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How are Therapeutic Professionals Interpreting Ethics in Practice with Migrant Clients?

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ABSTRACT

HOW ARE THERAPEUTIC PROFESSIONALS INTERPRESTING ETHICS IN PRACTICE WITH MIGRANT CLIENTS?

by

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The research study aimed to understand the praxis of mental health professionals working with immigrant and refugee populations in relation to ethical guidelines and agency protocols. Through practice-led inquiry, seven mental health professionals were interviewed from differing therapeutic backgrounds and orientations; including Marriage and Family Therapy, Clinical Social Work, Counseling, and Art Therapy. The researcher sought to identify how theory of therapeutic professionals differ, where professionals are engaging in culturally competent practice and what impact this has on the therapeutic relationship. Participants identified the key components of a positive therapeutic relationship include trust, cultural competency, approach, presence, as well as gift giving/receiving, and food sharing. A major finding highlighted that agency protocols are obstacles to the professional's ability to practice in a culturally competent manner, as well as the importance of general helping skills. The researcher incorporated findings and proposed ethic committees create a proposal for therapeutic professionals to utilize that supports the need for culturally competent considerations in agency policy development.

Keywords: migrant, immigrant, refugee, therapeutic relationship, rapport, culture, cultural competence

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Chapter I

My initial interest in migrants came from a love of culture, of people, and that which is an alternative worldview from my own. As I engaged in international travel, my understanding of human rights and advocacy began to evolve. I seek to promote art therapy as a viable means of communication with the migrant community and a possible avenue to work through mental health concerns associated with the migration process. Culture may arguably be the uniting element that has the potential to make or break the therapeutic alliance. I wish to understand this link more fully and therefore am examining the therapeutic relationship of therapists working with migrant populations from a practice-led perspective.

Problem Statement

Literature in counseling and mental health services discusses the need for multicultural competency when working with clients from other cultures (Sue & Sue, 2008). Altschuler (2013) outlined, "the current annual growth rate in the number of international migrants (to the United States) is estimated to be 2.9% and predicted to increase further" (p. 546). There is a lack of culturally sensitive service providers in the mental health fields currently (American Psychological Association, Presidential Task Force on Immigration (APAPTFI), 2013). Victor (2007) noted that with the increasing population of migrants within the United States, the migrants, "cannot wait for a new generation of therapists," as the need for early access to culturally appropriate mental health services rises (p. 271).

The literature and professional guidelines describe what an ideal culturally competent therapeutic practice might look like and provides a standard to which therapeutic professionals may strive. This includes the building of a positive therapeutic alliance, a space where clients feel they have a real place as a human being (Buhgra, 2004; Rousseau, Key & Measham, 2005), and collaboration, a close association for a common outcome is agreed upon by client and therapist (Brillantes-Evangelistsa, 2013; Joseph, 2011, Sue & Sue, 2008). Numerous articles have referenced cultural sensitivity as an essential element of developing and maintaining the relationship (Ahn et al., 2013; Appleton, 2011; Bhugra, 2005; Boccagni, 2011; Joseph, 2011; Lala, 2012; Messent, Saleh, & Solomon, 2005; Rousseasu et al., 2005). It is necessary to develop services that are culture bound, culture generic, psycho-educational, and collaborate with the client (Fong, 2004; Victor, 2007).

Current literature outlines that the therapeutic relationship with clients from different cultural backgrounds may look different, and there are many considerations a therapist must take in order to provide the client with culturally competent services. Hill (2009) acknowledged that building rapport, "an atmosphere of understanding and respect," is vital to the success of therapy (p.90), a component to which every client has a right.

Codes of ethics are value based, in the sense they are not mindful of how varying cultures would approach a helping profession or interaction (Corey, Corey, Corey, & Callahan, 2014). Mental health services are largely Western based, and therefore hold western values of rapport development, maintenance of the therapeutic alliance, as well as expectations of the client throughout the relationship (Sue & Sue, 2008). Specific

examples include how a client may offer a gift to a therapist, or offer to share tea or food; refusing this gesture may permanently damage the relationship. Firmly held expectations to timeliness and boundaries are also questioned.

The American Art Therapy Association (2011b) is guided by *Ethical Principles of Art Therapists,* wherein it is expected that practitioners seek counsel and knowledge on cultures different from their own. Art therapists are expected to have an extensive level of self-awareness and dual relationships are not encouraged.

The researcher engaged mental health professionals in one-on-one practice-led interviews to explore the praxis between mental health professionals and their clientele. Secondly, the participants were asked how they navigate their clinical practice in regard to ethics. I speculated that mental health providers would recognize that ethical guidelines insufficiently encompass the needs of the migrant demographic.

The research illuminates values held by therapeutic practitioners that are not evident in the literature, values, which may contradict the stated ethical guideline(s). The methodology of practice-led interviews was chosen to highlight these differences with the hope of amending ethical codes to include additional clarification when working with migrant clientele.

Definition of Terms

The term 'culture' can be defined in numerous ways; a single source is yet to be found that encompasses all that is 'culture.' Therefore, a working description seems most appropriate. Werbner (2005) identified culture as a crucial medium that includes transaction, relatedness, identity, subjectivity and moral virtue. In addition 'culture' also includes race, sexuality, gender, and social status (Keeling & Nielson, 2005; McNiff &

Barlow, 2011; Talwar, 2010). Ayiku (1997) described culture as, "the sum total of the ways of living built up by a group of peoples in a particular society and transmitted from one generation to another" (p. 6). Culture is complex; in order to fully grasp it's meaning and understanding within different contexts, culture must be looked at within each respective culture.

The term 'migrant' is defined as someone who has moved from one country or locality to another (Ahn, Miller, Wang, & Lazloffy, 2013), and therefore includes immigrants and refugees.

Chapter II

Review of Literature

The literature review encompasses the interrelated topics of migrants and their engagement in the therapeutic process: mental health, access, and approach. Table 1 outlines the search terms used by the researcher. Literature included in the review encompasses several therapeutic professions including counseling, social work, art therapy, as well as marriage and family therapy. In addition, a cumulative paragraph on art therapy will be presented in addition to ethical considerations under each heading

Mental Health and Access

Razum and Spallak (2014) indicated that migrant health opportunities are limited in comparison to western majority populations. The authors noted both medical and mental health access disparities. Migrant populations face different challenges when services may be needed. For example, therapeutic services may be sought by the client themselves or through recommendation or referral from another (Li & Seidman, 2010).

