompasses professional experiences and training in both Mexico and Canada. Thus, my interpretations are not limited to the Canadian framework and may shed light on different issues that mono-cultural investigators may not be aware of. Authenticity is also strengthened when the research has the potential to initiate action or change for the participants or phenomenon under investigation (Lincoln & Guba,

2007). In other words, the value of the research lies in its eventual use (Nutt-Williams & Morrow, 2008). Thus, the ultimate test for this criterion will happen in the future, as the results of the analysis can be used to by future therapist-trainees and even clinicians working with refugees to help them in better understanding their experiences and even to better help their clients. Due to my own experience in participating in the Multicultural Practicum with Refugees, I believe in the present project's potential to inform practice and change the way we deliver services. I was able to complete the analysis of the results before starting the Multicultural Practicum. Then, once I started working with refugee clients, I discovered that having immersed myself in the therapist-trainees' experiences was undoubtedly the best preparation to work effectively with my refugee clients.

Procedure

Description of the participants.

The population of this study is comprised of 14 therapist-trainees who were doctoral students in the Adult Clinical Psychology program at the University of Windsor. Thirteen of the fourteen participants were female and there was only one male. In terms of their general ethnic background, 11 trainees were racially White and 3 trainees were of East Asian descent. All trainees were raised in Canada. Most trainees in this study had been in Canada for more than two generations. One trainee can be described as belonging to generation one-and-a-half (see Boyd & Vickers, 2000), as she immigrated when she was three years old. One trainee can be described as first-generation immigrant as she arrived to the country as a young adult. These two trainees are from eastern European countries. Regarding languages spoken, four therapist-trainees only speak English, eight therapist-trainees are bilingual, one is trilingual and another one speaks four languages. An important component in the development of cultural sensitivity pertains to the

therapists' contact with people from diverse backgrounds (Tomlinson-Clarke & Clarke, 2010). The therapist-trainees in this study had several experiences, which exposed them to people from diverse cultural backgrounds. For instance, in the past, six therapists had the opportunity of living abroad for more than a month. Ten therapists reported growing up in neighbourhoods where their neighbours came from diverse cultural backgrounds. Most of the therapists also shared close friendships with people from diverse cultural backgrounds. Only one therapist reported having exclusively White/Caucasian friends. In terms of romantic relationships, most of the therapists had only dated White/Caucasian partners. Regarding previous experience providing therapy to culturally diverse clients, a couple of therapists indicated they had never worked with clients from different cultures, five therapists had worked with one to five culturally diverse clients, four therapists reported working with six to ten culturally diverse clients, and three therapists indicated they worked with 20-35 culturally diverse clients. While these numbers appear to suggest wide variability in therapists' levels of experience, it is important to interpret these numbers cautiously. The definition of culture can be narrow (i.e., considering only country of origin) or broad (i.e., considering other characteristics such as religion, sexual preference, age, etc.) (Cohen, 2009). The demographic questionnaire failed to specify a definition of culture. Thus, therapist-trainees could have been answering this question using different definitions, which could influence the number of cases considered to be "multicultural".

Inquiry mechanisms.

Critical incident journal (CIJ).

In the present research study, the therapist-trainees were asked to think about critical incidents following each therapy session with their refugee clients. Their

reflections were guided by the following four questions: *(a) What has been the most critical or impactful event for you in this week's session with your client? Please clearly describe the nature of the incident/ experience; (b) How would you describe your cognitive, affective, behavioural, and interpersonal reactions to this incident/experience?; (c) In what ways might this incident or experience have affected you in terms of your cultural awareness, knowledge, skills, and relationship with your client?; and (d) How has this incident/experience prompted you in making changes or adjustment in yourself and/or in your counselling work with the client in subsequent sessions?*

Demographic questionnaire for therapist-trainees.

The demographic questionnaire for the therapist-trainees includes information on age, gender, current year in the program, racial/ethnic background, the degree of importance they place in their racial or ethnic background, country of birth, mother tongue and languages spoken, experiences abroad, cultural and ethnic composition of their neighbourhood, cultural and ethnic composition of their close friendships and romantic relationships, their parents' occupation, level of education, and income, past coursework or workshops dealing with multicultural issues, past experience with multicultural clients, and their engagement in mindfulness- promoting activities such as meditation, Tai-chi, yoga, etc. (see Demographic Questionnaire in Appendix B).

Data collection.

The present study entailed the analysis of the therapists' Critical Incident Journals (CIJ). The data collection for this part of the study took place at the beginning of each of the three practicum courses (Fall 2010, Fall 2011, Fall 2012). At that time, all the participants were instructed to read and sign an information letter and a consent form (see

Appendix A). They were reminded that declining to participate in the study would not

affect their grades. It is important to note that as a part of the course, therapist-trainees

were required to complete CIJ after each session with their clients. These journals were

part of their self-reflective process, but were not graded for the content. In consenting to

participate in this study the only additional step the therapist-trainees had to take was to

send their journals via email to an email established specifically for research purposes

(multiculturalstudy@uwindsor.ca). In order to maintain the therapist-trainees' anonymity,

an independent research assistant gave their journal entries a research ID code. Thus, this

investigator was blind to the identity of the respondents. Anonymity from the researcher

is not typically possible or even desirable in qualitative research (e.g., in-person

interviews). In this case, however, anonymity was important because in the original

Research Ethics Board (REB) approval the participants were assured a research assistant

would code their journal entries. As a result I am blind to the participants' identities. It is

important to remember that the larger original study was designed using a post-

positivistic framework in which anonymity from the researcher was considered important.

The present dissertation does not share this post-positivistic framework. However, the

first part of this dissertation entails a secondary analysis of the data obtained from the

larger original study and as such is limited to the original conditions set forth on the REB

approval.

Analytical strategy.

Rennie's (2006) adaptation of Grounded Theory Method (GTM) is more in line

with the method originally proposed by Glaser and Strauss in 1967 as well as with

Glaser's later views. Rennie's (2006) adaptation of GTM doesn't incorporate a

conditional matrix or coding paradigm. These developments are not included in Rennie's

method due to various reasons, the first reason being that Rennie's method was developed

before Strauss departed from the original method. The second reason is because Rennie

believes that the adaptations developed by Strauss and Corbin undermined the inductive,

discovery focused approach of the method and may prematurely force the data into

categories, hence, risking premature closure of the analysis and limiting the

understanding of the phenomenon under study (Rennie, 2006).

Additionally, Rennie (2006) modified the traditional constant comparative method

typically used in GTM (Corbin & Strauss, 2008). Rennie (2006) and his team eliminated

the distinction between codes and categories. Following Rennie's method, the first step

was to read the document carefully. Then instead of line-by-line coding, and similar to the

phenomenological approach to analysis proposed by Giorgi (2006) the text was broken

into meaning units (MU). Meaning Units are the smallest possible conceptualizations of

meaning. At the beginning of the analysis all meaning units are considered categories

(Rennie, 2006). This is not to say that the analysis is not done as thoroughly as with line

by line coding; in fact, some MUs may be very short. Echoing Giorgi's (2006) views, by

dividing the text into MUs, the meaning of the text is allowed to remain together in terms

of themes and their properties (Rennie, 2006). Finally, instead of using the margins to

write down the categories or interpretations, Rennie proposes the use of filing cards

where the MU's are cut and pasted. These cards contain the categories to which the MU's

are assigned as well as the key word summaries of the MU's. This last point was adapted

in this study, as I used the software Dedoose and not physical index cards to organize the

data. A detailed description of the adapted procedure for data analysis can be found in

Appendix C. In addition, the analytical process is showcased graphically in Figure 1.
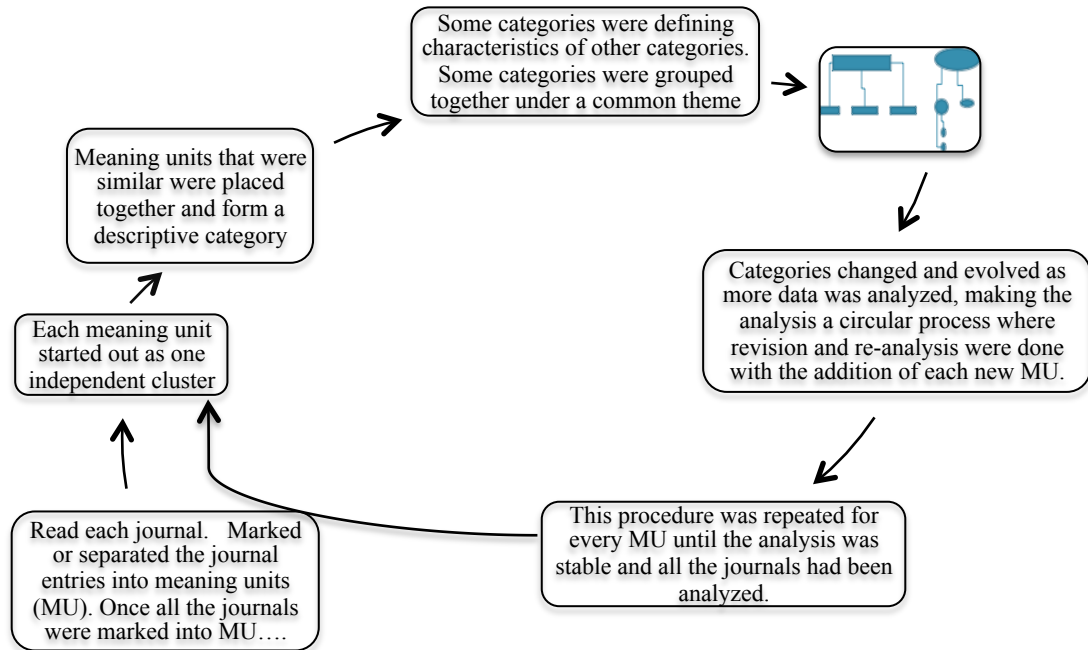
Figure 1. Data analysis procedure- Based on Rennie (2006).

Chapter IV

Results and Discussion

Overview

In line with the proposed research question, *"What were therapists-trainees'*

experiences regarding their Multicultural Counselling Competencies while providing

therapy to first-generation, government assisted, refugee clients?", the objective of

analyzing the therapists' Critical Incident Journal (CIJ) was to explore and describe in

detail their perceptions, experiences, and reflections through working with their refugee

clients. In analyzing the 165 CIJ entries a myriad of themes emerged. However many of

these themes pertained to general counselling competencies[13] and thus fell outside the

scope of the current research. In order to maintain the integrity and the focus of the

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[13] The excluded themes, while not fully developed, can be made available upon request.

present project such that the research question and the objectives were addressed, only themes that specifically pertained to cultural issues were included in the results.

The themes and the subordinate themes presented are all grounded in the therapists' CIJ entries. I endeavored to use the therapists' own words in the theme and sub-theme headings, as appropriate. In the interest of providing examples of the themes that emerged as well as to ensure richer descriptions, quotations from the therapists' CIJ are presented throughout the results section. In order to enhance readability, brackets […] were integrated into therapists' CIJ excerpts to reflect grammatical or spelling corrections or to show where additional material was removed[14]. Quotations ("…"), both in normal font and italicized font, reflect the therapists' actual written words and reflections. Each therapist's quotation is followed by a reference. For example, "101101Tc2s2j5" represents: Cohort from 2010-2011 (1011); Therapist number 1 (01T); Number of clients the therapist has seen, in this case it would be this therapist's second client (c2); Session number, in this case this therapist and client dyad have had two sessions (s2); and journal number, in this example the therapist has completed five CIJ, three with her previous client and two with this client (j5).

The second and third objectives of the present project were: a) to describe the therapist-trainees' developmental process in acquiring MCC and b) to describe the methodological procedure for analyzing qualitative data while integrating change and process. As I analyzed the data, I noticed that some of the themes describing the therapists' experiences mostly emerged in certain sessions or in certain phases of the therapy process. In line with the major therapeutic approaches (see Beck, 2011; Book, 2003; Greenberg, Rice, & Elliot, 1993), which consider the first 2 – 4 sessions of the

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[14] These omitted materials can be made available upon request.

therapy process the beginning or initial phase, I considered the therapists' first three CIJ

as the initial phase of therapy. The rationale for taking the first three sessions of therapy

as the initial phase is that research suggests that the therapeutic alliance is formed within

the first three sessions (Hovarth & Greenberg, 1989). The middle or working phase was

comprised of all the sessions that took place before the termination phase. Lastly, the

termination phase was considered as the final two sessions therapists had with their

clients. In keeping with the third objective of this project, the methodological procedure is

detailed in Appendix C. The organization of the results and discussion section does not

reflect the therapists' development over time. While I did notice certain experiences

arising in certain phases of the therapeutic process, it is not possible to define a trajectory

across time that encompasses all the therapists' experiences. However, in order to shed

light on the therapist-trainees' developmental process in acquiring Multicultural

Counselling Competencies (MCC), the stage or stages in which each theme and subtheme

emerged are noted throughout the results and discussion section. Furthermore, an

additional section entitled "Developmental aspects of the therapists experiences" was

included. This section summarizes the experiences that emerged within each phase of the

therapeutic process and details other developmental issues such as changes within the

same CIJ entry and individual changes in the same general theme across CIJ entries. In

order to acknowledge the temporal or unfolding nature of this project, the categories and

sub-categories are entitled using present-tense verbs (e.g., "Feeling the need to adapt").

However, the actual written material is mostly written in past tense or using tenses as

appropriate.

The purpose of qualitative research is to provide depth and insight, not to provide

quantities, as is the case in quantitative research. However, recognizing that many readers

of this document may come from a quantitative background, and may want to know how many therapist-trainees expressed their view on particular themes, I use qualifying language (e.g. "all" "nearly all", "most", "around half") to satisfy this interest. These qualifiers are based on Cooper and Rodgers' (2006) working paper on a scoring scheme for qualitative analysis. The qualifiers suggested for a 14 participant sample include: "One" when only one participant mentioned a certain experience, "a couple" when two participants mentioned an experience, "some" to refer to three to six participants mentioning an experience, "around half" refers to seven to eight participants, "most" refers to nine to eleven participants, "nearly all" refers to twelve to thirteen participants, and "all" refers to the fourteen participants mentioning an experience[15]. However, readers are reminded that in qualitative research the important part is not "how many" people had an experience. The important part is the description of the experience itself. Therefore, there is no hierarchy of what theme or experience is more meaningful than others as that is up to the reader to decide (Calderwood, personal communication, June 17, 2014).

As mentioned previously, thirteen of the fourteen therapists were female. In order to comply with the original REB approval I don't have access to information pairing the identities of the therapists with their assigned reference codes. Due to the sample consisting of a majority of females, therapists are referred to using female pronouns throughout the document.

In qualitative research it is common to present the results and discussion sections together (Meloy, 1994). I decided to merge these sections for two main reasons. First,

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[15] Please see Appendix D for a table summarizing this information.

combining the results and discussion section aided in providing a thicker description of the therapist-trainees' experiences by relating themes to each other to better understand the therapist-trainees' experiences. Second, combining these sections contextualized the findings in relation to the wider body of literature. Thus, the reader will notice that there is much literature review integrated in the results and discussion section. Echoing several authors (Charmaz, 1995; Glaser, 2006; Meloy, 1994), I noticed that it was only after the results emerged that I had a strong foundation or ground from which to focus the literature review presented in this section.

Figure 2 depicts the three main themes that emerged from this analysis[16]. These themes are interconnected and should be considered in relation to each other. However, in order to ensure the clarity of the presentation, I separated these themes into three distinct sections
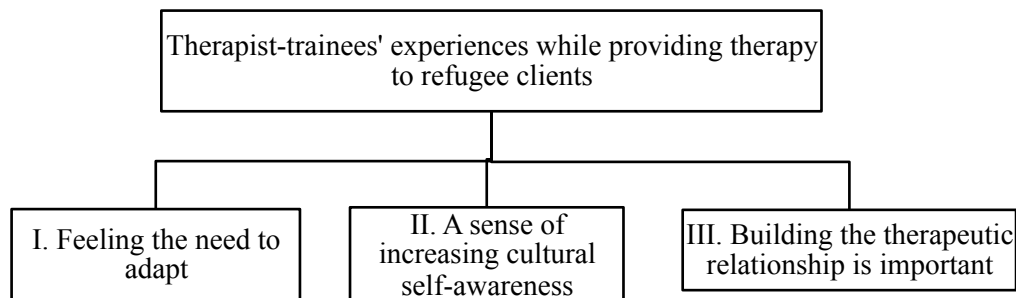
Figure 2. Three main themes. These were the main themes that emerged and which describe therapist-trainees' experiences while providing therapy to refugee clients.

The reader will notice that throughout the three main themes there is an underlying thread, which pertains to therapists' expectations. The therapeutic encounter provides the rare opportunity to build a close and intimate relationship with another human being (Kottler, 2012). This relationship allows us to learn about ourselves and

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[16] Figures detailing the reader's place in the document were added in order to strengthen the clarity of the document and to aid the reader in locating him/herself within the document. This figure is meant as an introduction.

others and, in general, might challenge our beliefs even while working with clients from

our same culture. Therefore, it is not surprising that working closely with clients from

such different cultures and backgrounds would challenge therapists' and possibly, even

clients' worldviews, assumptions, and expectations.

<center>**Section I. Feeling the Need to Adapt[17]**</center>

The theme "Feeling the need to adapt" exemplifies how the therapists became

aware that therapy with their refugee clients was not going to be "business as usual"

(111209Tc2s4j7). The components of Multicultural Counselling Competencies (MCC)

have been extensively debated in the literature, such that even the need for MCC has been

questioned (Patterson, 2004; Weinrach & Thomas, 2002). In contrast, in the present

study, all the therapists mentioned feeling the need to adapt and be more flexible in order

to work with their refugee clients. Therapists' need to adapt supports the idea that certain

modifications and competencies are needed in order to work with clients from other

cultures, in this case refugees. Therapist-trainees mentioned having to adapt in several

ways in order to work with their refugee clients. Therapists' need to adapt was illustrated

by four subordinate themes presented in Figure 3.

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[17] Please note that the numbering of the sections only intends to clarify the document, it does not reflect hierarchical or chronological order.
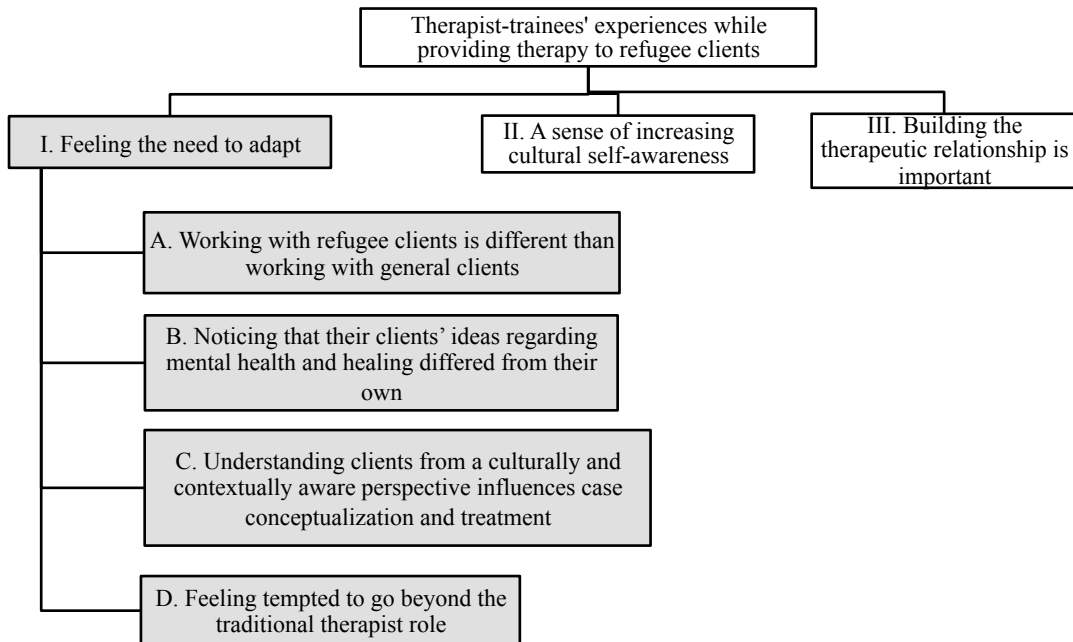
Figure 3. Sub-themes that emerged under the theme "Feeling the need to adapt". The shaded parts highlight the themes referenced in the current section.

A. Working with Refugee Clients is Different than Working with General Clients

The subordinate theme "Working with refugee clients is different than working with general clients" demonstrates therapists' reflections where therapist-trainees explicitly mentioned differences between their refugee clients and their general clients. This theme is divided into three sub-themes as shown in Figure 4. The first[18] sub-theme, "Working with refugee clients versus working with general clients: explicit differences" showcases the explicit differences between refugee clients and general clients as described by the therapists. The second and third sub-themes, "listening to the refugee client's life stories and experiences is impactful" and "providing therapy through an interpreter was challenging and beneficial" further evidence the differences between working with refugee clients and general clients.

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[18] Please note that the present numbering was used in order to aid in the clarity of the document. These numbers do not reflect hierarchical or chronological order.
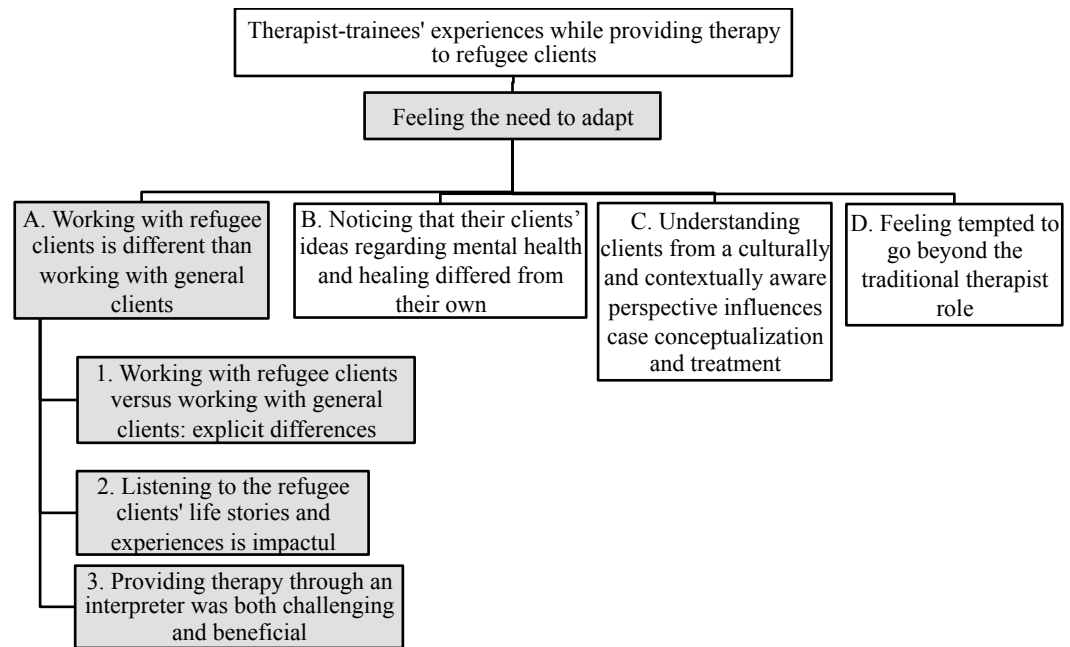
Figure 4. Three sub-themes emerged within theme "Working with refugee clients is different than working with general clients". The shaded parts highlight the themes referenced in the current section. In order to aid with clarity, the two major themes "A sense of increasing cultural self-awareness" and "Building the therapeutic relationship is important" were omitted from this figure.

1. Working with refugee clients versus working with general clients: explicit differences.
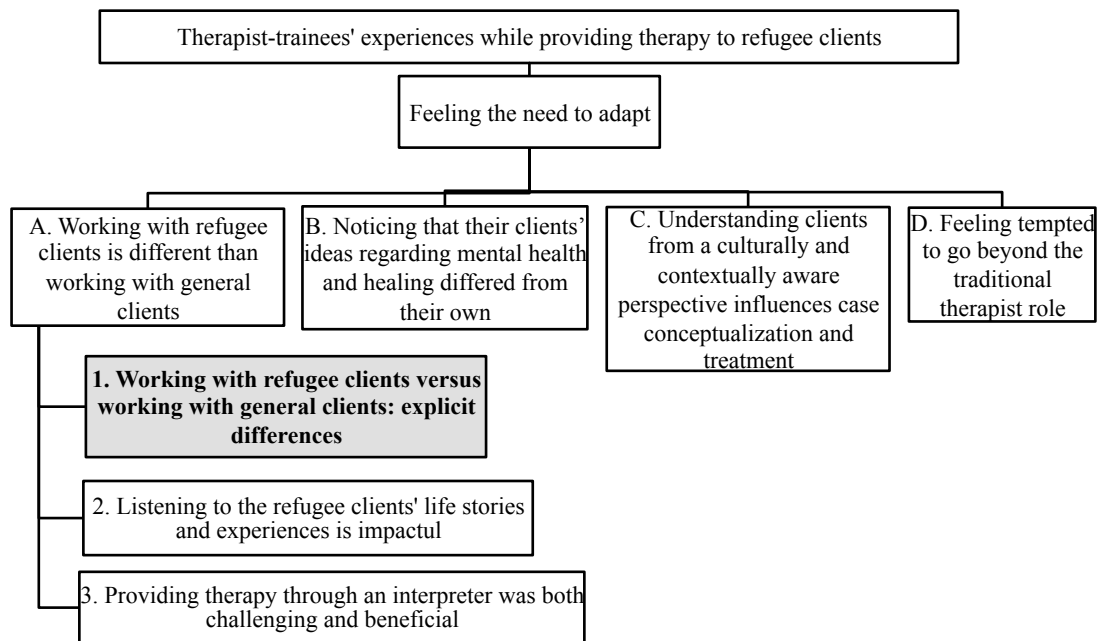
Figure 5. Thematic overview. Locating the theme "Working with refugee clients versus working with general clients: explicit differences". The shaded and bolded area illustrates the theme referenced in the current section.

Most therapists reflected on the differences in providing therapy to refugee clients versus general clients. These reflections emerged mostly during the working phase of therapy and to a lesser degree in the beginning phase of therapy. These therapists explicitly mentioned differences between their refugee clients and general clients. The therapists identified these differences in several interrelated areas including:

1.1. General clients' individualistic worldview versus refugee clients' more collectivistic worldview.

1.2. Refugee clients' expectations and reactions to therapy were different than general clients' expectations and reactions

1.3. Willingness to engage in more self-disclosure and to be more genuine with refugee

clients than with general clients

1.4. Responding to ethical issues and to diagnostic decisions when working with refugee

clients was different than working with general clients: endeavoring to work from a

culturally informed framework.

1.1 General clients' individualistic worldview versus refugee clients' more

collectivistic worldview. [19]

Therapists noticed differences between their general clients' more individualistic

worldviews and their refugee clients' more collectivistic worldviews. One of these

differences pertained to the process of getting to know their refugee clients. For

example, therapists noted that unlike clients who were more acculturated and had a

more individualistic worldview, refugee clients had a tendency to talk more about their

family and context. For instance, when one therapist asked the refugee client to talk

about herself, the client talked about her community and social context. The refugee

client's inclusion of her community and social context when talking about herself

sharply contrasts with general clients' self-descriptions which typically focus only on

themselves as individuals. This therapist reflected:

> *"I reflected afterward that, given her collectivist cultural roots, in order for*
> *me to know the client, it is necessary for me to know her in her community*
> *context. When a Westerner is instructed to tell about themselves, they will*
> *focus on their own attributes with minimal focus on their family and social*
> *roots. For individuals from other cultures, to tell about themselves implies*
> *having to share where they come from – who they are is who their family is I*
> *suppose" (101103Tc1s3j3).*

The therapist's insight is aligned with psychotherapy in the Canadian-American context.

In this context, culturally, the understanding of the person focuses on individualism. In

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[19] Please refer to Figure 5 for an overview of the location of this theme within the broader
analysis.

this view, each individual has the right to pursue his or her private goals autonomously

(Kirmayer, 2007). In contrast, other cultures view the self as embedded not only within

their family system but also within the larger community and sometimes even within the

spirit world (see Comas-Diaz, 2006; Kottler, Carlson, & Keeney, 2004; Nussbaum,

2003). The importance of the family system and of being flexible was highlighted when a

couple of therapists' clients asked for their family members to accompany them for a few

therapy sessions. Requests for family to join in the session also highlighted the therapists'

own individualistic worldview and training in psychotherapy. For instance, after a client

requested for her daughter to join them in therapy, the therapist felt "torn". This same

therapist was also very aware of the need to adapt to such requests that she "might not

expect from clients from the mainstream culture". This therapist's refugee client asked for

her daughter to join in the session, a request not typically made by general clients, this

therapist reflected:

> *"At first, when presented with this request from my client I felt torn. On the one hand I had been taught that these types of requests can be detrimental to the therapeutic process and should be entered into very cautiously and temporarily, if at all. On the other hand, I was aware of the need to be more flexible and open to situations that I might not expect from clients from the mainstream culture" (111205Tc1s2j2)*

1.2 Refugee clients' expectations and reactions to therapy were different than

general clients' expectations and reactions [20].

Therapist-trainees also noticed that refugee clients' expectations and reactions to

therapy were different from general clients' expectations and reactions. For instance,

around half the therapists noticed that a difference between refugee clients and general

clients pertained to the level of trust displayed within the therapeutic relationship. For

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[20] Please refer to Figure 5 for an overview of the location of this theme within the broader analysis.

instance, during the first session with her refugee client one therapist described how her

client's body language conveyed a sense of distrust, as compared to general (student)

clients who typically respond in a "warmer" manner:

> *"First, my client sat down and pushed her chair far away from me,*
> *communicating a deeper sense of distrust or discomfort with the session*
> *compared to how my usual clients react in a warm and approaching manner.*
> *Second, compared to student clients, my client expressed much more concern*
> *and vigilance when discussing videotaping, confidentiality, and informed*
> *consent" (121313Tc1s1j1).*

Along the same lines of refugee clients' distrust or discomfort within the therapeutic

relationship, these therapists also talked about the clients' difficulties in getting close to

others and trusting others. These observations are consistent with the literature, which

indicates that it is not uncommon for refugees to feel mistrustful of others, as many of

them could have been denounced by people they knew. Moreover refugees could have

suffered torture at the hands of members of their own community (Fabri, 2001; Gorman,

2001; Tribe, 2002).

Not only were refugee clients more distrustful of therapy than general clients, they

also had very different expectations of treatment. For instance, in contrast to general

clients who typically know what to expect from therapy, some refugee clients seemed to

lack clear expectations of what therapy entailed. Thus, this point highlighted therapist-

trainees' need to adapt therapy to the refugee clients' needs and expectations. For

instance, a therapist described an impactful experience during the first session with her

client when she realized that unlike her student clients, her refugee client didn't have

clear expectations of therapy. Therefore, the therapist realized that she had to adjust her

interventions:

> *"I was very impacted at an emotional level when I inquired about the feelings*
> *of fear and loneliness that brought her here. She reacted in a surprised, and*

almost defensive manner, asking " you want me to talk about my feelings?",
whereas student clients have always been clear about the process of therapy.
Together, these initial interactions highlighted the need to adjust standard
therapy to meet the specific needs of every client" (121313Tc1s1j1).

It is important to note that individual talk therapy where the client is expected to

discuss his or her innermost thoughts and feelings is the preferred method of

psychological healing in the Canadian context (Kirmayer, 2007). However, while talk

therapy is the most scientifically studied healing method to alleviate psychological pain, it

is by no means the only healing method in existence (Rosenzweig, 1994; Summerfield,

2000). In other cultures healing practices involve not only the family but also the

community. In addition, contrary to Western/Canadian culture, in other cultures healing

practices don't involve discussing and reframing a person's innermost thoughts and

feelings. For example, in Sudan, Ethiopia, Libya, Tunisia, Egypt, Saudi Arabia, and in

some tribes of West Africa, psychological distress is believed to involve a "Zar spirit".

The Zar spirit typically attacks women. In order to heal, a "Zar ceremony" has to be

conducted with and by other women in the community. The aim of the Zar ceremony is to

appease the "Zar spirit" by providing special gifts such as jewelry, new clothing, or

expensive foods. The Zar ceremony provides a safe, non-judgmental environment, for the

"possessed" woman to express her wishes and desires. The hidden goal of the practice is

to restore balance, especially if the woman possessed by the Zar spirit is not treated well

in her everyday life (Grotberg, 1990; Tseng, 1999). A Zar ceremony is just one example

of myriad healing traditions across the world that don't rely solely on the individual

verbally describing his or her experiences and feelings to a healer (therapist). Thus, it is

not surprising that refugee clients who have been in Canada for less than a year, who are

not fluent in English, and who have their own ideas of psychological well-being and

mental health, are somewhat taken aback when we ask them to talk about their feelings.

Considering the multitude of psychological healing methods across the world it is likely

that, as therapists, we will be faced with the need to reflect on and adapt our interventions

to better serve clients from diverse cultures. Another therapist trainee who compared the

therapeutic process between her general clients and her refugee clients found herself

reflecting on how her therapeutic interventions and orientation reflected a "somewhat

mono-cultural" worldview:

> *"This experience has also lead me to depart from a rigid orientation that my*
> *client must sit with and work through her emotional pain, which I had*
> *envisioned would include a huge sense of tearful catharsis as has been*
> *modeled by other clients I am working with from other treatment modalities.*
> *In doing this, I am developing my multicultural competence as it addresses a*
> *somewhat mono-cultural worldview that therapeutic progress can best be*
> *achieved by accessing and exploring painful emotions as I have become*
> *accustomed to through my graduate training and work with undergraduate*
> *clients" (121313Tc1s5j5).*

1.3 Willingness to engage in more self-disclosure and to be more genuine with

refugee clients than with general clients [21].

In comparing general clients to refugee clients, therapists realized that they

engaged in more self-disclosure with their refugee clients than with their general clients.

The increased self-disclosure may have resulted from the therapists' attempting to

accommodate what they perceived to be their clients' expectations of treatment. As such,

some therapists mentioned engaging in more self-disclosure with their refugee clients

than with their general clients. Therapist self-disclosure is defined as personal

information that is verbally shared by the therapist and that would otherwise not be

known by the client (Burkard, Knox, Groen, Perez, & Hess, 2006). For example, a

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[21] Please refer to Figure 5 for an overview of the location of this theme within the broader
analysis.

therapist described how she answered her clients' somewhat personal questions:

> *"She even asked me about my own life (if I had children, etc.) and I felt comfortable sharing with her some things – things I would not have shared with a Western client, I don't think. This occurred at the "wrap up" part so it did not detract from clinical material, but I think it was a necessary part of the "give and take" dynamic that had developed in our relationship. To have been vague or avoided the questions would have been rude and equivalent to rejection of the relationship that had formed" (101103Tc1s3j3).*

This therapist's reflection on her self-disclosure as strengthening the therapeutic

relationship and being a necessary part of the "give and take dynamic" with her refugee

client is consistent with a hypothesis suggested by Burkard, et al. (2006). These authors

suggest that clients who are unfamiliar with the therapy process or who feel ashamed of

seeking help for their psychological difficulties may benefit from therapist's self-

disclosure. In these cases therapists' self-disclosure can help in modeling appropriate

behaviours and in developing a productive working alliance (Burkard, et al., 2006). In

contrast, studies on therapists' self-disclosure with general or same culture clients have

found mixed results contingent upon multiple contextual factors (Henretty & Levitt,

2010).

 Along the same lines, a couple of the therapists felt they reacted in a more

genuine manner toward their refugee client than toward their general culture clients. An

important part of creating a strong working alliance is that of being genuine with the

client. While being genuine in every therapeutic encounter with every client has been

encouraged throughout the literature (Rogers, 1961; Yalom, 2002), these therapists

noticed a difference between how genuine they were with their refugee client than with

their general clients. For instance, one of the therapists mentioned how she used a more

personal reference and was more genuine in responding to her refugee client's questions

regarding his symptoms and the ways these symptoms were influenced by his personality,

culture, and values. The therapist also commented that she would not have responded in

the same way, had this question been asked by a general culture client:

> *"I think this moment was especially important because I used a self reference
> to help explain my position that a multitude of factors contribute to peoples
> values, behaviours etc. I think I responded in a way that I would not respond
> with other clients and I integrated my cultural experiences to help explain my
> position. I feel like in these sessions, and at this moment in particular, my
> answers are more personal, or less cookie cutter answers. It's like I respond
> in a more genuine way, or in a way that alludes to my beliefs more. I think
> this has contributed to our strong working relationship. I think this
> experience helped me practice my skill to speak to my beliefs, describe my
> stance, which includes more self disclosure than I typically engage in with
> other clients" (101101Tc1s4j4).*

***1.4 Responding to ethical issues and to diagnostic decisions when working with
refugee clients was different than working with general clients: endeavoring to work
from a culturally informed framework[22].***

Not only were therapists more likely to self-disclose and to be more genuine with

their refugee clients than with their general clients; therapists indicated they were also

more likely to reflect on their clients' culture and context before reaching decisions

regarding diagnoses or ethical actions. During the working phase of therapy, some

therapists were faced with ethical dilemmas. Therapists mentioned they accounted for

their clients' culture before reaching a decision. It is important to note that therapists

acknowledged their responses were different than what they would have been with a

general client. For instance, a therapist working with a woman from a Middle Eastern

country who had been separated from her children explained how she reacted differently

to this client's "suicidal" expressions than she would have if these expressions came from

a general or "more Western culture" client:

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[22] Please refer to Figure 5 for an overview of the location of this theme within the broader
analysis.

"I was overcome with the strength of her love; her almost desperate desire to be near them. For my client, her children are her entire world. Her expressions of suicide seemed dramatic, and while I might be concerned about the implications of such statements from a client who came from a more western culture, I reminded myself that the meaning of such statements are different for different cultures" (111209Tc1s1j1).

