

Risk and Resiliency in Immigrant and Refugee Youth: Considerations for Counselling

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Abstract

This paper is an examination into the risk and resilience factors influencing immigrant and refugee youth during their acculturation development during resettlement. Counselling considerations are discussed with a focus on targeting the development of a strong sense of bicultural identity for youth. Counselling professionals are called on to serve a diverse group of clients; however, counsellors may lack the necessary knowledge of cultural and societal factors influencing mental health outcomes. Counsellors who work with immigrant and refugee youth should strive to develop knowledge of systematic and political processes that impact their clients' lives. This paper discusses important resettlement factors that should be addressed when working with these populations. Furthermore, a starting point for counsellors is suggested that encompasses the careful reflection of personal biases and attitudes that may impact multicultural work, and how to successfully situate their practice under a multicultural theory. Implications for counselling practice are summarized and future directions for research is presented.

Keywords: counselling, immigrant, refugee, acculturation, resilience, cultural competence

Introduction and Self-Positioning Statement

The research area I have chosen to focus on, risk and resiliency in immigrant and refugee youth, is personally relevant to me and an important part of my potential future work as a clinician. I immigrated to Canada in 1995 as a refugee from Bosnia. I was five years old, and my journey was both common and unique to the overall immigration patterns occurring at the time. I had a strong connection to my family's identity as refugees; it was a massive part of who we were and how we got to Canada. As I grew up in Winnipeg, Manitoba, through my childhood and most of my adolescent years, I became aware that my identity and worldview continued to evolve and be influenced by multiple cultures. My bicultural perspective helped to nurture my interests in future social humanities work; it also helped me embrace diversity within Canadian society. I believe I have a responsibility to develop knowledge and competencies in the field of psychological counselling for immigrants and refugees. Part of my journey has also involved working with children and youth in residential care and open community settings. Through this experience I have discovered areas for growth in understanding and developing culturally sensitive and responsible practices, both in social work and psychology practice. During this time I also developed my interest in working with young people and finding successful ways to connect with and help a diverse range of clients. I hope to continue to work with the adolescent population after completing my graduate studies, and I hope to bring my personal knowledge and experience to the practice of multicultural counselling.

In this paper, I outline the risk and resiliency factors that impact immigrant and refugee youth, as well as the specific skills and strategies for counsellors who work with them. After highlighting important definitions, I discuss how the adolescent stage of development influences the work done with this population and how counsellors can successfully anchor the therapy

process by exploring relevant cultural identity factors. Finally, I offer suggestions for further research and practice.

Background Information

Historically, it has been noted that global migration trends are often linked to anxiety for new immigrants and refugees, particularly in being labelled as not fit to contribute to society or as a potential threat to the dominant culture (Kirmayer et al., 2007). Recent government protectionism policies on immigration have harboured new fears and hostility in Western society towards newcomers, such as harmful stereotypes about terrorism and violence being equated to immigrant and refugee groups seeking safety and protection (Bäärnhielm et al., 2017). Despite these stereotypes, research has pointed out that immigrants and refugees come with protective and resiliency factors that benefit their long-term psychological adjustment in receiving countries, and also contribute significantly to those countries' well-being and economy (Guruge & Butt, 2015). These groups often resettle with a sense of hope and optimism, and the desire to contribute to society economically in order to establish stability for themselves and their families.

Mental health practitioners should be equipped to understand the realities of immigrants and refugees in resettlement, and authors have described the mental health needs of these populations as a humanitarian and ethical imperative (Whaley & Davis, 2007). Most recently, millions of people have fled conflict and persecution from areas across the globe including the Middle East, Southeast Asia, and sub-Saharan Africa, resulting in the highest displacement numbers since World War II (Matlin et al., 2018). With the increase in numbers, research has called attention to the insufficient focus given to addressing the mental health needs of these populations (Guruge & Butt, 2015; Matlin et al., 2018). Furthermore, the counselling psychology

field has long recognized the need for culturally sensitive services that are available to a diverse range of clients, specifically relevant to ethnic minority groups (Sue et al., 2009). The long-term health of societies in a continually evolving cultural landscape will be dependent on how effectively counsellors are able to develop competent mental health practices for a diverse range of cultures.

In Canada, immigration continues to play a major role in the productivity of the economy and the shaping of a multicultural identity that yields favourable immigration outcomes. Canada welcomed around 340,000 new permanent residents in 2019, the highest number in more than a century and the leader among nations in the world (Statistics Canada, 2021). Within this population group, immigrants are considered anyone who has emigrated to a new country by choice for factors related to economic opportunity, whereas refugee is a legal status recognized for those escaping violent persecution and civil war (Immigration, Refugees and Citizenship Canada, 2019). However, it has been noted that nonrefugee immigrants in Western nations have often experienced traumatic events (e.g., political violence and forced displacement) prior to immigration, but may not have qualified for refugee status (Sangalang et al., 2019). Although refugee is a status reserved for individuals seeking immediate refuge and needing protection, immigrants who have resettled in their receiving country often have had experiences with oppressive governments and persecution. Additionally, regardless of whether they come in as immigrants or refugees, newcomers face common postmigration challenges that may affect their mental health (Guruge & Butt, 2015). The common psychosocial experience when transitioning to a new country is termed *acculturation*, which Berry (2003) defined as a cultural and psychological process that occurs following intercultural contact. This process yields cultural changes within group customs and psychological changes pertaining to identity and social

behaviour (Phinney, 2003). There has been an evolving understanding of what changes occur among immigrants and refugees as they acculturate and resettle into the receiving country. In the next sections, I cover the conceptualization of acculturation and how it relates to immigrant and refugee youth development and mental health outcomes.

Acculturation Development

Unidimensional Acculturation Model

In 1980, Berry developed a model of acculturation that consists of four separate categories that represent an individual's pattern of acculturation: *assimilation* (adopts the receiving culture and discards the heritage culture), *separation* (rejects the receiving culture and retains the heritage culture), *integration* (adopts the host culture and retains the heritage culture), and *marginalization* (rejects both the heritage and receiving cultures). Research that has used this categorical model in the study of acculturating immigrant youth has found that the integration category is associated with positive psychosocial outcomes (Berry et al., 2006; Klein et al., 2020).

Schwartz et al. (2010) have critiqued Berry's (1980) model and suggested an expanded multidimensional model to acculturation that addresses some inherent limitations. For example, Berry's (1980) categories do not discuss the difference between an individual who immigrates to a new culture with the same language as their culture of origin versus someone who has had to develop new language skills altogether (Schwartz et al., 2010). This distinction may yield different mental health outcomes based on factors such as racial discrimination and stress of learning a new language. Furthermore, it has been argued that most studies using Berry's (1980) unidimensional model are limited in their ability to point to what exactly is changing during the acculturation process (Schwartz et al., 2010). For example, large epidemiological studies have

included only single factors in their assessment of acculturation, such as being born in the country of the dominant culture versus elsewhere (Corral & Landrine, 2008), or years spent in the host country (Alegría et al., 2007). These studies point to an *immigration paradox* that suggests more acculturated individuals are associated with more problematic health outcomes. For example, Hispanics born in the United States and those who have spent a considerable amount of time in the United States are more likely to be diagnosed with psychiatric disorders than Hispanics born outside of the United States or who have immigrated more recently (Alegría et al., 2007). Berry's (1980) categorical models of separation and assimilation are limited in their ability to identify if changes were due to receiving-culture practices, loss of heritage-culture practices, or a mix of both. Subsequently, it is difficult to identify if individuals should be discouraged from acquiring practices of their new host country or be encouraged to preserve practices from their country of origin.

Multidimensional Acculturation Model

A multidimensional conceptualization of acculturation has been suggested to broaden the understanding of what aspects of identity and behaviour change during acculturation and to help understand phenomena such as the immigration paradox. The expanded model of acculturation integrates three cultural factors that have been identified as important in the literature: cultural practices, cultural values, and cultural identifications (Schwartz et al., 2007). Cultural practices are identified as language use, media preferences, social affiliations, and traditions, among various others, which can be best conceptualized as behavioural acculturation. Cultural values are belief systems associated with a cultural group, such as cultures that value collectivism as opposed to individualism. Cultural identifications refer to attachments to cultural groups and the positive feedback received from these attachments. Cultural practices, values, and identifications

comprise an individual's cultural identity (Rudmin, 2009; Schwartz et al., 2007). The multidimensional model of acculturation identifies these concepts as changing factors during the acculturation process and contextualizes them in both the heritage-culture dimension and receiving-culture dimension. This delineation gives the ability to specify if the outcomes are due to immigrants' acquisition of receiving-culture practices, loss of heritage-culture practices, or both (Schwartz et al., 2010).