Mental health stigma. The stigma of mental illness has been identified ''most formidable obstacle to future progress in the arena of mental illness and health'' (U.S. Department of Health and Human Services, 1999, p. 3). Stigma may be manifested by bias, distrust, stereotyping, fear, embarrassment, anger, shame, or avoidance (Li & Seidman, 2010). Mental health services are often considered 'taboo' in many cultures (Downs-Karkos, 2004), where the term becomes synonymous with weakness or sickness (Downs- Karkos, 2004; Keeling & Nielson, 2005). Clients may prefer seeking services

Table 1

Alternative Search Terms for Literature Review

Mental Health	Access	Approach	Migrant	Therapeutic Alliance	Art Therapy
Counseling	Community	Alliance	immigrant	Therapeutic Alliance	Art
Therapy	Stigma	Techniques	Refugee	Rapport	Therapy
Psychotherapy	Personal Belief	Skills	Displaced person(s)	Relationship	Craft
Psychology	Resources	Trust	Internally displaced	Connection	Art Activities
Art Therapy **		Competency	Internally Displaced Person*	Engagement	Recovery
Theory		Presence	Escape	Interaction	Psycho-therapy
		Knowledge	Genocide	Communicate *	Alliance
		Awareness	War	Bond*	Holistic
			Triage	Affinity	Alternative Therapy*
			Crisis	Togetherness	Education
			War	Agreement	Expressive Therapy*
			Trauma	Interrelation-ship	Expression
			Asylum Seeker	Link	Resources
			Abuse	Unity	Education
			Persecution	Attunement	Arts in Therapy
				Gift	Helping
				Food Sharing	Create*

Note. * indicates an asterisk was applied as part of the search term
** see additional column

from a source that is more accepted in their culture of origin (e.g., priests or imams) (APAPTFI, 2013). Trust is difficult to develop and maintain (Kaczorowski, Williams, Smith, Fallah, Mendez & Nelson, 2011; Li & Seidman, 2010; Sue & Sue, 2008) where many cultures are hesitant to share family matters due to a cultural value of privacy (Bemak & Chung, 2007; Giacco, Matanov & Priebe, 2014). In fact, privacy is not just a cultural value but often a reaction to citizen rights, Segal and Mayada (2005) pointed out that many refugees and immigrants closely guard personal information due to their lack of rights for freedom of speech or choice.

Community. For treatment to be successful, it is suggested that a viable means of collaboration be integrated, including informing and consulting the community in which the client comes from or identifies (Giacco et al., 2014). Sue and Sue (2008) suggested having members of the community as primary staff and service providers. Working collaboratively with the community provided a significant opportunity to lessen imposition of the therapist's culture and enhance cross-cultural interventions (Brillantes-Evangelista; 2013, German & Ehntholt, 2007; Miller & Billings, 1994). In addition, Nuttman-Shwartz and Huss (2010) indicated that community support is a positive coping strategy. Awareness of how different cultures express affective symptoms would enhance assessment validity as well as impact the therapeutic relationship (Pumariega, Rothe, & Pumariega, 2005). Therefore, when uprooting and changing locations, a greater psychological support for social adjustment may be needed. For communities such as migrants, being made to feel welcomed in the new society, through its accessibility to housing, employment, and approachability of the persons there contribute to stressors (Bhugra, 2004).

Barriers. There are different needs and expectations with all populations seeking mental health services. In comparison to Western born citizens, migrants and their children are disadvantaged when it comes to mental health access. The current legal system in the United States "lacks procedural safeguards to ensure due process and care for the mentally ill [among refugees]" (Davis, 2014, p. 211). Davis (2014) suggested collaborating mental health services with social workers and attorneys to create a fairer system for migrant clientele. Even when services are available, many obstacles are overlooked, such as: the role of women in the family, level of literacy, socio-economic status, and migration history (Razum & Spallek, 2014).

Language barriers or frequently underestimated and overlooked in mental health services (Snowden, Masland, Peng, Lou, & Wallace, 2011). Limited English proficiency has been identified as a hindrance of timely and effective care (Sentell, Shumway, & Snowden, 2007). Access to mental health professionals with competency in alternative languages is necessary, in addition to professionals with expertise in various religions or willingness to refer clients to religious communities (APAPTFI, 2013).

Socio-cultural barriers including clients having conflicting views about the source of mental health problems, lack of knowledge and resources, distrust of the larger system, and challenges related to documentation status affect stress levels of clientele (APAPTFI, 2013). Culturally competent service providers should examine clinician bias, migration stage (Bhugra, 2004), and communication problems due to cultural nuances and language differences, in addition to how misunderstanding the role of religion or spirituality for a client can damage the therapeutic relationship but also lead to misdiagnosis, and

underestimating client resiliency (APAPTFI, 2013). In conclusion, the myriad of identified barriers, stigma, and access are obstacles to mental health access.

Therapeutic Approach and Stance

Razum and Spellak (2014) noted the exclusive versus inclusive strategies when adapting health services to migrant populations. The exclusive approach highlights the differences in "biology, life course, language, culture, etc," between the migrant population and the majority population (p. 893). The inclusive approach is considered to provide resources that address the needs of everyone. For some cultural demographics, a referral from a primary care physician increased the migrant client's likelihood of engaging in therapeutic services (Li & Seidman, 2010). Blanch (2008, as cited in Akinsulure-Smith & O'Hara, 2012) stated that while intentions of therapy aim to reduce trauma, very few of the models for analysis take into account the specific needs of immigrant/refugee populations.

Transcultural approach. Intersectional and transcultural perspectives are guiding current therapeutic practices (Calisch, 2011; Hoshino, 2003; Talwar, 2010). Where intersectionality becomes a tool for analysis of systems and oppression, S. Talwar (personal communication, January 31, 2013) pointed out that oppression must be examined from a personal and systemic dimension. Multiple levels of inequality are historically and globally situated, they are socially constructed on a basis of power and exploitation, and are simultaneously expressed through social hierarchy. Corey et al. (2014) challenged that it is not being privileged, but rather how the therapist uses that privilege. Therefore, Talwar underscores developing an understanding of ones own social class status is imperative to reduce imposition of ones beliefs.

