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10 COUNSELING AND PSYCHOTHERAPY WITH REFUGEES

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PRIMARY OBJECTIVE:

To assist the counselor/psychotherapist in understanding and providing effective mental health counseling for refugees

SECONDARY OBJECTIVES:

To develop and present the multilevel model (MLM) for counseling refugees

To incorporate an intervention approach that integrates Western with indigenous methods

To present a holistic framework as an integrated strategy to meet the complex needs of refugees

THE interrelationship of mental health problems and refugees has been well documented during the past decade (e.g., Beiser, 1987; Bottinelli, 1990; Cervantes, Salgado, & Padilla, 1988; Chung & Kagawa-Singer, 1993; Farias, 1991; Jenkins, 1991; Kinzie, Frederickson, Ben, Fleck, & Karls, 1984; Lin & Masuda, 1983; Mollica & Lavelle, 1988; Westermeyer, 1986). Refugee migrations in the latter part of the 20th

century have been characterized by exposure to serious, life-threatening traumatic events. Since World War II, there have been documented systematic policies that, at times, have included genocide or other attempts to destroy the cultural fabric of families, clans, and communities in various regions of the world, including Africa, Asia, Latin America, and Europe.

Many refugees left their countries of origin involuntarily. Relocation to new countries is most frequently not a self-determined choice, but rather an escape from intolerable and chaotic conditions. Leaving one's home country and the precariousness of the flight itself cause loss of family, identity, and culture; a downgrade in socioeconomic status and employment; language problems; dramatic shifts in social, familial, and gender roles; and acculturation problems in the new country (Chung & Kagawa-Singer, 1993; Lin, Masuda, & Tazuma, 1982; Lin, Tazuma, & Masuda, 1979; Mollica, Lavelle, & Khuon, 1985; Mollica, Wyshak, & Lavelle, 1987). These problems have created serious mental health issues for refugees.

Murphy (1977) differentiated "forced" and "free" migration; by his definition, refugees are forced to leave their countries of origin. His work was based on the 1951 Geneva Convention on the Status of Refugees (U.N. Convention Relating to the Status of Refugees, 1951, 31{1}), which focused on providing protective guidelines and protocol for refugee migration, with an understanding that people rapidly departed from their country of origin because of a well-founded fear of persecution on the basis of race, religion, political conflict, or war. The refugee population is therefore distinguished from other migrants, such as immigrants, sojourners, or guest workers, primarily by the involuntary nature of their departure. Forced migration means flight with little planning, preparation, or choice, as well as uncertainty, chaos, personal danger, and complete disruption of normal life-sustaining processes. Loss of reference groups such as family and community, culture, and country may mean, for the individual, loss and disruption of occupation, status, identity, and role definition.

Studies have found that refugees are more prone to psychological problems (Kinzie & Manson, 1983; Mollica & Lavelle, 1988; Mollica, Wyshak, Coelho, & Lavelle, 1985). In the majority of epidemiological studies investigating refugees and migrants, rates of psychopathology have been higher than in the general population (Garcia-Peltoniemi, 1991; Kinzie, 1993; Weisaeth & Eitinger, 1993). Marsella, Friedman, and Spain (1993) found greater rates of depression, anxiety, and posttraumatic stress disorder among refugees. Bemak and Greenberg (1994) found higher rates of depression among Southeast Asian refugees, and

Dube's (1968) earlier study indicated higher rates of psychiatric disorders among Punjabi refugees.

Acculturation takes place within the context of these mental health concerns. In its broadest sense, acculturation is defined as the process of adaptation from one culture to another. It is associated with complex clinical challenges for counselors and psychotherapists.

This chapter focuses on major contemporary issues in counseling refugees and presents a new model of psychotherapy specifically designed for refugee populations. We highlight the relevant issues to the refugee experience that are critical to consider in therapeutic interventions. Although some of the constructs are similar to those of other cross-cultural counseling situations, the cultural dynamics and history of each refugee present unique characteristics that are traceable to respective cultures of origin and cultures of resettlement. These differences must be clearly understood and incorporated into therapeutic relationships at multiple levels, including individual, family, group, and community.

The chapter discusses the following six topics: (a) cultural belief systems, (b) utilization of mainstream mental health services, (c) acculturation and mental health, (d) psychosocial adjustment and adaptations, (e) the implications of resettlement policies for mental health, and (f) a multilevel model approach to counseling and psychotherapy with refugees.

