

## **A Practical Approach to Counseling Refugees: Applying Maslow’s Hierarchy of Needs**

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*Conflicts across the globe push hundreds of thousands of refugees to pursue shelter and safety in other countries. As individuals and families continue to be resettled in the United States, both professional school and mental health counselors may encounter clients who are refugees or asylum seekers. This article addresses both the universal needs and the unique experiences people with refugee status have entering the United States. Use of Maslow’s Hierarchy of Needs provides a practical, humanistic framework for counselors who work with this population. Specific mental health needs and an approach to counseling are explored with a case study to illustrate application. Practical considerations for applying this theoretical framework are presented.*

*Keywords:* *refugee, hierarchy of needs, case study, Maslow*

The United States (U.S.) has a history of welcoming resettled refugees. Early in 2017, an executive order suspended certain immigration benefits and the issuance of visas to immigrants from specific countries (Banks & Oman, 2017); additionally, the refugee admission program was suspended (Office of the Press Secretary, 2017). A second executive order limited the number of refugees who will be admitted to the U.S. in fiscal year 2017 (Office of the Press Secretary, 2017). This ban and slow-down in allowing vetted and in-process refugees to enter the U.S. exacerbated the stressful conditions experienced by this population and previously resettled family members anticipating reunification with loved ones. Successful resettlement depends on more

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than just the ingenuity, resilience, and personal characteristics of the refugees, but also on the response of the host countries and the resources available to newcomers (Kim & Kim, 2014).

Professional counselors are called to work in culturally appropriate ways to empower clients from diverse backgrounds. Specifically, honoring diversity and promoting social justice are core professional values as defined in the American Counseling Association (ACA, 2014) *Code of Ethics*. Furthermore, social and cultural diversity are addressed extensively in counselor education programs (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016) with counselors-in-training developing competence to work with both nationally and internationally diverse clients. Taken together, these expectations and requirements point to the importance of counselors increasing comfort with, and competency in, working with diverse populations including individuals with refugee status.

Counselors in a variety of settings encounter these newcomers to the U.S. The authors propose that Maslow's hierarchy of needs can be applied when counseling people with refugee status. Several aspects of the migration experience may contribute to a decline in mental and physical health. Furthermore, after arrival in the U.S., resettled refugees often experience significant uncertainty across several life domains including adjustments in: education and employment; experiencing discrimination; housing and food insecurity; managing the stress of acculturation; and preexisting mental, emotional, and physical conditions (Kim & Kim, 2014; Montgomery, Jackson, & Kelvin, 2014). Counselors can play a key role in helping mitigate pre- and post-migration trauma, loss of social and economic status, and other mental health concerns.

While literature in working effectively with refugees has flourished in related helping professions including social work (Austin, & Este, 2001; Deacon, & Sullivan, 2009; Harding & Libal, 2012) and health care (Barko, Farkhour, & Arnetz, 2011; Jamil et al., 2005; Prince et al., 2007), there is a dearth of literature in professional counseling journals specific to this population. The purpose of this paper is to provide counselors with information specific to the refugee experience and strategies for working with this population. The first section will discuss specific refugee concerns. Then, Maslow's hierarchy of needs is reviewed and applied to this population in the second section. In the final section, a case example is provided along with practical considerations for applying this theoretical framework.

### **Refugee Experience**

In the fiscal year 2016, U.S. communities welcomed 84,995 refugees (U.S. Department of State [USDS], 2016). Additionally, tens-of-thousands of asylum-seeking refugees enter the U.S. each year in search for safety (Welch & Schuster, 2005). Currently, the top five states welcoming these newcomers are: Texas, California, New York, Michigan, and Ohio (U.S. Department of Health and Human Services [USDHHS], 2016). The majority of these newcomers were from Iraq, Burma, Iraq, Somalia, and the Democratic

Republic of Congo (USDHHS, 2016).

Individuals and families who meet certain criteria may apply for official refugee status and resettlement. These individuals are compelled to leave their current residence (homeland) to seek refuge outside of their country of origin. According to the United Nations High Commissioner for Refugees (UNHCR, 2011), United Nations Refugee Agency, refugees are people who have left their country of origin due to being persecuted, or have “a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion” (p. 10).

The primary difference between officially resettled refugees and asylum-seeking refugees is immigration status. People granted refugee status have undergone a rigorous application, interview, and security screening process (UNHCR, 2011). They are documented, enter the U.S. legally, and have a path to citizenship. Persons who enter the U.S. seeking asylum must engage in a specific legal process and are not guaranteed legal status. In this article, the terms refugee and newcomer are used interchangeably to encompass both populations. Both refugees and asylum seekers face similar issues in regard to mental, emotional, and physical needs.