Biculturalism

Biculturalism is an important concept when discussing the acculturation and mental health outcomes of immigrant and refugee groups that can be applied to adolescent development. Suárez-Orozco and Suárez-Orozco (2001) expressed that biculturalism allows young people an opportunity to integrate their sense of self by embracing traditional values while exploring future aspirations and competencies in their new culture. In the literature, the concept of biculturalism has been discussed as Berry's integration acculturation style (Berry et al., 2006). Research that has used this conceptualization of biculturalism has found that immigrant youth who adopt an integration style have better adjustment during resettlement and more favourable mental health outcomes (Kupper et al., 2018). Subsequently, biculturalism has been identified as a protective acculturation strategy for young people as they navigate bicultural stressors (Klein et al., 2020).

Adopting the multidimensional model in research, studies have found that biculturalism can take on two forms. For one, bicultural individuals may keep their heritage and receiving cultural identities separate, which may be due to incompatibility with conflicting elements between both cultures (Chen et al., 2008). For example, having cultural conflict on the appropriate levels of sexual openness or whether there should be any intimate relationships before marriage may result in having isolated relationships outside the home that cannot be

integrated into the heritage-culture stream. Having to reconcile such differences between two cultures can amplify the typical stressors experienced during identity formation for youth (Stroink & Lalonde, 2009). Conversely, other individuals may combine and integrate aspects of their two cultures in a “blended” form, which may not necessarily be an endorsement of both cultures but rather specific elements that are important to cultural navigation and identity development (Benet-Martinez & Haritatos, 2005). Blended bicultural individuals have been found to report higher levels of self-esteem and lower levels of psychological distress than those who have chosen to keep their heritage and receiving cultural streams separate (Chen et al., 2008). Schwartz and Zamboanga (2008) discussed the fact that a blended type of biculturalism seems to be associated with lower levels of acculturated-related stress because an individual possesses a toolbox that they can employ day to day based on the given cultural demand. As an individual practices and explores this repertoire of cultural skills and competencies, they are able to become better at activating the correct cultural schema based on their situation. As is discussed further, development of cultural competence is indicative of a favourable mental health outcomes for acculturating youth.

Most research has agreed that identifying the two dimensions of heritage culture and receiving culture are important considerations when studying the acculturation experience for immigrant and refugee youth (Oppedal et al., 2020). However, it has been suggested that conceptualizations of acculturation are still limited in being able to understand mental health outcomes holistically, as traditionally acculturation has been viewed as a stressful experience (Oppedal et al., 2020). Broadening the scope to include concepts of resilience and cultural competence is needed in order to understand that acculturation involves adaptive opportunities, discussed further in the next sections.

Resilience

Resilience is an important concept that can be applied to the study of immigrant and refugee youths' mental health. Resilience refers to the process an individual goes through as they are exposed to significant risk and adversity while managing to positively adapt (Luthar, 2003). Among children and youth, resilience has been understood as characteristics and competencies that the individual adopts to maintain positive functioning in challenging circumstances, such as accessing natural resources in their environment for support (Masten, 2013).

Studies have demonstrated that resilience among youth contributes to positive mental health outcomes, including lower levels of depression and anxiety (Luthar et al., 2000). For example, Wu et al. (2018) conducted a study among immigrant and refugee youth that explored whether resilience functions as a mediator in the association between acculturation and mental health. Drawing on research findings on favourable acculturation patterns, the study found that compared to integration-oriented youth, assimilation-oriented youth experienced poorer mental health as a result of lower resilience predicted by their acculturation pattern. Resilience was confirmed to be a mediator to mental health outcomes among all acculturation groups. Moreover, the authors asserted that consistent with previous literature, they found that the ability to endorse the new receiving culture is beneficial for youths' mental health when also accompanied with the continued development of their culture of origin identity. Wu et al. recommended the fostering of resilience and facilitating integration-oriented acculturation as public health strategies for this population.

Cultural Competence

Developing cultural competence in both their heritage culture and new receiving culture is an important part of bicultural identity development for immigrant and refugee youth. As

youth navigate their contexts, they will face demands typical of adolescence, such as identify exploration outside the home and practicing behaviours in various social settings. Cultural competence initially rests on being able to identify appropriate cultural behaviours and values for associated demands. Choosing appropriate behaviours and exploring values is a major part of bicultural identity development. Moreover, referencing Ramirez's bicultural model of culture change from 1983, Oppedal (2006) discussed how bicultural individuals develop ranging bicognitive capabilities as they experience acculturation. Having demands from the culture of origin and receiving culture contributes significantly to identity development in positive ways. These demands provide children and youth the opportunity to develop flexibility, become adaptable, and engage with others more empathetically (Oppedal, 2006). As bicultural individuals explore aspects of their identity, they develop working models that encompass culture-specific skills and interpersonal strategies. These working models are the foundation of culture competence development; integrating cultural knowledge and skills into a behavioural and cognitive toolbox that can be competently used in sociocultural settings (Oppedal, 2006). For example, youth may need to present with more collectivist values at home and engage in cultural traditions that strengthen intergenerational bonds, while demonstrating individualistic drives in education or sports outside the home, which would set them up for success in the receiving culture.

The development of cultural competence is intrinsically linked to the developmental tasks associated with adolescence (Jugert & Titzmann, 2019). As youth navigate their world and face bicultural stressors, they will be experiencing them from a developmental perspective by way of changes to their affective, cognitive, and social domains.

Acculturation and Adolescent Development

When considering the need to develop new skills and capabilities in order to navigate cultural demands, the adolescent developmental stage is identified as an important milestone where youth can explore new identities and behaviours. This stage is characterized by physical and cognitive maturation that young people experience as they develop more independence, broaden their relationships, and search for their identity outside the home (Jugert & Titzmann, 2019). This stage may be experienced in unique ways. Immigrant and refugee youth will negotiate their autonomy and level of freedom with adults while continuing to maintain emotional ties in order to receive intergenerational support. Additionally, they may be put in positions where they have increased family obligations due to immigration, such as language brokering and household management (Jugert & Titzmann, 2019). It has also been suggested that acculturation changes cannot be distinguished from ontogenetic developmental changes (individual changes attributed to experiences with the natural environment), because acculturation consists of social, emotional, and cognitive development within bi- and multi-cultural contexts (Oppedal, 2006). Rather, it is helpful to understand that developing cultural competence with the culture of origin will be different from developing cultural competence in the new receiving country and may take on conflicting developmental trajectories. Youth can explore and decide what skills and attributes are important to them in their respective contexts and how to engage appropriately in each culture.

In sum, adolescent long-term well-being is impacted by the ability to successfully meet important development markers associated with identity development (Kagitcibasi, 2005). Identity exploration and autonomy are key aspects of adolescent development, and developmental markers during adolescence, such as identity formation, are influenced by one's

cultural experiences (Yoo & Miller, 2007). When considering the importance of exploring identity during adolescence and developing cultural competencies, counsellors can consider biculturalism as a conceptual model for intervention that validates and reaffirms a person's identity through recognition of both cultures, and that promotes resilience through development of cultural competence. Covered in more detail in later sections, supporting immigrant and refugee youth in the development of their bicultural identity will be an anchor in therapy by exploring relevant cultural identity factors influencing the client's life. First, the next section covers how clinicians can assess for risk factors during the migration journey as well as identify protective factors already in place.

Historical Assessment and Migration Journey

A systematic inquiry into the client's migration journey along with appropriate follow-up on indicators of psychological and family functioning will allow clinicians to identify problems in adaption in a timely matter (Kirmayer et al., 2011). It is important to understand the migration journey of clients and assess for the various factors that pertain to psychosocial adjustment during resettlement. Investigations into the common mental health issues among immigrant and refugee youth have identified the pre- and post-migration (resettlement) stages as distinct experiences with their own respective risks and protective factors contributing to mental health outcomes (Guruge & Butt, 2015; Kirmayer et al., 2011). The next sections cover how counsellors can conceptualize and assess the migration journey and directly inquire about client experiences. Counsellors can then incorporate information into treatment planning by focusing on relevant risk and protective factors that contribute to mental health outcomes.