The Art Therapy Multicultural/ Diversity Competencies requires an awareness of personal values, biases and assumptions in order to practice (2011). Lala (2012) stated in her article on cultural sensitivity, in relation to the therapists' self-awareness:

> One of the most important pieces of information I have learned is that there are no specific strategies which work with ethnically diverse [clients], instead, it is the application of therapeutic strategies that makes interventions culturally sensitive. Furthermore, seeing clients from diverse backgrounds not through an ethnocentric lens but through one which is unbiased is what informs the approach and interventions used in the therapeutic work. (p. 33)

Techniques. The literature clearly emphasized that a therapist's understanding of the client's cultural background and his/her sensitivity is imperative to fostering the relationship (Ahn et al., 2013; Bhurga, 2005; Messent et al., 2005; Rousseau et al., 2005;). Several approaches are outlined in the literature: Messent et al. (2005) advised conceptualizing families as having 'transnational loyalties;' a helpful frame of reference that incorporates values of both host and home culture. Congress (2004) cautioned not to overgeneralize a client's perceived culture; each client is different, even when identifying with a specific ethnic origin. Li and Seidman (2010) outlined six solutions for higher culturally competent practice when working with multicultural clientele, and highlighted the inclusion of family members in the intake session, as clients may be more comfortable (Corey et al., 2014). Lala (2012) remarked that a therapist should use three lenses when working with ethnically diverse clients: seeing all humans as self-determining beings, recognizing mutuality of ethnicity between the client and therapist, as well as an awareness of the impact of colonialism. The impact of colonialism directly

relates to the understanding of historical and current social impact of the clinician upon others (American Art Therapy Association, 2011a).

Understanding a client's cultural background entails knowledge of the parent's country of origin, common beliefs and practices, in addition to specific child rearing practices. Western mental health practices "either overtly or covertly" communicate that parenting practices unlike their own are somehow wrong (p. 6). Validating parent's efforts in addition to feeling heard, valued, and validated are identified from clients as aiding rapport (Ahn et al., 2013).

The American Art Therapy Association requires that therapists are aware of "the differences in styles of communications with respect to self-disclosure, nonverbal behavior, directness, respect, and assertiveness. Therapists recognize how their unexamined assumptions can negatively impact the therapeutic relationships and the art therapy process" (1.B, 2011b). Woods and Springham (2011) suggested that empathy has its limitations in positive rapport development. Joseph (2011) indicated that the therapeutic process is more productive if therapists remain humble about their positions, avoiding the hierarchal position of power, even if the client may want to put them there.

Collaboration. Incorporating culture and cultural resources, without idealizing them, allows an open atmosphere for collaboration (Rousseau et al., 2005). Integrating cultural identity into therapy is seen as a vital component to addressing many of the acculturative stressors affecting mental health (Lemzoudi, 2007; Sue & Sue, 2008). Allowing the client to lead from where they are at, rather than pre-planning the session, positively impacts rapport; a skill that Guregard and Seikkula (2014) identified as being a challenge for more experienced therapists.

However this engagement requires ongoing self-awareness on part of the practitioner; it becomes essential to know ones' own biases, values, and customs (Doby-Copeland, 2006; Sue & Sue, 2008). Understanding one's own culture through the eyes of the migrant client is essential, taking into consideration perceived and held level of power, mistrust, access or approachability (Guregard & Seikkula, 2014).

Therapeutic relationship. Facilitating the growth of the therapeutic alliance is key to maintaining a positive experience for the clients in therapy (Rousseau et al., 2005). A positive therapy experience is productive and voluntary for the migrant client and works to cultivate trust (Ahn et al., 2013). Trust encompasses compassion and genuine care, in addition to validation, normalizing of experience, providing education, and developing an open stance (Ahn et al., 2013; Guregard & Seikkula, 2014).

As members of oppressed groups, immigrants and refugees, are among clientele that are slow to form trusting relationships; therapeutic professionals must understand the history of this distrust in order to build an alliance with this demographic (Corey et al., 2014). Careful consideration of psychodynamic theoretical approach values such as privacy, payment, and punctuality need to occur, as these guidelines may not best serve this demographic.

Therapists may be presumed to provide a different role that what is traditionally allowed for, where counselor or therapist becomes someone more akin to a social worker or friend (Carlier & Salom, 2012). According to the American Art Therapy Association (2011b) care to avoid ambiguity regarding the role and relationship of the therapist is necessary in order to not undermine the clinician's competency and effectiveness (1.6). While explicit mention of the relationship was not presented, the APAPTFI (2013)

suggested "clinicians should assess the capacity of programs to provide services in ways that are acceptable and effective with multicultural populations" (p. 11). Guregard and Seikkula (2014) recognized communication as an important component in building the therapeutic alliance, yet clients presented with an "urgent need for practical help and advice to come before any therapeutic agenda" (p. 57).

Best practices. Definitive best practices when working with migrant populations include cultural competency. It is necessary to provide an environment where sensitivity, respect, and an understanding of differing beliefs are prominent (Appleton, 2011; McNiff & Barlow, 2011). The APAPTFI (2013) recommended clinicians use an ecological perspective, integrate evidence-based practice with practice based evidence, provide culturally competent treatment, partner with community organizations, and incorporate social justice principles. Taking a "genuine stance of not knowing" may pave a way to further discovery in the therapeutic process (p. 63; Ahn et al., 2013). Creating a safe space was seen as a primary objective in the practice of Carlier and Salom (2012).

Art therapy. Literature has shown that art therapy has been utilized to address mental health concerns in regard to the migrant populations. Case studies have included migrant clients across the life span: latency age children (Akhundov, 1999; German & Ehntholt, 2007; Miller &Billings, 1994; Nuttman-Schwartz & Huss, 2010; Rousseau & Heusch, 2011; Wertheim-Cahen, Euwema, & Nabarro, 2005), young adults (Czamanski-Cohen, 2010; Chu, 2011; ter Maat, 1997), adults (Huss, 2009), and families (Akhundov, 1999; German & Ehntholt, 2007; Rousseau et al,, 2009; Somoasundaram & Sivayjokan, 2013). Common mental health concerns specific to the migrant demographic have included acculturative stress (Benson, Sun, Hodge, & Androff, 2011; Brillantes-

Evangelistsa, 2013; Huss, 2009; ter Maat, 1997; Yakushko & Espin, 2010;), post-traumatic stress disorder (PTSD) (Wertheim-Cahen et.al., 2005), trauma and violence (Czamanski-Cohen, 2010; Somoasundaram & Sivayjokan, 2013; Wertheim-Cahen et.al., 2005), relocation (Nuttman-Shwartz & Huss, 2010), identity (Emberly, 2005; ter Maat, 1997), attachment needs (Carlier & Salom, 2012; Robb, 2002; Somoasundaram & Sivayjokan, 2013; Wong-Valle, 1981), and loss (Altschuler, 2013; Lemzoudi, 2007; ter Maat, 1997).