### **Refugee Mental Health Concerns**

Many refugees who come to the U.S. struggle with a host of mental health concerns (Jamil et al., 2005). Counselors working with newcomers need to be prepared to recognize and work with a variety of mental health concerns including: depression, anxiety, drug or alcohol issues, suicidal ideation, posttraumatic stress disorder (PTSD), and schizophrenia. These may be brought on by the stress of residing in refugee camps or the required adjustments to life in the U.S. (Jamil et al., 2005). Several studies have identified pre- and post-migration experiences that increase newcomer susceptibility to emotional distress (Harding & Libal, 2012; Jamil & Ventimiglia, 2010; Montgomery et al., 2014; Schweitzer, Melville, Steel, & Lacherez, 2006; Willard, Rabin, & Lawless, 2014). Furthermore, within some communities of resettled refugees, the suicide rate may be more than three times as high as in the general U.S. population (Refugee Health Technical Assistance Center, n.d.).

Research shows rates of mental illness among resettled refugees is higher than the general population and include PTSD, depression, and anxiety disorders (Mitschke, Praetorius, Kelly, Small, & Kim, 2017; Yanni et al., 2013). In particular, PTSD and past experiences of torture may be part of the newcomer’s concerns. In the context of trauma, Gorst-Unsworth and Goldenberg (1988) found that the loss of social networks and separation from family members among refugees from Iraq were important factors that perpetuated psychiatric symptoms, particularly depression and PTSD. Additionally, the long-term effects and accumulated strain of poor health care, chronic stress, and substance abuse experienced by some clients with PTSD can continue to impair client functioning even after the initial resettlement transition (Vrana, Campbell, & Clay, 2012). PTSD has received the most attention with regard to refugee mental health

treatment (Vrana et al., 2012). It is also imperative that counselors not assume that all clients struggle with PTSD symptoms, and are careful not to pathologize client's struggles with an over-focus on diagnosis (Kim & Kim, 2014).

Additionally, torture is a primary issue discussed in refugee mental health literature and is closely related to PTSD and depression (Gorst-Unsworth & Goldenberg, 1988; Shoeb, Weinstein, & Mollica, 2007; Willard et al., 2014). The effects of torture have been examined in numerous studies of refugees (Jamil et al., 2005; Montgomery et al., 2014; Shoeb et al., 2007; Willard et al., 2014; Vrana et al., 2012; Yanni et al., 2013). While some studies estimated 5–35% of the world's refugees have been tortured, there is limited data on the prevalence of torture in refugee populations resettled in the U.S. (Willard et al., 2014). The early identification of torture and mental health symptoms is particularly important. If newcomers do not receive needed physical and mental health services, it can impact the entire family (Willard et al., 2014).

### **Post-Migration Displacement and Acculturation**

Refugees undoubtedly face several issues before entering a host country. However, the challenges do not cease once they arrive in the U.S. In fact, many challenges, including language and cultural barriers, stem from the resettlement and post-migration experience. Newcomers contend with numerous factors related to displacement and the acculturation process (Casimiro, Hancock, & Northcote, 2007; Park-Taylor, Walsh, & Ventura, 2007). Common challenges include: pressure to assimilate to the new culture, xenophobia, prejudice and discrimination, understanding legal practices, a decline in ethnic identity, changes in family dynamics, and financial stress (Bemak & Chung, 2017; Yoon & Langrehr, 2010). These difficulties hinder psychological, biological, and social development and may exacerbate post-migration anxiety, feelings of helplessness, intergenerational conflict, physical illness, and low self-esteem (Bemak & Chung, 2017; Park-Taylor et al., 2007). Furthermore, Bemak & Chung (2017) noted that existing trauma may be compounded by any or all of these factors. Counselor awareness and understanding of these challenges may enhance rapport and empathy.

Acculturation is defined as experiences related to changes in beliefs, personal relational styles, behavior, thoughts, values, and language cultural minority group member's encounter in the dominant culture (Hays & Erford, 2014). Acculturation occurs across a range of life domains including basic behaviors (e.g., exchanging appropriate greetings, social interactions), fundamental knowledge (e.g., where and how to acquire food, obtain and utilize transportation), and values (e.g., family member roles, education) (Yoon & Langrehr, 2010). According to a meta-analysis conducted by Yoon & Langrehr (2010), a negative association between psychological distress/depression and acculturation exists among immigrants to the U.S. The acculturation process is not a time limited event; rather it is ongoing through years of group engagement.

During the initial resettlement years, newcomers face acquiring new ways of behaving, communicating, and coping in a new environment while endeavoring to meet

fundamental needs of employment and housing (Bemak & Chung, 2017). Acculturation concerns include, “the sociopolitical context of entry and loss of social supports and status, which combined with the circumstances of their departure, contribute to mental health risk” (Montgomery et al., 2014, p. 774). Additionally, acculturation factors influence identity development (Phan et al., 2005).