Another therapist whose client was suffering from domestic violence faced an ethical dilemma regarding duty to report when there is suspected child abuse or neglect. This therapist described how the client's culture and context influenced her decision, as she would have reacted differently with a client from the dominant culture:

"After extensive thinking, reviewing of ethical standards, and consultation with my supervisor, I decided that my concerns were insufficient to warrant reporting. However, if this client were a North American Caucasian individual, I believe that I would have decided otherwise. The sole factor was my consideration of the views of her culture on physical punishment as well as the magnitude of harm it would cause her to have this reported (i.e., losing her family, husband, reputation, trust in Canada, and trust in therapists in general)" (101103Tc1s2j2)

These therapists' responses were aligned with ethical relativism. This theory states that morality or judging right from wrong is dependent upon societal and cultural norms (Velazquez, Andre, Shanks, & Meyer, 1992). Ethical relativism was emphasized when the therapists mentioned that they would have reacted in a different way had their client been from the dominant culture. Ethical codes for psychologists affirm the importance of cultural sensitivity. However, these codes provide little guidance regarding how to proceed when faced with real dilemmas that originate in the work with culturally diverse clients (Sadeghi, Fischer, & House, 2003). In this case, therapist 101103T consulted with her supervisor and thoughtfully evaluated her response so that the client's interests and wellbeing were protected. This therapist's reasoning is consistent with a model of ethical decision making for multicultural therapy proposed by Frame and Williams (2005). This model integrates the culturally diverse clients' values and worldviews into the ethical

decision-making process.

Furthermore, acculturation concerns are not typically seen when working with clients from the general culture but play a critical role in treatment and diagnosis when working with immigrants and refugees. Nearly all the therapists mentioned their clients were struggling with acculturation concerns, immigration and legal issues. The acculturation and migration experience can play an important role in refugee clients' wellbeing. As one therapist reflected:

> *"In general, this experience has reminded me how acculturation issues can influence any and all concerns that a client is having. It will be important for me to keep in mind that acculturative stress is equally as important as any other concern that I am more used to working with in therapy sessions and not to disregard it or give preference to other topics because I am more used to talking about them. In future sessions I think I will have to pause and ask myself how the client's immigration experience is impacting on the situations he is speaking about in order to view him as the complex, multi-faceted individual that he is" (111206Tc3s3j13).*

2. Listening to refugee clients' life stories and experiences was impactful.

The second sub-theme, "Listening to refugee clients' life stories and experiences was impactful", further illustrated how working with refugee clients was different than working with general clients as well as the fact that therapists had to adapt in order to work with these clients.

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┌─────────────────────────────────────────────────────────────────┐
│   Therapist-trainees' experiences while providing therapy to refugee clients   │
└─────────────────────────────────────────────────────────────────┘
                          ┌──────────────────────────┐
                          │   Feeling the need to adapt   │
                          └──────────────────────────┘
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| A. Working with refugee clients is different than working with general clients | B. Noticing that their clients' ideas regarding mental health and healing differed from their own | C. Understanding clients from a culturally and contextually aware perspective influences case conceptualization and treatment | D. Feeling tempted to go beyond the traditional therapist role |

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  ┌────────────────────────────────────────┐
  │ 1. Working with refugee clients versus   │
  │ working with general clients: explicit   │
  │ differences                              │
  └────────────────────────────────────────┘
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  │ 2. Listening to the refugee clients' life │
  │ stories and experiences is impactul       │
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  ┌────────────────────────────────────────┐
  │ 3. Providing therapy through an interpreter was both │
  │ challenging and beneficial               │
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Figure 6. Thematic Overview. Locating the theme "Listening to the refugee clients' life stories and experiences is impactful". The shaded and bolded area illustrates the theme referenced in the current section.

Refugee clients presented with many diverse problems and experiences that are not commonly encountered when working with general culture clients. Therapists described how their refugee clients experienced and/or witnessed torture in their country of origin, some clients had either experienced or were experiencing domestic violence at the time of therapy, and some clients were suffering from bereavement and grief from losing or being apart from their loved ones. The refugee clients' experiences were consistent with the literature (Gong-Guy, Cravens, & Patterson, 1991; Veer, 1992). While the therapists were familiar with the difficulties refugee clients face through assigned readings in the practicum course and news stories, around half the therapists mentioned how listening to their clients actually brought what they had read or seen in the news to a more personal level. These therapists remarked how listening to their clients made what they had seen or read about more personally meaningful and, in some cases, more painful.

These insights emerged in the beginning and working phases of therapy, particularly

within CIJ number three. Two therapists expressed the following:

> *"[in the photo] The marks on the wall made it clear where some of the terrorists had blown themselves up. It was a little unreal to be looking at such honest photos and knowing the personal story of one of the few people who made it through this attack. It struck me how utterly different this was from watching the news, how much more personal, and so much more painful"* (111205Tc1s3j3)

> *"My client's description reminded me of documentaries I have read about the Nazis and Jewish concentration camps. It increased my awareness in understanding that people do not have a choice but to follow the Taliban orders and the orders (or any body of people in control in similar situations). [...] I was also thinking how different it is to hear the story than simply read or see similar things on television"* (101101Tc1s3j3).

Most therapists mentioned feeling impacted while listening to their clients'

experiences. For instance, a therapist described how learning that her client was detained

and tortured at a Taliban training camp was impactful for her:

> *"The most impactful part of today's session was hearing my client's account of being captured by the Taliban and detained in the Taliban training camp"* (101101Tc1s3j3).

Another therapist explained that listening to her client's experiences undergoing

domestic violence at the hands of her brother and seeing her client's intense emotional

reactions was very impactful:

> *"The most critical or impactful event in this week's session with my client was hearing my client disclose the intensely traumatic experiences that she has endured, and seeing her moment-to-moment emotional and physical reactions to the memories of these painful experiences. Specifically, my client described experiences of her older brother psychologically and physically tormenting her and her ill mother, while her father was too old to intervene. As my client related these experiences, she became extremely distressed, crying loudly and uncontrollably, breathing rapidly and heavily, and shaking in her seat"* (121314Tc1s2j2).

Therapists' feeling impacted by their clients' traumatic experiences is not

surprising. These types of traumatic life experiences are hard to imagine in a country,

such as Canada, where human rights' are considered a priority and where peace has

existed for more than a century (Minister of Public Works and Government Services

Canada, 2009). It is important to note that even though therapists had very different life

experiences from their clients, most therapists reflected on experiencing a deep felt sense

of empathy, of placing themselves "in their client's shoes". This deep sense of empathy

emerged throughout the beginning and working phases of therapy. However, it is

interesting to note that these reflections also appeared more frequently in CIJ number

three. This is consistent with previous research, which typically considers the therapeutic

alliance to be reasonably strong and well developed between the second and fourth

sessions (Hovarth & Greenberg, 1989). In her third journal entry after the third session

with her client, one therapist reflected on how she attained a deeper understanding of her

client through imagining herself in the client's position:

> *"Understanding her experience from her point of view was difficult coming from a different culture, but also a society in which I have never really lived in fear. [...] Looking at the photos and placing in the context of what my client had revealed about this incident brought it to life, helped me to imagine what it was like to be lying there completely certain that you would die, and yet praying so hard to live.... I could feel a slightly deeper understanding of what level of terror my client underwent lying there in the blood. I further felt that I was gaining a better understanding of how such an incident causes PTSD, and the symptoms that my client has experienced. How does one reclaim meaning when your existence is threatened to that point, and you begin to accept your own death, as your life's purpose becomes trying to save your child. Then to survive and to go on afterwards, changed forever by this event, I began to understand better my client's struggle. This [realization] was deeply touching" (111205Tc1s3j3).*

The impact of working with refugee clients who had lived through so much suffering was

further illustrated by two sub-themes namely:

2.1 Wondering if they will be able to help the client: feeling doubtful and helpless

2.2 Feeling guilty

2.1 Wondering if they will be able to help the client: feeling doubtful and helpless.[23]

As mentioned earlier, refugee clients presented with diverse problems, many of which were extremely painful. The sub-theme: "Wondering if they will be able to help the client: feeling doubtful and helpless" further illustrates how impactful the clients' problems were. Around half the therapists mentioned having feelings of "doubt" and in some cases even "helplessness" and "hopelessness" about whether they could actually help in the face of the clients' immense losses and trauma. These reflections mostly emerged during the beginning and working phases of therapy. As three therapists reflected:

> *"I reacted with feelings of helplessness and hopelessness. At first, I hoped that unpacking the situation would shed light onto the situation and help my client view her situation in a new light. For example, by becoming aware about how her own thoughts and interpretations of the situation contribute to the experiential impact of these conflicts. However, as she continued to describe the terrifying situations she constantly faces, and continued to complain, with a tone of resignation, I felt more and more hopeless" (121313Tc1s3j3)*

> *"I couldn't help but feel I was not doing enough and had doubts about my competence in effectively helping my client get better. After the session, it took more time than I had anticipated for me to shake these feeling away and I had felt sad for the rest of the day" (121314Tc1s2j2).*

> *"I also felt guilty for having brought it up, but also for having had a much easier life in comparison. I told her that I had no idea and reflected that she had lost so much.[....]I felt helpless in the face of her loss and the despair and hopelessness that she reported" (111209Tc2s5j8).*

The second excerpt by therapist 121314T portrays how working with these vulnerable clients had a deep emotional impact such that the therapist felt sad for the rest of the day. The third therapist not only felt helpless, she also felt guilty for having an easier life as

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[23] Please refer to Figure 6 for an overview of the location of this theme within the broader analysis

compared to her client:

2.2 Feeling guilty[24].

As evidenced above by therapist 111209T some therapists also felt guilty.

Feelings of guilt, sadness, and distancing or avoidance are not uncommon in therapists

working with survivors of trauma (Danieli, 1984; Lansen, 1993). Some therapist-trainees

expressed several reasons for feeling guilty such as: having "an easier life" than the

client, feeling that "they are not doing enough" for the client, and when nearing

termination, feeling they were "turning their back" on the client. For example a therapist

who was about to terminate treatment with her client reflected:

> *"I felt very guilty. I have formed a strong relationship with [client] and felt like I was turning my back on her or hanging her out to dry when she needs my support the most. I felt a strong need to reassure her that she would be okay and that there are other resources available to her, but I am skeptical that there actually are" (121310Tc1s11j11)*

One therapist also felt guilty for not being "fully attentive" during session. This therapist

found herself "zoning out" during her session with her client:

> *"There were a couple of times during this session where I would catch myself zoning out for a brief moment. This is very atypical of me; I never have these moments in therapy. Usually I am fully attentive and my mind is racing, trying to balance following the client and guiding the process. Thus, the experience this session was also associated with a guilt, because I know it's my job to be fully attentive during therapy" (121312Tc1s16j16)*

This last therapist's experience echoes Holmqvist and Anderson's (2006) findings

regarding therapists' emotional reactions when working with survivors of torture. These

findings suggest that, over time, therapists working with clients who have suffered from

trauma felt more bored and indifferent and were less empathic. It is important to note that

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[24] Please refer to Figure 6 for an overview of the location of this theme within the broader analysis

this therapist noticed she was "zoning out" during the 16th session with her client. This

therapist's experience is congruent with Holmqvist and Anderson's (2006) finding that, as

time went by, therapists working with survivors of trauma reported higher levels of

boredom and indifference as well as feeling more distant. These feelings of disinterest

may suggest the therapist is at risk for burnout (Holmqvist & Anderson, 2006). Because

this therapist indicated she only experienced herself "zoning out" with this client and not

with others, this experience may indicate she was at risk for burnout. This experience may

also be interpreted as a negative case as other therapists did not report these feelings. In

fact, other therapists appeared to maintain consistent interest in their client throughout

treatment. This finding has important implications within training and professional

contexts as it can help supervisors, therapist-trainees, and even experienced therapists in

monitoring their reactions to their work with their clients and to engage in self-care

strategies before suffering from burn out.

3. Providing therapy through an interpreter was both challenging and beneficial.
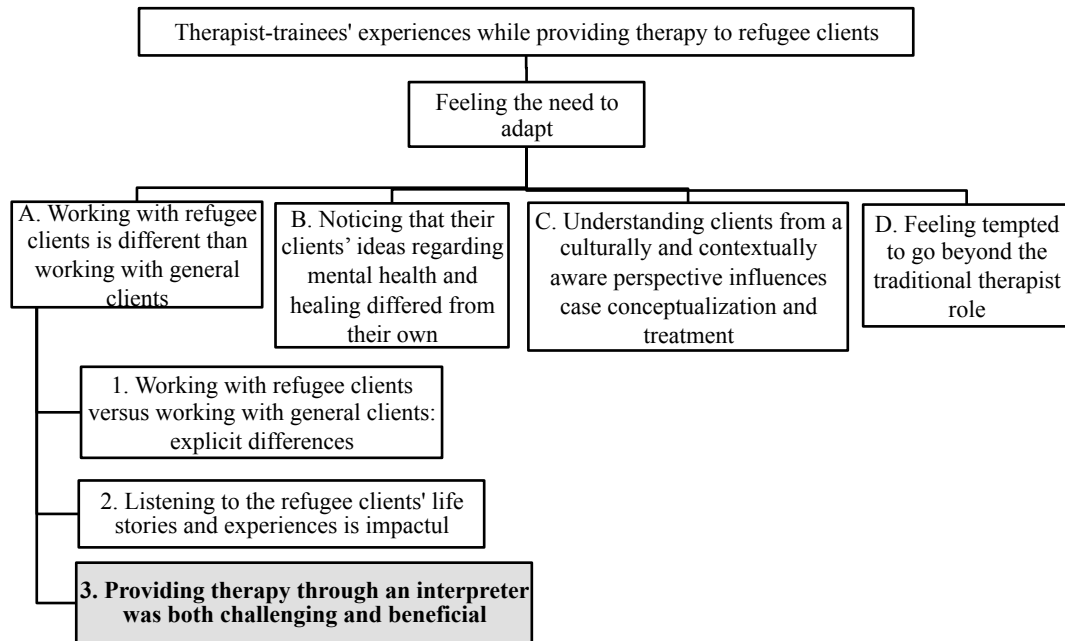
Figure 7. Thematic Overview. Locating the theme "Providing therapy through an interpreter was both challenging and beneficial". The shaded and bolded area illustrates the theme referenced in the current section.

The third sub-theme "Providing therapy through an interpreter was both challenging and beneficial" further illustrates an important difference between working with refugee clients and general culture clients: the need for interpreters. Therapists indicated that a major difference they had to adapt to when working with their refugee clients pertained to language barriers between themselves and their clients. Since most of the clients were not fluent in English, therapist-trainees had to adapt to providing therapy through interpreters. Approximately half of the therapists mentioned facing challenges when working through the interpreter. These reflections emerged mostly in the beginning and working phases or therapy. Some of the challenges mentioned by the therapists were consistent with the literature (Farooq & Fear, 2003). These challenges included therapists

finding themselves questioning the accuracy of the interpretation by the interpreters. For

instance, therapists noticed the interpreters sometimes added or changed the intended

message:

> *"Last session in the middle of therapy, the language aid told a 3 minute fable to my client. The take home message of this story was that peoples' interpretation of situations impacts their feelings and behaviours (i.e., [language aid] was reinforcing the point I had just made). As a result, at the beginning of this session, I pulled [language aid] aside and briefly discussed with him our respective roles. As politely as I could, I reminded him that his role was to be the voice, and to refrain from inserting his own commentary during session. I also took the opportunity to remind him to translate things exactly as they are said"* (121312Tc1s11j11).

Another challenge that arose from using interpreters was the issue of trust between

the client and the interpreter. One therapist trainee's experience with her client was

consistent with previous qualitative research, which indicates that sometimes clients of

one ethnicity distrust clients of other ethnic groups (Miller, Martell, Pazdirek, Caruth, &

Lopez, 2005). During her second session with her client a different interpreter was

assigned. It was then that this therapist trainee found that her client's willingness to

disclose was being influenced by the interpreter's ethnicity:

> *"I confirmed that we would keep the current interpreter (who is from Lebanon, which the client indicated was not a problem because her experience has been that people from Lebanon are not gossips) and that I would do my best to ensure that the previous interpreter did not speak about the client's experiences"* (111209Tc2s2j5)

In contrast to the client distrusting the interpreter, some of the therapists noticed

that their clients were more engaged with the interpreter than with them. For instance, one

of the therapists mentioned that even though she felt prepared for the challenge of

working with an interpreter, she was not ready for the experience of having her client

being more engaged with the interpreter than with her:

"The most critical event for me in this week's session was my experience of working with the interpreter. Although I was prepared for this, I experienced the client as very engaged with the interpreter in terms of eye contact and body language. As the session went on the client was more engaged with me, but he was still largely engaged with the interpreter" (111208Tc1s1j1).

This experience mirrors the findings of a qualitative study conducted by Miller, et al. (2005), where several therapists who were working with refugee clients using interpreters described how at first, their clients formed a stronger bond with the interpreter than with them.

Another issue mentioned by one of the therapists pertained to the interpreter's reactions to the client's story. This therapist believed the interpreter reactions to have influenced the issues the clients chose to disclose:

"Based on the interpreter's reaction at some points (such as a sigh or verbal indication that expressed surprise), prior to the translation, I wondered that if interpersonally, the client would have less reservations if the interpreter was not present and reacting to his story. I wondered if interpersonally, the client had more reservations based on the interpreter's reactions. Having said this, I still feel that interpersonally, we are forming a strong alliance" (101101Tc1s2j2)

It is important to remember that while the interpreters' reactions might have influenced the client's level of disclosure, the therapeutic encounter itself may have felt unfamiliar, even uncomfortable to the client (Summerfield, 2000). In addition, being unable to express themselves and having to work with an interpreter may initially feel strange, frightening, and disempowering for clients (Tribe, 2007). Moreover, the client is faced with building a trusting relationship with both the therapist and the interpreter. Building such a relationship is harder for clients who have survived torture and trauma (Miller, et al., 2005). Hence, time and patience are needed in order to develop a trusting and safe relationship between refugee clients and their therapists (Tribe, 2007).

In the same vein, of interpreters reacting to the client's stories, a couple of therapists noticed that the interpreters were being emotionally affected by the client's experiences. As one therapists explained:

> *"The interpreter began to cry although she tried to hide her face so that neither the client nor I would see. [....] I think I will be more aware of the impact that the sessions may be having on the interpreter now that I know of the similarities of her background. I will also be more prepared to offer her ways to avoid vicarious traumatization"* (121310Tc1s9j9)

It is not uncommon for interpreters to have certain experiences in common with the refugee clients and in some cases for them to be refugees themselves (Miller, et al., 2005). Miller et al. (2005) found that all but one of the interpreters described their work as "stimulating, gratifying, and minimally disruptive to their overall wellbeing". In the present study only a couple of therapists noticed the interpreter being adversely affected when translating the therapeutic work. Therefore, while emotional reactions from interpreters were not a common occurrence in either study, it is important to be aware of how the interpreter is being affected by the therapeutic work. As therapist 121310T mentioned, "it is important to be prepared to offer interpreters strategies to avoid vicarious traumatization". One of the strategies suggested by Miller, et al. (2005) was for the therapists to offer debriefing meetings to help interpreters manage distressing clinical issues.

An additional issue pertained to the role of the interpreter within the session. In the present study, therapists differed in how they perceived the interpreter's role. A couple of therapists' views were more aligned with the "black box" perspective. The "black box" perspective takes the presence of the interpreter as a necessity and seeks to minimize the awareness of his or her presence (Westermeyer, 1990). As one therapist explained when problem solving with the interpreter:

> *"As politely as I could, I reminded him that his role was to be the voice, and to refrain from inserting his own commentary during session. I also took the opportunity to remind him to translate things exactly as they are said. Finally, I reminded him to translate every little thing that is said, even side comments before or after the session (e.g., when I ask the client whether he would like something to drink while in the waiting room)" (121312Tc1s11j11).*

In contrast, a couple of therapists considered the interpreter to be an important element of the therapeutic relationship. This is consistent with the view that having an interpreter aids the client in feeling more comfortable with both the therapist and the therapeutic process and may help the therapist understand the client better (Raval, 1996). A study conducted by Miller, et al. (2005) suggests that the relationship between the client and the interpreter is an important part of the therapeutic triad. Adopting this relational perspective can turn working with an interpreter into an advantage as long as trust is fostered among client, interpreter, and therapist (Miller, et al., 2005). Consistent with these findings, a couple of therapists found the interpreter helped facilitate the interaction. These therapists considered the interpreter an integral part of the therapeutic relationship. One of the therapist's clients brought in a drawing depicting the therapist, the interpreter and the therapy room. The client indicated that looking at the drawing made her feel better. The therapist explained how touching this event was for everyone involved:

> *"I was incredibly touched when [client] shared the picture she drew and my heart warmed as we looked at it together. I told [client] how much I loved the drawing and appreciated her sharing it with me. Our interpreter appeared very touched by the moment as well, and thus, I asked [client] if I could make copies for both of us (she agreed). During this moment, I felt that a strong warm bond was shared among all three of us. [...] This experience also made me more aware of the benefits of having good relationships present between the interpreter-client and interpreter-therapist in addition to client-therapist toward helping cultivate an atmosphere of warmth and safety for the client (as I had read about in our course readings)" (121314Tc1s5j5)*

Consistent with the above therapist's description, a qualitative study conducted by

Mirdal, Ryding, & Sondej (2012) which interviewed therapists, clients, and interpreters

found that a good, trusting relationship between the three parties was considered s the

most important healing factor by everyone involved, namely therapists, clients, and

interpreters.

In terms of specific therapeutic interventions, therapists found that implementing

therapeutic interventions was possible with the help of a competent interpreter. As a

couple of therapists explained:

> *"It was also very interesting to see how easy it was to implement a relaxation exercise with the help of a language aid. There are some therapeutic interventions (e.g., chair work, relaxation) where you might expect that having an extra person involved would complicate or detract from the intervention. However, this was not the case. [Interpreter] did a good job of mimicking the soft tone of my voice (something which I had asked him to do in advance), and I do not think there was anything lost in the intervention. Interestingly, [interpreter] joined the client in closing his eyes throughout this exercise" (121312Tc1s15j15)*

> *"Overall however, I was excited and happy that we were able to do "therapy" using a CCRT psychodynamic model in a setting with an interpreter" (101101Tc1s9j9).*

B. Noticing Their Client's Ideas Regarding Mental Health and Healing Differed

from Their Own

The main sub-ordinate theme, "Noticing their clients' ideas regarding mental

health and healing differed from their own" further illustrated the therapists' need to

adapt. In other words, therapists had to adapt as they noticed that their client's ideas

regarding mental health and healing differed from their own. This theme is further

evidenced by three sub-themes, shown in Figure 8:
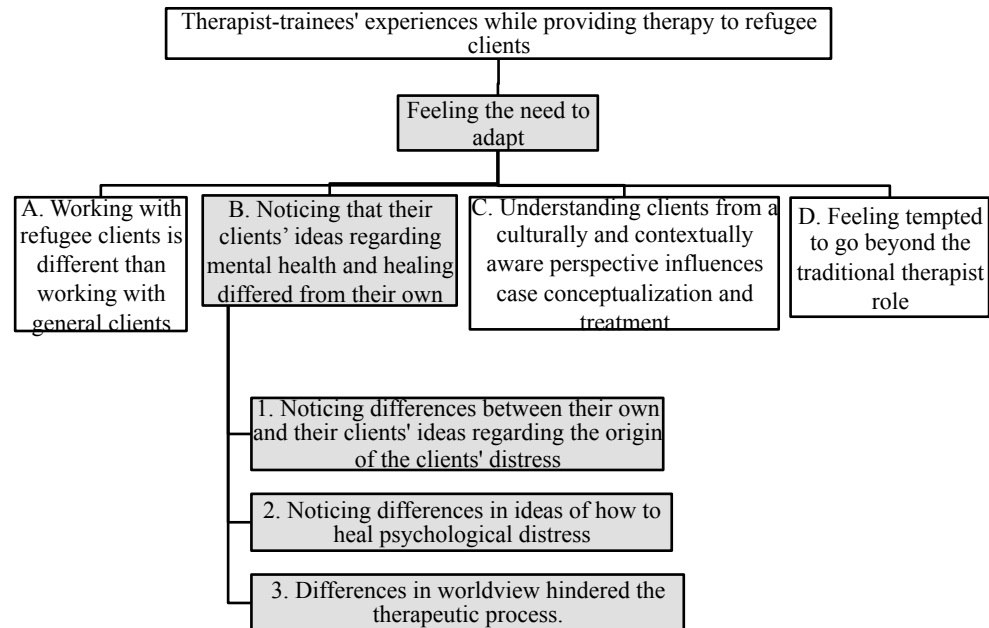
Figure 8. Three sub-themes emerged within theme "Noticing their clients' ideas regarding mental health and healing differed from their own". The shaded parts highlight the themes referenced in the current section. In order to aid with clarity, the two major themes "A sense of increasing cultural self-awareness" and "Building the therapeutic relationship is important" were omitted from this figure.

The first two sub-themes "Noticing differences between their own and their clients' ideas regarding the origin of clients' distress" and "Noticing differences in ideas of how to heal psychological distress" illustrate the differences in ideas about the etiology and treatment of psychological distress between therapists and clients. The third sub-theme "Differences in worldview that hindered the therapeutic process" illustrates how therapists perceived some of the differences in worldview between themselves and their clients as hindering to the therapeutic process.

1. Noticing differences between their own and their clients' ideas regarding the origin of clients' distress[25].
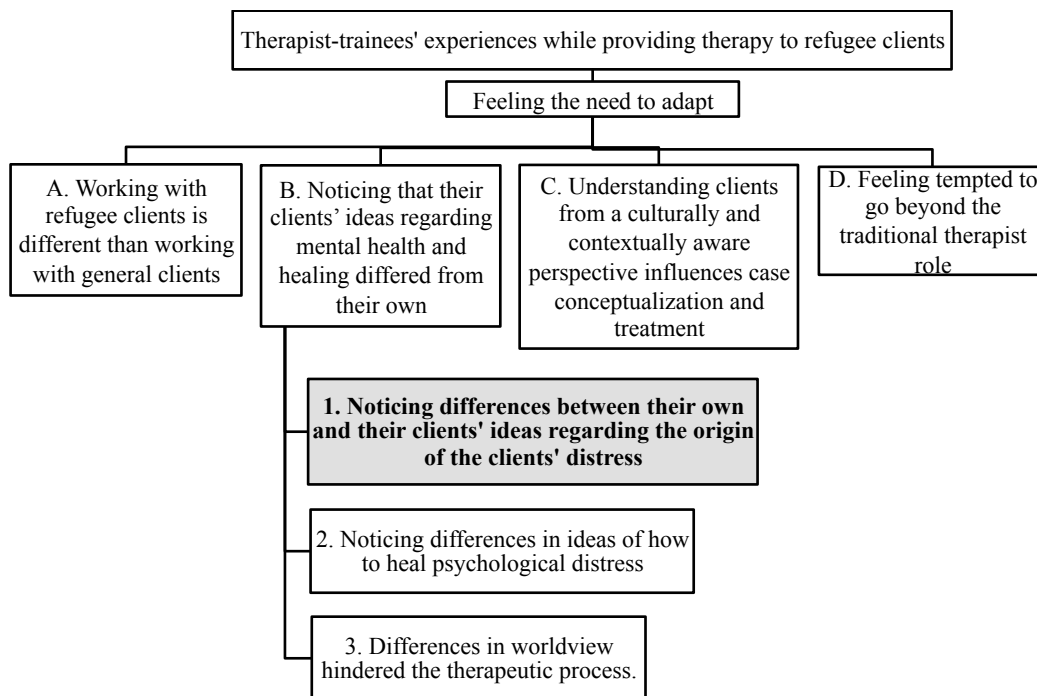
Figure 9. Thematic Overview. Locating the theme "Noticing differences between their own and their clients' ideas regarding the origin of the clients' distress". The shaded and bolded area illustrates the theme referenced in the current section.

During the working phase of therapy, around half the therapists noticed differences in their own and their clients' ideas regarding the origin and treatment of the client's distress. In light of these differences, therapists reflected on how to help their client given that client and therapist had "conflicting worldviews" as to the origins of the client's distress. For instance one of the clients believed his problems were caused by his family's attitude, his inability to speak English, and his lack of familiarity with Canadian culture. In contrast, consistent with Western psychological models, the therapist believed that the client's problems were aggravated by internal thoughts and feelings. The therapist explained to the client that he could control his own reactions and perceptions in order to

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[25] The location of this theme within the larger analysis is illustrated in figure 9.

better deal with external challenges. Despite the therapist's attempts at psycho-education,

the client maintained his position that his problems were all due to external causes. After

their session, this therapist expressed:

> *"The biggest challenge for me is how to help the client understand his role in maintaining his difficulties in a way that is not off-putting to him. At a broader level, this is an issue in which the client and therapist have two conflicting worldviews (e.g., viewing psychological distress as having primarily internal vs. external causes), and how this can impede progress in therapy"* (121312Tc1s6j6).

The therapist demonstrated cultural sensitivity in recognizing that the differences

in opinion between herself and her client were due to differences in worldviews, as

opposed to assuming the client's position was "wrong". It is important to note that

Canadian culture ascribes mental health issues to individual, internal causes, such as an

individual's thoughts and feelings. In contrast, several cultures ascribe the causes of

mental health issues such as anxiety or depression to external causes such as: stressful life

situations, punishment from god, or supernatural events such as witchcraft or curses (Mull

& Mull, 1983; Sheikh & Gatrad, 2000; Weatherhead & Daiches, 2010). In this case it is

important to validate the client's current difficulties. The process of getting established in

a new country and culture presents refugees and immigrants with various challenges.

These challenges may vary depending on the refugee's context and characteristics. For

instance, refugees may miss their countries of origin, they probably are at a disadvantage

in terms of communicating in the language of the host culture, they might be having

difficulties finding a job, and they may face social isolation and feelings of worthlessness

(Bemak & Chung, 2004).   Therefore, it is important to consider that when working with

refugee clients, in addition to internal issues, external events may play an important role

in the etiology of the client's mental health issues.

2. Noticing differences in ideas of how to heal psychological distress.

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┌────────────────────────────────────────────────────────────────┐
│   Therapist-trainees' experiences while providing therapy to    │
│                        refugee clients                          │
└────────────────────────────────────────────────────────────────┘
                 ┌──────────────────────────────┐
                 │     Feeling the need to adapt │
                 └──────────────────────────────┘
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A. Working with refugee clients is different than working with general clients	B. Noticing that their clients' ideas regarding mental health and healing differed from their own	C. Understanding clients from a culturally and contextually aware perspective influences case conceptualization and treatment	D. Feeling tempted to go beyond the traditional therapist role

> 1. Noticing differences between their own and their clients' ideas regarding the origin of the clients' distress

> **2. Noticing differences in ideas of how to heal psychological distress**

> 3. Differences in worldview hindered the therapeutic process.

Figure 10. Thematic Overview. Locating the theme "Noticing differences in ideas of how to heal psychological distress". The shaded and bolded area illustrates the theme referenced in the current section.

Therapists and clients also differed on their ideas of how to heal psychological distress. For instance, a therapist noted that she and her client had different views on their goals for treatment, such that the therapist wanted to work on enhancing positive thoughts while the client's goal was to "turn off" her worrisome thoughts:

> *"This session highlighted the differences that a client and I may have in speaking about their concerns and their recovery. Whereas I wanted to talk about enhancing the client's positive thoughts, her goal was to 'turn off' the worrying part of her mind so that she could get back to her important responsibilities" (111206Tc1s7j7).*

This idea of "turning off" the worrisome thoughts or not talking about previous traumatizing experiences parallels clients' views in a qualitative study conducted by Mirdal, et al. (2012). In that study, the clients expressed that talking about traumatizing events made them feel worse and that there was no reason to "wake up the demons" (p. 454). However, within the Canadian context and depending on the therapeutic orientation,

the goal is usually not to "turn off" thoughts but to examine and work through the

thoughts by exploring the associated emotions and developing more functional

cognitions.

In line with differing ideas on how to heal psychological distress, some therapists

described interventions and ideas that didn't work out for their clients. For instance, some

therapists found their client rejected their ideas or interpretations, as one therapist

described:

> *"My interpretation or "idea" that the migration process in and of itself flies in the face of Iraqi normative traditions was not accepted by the client. The client feels that he has been wronged and will not explore his own emotions, thoughts, or responsibility for his current situation. This was very frustrating from a therapeutic standpoint" (111208Tc1s4j4).*

Another therapist described how her client kept forgetting meaningful clinical

material from previous sessions. Finally some therapists described how their interventions

were not a good fit for their clients. Finding that their techniques were not effective

affected the therapists. In contrast to the previous sub-theme, "Wondering if they will be

able to help the client: feeling doubtful, helpless" (p. 66) where therapists wondered if

they would be able to help the client through his or her losses, in the present theme

therapists felt helpless due to their interventions being ineffective. For instance, one of the

therapists indicated that finding her techniques were not effective made her feel helpless

and made her question her ability to help the client:

> *"As she [w]as becoming more agitated, I thought I could help with a breathing exercise, but as my techniques did not seem to work for her, I felt helpless and wondered about my ability to really be supportive of her. When she returned to her seat, I focused on expressing to her my understanding, my support and acceptance and tried to normalize her experience, so that she feels I am truly understanding her" (111207Tc1s3j2).*

It is important to note that as exemplified in the above excerpts by therapists 111208T and 111207T, therapists felt frustrated, helpless, and in other instances, generally ineffective when their interventions were not a good fit for the client. There is a dearth of research regarding unsuccessful interventions with multicultural clients. While it is tempting to hypothesize as to the reasons interventions were not a good fit for these clients, I don't think this approach would be fruitful. In analyzing these excerpts, I was confronted with two of the limitations of the present study. The first limitation is that due to the ethics agreement and to therapist-client confidentiality I can't identify specific therapists or link them to their clients. Therefore, I am unable to interview specific therapists in order to further explore the reasons they thought their interventions didn't work for their clients. The second limitation of this study is that I am ethically and circumstantially precluded from contacting the clients in order to interview them and learn first-hand the specific reasons why the interventions didn't work for them.

3. Differences in worldview that hindered the therapeutic process.
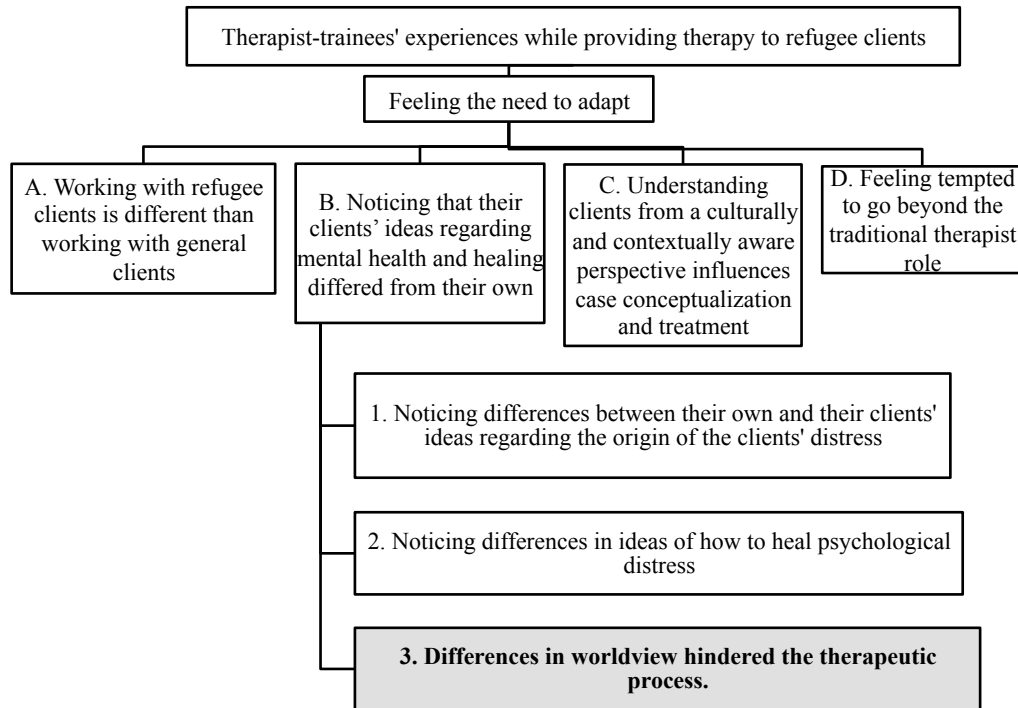
Figure 11. Thematic Overview. Locating the theme "Differences in worldview hindered the therapeutic process". The shaded and bolded area illustrates the theme referenced in the current section.

Not only did therapists need to adapt in order to accommodate differences in worldview with their clients, but also therapists mentioned several issues they perceived to be hindering to the therapeutic process. The present sub-theme "Differences in worldview hindered the therapeutic process" is divided into two categories:

3.1 Communication and cultural misunderstandings hindered the therapeutic process

3.2 Client characteristics hindered the therapeutic process

3.1 Communication and cultural misunderstandings hindered the therapeutic process[26].

Some therapists mentioned that communication difficulties and misunderstandings

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[26] Please refer to Figure 11 for an overview of the location of this theme within the broader analysis

regarding the therapeutic work itself impacted the therapeutic process. These reflections

emerged in the beginning phase and, more prominently, in the working phase of therapy.

After her first session with her client, one of the therapists mentioned that explaining

psychological questions was more challenging than she had initially expected. In

addition, she was able to empathize with how strange the experience probably was for her

client:

> *"This is the first time I feel that I have a real concept of the barrier that language and culture presents, beyond the intellectual understanding of it. Trying to explain psychological questions in plain straightforward language was much more challenging than I expected. I also felt that this must seem a strange experience for her as well" (111205Tc1s1j1).*

As hinted by the therapist mentioned above, the communication difficulties mentioned by

the therapists not only pertained to language differences, but also seemed to imply a

deeper level of cultural misunderstandings. These cultural misunderstandings are not

surprising given that, as mentioned previously, each culture has their own

conceptualizations and methods to reduce psychological or emotional distress. Other

countries that admit refugees such as Thailand and the Philippines further highlight the

cultural differences in views of mental health and healing. For example, services in

refugee camps such as Phanat Nikhom, Thailand and in the Philippine Refugee

Processing Center (Bataan) include services provided by traditional healers. These healers

successfully use rituals, incantations, steam baths, massages, and herbs to heal clients'

distress (Gong-Guy, et al. 1991).