Literature promotes the use of art therapy as an alternative to talk therapy within international and cross-cultural communities, on the premise that images are a universal language (Chu, 2011; Emberly, 2005; Lofgren, 1981; McNiff & Barlow, 2011; Robb, 2002; Roijen, 2005; ter Maat, 2011;Victor, 2007). Art therapists consider indigenous helping practices, as well as materials for creation, and are not tied to solely verbal expression (American Art Therapy Association, 2011a). In an ethnographic study, Gold (2004) found that photography as well as the making and sharing of photographs, significantly assisted building rapport. McNiff and Barlow (2011) stated the art object becomes the "tangible meeting point" for the differing cultures, where art therapy became the "coexistence of the two worlds" (Lemzoudi, 2005). Appleton (2011) indicated the stage of building the therapeutic alliance is marked as one of resistance. Therefore, the art therapist is respectful of the pace at which the client discloses through symbolic means. However, it is imperative to remember that symbols vary between cultures. An art therapist needs to understand these differences, engaging the client in this understanding can build the alliance and may empower the client (Joseph, 2011).

Therapeutic Relationship Within a System

Hocoy (2011) expressed that Western therapeutic traditions have imposed their values for too long on minority and international demographics. As this is accomplished, a weakening of literal and metaphoric boundaries may occur and an atmosphere of collaboration can take place amongst expressive therapists and/or their clients (Landy, 1995). S. Talwar (personal communication, January 31, 2013) suggested incorporating an identity of the self, where it is fluid and plural, rather than static and singular; leading to a goal of empowerment, thereby furthering social and economic justice. Seeking supervision and assistance when working with clients from a culture different from the therapist's own is an expectation outlined by the American Art Therapy Association (2011b, 6.5).

Ethics. While ethical considerations have been dispersed throughout the literature review, it is key to recognize that different ethical guidelines will color practice, as ethical codes may be different between locations (Remenyi, 2011). Within the research study, the American Counseling Association (ACA, 2014), Art Therapy Credential Board (ATCB, 2011), American Art Therapy Association (AATA, 2011b), as well American Association for Marriage and Family Therapy (AAMFT, 2015), are taken into consideration. Appendix B offers a figure, which outlines essential components from each ethical code in juxtaposition to one another, in regard to cultural competence. AATA (2011b) published an additional counseling framework when working with multicultural groups, which requires the continual awareness and implantation of culturally competent skills in practice (7.0). According to the American Art Therapy Association's Multicultural/Diversity Competencies (2011a), cultural competency

"involves a three-stage counseling framework of awareness, knowledge, and skills… is essential to ethical practice, and competence must become the cornerstone for effective practice" (p.1).

Gift giving. Numerous cultures often offer tokens of gratitude yet, "there is little written about it in ethical guidelines" (Furman, 2013, p.77). Gift giving has received, "little attention in theoretical literature and even less attention in the empirical literature" (Knox, DuBois, Hess, & Hill, 2009, p. 350). It is recognized that clients give gifts for a variety of reasons, including: expression of transference, symbolic desires, become an actual object, or manipulation. While most therapists only accepted gifts of minimal monetary value, it was common practice to address the meaning of the gift with the client in session (Knox, DuBois, Hess, & Hill, 2009).

Ethical guidelines such as the American Counseling Association (2014, A.10.f) recognized that in some cultures, gift giving is a gesture of respect and gratitude, and that to refuse a gift would be extremely disrespectful and certainly damage the therapeutic relationship (Lettenberger-Klein & Fish, 2013). Exploring several factors may support the therapists ethical decision making process to accept or graciously decline the gift, such as monetary value, motivation for client offering the gift, and the therapist's motivation for wanting to accept or decline the gift (ACA, 2014, A.10.f). Smolar and Eichen (2013) suggested that this exploration has greater potential for therapeutic gain than the symbolic meaning of the gift itself.

Food sharing. Food sharing requires another ethical navigation. A shared meal is a social event, important and telling of one's culture, and recognized as a time to build relationships (O'Hara, Helmes, Sellen, Harper, ten Bhomer, & van den Hoven, 2012).

Like gift giving, the narrative exchange is just as important as the nutritional purpose of the food. Park (2011) shared that partaking in a meal with others encourages reconnection with oneself and others; it is a space for healing, and "an intercultural practice of care." It is recognized that attending social events may confound the therapeutic relationship, however it is also noted that an absolute ban on this multiple relationship may be destructive and undermine clinical effectiveness, "some boundary crossings may be beneficial" (Corey et al., 2014, p. 264). Flexibility in boundary crossing can be clinically appropriate when applied ethically on a case-by-case basis (Corey et al., 2014).

Summary

Present research on migrants, art therapy, and the therapeutic alliance indicated cultural sensitivity is vital to sustaining a therapeutic relationship. Incorporating the client's community and or family may provide the clinician with insight as how to best approach cultural incongruence, and reduce stigma of receiving services. Additional research on how art functions as part of specific cultures as a means of metaphor and ceremony may provide insight into how art therapy can be used more effectively in different culture populations (Hocoy, 2011; Lemzoudi, 2007). In addition, continuing research is needed to better comprehend and understand culturally appropriate ways for helping professionals to assist traumatized individuals such as some migrant poulations (Victor, 2007), while at the same time maintaining and supporting the cultural identity and values of home culture (Fong, 2004). This may include practices such as gift giving and receiving or food sharing. Cultural competency training and education is essential to the development of the art therapy field (Doby-Copleand, 2006; Hocoy, 2011; Kalmanowitz & Potash, 2010; McNiff & Barlow, 2011).

Major themes that arose from the literature review include: the stigmatization of mental illness across cultures with the frequency of stressors due to acculturation and trauma, the implications in regard to power and privilege, as well as the role of community within the therapeutic process. All of these influence the ability to develop a positive therapeutic relationship. Mental health acess, therapeutic approach and stance, as well as therapeutic relationship within a system therefore were constructed as a priori themes for data analysis in chapter IV.

Chapter III

Methodology

Practice-led research aims to discover new knowledge in hopes of advancing a practice (Candy, 2006; Rust, Mottram, & Till, 2007). A semi-structured interview format was applied; this allowed the expertise and expansive experience of the participant to be highlighted (Csorda, Dole, Tran, Stickland, & Storck, 2009). Questions are "directed to the participant's experiences, feelings, beliefs and convictions about the theme in question" (Welman & Krueger, 1999, p.196).