A fundamental aspect of post-migration stress and adjustment may include language acquisition. Refugees’ physical and mental health concerns may persist or become more significant after encountering language and acculturation barriers (Nadal et al., 2012; Nesdale & Mak, 2003). Research indicates language barriers are problematic in several areas of life functioning (Casimiro et al., 2007; Goodkind & Deacon, 2004). Specifically, language is a barrier when addressing medical needs (Saadi, Bond, & Percac-Lima, 2012), contributes to social isolation, and increases material insecurities (e.g., food, financial, housing) (Casimiro et al., 2007). Moreover, Deacon and Sullivan (2009) found refugee women’s lack of English language skills was an impediment to forming social support networks. When examining language and acculturation, research confirms that mainstream social encounters and U.S. cultural competency typically follow immigrant proficiency in the English language (Yoon & Langrehr, 2010).

### **Theoretical Framework**

Many refugees encounter professional counselors in the community and in schools (Chung, Bemak, & Wong, 2000). Yet, there is very little research or discussion on how counselors can effectively frame refugees’ needs and experiences (Slobodin & de Jong, 2015). Counseling specific research has focused primarily on the coping mechanisms of specific populations (Clarke & Borders, 2014), pre- and post-migration experiences (Chung & Bemak, 2002), and mental health concerns (Chung, Bemak, & Wong, 2000; Mitschke et al., 2017). Recently, researchers have called for the need for counselors to adopt a “holistic and advocacy-based counseling approach” (Clarke & Borders, 2014, p. 294) and have noted that effective mental health support includes addressing practical needs (Mitschke et al., 2017). This points to professional counselors’ need for a framework for conceptualizing clients that includes the multiplicity of refugee needs. The World Health Organization (WHO) has established a link between physical and mental health (Prince et al., 2007; WHO, 2013). Therefore, using an approach that acknowledges this link benefits both counselors and clients as multiple factors across domains related to wellness and mental health are considered. Use of Maslow’s (1943) hierarchy of needs provides just such a framework.

A humanistic counseling approach is fitting for this population as it considers the full range of human experiences and values human dignity (Brady-Amoon, 2012). Furthermore, the humanistic principles of maximizing one’s own potential within the context of one’s experiences is appropriate for working with this population. Specifically, utilizing Maslow’s (1970) hierarchy of needs for conceptualizing the complex needs of refugee clients provides counselors with a practical, comprehensive humanistic

framework. The authors propose that using Maslow's hierarchy can increase counselor knowledge of lower order needs that impact resettled refugees and may elucidate potential barriers that effect pathways to fulfilling higher order needs (Schweitzer et al., 2006) leading to more successful counseling outcomes. This framework allows counselors to attend to multiple levels of intervention surrounding the primary mental health concern which may result in increased advocacy and extend the network of complimentary and wrap-around services while delivering culturally responsive counseling interventions and treatment strategies.

### **Maslow's Hierarchy of Needs**

Maslow's work addressed human motivation in regard to meeting goals and fulfilling needs. Maslow's ideas have been applied effectively to mental health concerns of various populations such as persons struggling with homelessness (Padgett, Smith, Derejko, Henwood, & Tiderington, 2013) and children in crisis (Harper, Harper, & Stills, 2003). Many refugees face concerns similar to these populations (e.g., food and housing insecurity, barriers to employment, and trauma histories) coupled with additional unique challenges including language barriers and acculturation (Harding & Libal, 2012).

Maslow's hierarchy of needs is commonly understood as five layers arranged sequentially in a pyramid diagram. However, in his later work, Maslow (1969a as cited in Koltko-Rivera, 2006) included a sixth level, self-transcendence. Self-transcendence refers to a person's motivation to promote a cause outside of themselves (e.g., service to others, social justice, religious faith) and "to experience a communion beyond the boundaries of the self through peak experience" (Koltko-Rivera, 2006, p. 303). The six-level version of Maslow's hierarchy is utilized here.

In Maslow's (1943) hierarchy or pyramid, the needs at the bottom (i.e., physiological needs such as water and food) need to be satisfied before other needs (i.e., self-esteem) are met. The six universal needs are: physiological, safety, love and belonging, esteem, self-actualization, and self-transcendence. Maslow operationally defined the needs as classifications of motivations, "based upon goals rather than upon instigating drives or motivated behavior" (p. 3).

Maslow (1971) attempted to develop his theory based on examining healthy people, rather than those who were functioning poorly which aligns this theory with the wellness perspective embraced by professional counselors. Several authors have proposed updated models of Maslow's hierarchy (Gorman, 2010; Kenrick, Griskevicius, Neuberg, & Schaller, 2010). These more recent reinventions of the hierarchy include: overlapping (as opposed to distinct) tiers (Kenrick et al., 2010), linking higher order needs to culture (Gorman, 2010), and a general expansion and incorporation of needs in a contemporary context (Kenrick et al., 2010). The authors take the approach that the basic motivations proposed by Maslow (1943, 1971) hold true for most clients and the needs (a) may overlap, (b) may compete, and (c) are influenced by the client's cultural

context which includes barriers and supports.