The deeper, "cultural" misunderstandings mentioned by therapists in the present

study and that therapists thought hindered the therapeutic process emerged in several

ways. For instance, some therapists mentioned that they would pose a question and their

client would respond in a "tangential" or only "partially related" way. One therapist

explained that these misunderstandings were frustrating to her:

> *"I was very confused as to the reason why the client was not responding to the questions I posed to him. He seemed to be replying within a completely different subject area. I was unsure whether this was a result of the interpretation gone awry, a cultural misperception of my question, or a defensive response on the part of the client. Even after repeating the same question several times, I still did not obtain an answer to questions I asked such as, "What made you most angry about that situation?" "How were you feeling when that happened?" At times, he responded defensively stating, "How should [a] person feel who has had this happen to them?" Emotionally, this incident made me feel very frustrated and irritated with the client" (111208Tc1s15j15).*

Other cultural misunderstandings mentioned by the therapists pertained to the

therapy process itself. For instance, a couple of therapists mentioned having difficulties

setting goals for therapy as well as explaining the mechanisms of therapy. As one

therapist mentioned:

> *"The language barrier seemed to play a role, as it was difficult to explain to the client why it would be good to have specific areas of focus. It was also difficult to explain why it might be useful to talk about traumatic events in detail with the client" (101104Tc1s4j4).*

Explaining to the clients that the main premise of western therapy involves talking about

painful or traumatic events may be even more challenging due to several cultural beliefs.

For instance, some cultures maintain that talking about traumatic events is not helpful and

can worsen symptoms. Moreover, they might not even believe in talking as a healing

method (Mirdal, et al., 2012). Additionally, clients may expect the therapists to take a

more active role in alleviating their symptoms by providing remedies or rituals (Mull &

Mull, 1983; Yeh, Hunter, Madan-Bahel, Chiang, & Arora, 2004).

3.2 Client characteristics hindered the therapeutic process[27]

Along the same lines, some therapists mentioned characteristics in their client, which

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[27] Please refer to Figure 11 for an overview of the location of this theme within the broader analysis.

they felt interfered with the therapeutic work. These therapy-hindering client

characteristics are in turn divided into three subthemes:

3.2.1 Client's deference to authority hindered the therapeutic process

3.2.2 Client not contacting and not experiencing emotions hindered the therapeutic

process

3.2.3 Other client characteristics hindered the process (i.e., education level, previous

diagnoses)

Most of these therapy-hindering characteristics emerged in the working phase of

therapy and seemed to be influenced by culturally based differences or perceptions.

3.2.1 Client's deference to authority hindered the therapeutic process

A couple of therapists described how they felt that their clients' respect and deference

to authority affected the therapy process.   As one therapist expressed:

> *"This experience highlighted again how careful I have to be working with people of certain cultures that put great emphasis on showing respect for those in authority. I often do not think of myself as a person of authority, but this is how I am viewed by my clients. I need to be more aware that when I offer suggestions about experience, even to assist a client who is having trouble expressing things that are happening in her life, they will be reluctant to disagree with me" (111206Tc1s6j6).*

It is important to note that most western therapies encourage therapists to work

collaboratively with their clients. The client is considered an expert of his or her own life.

In other words, while the therapist is the expert and has some authority, the client is

considered to be the ultimate expert of his or her own experiences (Greenberg, et al.,

1993). Following this principle, in most therapeutic modalities, therapeutic interventions

are made tentatively, usually asking for the client's input regarding the degree of fit with

their lived experience (Paivio & Pascual-Leone, 2010). In contrast, traditional healers,

shamans, or "curanderos" typically assume more responsibility for the healing process

and the problems or issues are often assumed to be beyond the client's control as they are attributed supernatural, spiritual, or systemic etiologies (Mull & Mull, 1983; Yeh, et. al., 2004). Refugee clients' views of therapists as authority figures are to be expected when considering the following two factors: the expert position of traditional healers, which may be more familiar to refugee clients and some cultures' emphasis on hierarchy and authority. However, therapists are placed in a difficult position; on the one hand their refugee clients view them as authority figures and may want more direct advice from the therapists. On the other hand, therapists are reluctant to provide direct advice as they are making every effort to be culturally sensitive and not impose their cultural values on their clients.

3.2.2 Client not contacting and not experiencing emotions hindered the therapeutic process[28]

Another important issue that interfered with the therapeutic process concerned the clients' emotional expression in session. Some therapists described how their clients were reluctant to disclose their emotional experience in session. These therapists mentioned their clients were reluctant to discuss personal feelings, as one therapist wrote:

> *"I found the client's defensiveness or inability to discuss his personal feelings and reactions to be somewhat of a hindrance during session for exploring deeper meaning" (111208Tc1s7j7).*

It is important to note that most western psychotherapies rely on verbal and emotional expression and exploration (Sue, Zane, Nagayama Hall, & Berger, 2009). Emotional connection is an important component of therapeutic work in western cultures. Thus, it is not surprising that the therapists found the clients' lack of emotional connection hindering

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[28] Please refer to Figure 11 for an overview of the location of this theme within the broader analysis.

to the therapeutic process. Moreover, a couple of therapists described feeling

"incompetent" for not being able to get the client to "open up". As one therapist

mentioned:

> *"Regarding myself, I felt a bit incompetent and frustrated that I could not get*
> *her to open up more about her experiences" (111206Tc1s1j1)*

It is important to mention that the client's lack of emotional expression was probably

unrelated to the therapists' level of competence. As mentioned previously, Western ways

of healing psychological pain are not universal. Different cultures have different ways of

healing, most of which are not centered on verbal and emotional expressions (Kottler, &

Carlson, with Keeny, 2004). Thus, it is foreseeable that therapists would fail at eliciting

emotional expressions from their clients if their clients' belief systems do not include

emotional and verbal expressions as viable options for healing psychological distress

(Dwairy & Van Sickle, 1996). However, consistent with their training and with research

that suggests that emotional experiencing (Greenberg, et al., 1993) and meaning-making

in therapy are curative (Mirdal, et al., 2012), some therapists encouraged their clients to

connect with their emotional experience to no avail:

> *"I also tried to redirect the focus at some points by reflecting the emotional*
> *experience the client may have experienced (e.g., when discussing the death*
> *of his parents), but the client did not seem to follow this path. Instead, the*
> *client responded with phrases such as "That's life!" in one instance"*
> *(101101Tc1s2j2).*

Another therapist realized after her session with her client that her attempts to explore

emotional experiences were probably very confusing for her client:

> *"Reflecting after the session, I'm now much more aware of how my attempts*
> *to explore his emotional experience were completely foreign and confusing*
> *for [client]" (121311Tc2s2j4)*

A couple of therapists also described how their clients were more willing to describe

somatic complaints as opposed to emotional experience:

> *"Interpersonally, I expected myself to take the somatic description, but rather I found myself probing further for any hint of psychological/emotional pieces (which I did not find)[....] In terms of cultural awareness & knowledge, I think it just really "drove home the point" that in many cultures emotions are not the focus, but rather the somatic presentation is most salient" (101102Tc1s1j1).*

It is interesting to note that this therapist indicated she was expecting somatic descriptions from her client and still insisted on searching for emotional correlates. This therapist's expectations were aligned with the literature, which suggests that, across cultures, somatic symptoms are the most common indicators of emotional distress (Kirmayer & Young, 1998). In the above excerpt the client is likely suffering some form of emotional distress. However it is also important to note that this was the client's first session, a time when the relationship and trust between therapist and client is just beginning to develop. Thus, reporting somatic symptoms may have felt somewhat safer than talking about emotional experiences.

3.2.3 Other client characteristics hindered the process[29]

Some therapists mentioned other client characteristics that they thought interfered with the therapy process. For instance, one therapist had a client who had been previously diagnosed with Cognitive Disorder Not Otherwise Specified (NOS). This therapist hypothesized that this disorder affected the client's ability to understand and remember what was discussed in session, thus hindering the therapeutic process.

In addition, some therapists mentioned their client's low level of education as an aspect that influenced the therapeutic process. As one therapist described:

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[29] Please refer to Figure 11 for an overview of the location of this theme within the broader analysis.

> *"One characteristic of the client that I should have been more aware of was the fact that she had very little education, and her educational experience was halted due to the war in her country of origin. While an individual's specific culture may influence their views toward therapy and talking to others about their lives, so will education level and how this interacts with cultural beliefs. This experience highlighted the importance of psychoeducation within all of my sessions" (111206Tc2s2j9).*

It is important to note that refugee clients that come from war torn third world countries may not have the same educational opportunities to those of an average Canadian citizen. Thus, therapists need to be mindful not only of cultural differences but of educational disparities when working with these clients.

C. Understanding Clients from a Culturally and Contextually Aware Perspective Influenced Case Conceptualization and Treatment

The theme "Understanding clients from a culturally and contextually aware perspective influenced case conceptualization and treatment" demonstrated therapists' need to adapt their understanding of their clients while taking into account a culturally and contextually aware perspective. This theme is made up of three sub-themes illustrated

in Figure 12:
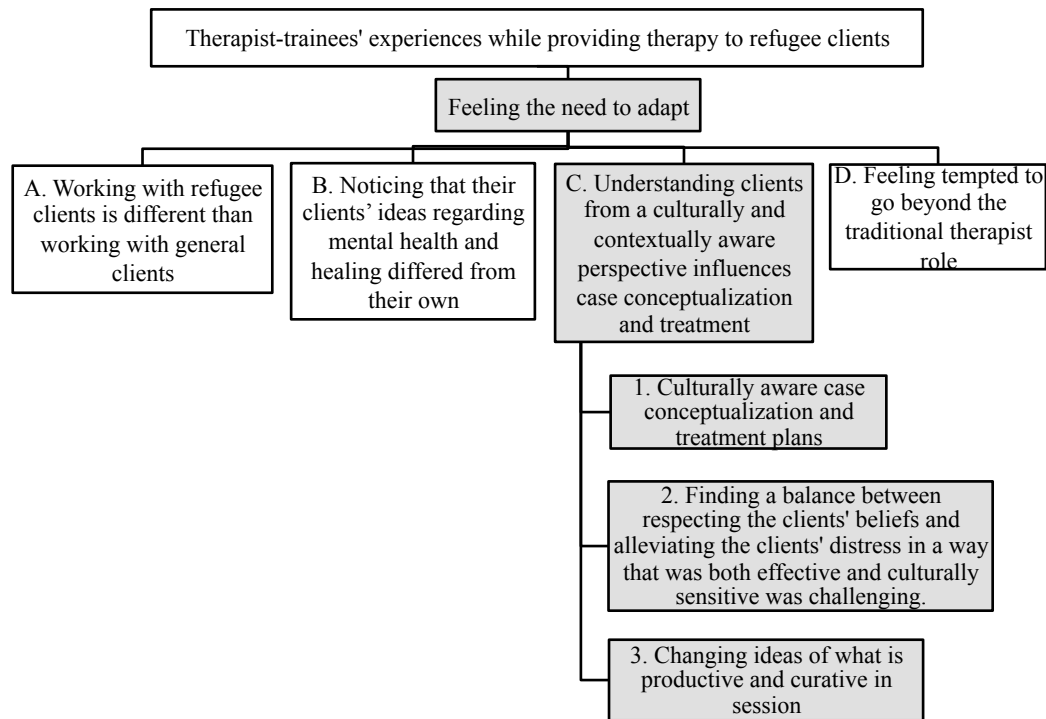
Figure 12. The theme "Understanding clients from a culturally and contextually aware perspective influences case conceptualization and treatment" was further evidenced by three sub-themes. The shaded parts highlight the themes referenced in the current section. In order to aid with clarity, the two major themes "A sense of increasing cultural self-awareness" and "Building the therapeutic relationship is important" were omitted from this figure.

The first sub-theme, "Culturally aware case conceptualizations and treatment plans", showcases the modifications therapists made in their case conceptualizations and treatment plans in order to better accommodate for the clients' cultural context. The second and third sub-themes, "Finding a balance between respecting the clients' beliefs and alleviating the clients' distress in a way that was both effective and culturally sensitive was challenging" and "Changing ideas of what is productive and "curative" in session" further evidenced how culturally aware perspectives shaped treatment.

1. Examples of culturally aware case conceptualizations and treatment plans.

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┌─────────────────────────────────────────────────────────────────────┐
│   Therapist-trainees' experiences while providing therapy to refugee clients   │
└─────────────────────────────────────────────────────────────────────┘
                    ┌─────────────────────────────┐
                    │   Feeling the need to adapt   │
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┌────────────────┐ ┌────────────────┐ ┌────────────────┐ ┌────────────────┐
│ A. Working with │ │ B. Noticing that │ │ C. Understanding │ │ D. Feeling tempted │
│ refugee clients │ │ their clients' ideas │ │ clients from a │ │ to go beyond the │
│ is different than │ │ regarding mental │ │ culturally and │ │ traditional therapist │
│ working with │ │ health and healing │ │ contextually aware │ │ role │
│ general clients │ │ differed from their │ │ perspective │ └────────────────┘
└────────────────┘ │ own │ │ influences case │
                   └────────────────┘ │ conceptualization │
                                      │ and treatment │
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┌──────────────────────────────────────┐
│ **1. Examples of culturally aware case** │
│ **conceptualization and treatment plans.** │
└──────────────────────────────────────┘

┌──────────────────────────────────────┐
│ 2. Finding a balance between   │
│ respecting the clients' beliefs and   │
│ alleviating the clients' distress in a   │
│ way that was both effective and   │
│ culturally sensitive was challenging.   │
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│ 3. Changing ideas of what is   │
│ productive and curative in session   │
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Figure 13. Thematic Overview. Locating the theme "Examples of culturally aware case conceptualization and treatment plans". The shaded and bolded area illustrates the theme referenced in the current section

Therapists had to adapt their understanding of their refugee client to include cultural and contextual issues. Nearly all therapists explicitly mentioned culture and the client's context in their clinical understanding of their clients. While these reflections emerged throughout the therapy process, most of these reflections occurred with the working phase of therapy. Notably, most reflections on adopting a more culturally aware perspective emerged following therapists' fifth session with their client, in their fifth CIJ. One of the therapists provided an excellent example of identifying the "typical western" hypothesis and rationale for the client's change and then thoughtfully account for the client's culture in developing a culturally sensitive rationale and case conceptualization:

> *"I remember thinking, [....] about what truly had pushed her to the point of leaving her husband. After all, per her account, he had been abusing her*

physically and sexually on a daily basis for years. Why now? I remember turning this over in my head, because I knew that the answer would not be a typically "Western" explanation. From the Western perspective, one might hypothesize that she became empowered through therapy to assert herself and act in her best interest. One could also hypothesize that her inner sense of self and personal value had become strengthened. However, these explanations are from an individualistic stance. This client's culture is collectivist, where doing something to benefit oneself is not considered to be a sign of positive growth and is actually frowned upon. After quite a bit of deliberation, I venture the following explanation: Up until now, the client had been suffering abuse in silence, hoping that doing so would afford her husband the opportunity to repent his behavior. According to her cultural and religious views, revealing the nature of the abuse or seeking safety in the form of soliciting punishment of her husband from the authorities would be selfish. However, when her husband made a vow to her, her children and to God that he would never raise his hand to them again, the interests of the collective were strengthened. As such, when he broke his vow, he was not just breaking a promise to her – he was breaking his promise to them all. Moreover, given the degree of importance and significance of God in the Karen culture, the fact that the husband had broken his promise to God was much more significant, and allowed her to break away from him" (101103Tc1s5j5).

The above therapist's cultural conceptualization is consistent with research on displaced Karen refugees. Karen culture highlights the importance of spiritual values and a collectivistic worldview where culture, religion, spirituality, and social values are considered a united entity (Worland & Vaddhanaphuti, 2013). In addition to highlighting therapists' ability to adapt, their ability to understand their clients' underlying core values shows that these therapists were developing their cultural self-awareness (Richardson & Molinaro, 1996).

Understanding the client from a culturally aware perspective also influenced the therapists' conceptualization of the client's presenting problem. For example, another therapist emphasized the importance of considering culture in identifying and assessing the client's presenting problem:

"This experience has highlighted the importance of culture in the identification and assessment of the presenting problem. My

conceptualization of her primary concern being that of her overly close relationship with her children needs to be tempered by issues of culture. What I might consider overly close by Western standards may be much closer to normal parent-child interactions in Middle Eastern culture. This will also influence the course of treatment and my therapeutic approach. In this first interaction it became apparent that I will need to include a cultural framework in working with this client, and that we cannot simply proceed with 'therapy as usual' "(111209Tc1s1j1).

The above therapist's insight that her assessment of the client's concern needs to be "tempered" by cultural awareness is accurate. In fact, the literature suggests that in contrast to Western cultures' emphasis on individual development and psychosocial separation from the family unit, other cultures (including Middle Eastern cultures) emphasize the individual's belonging to and identifying with the collective identity of the family and community (Dwairy & Van Sickle, 1996). This point echoes the therapist's assertion that therapy with her client was not going to be "therapy as usual". Psychotherapeutic assessment and treatment should be modified in order to better fit the client's culture and worldview (Dwairy & Van Sickle, 1996). The challenge of understanding the refugee clients from a culturally aware perspective was further evidenced by the therapists' reflections on the challenges of ensuring therapy was effective and culturally sensitive.

2. Finding a balance between respecting the clients' beliefs and alleviating the clients' distress in a way that was both effective and culturally sensitive was challenging.
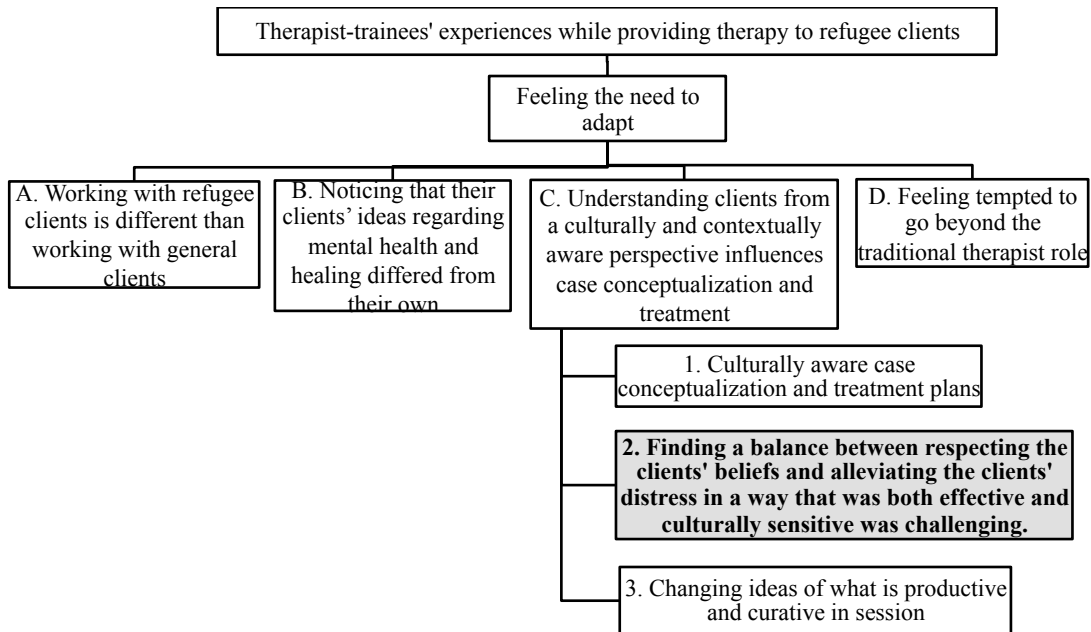
Figure 14. Thematic Overview. Locating the theme "Finding a balance between respecting the clients' beliefs and alleviating the clients' distress in a way that was both effective and culturally sensitive was challenging". The shaded and bolded area illustrates the theme referenced in the current section

This theme further evidences how understanding clients from a culturally aware perspective influenced treatment planning. This theme is further illustrated by one sub-theme which describes the ways in which therapists actually modified and adapted the therapeutic interventions in order to better work with their clients: "2.1 Modifying and adapting therapeutic interventions in order to ensure therapy was both effective and culturally sensitive".

The theme "Finding a balance between respecting the clients' beliefs and alleviating the clients' distress in a way that was both effective and culturally sensitive

was challenging" refers to the therapists' ideas and thoughts regarding cultural sensitivity

and therapeutic efficacy. Some therapists reflected on the challenges inherent in finding a

balance between respecting the client's beliefs and alleviating the client's distress in a

way that was both effective and culturally sensitive. These reflections mostly emerged

during the working phase of therapy. For example, during her sixth session with her

client, one of the therapists was faced with a difficult situation in which the client didn't

want to disclose her concerns. The client believed that if she spoke of her concerns

something bad would happen to her son. The therapist reflected on the dilemma of

wanting to be culturally sensitive while at the same time endeavoring to provide effective

therapeutic care:

> *"This experience indicated a strong need to balance the beliefs of the client with doing what will be helpful for the client. I am willing to find a compromise that will be both beneficial to the client, but that will also make her feel comfortable. I can only imagine the damage that could be done if she were forced to tell me her concerns and then coincidentally something happens to her son. Certainly, that kind of event would be hard enough to withstand and it would only be made worse with the damaging belief that you contributed to its occurrence." (111205Tc1s6j5).*

The therapist in the excerpt above is being culturally sensitive by respecting and, in some

ways, embracing her client's worldview and not insisting the client disclose her concerns.

Within this same sub-theme, some therapists described how balancing the clients'

collectivistic views pertaining to their family and finding appropriate, culturally sensitive

interventions was challenging. For instance, a therapist reflected on the cultural

appropriateness of an intervention, which aimed at helping the client to express his

emotions:

> *"I wonder whether this intervention is culturally appropriate. On the one hand, if the client is hesitant to express anger towards his brothers for cultural reasons (e.g., emphasis on the family and harmonious relationships), then I want to be sensitive to that. On the other hand, I genuinely believe that*

anger is a justifiable reaction in this case, and one that is more adaptive than his current reaction of self-blame. Further, the client need not express this anger towards his brothers (e.g., confronting them); however, he may still benefit from acknowledging that those feelings exist in him (assuming that is the case!) and from expressing those feelings to me in therapy" (121312Tc1s3j3).

Another therapist described a similar situation. This therapist described the challenge of finding culturally sensitive directions to alleviate her client's distress by finding emotional resolution from family issues, while at the same time allowing the client to remain close to her family:

"However, it has also taught me to tread carefully; it's clear that while she is able to see where her family has let her down, she still feels close to them. Resolution will therefore not come from distancing herself from them, but from finding a way to express the hurt in a way that makes her feel heard, if only in therapy, but allows her to maintain a relationship with her family" (111209Tc1s3j3).

These experiences showcase how western psychotherapy, which is based on individualistic values, needs to be modified for clients who hold collectivistic values. Research into several collectivistic cultures suggests that, within these societies, a person's concept of self is based on interdependence (Dwairy & Van Sickle, 1996; Tamasese, Peteru, Waldgrave, & Bush, 2005; Worland & Vaddhanaphuti, 2013). In other words, there is no concept of "self" independent from the community. Moreover, in collectivistic cultures, mental health is equated with harmonious relationships both within the community and the spirit world (Dwairy & Van Sickle, 1996; Tamasee, et al., 2005). Thus, emotions such as anger or disappointment toward the family or community group are usually repressed. For instance, in Arabic cultures it is common to avoid direct expressions of anger, disappointment, or disagreement in order to maintain vital social supports and relational harmony. Emotional disclosures and mental health issues are supposed to be discussed only within the family context (Dwairy & Van Sickle, 1996).

Conversely, western psychotherapy encourages individuation through self-expression and self-actualization. The goal of successful treatment by western standards is that the client becomes more aware of his or her repressed emotions and for him or her to be able to appropriately express these emotions (Dwairy & Van Sickle, 1996). Collectivistic worldviews on mental health and wellbeing sharply contrast with western individualistic worldviews. Therefore as the therapists aptly noted, it is important to modify treatment so that the client's familial relationships are preserved.

　　　2.1 Modifying and adapting therapeutic interventions in order to ensure therapy was both effective and culturally sensitive[30].

　　　Therapists' need to adapt and understand their clients from a culturally sensitive perspective was also highlighted by therapists actually modifying their interventions. Most therapists mentioned instances in which they modified their therapeutic interventions in order to ensure therapy was both effective and culturally sensitive. Contrasting with the previous sub-theme, which portrays therapists' reflections and perceived challenges in being both culturally sensitive and effective when working with clients with different beliefs, this sub-theme describes therapists' actual modifications and adaptations pertaining to the therapeutic interventions.

　　　In light of differing views and beliefs between themselves and their clients, most therapists mentioned having to adapt their interventions to better suit their clients. In general these adaptations pertained to adopting a more collaborative style with their clients, adapting to accommodate language differences, and allowing family members to partake in the session. Most of these reflections emerged during the working phase of

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[30] Please refer to Figure 14 for an overview of the location of this theme within the broader analysis.

therapy. However, some therapists realized that they needed to adapt their interventions

early on in the therapy process. For instance, after her first session with her client, one

therapist acknowledged that she would modify her style as she felt she was too directive

with her client:

> *"It was a strong indicator to me that I could not rely on the methods I have used before, but that I need to expand my style of interacting. While I wanted her to be able to speak openly, I feel I was more directive than I should have been and this is something I intend to work on in the coming sessions" (111205Tc1s1j1).*

Along the same lines, around half the therapists mentioned that the main modifications to

their approach involved being less directive, adopting a more collaborative stance, and

allowing their clients to have more control of the session. For example, a therapist

described how she felt therapy could be most helpful by maintaining a close collaborative

relationship with her client and allowing the client to guide so that the sessions would fit

better with the client's cultural background:

> *"It encouraged me to maintain a close collaborative relationship with the client [...] I like to see the client as an equal partner in our work, but in particular in this context, I feel that the only way I can truly be helpful is if I ask my client to be a guide for me so we can work together towards making our sessions fit with her cultural background" (111207c1s2j1).*

The idea of adopting a more collaborative stance in order ensure the therapeutic work was

a good fit for the client's background is echoed in the literature. For instance, Dyche and

Zayas (1995) advise therapists working with culturally diverse clients to adopt an attitude

of openness, receptivity, and curiosity in order to ensure the client is truly listened to and

understood. This receptive and collaborative attitude is likely to reduce the power

imbalance usually found in therapist-client relationships and fosters a sense of equality.

Moreover, this collaborative stance is likely to facilitate the process of finding novel

solutions and meanings for the client's presenting issues (Dyche & Zayas, 1995; Semmler

& Williams, 2000). Along the same lines another therapist mentioned that she

endeavored to refrain from imposing labels from Canadian culture onto her client's

experiences, thus allowing the client to speak in her own terms:

> *"One way that I have tried to make the topic more comfortable for the client*
> *is to speak about these incidences in her own terms, rather than imposing*
> *labels from my culture on her experience" (111206Tc2s1j8).*

This therapist's willingness to encourage the refugee client to speak about her experiences

in her own terms is important as in many cases refugees are not given this opportunity

(see Ortiz, 2001; Watters, 2001).

Some therapists reflected on being flexible and adapting their therapeutic

interventions in order to accommodate the language differences. For instance, a therapist

reflected on the difficulty of providing more comprehensive psycho-education, which for

her would typically involve the use of written materials and written exercises. Due to the

lack of materials in the client's native language, the therapist had to be flexible and

modify her approach. The therapist explained how she modified her intervention by

substituting written activities with verbal activities:

> *"The second incident that stood out was the difficulty of trying to provide*
> *therapy using written materials when the client does not speak English [...]*
> *(this) requires me to increase my flexibility with the procedures I would*
> *usually follow with my client. Given that the use of written material is*
> *difficult, I will try to adapt some of those written activity to oral exercises"*
> *(121310Tc1s7j7).*

Along the same lines, some therapists reflected on the importance of being very

clear and specific in their communications with their clients in order to ensure mutual

understanding and to "connect" with the client. These reflections emerged mostly during

the working phase of therapy. As one therapist expressed in her sixth journal:

> *"… it's yet another lesson in specificity: get as much information as possible*
> *to fully understand how my client sees the meaning of what they said. If I*

were to not seek the specificity, I would have missed the element of exasperation and instead I would have called 911. Not the best care. So ask questions until I move past my own assumptions and connect with the client"(111207c1s7j6).

These therapists' insights echo previous research, which suggests that ensuring clear and accurate communications especially when the client and therapist don't speak the same language is fundamental to successful treatment. Lack of clarity can lead to misinterpretations that can result in therapists and clients having different goals and expectations for therapy; such misunderstandings hinder treatment and increase the likelihood of client attrition (Mirdal, et al., 2011).

Another treatment adaptation involved including family members in the therapy session. A couple of therapists modified their usual way of conducting individual therapy by allowing their clients to bring family members into the session. Echoing previous research (Cardemil & Sarmiento, 2009; Mourad & Abdella-Carolan, 2010; Tamasese, et al., 2004; Yeh, et al., 2004) both therapists found that including family members in session seemed to make the client feel more comfortable. In addition, family members' reports gave the therapists further insight into understanding their clients. As one of the therapists mentioned:

> *"The client decided to bring her husband to the session as support and comfort for her. Having them both in the session and hearing their opinions on certain subjects, I could see more clearly how the client was reacting differently to her present situation than her husband. Up until this point I had attributed some of the client's characteristics (her quiet nature, her reluctance to talk more in depth about her life) to her cultural background and differences in emotional expression based on her worldview. Yet, by hearing from her husband about his concerns, I came to the conclusion that some of these characteristics appeared not to be fully culturally-based, but a reflection of the client's personality and current struggles" (111206Tc1s2j2).*

While the therapists were willing to adapt in order to work better with their clients, only one therapist considered that adopting a multicultural stance was "liberating"

in terms of allowing her to engage in meaningful, but unconventional, interventions:

> *"In a way, multicultural therapy has been liberating for me. I often feel that this approach grants me permission to do things that—despite feeling natural and consistent with a therapeutic approach—are outside the range of things that are typically done in therapy. For example, I believe it makes a lot of sense for therapists to offer to take a picture with clients (should the client be interested in doing so) and then give that picture to the client in the final session. It can be symbolic and meaningful for both parties, and can provide a nice transition into the end of therapy. Yet this is not something that is traditionally done. My experience in this session with the client showed me how such unconventional interventions can really serve to acknowledge the therapist-client bond" (121312Tc1s18j18).*

3. Changing ideas of what is productive and "curative" in session.
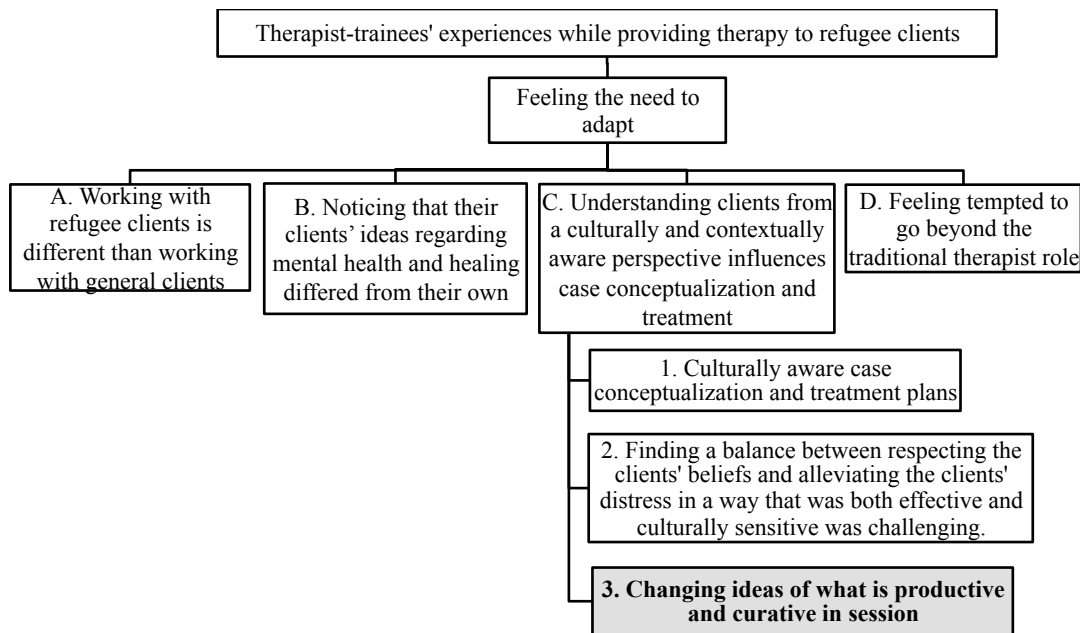
Figure 15. Thematic Overview. Locating the theme "Changing ideas of what is productive and curative in session". The shaded and bolded area illustrates the theme referenced in the current section.

Not only did the therapists find themselves adapting their therapeutic interventions for their clients; throughout the therapeutic process, some therapists found themselves changing their ideas of what is productive and "curative" in session. These reflections further evidenced the importance of understanding clients from a culturally aware

perspective. In general these curative gestures entailed the therapists' showing they cared

about their refugee clients. For example, a couple of therapists acknowledged the

curative effect of just "being there" or "providing a listening ear". One of the therapists

realized that her client was more in need of someone to listen to her due to being isolated

in her new host country:

> *"This experience has been really good for me. I have never felt a client's*
> *need for support so strongly as I have with [client], and it underscores the*
> *benefits that therapy can provide, even if its role is just in providing an ear to*
> *listen to. I think this is particularly relevant to clients who are more isolated*
> *as a result of not being from the dominant culture" (121310Tc1s14j14).*

These therapists' experiences are consistent with a previous qualitative study,

which explored refugee client's perceptions of curative factors in session. In that study,

refugee clients expressed that feeling "welcomed", liked, and appreciated were, in

themselves, curative experiences (Mirdal, et al., 2012). It is important to remember that

refugee clients are typically separated from their family and have limited social supports

in their new host country (Beiser, 2005; Tribe, 2002). As a result, the support of a strong,

trustworthy, safe, and caring therapeutic relationship can be curative and therapeutic in

itself. A couple of therapists wrote about the healing impact of allowing clients to share

their positive experiences in a safe space. These therapists noted that reminiscing about

positive experiences is not common in therapy with general clients. Moreover, before

their work with their refugee clients these therapists didn't consider that providing a safe

space for their client to talk about positive experiences was a healing therapeutic

intervention in itself. For instance, in the following excerpt, one of the therapists became

aware of the curative effect of providing a safe space for her client to explore past

positive and meaningful experiences. This therapist also puts forth the idea that

productive therapeutic interventions are different for each individual client:

> *"It made me think that gauging what is and is not productive therapeutic work in a session is not the same across every individual, nor across every culture. I think that for the client, being able to have a safe environment in which she was able to let her guard down, focus on herself, and allow herself to reminisce about the better times in her life had a very curative effect. This is something I have not really done with other clients – most have focused on problems in their life and not reflections about positive experiences. It felt nice to see her smile, to allow her to remember what it's like to be genuinely happy and be able to take time to let those emotions bubble to the surface"* (101103Tc1s4j4).

Some therapists provided further examples of the healing nature of gestures that they would usually not consider to be therapeutically useful. These therapists found that behavioral demonstrations or "acts of caring" were very important for the clients. For example, a therapist mentioned the impact of actively trying to contact the client after the client missed a session. According to this therapist, her client was very happy and felt that someone cared about her:

> *"We were talking about how she feels isolated and wants people around her and she spontaneously said that last week when we (her case worker and I) were so worried about her after she couldn't be reached and didn't show up for her appointment that we showed up at her apartment she was tired from the hospital but she was so unbelievably happy to see us. She said she felt that someone cared about her"* (111209Tc2s3j6).

Another example of a gesture that would ordinarily not be considered therapeutic but which turned out to be very useful, was the ritual that one of the therapists developed with her client at the end of each session. This therapist realized that at the end of each session she and her client would take some time to schedule their next meeting. The therapist emphasized how this ritual showed she cared and valued her time with the client while at the same time modeling a way to concretize plans for her client:

> *"I concluded the session in the same way I have since the beginning of therapy, by telling [client] I would love to see him again the following week. I then offered him one afternoon and one evening time slot, as I know his*

schedule varies, and he agreed to the one that worked best for him. As soon as [client] left the room I was struck by how the way in which we have been ending the sessions fit so perfectly with the content of the session. During the session we had focused on how [client] leaves open invitations for friends and acquaintances to visit him, but does not make specific plans, and feels as if others don't care about him when [they] don't follow through and come to visit. I realized that at the end of each session I have been explicitly communicating that I care about him and value our time together. Further, I have been modeling how to make specific plans to meet with another person, something which [client] is extremely unfamiliar with. Prior to this session I had not truly really realized the importance of this small act of saying goodbye and planning the next session" (121311Tc2s5j7).

D. Feeling Tempted to Go Beyond the Traditional Therapist Role

Another adaptation mentioned by most of the therapists referred to feeling tempted or even going beyond the traditional therapist role. This theme is made up of two subthemes as illustrated in Figure 16.
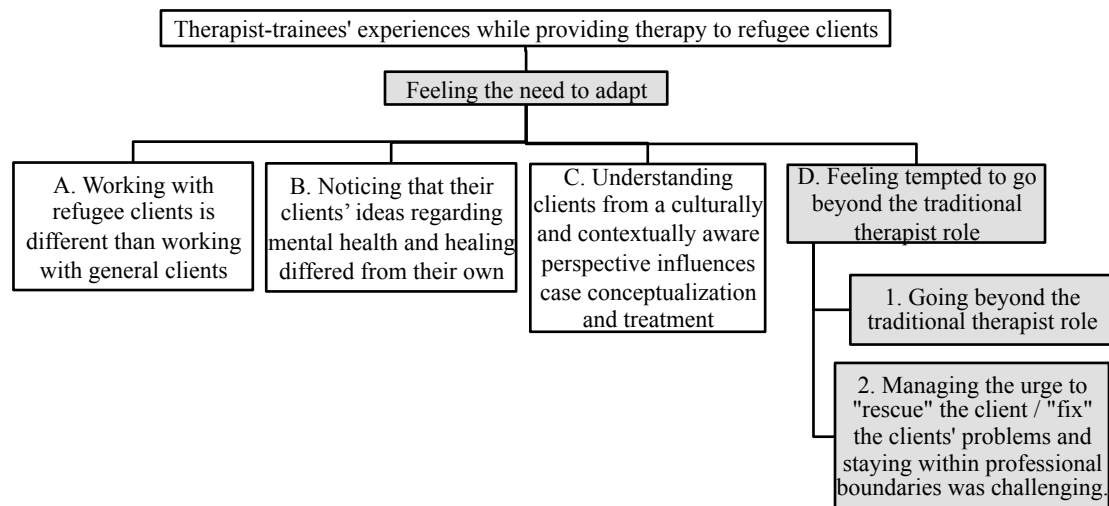
Figure 16. The theme "Feeling tempted to go beyond the traditional therapist role" was further evidenced by two sub-themes. The shaded parts highlight the themes referenced in the current section. In order to aid with clarity, the two major themes "A sense of increasing cultural self-awareness" and "Building the therapeutic relationship is important" were omitted from this figure.