Premigration and Migration Assessment

The premigration period for immigrant and refugee groups typically involves disruptions to social roles and support systems (Kirmayer et al., 2007). Guruge et al. (2015) used a community-based approach in Toronto to interview newly arrived refugee youth from Afghan, Karen, and Sudanese backgrounds. Among the 57 newcomer youth, the researchers identified premigration risk factors to be associated with poor mental health outcomes. Many refugee youth expressed stories of having witnessed violence through war and acts of torture, targeted persecution, forced labour, and family separation. Participants discussed the impact these premigration stressors had on their mental health, which included phenomenological themes of worry and fear, sadness, depression, and going “crazy,” characterized by disorganized thinking (Guruge et al., 2015).

During the migration period, immigrants and refugees can be exposed to extended time at refugee camps, experience distressing uncertainty around gaining acceptance in the receiving country, and encounter situations that can expose them to prolonged violence (Silove et al., 2000). Displaced individuals who experience camps or detention centres often develop a sense of powerlessness that later leads to depression and anxiety (Silove et al., 2007). Forced displacement due to civil unrest often causes an influx of migration into neighbouring safe zones that may consist of an in-between period for eventual immigrants and refugees. The region of the former Yugoslavia is an example of such patterns in migration experience and of risk factors associated with displacement. Yugoslavia encompassed multiple states, now independent nations, and the civil war that ensued caused hundreds of thousands of people to flee to neighbouring regions. Porter and Haslam (2001) conducted a meta-analysis that looked into the effects of specific stressors faced during civil unrest and compared findings between refugees and

nonrefugees from the former Yugoslavia. Consistent with refugee status, refugees were found to have higher rates of war-related trauma. Additionally, the study found that psychosocial consequences of forced displacement varied based on type of traumatic factors, such as locus of displacement, type of accommodation in exile, and degree of war exposure (Porter & Haslam, 2001).

A major risk factor for poor mental health outcomes is when children are separated from their caregivers during migration (Jakobsen et al., 2017). Unaccompanied adolescents are more likely to be exposed to premigration trauma, as well as show higher levels of depressive symptomology following resettlement, when compared to accompanied minors (Derluyn et al., 2009). In their literature review, Huemer et al. (2009) found that unaccompanied minors presented with higher levels of posttraumatic stress disorder (PTSD) symptoms when compared to accompanied minors and minors from nonrefugee populations. PTSD symptomology is indicative of potentially more severe traumatic experiences premigration and should be clinically assessed with the purpose of targeting appropriate intervention and referral (Huemer et al., 2009).

Protective factors during the premigration stage have been found to mediate the relationship between negative experiences and future-adjustment. Rousseau et al. (1998) conducted a study using unstructured and semistructured interviews with Somali unaccompanied refugee youth who arrived in the cities of Toronto, Montreal, and Ottawa between the ages of 13 and 18 years old. Rousseau et al. (1998) found that individual youth within the collective culture were protected through their shared meaning of separation, which was associated with their nomadic identity. This cultural meaning helped protect individuals from the patterns of displacement and unrest during premigration. It is important to consider that just because

individuals may have experienced events related to forced displacement or violence, they have necessarily been impacted in a traumatic way. A similar study with Cambodian refugee youth demonstrated that parents' preservation of traditional values seemed to mediate the traumatic events experienced during premigration (Rousseau et al., 2003). Exposure to violence was mediated by the concept of cultural resilience, and subsequently did not impact adolescent psychosocial adjustment negatively in the receiving country (Rousseau et al., 2003).

In sum, premigration trauma has been found to predict poor mental health outcomes, including PTSD. Additionally, mental health outcomes can be linked to migration trajectories and adversity experienced, which calls for an inquiry into clients' experiences. However, resilience factors mediate the relationship of risk factors and can influence adjustment during resettlement.

Resettlement and Postmigration Assessment

In the context of resettlement, newly arrived immigrant and refugee youth often experience uncertainty about the future, intergenerational conflict, and discrimination, to name a few psychological risk factors (Betancourt et al., 2015). Inman et al. (2007) conducted a study for the purpose of exploring common psychological struggles experienced between children and their parents during resettlement. They interviewed 16 first-generation Asian Indian mothers and fathers about the influence of immigration on retention of their own ethnic identity and their ability to promote a sense of ethnic identity in their second-generation children. The study identified themes regarding feelings of isolation and loss, compounded with lack of identification with the new country, which subsequently had a negative impact on sense of self for the participants' children. Additionally, parents reported that they struggled to transmit cultural

values and identity onto their children due to barriers in society, such as discrimination and lack of family supports (Inman et al., 2007).

Newcomers often report a significant source of stress around uncertainty about citizenship and long-term security after they arrive in the receiving country (Inman et al., 2007). Additionally, Wilson et al. (2018) suggested that policies and processes mandated by the Canadian government seem to worsen mental health concerns during resettlement for refugees. In their study, specific stressors reported by participants included delays and complications in processing applications, paperwork errors pertaining to language barriers, and no agency in deciding what city they will be resettled into. These challenges were found despite resettling in Canada being viewed as a positive milestone (Wilson et al., 2018).

Discrimination experienced in the receiving country is another postmigration risk factor that influences long-term mental health outcomes. In their mixed method study of 220 newly arrived refugees from Sudan, Simich et al. (2006) found that refugee youth faced continued stressors during their resettlement process and economic hardship pertaining to family poverty. Additionally, these refugee youth faced social isolation, racism, and discrimination as they went through the process of acculturation. Similarly, a study of 131 refugee youth from the Middle East who were residing in Denmark found that discrimination faced in the receiving country was strongly associated with internalizing problems, which impacted social adaptation (Montgomery & Foldspang, 2007). It is important to note that immigrant and refugee youth of colour often experience discrimination and racism within multiple levels of society. As is discussed in later sections, discrimination is a major risk factor, in particular for boys, when attempting to develop a bicultural identity and make appropriate adaptations in the receiving country.

With regards to resilience, newly arrived immigrants and refugees often arrive with a sense of hope for the future as they begin to resettle (Wilson et al., 2011). An exploratory study done in Australia that looked into the experiences of refugee youth identified positive adjustment among participants early on in resettlement, despite hostility from government policies (Earnest et al., 2015). The strategies adopted by the refugee youth that promoted resilience were learning the English language, engaging in sports, furthering their education, and seeking employment. All participants reported having a positive education with teachers. Additionally, support networks were identified through social activities that revolved around friends, family, and religious groups (Earnest et al., 2015). The results of Earnest et al.'s (2015) study highlight the important fact that refugee youth who have experienced various risk factors are resilient and want to succeed in the receiving country.

The social determinants of health are nonmedical factors that influence health outcomes, and research has suggested that social determinants can be more important than health care or lifestyle choices in influencing long-term well-being (Government of Canada, 2020). In their review of social determinants of mental health among refugees, Hynie (2017) suggested that focusing on postmigration stressors, as opposed to premigration trauma, is important to refugee mental health because of the immediacy of resettlement needs. Consequently, intervention needs to be holistic and focus on factors that address conditions of refugees' lives. These postmigration factors that influence functioning in resettlement involve housing, employment, social supports, asylum-seeking, and discrimination in the receiving country (Hynie, 2017). Similarly, Shakya et al. (2010) conducted a report on the social determinants of mental health for immigrant and refugee youth and identified that the resettlement challenges and barriers closely linked to the mental health outcomes of youth, including discrimination and exclusion, are predictors of long-

term health outcomes. The authors suggested proactively addressing the determinants of newcomer youth mental health as well as making mental health services more sensitive and accessible to the needs of this population.

In sum, although premigration trauma can be a strong predictor of mental health outcomes for immigrant and refugee youth, the postmigration context can be an equally influential determinant of their mental health outcomes. Focusing on fostering protective factors in the client's natural setting can increase resilience and subsequent positive adjustment. Consequently, common challenges to accessing and receiving mental health care among newly arrived immigrants and refugees should be addressed at the forefront of treatment in order to undertake a holistic mental health approach. These challenges can be addressed by establishing safety and trust in the counselling environment, as well as being able to identify common barriers for the client inside and outside the counselling alliance, covered in the next section.