The hierarchy of needs address universal needs that affect all people regardless of national origin (Tay & Diener, 2011). Human beings are conceptualized as motivated to grow fulfillment of needs often shifts or is disrupted. Counselors can utilize Maslow's framework as a practical guide while assessing clients and establishing client goals.

While Maslow's (1943) hierarchy of needs was designed to be linear and hierarchical, a post-modern, humanistic perspective allows for acknowledging a fluid human experience. At various times, a specific client concern may comprise multiple hierarchical needs. For example, a newcomer who was a professional engineer in his home country may find himself struggling to obtain a position as a custodian or a physical laborer in the U.S. The need for employment is immediate because this is how basic food and shelter needs can be met. However, even when successfully employed, the client may struggle with safety (e.g., financial insecurity, racial discrimination) and self-esteem needs related to underemployment. One of the benefits of using Maslow's hierarchy of needs is the framework to address the client's needs with all stakeholders and service professionals. This includes the client, family members, school personnel, case managers, supervisors, and medical professionals. At times, client needs may compete with each other and counseling priorities may shift. Additionally, this framework provides a structure in which clients can articulate, identify, and prioritize their needs with the counselor. The following sections provide examples of using Maslow's hierarchy to frame newcomer client concerns.

***Physiological needs.*** Physiological needs include food, breathing, water, physical intimacy, and homeostasis (Maslow, 1943). Refugee's physiological needs are often this basic. Throughout the counseling process there may be times when these needs are met at differing levels – fully, partially, or temporarily. Clients may bring concerns about being hungry and needing food, housing, or transportation assistance to counseling. Counselors working with this population may need to provide case management and referral support services in addition to traditional counseling (Brar-Josan & Yohani, 2014). Time spent engaged with clients in assessing physiological needs may be used to establish rapport and begin trust-building. If counselors fail to address basic physiological needs clients may terminate counseling prematurely. Additionally, physical and medical needs may be represented in both this tier and the following tier.

***Safety needs.*** Safety needs include financial security, employment, personal security (protection from bodily harm), physical health, and well-being (Maslow, 1943). Although the fear of physical threat may not be as great in the host country in comparison to the country fled, threats of bodily harm still exist (Barko et al., 2011). Counselors working with newcomers need to acknowledge that these fears are well founded. For example, in some countries police or other authority figures perpetrate physical or sexual abuse or engage in abduction and are to be avoided as opposed to trusted. Additionally, many newcomers have family and friends located in other parts of the

world who are still in danger.

Research indicates that refugee children face racism and intolerance in schools (Constantine & Gushue, 2003). When working with children, counselors may need to employ culturally appropriate psychoeducational approaches to address safety needs like bullying or parenting style as they pertain to issues that involve both school and family (Rousseau & Guzder, 2008). Additionally, school counselors are well positioned to incorporate diversity curriculum to provide accurate information about different cultures, increase acceptance, and counteract negative stereotypes. Schools and communities with larger numbers of newcomers may be better equipped to work with these students and families. They may also serve as resources for counselors with less refugee immigrant experience.

***Belongingness and love needs.*** Belonging needs such as friendship, family connectedness, and emotional intimacy are commonly addressed in counseling (Casimiro et al., 2007; Pedersen, Lonner, Draguns, & Trimble, 2007). Counselors help clients grow so that they can foster better relationships with important people in their lives (Pedersen et al., 2007). The belonging and love needs of refugees are similar other clients, but the barriers to meet these needs may differ.

Nesdale, Rooney, and Smith's (1997) study on psychological distress and migrant ethnic identity highlights the importance of social networks. These authors found newcomer refugees are often separated from their families and their loved ones by geographic distance and for long periods of time. Their research confirmed migrant psychological distress has a negative impact on both structural social support and functional social support. Furthermore, the authors noted that separation from loved ones is one of the most traumatic experiences refugees face. In some cases, adult siblings are separated during the refugee experience, are sent to different refugee camps, and may be resettled to different host countries (UNHCR, 2012).

The educational attainment for children and adults varies based on the cultural norms and opportunities available pre-migration (UNHCR, 2016). Some youth and families may value work over education as a practical means to support the family and to limit outside influence on family members. Once resettled, children may begin to have some belonging needs met through participation in school and educational activities. It is important for counselors, particularly school counselors, to be aware of the challenges that are faced by children, parents, and families as they learn to navigate the U.S. school system. Psychoeducation programs and links to community resources for families may be appropriate.

***Self-esteem needs.*** Maslow (1943) described self-esteem as, "the desire for strength, for achievement, for adequacy, for confidence in the face of the world, and independence and freedom" (p. 381). This includes a longing for prestige or status – both of which are important considerations when working with newcomers. Many refugees have been stripped of their sense of self-worth and usefulness. Newcomers

often experience extreme changes in social standing, economic status, and threats to their ethnic identity.