The first sub-theme, "Going beyond the traditional therapist role" shows how therapists found themselves actively advocating or helping their clients in more active or

"hands on" ways than is typical for psychologists within the Canadian context. The

second subtheme "Managing the urge to "rescue" the client / "fix" the client's problems

and staying within professional boundaries was challenging" further evidences therapists'

temptations to go beyond the traditional professional boundaries in order to "rescue" or

"fix" their refugee clients.

1. Going beyond the traditional therapist role.
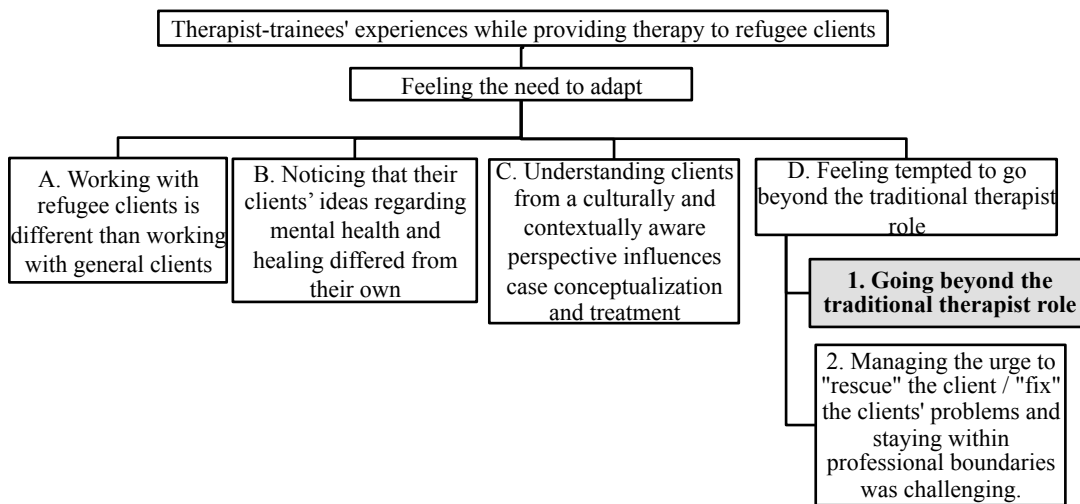
Figure 17. Thematic Overview. Locating the theme "Going beyond the traditional therapist role". The shaded and bolded area illustrates the theme referenced in the current section.

Throughout the therapeutic process, some therapists described how they went

beyond their traditional therapist role by advocating for their refugee clients and by

helping their client outside of session. The value of these interventions is echoed in

Mirdal et al. (2012). In that study, therapists and interpreters indicated that helping the

client in practical ways (such as taking the client shopping for food) was curative for the

client. In the present study, therapists described various ways in which they went beyond

their traditional role. For instance, a therapist helped her client organize resources, such as

her stay at Hiatus House (a local women's shelter). This same therapist also aided the

client in calling the police when the client decided to leave her abusive husband. Another

therapist met with her client at the Alzheimer's Society in order to help the client find a

volunteering position. Yet another therapist had to help her client understand her rights to

medical confidentiality in a situation where the client's physician was disclosing

information about the client's health to the client's husband. This therapist indicated:

> *"I believe this incident has made me want to take on more of a role in advocating for the rights of my client than I had expected. I do not tend to be a very pushy individual, yet I realize that for something as important as the well-being of my client I will be able to adopt this broader role"* (121310Tc1s2j2).

Around half the therapists went beyond their therapeutic role by spending time

outside of session researching and trying to learn more about their client's culture. These

therapists engaged in research activities mostly at the beginning phase of the therapy

process. One of these therapists also spent time reviewing materials her client gave her.

This therapist shared that her client gave her pictures of a terrorist attack in which she was

a victim. The therapist described how she spent time looking at the pictures and gaining a

deeper understanding of her client's painful past experiences. Another therapist

commented on how she spent time after session trying to learn more about her client's

culture, and wrote:

> *"The client's account of his life, honour crimes, government, living during the war and his experiences with the Taliban definitely impacted me in terms of wanting to gain more information and knowledge about the living conditions in Afghanistan. I found myself doing independent research and wanting to understand the culture and environment in Afghanistan more thoroughly"* (101101Tc1s2j2).

One of the components of Multicultural Counselling Competencies is cultural

knowledge (Sue, Zane, Nagayama-Hall, & Berger, 2009). Therapists appeared to be

strengthening their multicultural competency by increasing the cultural knowledge

regarding their clients' culture. For instance, therapists indicated that researching their

clients' culture helped them feel more competent and better able to understand their

clients. Therapists mentioned that researching their clients' culture also helped them in

trying to ensure they made culturally sensitive interventions. For instance one of the

therapists realized that in order to work with her client she would need a good

understanding of the political situation in Colombia as these political issues were relevant

to the client's presenting concerns:

> *"My work with this client will definitely involve me doing more research about the political situation in Colombia and the surrounding area. His current struggles are very closely tied to his involvement with the government and other agencies, therefore I will require a good understanding of these in order to adequately work with this client" (111206Tc3s1j11).*

The role of knowledge in Multicultural Counselling Competencies is

controversial. While knowledge of the client's culture can help therapists in being more

culturally sensitive in the ways in which they conceptualize their clients and deliver their

interventions; knowledge is not enough to ensure effective therapy (Patterson, 2004; Sue

et al., 2009). In other words, knowledge of the client's culture is not necessarily linked to

effective psychotherapy processes (Sue & Zane, 1987). In the present study knowledge of

the client's culture helped shape therapists' culturally sensitive case conceptualizations

(see p. 85 in this document) and it helped the therapists broaden their understanding of

their clients. In addition, therapist-trainees' writings demonstrated that the main

advantage of gaining knowledge about their client's culture consisted of the therapists'

own feelings of increased confidence and preparedness. However, as one therapist aptly

mentioned, even though she felt more confident, her first session with the client reminded

her of the importance of remaining open-minded to what the client might bring:

"Prior to our first session, I spent a lot of time educating myself about the client's country of origin, ethnicity, and political situation. This allowed me to feel more prepared and confident entering in session, and to develop some cultural hypotheses about the client. While this was important for me to do, this incident reminded me of the importance of being open-minded and expecting the unexpected with clients" (121312Tc1s1j1)

2. Managing the urge to "rescue" the client / "fix" the client's problems and staying within professional boundaries was challenging.
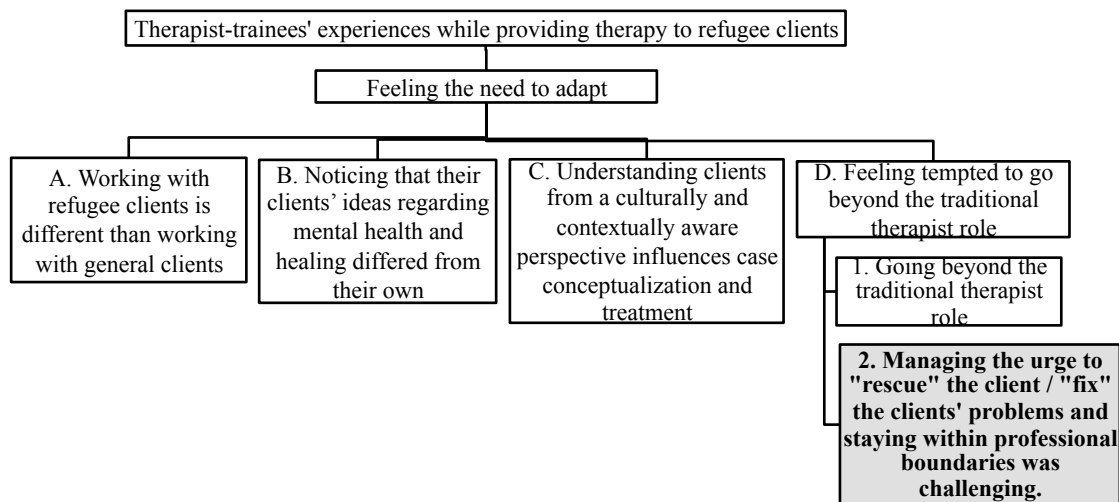
Figure 18. Thematic Overview. Locating the theme "Managing the urge to "rescue" the clients/ "fix" the clients' problems and staying within professional boundaries was challenging". The shaded and bolded area illustrates the theme referenced in the current section

Therapists' inclinations to move beyond the boundaries traditionally set in clinical psychology were further evidenced in their internal struggles to manage their urge to "rescue" their refugee clients. In the field of psychology, the importance of maintaining clear professional boundaries and the challenge to deliver the best, most compassionate, and ethically informed standard of care has been extensively discussed in the literature (Bersoff, 1994; Gabbard & Crisp-Han, 2010; Handelsman, Knapp, & Gottlieb, 2009; Knapp, Gottlieb, Handelsman, & VandeCreek, 2013). Echoing the importance of this

issue, around half the therapists provided insights into how working with this vulnerable

refugee population tested their abilities to set professional boundaries and to stay within

their professional role. These therapists talked about having difficulty not becoming

personally involved with their client's issues and managing their own need to "rescue"

their clients. These insights appeared mostly in the beginning and working phases of

therapy. For example, one therapist explained how difficult it was for her to restrain

herself and not "rush in to fix everything" due to her client's extremely vulnerable and

likeable presentation:

> *"I have since been questioning what it is about this client that makes me want*
> *to cross boundaries that I wouldn't with other clients. I've had clients before*
> *who tell me how much they've enjoy coming. I've also have suicidal clients.*
> *But I've never had such an endearing, likeable client, with such severe*
> *trauma, and in such despair. I often have to fight my urge to rush in to try to*
> *fix everything" (111209Tc2s4j7)*

Within the same journal but further into the writing, this therapist reflected on how the

cultural differences along with feeling more flexible in her therapeutic approach

influenced her feelings of personal involvement with the client. As the therapist continued

writing, she concluded that having boundaries was positive as they can help in providing

more appropriate care for the client:

> *"Our cultural differences don't seem to have hindered our alliance, but they*
> *have altered the way I interact with her. Knowing that with these clients*
> *therapy isn't just business as usual has allowed me to feel more flexible in my*
> *approach.[...] However, by feeling that flexibility, my own needs to help the*
> *client have slipped in and I find myself becoming more personally invested in*
> *her case. I struggle to remain within these boundaries and also to be real and*
> *genuine with clients, which I think is the only way that a meaningful*
> *relationship can form for change. But there are boundaries for a good*
> *reason, in part because it's not our jobs to be friends or fulfill a need they*
> *aren't getting, at least not in the long term. So I think this has been a good*
> *reality check for balancing genuine caring and a personal need to rescue*
> *someone" (111209Tc2s4j7)*

These therapists also had insights about their own need to "fix things", "rescue" or

"save" their client. For instance, one of the clients was having problems with a neighbour and was considering moving out and breaking her lease. The therapist reflected on her strong desire to actively help her client:

> *"Similar to last week's session, when client asked if I would take her to the doctor and I had to decline, I felt a strong compulsion to go beyond my professional duties and help my multicultural client. I was very mindful of the images swirling in my mind—enlisting friends and helping her move, calling the building manager or even lawyer to help her break her lease, giving her money to cover the penalty. The combination of hearing about her difficult circumstances, the seemingly simple solution that I could easily help coordinate, and the sadness, resignation, and vulnerability projected by the client made it very difficult for me to say no" (121313Tc1s2j2)*

However, similar to therapist 111209T, as this therapist continued writing and reflecting on her own feelings and schemas she also became aware that maintaining professional boundaries can help her be a more effective therapist for her client:

> *"How much of my reactions is counter-transference, fuelled by my client's vulnerable presentation and my own desire to help her feel safe? I realized that I must be more aware of my own therapist schemas—especially the desire to "save" my clients being activated in this dynamic…. It became clear to me that both the caseworker and I have to set limits to the scope of our responsibilities—we can't bend over backwards to help all our clients, although it can be very difficult to help clients who present with so much distress. I must maintain my professional responsibilities and boundaries if I seek to be an effective therapist to my client" (121313Tc1s2j2).*

These therapists' reflections on how boundary crossing would negatively influence the treatment are valuable. Many non-sexual professional boundaries in clinical practice depend on contextual issues and need to be approached with a thoughtful attitude that is open to questioning and reflection (Pope & Keith-Spiegel, 2008). Paying attention to the nature of the boundary crossing, the client, the context, and the potential benefit or harm is essential to a sound approach to ethical and effective treatment (Pope & Keith-Spiegel, 2008).

Another topic that emerged associated to the need to "fix" the clients pertained to

therapists feeling that they needed to quickly alleviate their clients' symptoms. Some

therapists mentioned feeling the need to quickly relieve the client's pressing concerns,

make "concrete gains" and prove to the client that therapy was effective. For instance,

one therapist found her client did not feel relief from her anxiety after the first session.

This therapist found herself feeling pressured to relieve the client's symptoms quickly:

> *"... the session had not relieved her anxiety. I had attempted to explain previously that this was a process that took time, but I couldn't help feeling like she had been disappointed at not being immediately relieved. She reported being willing to return, however, I noticed in myself this unusual pressure to somehow try to relieve some of her symptoms as quickly as possible" (111205Tc1s1j1).*

It is important to note that psychotherapy is a process and relief from distressing

symptoms usually comes gradually. However, it is common for clients who are new to

Western psychotherapy to believe that one session should be enough to alleviate their

symptoms. Thus, for these clients the need for weekly visits may suggest that the

treatment is not being effective (Gong-Guy, et al., 1991). This is another example where

client and therapist had different expectations of the process, which made the therapist

feel pressured to "fix" or "help" the client as soon as possible. The pressure to relieve her

client's symptoms described by this therapist is common in the treatment of culturally

diverse clients who are seeking fast relief and who attend therapy as a last resort (Parson,

1993). The refugee client's urgency and expectation for immediate relief stands in stark

contrast to the psychotherapy literature which in many cases emphasizes the slow and

progressive course of action of therapy processes (Greenberg, et al., 1993).

Section II. Feeling a Sense of Increasing Cultural Self-Awareness

Cultural self-awareness is considered to be a fundamental component of culturally

sensitive therapy and of cultural competence (Roysircar, 2004; Sue et al., 1992).

Furthermore, cultural self-awareness has been suggested as a necessary antecedent to the

development of Multicultural Counselling Competencies (Richardson & Molinaro, 1996).

Cultural self-awareness is defined as a self-reflective process in which the therapist

becomes conscious of his or her cultural biases, assumptions, values, pre-conceived

notions, and limitations (Sue et al., 1992). Cultural self-awareness aids the therapists in

the process of more accurately understanding their culturally diverse clients (Roysircar,

2004). Consistent with the importance placed on cultural self-awareness in the literature,

nearly all the therapists mentioned attaining personal insights regarding their own culture,

biases, worldviews, as well as insights regarding other cultures, worldviews and contexts.

Therapist-trainees had a sense of increasing cultural self-awareness throughout their work

with their clients. Four subordinate themes emerged which illustrated therapist-trainees'

development in their cultural self-awareness. These themes are showcased in Figure 19.
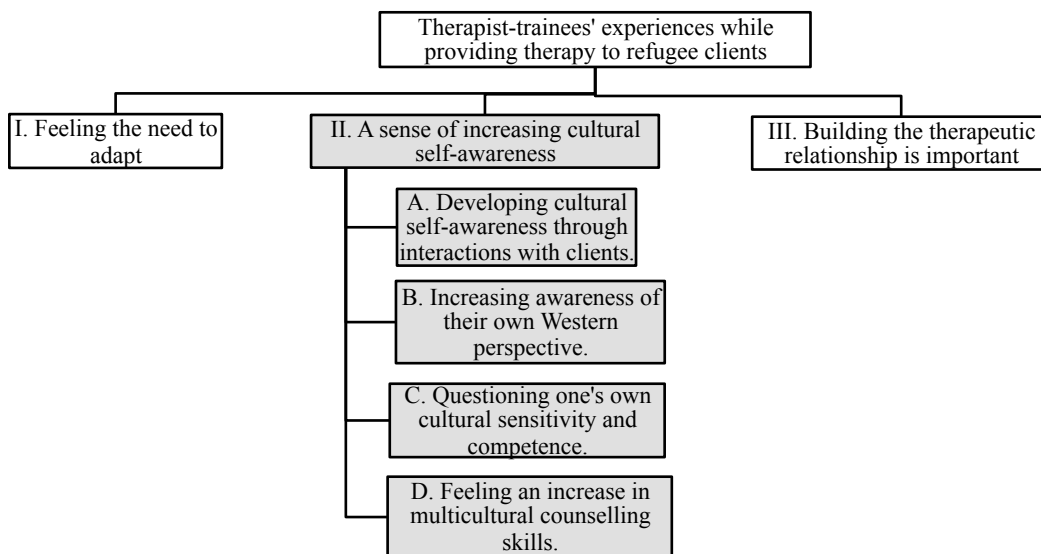
Figure 19. Four sub-themes emerged under the theme "A sense of increasing cultural self-awareness". The shaded parts highlight the themes referenced in the current section.

A. Developing Cultural Self-Awareness through Interactions with Refugee Clients

Through engaging in therapy with their clients, most therapists mentioned learning about other cultures, learning about systemic barriers faced by refugees, and gaining personal insights concerning their own culturally-based worldviews. In other words, interactions with their clients fostered an increase in the therapists' cultural self-awareness. The ways in which interactions with clients fostered therapists' cultural self-awareness were further evidenced by four sub-themes:
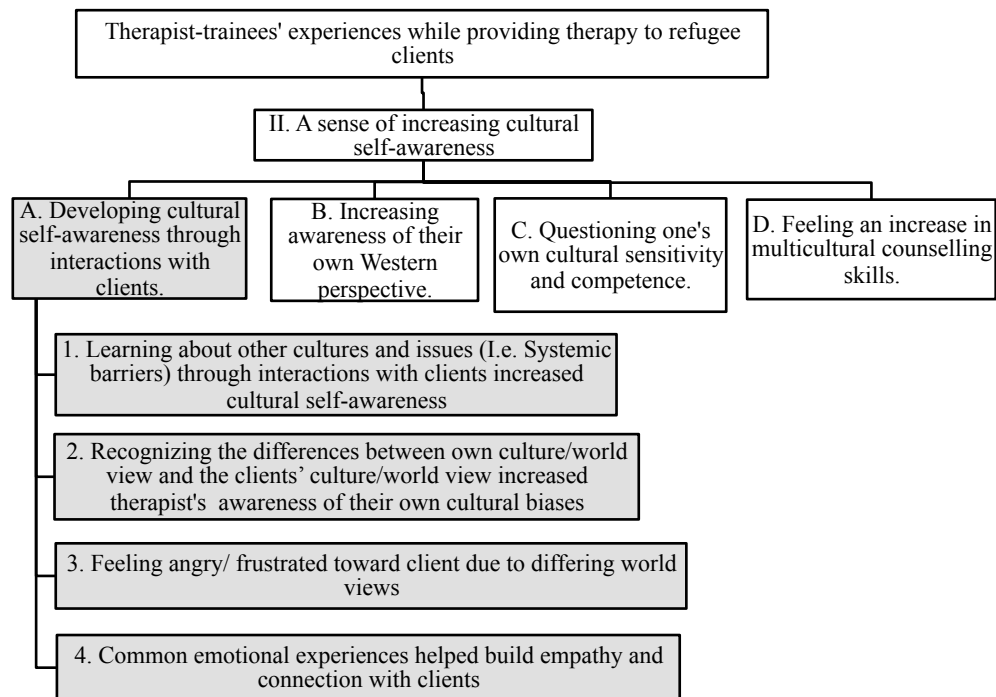
Figure 20. Four sub-themes emerged within the theme "Developing cultural self-awareness through interactions with clients". The shaded parts highlight the themes referenced in the current section. In order to aid with clarity, the two major themes "Feeling the need to adapt" and "Building the therapeutic relationship is important" were omitted from this figure.

The sub-theme "Learning about other cultures and issues (e.g., Systemic barriers) through interactions with clients increased cultural self-awareness" demonstrates how therapists' self-awareness increased through working with their refugee clients and

learning from them. The second sub-theme "Recognizing the differences between own culture/world view and the clients' culture/world view increased therapist's awareness of their own cultural biases" further illustrates how therapists' self-awareness was fostered as they recognized the differences in worldview between themselves and their clients, thus increasing their understanding of their own cultural biases. The third sub-theme "Feeling angry/ frustrated toward client due to differing world views" demonstrates how therapists' cultural self-awareness increased through recognizing their own feelings of anger and frustration toward their refugee clients due to deeply rooted differences regarding culture and belief systems. Conversely, sub-theme "Common emotional experiences helped build empathy and connection with clients" illustrates therapists' increase in cultural self-awareness as therapists noticed the similarities and common lived experiences between themselves and their clients.

1. Learning about other cultures and issues (e.g., systemic barriers) through

interactions with clients increased cultural self-awareness.

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┌─────────────────────────────────────────────────────┐
│  Therapist-trainees' experiences while providing     │
│  therapy to refugee clients                          │
└─────────────────────────────────────────────────────┘
               ┌──────────────────────────────┐
               │ II. A sense of increasing     │
               │ cultural self-awareness       │
               └──────────────────────────────┘
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| A. Developing cultural self-awareness through interactions with clients. | B. Increasing awareness of their own Western perspective. | C. Questioning one's own cultural sensitivity and competence. | D. Feeling an increase in multicultural counselling skills. |

1. Learning about other cultures and issues (I.e. Systemic barriers) through interactions with clients increased cultural self-awareness

2. Recognizing the differences between their own culture/world view and the clients' culture/world view increased therapist's awareness of their own cultural biases

3. Feeling angry/ frustrated toward client due to differing world views

4. Common emotional experiences helped build empathy and connection with clients

Figure 21. Thematic overview. Locating the theme "Learning about other cultures and issues (i.e. systemic barriers) through interactions with clients increased cultural self-awareness". The shaded and bolded area illustrates the theme referenced in the current section

Therapists' development of cultural self-awareness was evidenced by their accounts

of learning from their clients. Therapists learn from several sources including books,

courses, and supervisors. However, one of the most important and, somewhat

understudied, sources of learning pertains to therapists' interactions with their clients

(Hatcher, et al., 2012; Ronnestad & Skovholt, 2003). Most of the research on the lessons

therapists learn from working with their clients refers to same-culture encounters (see

Freeman & Hayes, 2002; Kahn & Fromm, 2001; Kottler & Carlson, 2005b). Researchers

in Multicultural Counselling Competencies recommend being open to learning from

culturally different clients by adopting an attitude of curiosity and naïveté (Dyche &

Zayas, 2001). However, there is a dearth of research focused on the specific things

therapists learning from their culturally diverse clients. In the present study, most

therapists reflected on the personal learning and deepening awareness brought forth by

listening to and interacting with their clients. Three sub-themes illustrated therapists'

learning about other cultures and deepening their cultural awareness:

1.1 Learning more about their client's culture

1.2 Attaining deeper awareness of systemic barriers faced by recently immigrated

refugees

1.3 Learning from their clients' strength and resilience: feeling inspired

Through working with their refugee clients these therapists learned more about

their clients' culture, their clients' struggles with systemic barriers, and on a more

emotional level, they even felt inspired by their clients. These insights arose throughout

the therapeutic process.

1.1 Learning more about their client's culture[31].

Some therapists mentioned that through interacting with their refugee clients, they

learned about other cultures' family and social norms, religious beliefs, and politics. For

instance, a therapist mentioned attaining a better understanding of her client's culture and

cultural situation within the larger Canadian context:

> *"In terms of the content of the client's story, I also learned a little bit about family norms within the Iraqi culture and the hierarchy that exists within the family…. This incident also helps me understand more about the political climate surrounding Iraq and Iraqis in Canada" (111208Tc1s1j1).*

These therapists indicated that learning about these cultural issues helped them to

better understand their clients. Additionally therapists believed that learning about their

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[31] Please refer to Figure 21 for an overview of the location of this theme within the broader analysis.

clients' culture helped build the therapeutic relationship. Only one therapist described

feeling guilty because her client had to educate her on the current human rights violations

taking place in Colombia.

1.2 Attaining deeper awareness of systemic barriers faced by recently immigrated refugees[32].

Not only did therapists learn more about their client's culture and worldviews, some

therapists developed a deeper awareness of the systemic barriers faced by recently

immigrated refugees trying to establish themselves in Canada. Therapists' insights into

the systemic barriers emerged throughout their work with their clients, especially during

the working phase of therapy. The systemic barriers mentioned by the therapists were

varied. Excerpts exemplifying each of the barriers identified by the therapists will be

provided. Awareness of systemic barriers is important because these barriers may

adversely affect clients' mental health (Ratts, 2009; Ratts & Pedersen, 2014). Therapists

that are cognizant of systemic barriers can help acknowledge and address these barriers

and their effect on the clients' wellbeing (Ratts & Pedersen, 2014). Thus, actively

helping the clients in the process of self-affirmation, empowerment, and critical

consciousness (Brown, L.S., 1997; Freire, 1970).

Systemic barriers can further victimize a client when he or she arrives in the host

country. As one therapist whose client's house was burglarized explained:

> *"This incident also made me acutely aware of the potential difficulties that refugees may have upon coming to Canada. They may be at higher risk of being victims of crime due to the areas in which they live, their lack of mastery over language and cultural norms within Canada, or forming trusting relationships with individuals that they do not know well. Through putting these individuals into challenging and confusing situations in Canada*

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[32] Please refer to Figure 21 for an overview of the location of this theme within the broader analysis.

without proper knowledge of what their rights are and how they can cope with these situations we are victimizing them once again" (111206Tc3s7j17).

Another therapist wrote about her feelings when she became aware of the societal

barriers her client was encountering in the process getting established in Canada:

"One prominent emotion that surfaced in therapy was a feeling of helplessness – helplessness at societal barriers to equality, and the injustice of policies implemented by leaders. We acknowledged this helplessness but also talked about goals the client may formulate to reformulate his role as an Iraqi living in Canada" (111208Tc1s3j3).

Along the same lines, another therapist empathized with the client's struggles in

finding meaningful work in Canada. This therapist's client was a dentist in her country of

origin. However, this client was not allowed to practice dentistry in Canada due to

professional regulations that make it almost impossible for new immigrants to find

meaningful work in their field (Rashid, Gregory, Kazemipur, & Scruby, 2013). This

therapist expressed:

"I recognized the frustration she must have in not being able to do what she was trained for. I felt sad and frustrated for her, and tried to show that I agreed with her that the system here is unfair for new immigrants [....] I think this helped me to further identify with the client's struggles, which are somewhat existential in nature. Because of her refugee status, she is unable to find meaningful work, and is left feeling unfulfilled. However, this has propelled her to take on new training, and work towards eventually being able to work in her field once again" (101104Tc1s7j7)

One of the clients was in the process of leaving an abusive relationship and sought

shelter at a local social service agency, which offers help for victims of domestic

violence. The therapist met with her client at this agency and became aware of the

limitations of social services in addressing the needs of culturally diverse individuals:

"This situation really made me aware of the obstacles and difficulties facing individuals from different cultures – especially women in domestic violence situations. Although [agency] is excellent in many ways, the concept of a shelter may not be quite the same "safe haven" for someone of a different culture. For one thing, the food is generic Western style food. It's healthy and

nutritious, but for someone not accustomed to it, it's foreign and uncomfortable. At a time when the need for comfort is paramount (and the familiarity of something as basic as customary food), it just seems to accentuate the severity of the situation. Also, while clean and brightly lit, the centre is very institutional. It is not at all "house-like" and the fact that it is a shelter is very obvious. In addition, the language barrier for my client was especially problematic for her to be able to form acquaintances with the other women at the shelter as the interpreter could obviously only be present for formal appointments. I guess I just felt a bit hopeless that although there are such great services available (i.e. it is truly amazing that [agency] can offer housing for battered women for a substantially long period of time), the gaps in service delivery to the most marginal and vulnerable populations still exist" (101103Tc1s6j6)

Finally, as one of the therapists and her client approached termination, the therapist

became aware of the lack of suitable referral services for her client to continue

psychotherapy:

"I also felt pretty hopeless at the idea of finding someone to refer her to given that she does not have a lot of disposable income and would need an interpreter to attend her sessions" (121310Tc1s12j12)

1.3 Learning from their clients' strength and resilience: feeling inspired[33].

The therapists not only learned about their clients' culture and the systemic barriers

they faced. Therapists also learned from their clients on a more personal level. Some

therapists mentioned feeling admiration for their clients' strength and resilience. As a

couple of therapists expressed:

"On the other hand, I was amazed at how strong my client was, for surviving such an event and managing to pick up her life and move to Syria, then to Canada. I thought to myself that indeed, she is experiencing PTSD and depression symptoms, but she is truly a survivor, and I admired her resilience and strength" (111207c1s3j2)

"Now that I think about her choices, I am filled with amazement. There are women who were born and raised in North America, are familiar with the rights, freedoms and protections offered by the Criminal Code and the Charter of Rights (or the U.S. Constitution), speak English, and understand

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[33] Please refer to Figure 21 for an overview of the location of this theme within the broader analysis.

the judicial process, who oftentimes do not have the courage to follow through with pressing charges against their assailant – especially regarding sexual assault. However, this woman, having barely any English skills, not knowing our laws, not fully feeling comfortable with the police, and having very strong cultural beliefs AGAINST breaking the bond of marriage, did just that. She chose to press charges on both counts (physical assault and sexual assault), and to take her children with her to a women's shelter. I felt so in awe of her courage, and perseverance in the face of fear and cultural taboo" (101103Tc1s5j5).

Similarly some therapists expressed feeling honoured and inspired by working with their clients. For instance, one of the therapists reflected after her last session with her client:

"Further, although I will miss meeting [client], I have been honoured to support [client's] recovery, and I will draw from our connection an enduring feeling of inspiration from being witness to both her resilience and incredibly tender-heart" (121314Tc1s17j17)

Another example of feeling honoured and inspired came from a therapist who mentioned being in awe of her client and even feeling inspired to become more involved in human rights advocacy:

"As I was talking to the client, I was internally in a state of awe. This man had gone through so much hardship, and had not only survived, but had tried to make large changes in the world so that others did not have to experience the same horrors that he did. I had a lot of respect for this client and was strongly motivated to help him so that he could continue the great work he has been doing for the past eight years [...] My work with this client so far has made me think about adjustments in myself. I was faced with a man who had gone through horrible struggles, but was still able to think of others and make large changes to help others. This made me think about why I could not also work to make improvements in human rights on a larger scale. As time goes on and I continue to work with this client I hope to continue to gain inspiration from him and learn about ways that I can become more involved in treatment beyond just the individual in therapy" (111206Tc3s1j11)

2. Recognizing the differences between their own culture/worldview and the

clients' culture/worldview increased therapists' awareness of their own cultural
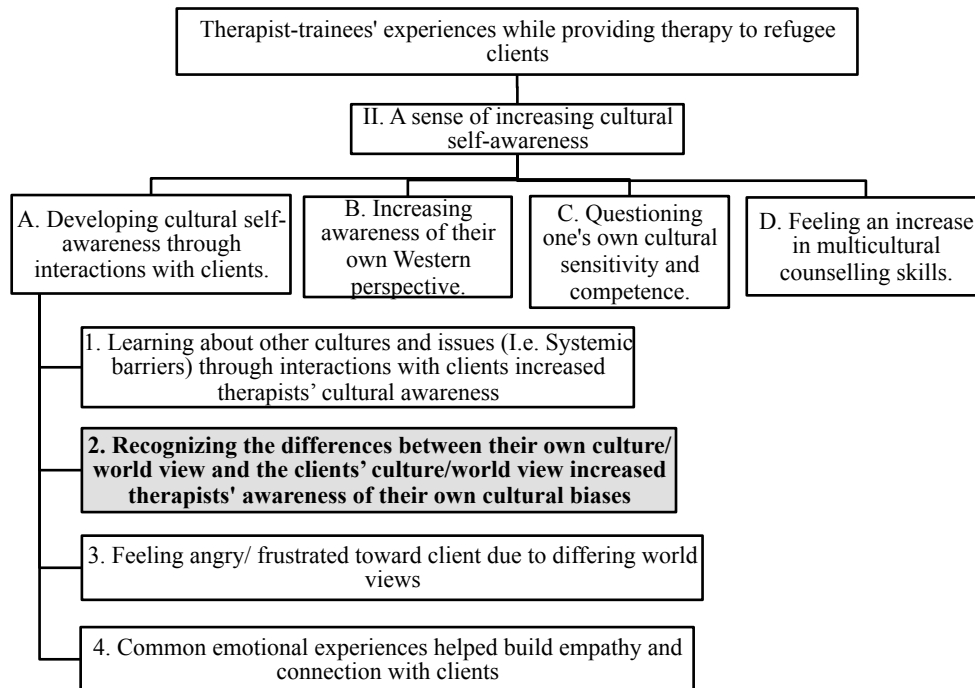
biases.

Figure 22. Thematic Overview. Locating the theme "Recognizing the differences between their own culture/world view and the clients' culture/world view increased threapists' awareness of their own cultural biases". The shaded and bolded area illustrates the theme referenced in the current section.

The therapists reflecting on the differences in worldviews between themselves and

their refugee clients further demonstrated the ways in which interactions with the refugee

clients fostered therapists' cultural self-awareness.

Throughout the beginning and working phases of the therapy process with their

refugee clients about half the therapists reflected on the differences between their culture,

living conditions, upbringing, religious views and general worldviews as compared to

those of their clients. There is a lack of research pertaining to therapists' experiences and

reflections addressing differences in living conditions and quality of life between

themselves and their clients. Therapists reflected on the differences between their own

and their client's living conditions and upbringing mostly at the beginning phase of

therapy. As one of the therapists noted after her second session with the client:

> *"Hearing the client's account also made me think that his upbringing is markedly different than the upbringing and living conditions that occur in Canada, and that life is so much tougher in Afghanistan" (101101Tc1s2j2).*

I think this issue is very important as it provides therapists with further awareness of their

client's past living conditions and resilience, as well as a deeper appreciation for living

conditions in Canada. For example, through her client's account of moving to a refugee

camp that had running water, one of the therapists became aware of the differences in

quality of life and the services that we take for granted or "just expect" in Canada:

> *"This really gave me great respect for her, and highlighted the difference in western ideals and things that we just expect – It seems like a westerner would be outraged at such living conditions, but the client spoke of them without any negativity, but rather with appreciation of what she experienced as improvements in her circumstances" (101102Tc1s2j2).*

Furthermore, one of the therapists described how the differences between the contexts in

which she and her client grew up, made it hard to understand the client's experiences.

However these differences also deepened this therapist's self-awareness and

understanding of the client's context:

> *"Understanding her experience from her point of view was difficult coming from a different culture, but also a society in which I have never really lived in fear. I have never experienced even a fraction of what happened in that church, and seeing such things on the news is so much more distant. Furthermore, looking at the grieving community left behind after this incident was interesting for me in terms of deepening my understanding of being a Christian in a fairly extreme Islamic country" (111205Tc1s3j3).*

Along the same lines, only one of the therapists explicitly reflected on the racial

differences between she and her client. This therapist empathized with the possible

difficulty the client could have in feeling understood and in building the alliance:

"It drew my attention to the client's awareness and thoughts of being a refugee client, from another culture, and essentially, not the same as me, a white therapist. It highlighted that the client sees us as different and the client perhaps wonders how much someone with such different experiences (growing up in Canada) can understand him" (101101Tc1s4j4)

Some therapists reflected on having significant differences with their clients in terms of religious beliefs. Consistent with previous research, therapists wanted to further understand their client's beliefs; while at the same time being mindful of respecting their clients' religious beliefs (Crossley & Salter, 2005). One of the therapists shared the same religion with her client. However, the therapist noticed that she and her client had very different ways of approaching the same religious beliefs:

"It surprised me to see that even though we share the same religion, we take such different approaches. She is more orthodox, more traditional and strong in her beliefs, whereas I was rather lax, allowing the principles to shift as I need them" (111207c1s5j4).

This therapist reflected on her client's religious struggle, which centered on the decision of leaving her husband. The therapist recognized she and her client had very different views on this issue. However, as the therapist continued to reflect upon this issue, she seemed to become more aware of her own cultural biases, such that she mentioned the importance of not allowing her biases to influence therapy with this client.

"What impressed me the most was the importance of the religious factors. She is Christian, as I am and she quoted an old principle that stated one remains married to the person in the eyes of God despite any worldly divorces. Therefore she can never "leave" this marriage, nor become married to someone else. I always thought this teaching was outdated and that no one pursued it anymore, so it was new to see it take such an important place in her life. At the same time, I could not help myself thinking that she is literally giving up her happiness for the promise of righteousness in the afterlife. Existentially, I kept thinking that she only has one life, so what she does in it should matter and that she should want to be happy now, while she is alive. But existential theories come counter to the Christian religion, which explains sacrifices in this life for the promise of heaven. So how can I tell her to enjoy something that is considered fleeting (current life) at the expense of

eternity. [...] I need to be careful to not allow my bias to influence therapy (knee-jerk reaction for me is still that she should leave him)" (111207c1s5j4).