CULTURAL BELIEF SYSTEMS

The World Health Organization (1987) defined *health* as a "state of complete physical, mental and social well-being" (p. 1). Historically, psychotherapy has focused on fostering mental health, utilizing individual psychotherapy as a means to enhance optimal independent functioning, coping abilities, and adaptation. This is in direct contrast to the cultural context for refugees, who most often come from countries where family and community social networks are essential aspects of their lives. As a result, the clinical interventions are frequently in conflict with fundamental societal beliefs and value systems that incorporate family and community interdependence. Understanding and providing mental health interventions for problems within a culturally relevant framework for refugees is thus a complicated process.

The professional psychotherapist and refugee client will typically have different perceptions of both the mental health problem and effective intervention strategies. For example, a Hmong refugee may believe in animism or spirits as the cause of emotional imbalance and may be

visualizing and hearing a deceased relative. Traditional Western psychotherapists correlate these symptoms with psychosis and employ counseling techniques and medication that focus on the symptomatology (the "hallucination") to treat the underlying psychosis. Indigenous healing methods would approach the same symptoms from a different cultural belief system, incorporating the concept of the deceased relative and spirit as an important and relevant personal and spiritual communication potentially contributing to the stabilization of the individual and even the entire family. Disparities in cultural beliefs, values, philosophical constructs, and spiritual and religious customs and practices have been discussed by Kleinman and colleagues (Kleinman, Eisenberg, & Good, 1978; Kleinman & Good, 1985). They underscored these differences by identifying the need to understand and validate the client's conceptualization of problems within the context of culture. Therefore, it is important for the therapist to be knowledgeable and aware and to develop and employ culturally sensitive therapeutic interventions and skills (Kagawa-Singer & Chung, 1994; Pedersen, 1988). Simultaneously, the therapist should maintain an awareness of cross-cultural errors in underdiagnosis or overdiagnosis of symptomatology and subsequent mental health problems.

Other cultural beliefs may also influence the psychotherapeutic process. The value system and social class of the therapist may be in sharp contrast with those of the refugee, creating barriers in communication and understanding. This is evident with refugees and mental health professionals from different cultural and socioeconomic backgrounds who have conflicting beliefs about issues such as child rearing, gender equity, or responsibility to extended family and community. Inconsistencies may manifest in generalized life themes such as perspectives on and relationships to time, planning with regard to short- versus long-term goals, passive versus action-oriented responses to various life situations, and patterns of verbal and nonverbal communication.

UTILIZATION OF MAINSTREAM MENTAL HEALTH SERVICES

Although there are indications that a disproportionate number of refugees have serious mental health problems (Gong-Guy, 1987; Struwe, 1994), there is a historical reluctance to seek help from mainstream mental health services (Higginbotham, Trevino, & Ray, 1990). This may be related to several factors. First, mainstream mental health services in

countries of resettlement may be the last choice of treatment by refugees. Prior to contacting the mental health professional, refugees may look to indigenous healers, elders, family and social support networks, and religious leaders. Only after failing to locate or receive help from such sources do they seek out mainstream mental health professionals. Thus the choice is by default rather than preference. The situation is further complicated because by the time refugees finally access a counselor or psychotherapist, the problem has become acute (Sue, 1993).

A second reason for low utilization of mainstream mental health services is inaccessibility (Higginbotham et al., 1990; Lin, Inui, Kleinman, & Womack, 1982). Clinics and private offices are frequently located in areas that may be difficult to reach. Public transportation systems may be complicated and time consuming to use so that the refugee must weigh the benefits of spending time and money to receive psychotherapy. Sometimes, in urban areas, mental health offices are located in poorer communities that refugees perceive as dangerous and thus avoid.

If refugees overcome these obstacles and actually go to a mental health facility, they may be greeted by insensitive receptionists, staff, or professionals. It is confusing for refugees who arrive late for a counseling appointment and are told by an unsympathetic secretary or psychotherapist that they will be unable to have an appointment that day. Cultural differences in time, language barriers, tone and volume used in communication, and nonverbal communication such as eye contact, as well as refugees' own personal responses to forceful communication triggered by past experiences, may create misunderstandings and heighten refugees' negative response to mental health services.

In many refugee communities, there is a traditional significance placed on friends and family. This is based on cultural norms as well as the shared experience of displacement. Individual experiences are considered reflections on the family or clan rather than solely the responsibility of one person. Consequently, if an individual is receiving mental health services and it is publicly known in the community, it may cause embarrassment and shame for the family and at times the community. The shared responsibility for mental health problems, coupled with negative stereotypes of mainstream mental health practices, may thus result in an avoidance of mental health services.

Another key problem for refugees working with mental health professionals is language. Not knowing the native language of the host country may be an obstacle to receiving counseling. Many mental health services do not have professionals and\or trained translators who can effectively communicate with refugees in their native language. Although children

may act as translators for the family, this is not necessarily an effective method of communication with mental health professionals (Chung & Lin, 1994). Translators must not only be carefully trained but have a well-defined partnership with the mental health professional. An established and well-understood therapeutic alliance between bilingual mental health worker and psychotherapist is critical for effectively overcoming the language barrier.