Addressing Challenges

Establishing Trust and Safety

In counselling, *working alliance* describes the collaborative relationship between therapist and client, in which both parties hold the goal of achieving positive change for the client (Norcross & Lambert, 2011). The working alliance has been found to be the main curative force in counselling alongside client factors (Norcross & Lambert, 2011). The strength of the working alliance is of central importance when counselling immigrant and refugee youth, and it is primarily established through the development of trust and safety (Patel & Reicherter, 2016). Murray et al. (2010) highlighted the importance of using empathy and positive regard when listening to the migration story of young people, as well as being able to reflect an understanding of their experience and reasons they are seeking counselling. Emotional containment is of

particular importance when assessing and discussing the trauma and conflict youth may have experienced (Warr, 2010).

Moreover, Guregård and Seikkula (2014) discussed the importance of establishing safety in the counselling environment with refugee clients due to traumatic events they may have endured, which may be contributing to a presentation of paranoia and hypervigilance around others. Immigrants and refugees who leave their homeland in search of a better life often have an experience of disempowerment and mistrust towards systems that hold authority and power (Hundley & Lambie, 2007; Scuglik et al., 2007). Visible racial minority groups may mistrust service providers who represent the dominant group due to their experiences of marginalization in the receiving country (Scuglik et al., 2007). In order to establish an effective treatment plan with immigrant and refugee youth, counsellors should prioritize building trust and rapport with their clients, a process that may take longer than usual (Ehnholt & Yule, 2006).

Addressing Barriers

Language

For mental health practitioners, being able to effectively communicate with clients is a crucial tool for both the assessment and diagnosis of presenting concerns, as well as relationship development with the client (O'Hara & Akinsulare-Smith, 2011). However, for clients who are not able to proficiently communicate in English, verbal communication is a major barrier in accessing and receiving mental health care (O'Hara & Akinsulare-Smith, 2011). Language barriers in counselling have resulted in immigrants and refugees perceiving their care as dissatisfying, with some studies finding inaccurate diagnosis and treatment for these populations (Hansen & Cabassa, 2012; Kirmayer et al., 2003). Communication needs to be adapted to the

ability of the client, especially when going over the informed consent process (College of Alberta Psychologists, 2019).

In the case of minors, it is important for counsellors to consider the process of obtaining informed consent from parents or guardians. Even if a youth may be proficient in English, the parents or guardians may not be. With ranging linguistic abilities among newcomers and their family members, counsellors should note that clients may prefer that services be delivered in multiple languages (Ellis et al., 2013). This preference can be supported with an interpreter or cultural broker such as a member from the cultural community (Nadeau & Measham, 2005). The need for trained translators in health services is high (Guruge & Butt, 2015). Obtaining a translator may be difficult, and provision of translators will continue to be a major milestone health services need to reach to offer adequate services to immigrant and refugee families.

Language skills can affect immigrant and refugee youth in other ways. When children and youth develop language ability faster than other family members, they may become interpreters for their families and be expected to take on responsibilities in situations that are not typical to adolescent development (Umaña-Taylor, 2003). Furthermore, language barriers at school are a major obstacle for educational success and positive adjustment for immigrant youth (Horswood et al., 2019). Mental health practitioners may need to advocate for their clients for incorporation of professional supports in the school setting and increased communication with teachers that can help build an integration of services (Fazel et al., 2016).

Informed Consent

Situations may occur where a young person is seeking mental health services but is unable to access them because they have not received consent from their parents or guardians. In order to receive counselling services, young people under the age of 18 (minors) must receive

consent from their legal guardians, and then the minor can then give their assent for services (College of Alberta Psychologists, 2019). This legal standard can become an obstacle for young people, particularly for immigrant and refugee youth. Those who want to access mental health services are often reluctant or unable due to the stigma associated with seeking help and receiving a mental diagnosis perpetrated by their respective cultures (McCann et al., 2016). Clinicians can support the client in accessing and receiving care by declaring them a mature minor in situations where it is appropriate (Colucci et al., 2015). In Canada, mature minor case law allows young people under the age of 18 the personal autonomy to exercise their rights and consent to medical services, including mental health services. This law was created in recognition of youth developing greater ability to make independent choices regarding their well-being as they age. The Supreme Court of Canada ruling in *A. C. v. Manitoba* (2009) found that minors may exercise autonomy in making decisions about their medical treatment if they have the sufficient cognitive skills and understanding to appropriately assess what is being proposed to them (College of Alberta Psychologists, 2019). These choices should be protected by confidentiality. In Alberta, psychologists hold the responsibility for determining whether a minor is a mature minor. According to the courts, a minor must be able to understand the information that is relevant in making the decision, which includes an appropriate appreciation of the reasonably foreseeable consequences of the decision or lack of a decision (College of Alberta Psychologists, 2019).

The psychologist needs to consider a variety of factors before declaring a minor a mature minor. Factors include the age and maturity of the minor, the nature of their relationship with parents or guardians (level of independence versus dependence), and the ability to understand the type of and complexity of the proposed treatment (College of Alberta Psychologists, 2019).

Psychologists will need to assess if the young person has the intellectual capacity to understand the relevant information with its potential consequences. Moreover, psychologists should consider the emotional and mental state of the client as it pertains to their mental health and decide whether a psychological condition is present that may be leaving them vulnerable. Additionally, a consideration of the broader social impact is necessary when declaring a youth a mature minor by exploring what impact their decision-making will have on family and social affiliations (College of Alberta Psychologists, 2019). Psychologists should document the pertinent details of the discussion had with the mature minor.

Socioeconomic Conditions

Counsellors should be prepared to understand the client's socioeconomic condition and how it can affect the treatment process. Professionals have noted that new refugees may have urgent needs such as living-situation difficulties, lack of access to community support, and even food insecurity that need to be addressed (Nadeau & Measham, 2005). Financial issues are among the most common stressors for immigrant and refugee families, a factor that has been shown to affect their children's adjustment levels (Gilbert et al., 2017; Yu et al., 2020). Some studies have found that depression and anxiety among this population are directly associated with financial strain and unemployment in the receiving country (Lindert et al., 2009). Furthermore, young refugee women are often in a position of heading the household and needing to find employment, with women heading most single-parent refugee families (United Nations High Commissioner for Refugees, 2020). Mental health counsellors should have knowledge of services and programs that can help immigrant and refugee clients with urgent resettlement needs, then take an advocacy role, if needed, or provide referrals for additional services (Bäärnhielm et al., 2017; Warr, 2010).

Stigma

The stigma surrounding mental illness with various cultures can be a major barrier to seeking mental health services. In fact, the stigma associated with help-seeking can be perceived more negatively than enduring mental health symptoms (Ellis et al., 2013). Additionally, Henderson et al. (2014) found that when individuals internalize the social stigma associated with mental illness, it can worsen mental health symptoms over time. Consequently, stigma is an important issue to address when counselling immigrant and refugee youth. Rousseau et al. (2004) suggested that in order to diminish the effect of stigma on minorities receiving help, it would be helpful to integrate mental health services with other more acceptable forms of support. It has been suggested that counselling services available in primary and secondary education settings would be one effective strategy for refugee and immigrant youth (Rousseau & Guzder, 2008). The education system is one setting that is viewed as acceptable because education attainment is perceived as an important part of future success in the receiving country (Rousseau & Guzder, 2008). Moreover, the school setting can promote easier access through already-established communications with teachers. Youth would not have to commit additional hours outside of school, and families would be more likely to be accepting of professional help in an educational setting. Furthermore, community cultural organizations and outreach programs can be used as an informational hub on mental health services that serve as a promotion tool for mental health check-ups (Correa-Velez et al., 2010).

Im et al. (2017) discussed how important it is to develop a culturally relevant framework in mental health assessment and treatment in order to encourage wider use of services, which involves developing an understanding of common cultural idioms of distress. Cultural idiom of distress (CID) refers to culture-specific expressions, symbols of emotional suffering, or

culturally acceptable ways for individuals to communicate distress (Dein & Illaiee, 2013). Finding culturally acceptable ways to communicate distress is an important part of reducing stigma. In their study, Im et al. recruited participants from the Somalian community in Kenya who had immigrated there with refugee status. Using key informant interviews and group focus interviews, the authors identified seven words that symbolized ranging conceptualizations of mental health problems and symptoms, including mental states associated with stigma. Im et al. suggested that counsellors should strive to become aware of cultural idioms in order to mitigate stigma.