Some therapists reflected on differences between their own and their clients' views on gender equality. A couple of therapists noticed these differences in views when working with their female clients. One of the therapists was working with a female client whose husband abused her. This client wanted to reconcile with her husband. As the session progressed this therapist noticed that her perceptions shifted from judging the client for wanting this reconciliation to better understanding the client's reasons and life circumstances. Thus, the therapist became more aware of her own and her client's cultural context and life circumstances:

> *"As the client told me about her experience and wanting her husband back, I initially thought that her values must be so warped to risk re-entering into an abusive relationship. I began asking some questions about the likelihood of her reuniting with her husband in order to ensure that there was no immediate risk to her safety. As we continued to talk, I began to realize that this was not an indication of her skewed views, but of how stretched thin she currently is. While my initial thoughts were that she has no regard for her own safety, I began to see that providing her children with a supportive and caring home was more important than her own needs. The comments I first viewed as reckless were more likely based in her love for her family and wanting to provide for them" (111206Tc2s1j8)*

This client's dilemma is consistent with the lived experience of other refugee and immigrant women. These women face additional stressors when deciding to leave an abusive relationship. For example, these women may be worried about deportation issues, losing custody of their children, financial need, lack of social support, language barriers and infringing traditional cultural values (Sharma, 2001).

Another therapist seemed to become more culturally aware as she clarified her own values as a woman strongly opposed to domestic violence, while at the same time deciding that in order to be more culturally competent she needed to empower the client

by allowing her to explain her position:

> *"My own cultural views certainly also came into play as a woman who is adamantly opposed to domestic violence and child abuse. However, this view is not solely a North American dominant culture view – it is also a gender-influenced view. So, I feel that I have a culturally competent and respectful way of addressing these issues with the client such that a dialogue can be fostered in which the client feels comfortable, equal, and empowered to educate me about where she is coming from" (101103Tc1s2j2).*

3. Feeling angry/ frustrated toward client due to differing worldviews
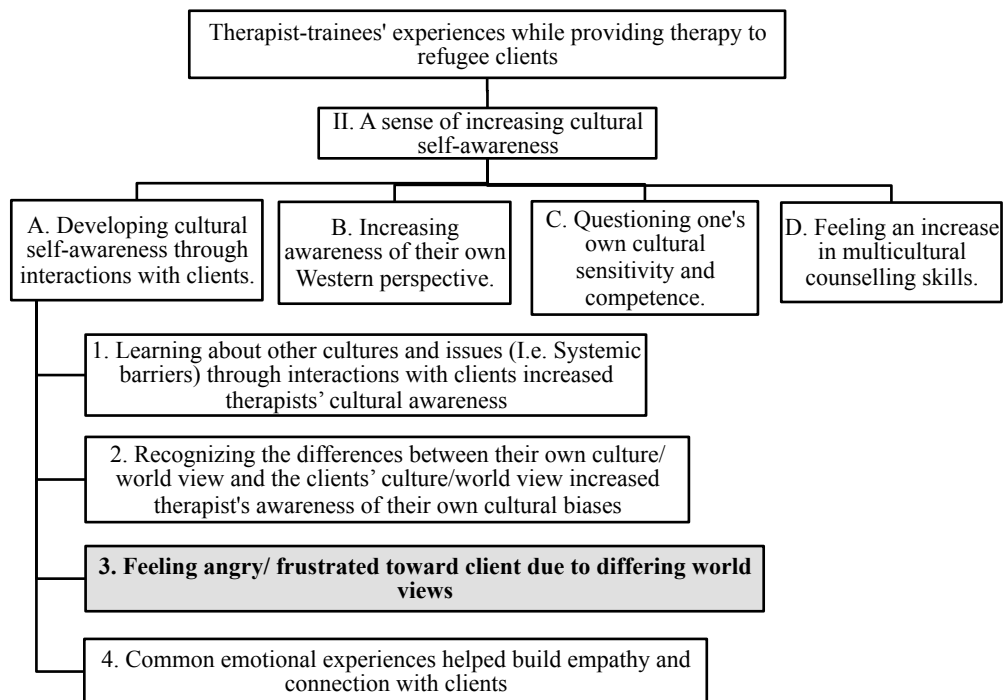
Figure 23. Thematic Overview. Locating the theme "Feeling angry/ frustrated toward client due to differing world views". The shaded and bolded area illustrates the theme referenced in the current section.

Although working with these clients was rewarding and elicited generally positive emotions, some therapists found themselves feeling frustrated, angry and, at times, even disliking their clients. While there is some research on working with anger within the therapeutic relationship (Hill & Knox, 2009), there is virtually no research on therapists' feelings of anger or frustration toward their clients due to differences in worldview. Therapists' feelings of frustration toward their clients were mainly due to deep-seated

differences in culture and belief systems, which therapists thought interfered with the

therapeutic work. These feelings emerged mostly in the working phase of therapy. As

one therapist described when faced with her client's deep faith in God's will:

> *"First I double checked that I understood her right and that she was indeed putting all responsibilities away from her own decision making process and onto luck. After I clarified that I had understood her correctly, I felt frustrated, hopeless and sad. I was frustrated and almost angry that all this work she and I have done together is now undermined by her lack of existential responsibility. It was like she was saying she gives up control over her destiny to "fate" and "God". While I am Christian myself, the idea of leaving it up to God to fix up our lives has never sat well with me because it leaves a lot of uncertainty and a hefty chance that things will not work out well at all"* (111207c1s8j7).

Acknowledging their feelings of anger and frustration toward their clients helped the

therapists in becoming more aware of their own values and biases which were based on

past experiences. As one of the therapists noted:

> *"One thing that really affected me emotionally was the client's statement that she wished that her husband would repent for what he had done. I felt a sense of deflation, given that I had felt she had taken such great steps toward securing her safety and that of her children. The idea of her changing her mind and wanting her husband to repent so that she could forgive him and eventually get back together with him made me feel frustrated. I realized that these emotions were based on my values and not hers, and that they were related to circumstances that I had encountered with other domestic violence survivors (i.e. getting back together with an abusive partner only to endure the same abuse all over again)"* (101103Tc1s7j7)

Therapist cultural self-awareness was also increased as therapists were faced with

clients whose belief systems were not only different but also somewhat "insulting" to the

therapists. Not only did therapists become more aware of their values but they also came

up with more productive ways to address these differences in therapy. For example, one

of the therapists described how she felt extremely uncomfortable and started to view the

client in a negative way when the client expressed negative opinions about women's

rights and gender equality:

> *"From a personal standpoint, I found it extremely uncomfortable to sit and listen while the client was talking about his belief that "freedom in women" is bad or "wrong." I found it personally insulting and I found that I was beginning to view the client negatively. Rather than maintaining an empathic stance towards the client, I began to think that he was aggressive, controlling, and perhaps abusive toward women. [...] Different beliefs between two people will remain different beliefs, but in order to be therapeutically helpful we must identify common goals in therapy (i.e., find a common ground, so to speak). [...] It seems that rather than trying to change the client's beliefs or attempt to emphasize with them (as this would not be genuine), it would be therapeutically productive to identify the client's goals for treatment and to facilitate change. (111208Tc1s4j4).*

There is an unusual lack of research regarding controversial topics such as therapists' reactions to clients who hold societal and cultural views that are contradictory to western egalitarian values. This lack of research extends to how to work in psychotherapy with these clients. However, Rasheed Ali, Ming Liu, and Humedian (2004) mentioned an empowerment model, which might be helpful in these situations and can aid therapists and clients in productively working with each other. This model emphasizes collaboration, context, critical consciousness, competence, and community. Consistent with the above therapist's idea of identifying goals, the concept of collaboration aims for client and therapists to work together in defining the problem and agreeing on interventions and strategies for change. Within this model, the role of larger social forces in the client's presenting problem is acknowledged, cultural self-awareness is fostered in both client and therapist, the therapist is able to recognize the client's strengths and resources, and finally the client is encouraged to access his or her social supports. Although the therapist didn't mention this model in her journals per se, further along the treatment with her client, this therapist's increased awareness led her to being able to adjust her work. The therapist seemed to be better able to work productively with her client as therapy progressed. In fact, in her 10th CIJ entry the therapist mentioned

adjusting her therapy work with her client to be more directive and to foster the client's

feeling of empowerment and guiding the client to assume responsibility for his actions:

> *"Working with this client has prompted me to make a major adjustment in terms of my style as a therapist. I am significantly more direct, concrete, and problem-solving focused than is my norm. I find that working within an existential framework with this client promotes the most meaningful therapeutic work and pushes him to get out of his victimized position and feel empowered to make decisions and take responsibility for the consequences of his decisions" (111208Tc1s10j10).*

Addressing differences in core values between clients and therapists is an increasingly

significant issue due to globalization and shifts in global population (Wiggins & Braun-

Williams, 2005). As therapists committed to the ideals of multiculturalism which

encourage the respect of diversity and appreciation of cultural differences, we usually

endeavor to maintain a neutral and non-judgmental stance (Kinnier, Dixon, Barratt, &

Moyer, 2008; Meetoo & Mirza, 2007). Meanwhile, there are certain practices that are

condoned under the guise of "culture" that go against basic human rights such as, honour

killings, female genital mutilation, child brides, genocide, domestic violence, etc.

(Kinnier et al., 2008; Meetoo & Mirza, 2007). These practices are not necessarily culture-

bound; this is especially true considering that members of such cultural groups frequently

condemn these acts themselves. For instance, Muslims have openly opposed violence

against women, sharia law, and the ban on driving (Al Sharif, 2013; Bennett, n.d.;

Siddique, 2011); Mexicans have opposed "machismo" and inequality (Castaneda, 2002);

Africans have opposed female genital mutilation (Dirie, 2014). As therapists we should

be able to address these problematic issues in a culturally sensitive and morally sound

way. A way to address these difficult issues is by taking a "wide" constructivist stance

where universal values are formulated on the basis of principles endorsed by multiple

religious and secular texts. Kinnier, Kernes, and Dautheribes (2000) endeavored to

accomplish this task by developing a shortlist of universal moral values. Across religious

and secular texts, the most frequently mentioned core value was the "golden rule": "Do

unto others as you would like others to do onto you", which includes not only other

humans but the environment and all living creatures (Kinnier, et al., 2008). As therapists,

it is important to value a person's safety and basic human rights over cultural imperatives.

As one of the therapists wrote when working with her client who was suffering from

domestic abuse:

> *"the session illustrated well for me that despite my client's best interests, abuse will escalate eventually, but that there is indeed a breaking point, when cultural values take a back seat. This will be something for me to consider in the future, as I help clients negotiate their needs against their culture's expectations" (111207c1s11j10)*

4. Common emotional experiences helped build empathy and connection with clients.
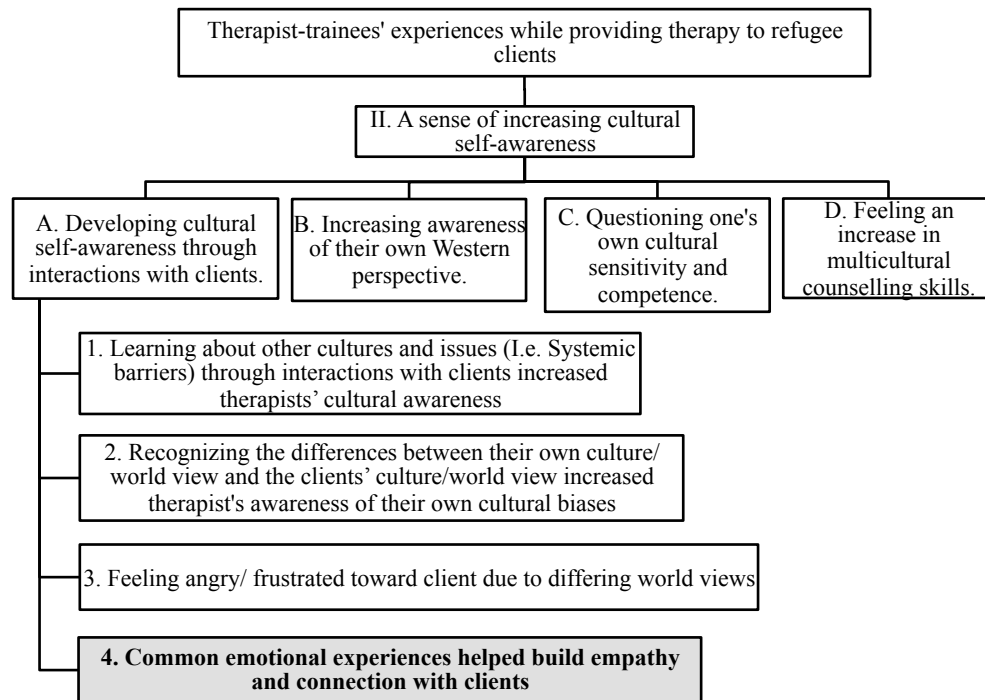
Figure 24. Thematic Overview. Locating the theme "Common emotional experiences helped build empathy and connection with clients". The shaded and bolded area illustrates the theme referenced in the current section.

As discussed above, therapists' cultural self-awareness developed through them recognizing the differences between themselves and their clients. However, therapists' cultural self-awareness and ability to empathize with their clients was also fostered through therapists noticing the similarities between themselves and their clients. During the beginning and working phase of therapy, around half the therapists reflected on similarities between themselves and their clients. Consistent with previous research, these therapists emphasized the common humanity that unites them with their clients (Dyche & Zayas, 2001; Vontress, 1996), in spite of the differences in culture, worldviews, and upbringing. As one therapist noted:

"Overall I was taken aback by the realization that even though my client is very different from me in background, life experiences, language (etc.), the emotions that we feel are similar. Even though there are cultural differences in the way that emotions are experienced or expressed, the experience of distress cuts across cultural lines and therefore is relatable. This realization to me was comforting, and allowed me to feel more connected to my client than I thought that I would be able to. Furthermore it made me more eager to work with her as I felt that we truly understood each other" (121310Tc1s1j1)

The parallels these therapists identified mainly referred to similarities in the emotions felt both by them and their clients. For example one therapist whose client talked about happy childhood experiences wrote:

"... the general theme was that despite the poverty, death, danger, sadness, and grief, her memories of her childhood contain genuine gleeful happiness. What struck me is how simple and elemental her experiences were. The excitement, joy, and exuberance she felt as a young child were the same as I probably felt, except that she had so very much less than I had" (101103Tc1s4j4).

Other therapists found they shared similar experiences, similar ways of expressing feelings, and in general alluded to the "the universality of human suffering". As a couple of therapists expressed:

"The most impactful events of this week's session for me was the realization that even though my client comes from a very different culture than my own and from those of my previous clients, and even though she has lived through experiences that were very different from my own, her reaction to and the effect that these traumatic experiences had on her were very similar to the way that a traumatic experience would impact an individual from this culture. What stood out to me the most was the universality of human suffering." (121310Tc1s1j1)

"Initially, thinking about the client being in an existential crisis made me think about how universal these forms of struggles are. Everyone in their lives will feel alone, without meaning, and a fear of what is to come through old age and death. It is amazing that while the experiences that people have can be incredibly divergent, the underlying concerns they have are quite similar" (111206Tc3s3j13)

Just as the above therapists expressed, other therapists also mentioned how noticing similarities in feelings and emotions helped them in feeling better able to

understand their clients and to build the therapeutic alliance.

B. Increasing Awareness of Own Western Perspective.

The theme "Increasing awareness of own Western perspective" further illustrates

the development of therapists' cultural self-awareness. This theme is comprised of three

sub-themes, which further evidence the therapists' increasing awareness of their own

Western perspective:
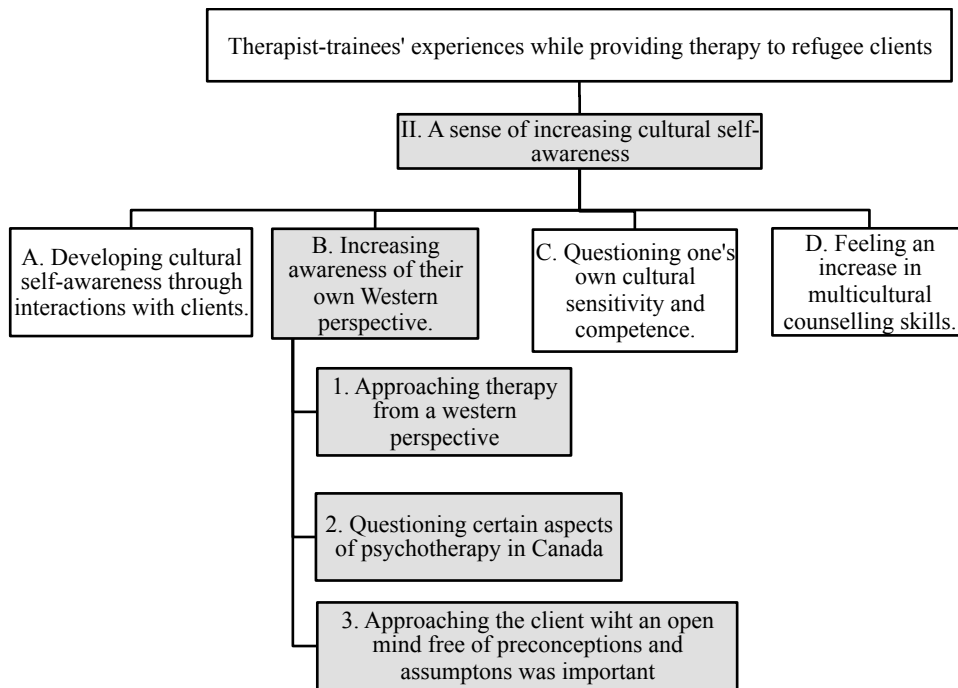
Figure 25. Three sub-themes emerged under the theme "Increasing awareness of own Western perspective". The shaded parts highlight the themes referenced in the current section.

The first sub-theme, "Approaching therapy from a Western perspective",

showcases therapists' explicit reflections on how they approach therapy from a "western

perspective". The second sub-theme, "Questioning certain aspects of psychotherapy in

Canada", illustrates therapists' becoming aware that certain aspects of psychotherapy in

Canada such as therapist-client boundaries are culture-bound and not necessarily

applicable across cultures. The third sub-theme, "Approaching the client with an open

mind free of preconceptions and assumptions was important" demonstrates the

importance of suspending cultural expectations and assumptions in order to be better able

to understand and work with clients from different cultures. This third sub-theme is an

important component of therapists' increasing awareness of their own Western

perspective because in order to suspend their cultural expectations and assumptions,

therapists first needed to be aware of such expectations and assumptions.

1. Approaching therapy from a Western perspective.
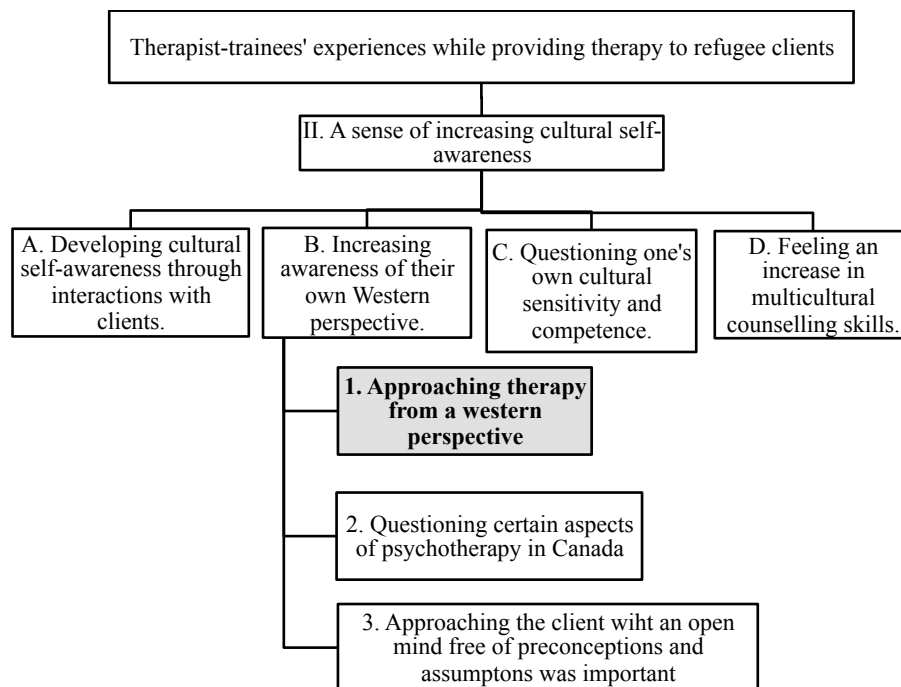
Figure 26. Thematic Overview. Locating the theme "Approaching therapy from a Western perspective". The shaded and bolded area illustrates the theme referenced in the current section.

Some of the therapists explicitly mentioned becoming aware of their "Western

perspective" when working with their refugee clients. These insights arose within the

beginning and working phases of therapy. For instance, one therapist wrote:

> *"Sometimes we approach therapy from a very Western perspective, for example, thinking that the client will know exactly what we mean when we tell him to identify his therapy "goals." In this case, the client could not*

identify goals and did not know what was meant by this statement...."
(111208Tc1s5j5).

The values of the dominant culture are so pervasive that that they become

"invisible" (Katz, 1985). As a result, Western cultures' ideas and interpretations are

understood as objective reality (Fish, 2004). Psychological theory, treatment, and practice

are embedded and derived from the dominant culture (Katz, 1985). For instance, the

above therapist mentioned therapy goals, which reflect Canadian/Western cultural values

that emphasize goal orientation and progress (Katz, 1985). It is important to note that

therapist-trainees participating in this study are immersed in the dominant culture. Thus,

therapists' becoming aware of how their Canadian ("western") cultural background,

experiences, attitudes, values and biases influence their therapeutic work with clients is a

compelling indication of their increasing cultural self-awareness.

2. Questioning certain aspects of psychotherapy in Canada.
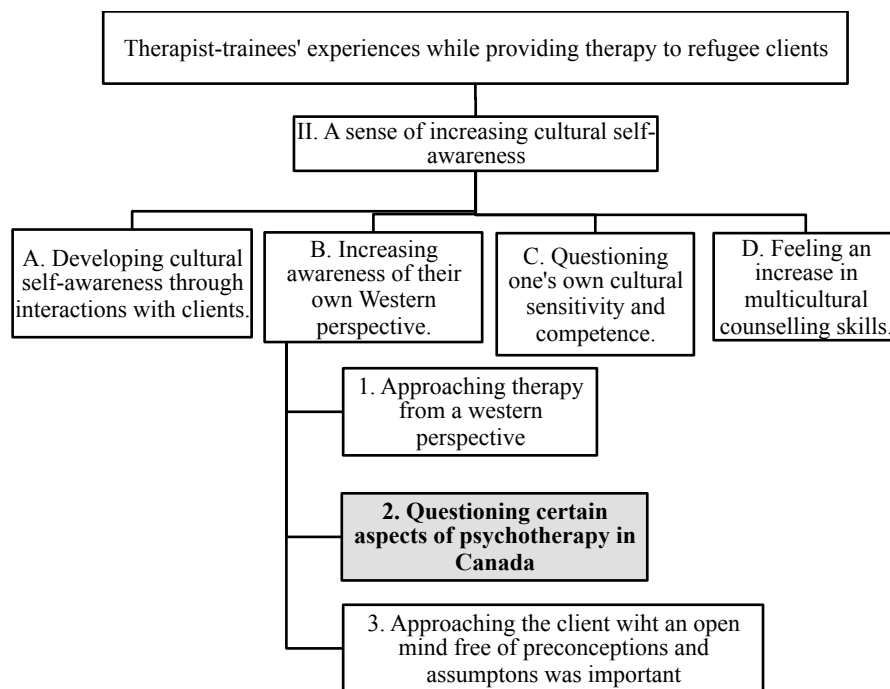
Figure 27. Thematic Overview. Locating the theme "Questioning certain aspects of
psychotherapy in Canada" within the analysis

Therapists' insights on approaching therapy from a western perspective were further evidenced by therapists' questioning of certain aspects of the practice of clinical psychology in Canada. For example, a couple of therapists reflected on the boundaries typically set by the therapeutic relationship as defined by the Canadian context. In this context, therapists carefully endeavor to maintain a professional distance from their clients. However this approach may not be the best way to build a relationship with the client. As one therapist reflected:

> *"I think that this has opened my eyes a bit more to the idea that the boundaries defined by clinical psychology as I learned it (in a Western context) may not be as absolute when working with those from other cultures. What I mean by that is that the therapeutic relationship can (and must) be fostered in many different ways. Perhaps Western clients feel a certain element of comfort with a psychologist who is the consummate professional – caring, soft, compassionate, but definitely observant of professional conduct. However, such an "antiseptic" stance may alienate individuals from other cultures. For them, the idea of a helper is someone who knows them and who is somewhat known to them. As such, it is important to not be dismissive of an individual's attempts to forge their own connection with you. If that means disclosing a bit about yourself, so be it. If that means taking an extra 10 minutes at the start of the session for social "chit chat" to respect a client's idea of social etiquette, so be it." (101103Tc1s3j3)*

This therapist's insight on building the relationship with her refugee client though the use of self-disclosure is consistent with the process of bi-directional empathy suggested by Parson (1993). Bi-directional empathy entails the therapist self-disclosing to the client in order to build a stronger therapeutic relationship based on trust, hope, respect, and mutual knowledge (Parson, 1993). However, even if self-disclosure is judiciously used, the professional relationship and professional distance are to be maintained with clients.

In the Canadian context, the relationship between therapist and client is defined as a professional one. Friendship between therapists and current clients is forbidden.

Establishing a friendship with a current client is considered a dual relationship, which

may interfere with treatment or even harm the client (CPA, 2000). Some therapists

described how their clients expressed their views of the therapist as being "friends" and in

one case as "being like family". A couple of these therapists took the clients' expressions

as positive signs of relationship building. For example, one of the therapists indicated:

> *"I was really happy when she said it felt like I was one of her daughters, both because it meant my goal of alliance building was going very well, but also because it made me feel like I was being viewed as part of her family. Family is the most important thing to this client, and I felt like I was being invited into that inner circle. I was genuinely touched and thanked her for saying so"* (111209Tc1s2j2).

However, another therapist at first perceived her client calling her a "friend" as a negative

thing. Through this experience, this therapist became aware of how her cultural

background and training influenced how she interpreted her client's expression. This

therapist's perceptions toward her client calling her "a friend" evolved as she reflected

upon the incident:

> *"My initial reaction, to believe that somehow, our work and our relationship is perceived and understood (by him) incorrectly because he called me his friend or that somehow I have done something incorrectly, is strongly formed from my training that focuses on therapy with white, middle to upper class clients. This initial reaction was not taking a culturally sensitive approach to therapy. [...] Clients who are not accustomed to therapy are less familiar with the nature of the relationship and what to expect in therapy. Given my clients life experiences, I would expect that he may experience some challenges related to trusting others and describing his experiences. I would also expect that he may be wary about who he appoints as a friend, [...] I think this made me aware that this was a manner in which he was describing my "acceptance" into his "in-group" or people he sees as close to him."* (101101Tc1s7j7).

3. Approaching the client with an open mind free of preconceptions and assumptions was important.
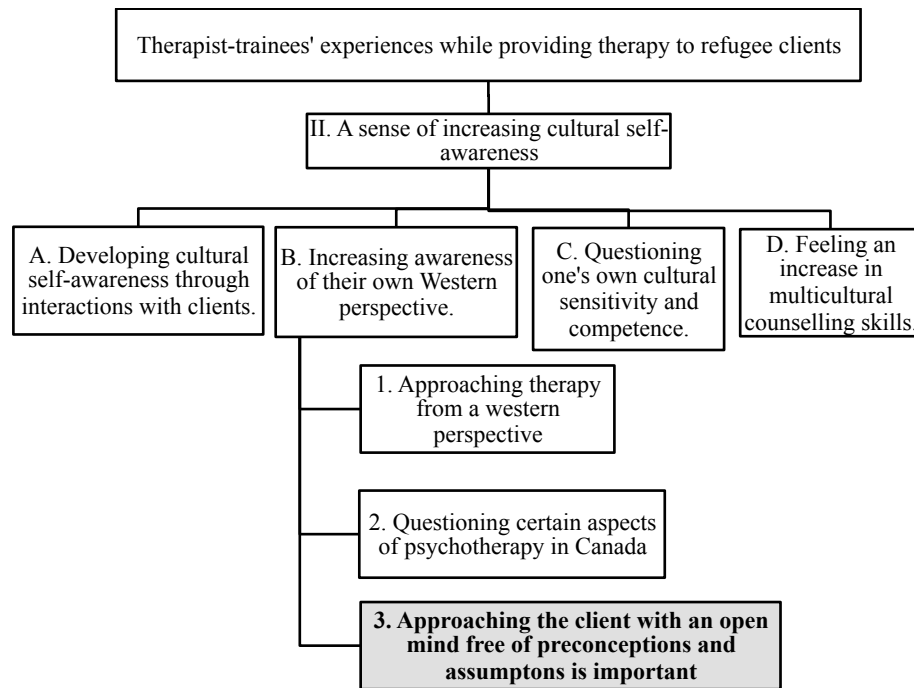
Figure 28. Thematic Overview. Locating the theme "Approaching the client with an open mind free of preconceptions and assumptions is important".

Throughout the therapeutic process, around half the therapists mentioned the importance of not making assumptions and of approaching the client with an open mind. In order for therapists to be able to approach their clients free of preconceptions and assumptions, they first needed to become aware of these preconceptions and assumptions. In other words, therapists' awareness of their western assumptions and resulting increase in their cultural self-awareness made them more conscious of the importance of approaching the client with an open-mind, free of assumptions. For instance, after her first session with her client, one of the therapists reflected on how her cultural awareness increased as a result of realizing that not all clients share her assumptions regarding psychological treatment:

> *"This incident has affected my cultural awareness by driving home the need for not making assumptions. In this case, it was related to my unconscious assumption that everybody, from all cultures, would have a mutual understanding that psychological treatment requires the sharing of thoughts and feelings" (121313Tc1s1j1).*

In order to be able to approach the client with an open mind, therapists also had to be aware of their own ideas and expectations regarding their clients' cultural background. As such, some therapists reflected on the importance of being aware of their assumptions and expectations regarding their client's culture. These therapists emphasized the importance of really getting to know their individual clients as they could have experiences and ideas that differ from those of their culture of origin. For example, one of the therapists wrote:

> *"I think this experience was an excellent example of therapists' need to hold "cultural hypotheses" about their clients, which will always need to be revised as new information comes to light in session. Although it was important for me to be aware of the values and beliefs generally held by the client's cultural group, this event exemplified the idea that racial/ethnic identity is merely one of individuals' many identities. Thus, therapists cannot assume that an individual's values and beliefs will be synonymous with that of their racial/ethnic group" (121312Tc1s1j1)*

Another therapist was surprised to find that her assumptions about her client were inaccurate, as her client held values that were more consistent with Canadian values regarding domestic violence and gender roles:

> *"It really seemed like I went in to my work with this client with a specific set of expectations in mind based on the client' culture. As I continued to talk to her, I began to see that these assumptions were likely inaccurate at least to some degree. For example, she stated that many other people might be in a relationship like she was, but they may be alright with that situation. She was not, and acted to make changes to her situation. She indicated that some people in her community blamed her for breaking up her family, which I would expect based on cultural beliefs about relationships and gender roles. Yet, she said that she did not pay any attention to these people and did not care about what they said" (111206Tc2s3j10)*

Therapists face a challenge: on the one hand they need to keep an open mind free

of preconceptions and assumptions; On the other hand, therapists need to have enough

knowledge about the client's culture to modify and adapt their interventions. The above

therapists' insights regarding the importance of approaching the clients with an open

mind and not making assumptions have been echoed throughout the literature (Dyche &

Zayas, 1995; Glauser & Bozarth, 2001; Kwong, 2009). In contrast, knowledge has been

defined as a fundamental component of Multicultural Counselling Competencies

(Roysircar, 2006). "Knowledge" refers to the therapists' familiarity with the client's

culture of origin and the therapists' ability to assess the clients presenting problems as

well as adapt the therapeutic interventions to better suit the client (Constantine et al.,

2008). Typically, cultural knowledge has been emphasized in training programs.

However, the emphasis placed on cultural knowledge can lead therapists to stereotype

their clients. Thus, preventing therapists from developing a more genuine relationship

with their clients and really getting to know them (Sue & Zane, 1987). It is important to

emphasize individual diversity within each culture, in other words, not every individual

can be known by virtue of knowing something about his or her culture (Goodkind, 2006).

Based on the literature and on the therapists' experiences, I think Multicultural

Counselling Competency entails having knowledge about the client's culture while

simultaneously being able to suspend that knowledge and approach the client from an

open and curious stance. This idea is congruent with Dychee & Zayas (1995) who

encourage therapists to maintain a stance of "evenly suspended attention" when working

with clients. This stance entails letting go of preconceptions and assumptions. In essence,

approaching the client with an open mind free of preconceptions and assumptions

requires cultural self-awareness. In order to release their preconceptions and assumptions,

the therapists first need to become aware of them and acknowledge them. Once therapists

are aware of their own preconceptions and assumptions they are more likely to be able to

make a conscious effort to suspend them and to really get to know their client (Dychee &

Zayas, 1995).   As one of the therapists aptly remarked:

> *"This incident really underscores the importance of not making assumptions*
> *about our clients' knowledge base. This is especially the case when it comes*
> *to topics that vary greatly between cultures. I will be extra aware and try to*
> *avoid making assumptions in the future with all of my clients."*
> *(121310Tc1s5j5)*

C. Questioning One's Own Cultural Sensitivity and Competence

As mentioned before, therapy as practiced in the Canadian context is a somewhat

mono-cultural system. Therapists are immersed in this mono-cultural system. Cultural

values and worldviews act as an "invisible veil", such that it is easy to assume that

everyone regardless of race, ethnicity, or gender shares the same worldview (Sue, 2001).

The values and worldview of the dominant culture are rarely questioned because we are

so immersed within them. Therefore, the act of questioning their own cultural sensitivity

and cultural competence in itself helps therapists in further developing their cultural self-

awareness. This theme, "Questioning own cultural sensitivity and competence" illustrates

how therapists explicitly questioned their cultural sensitivity and competence. Throughout

the beginning and working phases of the therapeutic process, some therapists questioned

their own cultural sensitivity and competence. These therapists wondered if they were

behaving in a culturally sensitive manner toward their refugee clients. For example, after

noticing her client seemed a little "fidgety and disengaged", one of the therapists

reflected:

> *"I left the session very worried about whether I had somehow behaved in a*
> *culturally insensitive manner that had inhibited the development of the*
> *alliance and prevented [client] from being open with me about her fears."*
> *(121311Tc1s1j1).*

Another therapist expected her client to talk about traumatic experiences.
However, the client denied having any concerns aside from being separated from her
parents. The therapist worried that her reactions toward the client were insensitive, this
therapist wrote:

> *"Because I was surprised that I was not getting the information I was
> expecting from the client, I am worried that my reactions were insensitive and
> that the client and I are not on the same page regarding the purpose of
> therapy." (111206Tc1s1j1)*

Therapists questioning of their own cultural sensitivity and competence was
further evidenced by two sub-themes, illustrated in Figure 29:
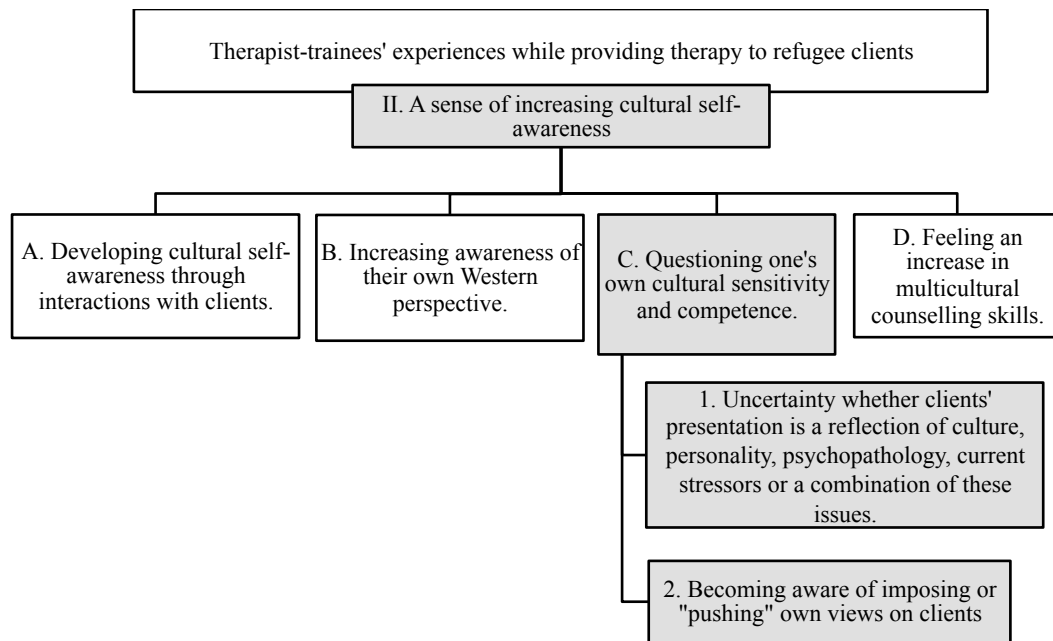
Figure 29. Sub-themes that emerged under the theme "Questioning own cultural
sensitivity and competence". The shaded parts highlight the themes referenced in the
current section.

The theme "therapists questioning their own cultural sensitivity and competence" was
further explained by therapists' uncertainty regarding the etiology of the clients'
presentation illustrated in the sub-theme "Uncertainty whether the clients' presentation is

a reflection of culture, personality, psychopathology, current stressors, or a combination

of these issues". The second sub-theme: "Becoming aware of "imposing" or "pushing"

view on clients" further showcases therapists' questioning of their own cultural sensitivity

and competence as they wondered if they were imposing their views on their clients.