The goal in using a practice-led design is for the researcher to better understand the clinical practice of working with migrant populations. Therefore the research questions were: 1) How do therapeutic professionals interpret ethics in the therapeutic relationship with migrant clients? 2) How do ethical boundaries affect the therapeutic relationship? In addition, I explored how different cultural backgrounds between the client and therapist may impact the helping relationship.

Participants

The study included art therapists as well as helping professionals with a minimum requirement of a master's level degree. The research was initially intended to only include art therapists practicing in St. Louis, Missouri and compare practice to Montreal, Canada. However due to limited participation the requirements for participation were opened to include mental health professionals practicing in a counseling or therapeutic capacity in the Midwest region of the United States, and included an interested participant from Montreal, Canada. Participants were recruited

through an electronic list-serv, as well as through snowballing by suggestions from colleagues, acquaintances of the academic community, and the recommendation of previous possible participants (Temple & Brown, 2011).

The study aimed to include 35 participants, the saturation point for grounded theory qualitative research studies (Mason, 2010). Seven therapeutic professionals agreed to participate. Figure 1 visually represents participant demographic data. All participants had at least a master's degree, and specializations included Social Work and Marriage and Family Therapy. Master's degrees included Art Therapy, Counseling, Psychology, and/or, International human rights law. One candidate had a doctoral degree and one candidate was currently pursuing this title. Licensures included Clinical Social Work, Marriage and Family Therapy, and Counselor Practitioner. One male and six females participated; the average years of working in an immigrant/refugee demographic was 10.9 years. Participants selected worked predominately within the mid-west United States, including Kansas, Missouri, Wisconsin, and representation from Montreal, Canada, as well as a practitioner currently working in Mexico. Six of the seven participants are female, while five of the participants self-identified as Caucasian, one participant identified as half Asian, and one participant identified as Italian. No participants self identified as a migrant.

Internal Review Board approval was obtained prior to contacting participants in order to minimize potential risks. Each participant was given a letter of informed consent describing the study and the intended purpose. Participants were informed of the potential risks associated with the study, that the interviews would be recorded and transcribed by an outside party.

Participant	Gender	Credentials	Years in Practice	Identified Race
1	Female	LMSW, seeking LCSW	5	Half Asian
2	Female	PhD, ATR-BC	20	Caucasian
3	Female	LCSW	4	Caucasian
4	Female	LMFT	10	Caucasian
5	Male	MA, PhD candidate school counselor/psychologist and art therapy	14	Caucasian
6	Female	MA, EMDR, counseling student legal advisor for asylum seekers and mental health counseling	6	Caucasian
7	Female	MA, AT certificate art therapy and career counseling	17	Italian

Figure 1. Participant Demographics. This figure illustrates the demographic data of the seven participants in the research study.

Procedure

The interviews followed a semi-structured pattern that allowed for open-ended inquiry and ability for the researcher to tap into the areas of passion and expertise from each participant. Table 2 outlines the timeline of the research. From beginning to end, the research process commenced in February 2014, data was collected until September 2014, and compilation of material and writing of results occurred through March 2015.

Participant interviews were semi-structured; the researcher had a set of predetermined inquiries that the researcher used to guide a basic structure for the interview. The broad theme of the interviews were in regard to building a therapeutic relationship with migrant clients and how this is affected by the ethic guidelines followed

Table 2

Timeline of Research

Month	Description of Activity
February 2014	IRB submission and contacted participants
May-September 2014	Interviews conducted
September-October 204	Transcription of Interviews
October-December 2014	Data analysis and compared to codes of ethics

by the participant. Sample questions included can be found in Appendix D. Interviews were conducted through Skype or recorded phone call in the researcher's home, interviews lasted between thirty and ninety minutes. Each interview was recorded using a smart phone app CallRecorder, or Garage Band, when the interview was done through Skype. Questions were asked in an open-ended fashion to ensure the expertise and perspective of the participant was elicited and not colored by the opinions of the researcher (Csorda et al., 2009). Additional sample questions can be found in Appendix C.

Words may have multiple meanings, or different meanings to each participant that vary with the context (Campbell, Quincy, Osserman, & Pedersen, 2013). When applicable, as deemed by the researcher, the researcher questioned how the participant defined specific words or sought clarification on the participant's point of view. Upon the conclusion of each interview the researcher included in her notes an emic understanding of the content received, including the researcher's inferences, interpretations, and

inductions (Hornberger, 2013).

Data Analysis

The researcher used thematic analysis to code and synthesize the collected data. The style of thematic analysis used in this research is modeled off of Glaser and Strauss' (1967) grounded theory approach. Burnard (1991) outlined a fourteen-stage process that can be used to code the data in a way that encourages validity and reduces researcher bias. This style was adapted to enhance the data collection and analysis.

As much of the content was related within different interviews, the researcher created notes after each interview remarking on topics discussed in order to differentiate one interview from another. The researcher recorded salient point of the themes discussed so that these topics were readily available, and served as a starting point for the coding process. This process served the purpose of 'memory jogging' (Field & Morse, 1985) which aided in the creation of initial theme, or Nodes, in the software used for data analysis Nvivo.

The researcher imported all transcripts into Nvivo and created nodes based off of the questions asked to each participant. The structure of the interview questions provided a structure to categorize the transcript by specific questions that were asked. The researcher had all of the interviews transcribed verbatim, and went through these transcripts multiple times, first, to collect general themes, then the researcher broke these general themes into categories and sub-categories.

Once this process was completed the researcher went back to the transcripts and "collapsed" similar categories to create broader categories that were more inclusive of a wider range of information. This information was presented in an excel spreadsheet that

looked at all of the sub-categories in relation to one another. The researcher color-coded related sub-categories that were present in multiple larger categories and created a new list of main categories. This new list was worked through to generate a final list of content categories. Then the researcher went back and pulled the context of each final content category and juxtaposed this to the original transcript to ensure the content was truly representative of the perceived meaning. Adjustments to the final categories were made as necessary. Transcripts were then re-read following the final list of categories and sub-headings. At this stage each transcript was officially coded with the intention to maintain the context of each commentary, and group comments from the similar category. All copies of original transcripts were kept for reference; at this point the writing process began (Burnard, 1991). The final list of content categories included: components of trust, type of relationship, being and presence, power and privilege, gifts, and food.