Counselors may be able to help refugees create a new understanding of their new world if this new world a place where they are unwelcomed. Counselor may talk with newly arrived refugees about how they feel they are perceived in the U.S. The discussion may include topics about gender, ethnic, and racial identities (Rumbaut, 1994). Counselor may note during session how much clients have learned about the culture which they have become part of and the obstacles they have faced and overcome. Client's confidence may increase through steady navigation of elements of the hierarchy. Furthermore, school counselors are well positioned to address self-esteem with children and adolescents through individual, small group, and classroom guidance with a strength-based focus.

***Self-actualization needs.*** Self-actualization has been a part of the western intellectual landscape for many years (Geller, 1982). Self-actualization is defined as “a harmonious unity of physiological and psychological capacities or needs that exert a constant pressure on the organism for release and fulfillment” (Geller, 1982, p. 62). Because self-actualization is a Western concept (Neher, 1991) it may be challenging to apply to clients from non-Western cultures. Counselors may conceptualize this part of the hierarchy as including aspects of self-such as creativity, problem solving, and acceptance. Additionally, attending to client spirituality aligns with this level of the hierarchy (Gold, 2013). Moreover, when working with newcomers, it may be helpful to assess whether they have achieved a sense of self-actualization at some point prior to their forced migration. This can be used to help clients maintain a sense of hope.

***Self-transcendence needs.*** Many newcomers may have been healthy and functioning optimally prior to displacement. It would be a disservice to assume that due to their current status that they had not been previously motivated toward the attainment of “mountain top” experiences as described by Maslow (1971) or the active engagement in transpersonal experiences that extended beyond themselves into the realm of aesthetics, nature, emotion, or spiritual/mystical (Koltko-Rivera, 2006). This sixth need in the hierarchy is also sometimes referred to as intrinsic values (Skelsey, 2014). Similar to understanding and conceptualizing the self-actualization needs and achievements of clients, the commitment or connection to something beyond oneself may be a source of strength. Clients' needs for altruism, as well as spiritual and religious aspects of human existence may be multiculturally integrated and addressed in this level of the hierarchy.

### **Cautions in Applying Maslow's Theory**

Inherent cultural model bias is a significant and long-standing criticism of Maslow's (1943) hierarchy of needs (Neher, 1991). This is most evident in the static hierarchical nature of Maslow's model and in the individualistic concept of self-actualization.

Montgomery et al. (2014) stated that many of the ideas and notions of mental health are based on Western concepts. Attention to multicultural and social justice counseling competencies (Ratts, Singh, Nassar-McMillan, Butler, & McCullough, 2015) are essential when working with refugee clients. A study by Tay & Diener (2011) found that while the needs identified by Maslow were universal, the order and hierarchy were not. While basic needs may be most pressing, other, higher order needs exist (and can be met) concurrently.

### **Application**

The authors propose addressing acculturation specific concerns through an integrative, constructivist approach. Humanistic counselors conceptualize client-specific and contextually-based needs and strengths at every level of the hierarchy. Counselors working with this population also recognize there may be areas of transition between levels of the hierarchy where a client's presenting concerns overlap multiple needs. For example, lack of English language skills in the U.S. could be present as a safety need (e.g., reading traffic signs, understanding a police officer). This same language deficit may present as inhibiting personal connections and friendships as and a love/belonging need. Career and satisfactory employment at a livable wage also crosses levels of needs and is rooted in specific cultural contexts (e.g., language, gender roles, underemployment) (Austin & Este, 2001). Many refugees face difficulty securing a job. Difficulties may be due to language barriers, job skills, literacy, or education level (Austin & Este, 2001). The following case study applies humanistic principles and Maslow's hierarchy of needs to a client.

### **Case Study**

Mary is a woman in her mid-forties. She arrived in the U.S. about nine months ago from her home country, the Democratic Republic of Congo (DRC). Mary completed two years of university and was employed as a journalist. The divorced mother of three was kidnapped, sexually assaulted, imprisoned, and tortured prior to being snuck out of the country and travelling to the U.S. as an asylum seeker. Following her arrival in the U.S., Mary received word that her children were in the care of her sister who had fled DRC. They are living in a refugee camp and have contacted a UNHCR representative with hopes to begin the process of applying for official refugee status. Health problems originating from her captivity and abuse included: liver disease, damage to her vaginal area, headaches, and multiple scars. Mary is a woman of faith who prays multiple times a day. She lives with a Congolese family who resettled in the U.S. several years ago and who are well-educated and successfully employed. Due to her pending legal status, Mary is unable to obtain employment. She navigates the local bus system and relies on others for transportation. Mary can read and write fluently in French, and speaks three

other African languages. She also speaks and writes in English.