Mental health assessment and interventions should approach mental illness in terms of subjective experience and symptom descriptions, whether psychological or somatic (Im et al., 2017). One strategy to help counsellors and clients talk about mental health difficulties is to use the cultural formulation interview (CFI) within the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, 2013). The CFI is a set of 16 questions that clinicians may use to obtain information during a mental assessment about the impact of culture on key aspects of an individual's clinical presentation (American Psychological Association, 2013). Answers can help counsellors appreciate how culture has influenced the client's worldview and perception of mental health, as well as create a common language and understanding to anchor with the client as both move forward with clinical management.

In the following sections, I discuss how to adopt an intervention approach that focuses on bicultural identity exploration. Exploration of bicultural identity factors during the adolescent development stage will be an anchor in the therapy process regardless of presenting symptomology, after the important considerations discussed above have been addressed.

Intervention Approach

Researchers and counselling therapists have called for a shift away from emphasizing the experiences and symptoms of trauma, toward a more positive and holistic approach that highlights the inherent strengths and coping abilities of immigrants and refugees (Murray et al., 2010; Papadopoulos, 2007). Additionally, it has been suggested that counselling professionals should adopt a strength-based approach when working with immigrant and refugee youth, focusing on the innate resources and abilities a young person brings into the counselling environment (Marshall et al., 2016; Miller et al., 2019). Although specifically for refugee youth the risk of mental health difficulties is significant based on their premigration risk factors, they also possess strengths that can help them adjust successfully in their host country (Yakushko et al., 2008). Additionally, studies have declared that a focus on protective factors and resilience contributes to a positive mental health trajectory for refugee youth (Betancourt et al., 2015; Ehntholt & Yule, 2006). Similar findings have been asserted when studying immigrant families, where it has been recommended that mental health treatment be catered towards immigrant families' cultural protective factors in order to prevent various mental health disorders, including PTSD, along their resettlement journey (Cardoso & Lane, 2016; Theron et al., 2011).

Omizo et al. (2008) expressed that safe exploration of a bicultural identity in immigrant youth can serve to increase their resiliency. Stroink and Lalonde (2009) discussed how having an awareness of unique personal characteristics and cultural characteristics among immigrant youth in the counselling environment is a strong predictor of success in forming a bicultural identity. Similarly, Kassan and Sinacore (2016) discussed that counsellors need to be open to taking time to discuss the various influences on the client's cultural identity and how the client understands their experience. There are important cultural identity factors that counsellors should address in

their work with clients; specifically, the role of parent–child relationships and intergenerational influences, as well as gender socialization inside and outside the home. By exploring these areas with clients, counsellors will be able to support youth in their bicultural identity development and subsequently foster resilience in them.

Intergenerational Influences

Intergenerational factors can be understood from a cultural psychology perspective. Chiu et al. (2010) discussed how cultural members are active participants in the construction of their identity. Individuals absorb cultural practices from their parents, extended family members, and community members, but will act out these customs and behaviours in a way that may be distinct from their larger cultural group. This tendency is relevant in understanding that exploration of intergenerational influences is important in so far as the client’s subjective interpretation is also honoured in the process. With the goal of developing a strong bicultural frame of reference to more effectively navigate stressors, counsellors can assist their clients in exploring intergenerational influences that contribute to their individual development and adjustment.

Immigrating to a new country will create differences between children and their parents, including conflicting worldviews where the youth must balance multiple demands from culture of origin and the new host culture (Zaidi et al., 2014). Salami et al. (2017) shared that “an acculturation gap brought about by the value mis-alignments between parent and child creates tension within the family and can distort the cognitive home environment for transnational families” (p. 28). Counsellors who see immigrant and refugee youth should be aware that their clients’ struggles may be associated with acculturation gaps within the home. Schwartz et al. (2010) studied the differences in acculturation between Cuban youth and their parents, and the impact those differences had on the younger immigrants’ mental health. Strong acculturation

gaps led to significant family conflict as well as a higher risk of conduct disorder and substance abuse for the child. Youth who experience these acculturation gaps within the home can either overidentify with their culture of origin, overidentify with the mainstream culture, or become alienated from both their families and mainstream peers (Schwartz et al., 2010). Furthermore, the immigration experience itself has been shown to create rifts between parents and children as they go through the acculturation process. For example, among Asian Canadian immigrants, decreased parental communication and emotional distancing from their children due to acculturative stress were associated with symptoms of depression and anxiety for their children (Moon & Ruiz-Casares, 2019).

Regardless of the level of direct family involvement in the counselling process, Bettman and Digiacommo (2021) discussed the importance of exploring parent–adolescent relationships during therapy. The authors pointed out that practitioners should look into what aspects of a youth’s surrounding culture are responsible for their personal strengths because youth will use intergenerational support to enhance their resilience during resettlement. For example, Piña-Watson et al. (2015) found that female adolescents of Mexican immigrant descent who were supported by a positive female caregiver were able to deter the negative impacts of acculturative stress more effectively and improve their overall well-being. The involvement of a female caregiver role was valued as a source of empowerment in the home, helping to shape the younger women’s identity. Additionally, strong relationships with extended family members have shown to be a protective factor for immigrant youth, as cultural support networks increase a youth’s sense of identity by having a safe base to manage bicultural stressors (Sano et al., 2015).

Acculturation gaps can also create an opportunity for children to develop cultural competence, as

children are often better prepared to deal with the new culture's demands and may need to lean on their independence in this area (Frazer et al., 2016).

If there is a strong disconnect at home between parents and children, then counsellors can help immigrant and refugee youth connect with their culture of origin through positive relationships in the community of the host country, such as religious leaders and mentors, which may serve as a protector factor against negative adjustment at home (Rossiter & Rossiter, 2009). Research with refugee Cambodian and Vietnamese families has shown that interventions targeting youths' perception of intergenerational cultural gaps helped them enhance strategies to manage conflict with this stressor and strengthen bonds with parents that may aid in preventing problematic behaviour (Choi et al., 2007).

In sum, therapists who are counselling immigrant and refugee youth need to understand family context and family history relating to the migration journey in order to establish both risk and protective factors that will contribute to adjustment. Resilience can be promoted by extracting intergenerational strengths and supports, such as role models who promote empowerment of the youth. Acculturative gaps can contribute significantly to alienation and family conflict, or they can be used to create more skills related to autonomy through mature communication with parents.

Gender Socialization

Research on immigrant and refugee youths' acculturation process has demonstrated the influential role gender and socialization play in positive adjustment and mental health outcomes during resettlement (Hilario et al., 2014; Kupper et al., 2018). Recently, Klein et al. (2020) discussed how immigrant youth cope with acculturative stress by adopting beliefs, attitudes, and behaviours related to both their culture of origin and the host culture, harnessing protective

factors from both cultures in order to manage bicultural stressors. Based on Berry's (1980) bidimensional model, Klein et al. (2020) focused on gender-related differences with the four identified acculturation patterns (assimilation, separation, integration, and marginalization). The study found that boys scored higher on separation and marginalization compared to girls, with girls more often showing an integrative acculturation pattern. However, the study found that regardless of gender, marginalization contributes to higher levels of anxiety and depression (Klein et al., 2020). These findings can be instructive for mental health practitioners: Counsellors can identify that weak bonding to peers and members of the host culture while distancing from culture of origin will contribute to social isolation and directly impact identity development, contributing to depressive and anxious symptoms. Furthermore, specific gender differences discussed in the above findings can be explained by different experiences during the resettlement processes. For example, male youth are more likely to experience discrimination in the host country, causing them to distance from the host culture (Lazarevic et al., 2018).

Boundaries between ethnic identities appear to be less fluid and less permeable for boys than for girls (Hilario et al., 2017). Immigrant boys of colour specifically can struggle with engagement in school, which is in part due to the perception that they are unwelcome in mainstream society because they look and speak differently (Hilario et al., 2017). Counsellors should be aware that men seem to have more difficulty in assuming bicultural competencies and making successful bicultural adjustments. Studies have found that issues surrounding employment and social status can be especially difficult for refugee men who carry traditionalist beliefs regarding gender role expectations because it contradicts their sense of self-worth and identity (Colic-Peisker & Tilbury, 2007). Likewise, immigrant boys often have hopeful outlooks

on their future and a positive perspective of their host country but consistently struggle with a feeling of second class-citizenship (Hilario et al., 2017).