ACCULTURATION AND MENTAL HEALTH

The process of migration has long been investigated as an etiological factor in mental health. The correlation between mental health problems and migration points toward migrants' problems in adjusting to a new culture. One of the first classic studies by Odegaard (1932) examining the relationship of migration to mental illness provided a foundation for understanding this problem for refugee populations. Initially, these studies examined psychiatric hospital admission rates and found that immigrants were disproportionately represented (Eitinger, 1960; Hitch & Rack, 1980; Mezey, 1960). The study of acculturation generally considers the following dimensions: models of acculturation (which comprise assimilation, integration or biculturalism, rejection, and deculturation), social indicators, stress, and adaptation. Researchers (e.g., Berry, 1986; Szapocznik & Kurtines, 1980; Wong-Reiger & Quintana, 1987) have concluded that biculturalism or integration produces healthier acculturation outcomes. For detailed descriptions of these models, see Berry (1986) and Wong-Reiger and Quintana (1987).

For refugees, the difficulties of the acculturation process are compounded by their premigration trauma experiences. Mollica et al. (1987) categorized four major categories of trauma: (a) deprivation (e.g., of food and shelter), (b) physical injury and torture, (c) incarceration and reeducation camps, and (d) witnessing of torture and killing. The experience of trauma correlates with the psychosocial maladjustment of refugees and hinders the adaptation process. The postmigration experience includes culture shock, which precipitates feelings of helplessness and disorientation. All refugees are separated by migration and death from members of their nuclear or extended families as well as the community network. The arrival into countries of resettlement introduces new cultures and reference groups that are most frequently individualistic rather than collectivistic in nature (Bemak & Greenberg, 1994). Triandis (1990) differentiated between individualistic cultures, in which social behavior

is motivated by personal goals, and collectivistic cultures, in which family, friends, associates, and colleagues are more highly valued and associated with goals and behaviors. Thus refugees not only face a new society in which there is most often a focus on self rather than family or group but simultaneously must contend with loss of their family, community, and social network reference group (Bemak & Greenberg, 1994).

Individual differences play an important role throughout the process of acculturation so that each person adapts in different ways to varying levels. The degree of adaptation will differ according to the refugee group and individual characteristics, and be based on the ability to integrate culture of origin with the new culture of relocation. Successful acculturation is influenced by important factors such as the individual's desire and willingness to adapt, the successful integration of two or more cultures, ability to identify with a new reference group, the acceptance of the host country's culture, supportive strength of the social and family network, and the resolution of past psychological trauma.

PSYCHOSOCIAL ADJUSTMENT AND ADAPTATION

Implicit in the discussion of acculturation is the issue of psychosocial adjustment. Ben-Porath (1991) described antecedents of flight, the period of flight, and the process of resettlement as important elements in psychosocial adjustment. Each of these adjustment phases represents potential sources of stress and mental health risks for the refugee and needs to be considered by the psychotherapist. As the psychotherapist provides counseling for refugees, the dynamics in each phase of the therapeutic relationship must be carefully evaluated and fully understood within the context of past and present experiences.

Tayabas and Pok (1983) identified the first 1 to 2 years of resettlement as a crucial period when refugees attempt to meet basic needs such as housing and employment. Bemak (1989) outlined a three-phase development model of acculturation affecting psychosocial adjustment. During the first phase, the refugee attempts to use existing skills to master the new environment and feel psychologically safe. Successful completion of Phase 1 leads to the second phase, during which former skills from the culture of origin and newly acquired skills are integrated as acculturation takes place. Phase 3 follows successful adaptation and is highlighted by a growing sense of future. In this developmental model,

it is only after a basic mastery of culture and language and a sense of psychological safety that the refugee begins to contemplate and plan for future realistic and attainable goals and implement strategies to achieve them.

Many refugees have experienced severe incidents of trauma prior to migration. These past events may continue to interfere with psychosocial growth and stability and present barriers to adjustment. Adaptation for refugees in the resettlement country includes learning new coping skills as well as new behavioral and communication patterns. Many refugees have learned survival skills that may appear aversive, antisocial, or even psychopathological in the host country (Stein, 1986). For example, refugees who have experienced or witnessed torture, rape, and other incidents of abuse or death remained alive by acting "dumb." This reaction is common to survivors of atrocities (Chung & Okazaki, 1991). Mollica and Jalbert (1989) described the Khmer term *tiing mooung* ("dummy" personality, puppet, or scarecrow), which was commonly used by Cambodians to describe behavior of refugees under the Khmer Rouge regime. To survive, individuals acted as if they were deaf, stupid, foolish, or confused and learned to obey orders without asking questions or complaining because they knew that if they appeared "smart" they would be tortured or executed. The fear of this happening has remained for many refugees, causing them to continue to "act dumb" and be afraid to express feelings. This behavior, if continued in the resettlement country, may appear strange and inappropriate and lead to negative reactions toward the refugee.