Chapter IV

Results

The major finding of the research study showed that basic helping skills are essential elements underscored by participants, therefore not endorsing specific cultural based interventions. Themes that emerged from the data include: therapeutic approach and stance, transcultural approach, best practices, collaboration, barriers, and therapeutic relationship within a system. The categories present in the data analysis are presented below in Tables 3-5 itemized by the frequency the categories were present in participant interviews. Categories present in five or more interviews are considered frequent, 3-5 interviews are considered typical, and 1-2 are considered variant. Participant quotations are included to illustrate the content of the data presented.

Praxis related results indicated that participants lead from a stance of cultural competency. Participants are incorporating ethical documents into their practices as guidelines, integral to their considerations when deciding competent practice. In contrast, agency regulations became the source in which participants did not deviate, and were therefore rigid in contradicting these protocols in practice.

Components of Therapeutic Relationship

Participants noted a difference between building and sustaining the therapeutic relationship. The imperative need for the therapist to be culturally competent was evident in each interview. Participant 7 identified that there comes a point in the relationship where the therapist cannot rely on the client to educate the therapist regarding his or her culture, *"not just reading about culture, but being aware of how they live... immersing*

yourself and actually living the culture is necessary to understand it." Respondents indicated this includes being open to indigenous practices, as well as having an awareness of cultural values.

Table 3

Frequent Categories in Data

Category	Example
Barriers	"Barriers have a lot to do with me rather than my clients... most of the barriers revolve around comfort and discomfort" "I see a lot more of the barriers that might prevent someone from getting to [the session], or why they wouldn't remember without a reminder phone call"
Language	"I am not familiar with [that word] can you tell me?" "Someone could draw a sheep, that doesn't mean it's a sheep" "It's pretty hard to go in-depth when language is a barrier"
Transcultural Approach	"Let me know if a holiday is coming, I would like to be aware of it' just saying that, it just means I'd like to learn more."
Awareness of Culture	"There are so many different elements, just learning another person's culture and learning how to interact in an appropriate way. It's literally like learning a new language."
Self-Awareness	"Its very humbling, and then just awareness of, wow, I come from such a different, privileged, safe [place]" " I don't know that we can't impose our own values on someone. That's who we are, and we have to be a person with the client."
Therapeutic Relationship	"Always checking in along the way, asking if they need anything, how all of this feels to them is really important.
Cultivation of Trust	"Validating their emotions, Building that trust so they know that I'm not afraid of these emotions and I'm not going anywhere"
Best Practices	"I'm very much aware that whatever our encounter is in that moment, it just represents one little corner of that person's life, so I can't make assumptions about that life."
Ethics	"Having to deal with bureaucracy, having to deal with the system, I didn't want that to be another barrier"
Gift Giving	"Saying 'no' to a gift for most [clients] is hurtful, so I finally said, 'if I accept this from you I could have the potential to lose my license and be fired."
Food Sharing	"I wouldn't refuse to go to a client's home for dinner unless I had a really good reason...if it was an invitation to bolster authority in the family to show [the therapist] is on [the client's] side, achieve the client's goals but not the therapeutic goals, then I would refuse"

The literature provided general concerns to malpractice in cross-cultural terms; the participants shared personal case studies that, due to their unfamiliarity with a cultural practice or way of interpersonal communication, created moments of disconnection within the therapeutic space. Working with this disconnection to then further build rapport was evident in multiple interviews. One component of the cultural competency paradigm was that in some practices clients had an assumed knowledge that therapists were more aware of the client's cultural background then was perhaps accurate. Two participants discussed personally held guilt in relation to power/privilege. Participant 2 highlighted types of guilt: survivor guilt, power guilt, white guilt, and guilt of privilege. The therapist's awareness of their role in the power dynamic as well as personal bias is

Table 4

Typical Categories in Data

Category	Example
Stigma	"[I] was recently reading how PTSD may be an American construct" "The concept and idea of therapy doesn't exist in some cultures, they don't talk about their personal grievances or their problems, or rape being stigmatized.."
Distrust	"The parents would feel very untrusting of anybody who represented the dominant system, the dominant culture"
Community	"[client's in group therapy] realize they're not the only people in the world that feel this pain"
Collaboration	"It's like a big supper table, we all sit in different chairs, and we all change chairs in all our lives...we're all pretty much equal" "Meeting the client where they're at, co-constructing goals together, checking in often, and really hearing what they want to do in therapy"
Boundaries	"We can be friendly and we can talk about things, but it doesn't necessarily mean we're crossing all sorts of boundaries. If I'm going to throw up a front of like, 'really? Why is it important you know about my weekend?' that's not going to be considered culturally competent"
Art Therapy	"I had this visual image that would come up...gave me a frame of reference for understanding where [my client] was coming from"

strongly correlated to culturally competent practice. Participant 4 and 5 highlighted that as practicing professionals, their clientele have not questioned their abilities, despite language barriers, to practice competently due to the position of presumed authority the client places upon them.

Efforts to minimize clients placing therapists in a position of power were offered. Participant examples included highlighting connections and equalizing the relationship from a position of being human beings. However, unlike the literature, participants

Table 5

Variant Categories in Data

Category	Example
Informed Consent*	" Make it pretty clear when we first start what they can expect in terms of privacy"
Attunement*	"Just trying to be warm, open, and receptive"
Resiliency*	" Remembering that these are really strong people" "Not backing off or shying away if [I] touch something that's dark and twisty...just letting them know that [the therapist] isn't going anywhere"
Presence*	"The therapeutic relationship, it's all about presence, and the quality of presence.."
Non-Verbal	"Things you might do like paraphrasing and reflecting, does get lost in translation, I do a lot of mirroring of my emptions, make sure that my face is empathetic and that I'm tracking them... I may not understand the words, but I grasp what they are trying to tell me"
Environment	"Set up is huge as far as how you position your body..."

Note. * indicates item was not found in literature

recognized that no matter what interventions are implemented, there would always be a level of inequality due to the way systems of service are arranged

Development and maintenance of therapeutic rapport is strongly dependent on trust. A clear breakdown of the components of trust in the therapeutic relationship can be found in Figure 2.