A study with refugee youth in Canada reported similar findings regarding compounding forms of discrimination related to language proficiency, newcomer status, and being part of a visible minority being negatively associated with their sense of hopefulness and empowerment (Edge et al., 2014). Marginalization for men seems to be the main contributor to self-insecurity, which leads to anxious-depressive symptomology. Counsellors can feel confident in moving forward with goals and interventions that target a man's sense of bicultural development. This focus will involve perceptions of discrimination for young people as they navigate school and other social settings, and strategies that may confront or externalize feelings of oppression (Hilario et al., 2017).

In their Canadian study, Tastsoglou et al. (2014) asserted that mental health clinicians lack familiarity with various gender-role expectations and cultural norms among immigrant and refugee populations. Gender roles are an important aspect of culture that influence the client's worldview and identity, as such it is integral that counsellors understand them. An important reality regarding gender socialization inside the home is that young people's development is influenced by levels of supervision, monitoring, and control. Young women typically receive higher supervision from family members with more restrictive standards in regard to cross-gender relations (Alizadeh et al., 2010). The role of supervision of gender expectations has both positive and negative effects. Zhou and Bankston's (2001) research with immigrant Vietnamese girls showed that high levels of parental control contributed to educational success. This finding asserts the idea that although gender-specific demands and expectations can be compounded

stressors in identity development for girls, they can also be a protective factor by promoting engagement in school, which contributes to an integrative acculturation pattern.

However, a common area of concern for young immigrant and refugee women when entering counselling is rules of honour within the family and the associated risk of disclosure of secrets from family members (Alizadeh et al., 2010). This is an important consideration for young females when attempting to support their development of a bicultural identity. Alizadeh et al. (2010) reported that the reason behind keeping secrets and having a double life within and outside the home is based on the search for autonomy and identity among acculturated female youth. Additionally, the authors found that the stress around concealing secrets from family members was motivated by fears of being isolated, abandoned, or even violently perpetrated against. Moreover, the clinicians in the study reported that empowerment was the key to intervening with this chronic state of stress. Empowerment included offering instructions about bodily function, providing a language for sexual matters, taking sides with the young woman, and encouraging her to take control of her own body (Alizadeh et al., 2010)

In sum, exploring facets of a bicultural identity involves amplifying resilience and protective factors embedded in the youth's culture while mitigating risk factors by focusing on inherent skills and resources to manage ranging bicultural stressors. Specific risk factors discussed above, such as acculturative gaps between child and parent, can contribute to poor mental health outcomes for immigrant and refugee youth. Counsellors can target intergenerational factors and gender identity factors among adolescent youth in order to develop interventions that target a strength-based identity development.

Counsellor Skills and Competencies

The work done in the counselling environment can be successful only in so far as the counsellor commits to the ongoing process of developing multicultural competencies and adhering to the highest standards of ethical practice. The counselling literature has pointed to the fact that there are distinct skills and competencies counsellors need to incorporate and build on in their career if they hope to attend to clients of diverse cultures (Arredondo & Perez, 2006; Collins & Arthur, 2010; Sue et al., 2009). The unique combinations of identity factors related to migrating youth make the attempt at multicultural counselling a complex approach rather than a generalized one. In the following sections, I discuss the specific competencies counsellors need to focus on to develop a multicultural practice. First, I discuss how counsellors can situate their counselling theories under a multicultural framework.

Multicultural Theory of Work

The goals of a multicultural theoretical orientation are to empower individuals and groups by honouring how their cultural experience shapes who they are and their goals for the future (Oppedal, 2006). To become a culturally sensitive counsellor, individuals need to reflect on traditional theories of change and approaches to healing, and how they may fit in terms of counselling diverse groups. The psychology field recognizes that Western counselling approaches hold ethnocentric assumptions that may not be a fit for clients from diverse backgrounds (Sue et al., 2009). In order to use traditional theoretical approaches with diverse clients, clinicians must examine imbedded assumptions and reflect on whether a given approach would be a good match for their clients (Collins & Arthur, 2010). For example, traditional viewpoints of lack of client progress often label the problem as the client's inherent resistance. Client resistance can be better conceptualized as a potential mismatch between client and

counsellor regarding treatment goals or a rupture in the working alliance (Comas-Diaz, 2012). Here, the counsellor holds the responsibility for monitoring and evaluating the therapeutic relationship and is in a position to reflect on what would be a better match for the client in order to optimize outcomes.

Furthermore, in order to pivot towards a multicultural orientation, clinicians are asked to adopt a position of “knowing that they don’t know” and place their focus on the relationship development with client as a source of information (Comas-Diaz, 2012). A stance of not-knowing allows the client the opportunity to teach the clinician about unique insights and perspectives on culture, mental health, and well-being. From this position, counsellors will be better equipped to respond to the client’s cultural needs.

Postmodern social-constructivist theories give clinicians an effective theoretical guide to integrate into their multicultural practice. The constructivist approach also calls for a not-knowing conceptual stance, keeping preconceptions to the side while the client is placed as the expert of their own lives (Jong & Berg, 2001). For example, solution-focused therapy (SFT) and narrative therapy are both constructivist approaches that attend to the client’s way of viewing problems and situations (Metcalf, 2017). Whereas SFT concentrates on new solutions for a problem rather than on the origin of the problem, narrative therapy examines a client’s self-narratives to learn how they view their lives (Metcalf, 2017). Meyer and Cottone (2013) expressed that SFT is an approach sensitive to culture, as it is client centred and takes into consideration the client’s worldview and language. Although the research Meyer and Cottone conducted was specific to American Indians, these authors shared that the solution-focused approaches were successful due to embracing client diversities related to healing. Immigrant

youth can benefit from this culturally inclusive approach, as they would be encouraged to embrace aspects of the cultural identities that they believe are working to their advantage.

White and Epston (1990) introduced narrative therapy, and in their approach, clients are invited to share their lived experiences and work with the counsellor to form more productive thoughts and beliefs related to the stories they hold about themselves. In relating narrative therapy to working with Chinese children, Chen (2012) suggested that it allowed for clients to share their cultural experiences without being judged. Chen also expressed that because narrative therapy can be practiced in many ways, including family and individual therapy, this approach allows children, who are not familiar with therapy, to become more comfortable with the practice.

Culture can impact every aspect of mental health, including how individuals interpret and react to symptoms, how they begin to explain their sensations and feelings, and how individual patterns of coping and help-seeking behaviours present (Sue et al., 2009). The literature indicates that immigrant patients within primary care who present with mental health problems often present with issues related to physical complaints. Kirmayer (2004) found that depressive and anxious symptomology can commonly present as culturally specific bodily idioms of distress. In Kirmayer's study, physicians found that unexplainable symptoms such as general pain or fatigue can be common representations of mental health issues. Kirmayer et al. (2011) asserted that maintaining flexibility and harnessing a client-centred approach to understanding the presenting concerns of diverse clients will not only help clients feel safe and secure about exploring mental health challenges, but also will place the clinician in a position where they are able to learn how a particular culture may explain an illness.

Counsellor Self-Awareness

In their framework for enhancing multicultural competencies among counsellors in Canada, Collins and Arthur (2010) discussed counsellor self-awareness as a core competency. Psychologists are called to explore and reflect deeply on who they are as cultural beings in order to be prepared to share a cultural environment with another client. Counsellors can appreciate their clients' bicultural identity exploration after they have self-reflected on personal and cultural identity factors that impact their own worldview (Collins & Arthur, 2010). Self-reflection will help practitioners in two ways. First, it will challenge counsellors to recognize where assumptions and biases come into play in their assessment and judgements of others. Second, they will begin to appreciate what aspects of their personal and cultural identity differ from the person sitting across from them, which places the counsellor in a position that is conducive to the acceptance of diversity (Collins & Arthur, 2010).

Similarly, counsellors can reflect on their views on topics such as religion, immigration, and family values in order to become more aware of topics that evoke strong feelings or beliefs. In doing so, they are more likely to form supportive therapeutic relationships with clients, which promote cultural exploration and are void of cultural infringement. In their study of immigrant adolescent female clients, Kassan and Sinacore (2016) found that self-awareness was a necessary trait for counselling to be considered culturally competent. Demonstrating counsellor self-awareness promoted clients to feel open and safe in exploring various cultural factors pertaining to identity, because the counsellor was able to attend to changing needs within the counselling session.