Mary's host family connected her with a non-profit, non-governmental organization to assist her with adjusting to life in the U.S. and to provide support and case management services. Volunteer case managers quickly recognized Mary was struggling physically and emotionally. The complexity of her needs resulted in a referral for counseling services. Mary enters counseling because she is distressed by not being with her children, has frequent headaches, and continues to have frequent symptoms of depression (such as lack of appetite, sleeping more than usual, crying spells, and withdrawal from friends and activities). Informed consent was obtained utilizing a document written in both English and French. The counselor is English speaking. In consultation with the client and her case manager, it was determined that the client was proficient and comfortable enough to engage in counseling in English and preferred not to utilize a language interpreter. One of Mary's initial concerns was not feeling safe to share her story if another Congolese person was present. Distrust among different factions of people from the DRC was a concern as was the safety of her family.

A sample of conceptualizing Mary using Maslow's hierarchy of needs follows. The counselor worked to establish rapport with Mary, utilized an existential counseling approach, and used Maslow's hierarchy of needs to assess the various hierarchical domains. This approach helped the counselor gain a "big picture" understanding of the client's situation as well as identify specific areas to approach in counseling.

***Physiological needs.*** Basic needs are being met with housing, food, and clothing being provided by members of the Congolese community. It took several months for Mary to trust that these needs would be met without restriction. For example, although the host family invited her to eat with them and help herself to food, it was difficult for Mary to trust these strangers and their hospitality. While Mary was imprisoned, she had often been denied food and water. This contributed to her current feeling of insecurity related to food. At times she denies herself food and drinks only water. The counselor recognizes the client is completely dependent upon others to meet her basic physical needs. This is one area where the application of a humanistic approach with a focus on dignity is particularly applicable.

***Safety needs.*** Mary's life was threatened by guards who had pretended to be kind to her and she was beaten and raped repeatedly. She also came from a culture where it was not safe to trust people in positions of power or public service (e.g., government clerks, law enforcement). Connected to Mary's sense of safety was concern for the safety of her children who are living in a refugee camp.

Additionally, because of the severe physical abuse Mary endured she has several medical conditions that need to be assessed and addressed. These include headaches from head trauma, physical injuries to her reproductive organs, and hepatitis. It was important to help Mary locate health care services and health educators who could speak with her in her native language and had a general understanding of Central

African geography, history, and culture. The counselor assisted Mary in finding a volunteer who would aid her with advocating for her health care needs and could assist with transportation to medical appointments.

It was important for the counselor to understand that Mary was previously self-sufficient in providing for her own basic needs and the needs of her children. Although physical safety was a real concern in her country of origin, she was making sure her children received an education and worked to keep them from physical harm. Now she is unable to provide protection and care for her children and has limited means and opportunity to contact them. Concerns for the physical and emotional safety of her children are well-founded. The client experiences nightmares related to past abuse. Addressing feelings of helplessness was incorporated into the treatment plan.

***Belonging and love.*** Mary did not want to leave the DRC. She was forcibly abducted. She was denied access to her family, her birth certificate, and other documentation. One of the challenges for Mary was not being able to be in contact with her family or friends in the DRC.

Prior to her migration, Mary had a secure sense of belonging among friends, family, and her community – both in the village where she was raised and in a large city in the DRC where she attended university and worked. She had a successful career as a journalist. Mary was active in her church and in her children’s schools, and assisted with the family farm.

In the U.S., Mary’s need for belonging and love were met in part by engaging with other members of the Congolese community located in the city where she currently resides. It was a process to find and get connected with this community. The counselor actively investigated resources and identified cultural community leaders in the local area. In addition to a sense of belonging, the client’s religious and spiritual needs were met by regular worship, service, and membership in a Christian church and singing with a Congolese choir. These activities and relationships were essential to rebuilding the client’s sense of self.

***Self-esteem.*** Being stripped of her familial and work identities damaged Mary’s self-esteem. What value did she have as a person who could not legally work in this country? What was her purpose if she could not raise her children? What did it mean that she had moved from a position of self-sufficiency to dependence on others? Furthermore, Mary felt frustrated by the limitations of education and work requirements she faced in the U.S. Common to the experience of many newcomers, her education in DRC was not recognized in the U.S. Much of the self-esteem work related to career counseling. Mary enjoyed attending a weekly English as a Second Language (ESL) class. When initially presented with the opportunity to earn her General Educational Development (GED) certificate, Mary challenged the counselor. It was unfair that she had to start at a low level of educational attainment. It took time for Mary to move to a place where she could see the opportunities this would potentially open for her if she gained legal status in the U.S. It also provided a space for Mary to begin to think about herself

and what she might want to do or become professionally outside the cultural, social, and economic boundaries of her home country. ESL classes also provided a source of social support and connection.

***Self-actualization and self-transcendence.*** Mary could remember a time when she was happy and fulfilled in life. Prior to her abduction, she held a position that entailed helping other women who were less fortunate than herself. She had a sense of past achievement and morality. She also had a well-developed spirituality.