Another important factor in refugee adaptation to a new country relates to the marked ambivalence about actually relocating. The refugee experience is characterized by the loss of control over decision making with regard to essential questions in one's life such as geographic location, job opportunities, and social networks. Furthermore, there may even be resentment on the part of the refugee toward the host country. For example, some Southeast Asian refugees may feel that the United States expanded the war in Vietnam and then abandoned them. These feelings may contribute to an uneven adaptation process.

Survivor's guilt is a common problem that has been associated with refugees (Brown, 1982; Lin et al., 1982; Tobin & Friedman, 1983). Many refugees are haunted by feelings of guilt because they successfully escaped dangerous conditions in their home country but left behind family, friends, and loved ones. Awareness that the people who remained in the country of origin are alive and not ill or suffering may partially relieve survivor's guilt, but knowledge about their living in unpleasant

conditions generates added emotional stress. If refugees have little or no information, they may be plagued by feelings of intense stress and guilt. The cycle of pain and sadness continues so that the more happy and successful one becomes, the greater the barriers to enjoying that sense of well-being because the hurt and associated guilt intensify.

Language Barriers

Language plays an important part in refugee adjustment. English as a second language (ESL) programs provide language training, yet falls short in providing the necessary holistic perspectives to address issues that emerge with cultural language acquisition. Learning a new language symbolizes leaving one's homeland and may be a catalyst for feelings of cultural identity loss. For example, a Cambodian adolescent, whose mother had been executed during the period of mass genocide under the Khmer Rouge regime, had a dream one night after migrating to North America in which her mother angrily appeared to her, extolling her to "Stop speaking English. You must speak Khmer! Remember you are Cambodian!"

Experiencing the frustration of trying to learn a new language may also bring back memories of "better times and easier communication" with neighbors, friends, and family. The current struggle with language may exacerbate emotional problems and frustrations in understanding the new environment. ESL classes may also create feelings of helplessness and cause regressive behavior similar to that of earlier developmental years when, as a child, one was learning to master one's environment. This may evoke questions about self-worth and cause a loss in social status marked by feelings of inadequacy and low self-esteem.

Finally, learning the language of the new culture may stimulate a redefinition of family relationships, causing dysfunction, conflicts, role confusion, and painful social restructuring. One example of this is the child who acquires language skills more quickly than the adults in the family, thereby causing a reversal of roles. The adults become dependent on the child for cultural and language translation. Given the context, in many refugees' cultures of origin, of a highly structured, hierarchical family organization, this is a particularly confusing issue for families and may result in serious role confusion affecting many aspects of the established family patterns. This can also be seen in the case of an Ethiopian wife who studied ESL classes at night. Learning the new language was important but required her to leave home in the evenings so that she was unable to fulfill her traditional duties. As she became

more proficient in the new language, she identified with the customs and practices of the new culture. This created a greater sense of independence and a rejection of her traditional role as a wife, which, in turn, fostered marital disequilibrium and conflict.

Education and Employment

Many refugees face not only social readjustment problems but difficulties with matching past training and education to equivalent employment. Educational qualifications from countries of origin may not be transferable in resettlement countries. Furthermore, jobs held in countries of origin may not be applicable to the skills needed in a more technologically advanced society. Consequently, the status that refugees previously received for their skills and education is often not accorded by the new culture, creating a situation in which they must "begin again." This search and struggle for gainful employment may result in a decrease in status, low self-esteem, and feelings of hopelessness. Refugees who have achieved professional status in their country of origin may encounter problems with licensure and credentialing in addition to the usual fluctuations of a competitive employment market and may consequently experience downward mobility.

Changes in familial and gender roles add to the already strained family situation. Unemployment or underemployment of refugee men commonly forces wives to work. Such changes in gender roles produce a conflict between the values of the culture of origin and those of the host country (Chung & Okazaki, 1991). Ironically, whereas refugee men's socioeconomic status may deteriorate, that of refugee women from developing countries may improve.