1. Uncertainty whether clients' presentation is a reflection of culture, personality, psychopathology, current stressors or a combination of these issues.
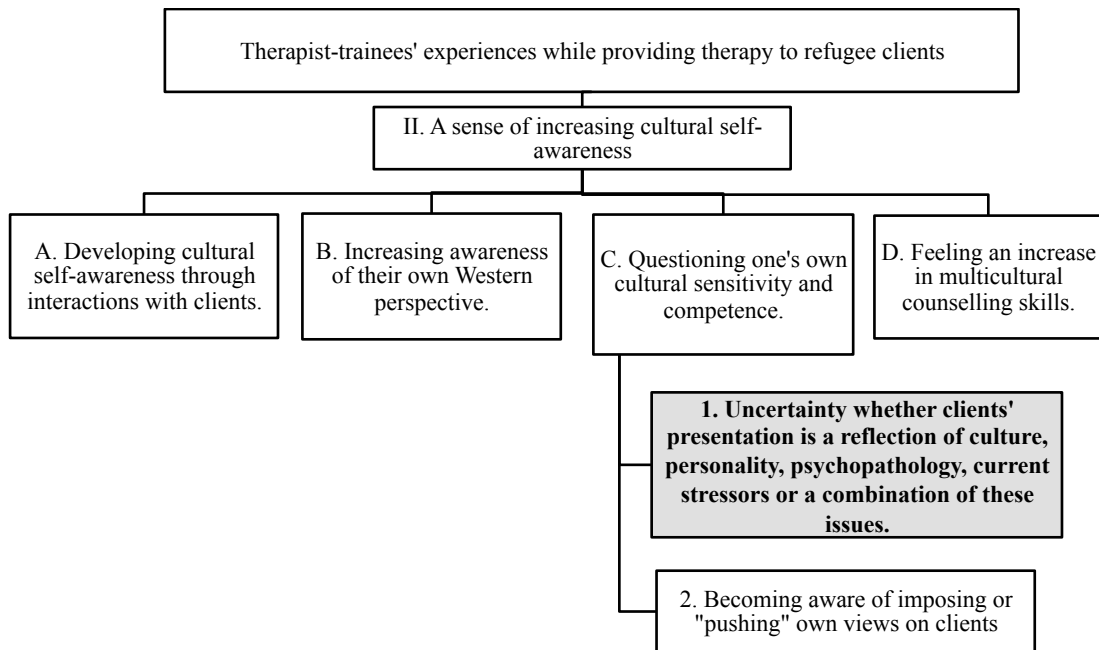
Figure 30. Thematic Overview. Locating the theme "Uncertainty whether clients' presentation is a reflection of culture, personality, psychopathology, current stressors or a combination of these issues" within the analysis.

During the beginning and working phases of therapy, some therapists expressed

uncertainty regarding whether their clients' presentation was a reflection of their culture,

their personality, their current stressors, or a combination of all these issues. The

therapists' cultural sensitivity and competence were demonstrated by the therapists'

reflections regarding being careful not to pathologize their clients as well as their

willingness to question themselves regarding the culture-bound aspects of the clients'

presentation. These therapists' sense of uncertainty and confusion regarding the clients'

presentation as culturally or psychologically based further evidenced therapists'

questioning of their own cultural sensitivity and competence. For instance, one of the

therapists described her reactions to learning that her refugee client was having

premonitory dreams. This therapist reflected on whether her client's dreams were more

consistent with a culturally specific belief or if these dreams were indicative of a more

serious psychiatric issue. This therapist recalled:

> *"I was very disconcerted and confused initially with her description. I was
> thinking to check if this is a psychotic feature or rather a culturally specific
> belief. And wondering how I can discriminate between the two options. In the
> Canadian culture, beliefs in psychic skills are usually subject to in-depth
> evaluation, but in other cultures, there is support and understanding of such
> "gifted" people who are given positions of power in society. On the other
> hand, I was thinking that such a claim sounds like a delusion, especially since
> she stated that "every" dream becomes true. I was worried that regardless
> my decision, I would make a mistake and affect the wellbeing of my client"
> (111207Tc1s2j1).*

The above therapist's reflection regarding the cultural relativity of "psychic skills"

demonstrates a culturally aware perspective. The concepts of wellbeing and

psychopathology are defined on the basis of culture-dependent normative understandings

(Christopher, 1999; Draguns & Tanaka-Matsumi, 2003). Psychic skills are interpreted

differently across cultures. For instance, in western societies psychic skills or "unusual

states of consciousness" are typically viewed as a sign of pathology and mental illness

(Watson, 1994). In contrast, in other cultures people who have psychic skills are

consulted for the knowledge and wisdom they attain from spirits. For example, in

Cambodia diverse spirits can possess mediums; each spirit serves a distinct social or

therapeutic function (Bertrand, 2005). Similarly, Balinese shamans, Balians, are believed

to be in contact with the "unseen". They can gain information through visions, hearing

voices (auditory hallucinations), divination, meditation, and premonitory dreams (Stephen

& Suryani, 2000). Thus, therapist 111207T was being culturally sensitive in trying to not

pathologize the client's presentation, while at the same time trying to assess the client's

presenting problem accurately.

Along the same lines, another therapist reflected on her level of comfort in regard

to encouraging her client to make some changes in her level of expression. This therapist

reflected on how aiming to modify her client's behaviour would be acceptable as long as

these behaviours were a function of the client's personality. However, the therapist

indicated she would feel uncomfortable trying to modify her client's behaviours if they

were culturally based:

> *"I am unsure which aspects reflect culture and which reflect her personality style. [...] I think I will feel more comfortable pushing the client towards some small changes in expression operating under the assumption that her quietness within the session is based more in personality than culture [...] I began to think about why this would make such a difference to me. I think that if her personality style was to be shy and generally apply less insight to her experiences then within the therapy sessions I would try to slowly make her more comfortable with these types of expression. If these reactions are based on her culture I would feel uncomfortable trying to change them. Rather I would try to work within the framework of her worldview within the session" (111206Tc1s2j2).*

Echoing the above therapist's concerns regarding changing culturally based

behaviours or beliefs, a couple of therapists mentioned feeling "stuck" or "uncertain" as

to how to proceed when the client appeared to have a "culturally-based" belief, cognition,

or behaviour that interfered with the therapeutic process or the client's wellbeing. One of

the therapists expressed:

> *"The most impactful event for me in this week's session was [client] describing a saying about how the only person that can heal the wounds inside of you is yourself. This is a very discrepant view from the one that I hold. [...] It was difficult to hear this. [...] I think that this belief will be hard to work on in therapy. [...] I feel that this belief is consistent with [client's]*

culture, though, and therefore don't want to invalidate it by challenging it. I am also skeptical that trying to modify it would be effective since it is so ingrained. This leaves me feeling kind of stuck" (121310Tc1s10j10).

These therapists' discomfort with changing or challenging culturally-based behaviours and beliefs is an example of their developing self-awareness and cultural sensitivity. These therapists were trying to avoid invalidating the client, thus avoiding potential racial micro-aggressions. Racial micro-aggressions refer to intentional or unintentional subtle insults against people from a minority group (Sue, et al., 2007). A common racial micro-aggression within the therapeutic context consists of pathologizing cultural values or communication styles that differ from those of the dominant culture (Sue, et al., 2007).

In addition to the challenge of distinguishing between culturally based beliefs and issues stemming from the client's personality and coping style, therapists also had to consider other matters relevant to recent immigrants. Some therapists emphasized the importance of considering acculturation when working with clients who come from different cultures:

> *"In general, this experience has reminded me how acculturation issues can influence any and all concerns that a client is having. It will be important for me to keep in mind that acculturative stress is equally as important as any other concern that I am more used to working with in therapy sessions and not to disregard it or give preference to other topics because I am more used to talking about them. In future sessions I think I will have to pause and ask myself how the client's immigration experience is impacting on the situations he is speaking about in order to view him as the complex, multi-faceted individual that he is" (111206Tc3s3j13).*

Another therapist described how her client was in the midst of the acculturation process:

> *"On one hand, it felt that she was taking one step towards becoming Canadian, but I also realized that she was taking a step away from being Iraqi and that such strength, assertiveness and independence may help her as an individual, but not as a person within an Iraqi community. [...]On the other hand, the situation definitely brought up the tension between Canadian*

and native values, as well as the difficulties in finding a compromise between the two. Effectively, a client may try to find a common ground for both values, but in most cases, they seem to be at polar ends so the person experiences increased stress as they try to make a choice. The choice may push them towards their culture (and potential source of initial distress) or away from their culture (and elements that are helpful, familiar) and into the Canadian culture (which at first remains foreign to them). It seems to be a very difficult and delicate process, for which I am not sure I would always have the right answer" (111207c1s10j9)

Adapting to a new culture can be a difficult and slow process (Berry, 1997). New immigrants and refugees have to adapt to a new culture, learn a new language, and overcome obstacles in finding meaningful work (Rashid et al., 2013). In addition, at times, these populations face these challenges without their family and friends (Bemak & Chung, 2004). These therapists are demonstrating cultural sensitivity in recognizing the inherent difficulties in adapting to a new culture and the ways in which this issue influences the client's presenting problems (Yeh & Kwan, 2010; Sue & Sue, 2008).

2. Becoming aware of "imposing" or "pushing" views on clients.
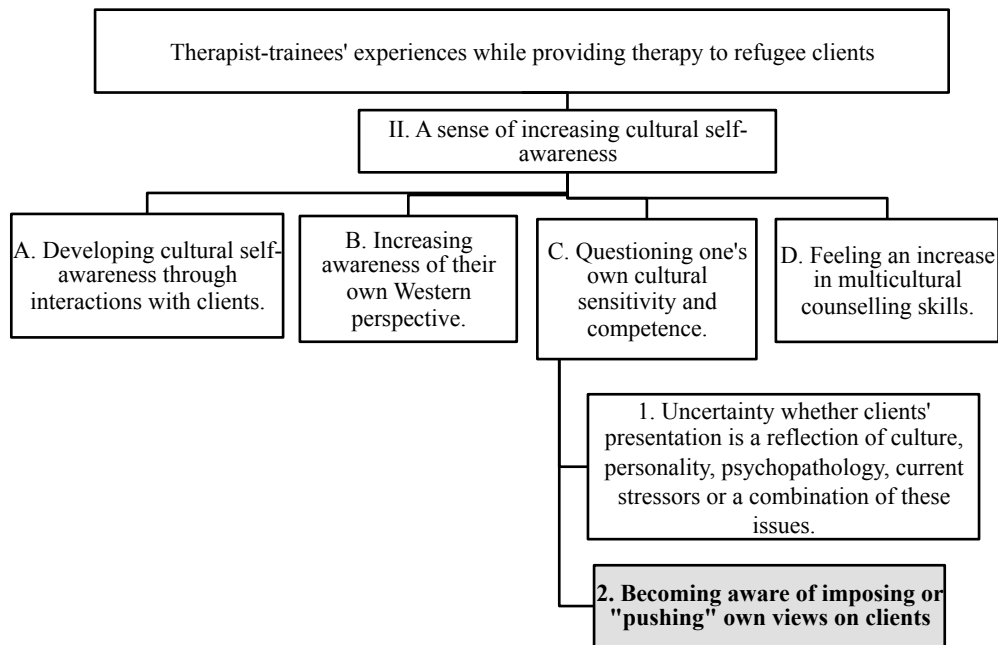
Figure 31. Thematic Overview. Locating the theme "Becoming aware of imposing or "pushing" own views on clients" within the analysis

Some therapists caught themselves somewhat "imposing" their views on their clients. Therapists' reflections on their tendency to "push" their views onto their client emerged mostly in the working phase of therapy. The therapists' tendency to "push" their worldviews on their clients is somewhat understandable as western psychological theories and treatment are culture-bound and culturally-biased (Duran, Firehammer, & Gonzalez, 2008). The fact that therapists became aware of their tendency to "impose" or "push" their views on their refugee clients further evidenced their willingness to question their cultural sensitivity. Moreover, therapists' willingness to recognize their tendency to "push" their views onto their clients further illustrated the development of their cultural self-awareness. For example, one of the therapists described how she and her client had very different views on social supports. This client suffered from depression, a disorder that is highly stigmatized in her culture. Thus, the client was resisting the idea of

accessing her social supports, as she believed that if she opened up to others "they will

judge her and think she is crazy". The therapist talked about how discussing this issue

with her client made her wonder if she was "forcing her Western" values onto her client:

> *"The discussion around social support was difficult for me as well. I wanted her to see the importance of social support without it seeming like I was pushing it on her. I also struggled with whether my being persistent about this topic reflected me trying to force my Western values upon her" (121310Tc1s12j12).*

This same therapist also mentioned how this experience fostered an increase in her

own cultural self-awareness:

> *"Our discussions around social support have also increased my cultural awareness. Although I was aware that there was varying degrees of stigma surrounding mental illness between cultures, this is the first time that I have seen that stigma have such a debilitating effect on a client" (121310Tc1s12j12).*

In the same vein, these therapists noticed themselves being persistent and

"pushing" their views of the therapeutic process, trying to make the client's experiences

"fit" the therapists' conceptualization. As one therapist expressed:

> *"At times I tried to get the client to express the benefits of therapy in a way that made sense within my conceptualization of our work. Yet, as the session progressed I realized that what I thought did not actually matter. [...] I was constantly stuck in my own views of therapy, rather than seeing things from the client's point of view. In the future, I need to be more in tune with how the client speaks about their unique problems, and try harder to think about them in the same way, or at least closer to the client's view of recovery. Different cultures view the processes of the mind and emotions differently, with some aspects more in the client's control than others. I have noticed that I tend to push my own opinion of these processes more than I should" (111206Tc1s7j7)*

Another therapist found that she and her client held different ideas of how to

alleviate psychological distress. This therapist noticed she was insisting on trying to

convince the client about the usefulness of processing painful emotions in therapy. The

therapist found herself reacting to the client's resistance by persisting and providing

psychoeducation:

> *"I reacted to her resistance by further persistence and psychoeducation about the utility of processing painful emotions. When she continued to resist all attempts to explore the past, I held the conviction that my interventions were not working as I had the attitude that clients must sit with and process negative emotions and memories to work through psychological suffering. Theories from my Emotion-Focused Therapy and trauma training mandating that "the only out is through [negative emotions]" kept on playing out in my mind and I continued to persist. When [client] stated that it is not helpful for her to focus on the past when there is nothing that can be done to change anything (e.g. she cannot return to see her family, she has survived for over two decades by avoiding the emotional pain of dwelling on her losses), and the most useful strategy is to focus on positive experiences in the present, it was hard for me in the moment to accept that this coping strategy may be adaptive for my client and not to label her processes as a form of avoidant coping" (121313Tc1s5j5).*

D. Feeling an Increase in Multicultural Counselling Skills
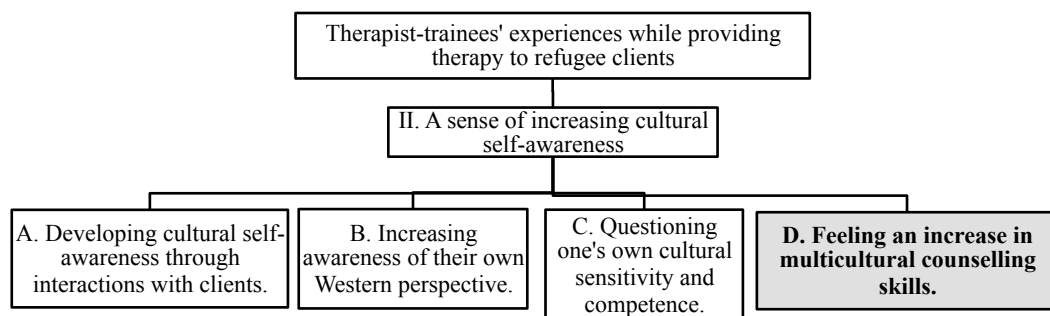
Figure 32. Thematic Overview. Locating the theme "Feeling an increase in multicultural counselling skils" within the analysis

The fourth subordinate theme "Feeling an increase in multicultural counseling skills" further illustrates therapists' sense of increasing cultural self-awareness as they felt an increase in their multicultural counselling skills. There is a gap in the literature between the didactic learning of Multicultural Counselling Competencies and their actual application in real life situations. The present theme highlights the importance of actual practice in the development of multicultural counselling skills. A few qualitative studies

have asked therapist-trainees to talk about their experiences after participating in courses

focused on Multicultural Counselling Competencies (Sammons & Speight, 2008;

Tomlinson-Clark, 2000). These studies have found that there is a gap between the

multicultural competencies as defined and measured by several instruments and actual

skills (Worthington et al., 2007). For instance, after taking courses in multicultural

competency, students still find it difficult to integrate their knowledge into culturally

sensitive skills (Sammons & Speight, 2008). Moreover, Constantine and Ladany (2000)

found that the self-report multicultural competency scales were not significantly related to

counselor's ability to develop a case conceptualization using a multicultural perspective.

Unlike therapists in the previous studies, in the present study therapists actually

had the opportunity to develop their skills by providing therapy to real refugee clients.

Around half of the therapists explicitly mentioned certain experiences they thought

"would increase their multicultural counselling skills". These reflections emerged

throughout the therapy process. Therapists' experiences were varied and included

instances such as: trying to work through their client's emotional detachment, working

with their client despite having very different beliefs and worldviews, and thinking about

different ways of achieving therapeutic progress. As several therapists explained:

> *"Also, considering none of my previous clients are never this emotionally detached, this experience of witnessing such individual differences are increasing my skills as a therapist" (101102Tc1s4j4).*

> *"This experience indicated a strong need to balance the beliefs of the client with doing what will be helpful for the client. [...] I feel that getting through this hurdle will help to hone my multicultural counselling skills in that it will be good practice working through mismatched beliefs" (111205Tc1s6j5).*

> *"It has also forced me to think more about how I may be able to help this client, in spite of the fact that she appears relatively content with her life. It has tested my skills as a therapist to think beyond the usual presenting problems that I have seen in the past with clients" (111206Tc1s1j1)*

Therapists explicitly mentioned other issues they considered relevant to their

MCC skill development. For instance, a therapist mentioned that answering her client's

questions gave her an opportunity to "practice her skills" in describing her own "beliefs

and stance". Another therapist described feeling: "better equipped to handle

termination". An additional therapist indicated that listening to her client's painful story

helped in developing her skills:

> *"As per my skills it helped [me] become familiar with being able to listen to another's account of their torture" (101101Tc1s3j3).*

After her client brought a cake to the session, one therapist reflected on how she

felt better prepared to receive "small gifts of food" in a culturally sensitive manner:

> *"I believe my experience with this incident improved my skills in receiving gifts of food from clients. In this instance, instead of being distracted, confused, or worried about whether I had acknowledged and received [client's] gesture in a culturally appropriate way, I realize it would have been best and most simple to ask [client] herself for cultural direction in regard to the manner in which we should enjoy the cake she brought" (121314Tc1s13j13)*

Section III. Building the Therapeutic Relationship is Important

This third main theme describes the therapists' reflections on the importance of

the therapeutic relationship. The importance of the therapeutic relationship has been

emphasized throughout the literature. Recent psychotherapy outcome research found that

40% of clients' change was attributable to client's resources, 30% to the therapeutic

relationship, 15% to clients' sense of hope, and 15% to the therapists' techniques and

strategies (Kottler & Carlson, 2005a; Cooper, 2008). Other authors assert that the

personality of the therapist and his or her ability to form a warm and supportive

relationship is the greatest predictor of client outcome (Luborsky, McLellan, Woody,

O'Brien, & Auerbach, 1985). These findings are echoed in MCC research, in addition to

knowledge of psychopathology and intervention, a successful psychotherapist needs to

build a warm, empathic, and collaborative relationship with the client (Constantine &

Ladany, 2001; Roysircar, 2006; Roysircar & Gill, 2010). Moreover, when working with

refugee clients, it is essential to create a sense of safety within the relationship for two

reasons. First, this creates the basis for therapeutic work. Second, at the same time, this

allows the client to attain a sense of safety in the world, and this constitutes one of the

main goals for treatment with refugees (Gorman, 2001).

Throughout their work with their clients, all the therapists reflected on their

therapeutic relationship with their clients. Two main themes emerged which further

illustrated the importance of the therapeutic alliance:
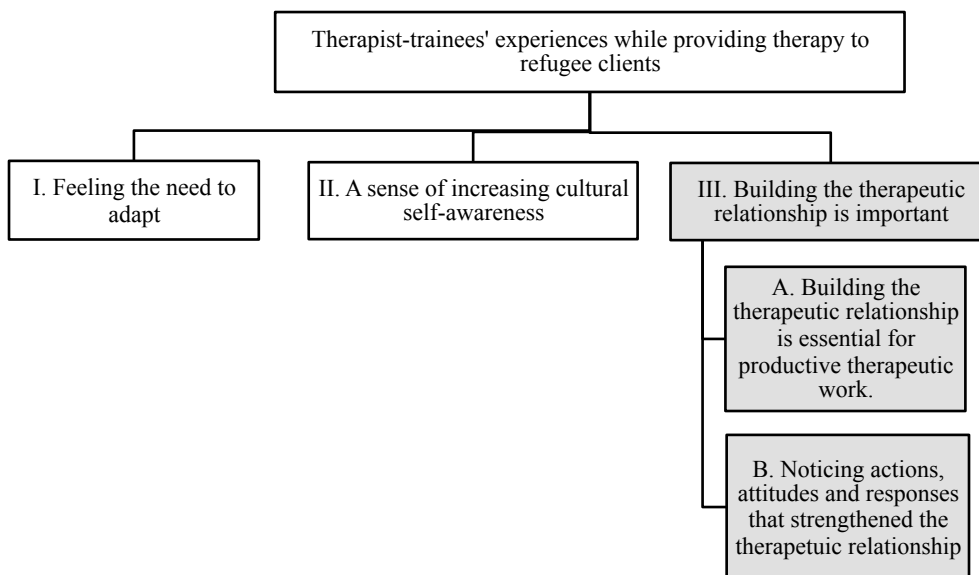
Figure 33. Two sub-themes emerged under the theme "Building the therapeutic relationship is important". The shaded parts highlight the themes referenced in the current section.

A. Building the Therapeutic Relationship is Essential for Productive Therapeutic

Work

Echoing previous research, which suggests that the therapist's ability to cultivate a

warm and empathic relationship is one of the most important predictors of client outcome

(Kottler & Carlson, 2005; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985),

most therapists reflected on the importance of the therapeutic alliance when working with

their refugee clients. These reflections mainly emerged within the beginning and working

phases of therapy. The importance of the therapeutic alliance for productive therapeutic

work was further evidenced by two subordinate themes illustrated in Figure 34:
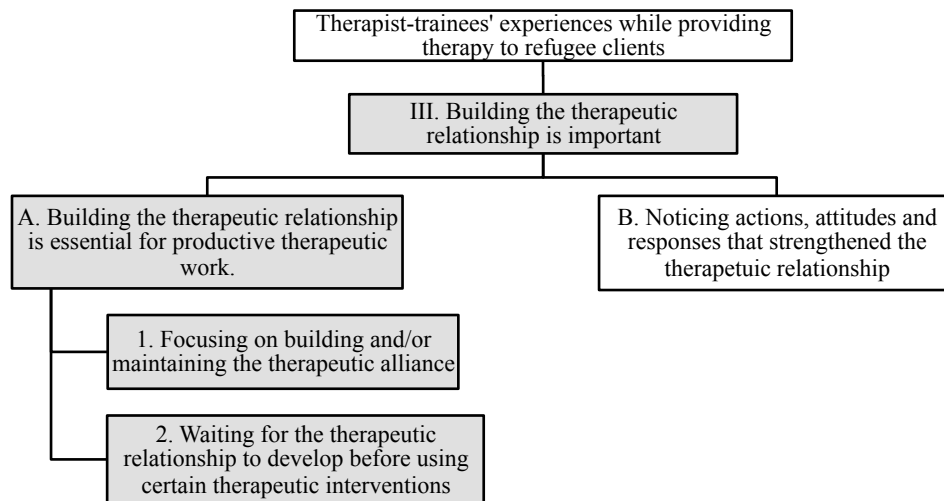
Figure 34. Two sub-themes emerged within the theme "Building the therapeutic
relationship is essential for productive therapeutic work". The shaded parts highlight the
themes referenced in the current section. In order to aid with clarity, the two major
themes "Feeling the need to adapt" and "A sense of increasing cultural self-awareness"
were omitted from this figure.

1. Focusing on building and/or maintaining the therapeutic alliance.
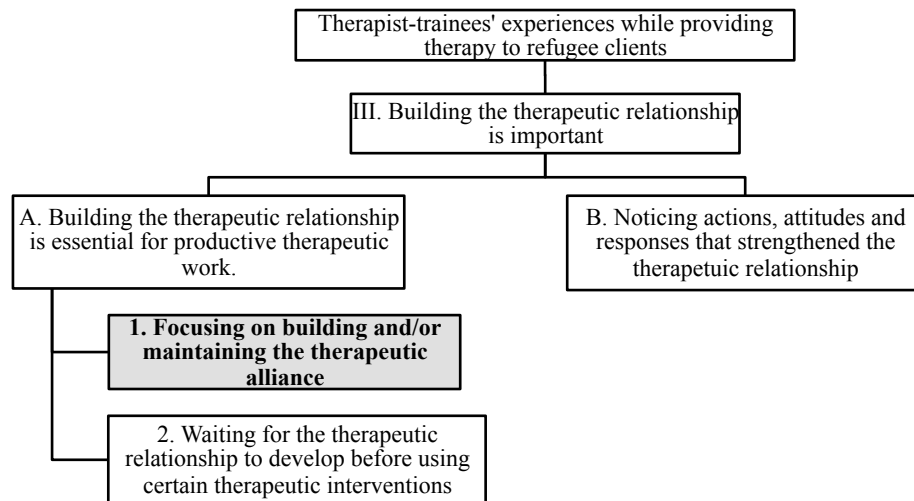
Figure 35. Thematic Overview. Locating the theme "Focusing on building and/or maintaining the therapeutic alliance" within the analysis.

Some therapists reflected on how focusing on building or maintaining the therapeutic relationship was essential for working with their refugee clients. These reflections emerged throughout the therapy sessions. For instance, a therapist who was having the first session with her client indicated that before the session she was feeling unsure as to what to focus on. This therapist described how building the therapeutic relationship became a natural focus for the session:

> *"However, when I saw my client for the first time, a sense of direction naturally arose within me that came with the realization of the most important goal—cultivating an emotional connection with my client and building a relationship that provided support, unconditional acceptance, and warmth. This focus became a natural and intuitive reaction as soon as I began listening to my client's heart-wrenching experiences for the first time"* (121314Tc1s1j1).

This therapist's reflection is consistent with client-centred psychotherapy, which emphasizes the importance of adopting a warm stance characterized by unconditional acceptance and non-judgment (Rogers, 1961). Therapists' emphasis on developing the therapeutic relationship is consistent with the literature that suggests that the relationship

is one of the clearest predictors of positive outcome (Castonguay, Constantino, &

Holtforth, 2006).

Similarly a therapist who was on the ninth session with her client reflected on the

importance of building a strong therapeutic relationship and on how the relationship was

more important than the techniques employed:

> *"My experiences in this session, and this highly interpersonal moment*
> *reminded me of the importance of the therapeutic relationship. It is not*
> *simply about techniques, but it is about rapport, particularly with this client*
> *and in my opinion, likely with such clients who are not accustomed to the*
> *concept and expectations of therapy, and who likely have not experienced*
> *trusting and solid relationships in the past. It brought to my attention that our*
> *cross cultural clients, especially when working with an interpreter, are really*
> *forming their opinion and assessing my suitability as someone to trust by my*
> *reactions to them in session (not my specific technique per se)"*
> *(101101Tc1s9j9).*

The above reflection is consistent the view that the therapeutic relationship and the way in

which interventions are delivered are more important than any specific technique

(Glauser & Bozarth, 2001; Norcross & Lambert, 2011; Wampold, 2001; 2007).

Moreover, the importance of the therapeutic relationship is highlighted by the fact that the

relationship in itself can be a curative factor within therapy (Coleman, 2000; Rogers,

1961). Consistent with this view, some therapists mentioned the curative potential of the

therapeutic relationship. As one therapist wrote:

> *"I think that our relationship will be a very important therapeutic vesicle, as*
> *I will essentially be bearing witness to her struggle while standing beside her*
> *(figuratively and literally) as she faces her upcoming challenges. I think that*
> *having someone by her side who has "heard it all" and still accepts her and*
> *wants to help her will be tremendously curative for her, and hopefully make*
> *this process easier to get through than if she did not have such an advocate"*
> *(101103Tc1s6j6)*

At its core, when building the therapeutic relationship, client and therapist are aiming to

form a meaningful human relationship in the midst of varying social and cultural contexts

(Coleman, 2000). Some therapists who endeavored to maintain a strong therapeutic

relationship with their clients echoed this view. As one therapist wrote when she realized

she and her client had very different beliefs:

> *"[...] I was a little uncertain of how to proceed. I did make sure not to communicate to my client that this belief was unacceptable or strange, which I felt was important. I wanted the relationship with my client to remain strong despite differences in beliefs"* (111205Tc1s6j5).

Building a strong therapeutic relationship was even more meaningful due to the clients'

sense of distrust and/or difficulties in getting close to others. Around half the therapists

mentioned their clients' having difficulties trusting others and building relationships. For

instance, a therapist whose client avoided becoming close to others, highlighted the

relevance of her client feeling comfortable within the therapeutic relationship and

disclosing issues he had never talked about before:

> *"Hearing this story reinforced my belief that he has gone through so much, seen the aggressive and untrustworthy side of others and it is no wonder he has lived a lifetime of isolation, where he has not been able to trust others or form close interpersonal relations. It [...] highlighted my awareness of how comfortable he feels interpersonally in this working relationship, as he is disclosing events that he has never repeated before"* (101101Tc1s10j10).

2. Waiting for the therapeutic relationship to develop before using certain therapeutic interventions.
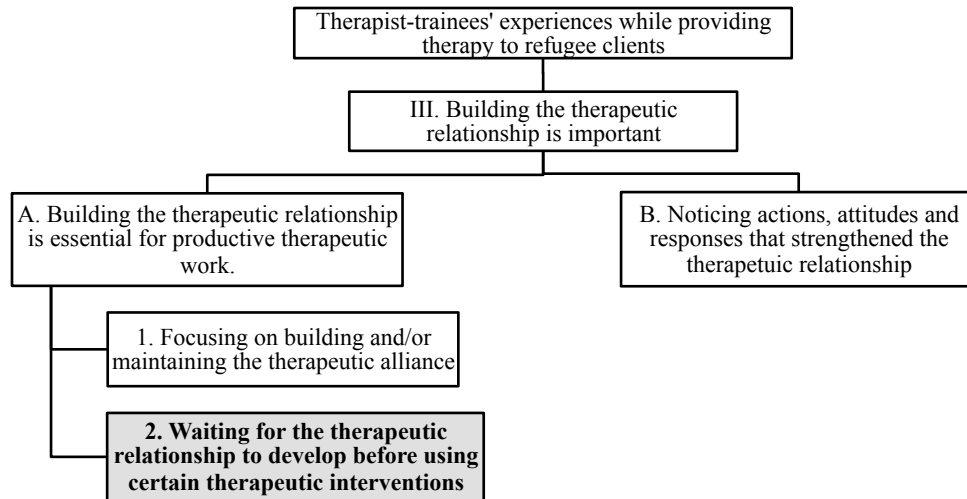
Figure 36. Thematic Overview. Locating the theme "Waiting for the therapeutic relationship to develop before using certain therapeutic interventions" within the analysis.

The importance of the therapeutic relationship for productive therapeutic work

was further evidenced by a couple of therapists describing how they waited to make

interventions until the therapeutic relationship was stronger. These reflections emerged at

the beginning phase as well as within the working phase of the therapy process. As one

therapist expressed after her third session with her client:

> *"In hearing her talk about them I wanted to express my sadness for what she experienced at the hands of her own family and encourage her to express anger. However, I also recognized that our relationship might not yet be strong enough for that, and that she may not be ready to express her anger towards them" (111209Tc1s3j3).*

Waiting for the therapeutic alliance to develop before using certain therapeutic

interventions is consistent with the literature and with certain models of psychotherapy

(Beck, 2011; Book, 2003; Greenberg, et al., 1993; Sue & Sue, 1999). Along the same

lines, some therapists talked about feeling more confident in their interventions due to

having developed a strong working alliance with their clients. These reflections emerged

mostly during the working phase of therapy. A couple of therapists described:

> *"I think that my client and I have built a strong enough alliance and have talked about his issues enough that it has led us naturally to a point where we are ready to explore his anger and what that means to him. I am looking forward to this work" (111208Tc1s11j11).*

> *"I will bring up the issue of fate with the client and ask her to help me work with her belief. She and I have a strong alliance by now, therefore I hope that when I bring up this topic, she will be willing to help me find a way to use her religious beliefs to help us in the search for a solution" (111207c1s8j7)*

B. Noticing Actions, Attitudes and Responses that Strengthened the Therapeutic Relationship.

The theme "Noticing Actions Attitudes and Responses that Strengthened the Therapeutic Relationship" showcases numerous behaviours that the therapists considered helped strengthen the therapeutic relationship. Throughout every phase of the therapeutic process, all the therapists reflected on different elements that strengthened the therapeutic relationship with their clients. These elements included their own responses, attitudes, and actions toward the clients, the client's responses, and the interactions between therapists and clients. The actions, attitudes, and responses that strengthened the therapeutic relationship are demonstrated by three interrelated sub-themes, illustrated in Figure 37:
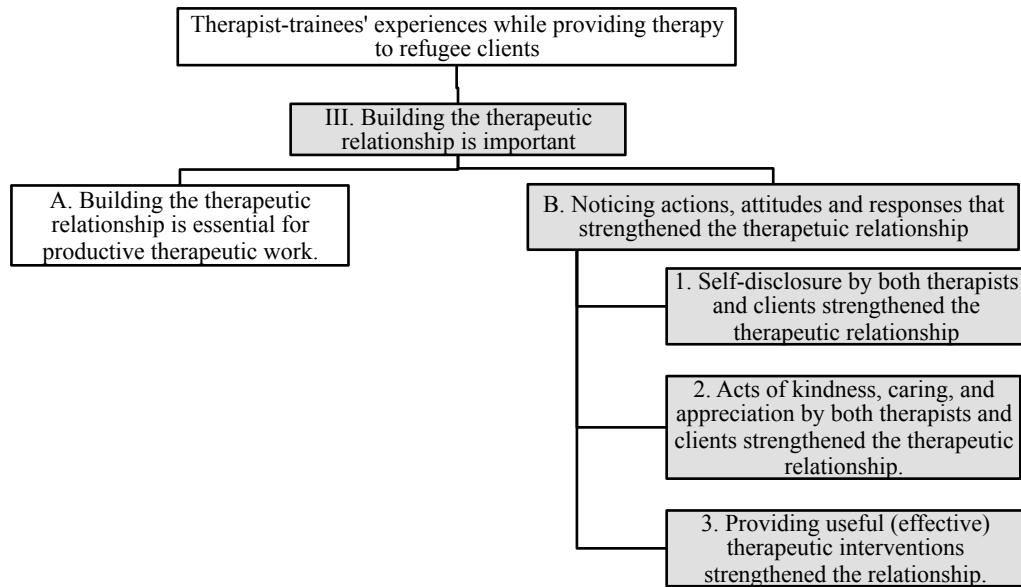
Figure 37. Three sub-themes emerged under the theme "Noticing actions, attitudes, and responses that strengthened the therapeutic relationship". The shaded parts highlight the themes referenced in the current section.

1. Self-disclosure by both therapists and clients strengthened the therapeutic relationship.
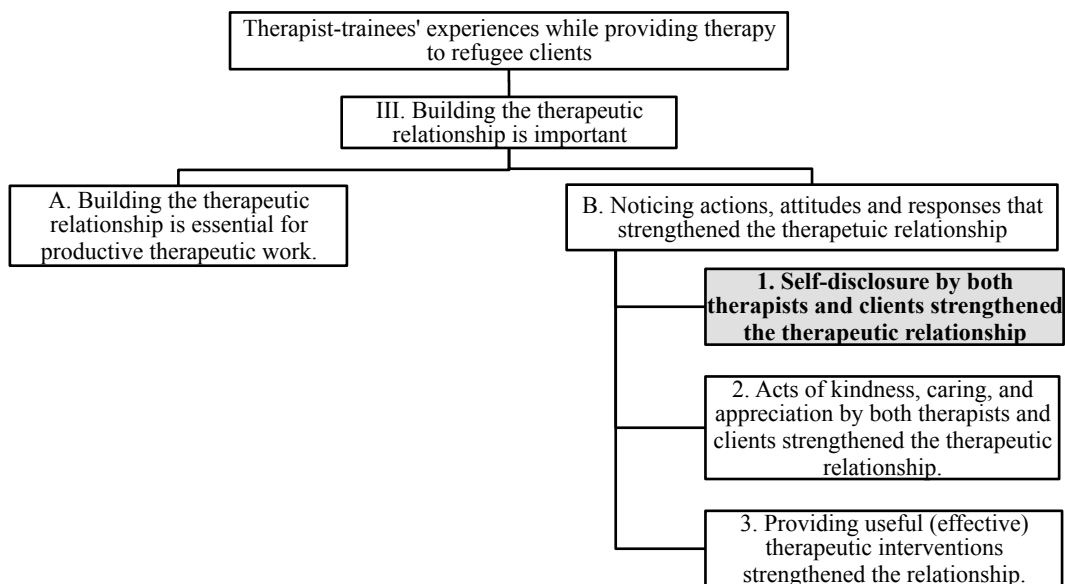
Figure 38. Thematic Overview. Locating the theme "Self-disclosure by both therapists and clients strengthened the therapeutic relationship" within the analysis

Echoing previous research, some therapists considered that their self-disclosures strengthened the therapeutic relationship (Parson, 1993). As a couple of therapists reflected:

> *"I think this moment was especially important because I used a self reference to help explain my position that a multitude of factors contribute to peoples values, behaviours etc. I think I responded in a way that I would not respond with other clients and I integrated my cultural experiences to help explain my position. I feel like in these sessions, and at this moment in particular, my answers are more personal, or less cookie cutter answers. It's like I respond in a more genuine way, or in a way that alludes to my beliefs more. I think this has contributed to our strong working relationship"* (101101Tc1s4j4).