The counselor had a responsibility to work collaboratively with the client to determine and assist with co-constructing a culturally appropriate concept of self-actualization. Keeping self-actualization in mind while conceptualizing the client's concerns and meeting other fundamental needs is helpful and may be used as a way to activate client strengths. In Mary's case, unforeseen barriers existed to keep her focused on lower level needs. Additionally, the client struggled with the immigration application process. Legal assistance was required.

### **Client Progress**

The client continued to experience bouts of depression. Eventually Mary accepted that she could not return to the DRC. This allowed her to begin visioning and working toward being more engaged in her activities of daily living. She continued to feel angst at being unwillingly absent from family life. Mary experienced increased self-esteem as she completed her GED and was recognized by her instructors as an exceptional student. She also participated in a community garden which allowed her to reconnect with her farming heritage and grow some of her own food which increased her sense of self-sufficiency.

Although Mary made progress, she also faced setbacks. At times, Mary's hope increased as she prayed for her children's migration from DRC to the U.S. and then waned as she felt the backlash against refugees and immigrants both during and after the presidential campaign and election. During Mary's asylum application and interview process (to obtain official refugee status) she experienced increased feelings of discouragement as the court system was backlogged. This increased her anxiety and fear of deportation. Additionally, the political climate in the U.S. changed; while Mary is not Muslim, or from one of the 'banned' countries she is scared she may never be reunited with her children since there is a slowdown in the already long process of vetting and admitting refugees to the U.S. This made it challenging for Mary to gain and maintain the sense of control over her life she was working toward.

### **Counselor Development**

The counselor engaged in peer supervision during her work with this client to mitigate the effects of vicarious trauma. The counselor also expanded her case management

skills and network of resources and referrals by contacting medical and legal professionals and finding an appropriate GRE course provider. The counselor advocated for client access to needed resources and assisted the client in developing self-advocacy skills. The counselor also felt frustrated by the change in political climate and at times felt angry and helpless when working with Mary. The counselor channeled these feelings into legislative advocacy efforts and engaging with others to raise awareness of the barriers faced by members of the refugee community in her local area.

## **Discussion**

Practical considerations for work with refugee clients exist across levels including: direct client care, professional counselor competency, organizational (e.g., agencies, counselor preparation programs), and profession-wide. It is imperative for both school and community-based counselors to locate refugee services, nonprofits, ESL providers, and ethnic communities in the local area (e.g., the office of refugee resettlement website lists state coordinators and resources by state; a list of voluntary agencies that support refugees can be found at <https://www.acf.hhs.gov/orr/resource/voluntary-agencies>; World Refugee Day is celebrated annually in June with events across the country). Furthermore, advocacy efforts occur not just at the local or individual level, but also on a larger scale that may influence organizational structure or public policy (e.g., refugee resettlement facts are available through UNHCR <http://www.unhcr.org/en-us/resettlement-in-the-united-states.html>; legislative action can be followed at <https://www.congress.gov/>).

### **Counselor Competency**

Providing counseling and other mental health services to refugees requires significant multicultural competency and cultural sensitivity. The Multicultural and Social Justice Counseling Competencies call counselors to take an action-oriented response to client social justice and cultural considerations (Ratts et al., 2015). These competencies also recognize that counselors and clients may have areas where aspects of identity intersectionality are salient. Counselors can assist clients to cultivate awareness around the many ‘isms’ they experience and provide a safe space for expressing and exploring these encounters (Ratts et al., 2015).

Utilizing Maslow’s (1943) hierarchy with refugee clients also provides a natural framework for identifying areas to increase counselor advocacy. Counselors may recognize places where they can advocate for client needs and for institutional or societal change. Furthermore, counselors have multiple opportunities to assist clients with developing self-advocacy skills. The humanistic counselor empowers and nurtures clients as they move toward their goals.

Client need for multilingual counseling services or comfort with using a translator may pose barriers to access. Moreover, attention to the collectivist focus of some cultures when working with newcomers is crucial. While an individual may initially

present as the client, and interventions and resources may be geared toward one person, they are often shared among the family and community. Interventions that utilize a group format rather than individual counseling have been shown to increase participants' sense of belonging. Participants in Mitschke et al. (2017) indicated that along with assistance addressing barriers and developing skills to navigate the complex education, medical, and financial systems they encountered in the U.S., being part of a group increased their sense of mutual aid and social support. Understanding specific cultural and political histories becomes critical when working with newcomers.