Changes in Family Dynamics

Relocation of families may also change child-rearing practices. Refugees are faced with new laws regarding discipline and punishment that are reflective of new rules of behavior in the country of resettlement. Practices that may have been commonplace at home before migration may become infractions of the law in the new environment. New rules guiding behavior such as child rearing may create confusion and adjustment difficulties within the refugee family. For example, coin rubbing is a form of medical treatment that is employed by Southeast Asian refugees to treat certain illnesses. This technique leaves bruises on the skin that have often been mistaken by school teachers as evidence of child abuse (Nguyen, Nguyen, & Nguyen, 1987).

Furthermore, children and adolescents acculturate faster than parents. Adaptation to the host culture causes a decrease in appreciation and adherence to traditional values, resulting in the loss of authority by the adults and intergenerational conflicts. In the resettlement country refugee children and adolescents may witness the transformation of their parents from previously autonomous and culturally competent caretakers to depressed, overwhelmed, and dependent individuals who are slow to acquire a new language and understand different customs. In this situation, confidence in parents is inevitably undermined.

Conflicts between parents and children also emerge concerning differences in cultural practices and customs. Dating, marriage, curfews, and other supervisory guidelines become negotiated issues rather than prescribed parental norms. The fact that these issues become open for discussion rather than remaining non-negotiable, clearly prescribed social patterns of behavior creates intense anxiety for the parents as they experience a loss of authority and control.

School

In addition, refugee children and adolescents often face problems in schools (Huang, 1989). The norms regulating classroom and school behavior are different from those of the home country, the ongoing social and extracurricular life is not easily accessible for newly enrolled refugees, and expectations for academic and personal growth may not fit with life perspectives and worldviews. For example, the 10th-grade Nicaraguan child is expected to meet with a guidance counselor to define class selections that will have a significant impact on his or her life career and work. Choosing a future vocation through academic courses at the age of 15 is quite different from the focus the child had in Nicaragua, where he or she may have not attended school or considered alternative future vocations.

Added problems in schools may relate to being a foreigner. Different language, dress, ways of socially interacting, habits, and foods may elicit prejudicial responses from peers and staff. There has been documentation of increasing violence in U.S. schools, and refugees may be targets of physical and emotional abuse, harassment, or robbery. The U.S. Bureau of Justice Statistics (1992) reported that approximately 10% of all nonfatal violent crimes toward persons aged 12 and over took place near or in schools. A national student survey investigating the use of weapons by 8th and 10th graders found that 16% had carried knives to school in the past year and that nearly 2% of the 11,000 students reported carrying guns in the same time period (Prothrow-Stith, 1991).

In a similar survey by the Center for Disease Control (1991), it was found that 20% of 9th to 12th graders had carried a firearm, knife, or club at least once during the past 30 days, while 13% of 12th graders had been threatened with weapons, and 6% had been injured by weapons (Johnston, O'Malley, & Bachman, 1991). Within this context, school personnel and other mental health professionals may be confused and misdiagnose aggressive behavior that has been documented with children who have been exposed to sustained trauma (Freud & Dann, 1951; Pinsky, 1949; U.N. Educational, Scientific, and Cultural Organization, 1952). Van der Kolk (1987) stated that "traumatized children have trouble modulating aggression. They tend to act destructively against others or themselves" (p. 16). Others working directly with refugee populations have suggested similar patterns: for example, Dadfar (1994) for Afghan refugees, Ajdukovic and Ajdukovic (1993) for Croatians, and Boothby (1994) for all refugee children.

RESETTLEMENT POLICIES: IMPLICATIONS FOR MENTAL HEALTH

A driving force in resettlement policy has been the importance of economic self-sufficiency. These policies reflect the clear expectation in virtually all resettlement countries that refugees will achieve financial autonomy within a prescribed time period. A distinction needs to be made between countries of final settlement and countries of first asylum that house refugees in camps or other aggregate living situations. The latter situations are oriented to provide for basic survival needs until resettlement or repatriation of the refugee can be determined and therefore do not aim at attaining self-sufficiency.

One of the shortcomings of refugee resettlement policies has been the neglect of longer term support around such issues as mental health, education, health, employment, and housing. Consequently, the refugee is forced to obtain employment and job training without adequate language skills, and with potential lingering mental health problems that interfere with successful adaptation. Paradoxically, the demands and stress associated with economic independence may contribute to exacerbating individual mental health problems rather then providing a psychological and cultural foundation from which to resolve past traumatic experiences and make a smoother transition into the new culture. Consequently, the goals of the resettlement policies are frequently undermined by mental health concerns that interfere with accomplishment of predetermined timelines for financial independence.