Therapeutic Approach and Stance

Overlap is inherent with components of trust and the types of relationships therapeutic professionals aim to develop with immigrant and refugee clientele. There is some variation in what is considered to be best practice when working within this demographic. Participant six identified: *"Early on I learned imposing theories and different ideas of what I thought the clients should be doing is not how it goes."* However, a recurrent theme was that the participants were more aware of building the relationship than they may otherwise be when working with another demographic. This may be linked to the idea from the literature that the immigrant and refugee demographic are slower to form trusting relationships due to a probable lived history of distrust. Participant 5 mentioned that, despite psycho-education, clients have a misunderstanding of the therapeutic process, *"Considering what many clients have gone through, mistrust was part of survival."*

Informed Consent. Divergent from the literature, participants identified that at the outset of therapy, the informed consent process is very important. Participants mentioned limits of confidentiality, what to expect from therapy, and clarification of the role of the therapist as well as the client. In addition discussion when consenting included how the therapist will react to the client outside of the therapeutic space, and how to handle if the therapist offends or frustrates the client should be addressed. Finally, client

rights need to be discussed in a manner that the client clearly understands and agrees to, which may be challenging with language and cultural barriers.

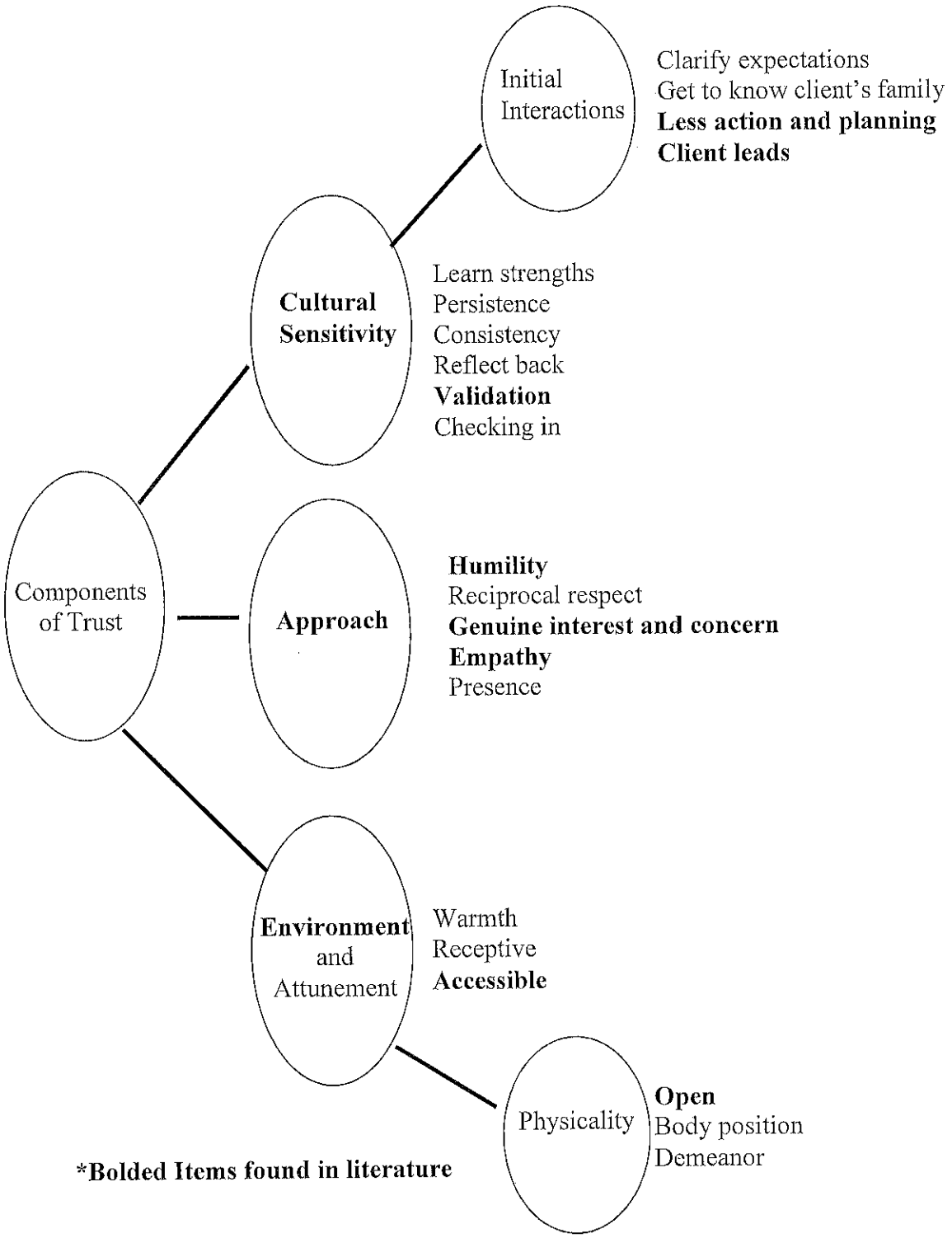

Figure 2. Operationalized breakdown of typical and variant terms in components of trust in a therapeutic relationship. This figure illustrates the themes found in participant responses on what skills or elements are involved in the creation of trust within a therapeutic relationship with migrant clientele.

Collaboration. Clients and therapeutic professionals work through expectations of both parties in a manner that equalizes the relationship. Aligned with the literature, participants adamantly pointed out that a key when building the relationship was to limit planning and action at the initiation of therapy. Many systemic factors influence the relationship outside of the client and therapist, such as political systems, family, and cultural context. Recognizing that the client is an individual within an identified culture, and therefore has a unique culture identity, is necessary.

Client leads. Participants were aligned with the literature review in stating that collaboration and giving the client space to lead creates a symbiotic relationship. Participant 5 highlighted that the collaborative relationship becomes a model for the client to learn to trust others again. Utilizing the client's own resourcefulness and strengths is not only empowering for the client but offers an additional level of collaboration and communication.

Participants underscored following the client's pace and getting to know who they are as a whole person becomes crucial to the development of rapport. Participants mentioned that tuning into the body language of the client's affect will delineate an appropriate pace for sessions; however, therapists should be ready for a longer process when working with immigrant and refugee clientele.

Boundaries. While ethical guidelines and agency protocols stated ambiguity within the relationship should be avoided, participants specified that with immigrant and refugee clientele, the boundaries are looser. Traditional practice has such a "tight frame, client's can't get passed it" Participant 1. Participants mentioned the desire to be "more than they ethically can," with specific connection to the extreme isolation and loneliness their clients are going through. Consistency of the therapist becomes an integral part of the trust building relationship, as well as ensuring the client through verbal and non-verbal means that the therapeutic professional is able to sit with the client's emotions.