> *"She even asked me about my own life (if I had children, etc) and I felt comfortable sharing with her some things [...] I think it was a necessary part of the "give and take" dynamic that had developed in our relationship. To have been vague or avoided the questions would have been rude and equivalent to rejection of the relationship that had formed. [...] For them, the idea of a helper is someone who knows them and who is somewhat known to them. As such, it is important to not be dismissive of an individual's attempts to forge their own connection with you. If that means disclosing a bit about yourself, so be it. If that means taking an extra 10 minutes at the start of the session for social "chit chat" to respect a client's idea of social etiquette, so be it"* (101103Tc1s3j3)

Not only was the therapeutic relationship strengthened by the therapists' limited self-disclosures. Around half the therapists considered that their clients' willingness to trust them and talk about painful aspects of their lives also strengthened the therapeutic relationship. As a couple of therapists described:

> *"I think this disclosure and the fact that he has not mentioned this to anyone increased the strength of our relationship even more than it was because he reported feeling really comfortable that day (likely because he shared something that he has never shared before) and I felt honoured and really valued and appreciated the risks and openness he has taken in session"* (101101Tc1s10j10)

> *"In my work with [client], this disclosure has opened up an important new area for us to work on, and will likely be a primary focus in future sessions. Further, this disclosure has given me greater confidence in the strength of the*

alliance, which was certainly in question following last week's session"
(121311Tc2s8j10)

These therapists' insights are consistent with research which suggests that (a) clients are

more likely to disclose once they trust their therapists and (b) that the clients' disclosures

themselves accompanied by their therapists' validating and non-judgmental reactions

strengthen the relationship (Farber, Berano, & Capobianco, 2004). While these findings

are common to all therapeutic interactions, two issues are worth mentioning. First, it is

important to consider that establishing trust with refugee clients may be more difficult

(Tribe, 1999). Second, due to the differences in worldview and life experiences, it may be

more challenging for therapists to maintain a non-judgmental stance with culturally

diverse clients.

In addition, client disclosures helped therapists better understand and empathize

with their clients, which also strengthened the therapeutic relationship. As a couple of

therapists described:

> *"I think this experience allowed me to understand my client's daily*
> *experience and the pains she lives in on a daily basis. This allowed us to*
> *become closer and begin to form the therapeutic alliance" (111209Tc2s1j4)*

> *"I found myself projecting more warmth toward the client when she was*
> *speaking about her native country. I was drawn into the slightly happier way*
> *she described her life there and the important relationships she had with her*
> *friends and family. I did also feel some relief. I was finally getting somewhere*
> *in understanding where the client is coming from and it appeared she was*
> *becoming more comfortable speaking to me about the important things in her*
> *life, including her vulnerabilities. [...] I think this incident will enhance my*
> *alliance with my client" (111206Tc1s3j3).*

Another therapist described how the client's willingness to contact his emotions helped in

strengthening the therapeutic alliance:

> *"Once the client was able to connect with his inner emotions (rather than*
> *externalizing) I felt that the session flowed very smoothly and a strong*
> *therapeutic alliance was facilitated. I felt as though the client trusted me*

enough to put his guard down – with a little guidance he was able to speak from within" (111208Tc1s5j5).

2. Acts of kindness, caring, and appreciation by both therapists and clients strengthened the therapeutic relationship.
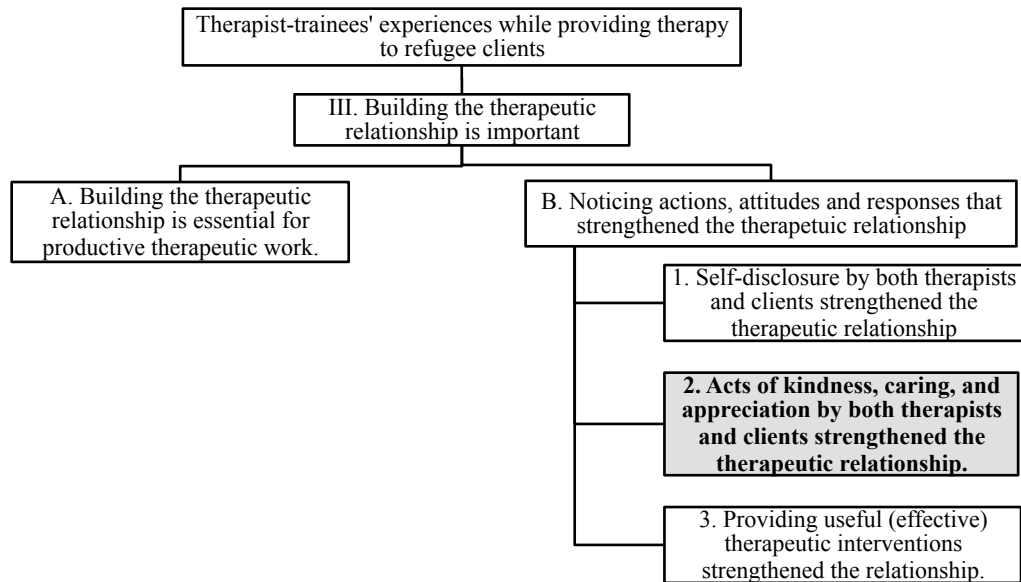
Figure 39. Thematic Overview. Locating the theme "Acts of kindness, caring, and appreciation by both therapists and clients strengthened the therapeutic relationship" within the analysis

Therapists and clients demonstrated kindness, caring, and appreciation toward each other in different ways. In their Critical Incident Journals (CIJ), therapists reflected on how these actions strengthened the therapeutic relationship.

In terms of their own actions, some of the therapists indicated that showing interest, caring, warmth, and kindness toward their clients also strengthened the therapeutic relationship. The importance that clients attribute to their therapists' acts of kindness, caring, and genuineness has been repeatedly cited in the literature (Johansson & Ecklund (2003; Kottler & Carlson, 2005b; Paulson, Truscott, & Stuart, 1999; Mirdal et al., 2012). These acts of kindness are even more important when working with refugee clients who are likely to count with few social supports and who may have difficulty

trusting others due to their past traumatic experiences. For instance, after her client didn't

show up for a session and couldn't be reached by phone, the therapist and the caseworker

went to the client's house to check on the client. This therapist felt that this action was

very good for their therapeutic relationship.

> *"We were talking about how she feels isolated and wants people around her and she spontaneously said that last week when we (her case worker and I) were so worried about her after she couldn't be reached and didn't show up for her appointment that we showed up at her apartment [...] she was so unbelievably happy to see us. She said she felt that someone cared about her. [...] This experience has definitely been good for our relationship. I think the client feels cared for and I feel more connected to her"* (111209Tc2s3j6)

Another therapist described how she demonstrated kindness by being interested in her

client and by advocating for her. The therapist reflected on how advocating for her client

had a positive impact on the client and strengthened the therapeutic relationship:

> *"In terms of my relationship with my client, it appeared that my interest in her problem and motivation to advocate for my client by speaking with her caseworker strengthened our relationship. My client thanked me several times at the end of the session, looked at me warmly, and shook my hand before leaving. It was a rewarding experience and highlighted how any small act of kindness and compassion can be highly impactful for multicultural and refugee clients"* (121313Tc1s2j2).

Along the same lines, clients' acts of kindness and appreciation toward the therapist

also contributed to strengthening the therapeutic relationship. One of the therapists

described how the clients' expressions of gratitude and appreciation helped her feel

motivated and strengthened the therapeutic alliance:

> *"[...] this has motivated and contributes to my appreciation, enjoyment, and eagerness to continue to work with him. His honestly and positive feedback contributed to strengthening our working relationship"* (101101Tc1s4j4).

Another therapist described how an unexpected gift exchange strengthened her

relationship with her client.

"The most critical and impactful event for me in this week's session with HM was when HM brought a cake that she baked for me to the same session that I had planned to give her a bead kit. [...] I believe, overall, this incident increased the bond between HM, as well as our mutual appreciation for each other"(121314Tc1s13j13)

3. Providing useful/effective therapeutic interventions strengthened the relationship.
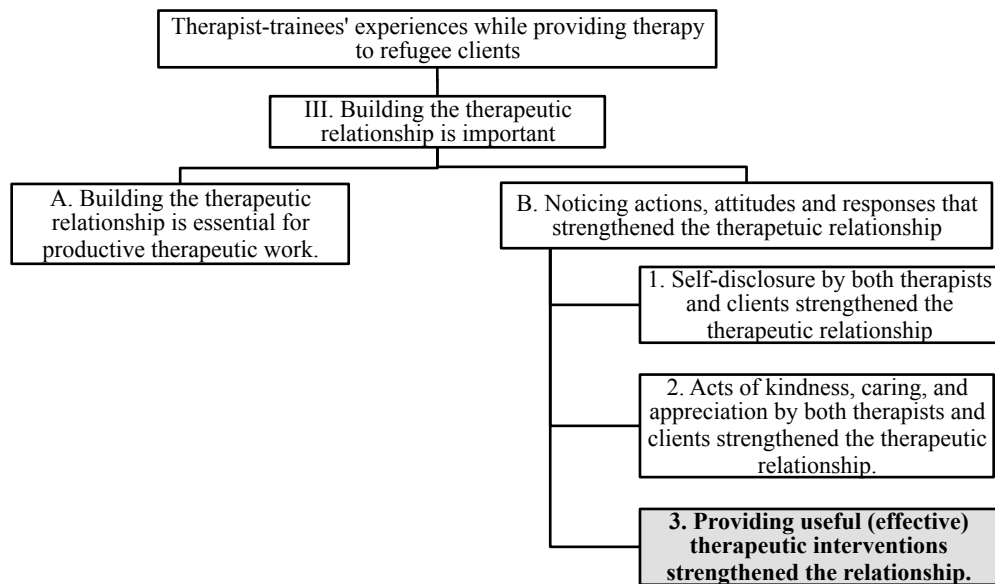
Figure 40. Thematic Overview. Locating the theme "Providing useful (effective) therapeutic interventions strengthened the relationship" within the analysis

It is important to keep in mind that in the present study, therapist-trainees were encouraged to use an integrative therapeutic framework when working with their refugee clients. As such, the terms "useful/effective" and "intervention" need to be broadened in order to include various therapeutic frameworks. The American Psychological Association Task Force on the Promotion and Dissemination of Psychological Procedures (1993) endeavoured to describe a clear causal relation between specific interventions and the specific disorders they "cure" (Bohart, O'Hara, & Leitner, 1998). This task force interprets the efficacy of psychological interventions solely on outcome measures of

specific disorders. While studying these relations is worthwhile, potentially important and

curative components essential to humanistic frameworks, such as the therapeutic

relationship and the therapists' individual characteristics are omitted. The guidelines set

forth by the task force are a better fit for certain therapeutic frameworks (such as those

endorsed by Cognitive Behavioural Therapies) and a less optimal fit for other therapeutic

frameworks (such as those based on humanistic or client-centered frameworks) (Bohart,

et al., 1998). Therefore, in this context, the definitions of "useful/effective" and

"intervention" were broadened to incorporate concepts that are inclusive of humanistic

and client-centered frameworks. In contrast to the task force's emphasis on curing

disorders and reducing symptomatology, the goal of humanistic psychotherapies is to

support the clients' meaning-making process so that he or she can lead a more satisfying

and purposeful life. In addition, unlike the standardized interventions emphasized by the

task force, and consistent with recommendations for cultural competency, the

interventions used by humanistic psychotherapists vary depending on the client, the

context, and the therapeutic relationship. However, underlying every humanistic

intervention there are attitudes such as unconditional positive regard, non-judgment,

congruence, and empathy (Bohart, et al., 1998). For instance, from a humanistic

perspective, the therapeutic relationship and the therapists' attitudes and presence are

fundamental components of the healing process. Accordingly, in the humanistic context,

therapy can be successful as long as it provides the client with a safe relationship and a

safe space to reflect and to engage in meaning making and deepening awareness,

regardless of symptom reduction[34] (Bohart, et al., 1998). Thus, in this context the

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[34] Symptom reduction may occur, however, symptom reduction is not the primary goal of humanistic therapies. Thus it is not an adequate criterion by which to measure the

usefulness or effectiveness of therapeutic interventions is extended to include the healing

aspects of the therapeutic relationship, such as accurate empathy, meaning making

experiences, and genuine human connection. Using the broader definition, I considered

useful/effective interventions to have one or more of the following characteristics: the

intervention was well received by the client, the therapist believed the intervention

strengthened the therapeutic relationship, and the interaction between therapist and client

suggested a deep and meaningful human connection.

Most therapists mentioned feeling that the therapeutic relationship was strengthened

when their therapeutic interventions were well received by the clients as well as when

they received positive feedback from their clients. For instance, one of the therapists felt

that expressing accurate empathy was very important in building the relationship with her

client:

> *"Despite this, we did experience one very pivotal moment of relationship building, in which the summary I made of the client's feelings fit perfectly with his experience and he exclaimed, "exactly!" (111208Tc1s1j1)*

Another therapist found the relationship with her client was enhanced by the

suggestion of a more concrete solution, which the client found useful:

> *"I think that providing her with this concrete solution has enhanced our relationship, as she feels as though therapy already has benefitted her"* (121310Tc1s3j3).

Some therapists found that engaging in different or "unconventional interventions"

also helped them in solidifying the therapeutic alliance. These interventions included

having a ritual to schedule the next session, allowing family members in the session,

taking a picture at the end of treatment, and looking at pictures together. The therapist

whose client brought the pictures described:

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effectiveness of these therapies.

"I was very moved when my client brought photographs of her family to share with me. [...] I felt very honoured that she wanted me to "meet" her family. It made me feel as though our relationship was growing and that she trusted me. [...]   I feel as though a new level of trust and comfort has been established, which will certainly be valuable in our continued work together. I felt as though the client was reassured that I was interested in her and where she came from, and that I had responded to her sharing of her family stories in an acceptable manner for her to trust me. (101103Tc1s3j3)

Consistent with the multicultural counselling literature (Coleman, 2000), one of the

therapists mentioned that having previous knowledge of the client's country of origin

helped in strengthening the therapeutic relationship:

"Cognitively, this was a very intellectually stimulating discussion for me. Fortunately, I have some knowledge about the Iraq-Iran war as I studied international relations and Middle Eastern politics in undergrad. In that way, I was able to communicate to the client some knowledge I had about this event and this seemed to strengthen the therapeutic alliance. This showed the client that I had some knowledge of his country and also encouraged him to share his thoughts and feelings further" (111208Tc1s3j3).

Finally, a couple of therapists indicated that reflecting on the therapeutic process was

important in consolidating and strengthening the alliance. These therapists mentioned:

"It is also these moments in which I speak about my impressions directly, and we discuss our relationship directly which helps strengthen our relationship and help him feel more comfortable to engage in session" (101101Tc1s7j7)

"I feel the incident strengthened my relationship with my client because we were able to reflect and share our thoughts and feelings about termination with each other." (121314Tc1s15j15)

Section IV. Developmental Aspects of the Therapists' Experiences

In line with the second objective of this study, the following section aims to describe

the therapist-trainees' developmental process in acquiring Multicultural Counselling

Competencies (MCC). Once the descriptive analysis was complete, I examined the

session-to-session aspects of the trainees' development of MCC. I did this by assessing

and re-evaluating the content of each theme and sub-theme and searching for subtle

differences that emerged within the different Critical Incident Journals (CIJ) (see Figure

41).
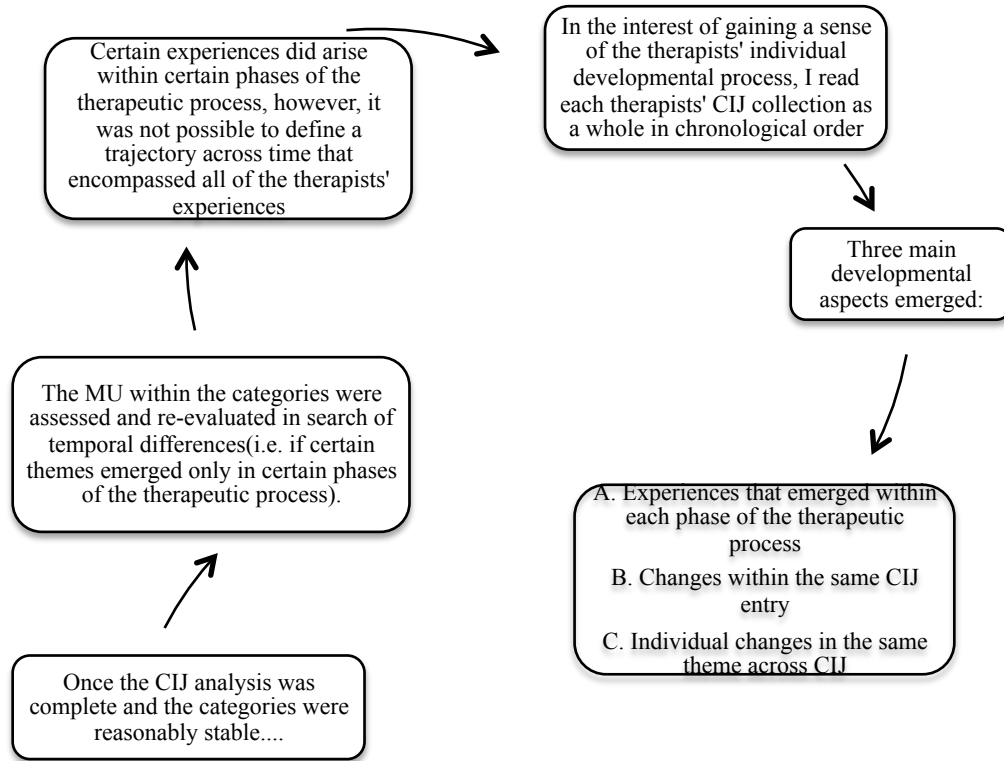
Figure 41. Procedure for analyzing the therapist-trainees' developmental process in acquiring Multicultural Counselling Competencies.

As noted throughout the Results and Discussion section, I did find that certain

experiences arose in certain phases of the therapeutic process. There were a couple of

instances where experiences appeared more prominently within a specific CIJ number.

These instances are clearly specified. Otherwise, themes are placed within the general

therapeutic phase in which they appeared. Other developmental changes included:

therapists attaining more awareness or reaching a certain resolution to their struggles as

they wrote their reflections on their CIJ (within the same CIJ) and therapists developing

skills or awareness as their work with their client progressed (across CIJ). This section is

divided into three subsections:

A. Summary of the experiences that emerged within each phase of the therapeutic

process,

B. Changes within the same CIJ entry, and

C. Individual changes in the same theme across CIJ.

 A. Summary of the Experiences that Emerged within each Phase of the Therapeutic

Process

The phases of the therapeutic process in which therapists' experiences emerged are

noted throughout the Results and Discussion section of this document. The following

intends to provide a summary of the therapeutic phases in which each theme appeared. In

order to avoid repetition, therapists' excerpts will not be provided within this sub-section.

Please note that while certain experiences did arise within certain phases of the

therapeutic process, it is not possible to define a trajectory across time that encompasses

all of the therapists' experiences. The developmental process of MCC was different for

each individual. As mentioned previously, consistent with the major therapeutic

approaches (see Beck, 2011; Book, 2003; Greenberg, Rice, & Elliot, 1993), I considered

the therapists' first three CIJ as the initial phase of therapy. The rationale for taking the

first three sessions of therapy as the initial phase is that research suggests that the

therapeutic alliance is formed within the first three sessions (Hovarth & Greenberg,

1989). The middle or working phase was comprised of all the sessions that took place

before the termination phase. Lastly, the termination phase was considered as the final

two sessions therapists had with their clients. Since many themes emerged across phases,

the presentation of the process is broken down as follows:

1. Beginning and working phases, but mostly beginning phase

2. Beginning and working phases

3. Beginning and working phases but mostly working phase

4. Working phase only

5. Throughout the therapeutic process but mostly working phase

6. Throughout the therapeutic process

1. Beginning and working phases, but mostly beginning phase.

It is important to note that no themes emerged solely at the beginning phase of therapy. This is probably due to clients opening up with their stories and trusting the therapists further within the therapeutic relationship. However, certain themes that emerged during the beginning and working phase of therapy appeared more prominently during the beginning phase of therapy. For instance, two experiences appeared more frequently within the third CIJ: (a) therapists found that listening to the refugee clients' life stories and experiences was impactful and (b) therapists felt a deeper sense of empathy for their clients. In addition, mostly at the beginning phase of therapy, therapists noticed communication difficulties and misunderstandings regarding the therapeutic work between them and their clients. Within these phases in the process, therapists also identified certain client characteristics that hindered the therapeutic process, such as clients' deference to authority, clients not contacting and experiencing their emotions, and their possible lack of education. Throughout the beginning and working phases of therapy, therapists recognized the differences between their own and their client's worldviews. However, therapists became aware of the differences between their own and their client's past living conditions and backgrounds mostly within the beginning phase of therapy. Noticing these differences increased therapists' awareness of their own cultural biases.

2. Beginning and working phases.

Other experiences emerged throughout the beginning and working phases of therapy.

Within the beginning and working phase of therapy, therapists found that providing

therapy through an interpreter was challenging, they felt doubtful and helpless, and

wondered if they could actually help their client through so many losses. Another

challenge faced by the therapists within the beginning and working phases of therapy was

managing their need to "rescue" the client or "fix" the client's problems while remaining

within professional boundaries. Therapists also felt uncertain of whether clients'

presentation was a reflection of culture, personality, current stressors, or a combination of

these issues. However, within these phases, therapists also realized that despite

differences, some emotional experiences were very similar and helped them build

empathy and connection with their clients. In addition, within these phases, therapists

became aware that they approached therapy from a Western perspective and questioned

their own cultural sensitivity and competence.

3. Beginning and working phases, but mostly working phase.

Certain experiences emerged within the beginning and working phases of therapy

appeared more prominently during the working phase of therapy. These experiences

included therapists' reflections of how working with refugee clients was different than

working with general clients and therapists modifying and adapting interventions to better

fit the clients' worldview and culture.

4. Working phase only.

Other experiences emerged only within the working phase of therapy. These experiences

included therapists noticing the differences in ideas regarding mental health and healing

between themselves and their clients and therapists reflecting on the challenges of

ensuring therapy was both effective and culturally sensitive. In addition, within the

working phase, therapists became more aware of their tendency to "impose" or "push"

their own views onto their clients. Likewise, within this phase therapists also wrote about

feeling angry/frustrated toward their clients due to differing worldviews and how these

differences affected the therapy process.

5. Throughout the therapeutic process but mostly working phase.

Some experiences emerged throughout the therapeutic process but mostly occurred during

the working phase of therapy. For instance, therapists' understanding of their clients from

a culturally and contextually aware perspective and the ways in which these

understandings influenced case conceptualization and treatment emerged throughout the

therapeutic process. However, culturally sensitive case conceptualizations mainly

appeared within the fifth CIJ. In addition, throughout the therapeutic process therapists

mentioned learning about other cultures and issues due to their interactions with their

clients. However, within this theme, therapists' increasing awareness of systemic barriers

faced by their clients emerged mostly during the working phase of therapy.

6. Throughout the therapeutic process.

It is important to note that none of the themes included within the discussion and results

section emerged exclusively in the termination phase of therapy. However, several

themes appeared equally throughout all phases of therapy. For instance, throughout the

therapeutic process, therapists reflected on the importance of building or maintaining the

therapeutic relationship and attained insights on actions, attitudes, and responses that

strengthened the relationship. Therapists also mentioned the importance of approaching

the client with an "open mind" free of preconceptions and assumptions. The therapists

also found themselves changing their ideas of what is productive and curative in session

and feeling tempted or even going beyond the traditional therapist role. Finally,

throughout the therapeutic process, therapists felt an increase in their multicultural

counselling skills.

B. Changes Within the Same CIJ Entry

The following excerpts show the evolution of individual therapist's reflections and

insights within a single journal entry. As therapists wrote in their CIJ they were able to

reach certain resolution to their struggles. For example, a couple of therapists were

feeling compelled to go beyond their professional boundaries, however as they continued

writing, their reflections shifted:

> *"I have since been questioning what it is about this client that makes me want*
> *to cross boundaries that I wouldn't with other clients. I've had clients before*
> *who tell me how much they've enjoy coming. I've also have suicidal clients.*
> *But I've never had such an endearing, likeable client, with such severe*
> *trauma, and in such despair. I often have to fight my urge to rush in to try to*
> *fix everything" (111209Tc2s4j7)*

Within the same journal but further into the writing, this therapist reflected on how

the cultural differences along with feeling more flexible in her therapeutic approach

influenced her feelings of personal involvement with the client. As the therapist continued

writing, she concluded that having boundaries was positive as they can help in providing

more appropriate care for the client:

> *"Knowing that with these clients therapy isn't just business as usual has*
> *allowed me to feel more flexible in my approach.[...] However, by feeling*
> *that flexibility, my own needs to help the client have slipped in and I find*
> *myself becoming more personally invested in her case. I struggle to remain*
> *within these boundaries and also to be real and genuine with clients, which I*
> *think is the only way that a meaningful relationship can form for change. But*
> *there are boundaries for a good reason, in part because it's not our jobs to*
> *be friends or fulfill a need they aren't getting, at least not in the long term. So*
> *I think this has been a good reality check for balancing genuine caring and a*
> *personal need to rescue someone" (111209Tc2s4j7)*

Along the same lines, the other therapist reflected:

> *"Similar to last week's session, when [client] asked if I would take her to the doctor and I had to decline, I felt a strong compulsion to go beyond my professional duties and help my multicultural client. I was very mindful of the images swirling in my mind—enlisting friends and helping her move, calling the building manager or even lawyer to help her break her lease, giving her money to cover the penalty. The combination of hearing about her difficult circumstances, the seemingly simple solution that I could easily help coordinate, and the sadness, resignation, and vulnerability projected by the client made it very difficult for me to say no" (121313Tc1s2j2)*

However as this therapist continued writing and reflecting on her own feelings and schemas she also became aware that maintaining professional boundaries can help her be a more effective therapist for her client:

> *"How much of my reactions is counter-transference, fuelled by my client's vulnerable presentation and my own desire to help her feel safe? I realized that I must be more aware of my own therapist schemas—especially the desire to "save" my clients being activated in this dynamic…. It became clear to me that both the caseworker and I have to set limits to the scope of our responsibilities—we can't bend over backwards to help all our clients, although it can be very difficult to help clients who present with so much distress. I must maintain my professional responsibilities and boundaries if I seek to be an effective therapist to my client" (121313Tc1s2j2).*

Through completing their CIJ, therapists were able to thoughtfully evaluate and recognize their countertransferential reactions and reach a sense of resolution to their struggles. Thus, this activity, showcased the value of encouraging self-reflection while working with culturally diverse clients.

Another therapist's reflection also evolved as she wrote on her CIJ, such that she became aware of her own biases. This therapist reflected on how although she and her client shared the same religion, they had very different beliefs and behaviours:

> *"What impressed me the most was the importance of the religious factors. She is Christian, as I am and she quoted an old principle that stated one remains married to the person in the eyes of God despite any worldly divorces. Therefore she can never "leave" this marriage, nor become married to someone else. I always thought this teaching was outdated and that no one pursued it anymore, so it was new to see it take such an important place in her life. At the same time, I could not help myself thinking that she is*

> *literally giving up her happiness for the promise of righteousness in the afterlife. Existentially, I kept thinking that she only has one life, so what she does in it should matter and that she should want to be happy now, while she is alive. But existential theories come counter to the Christian religion which explains sacrifices in this life for the promise of heaven. So how can I tell her to enjoy something that is considered fleeting (current life) at the expense of eternity" (111207c1s5j4)*

As this therapist continued reflecting within her journal, she became aware that even though she and her client had very different views, she had to be careful to not allow her views to influence therapy:

> *"I need to be careful to not allow my bias to influence therapy (knee-jerk reaction for me is still that she should leave him)" (111207c1s5j4)*

Another therapist's perceptions toward her client calling her a "friend" evolved as she reflected upon the incident:

> *"My initial reaction, to believe that somehow, our work and our relationship is perceived and understood (by him) incorrectly because he called me his friend or that somehow I have done something incorrectly, is strongly formed from my training that focuses on therapy with white, middle to upper class clients. This initial reaction was not taking a culturally sensitive approach to therapy" (101101Tc1s7j7).*

Further in her CIJ, this therapist continued reflecting:

> *"Clients who are not accustomed to therapy are less familiar with the nature of the relationship and what to expect in therapy. Given my clients life experiences, I would expect that he may experience some challenges related to trusting others and describing his experiences. I would also expect that he may be wary about who he appoints as a friend, or what Western clients may describe as " who he trusts" in the relationship" (101101Tc1s7j7).*

And finally this therapist realized:

> *"I think this made me aware that this was a manner in which he was describing my "acceptance" into his "ingroup" or people he sees as close to him." (101101Tc1s7j7).*

Another therapist's CIJ illustrated the development of the therapist's ability to understand and empathize with the client. First, the therapist indicated that understanding the client's experiences was difficult:

> *"Understanding her experience from her point of view was difficult coming from a different culture, but also a society in which I have never really lived in fear" (111205Tc1s3j3).*

Further in her journal, this same therapist talked about how looking at the pictures the client gave her really brought the incident "to life" and how she was able to better understand her client's experience:

> *"Looking at the photos and placing in the context of what my client had revealed about this incident brought it to life, helped me to imagine what it was like to be lying there completely certain that you would die, and yet praying so hard to live…. I could feel a slightly deeper understanding of what level of terror my client underwent lying there in the blood. I further felt that I was gaining a better understanding of how such an incident causes PTSD, and the symptoms that my client has experienced. How does one reclaim meaning when your existence is threatened to that point, and you begin to accept your own death, as your life's purpose becomes trying to save your child. Then to survive and to go on afterwards, changed forever by this event, I began to understand better my client's struggle. This [realization] was deeply touching" (111205Tc1s3j3).*

As their reflective writing progressed, these therapists demonstrated how their ideas seemed to become clearer in terms of how to provide the most effective psychological care for their clients. Furthermore, the evolution of ideas within the same CIJ entry demonstrates the importance of self-reflection in the development of Multicultural Counselling Competencies, which has been echoed throughout the literature (Arthur & Achenbach, 2002; Roysircar, Gard, Hubbell, & Ortega, 2005).

C. Individual Changes in the Same Theme Across CIJ

The following excerpts show the evolution of individual therapist's reflections and insights of the same theme across CIJ entries. For instance in her fourth CIJ entry, one of the therapists found herself feeling very uncomfortable while listening to her client's views on women:

> *"From a personal standpoint, I found it extremely uncomfortable to sit and listen while the client was talking about his belief that "freedom in women"*

is bad or "wrong." I found it personally insulting and I found that I was beginning to view the client negatively. Rather than maintaining an empathic stance towards the client, I began to think that he was aggressive, controlling, and perhaps abusive toward women. "[...] Different beliefs between two people will remain different beliefs, but in order to be therapeutically helpful we must identify common goals in therapy (i.e., find a common ground, so to speak). [...] It seems that rather than trying to change the client's beliefs or attempt to emphasize with them (as this would not be genuine), it would be therapeutically productive to identify the client's goals for treatment and to facilitate change. (111208Tc1s4j4).

Then on her tenth CIJ entry, this same therapist reflected on how she adjusted in order

to be better able to work with her client:

"Working with this client has prompted me to make a major adjustment in terms of my style as a therapist. I am significantly more direct, concrete, and problem-solving focused than is my norm. I find that working within an existential framework with this client promotes the most meaningful therapeutic work and pushes him to get out of his victimized position and feel empowered to make decisions and take responsibility for the consequences of his decisions" (111208Tc1s10j10).

Other therapists' evolution across CIJ was not as clear. In general, therapists

talked about very different topics between each CIJ. Thus, it was hard to find a clear

developmental path within each individual's CIJ collection. However, there was one

therapist who struggled with how to best work with her client. This therapist seemed to go

"back and forth" in her reflections suggesting a circular or iterative path in her

development. For example, after her fifth session in her fifth CIJ, this therapist described

how she struggled with the fact that her client was not working in therapy in expected

ways:

"Across our sessions, the client repeatedly expressed how much he enjoyed sharing his thoughts and feelings in therapy. While this made me feel good, I began to wonder whether the only thing that the client was gaining was the opportunity to voice previously unexpressed feelings. That is, I wondered whether catharsis was the sole benefit of therapy for the client. Therefore, at the start of this session, I stated that it was wonderful that he enjoyed sharing things with me, but that another aspect of therapy is to help change thoughts and feelings in order to make him feel better. The client replied that he was

not sure whether he will be able to change these things within himself; rather he needed his family to change in order for his feelings, attitudes, and thoughts to change. […] thus, he didn't think there was anything he could do to improve his problems […] After this session, I was pretty upset and I called one of my colleagues to debrief. She reminded me that it is not meaningless that the client feels comfortable and happy talking to me; this is still helpful. It is my own expectations for therapy (i.e., to help the client to arrive at a new understanding of his problems) that are not being met." (121312Tc1s5j5)

In the next session with her client, (session 6 CIJ 6), this same therapist described:

"Last session, I realized that the client attributes his psychological distress entirely to external causes (e.g., acculturative stress, the language barrier, his brothers' behaviour, and his poor health). He often responded to my suggestions with "Yes, but…" or "That is true, but…" (or some other version thereof). I felt tense and uneasy during last week's session because it felt like a power struggle, with me working hard to help the client change and the client appearing unwilling to entertain the idea that change could come from within himself (121312Tc1s6j6)

Further into the reflection but still within the sixth CIJ, this therapist seemed to reach

deeper insights:

"As stated above, I think this session was probably more consistent with the client's goals and expectations for therapy. I did worry a little bit about possible ruptures that may have occurred last session due to our conflicting views. Thus, this session may have been restorative to the therapeutic alliance. Additionally, I entered the session with lower expectations and a better understanding of the client's perspective. As a result, I felt less frustrated with the client during this session (121312Tc1s6j6)

However, it appeared that throughout the therapy sessions this therapist struggled with

managing her expectations of therapy with this client, such that in her 13th CIJ after the

13th session with her client, this therapist described how she vacillated between feeling

more patient and relaxed and feeling frustrated by her client's "lack of progress":

"Emotionally, I must admit that this experience has brought up feelings of hopelessness within me. I wonder about the point of repeating these concepts over and over, when there appears to be little to no progress made. I also vacillate between feeling more patient and relaxed (e.g., last session) and feeling frustrated by the lack of progress in therapy (e.g., this session)" (121312Tc1s13j13)

Chapter V.

Final reflections, Implications, and Future Directions

Final Reflections: Implications for Training and Practice

Engaging in therapeutic work with refugee clients challenged therapists'

expectations and worldviews. Therapists had diverse experiences, which were presented

in three main themes. These main themes were: "Feeling the need to adapt", "A sense of

increasing cultural self-awareness" and "Building the therapeutic relationship is

important". These themes are interconnected and should be considered in relation to each

other. In this section I will provide some final reflections and discussion on the

implications for training and practice.

Therapists mentioned feeling the need to adapt in order to work with their refugee

clients. Therapists' reflections on their perceived need to adapt highlighted their

awareness that working with refugee clients was different than working with general

clients. Broadly speaking, this theme brought attention to and emphasized the need for

therapy training in multicultural counselling competencies. Moreover, this theme

highlighted the need for therapists to develop these competencies by moving beyond

didactic classroom learning and engaging in directly providing therapy to multicultural

clients. In the present study, therapist-trainees described several experiences where they

felt the need to adapt because they noticed that working with their refugee clients was

different than working with clients from the general culture. Their efforts to adapt

translated into opportunities for them to practice their skills in providing culturally

sensitive treatment to their refugee clients. For example, therapists mentioned having to

modify their interventions in order to ensure they were effective and culturally sensitive.

These modifications included: adapting to working through an interpreter, broadening their traditional therapist role by actively supporting the clients outside of session by helping the client to access community resources, researching the clients' culture, and endeavoring to understand their clients from a culturally and contextually aware perspective. These adjustments in turn influenced therapist-trainees' skills in case conceptualization, treatment planning, and interventions. Previous research suggests that courses that emphasize knowledge and self-awareness don't necessarily translate into culturally competent skills (Priester, et al, 2008). In order to address the gap between knowledge and skills it is important for therapist-trainees to have access to information based on real hand-on therapy experiences in the field. As such, therapist-trainees' experiences can offer information to training programs in terms of practical, skills-based experiences, which can be discussed even within a didactic multicultural counselling class setting.

As mentioned above, the therapists in the present study not only became aware of the need to adapt, they actively engaged in on-going adjustments of their case conceptualizations, treatment planning, and interventions to better meet their clients' needs. In doing so the therapists found that their ideas of what was productive and "curative" in session changed. In other words, the experience of working with refugee clients entailed a somewhat reciprocal change such that the therapists had the opportunity to broaden what they consider therapeutically productive or curative. Challenging therapist-trainees' ideas of what is therapeutically productive or curative for different clients is another important issue to address in therapy training programs.

The need to adapt as well as therapists' increasing sense of cultural self-awareness was further underscored by therapists' reflections on how their ideas regarding mental

health and healing differed from those of their clients. It is important to remember that

therapist self-awareness is considered to be one of the most important components of

multicultural counselling competencies (Roysircar, 2006). In the process of working with

and learning from their clients therapists experienced changes in themselves, such that

they became more aware of their own personal and professional cultural biases and

questioned their own cultural sensitivity and competence. For instance, therapists became

aware of their professional biases by recognizing how they approached therapy from a

"Western perspective". As they became aware of their Western perspectives, therapists

questioned certain aspects of psychotherapy and the way it is typically practiced in

Canada, such as issues related to therapist-client boundaries, the cultural appropriateness

of their therapeutic approach, etc. The ability to recognize and question one's views

regarding psychotherapy, mental health, and healing is critical because it is the first step

in making psychology a more inclusive, open, and more trustworthy science (as

trustworthiness increases with the inclusion of multiple perspectives and viewpoints). The

differences in ideas regarding mental health and healing between therapists and clients

also highlighted the importance of questioning our assumptions and adopting a more open

perspective which allows us to learn about and value other cultures' contributions to the

field of mental health and healing. In terms of training and practice this theme highlights

the significance of encouraging therapist-trainees' to become aware and question their

own ethnocentric biases as well as to remain open to other perspectives in mental health

and healing.

The differences in worldview between therapists and clients not only increased

therapists' awareness of their cultural biases, they also brought up interesting emotional

experiences for the therapists. For example, some therapists found themselves feeling

angry, frustrated, and at times, even disliking their clients due to their differing cultures

and belief systems. Acknowledging negative emotions that stem from differing

worldviews and cultural conflicts with clients can enable a therapist to be more self-aware

and sensitive. As therapists, we are compelled to listen to our clients and to strive for a

deeper, more empathic and compassionate understanding of their difficulties despite our

differences in worldviews. In this study therapists described their anger and frustration, as

well as their willingness to continue working with and trying to help their clients. This is

a valuable insight and has implications for training and practice because this shows that

negative feelings about our clients can co-exist alongside with a genuine desire to help the

clients. Processing these feelings in a safe supervisory relationship has the potential of

making therapist-trainees more deeply empathic of their clients and of themselves and

eventually help them to become better and more well rounded therapists (Williams &

Day, 2007).