Additionally, Kassan and Sinacore (2016) suggested that continued self-reflection is an effective framework for counsellors to adopt in their ongoing professional development, as it will

assist them in pivoting and adapting to various client needs. I believe this point is important to consider when working with immigrant and refugee youth. The objective is to become aware of oneself in relation to another cultural being and to be in a position where one is able to respond to any personal biases and assumptions that come up as a practitioner. Counsellors must consistently reflect on their cultural identities in relation to clients, as these examples of cultural shifts inevitably influence how these identities are subject to change with respect to counselling relationships.

Cultural Awareness of Others

Throughout this paper I have discussed the importance of addressing and exploring multiple cultural identity factors common among cultural groups by anchoring on the personal story and developmental stage of the client. A client-centred approach places the client in an expert role, informing the counsellor of their multicultural experience. Exploring the differences and similarities between the values of counsellor and client can serve as a relationship-building tool and subsequently influence counselling outcomes in positive ways (Consoli et al., 2008). However, mental health practitioners are still responsible for their own development and need to commit more time outside their professional hours to increase knowledge of other cultural realities if they hope to develop multicultural competence (Collins & Arthur, 2010). Counsellors can become actively involved with members outside their own cultural group and, more important, outside the dominant cultural group experience, by finding opportunities to engage in community events, attend social and political functions, or become involved in celebrations and traditions (Sue et al., 2009). Professionally, practitioners can advocate for training opportunities through organizations or sign up for further education through outside professional associations (Collins & Arthur, 2010).

Implications for Counselling Psychology

The influential role counselling professionals possess as experts in their respective fields, as well as the ethical obligation to ensure the client is receiving optimal care, results in the need for mental health services to incorporate the client's broader societal realities. Consequently, counsellors should strive to be an advocate for clients and have knowledge of their social conditions in order to offer targeted and appropriate interventions (Kirmayer et al., 2011). This knowledge includes the systematic processes and policies of immigration and citizenship, which can readily change within a country's jurisdiction. Immigrant and refugee families are directly impacted by these policies, which can be a strong source of stress; thus, it is helpful to understand the current condition of families and how it may be impacting the presenting stress and adaption levels among youth (Kirmayer et al., 2011). Accordingly, counsellors may need to establish communication across services, with the counsellor acting as an anchor to help navigate resettlement demands. The important resettlement policies of the receiving country include services and supports that are extended to immigrant and refugee groups that assist with basic needs and language learning, as well as any legal standards and political rights that protect these groups (Guruge & Butt, 2015).

Researchers have suggested that health care providers have a duty to foster positive public attitudes towards immigrant and refugee groups in receiving countries because social integration is strongly associated with long-term well-being (Esses et al., 2017). Bäärnhielm et al. (2017) asserted that the health care of these groups is a humanitarian need that should involve multiple professionals within the provision of care to uphold the human rights of individuals who have experienced severe disruptions to their future. Furthermore, human rights groups have called attention to the vulnerability of children and youth during a time of unprecedented mass

displacement and increased globalization (Bäärnhielm et al., 2017). Counsellors should strive to maintain knowledge of the global situation for immigrant and refugee groups, as well as awareness of political policies that pertain to immigrant and refugee reform, that enhance services and provide opportunities, and that promote positive public attitudes. This learning can involve reaching out to local representatives of government and being an active member of advocacy group agendas. Both the American Psychological Association (2017) and the Canadian Psychological Association (n.d.) have guidelines and recommendations on their websites for ways practitioners can contribute to federal policies and reshaping of political attitudes. It is suggested that psychologists become active advocates by participating in expert consultations, undertaking research-based initiatives and partnerships, attending conferences and workshops, and meeting with or writing letters to members of government. Counsellors can situate their practice on optimizing the resettlement process by supporting both the developmental acculturation process and the broader social integration of these groups into the receiving country (American Psychological Association, 2017; Canadian Psychological Association, n.d.).

Furthermore, counsellors who work with immigrant and refugee youth should incorporate the client's environment in order to reach goals of reducing stigma, increasing access, and optimizing care. Sirin et al. (2013) discussed the importance of a coordinated set of services within the school setting, such as counsellor and community support, to help immigrant youth manage acculturative stress during these developmental years. Moreover, Fazel et al. (2016) found that the school setting offers an important location for mental health services for adolescents from immigrant and refugee backgrounds. These authors found teachers to play an important role in mediating the contact with mental health counsellors, and that various practitioners can use the school setting as a portal for integration of services. Mental health

practitioners should be ready to initiate contact with the school system and integrate this environment into their treatment planning. Findings have suggested the crucial part educational settings can play in reducing the barriers to mental health treatment, including stigma associated with help-seeking behaviours (Rousseau & Guzder, 2008; Rousseau et al., 2004). The ultimate goal is to remove barriers to service and optimize children's development by having mental health services readily available with adequate funding.

Finally, the current global situation and changing multicultural landscape calls for an increase in training programs within the counselling psychology field that would equip counsellors with the ability to adapt to a diversity of needs. Research has suggested that although psychology is taking steps in integrating diversity into its knowledge base, the need for culturally competent counsellors remains (Tastsoglou et al., 2014; Whaley & Davis, 2007). Possible solutions to increasing the diversity skill set are to seek out professional training in the use of non-Western or Indigenous practices of intervention and obtain training from experts in their respective fields (Collins & Arthur, 2010). These practices should be implemented in all levels of counselling practice. There is a need for graduate-level experience with immigrant and refugee groups, as graduate school is an optimal time for students to practice skills with a diverse range of clients under a high level of supervision and support. Practicum placements could be structured in which students could connect with experienced practitioners in the field who provide direct learning with diverse clients. Graduate school training programs should strive to network students with organizations servicing nondominant groups to see how to actively support and learn from their services. Accordingly, advocacy is needed at the educational level for multicultural training to meet these goals. This advocacy can be extended to organizations,

where counsellors can seek out training and start an advisory group that targets the promotion of multicultural competence at the organizational level.

Fundamental Next Steps in Research

In their scoping review of research on mental health outcomes for immigrant and refugee youth, Guruge and Butt (2015) wrote that the small number of articles (17) published over a 23-year period demonstrates the lack of research focused on these groups in Canada. In the 6 years since this review was published, various others have suggested that there continues to be a dearth of research on subjects pertaining to immigrant and refugee youths' mental health (Herati & Meyer, 2020; Khan et al., 2018). With regards to variability of mental health outcomes, there is a need to further assess prevalence rates and focus on pre- and post-migration factors to investigate trajectories in relation to adolescent development. Additionally, future research should assess the differences in use of mental health services between male and female youth, compare different ethnic groups, and study specific variables that may yield differences in outcomes such as immigration status and length of stay in Canada. Furthermore, subject areas addressed in this paper that are pertinent to the care of immigrant and refugee youth also require further research. These subjects include exploration into resilience and protection pathways, how trauma interacts with postmigration factors, the social determinants of mental health, interpersonal dynamics within families, and how familial relations interact with the socioeconomic environment.

Resilience should be a major goal of further research, as most studies with refugees have focused on vulnerability and risk (Earnest et al., 2015). Studies should involve larger prospective samples, investigated longitudinally, to understand how resilience varies over time with youth who have been exposed to significant risk factors and comparatively across countries. The goal should be to find effective means of promoting resilience among youth that can be sustained with

changing demands and as they move away from the recency of migration (Whaley & Davis, 2007). Moreover, researchers have suggested it would be helpful to understand how common challenges for these groups affect adolescents as they transition into adulthood, given that it is well understood that adolescence is a sensitive period that comes with its own risk for mental health challenges and can have ongoing impacts throughout adulthood (Oppedal et al., 2020). Such research could help sync preventive measures with appropriate culturally responsive interventions.

Focusing research on the acculturation of immigrant and refugee youth has the potential to contribute to the broader study of acculturation as it pertains to psychiatry, clinical psychology, social work, and public health. Having a better understanding of acculturation processes can inform the development of improved intervention models that focus on effective prevention through resilience and social supports (Oppedal, 2006). Research should also focus on developing appropriate conceptualizations and measurements, such as acculturation assessments that inform the work done in the working alliance. Advances in measurement of acculturation will have a direct effect on clinical utility for the delivery of culturally competency services.