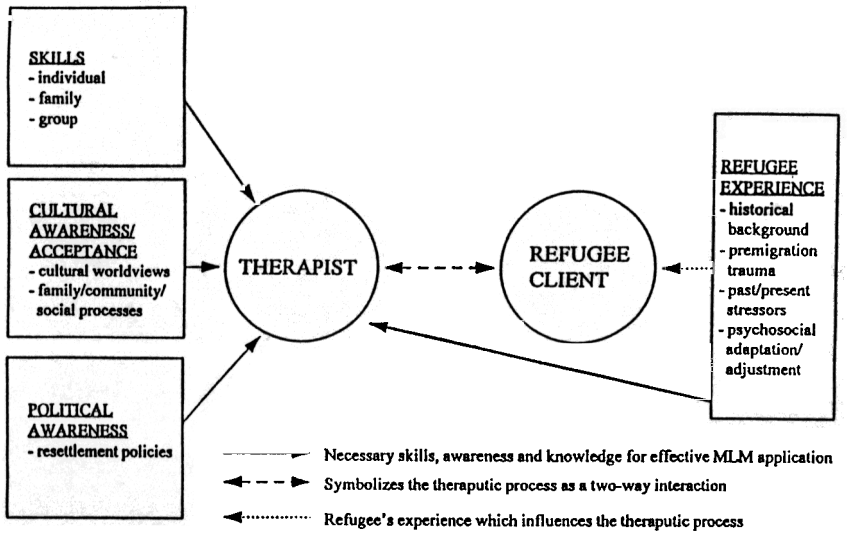

Figure 10.1. Therapeutic Prerequisites for Effective MLM Application
NOTE: Right-pointing (solid) arrows indicate necessary skills, awareness, and knowledge for effective MLM application. Broken two-way arrow symbolizes the therapeutic process as a two-way interaction. Left-pointing (dotted) arrows indicate the influence of the refugee's experience on the therapeutic process.

MULTILEVEL MODEL (MLM) APPROACH TO COUNSELING AND PSYCHOTHERAPY WITH REFUGEES

Psychotherapy with refugees requires unique skills, understanding, and sensitivity to the history, psychological realities, and deeply rooted trauma and loss associated with forced migration. Training and supervision have rarely addressed multicultural counseling themes that incorporate refugee experiences. Therefore, an ability to reconceptualize traditional training and applied experience is critical for effective clinical interventions. Given the complexity of the refugee experience, numerous issues need to be carefully considered when providing clinical interventions for refugees. Figure 10.1 depicts the skills that are essential to employ the multilevel model of psychotherapy effectively with refugees.

It is with the understanding of the uniqueness of refugees that we propose the MLM model of psychotherapy for refugees. The MLM takes into account the complexity of the refugee's historical background, past and present stressors, the acculturation process, and the psychosocial

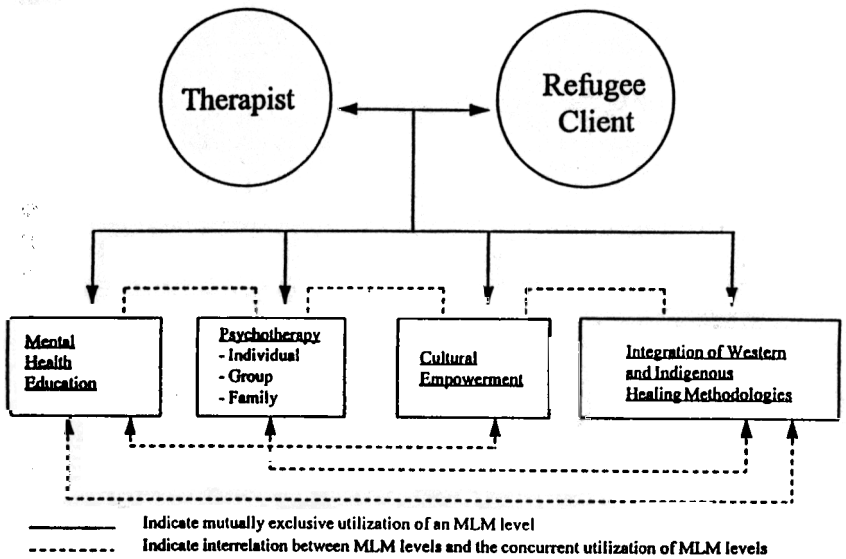

Figure 10.2. Multilevel Model Approach to Counseling and Psychotherapy for Refugees

NOTE: Broken lines indicate possible concurrent utilization of MLM levels.

ramifications of adapting to a new culture. Unlike traditional mental health precepts, which are rooted in psychodynamic constructs for cognitive and affective processes with a particular focus on prevention of emotional distress, the MLM is a psychoeducational model that comprises cognitive, affective, and behavioral interventions inclusive of cultural foundations and their relation to community and social processes. It is important to note that there is no fixed sequence to implementing the MLM levels, so that they may be used simultaneously or independently. Furthermore, the MLM is not a model that requires additional resources or funding. Rather, it is a reconceptualization and diversification of the role of the psychotherapist as a helper. The MLM includes the following four phases: Level I: mental health education; Level II: individual, group, and/or family psychotherapy; Level III: cultural empowerment; and Level IV: indigenous healing. Figure 10.2 shows the MLM model.