Counselors have an obligation to be aware of environmental and social factors outside of the client's control (Ratts et al., 2015). Professional counselors need to remain aware of the current social and political climate and to attend to the culture of fear that may exist in themselves or the dominant culture. Understanding the general attitude toward immigrants in general and refugees specifically is one place to start; in 2016, 41% of the U.S. population polled opposed taking in refugees and noted their primary concerns as being terrorism and the economic burden of accepting newcomers (Telhami, 2016). Additionally, those polled voiced concern about an increasing number of Muslims residing in the U.S. (Telhami, 2016). Many of these clients face additional unhealthy risk factors due to issues of inequality and prejudice. Also outside of the client's control are their material circumstances. Often, newcomers are resettled in urban areas and are subject to many of the problems related to living in high-density, low-income areas. These material and environmental circumstances include: increased exposure to violence, lower quality education opportunities, and less stable housing that can accompany living in higher-poverty neighborhoods (Singer & Wilson, 2006). Counselors need to be prepared to acknowledge, assess, and address these risk factors.

Another important consideration to take is the role of gender. Male counselors may find barriers with female clients similar to barriers female counselors may face with male clients. It is important to understand how gender roles are expressed in the client's culture and openly, appropriately address this with clients. Counselors require attentiveness to the multilayered, multi-contextual aspects on a local and global scale.

### **Agency and School Considerations**

Both mental health and school counselors can actively look for trends in the populations they work with to identify the presence of immigrants in local neighborhoods and communities. Developing culturally appropriate outreach programs is critical. This may include challenging the traditional model of counseling delivery that requires the client to seek out and travel to the clinic, agency, or school. Also important is providing education on what counseling is. To attend to client's practical needs (e.g., employment, language acquisition, access to care), counselors need to connect with non-profit organizations who serve the refugee population, as well as develop relationships with local health clinics, housing authorities, employment agencies, education centers, and spiritual or religious places of worship. School counselors can assess student, teacher,

and family needs and use this information to develop appropriate school-family-community partnerships (American School Counselor Association, 2016). Partnerships can be designed to assist with immigrant population acculturation to the education system and to connect families with community resources. School counselors may become expert in facilitating and fostering teacher and student capacity for increasing acceptance of diverse students. Furthermore, agencies and schools may play an important role in providing support to counselors working with this population who may experience compassion fatigue, burnout, or vicarious trauma. Supervision, a supportive environment, and attending to the amount of trauma work per caseload can ameliorate these occupational hazards (Lonn & Haiyasoso, 2016; Trippany, White Kress, & Wilcoxon, 2004).

### **Implications for Counseling Organizations and Training Programs**

While similar to the implications for agencies and schools, the implications for professional counseling organizations and counselor training programs focus on preparation and continued professional development. Counseling organizations at the local, state, regional, and national levels all provide avenues for focusing efforts to make an impact. For example, sign up for legislative alerts through professional organizations to monitor and respond to legislation that has the potential to harm vulnerable populations or restrict access to services. Counselors can take advantage of formal and informal opportunities to extend their knowledge of the culture and traditions of refugees' countries of origin. Additionally, counselors may need to expand the diversity of their colleagues and work/organization partnerships. The profession may benefit from openness to consulting and collaborating across helping professions, pursuing interdisciplinary work through grants, co-locating services, collaborative research efforts, and other steps toward preparing to provide clients with access to a full range of services with as few barriers as possible. While counselors are not typically case managers, counselors need to be able to appropriately integrate case management style support with clients who are navigating systems related to meeting basic needs such as housing, education, and health care. Providing outreach to the refugee community through psychoeducation may serve as a way to increase refugees' sense of empowerment and provide an avenue for positive interactions with the larger community.

Counselor preparation programs can continue to widen the scope of diversity education to intentionally include international as well as national considerations. A key aspect is helping students cultivate the habit of focusing on up-to-date information and on awareness of global perspectives on world events. Counseling programs may develop and offer opportunities for counseling and supervision in languages other than English and can assist student counselors in developing competencies to ethically and effectively provide client care with a translator or interpreter present (ACA, 2014).

Another way to enhance cultural competency is to include case examples centered on concerns prevalent in immigrant populations. Preparation programs may also facilitate opportunities for novice counselors to become familiar with non-Western, complimentary therapies to enhance and support the healing work clients are engaged in (e.g., spiritual or religious practices, Qi gong, nutrition, massage). Because many resettled refugees have experienced trauma, infusing a trauma-informed approach to counseling practice and supervision may also enhance the readiness of novice counselors for engaging with this diverse client population. From the framework presented in this article, counselor preparation programs and professional organizations bear a responsibility to assist their constituents in fostering the ability to be responsive to client's basic needs as well as their presenting mental health concerns.

### **Conclusion**

Counselors and other mental health professionals play an important role in promoting the wellbeing of asylum-seeking refugees. Although many articles focus on specific refugee issues, few provide a useful, culturally competent framework for counselors. Using Maslow's (1943) hierarchy of needs provides a humanistic approach for assessing and addressing the difficulties and barriers clients with refugee status face in the U.S. Integrating this framework into practice, in multiculturally sensitive ways, can foster the human tendency for growth to overcome these complexities no matter how difficult or foreign the experience.

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