Important research can also be done in primary care settings, where immigrant and refugee patients often present with physical complaints that may be indicative of mental health problems. As research has shown, medically unexplained symptoms, such as fatigue, pain, gastrointestinal symptoms, are common in primary care amongst this population (Kirmayer et al., 2011). This presentation of symptoms may be accompanied with a resistance to express any psychological distress in the medical setting because some cultural groups view it as inappropriate to discuss psychosocial concerns with their primary care doctor (Kirmayer et al.,

2011). Limited but emerging evidence has suggested that investigating these physical symptoms in relation to daily functioning can be helpful in understanding psychological distress and any pertinent intervention that may be needed. With evidence being limited, future research should focus on developing primary care strategies for promotion of mental health practice that is culturally sensitive to the diversity of these groups. Subsequently, mental health promotion can take on a holistic approach and involve multiple professionals across the healthcare continuum.

Recommendations for Practice

The work that is done with immigrant and refugee youth in the counselling room can be an important source for positive adaption during resettlement by approaching identity exploration and subsequent multicultural competence development as a focus of treatment (Bäärnhielm et al., 2017). Counsellors should be prepared to assess the client's history as it pertains to their migration journey and associated risk factors in order to identify appropriate mental health interventions in a timely matter (Kirmayer et al., 2011). Most researchers who have inquired into common mental health problems among immigrants and refugees have conceptualized their findings under separate stages of the migration experience. It is suggested that professionals inquire into the premigration experience, including any in-between period of migration or displacement, and subsequent postmigration resettlement context. Each phase of migration can be understood as associated with specific risks and exposures (Guruge & Butt, 2015). It is important to note that being exposed to a risk factor does not mean that counsellors should assume that this experience was traumatic or distressing to the point that it is impacting client functioning. Immigrant and refugee groups that have experienced risk factors show ranging responses, with some naturally overcoming trauma over time and adjusting positively (Earnest et al., 2015).

Although risk factors may be evident during assessment, especially among refugees who have had a higher chance of experiencing violence and forced displacement, the most powerful determinants of mental health are postmigration factors (Hynie, 2017; Shakya et al., 2010). Social realities such as discrimination, marginalization, and exclusion play important roles in immigrant and refugee mental health. A common experience that immigrant and refugee youth have is the interaction with the dominant culture as a point of acculturation. Having a sense of belonging in the receiving country and the ability to navigate cultural demands yield favourable outcomes. Moreover, identifying supports from the client's family and community can mediate the resilience process on the individual level. These psychosocial factors can be a focal point for resilience promotion as youth acculturate.

Adolescence is a crucial stage in development due to the rapid increase in physical and mental maturation that also accompanies developmental demands (Oppedal et al., 2020). Counsellors may be familiar with the typical developmental demands of adolescence, such as identity exploration, increased autonomy, enhanced mental and emotional capabilities, and broadening of relationships outside the home. What is important to consider for immigrant and refugee youth is that the process of acculturation should not be distinguished from the typical demands of adolescence, but rather integrated into a holistic clinical conceptualization (Oppedal, 2006). This idea of acculturation development suggests that children and adolescents with minority backgrounds experience acculturation as a part of natural development rather than a separate adaption process (Oppedal, 2006; Sam & Oppedal, 2002). An important focus for counsellors is to assist immigrant and refugee youth to figure out what working models are expressed in everyday routines, patterns of behaviours, and traditions within both their culture of origin and the receiving majority culture. Moreover, counsellors should strive to embed their

understanding of adolescent development under the guide of cultural practices, cultural identifications, and cultural values as interacting bidirectionally with changes to cognitive, behavioural, and emotional domains (Oppedal, 2006).

The literature discusses the need to go beyond the focus of maladaptive behaviours and negative aspects of migration to understand immigrant and refugee youths' condition (Guruge & Butt, 2015). Youth are equipped with resilience, and their culture consists of protective and adaptive factors that can be emphasized in the counselling environment. Additionally, social and political policies can either hinder or enhance the resilience process and promote social integration. In accordance, fostering positive public attitudes is crucial, and counsellors have a part in the evolution of knowledge and advocacy for these groups in society. Authors have suggested that the future should consist of immigrant and refugee groups participating in their own delivery of care (Hinton et al., 2012; Kirmayer et al., 2011). Subsequently, the work done in the counselling environment should be person-centred with a strength-based approach that honours the client's subjective reality and places the client in a position of expert of their own culture. Providing culturally safe counselling requires the counsellor to reflect on their personal values, attitudes, and practices as they pertain to the dominant culture and strive to promote a sense of mutual recognition that promotes belonging. Mental health care needs to address the client's current needs, incorporate their socioeconomic realities, and tackle barriers to care (Bäärnhielm et al., 2017).

Reflective Self-Statement

This topic has given me the opportunity to explore the literature on how to contribute to the social integration of historically underrepresented groups. One theme that has stood out to me is that although Canada has favourable policies on multiculturalism and has been viewed as

celebrating the diversity and differences within society, substantial work must still be done on the ground level with how counselling professionals can best care for the growing diversity of youth. Immigrant and refugee youth represent the future of nondominant cultures in Canada, and there continues to be a need to find ways to deliver culturally competent mental health care. I believe Canadian counsellors have a responsibility to engage in developing the necessary knowledge base and skill set to contribute to the well-being of diverse groups. Additionally, professionals should strive to gain knowledge on the systemic processes and social conditions that influence positive adjustment, and to undertake mental health intervention from a resilience framework. Without careful self-reflection on the part of the counsellor in relation to their multicultural practice, professionals run the risk of further contributing to barriers of care for these groups.

The individual counsellor possesses a great opportunity to learn from diverse cultures and increase competence by simply being prepared to respond in a culturally safe manner to the needs of youth and develop a relationship that contributes to a sense of safety during resettlement. As counsellors develop their counselling practice, they become an influential part in productive change for society. Moreover, the counselling psychology field is in a position to influence change in the broader social, economic, and political systems that are intrinsically tied to the positive adjustment of immigrants and refugees. By situating their counselling practice on exploring relevant factors that influence acculturation and identity development, I believe counsellors are in an optimal position to develop appropriate interventions for immigrant and refugee youth.

Conclusion

Citizens around the world are experiencing an age of globalization that continues to be perpetuated by difficult conditions in many parts of the world. The process of migration has afforded families the opportunity to develop new competencies that can contribute to long-term well-being within their receiving country. The process of migration also involves risks that manifest by the reality of conditions immigrants and refugees may be leaving. Resettlement comes with new opportunities to explore identities and develop skills in relation to personal goals, but it is accompanied by postmigration challenges that can lead to poor mental health outcomes. It has been recommended that a systematic inquiry into the migration trajectory and subsequent follow-up on culturally appropriate indicators of functioning can be an effective way to assist counsellors in recognizing problems in adaption promptly. Addressing challenges and responding timely to the diverse needs of these populations requires an understanding of how immigrant and refugee youth adjust to their new cultures and navigate stressors.

Understanding how acculturation interacts with adolescence is an important part of working with bicultural youth. The idea of acculturation development considers the process of gaining competence within both the cultural of origin and the new receiving culture as a developmental milestone that contributes to positive adjustment. Acculturation development models assume cultural competence is important to immigrant and refugee youth because it improves their chances of being accepted and successfully navigating their social reality. Counsellors who intervene appropriately by targeting the development of cultural competence for various cultural demands will help in the promotion of agency and adaptability among youth. Additionally, by focusing on resilience, counsellors can assist youth in coping with ranging challenges including mediating the effects of premigration trauma.

Specific obstacles and barriers to mental health care for immigrants and refugees include communication difficulties due to language, the influence of cultural stigma on mental health symptoms, family structure and beliefs, intergenerational conflict, and factors pertaining to acceptance of the receiving country. Counsellors can use trained interpreters or cultural brokers and become familiar with CID in order to tackle some of these issues. Being aware of socioeconomic conditions and citizenship demands will equip counsellors to reduce resettlement stress by increasing supports through resources and advocacy.

Mental health care of immigrant and refugee youth should be strength-based with a focus on resilience and natural protective factors. Additionally, increasing agency and autonomy through collaboration in the counselling environment will help youth in their development. Harnessing a person-centred approach that values the client as a cultural expert will strengthen the therapeutic process. To provide culturally responsible care, counselling professionals require self-reflection into their personal values, attitudes, and practices, as well as those of the dominant culture. Counsellors can promote a collaborative effort across services to increase social integration and belonging among immigrant and refugee youth.

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