The four levels in MLM are interrelated and may be implemented concurrently. Although they can be considered separately, their interrelationships are essential for attaining the desired goals of psychotherapy. Emphasis and utilization of any one level or combination of levels are based upon the assessment of the psychotherapist.

Level I, mental health education, focuses on educating client(s) about mainstream mental health practices and interventions. Refugees may not be aware of the types of services available or the expected normative behavior for themselves as clients or the psychotherapist. Basic fundamental procedures such as intake assessments, the role of the professional, interpersonal dynamics in the counseling process, the role of an interpreter, time boundaries, and usage or nonusage of medication may be strange to refugees. They may feel awkward and uncomfortable participating in the therapeutic relationship, especially without any prior knowledge or information. Thus Level I provides information for the individual, group, or family about the process of psychotherapy and the mental health encounter.

Level II is based upon more traditional Western individual, group, and family therapy interventions. Zane and Sue (1991) demonstrated that these traditional forms of individual and family therapy have been effective with members of several culturally distinctive groups. To provide relevant and qualitative psychotherapy for refugees, techniques must incorporate understanding of cultural norms and practices in healing. Traditional techniques rooted in Western psychodynamic practices are alien to many refugees. For example, Kinzie (1985) underscored the need to be more directive and active during psychotherapy with Southeast Asian refugees.

Other mental health professionals have identified specific therapeutic techniques that are effective in refugee work. Cognitive-behavioral interventions have been recognized as helpful with refugees (Bemak & Greenberg, 1994; Egli, Shiota, Ben-Porath, & Butcher, 1991). De Silva (1985) and Mikulas (1981) argued that cognitive-behavioral therapy was applicable to Asian refugees due to its compatibility with Buddhism, and Arce and Torres-Matrullo (1982), Comas-Diaz (1985), and Stumphauser and Davis (1983) depicted linkages between cognitive-behavioral approaches and Hispanic cultures. Beiser (1987) explained how cognitive-behavioral interventions with Southeast Asian refugees help them reorient to the present rather than maintain a painful preoccupation with past memories and an uncertain future.

Other techniques used may also be incorporated in MLM Level II. Pynoos and Eth (1984) described how storytelling and projective drawing for children who have experienced trauma assisted them to regain control over the event. Charles (1986), an anthropologist, wrote about utilizing cultural characteristics to provide counseling. On the basis of his work with Haitian refugees who held strong values, Charles suggested that an emphasis on moral development—that is, on remaining honest—would be highly effective in psychotherapy. Bemak and Timm (1994)

presented a case study in which dreamwork played an important part in the therapeutic intervention with a Cambodian refugee. Other techniques that may be employed in individual counseling include gestalt, relaxation, role playing, and psychodrama.

In addition to culturally relevant psychotherapeutic techniques, awareness and knowledge of theoretical counseling approaches, prevention and intervention models, and the therapeutic process are important. It is vital for the mental health professional to consider the refugee's background as it relates to current psychological functioning. Many refugees were politically persecuted in their countries of origin, and numerous others were forced to migrate. The forced and frequently dangerous intrusion into personal lives and behaviors by governments and people in authority led to fear and distrust. Daily survival dictated that refugees develop a hypersensitivity to the motives of those seeking personal information. Entering the office of the mental health professional and being asked personal and direct questions may be experienced as highly threatening and inappropriate. Because counseling requires self-disclosure about feelings and thoughts, as well as intimate social interaction to explore and resolve these issues, the psychotherapist must very carefully establish trust with the refugee client while keeping in mind the impact of personal experience on the worldview of the client and the therapeutic relationship. An example of this is the Cambodian adolescent who watched his mother get beaten and raped, yet knew that he would certainly face torture and possibly his own death if he expressed emotion at that time. When he first met a psychotherapist, he had blunted affect, was reluctant to express any feelings or opinions, and mistrusted the "true" motives of the counselor.

It is our belief that to foster interdependence and healing and facilitate acculturation, group psychotherapy is critical in working with refugees. Although group therapy has not been used extensively as a therapeutic intervention with refugees, it is viewed as a key element in the MLM. Curative factors in group work identified by Yalom (1985) that have applicability for refugees are universality and corrective emotional experiences. These healing factors have been used in refugee group therapy to resolve painful psychological issues. Galante and Foa (1986) described the benefit of children's discussing their shared experience of a traumatic event via group counseling. Friedman and Jaranson (1994) explained how highly traumatized refugees found solace in group therapy. Kinzie et al. (1988) instituted a 1-year therapy group for Southeast Asian refugees that incorporated discussions about somatization, cultural conflicts, and loss and allowed for flexibility with time. In the MLM, it is suggested that the usage of group psychotherapy with refugees be greatly

expanded and include MLM Level I psychoeducational information sessions, MLM Level II traditional psychotherapy sessions, and MLM Level III cultural empowerment group meetings.