Another important contribution of this project stems from the insight that despite

client-therapist differences in culture and worldview, about half the therapists found

similarities between their own and their clients' emotional experiences (i.e., joy, sadness,

etc.). Similarly therapists reflected on the universality of human suffering and on how

people can feel the same feelings even when they live in widely different contexts.

Noticing and reflecting on these similarities helped the therapists build a closer and more

empathic relationship with their clients. This insight has implications for multicultural

training, as it may be useful for supervisors to help students acknowledge both the

differences and the similarities in their own and their clients' experience.

There is some debate in the literature regarding the role of knowledge in

multicultural counselling competency (Patterson, 2004; Sue et al., 2009; Sue & Zane,

1987; refer to p. 107 of this document) In the present study, therapists mentioned the importance of approaching their clients with an open mind, free of assumptions. On the other hand, knowledge of the client's culture helped shape therapists' culturally sensitive case conceptualization and broaden their understanding of the clients. In addition, therapists' writings suggested that one of the greatest advantages of having knowledge of their client's culture was the therapists' added sense of confidence and preparedness. Thus, it appears that cultural knowledge does play an important role for the therapists when engaging in multicultural counselling. However, knowledge about the client's culture needs to be balanced with being able to suspend one's assumptions about the client so that the therapist can really get to know the client from a more neutral or open-minded stance.

One of the main themes in this study pertained to therapists' reflections on the importance of building the therapeutic relationship. This theme demonstrated the ways in which the strength of the therapeutic relationship could guide and shape multicultural therapeutic work. For instance, therapists noticed that they restrained themselves at times and waited to implement therapeutic interventions until their therapeutic relationship with their refugee clients was stronger. Similarly therapists mentioned feeling more confident in implementing therapeutic interventions when they felt that the therapeutic relationship was stronger. These reflections suggest that fostering a strong therapeutic relationship is important for productive therapeutic work. In addition, therapists mentioned specific behaviours that helped strengthen their therapeutic relationship with their refugee clients. These behaviours included: self-disclosures of both therapists and clients, acts of kindness, caring, and appreciation of both therapists and clients, and timely utilization of helpful therapeutic interventions. Furthering knowledge about the specific behaviours that

cultivate a strong therapeutic relationship is important for clinical training and practice as this can help clinicians, supervisors, and therapist-trainees to mindfully and intentionally implement these behaviours.

Around half of the therapists explicitly identified certain experiences, which they felt increased their multicultural counselling skills. This is important because these experiences can only take place through direct interaction with clients. These experiences are noteworthy because previous research on training in multicultural counselling competencies has repeatedly cited the need for practice in order to develop culturally sensitive skills (O'Toole, 1979; Roysircar & Gill, 2010).

This study demonstrated the importance of engaging in clinical work for the training and development of Multicultural Counselling Competencies (MCC). Furthermore, it added to the limited number of qualitative studies that have explored therapist-trainees' experiences while providing therapy to refugee clients. There are innumerable situations that will test a therapist's clinical skills and judgment while working with every client, including multicultural clients. Before working on this project, I would have opined that while reading and discussions are good ways to prepare for such situations, the only way to really develop these skills is through practice. However, after analyzing and writing up the results, my views have shifted somehow. While I still think the opportunity to practice these skills is invaluable, I found that reading about my peers' experiences really helped me in being able to handle difficult incidents when working with my own refugee clients. Thus, one of the key strengths of the present research is that it describes in depth the therapist-trainees' actual therapy experiences such that the information can help new therapist-trainees in vicariously learning how to address difficult situations with their culturally diverse refugee clients. An implication of this

research is that it can be used for training future therapist-trainees. I would recommend incorporating the present study as suggested reading or as part of the curriculum for multicultural counselling competency courses. The findings of this study will also be useful for experienced clinicians who may be interested in furthering their multicultural counselling competencies.

Strengths, Limitations, and Directions for Future Research

There are a number of reasons why this study's inquiry procedure was one of its most valuable contributions. The context of the study allowed therapist-trainees to be flexible in their therapeutic approach. This strengthened the study in that it allowed the therapists to focus on the actual therapy process and experiences rather than on the application of specific therapeutic approaches or techniques. Moreover, encouraging therapists to complete a Critical Incident Journal (CIJ) after each session with their clients was advantageous for several reasons. First, having therapists complete a CIJ after each session with their clients likely captured a more accurate reflection of their experiences than a final written recollection or reflection on their experiences at the end of the practicum course. Second, having therapists complete a CIJ after each session helped shed light on the phases of the therapeutic process (beginning phase, working phase, or termination phase) during which different experiences emerged. Third, having therapists write about their reflections on the CIJ without being concerned about being graded for the content of their journals likely contributed to their ability to more freely and fully express themselves. I venture this explanation based on previous research, which shows that therapist-trainees tend to avoid disclosing certain issues with their supervisors. These undisclosed issues pertained to clinical mistakes or interventions that didn't work for the clients and negative reactions toward the clients, such as frustration, boredom, and anger

toward the clients for being racist/chauvinistic (Ladany, Hill, Corbett, & Nutt, 1996). As noted previously in this study, therapist-trainees in fact wrote about interventions that didn't work for the clients (p.82) as well as their negative reactions toward their clients (anger and frustration p. 124; boredom/zoning out p. 71) in their CIJ.

An additional strength of this study pertains to my position as a first generation, immigrant woman who studied, received training in, and practiced psychotherapy first in my country of origin, Mexico, and later on in Canada. My experiences as a therapist in these culturally different contexts as well as my experiences as an immigrant in Canada have likely heightened my sensitivity to various issues that might not have been readily identified by individuals who are from a more mono-cultural background. However, this strength is tempered by the fact that my own immigration experience and acculturation process were relatively easy. Thus, while I can understand immigration experiences to a certain extent, the degree of acculturative stress and previous trauma suffered by the refugee clients are not experiences I share. Consequently, I was just as impacted as the therapist-trainees when learning about some of the refugee clients' experiences.

While this study sheds new light on many aspects relevant to the experience of providing therapy to refugee clients, it also helps point to new directions for future research in multicultural counseling. Future research could provide more nuanced and focused examination of certain themes that emerged in the present study and would enhance and refine the current findings. For example, future research could identify and explore the types of interventions that worked versus those that didn't work for refugee clients while taking into account therapy issues such as therapists' theoretical orientation and personal background, clients' cultural background and the strength of the therapeutic

relationship. In the present study, contacting specific participants in order to further

examine certain themes and experiences was neither possible nor permissible within the

ethical parameters of the study. This study's most significant limitation has to do with the

participants' anonymity and my being blind to participants' identities. Protecting the

participants' anonymity was important because it was set forth on the original Research

Ethics Board (REB) approval. Therefore, I am precluded from identifying and contacting

individual therapists in order to seek clarification or deepen the information they

provided. Moreover, due to client-therapist confidentiality and logistical limitations I

can't identify nor contact the clients in order to seek clarification regarding the

experiences from their point of view. In light of these limitations, future research should

focus on the simultaneous qualitative exploration of both the therapists' and clients'

experiences and perceptions of the therapeutic process. For example, future researchers

can focus on qualitatively exploring the nature of effective and ineffective interventions

from the therapists' and the clients' points of view respectively. Future research could

also replicate the present study by additionally integrating clients' feedback. Due to

language and time constraints, instead of the Critical Incident Journal, one could use a

shorter measure such as the Helpful Aspects of Therapy (Llewelyn, 1988) in order to

qualitatively explore therapists' and clients' perceptions of each therapy session. This

type of research will shed light on clients' and therapists' perceptions of both helpful and

hindering aspects of therapy. Furthermore, exploring the meaning of these experiences

from both therapist and client perspectives will provide a wealth of information in two

main areas. The first will be in further articulating the needs and perceptions of refugee

clients and the second will be increasing our knowledge on best practices in multicultural

counselling. This will in turn, be a first step in operationalizing effective counselling and

psychological interventions for refugee clients.

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Appendix A - Consent and information letters

University
of Windsor

CONSENT TO PARTICIPATE IN RESEARCH
(Client Version)

Title of the Study: Multicultural Counselling Training: Processes, Effects, and Implications

You are asked to participate in a research study conducted by Dr. Ben C. H. Kuo and Beatriz R. Rodriguez Rubio, a doctoral student from the Department of Psychology at the University of Windsor. This study is designed to help researchers better understand more effective ways of training psychologists and counsellors in developing cultural sensitivity and Multicultural Counselling Competencies in their work with clients.

If you have any questions or concerns about the research, please feel to contact the principal investigator, Dr. Ben C. H. Kuo at benkuo@uwindsor.ca , ph. (519) 253-3000, Ext. 2238 or the co-investigator, Beatriz R. Rodriguez at rodrigub@uwindsor.ca ph. 519-563-8956.

PURPOSE OF THE STUDY

In a multicultural society such as Canada, it is becoming increasingly important for health professionals to possess cultural sensitivity in working with clients/patients of culturally and linguistically diverse backgrounds. Given this background, this present research is intended to study clinical psychology graduate students' learning of Multicultural Counselling Competencies. Specifically, it will study the benefits of receiving multicultural training through taking a single course vs. taking a multicultural practicum training through working directly with culturally diverse clients.

The costless counselling service you are currently receiving from the University of Windsor is part of the multicultural practicum. Your participation in this study is very important because you can help researchers better understand, from your unique point of view as a client, how the training is affecting your counsellor's learning of cultural sensitivity through his/her counselling work with you. By participating in this study, you might also gain insights into your own changes and learning through this counselling service. Finally, your participation in this study will contribute to the development of more effective multicultural training programs for psychologists and counsellors and, in turn, benefits future clients who are in a similar situation as you.

PROCEDURES

If you volunteer to participate in this study, you will be asked to:

Complete a short checklist at the end of each weekly counselling session, and two additional short questionnaires at the later points of the counselling process. It is estimated that it will take only about 5-10 minutes to complete the questionnaires.

If you are not familiar with English, your language interpreter who accompanies you to the sessions will assist you in completing the questions in your preferred language.

POTENTIAL RISKS AND DISCOMFORTS

There are minimal risks or discomforts anticipated with taking parting in the present study. However, should you experience any distress or discomfort as a result of participating in this study, please contact the listed services here. For the Canadian Mental Health Association of Windsor-Essex County call (519) 255-7440 or the Distress Centre of Windsor call (519) 256-5000. You can also contact the principal investigator for the study, Dr. Ben C. H. Kuo, at (519) 253-3000, Ext. 2238 (e-mail: benkuo@uwindor.ca) if you have further questions or require further assistance.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY
Participation in this study may benefit you by having a better understanding how the counselling
service you are receiving at the university is helping you in improving the difficult situations you
face. Your participation will also contribute to the critical scientific knowledge needed for
researchers to identify more effective ways of training and preparing psychologists and
counsellors in developing greater cultural understanding and sensitivity in working with culturally
diverse clients.

COMPENSATION FOR PARTICIPATION
Beside the benefits of receiving counselling services, there will be no monetary compensation for
participating in the present research.

CONFIDENTIALITY
Any information that is obtained in connection with this study and that can be identified with you
will remain confidential and will be disclosed only with your permission. The data collected will
be securely stored in a locked cabinet, separately from your consent form, in the principal
investigator's research lab at the university. The data will be kept for 10 years after which it will
be shredded and deleted. The P.I. and co-investigator will be able to access the data which will be
coded, protecting your identifying information.

PARTICIPATION AND WITHDRAWAL
You can choose whether to be in this study or not, and this decision will not affect the counselling
service you receive from the university. If you volunteer to be in this study, you may withdraw at
any time without consequences of any kind. You may also refuse to answer any questions you
don't want to answer and still remain in the study. The investigator may withdraw you from this
research if circumstances arise which warrant doing so.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS
The results of this study will be available in August 31st, 2013 at www.uwindsor.ca/reb (click on
Study Results and scroll down to Participants/Visitors).
SUBSEQUENT USE OF DATA
This data may be used in subsequent studies.
RIGHTS OF RESEARCH SUBJECTS
You may withdraw your consent at any time and discontinue participation without penalty. If you
have questions regarding your rights as a research subject, contact: Research Ethics Coordinator,
University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; email:
ethics@uwindsor.ca

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE
I understand the information provided for the study 'Multicultural Counselling Training:
Processes, Effects, and Implications' as described herein. My questions have been answered to
my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____
Name of Subject

_____   _____
Signature of Subject   Date

SIGNATURE OF INVESTIGATOR
These are the terms under which I will conduct research.

_____   _____
Signature of Investigator   Date

University
of Windsor

CONSENT TO PARTICIPATE IN RESEARCH
(Therapist Trainee Version)

Title of the Study: Multicultural Counselling Training: Processes, Effects, and Implications

You are asked to participate in a research study conducted by Dr. Ben C. H. Kuo and Beatriz R. Rodriguez Rubio, a doctoral student from the Department of Psychology at the University of Windsor. This study is designed to help researchers better understand more effective ways of training psychologists and counsellors in developing cultural sensitivity and Multicultural Counselling Competencies in their work with clients.

If you have any questions or concerns about the research, please feel to contact the principal investigator, Dr. Ben C. H. Kuo at benkuo@uwindsor.ca , ph. (519) 253-3000, Ext. 2238 or the co-investigator, Beatriz R. Rodriguez at rodrigub@uwindsor.ca ph. 519-563-8956.

PURPOSE OF THE STUDY

In a multicultural society such as Canada, it is becoming increasingly important for health professionals to possess cultural sensitivity in working with clients/patients of culturally and linguistically diverse backgrounds. Given this background, this present research is intended to study clinical psychology graduate students' learning of Multicultural Counselling Competencies. Specifically, it will study the benefits of receiving multicultural training through taking a single course vs. taking a multicultural practicum training by working directly with culturally diverse clients.

Your participation in this study is very important because you can help researchers better understand the ways in which different models of multicultural training are experienced by clinical psychology students in the learning and the development of cultural sensitivity and competencies. By participating in this study, you might also gain helpful insights into your own changes and growth in response to receiving the multicultural practicum training. Finally, your participation in this study will contribute to the development of more effective multicultural training models for future psychologists.

PROCEDURES

If you volunteer to participate in this study, you will be asked to:

3.2 Complete a questionnaire package at the beginning of the multicultural practicum.
4.2 Complete a questionnaire package at the end of the multicultural practicum.
5.2 Complete additional brief measures throughout the multicultural practicum.
6.2 Give permission to the researchers to collect your regular journal assignments (as part of the practicum course requirements for 02-46-715 Psychological Services and Research Centre: Counselling and Psychotherapy with Refugees/Immigrants) for the qualitative component of this research.

POTENTIAL RISKS AND DISCOMFORTS

There are minimal risks or discomforts anticipated with taking parting in the present study. However, should you experience any distress or discomfort as a result of participating in this study, please contact the listed services here. For the Canadian Mental Health Association of Windsor-Essex County call (519) 255-7440 or the Distress Centre of Windsor call (519) 256-5000. You can also contact the principal investigator for the study, Dr. Ben C. H. Kuo, at (519) 253-3000, Ext. 2238 (e-mail: benkuo@uwindor.ca) if you have further questions or require further assistance.

POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY
Participation in this study may benefit you by gaining insights into your own learning process and development in response to receiving the multicultural course work. Your participation will also contribute to the critical scientific knowledge needed for researchers to identify more effective ways of training and preparing psychologists and counsellors in developing greater cultural understanding and sensitivity in working with culturally diverse clients.

COMPENSATION FOR PARTICIPATION
There will be no momentary compensation for participating in the present research.

CONFIDENTIALITY
Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. The data collected will be securely stored in a locked cabinet, separately from your consent form, in the principal investigator's research lab at the university. The data will be kept for 10 years after which it will be shredded and deleted. The P.I. and co-investigator will be able to access the data which will be coded, protecting your identifying information.

PARTICIPATION AND WITHDRAWAL
You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

FEEDBACK OF THE RESULTS OF THIS STUDY TO THE SUBJECTS
The results of this study will be available in August 31st, 2013 at www.uwindsor.ca/reb (click on Study Results and scroll down to Participants/Visitors).

SUBSEQUENT USE OF DATA
This data may be used in subsequent studies.

RIGHTS OF RESEARCH SUBJECTS
You may withdraw your consent at any time and discontinue participation without penalty. If you have questions regarding your rights as a research subject, contact: Research Ethics Coordinator, University of Windsor, Windsor, Ontario, N9B 3P4; Telephone: 519-253-3000, ext. 3948; email: ethics@uwindsor.ca

SIGNATURE OF RESEARCH SUBJECT/LEGAL REPRESENTATIVE
I understand the information provided for the study Multicultural Counselling Training: Processes, Effects, and Implications as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____
Name of Subject

_____   _____
Signature of Subject   Date

SIGNATURE OF INVESTIGATOR
These are the terms under which I will conduct research.

_____   _____
Signature of Investigator   Date

Letter of Information
Multicultural Counselling Training: Processes, Effects, & Implications

In a multicultural society such as Canada, it is becoming increasingly important for health professionals to possess cultural sensitivity in working with clients/patients of culturally and linguistically diverse backgrounds. Given this background, this present research is intended to study clinical psychology graduate students' learning of Multicultural Counselling Competencies. Specifically, it will study the benefits of receiving multicultural training through taking a single course vs. taking a multicultural practicum training by working directly with culturally diverse clients.

Although your participation in this study will range between one academic year (if you are a student or psychotherapy trainee) and one semester (if you are a client); this three-year project has the following two goals. First, the study will document and explore graduate therapist-trainees' learning and development of Multicultural Counselling Competencies through their participation in a supervised multicultural therapy practicum offered at the Department of Psychology at the U. of Windsor. This practicum experience involves providing costless counselling services to refugee clients in Windsor, Ontario. Second, the study will assess the added benefits, in terms of developing MCC, of the experientially-based multicultural therapy practicum over those acquired through a strictly didactic multicultural counselling course.

Your participation in this study is very important because you can help researchers better understand the ways in which different models of multicultural training are experienced by clinical psychology students in the learning and the development of cultural sensitivity and competencies. If you are a psychotherapist trainee, by participating in this study, you might also gain insights into your own changes and growth in response to receiving the multicultural practicum training. If you are a client, by participating in this study you have the opportunity of receiving costless psychotherapy and potentially improving your mental well being. Finally, your participation in this study will contribute to the development of more effective multicultural training models for future psychologists.

The results of this study will be available in August 31st, 2013 at www.uwindsor.ca/reb (click on Study Results and scroll down to Participants/Visitors). If you have any questions or concerns about the research, please feel to contact the principal investigator, Dr. Ben C. H. Kuo at benkuo@uwindsor.ca , ph. (519) 253-3000, Ext. 2238 or the co-investigator, Beatriz R. Rodriguez at rodrigub@uwindsor.ca ph. 519-563-8956. Should you experience any distress or discomfort as a result of participating in this study, please contact the listed services here. For the Canadian Mental Health Association of Windsor-Essex County call (519) 255-7440 or the Distress Centre of Windsor call (519) 256-5000.
          We sincerely THANK YOU for participating in this study!!
SIGNATURE OF INVESTIGATOR
These are the terms under which I will conduct research.

_____   _____
Signature of Investigator   Date

Appendix B - Demographic Questionnaire (For Graduate students and Therapist-

Trainees)

Demographic Information Sheet

1. Today's Date: _____   3. What is your gender?:

                                                              _____

2. How old are you?: _____

4. What year are you currently in the clinical psychology graduate program? _____ year (e.g., 5th
year)

  At _____ Master's level   _____ Doctorate Level

5. How do you describe your racial/ethnic background?

___White / Caucasian   ___ East Asian (e.g., Chinese, Japanese)
___South Asian (e.g., Indian, Pakistani)   ___ Hispanic / Latino
___ Arab/ Middle Eastern   ___ If other, please specify:
___ Black/ African Canadian   _____
___ Aboriginal/ Native Canadian

6. To what extent is your ethnic background important to you?

1	2	3	4	5
Irrelevant	Not very important	Neutral	Important	Extremely Important

Why?
_____
_____
_____

7. When you were growing up, what was your parent #1's (father/mother, [please circle])
occupation?: _____

8. When you were growing up, what was your parent #2's (father/mother, [please circle])
occupation?: _____

9. What is the highest level of education completed by your parent #1 (father/mother, [please
circle])? (please check one):

___ Elementary school or Middle school   ___ Graduated from college / university
___ Some high School   ___ Completed graduate degree or other
___ Graduated high school   professional certification
___ Some college / university   ___ Other

10. What is the highest level of education completed by your parent #2's (father/mother, [please
circle])? (please check one):

___ Elementary school or Middle school   ___ Completed graduate degree or other
___ Some high School   professional certification
___ Graduated high school   ___ Other
___ Some college / university
___ Graduated from college / university

11. What was your family's estimated annual income when you were growing up (i.e., parents' joint income)?

___ less than $10,000   ___ $60,000 - $69,999
___ $10,000 - $19,999   ___ $70,000 - $79,999
___ $20,000 - $29,999   ___ $80,000 – $89,999
___ $30,000 - $39,999   ___ $90,000 - $99,999
___ $40,000 - $49,999   ___ $100,000 and up.
___ $50,000 - $59,999

12. What is your country of birth?: _____

     If you were <u>not</u> born in Canada, please answer the following two questions:

     How long have you been living in the Canada?: _____years _____months

     How old were you when you first arrived in Canada?: _____ years old

13. What is your mother tongue? _____

14. What <u>languages</u> do you speak relatively fluently?
_____
_____

15. Have you ever lived abroad or in a different culture for an extended period of time (e.g., for more than a month)? **Yes** **No**
     If yes, where was it? _____ and for how long? _____

     To what extent did that experience impact your cultural awareness?

1	2	3	4	5
Not at all	Not really	Undecided	Somewhat	Very much

16. While growing up, what cultural groups listed below did you find living in your neighbourhood: **(check all that apply)**

___White / Caucasian   ___ East Asian (e.g., Chinese, Japanese)
___South Asian (e.g., Indian, Pakistani)   ___ Hispanic / Latino
___ Arab/ Middle Eastern   ___ If other, please specify:
___ Black/ African Canadian   _____
___ Aboriginal/ Native Canadian

17. Which of the following cultural groups have you ever been in <u>close friendships</u> with: **(check all that apply)**

___White / Caucasian   ___ Black/ African Canadian
___South Asian (e.g., Indian, Pakistani)   ___ Aboriginal/ Native Canadian
___ Arab/ Middle Eastern   ___ East Asian (e.g., Chinese, Japanese)

___ Hispanic / Latino   ___ If other, please specify: _____

18. Which of the following cultural groups have you ever been in a <u>romantic relationship</u> with:
(check all that apply)

___White / Caucasian   ___ East Asian (e.g., Chinese, Japanese)
___South Asian (e.g., Indian, Pakistani)   ___ Hispanic / Latino
___ Arab/ Middle Eastern   ___ If other, please specify:
___ Black/ African Canadian   _____
___ Aboriginal/ Native Canadian

19. Prior to this survey, have you ever had any course works or attended any training workshops on issues related to multicultural counselling/psychotherapy or cross-cultural psychology?
        Yes   **No**

     If yes, please describe briefly the nature and the context of the course work /training (e.g.,
     professional development workshop, academic symposium, etc.)
     _____
     _____

     Approximately how many hours of such course work/training did you receive?
     _____ hours

20. In your academic training and/or professional experience (e.g., therapy/counselling, assessment) thus far, <u>how many culturally diverse clients have you ever worked with</u>, whose racial/ethnic/linguistic backgrounds are different from yours?
_____

21. Do you do any of the following activities regularly? (Check all that apply)
___Meditation
___ Yoga
___ Tai-Chi
___ Other mindfulness practice

22. Do you believe any of the above activities could be helpful to you?

1	2	3	4	5
Not at all	Not really	Undecided	Somewhat	Very much

     Why?
     _____
     _____
     _____

22. Are there any other additional experiences you consider to be relevant to the development of your cultural awareness and multicultural understanding? If yes, please describe:
     _____
     _____

                    Thank you very much for your responses

Appendix C - Adapted Procedure for Data Analysis

The following procedure is based on Rennie's (1988 & 2006) adaptation of GTM. In order to aid in the clarity of the procedure, the steps are detailed and numbered. However, this is not to imply that the process is a linear one. This analysis involves a circular iterative process, which I will try to convey while at the same time providing detailed descriptions. The instances where Rennie's method is adapted to fit the present investigation are specified. The instances that require the citation of other authors or of Rennie's works from other years are specified as well.

1. Data collection – The first component of the present study is a secondary data analysis conducted on data that has already been collected in the form of therapist-trainees' critical incident journals completed following each session with the refugee clients.

2. Reflexivity: Identifying biases and expectations – Reflexivity involves the researcher engaging in introspection and awareness regarding his or her insights into the data as well as any biases or expectations. Moreover, reflexivity has been conceptualized as one of the defining characteristics of excellent qualitative research. Reflexivity involves "the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and in between researcher and participant to the social interaction they share" (Sandelowski & Barroso, 2002, p. 216). The researcher aims to start the analysis free of pre-conceptions and to allow the categories to emerge from the data (Charmaz, 1995). In being reflexive, the qualitative researcher identifies his or her biases and expectations. Biases are defined as a person's (in this case the researcher's) tendencies, inclinations, or

preferences, especially those which could interfere with being open-minded or with

understanding the data (Chodron, 1991; Hill, Knox, et al, 2005). Expectations are defined

as the researcher's beliefs, assumptions, or hypothesis which develop based on the

researcher's previous knowledge (e.g., the literature review) and experiences (Hill, Knox,

et al., 2005). Reflexivity aimed at the identification of biases and expectations is

encouraged throughout the analysis. However it is important to make these biases and

expectations explicit from the start of the analysis to limit their influences on the analysis

of the data. Additionally, making these issues explicit provides readers with a context

through which they can effectively evaluate the results of the investigation.

   3. Embodied reflexivity or awareness as an underlying condition for the analysis –

This is a state of being or frame of mind, which I believe is necessary when approaching

qualitative research. This state involves approaching the data in an open, accepting, and

empathic frame of mind. This step originated as a result of the interaction of three

elements, namely, reading about embodied categorizing, learning about theoretical

sensitivity, and finally engaging in reflexivity about the way I approach qualitative

research, which would allow me to develop this "step". The first element is based on

reading Rennie and Fergus' (2006) article in which they describe how paying attention to

the felt sense evoked by becoming immersed in the data and during the categorization

process can enhance the quality of grounded theory research. In their description these

authors state: "Good fits create stillness inside and have stability, at least for the present.

Thus a felt sense is engaged both prior to and after an articulation" (p. 495). The second

element, theoretical sensitivity, refers to the researcher's ability to identify subtle cues or

nuances in the data that are relevant for the construction of meaning (Corbin & Strauss,

2008). Researchers may initiate the analysis with different levels of theoretical sensitivity

depending on their previous experiences, knowledge, and interests as these attributes

sensitize them to identify certain process and issues in the data (Charmaz, 1995).

However, theoretical sensitivity develops and evolves through the researcher's immersion

in the data (Corbin & Strauss, 2008) Corbin and Strauss (2008) liken the development of

theoretical sensitivity while analyzing the data to peeling an onion. Each onion layer

taken off brings the researcher closer to the core. These authors describe the development

of theoretical sensitivity as the researchers' growing ability to be in tune with the

meanings in the data. In my interpretation, theoretical sensitivity resembles empathy in

the therapeutic sense. This resemblance is best explained by Corbin: "In addition to

increasing sensitivity to the data, what I find interesting are the changes in myself since

beginning this project. I can't help but be touched by the war stories I've read…. there is

something about the interaction that occurs between analyst and data during analysis that

has altered how I think and feel about combatants. It has to do with taking the role of the

other, feeling for a short time what it's like to be a soldier." (p. 231. In Corbin and

Strauss, 2008). Finally the third element, my own reflexive process. From my previous

experience engaging in qualitative analysis in a research study on the experiences of

graduate students enrolled in an introduction to psychotherapy training course (Pascual-

Leone, Rodriguez, & Metler, manuscript in progress). I became aware of the embodied

sense of fit as well as the feeling of empathy toward the participants and the data.

     4.Theoretical Memos – This step involves the analyst recording his or her

preconceptions, ideas, and "hunches" about the phenomenon under study, the possible

relations between categories and the sense of what may be the core category. Writing

theoretical memos requires self-awareness and is therefore closely related to the previous

step. Memo writing allows the researcher to go beyond looking at the clusters and categories emerged from the data. It allows the researcher to elaborate the processes, assumptions and actions subsumed under the categories (Charmaz, 1995). In other words, memos allow the researcher to further explain the processes within the categories as well as to find patterns in the data. In addition, keeping memos allows the researcher to preserve ideas or interpretations that are potentially meaningful but which are too early in the analysis to be determined.   Memo writing should be done throughout the process of both data collection and data analysis. Therefore it is not a step in a linear sense but an activity and reflection occur throughout the data analysis.

5. *Identifying meaning units* – This is the first step in the modified constant comparative procedure developed by Rennie. In this step the text entries are broken into passages or meaning units (MU). In this case this will be done using the qualitative research program NVIVO. This software will allow for efficient categorization, analysis, and organization of the data. The length of the MUs I am aiming for is located midway between the line by line coding suggested by Charmaz (1990) and Rennie's more ample conceptualization of MUs. This will result in a very detailed analysis. For example, in some instances where the MUs are within passages or sentences that contain other MUs, each MU will be identified and in cases where the MU by itself is not understandable, a short note of the context in which that MU arose will be included in parenthesis. This step ensures the MU retains its properties and allows the complexity of a section to be captured. The selected 5 therapists' collection of journals will be analyzed in random order. Once all the MUs are identified then categorization takes place.

6. *Categorization* – Each MU starts out being one independent cluster. MUs that share similarities are placed together in clusters based on their underlying meanings.

Categorization involves studying the MUs and deciding if they are similar or different, if they are judged to be similar then they are put together, if they are judged to be different they are kept separate. This method is consistent with Rennie's and with Glaser and Strauss' original description of categorization. I attempt to stay close to the meaning of the text, especially during the beginning stages of the analysis. Thus, in the early stages of the analysis category generation is descriptive, the name of the category closely reflects the language used by the participants. Using language similar to the one used by the participants (i.e., therapist-trainees) will ensure the analysis remains faithful to the meaning the participants intended to communicate. Describing the meaning units using the participant's language leads to a more objective analysis of the data as it gives less room for inaccurate interpretations (Charmaz, 1995). Moreover, this method allows for the therapist-trainees' "voice" to show and allows subtle nuances in the data to be preserved (Glaser, 2002). This procedure ensures the substance and meaning of the data is preserved.

As the analysis continues and more MU are assigned to a category, the density of the meaning of the category increases. As the analysis progresses, category cards are created where the compacted meaning of the collection of MU is expressed. Eventually it becomes clear that some categories are defining characteristics or properties of other categories. Higher order themes are developed from the MU clusters, thus allowing a greater understanding of the initial categories. This allows for categories with higher levels of abstraction to emerge as well as for certain categories to be grouped together under a common theme. The lower level categories will most likely reflect the participants' discourse, while the higher order categories may be more abstract. During

this step I will focus solely on identifying MU and categorizing, not yet searching for temporal changes in the data.

7. *Iterations* – It is important to note that while the analysis involves progressively moving through the text it also involves backtracking and constantly revising and re-analyzing the data to make sure that the definitions and concepts that emerge in the analysis remain true to the nature of the data – a truly circular analytical process. Clustering and categorization of the meaning units will constantly evolve as the researcher goes back to the original categories that emerged from previously analysed journals (in this case as additional collections of therapist's journals are included in the analysis) and refines the categories with new understanding gained from the analysis of additional journals.

8. *Assessing saturation* – Saturation is reached when further analysis of the data shows that no new categories or properties emerge from the new meaning units. Additionally, the categories are reasonably well-developed and their properties, dimensions, and variations are identified (Creswell, et al., 2007; Corbin & Strauss, 2008). Although variations in the data can always be discovered, signals of saturation are clear when further data gathering and analysis add little new to the conceptualization; new categories have ceased to emerge and there is repetition of the information and confirmation of existing conceptual categories (Corbin & Strauss, 2008; Rennie, 2006; Suddaby, 2006; Willig, 2001).

9. *Ensuring rigor: cross validation or peer review* - In order to ensure objectivity, once the categorization is completed a research assistant and a member of the Multicultural Research Group will cross validate the data by independently categorizing a number of the MUs. This is to determine if the research assistant's placement of the

meaning units is consistent with the original categorization. In addition, emerging

categories will be discussed with the research assistant and the member of the

multicultural research group in order to strengthen the credibility of the analysis.

10. Parsimony – Rennie suggests once saturation has been attained, the researcher

directs his or her attention to the categories and their relations with each other. Rennie

(1996) states that a manageable analysis has no more than 50 categories and remarks that

Glaser and Strauss recommend a maximum of 20. Therefore it is important to evaluate

and revise the analysis in order to keep the analysis and the resulting findings as coherent,

strong, and parsimonious as possible. Categories that have links with many other sub

categories are considered central categories. The categories may be linked together and

form a hierarchical structure where central categories include lower-order categories. This

structure may consist of several levels with the categories in each level being properties

of the category or categories at the next higher level. Central or core categories are the

most densely related to other categories. The core category in the analysis is typically the

last category to saturate, near the end of the analysis. While the central category may be

abstract, it is clearly defined by the categories subsumed by it. Categories are evaluated

depending on the degree to which they support the emerging hierarchical structure;

categories that have few connections with the central or core themes and with the analysis

in general are dropped or collapsed into other categories. Rennie, echoing Glaser (1978)

suggests only one core category be present in the analysis and if more core categories

arise it is important to determine if they can be included under the main core category and

if not they should be reserved for additional grounded theories so that the analysis and the

presentation of the analysis become less burdensome and complex.

11. *Assessing temporality* – Once the core category and its subcategories are

identified in a hierarchical model, the researcher will determine if changes over time are

apparent in some categories through the assessment and re-evaluation of the content in

the categories and searching for subtle differences that emerge temporally. This

assessment of the temporal dimension will serve to strengthen and clarify the emerging

theory. Saldana (2003) posits that change is contextual and is influenced by many factors

(e.g., social and cultural history of each participant, of the researcher, of the research

setting, and of the study itself). There may be diverse *types* of change within the same

analysis. Thus, Saldana (2003) suggests allowing the definition of "change" to evolve as

the study and the analysis progresses. It is important to note that the ways in which the

therapists' actions may be changed by the process, as well as the factors that play a part in

influencing their actions and/or changes can't be defined a priori as these will emerge

through the analysis. Moreover, the therapists may report additional types of change that

cannot be predicted at this time. Thus, allowing for the definition and scope of change to

evolve with the analysis permits different types of change to emerge from the data.

Collins and Pieterse (2007) conducted a study where they addressed the process of

attaining multicultural awareness. These authors substantiate that focusing on the process

allows for a more nuanced and complex understanding of what being culturally

competent really entails and they emphasize that competence is an ongoing process,

which involves effort and commitment.

12. *Sharing the results: Dissertation and Publication* – Once the document is finalized,

the results will be made available to the participants in the study. Participant feedback

will be welcomed and may be incorporated in future publications of this project. In

addition, while the full analysis and grounded theory will be presented as the coherent

end result of this dissertation study, in qualitative research it is common to find that one

or more important categories can stand on their own as they are coherent and

representative of the phenomenon under study (Rennie, 1996). Thus, the findings of this

study may be published as a series of interrelated but independent journal articles.

Appendix D – Scheme for the use of Qualifiers

Table E1.

Scheme for the Use of Qualifiers

Qualifier language	Number of participants (based on 14 participants)
All	14
Nearly all	12 – 13
Most	9 – 11
Around half	7 – 8
Some	3 – 6
A couple	2
One	1

Note. Adapted from "*Proposed Scoring Scheme for Qualitative Thematic Analysis,*" by B. Rodgers and M. Cooper, 2006, Working paper (Unpublished). University of Strathclyde, Glasgow, England.

Appendix E – Peer Debriefing

Table F1.

Summary of peer debriefing meetings

Date	Attendees	Summary of issues discussed during the meeting
Sept., 2013	Sobia Ali and Beatriz Rodriguez	Clarified and streamlined the themes that were relevant to the research question. Thoughtfully discussed the themes to include in the write-up and their relevance to the research question.
Oct. 2, 2013	Dr. Ben Kuo, Berri Batoul, Aviva Bellman, Eva Keatly, Angela Downie, Fareeha Nad, and Beatriz Rodriguez	During this lab meeting I was provided with valuable feedback and comments. The participants mostly talked about how the findings resonated with their experiences.
Oct. 11, 2013	Dr. Kimberly Calderwood and Beatriz Rodriguez	During this meeting we discussed the analysis of the findings and Dr. Calderwood provided helpful suggestions of how to write up the results.
Mar. 22, 2014	Dr. Kimberly Calderwood and Beatriz Rodriguez	This meeting lasted for almost for hours and took place once I had the first draft of the results section written up. The following issues were discussed: - Reorganization of the findings, linking themes with each other in a more cohesive way. - Discussing sub-themes that fit within more than one theme - Discussion on merging the results and discussion sections - Challenged my organization and interpretation of the results in several ways such that in the end the analysis was more cohesive. After this meeting I conducted a full review of the analysis. During this review, I re-organized the themes and was able to link them to each other in a more meaningful way.
April, 2014.	Natasha Koustova and Beatriz Rodriguez	Discussed the new theme arrangement. This discussion helped me clarify the new arrangement and ensure it was cohesive and not repetitive.

May 10, 2014	Dr. Kimberly Calderwood and Beatriz Rodriguez	During this shorter meeting we discussed the new arrangement of the categories and the preliminary write-up of the results and discussion section.
July 9, 2014	Dr. Kimberly Calderwood and Beatriz Rodriguez	Discussed how to better organize the results and prompted me to further specify certain themes so as to provide clarity on how they fit together. Thoughtful discussions challenged me to clearly explain the rationale for various decisions such as keeping certain themes separate or merging them.

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