The strong family bonds for most refugees and the necessity of family adaptation in countries of migration would make family therapy a natural means of addressing systemic rather than individual problems. Because of the cultural importance of the refugee family, the MLM also embodies family counseling as a major therapeutic intervention.

Despite the importance of family roots for most refugees, little has been written about the utilization of family therapy as an intervention. Bemak (1989), Charles (1986), Lee (1989), and Szapocznik and Cohen (1986) all described the importance of family therapy with refugees, explaining that family bonds, experiences, and subsequent family system problems with acculturation make family counseling an ideal intervention strategy. Professionals who provide family counseling must have a clear understanding and knowledge about the background and traditional relationships of families from specific cultures of origin.

MLM's Level III, cultural empowerment, assists the refugee in gaining a better sense of environmental mastery. Many professionals find themselves faced with refugee clients who are initially far more interested in understanding and effectively adapting to the world around them than in delving into intrapsychic and interpersonal problems or psychosocial adjustment issues. The frustration and anger of not understanding how systems work, how to access services, or where to go for assistance with certain problems related to education, finances, health, or employment may be a predominant issue that must be resolved before other psychological problems can be explored. Therefore, it is our contention that mental health professionals must be attuned and sensitive to these difficulties inherent in adapting to a new culture and provide case management through assistance and guidance that will empower the refugee.

In MLM, the psychotherapist is not expected actually to become the case manager for the client. Rather, the psychotherapist becomes a "cultural systems information guide," assisting the refugee with relevant information about how the cultural system works and what the client can do to resolve associated problems. The therapist may need to function in this capacity over an extended period, with a long-term goal of enabling the client to develop skills in dealing with the system within the new culture. The resultant mastery of these skills by the client creates successful experiences and cultural empowerment.

Level IV of the MLM, indigenous healing, is the part of the model that combines Western traditional and nontraditional healing methodologies. The World Health Organization (1992) described how an inte-

gration of indigenous healing with Western traditional healing practices resulted in more effective outcomes. Despite this, all too often indigenous practices that are successful in addressing mental health problems in the culture of origin are disregarded by the Western mental health professional. There is a need for a professional openness to non-Western, culturally bound forms of healing to support and enhance the psychotherapeutic process. Simultaneously the psychotherapist must be mindful that not all indigenous workers are legitimate healers. Therefore, one must critically assess the capabilities of indigenous workers before aligning with them in the therapeutic process.

Hiegel (1994) classified approaches to mental health problems by indigenous healers into the following four areas: (a) physical treatments, (b) magic healing methods, (c) counseling, and (d) medications. It is vital that the mental health professionals be knowledgeable and accepting of these traditional cultural practices to establish "treatment partnerships" that provide the refugee with the rich combination of healing sources from the culture of origin and culture of resettlement. In addition, religious leaders may play an important role in the therapeutic process, particularly in communities that are highly spiritual.

An example of cooperative treatment is the case of a Vietnamese young male adolescent who was having problems with anger. Because the adolescent adhered to the Buddhist faith, the psychotherapist referred him to a Buddhist monk to supplement the counseling. The adolescent spent weekend retreats with the monk and maintained his weekly sessions with the therapist. He shared how helpful the weekend activities were and simultaneously became more open and trusting with the psychotherapist, expressing appreciation for the therapist's understanding of "his" culture. The psychotherapist and monk maintained contact, working together to help the adolescent.

The therapist must not only be willing to make a referral to an indigenous healer but also be receptive to the healing intervention. It is also essential that mental health professionals be able to access healers and/or community elders to work cooperatively and in conjunction with them in the treatment process of their clients (Chan, 1987; Hiegel, 1994).

CONCLUSION

Counseling and psychotherapy with refugees is complex. To effectively assist the refugee in attaining a sense of mental health and well-being, we have proposed the multilevel model (MLM) of counseling and psychotherapy. This model is a four-level intervention approach that integrates traditional Western psychotherapy with indigenous healing methods, cultural empowerment, and psychoeducational training. The MLM takes into account cultural belief systems, acculturation, psychosocial adaptation, and the influence of resettlement policy on mental health. It provides a holistic framework that conceptualizes an integrated strategy to meet the multiple needs of the refugee population.

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