Consistent with the literature, participants indicated reconsidering traditional western therapeutic practice is necessary; the participants unanimously discussed a need for flexibility when working within the demographic. A recognition that this demographic may not be able to always arrive at the session on time due to transportation issues, caregiving, occupational constraints, etc., requires some pliancy. Participant 2 mentioned that therapy has traditionally been viewed through a psychodynamic lens, a lens where systemic perspectives and cultural appropriateness are conflicting, practicing from a framework that challenges these boundaries changes the "container of therapy." For example, participant 5 advised to implement a mindset similar to working with domestic violence clientele. The therapist has no clue what life is like for this demographic. If it is safe to, call ahead and see the client, even if only five minutes are left in the session.

Presence

In addition to not having a checklist, meeting the client where they are at, and being open to including family in treatment sessions, participants identified that a

practice of presence, meditative quality of being, was integral in their practice. The authentic presence of the therapist within the therapeutic space is one that participant 2 felt strongly for, describing presence as:

> *"Active, there is no separation in my mind between [the therapist] and the person I'm present with...When I'm not present...part of my mind is off doing something else. When I am present I quiet my mind and I quiet any kind of concerns that I have, and I just try to bring my focus into being with this other person... there isn't this sense of confrontation, I guess really there isn't this sense of judgment, because this person is right there with you... there is a sense of unity."*

Art Therapy

Participants recognized that learning how affect is expressed through the client's culture is imperative. Participant 5 offered a case example that illustrated this argument in the literature that art can serve as a resource to understand the client from another culture when there is a cultural disconnection or barrier. Participant 5 was not fully aware of the client's lived experience of a historic genocide, therefore she/he created a collage of images found online regarding this event and as it aided the client's therapeutic goals. The participant later shared this collage with the client; aiding the therapeutic relationship through understanding as well as further informing the therapist. While the literature highlighted art by clients can bridge a connection and communication barrier, participant 5 demonstrated that art by the therapist could serve the same purpose.

Gift and Food Sharing

Discrepancy among participants was presented in regard to gift giving and receiving, as well as food sharing. Six out of seven participants thought gift giving and

receiving was a gray zone, an area that is not clearly defined ethically. Like the literature review, five out of seven participants recognized there is clinical good in each of these actions that should be considered; however, some agencies have strict policies. There is some crossover in considerations of gift receiving and food sharing. Participants reported that the agency has protocols for gift giving and food sharing. However, more of the participants (3), in comparison to gift receiving (2), are in agreement that sharing a meal with a client or their family is never appropriate. For a portion of the participants, accepting on behalf of the agency was seen as a viable compromise.

The data represents professionals with different ethical codes, Participant 1 indicated, *"as a social worker it's ok [to accept gifts and food], as a clinician, you fall back on that you cannot take it due to agency rules."* Three participants indicated it is best to err on the side of caution where two indicated they did not accept due to agency rules.

Participants indicated gift giving is a way of equalizing and demonstrating appreciation for the relationship that can often be difficult to equalize, as well as indicative of culturally competent practice. Participant 4 mentioned, *"there are times where it is really inappropriate to continue rejecting [gifts]. There is no way I'm not going to accept the gifts that are given here, that would just be so highly offensive."* What is apparent is that the gift always communicates something; as mentioned in the literature, participants encouraged working through this in the session may produce therapeutic benefits. Art therapists sampled proposed the question of how art produced in the session is considered or not considered a gift.

Implications for Future Research

All participants were asked to identify future research within this demographic. Nearly every participant had a differing thought. Two participants mentioned a need for evidence-based practices specific to particular immigrant and refugee populations. Four participants mentioned a need to look at how rapport is built across the globe in regard to immigrant and refugee communities, specifically delineating any differences among particular culture groups. Research specific to art therapy practice included a desired to connect Cognitive Behavioral Therapy and the Expressive Therapies Continuum on how art influences the lives of persons from another culture and country. In addition looking at how current research regarding relief and aid workers in countries that have experienced genocide applies to therapeutic professionals working in the United States with clients that escaped from these same areas.

Summary

Participant interviews highlighted a need for a more expansive research. Themes were connected between participant interviews and the literature review, although more participation would yield further competency and detailed practice. The participants revealed that theory does not always align with praxis. Ideas such as using art to connect from therapist to client, leading from a place of presence rather than engaging in a traditional clinical practice, and adapting boundaries to be culturally contained and appropriate, challenge some of the literature and codes of professional conduct.

In conclusion, the practice and further development of cultural competency is essential to professional practice. Therapist's examination of self and his or her held power within the relationship is seen as a necessary element as well. Attempts to

minimize this may aid the relationship, however it is recognized that the power hierarchy will always be present within the relationship. Therapist awareness of personal biases and understanding the client's view may bridge this communication and connection barrier. Where the literature highlights that an agency's policies often dictate the therapist's ability to or not to engage in gift giving/receiving and food sharing, it is recognized that this is a gesture of respect in some cultures and the examination of the meaning for the client when either of these gestures is offered is considered culturally competent practice.

Chapter V

Discussion

It is imperative to note that the majority of participants were descendants from white European cultures and not migrants; what became apparent was the how much work the therapist has to do when working outside of their own culture. It is therefore apparent that most commentaries are outsider/ ally perspective.

Major findings of the research study highlighted the importance of cultural competency, basic helping skills, as well as therapist self-awareness. Variance in participant responses and what was found in the literature is presented in the Tables 3-5. While the literature review was congruent with all of the frequent and typical category responses of the participants, discrepancy in the variant responses were represented. These variant topics included: informed consent, attunement, and resiliency.

Cultural competency

Cultural awareness takes the form of being considerate and knowledgeable about a plethora of considerations, many of which are discussed in Sue and Sue (2008); the research illuminated cultural divergences in regard to the therapeutic relationship with values, distrust, power and privilege, communication variances, and stigma of mental health. Taking a transcultural approach and allowing clients to identify how they culturally identify becomes an integral part of building the relationship and trust in the therapeutic relationship.

Barriers

While all helping relationships are culturally diverse, therapeutic work specifically with migrant populations focuses on barriers that may hinder the development of the therapeutic relationship. Frequent barriers that were discussed included language; gift giving, and food sharing. In discussing how therapeutic professionals build relationships with immigrant and refugee clientele, participants often reveled a desire to extend boundaries beyond what agency protocols may allow. Blurring the boundary within a therapeutic relationship changes the container, the held space, that seems to be firmly held by practitioners or agencies that value traditional therapy.

Language. Participants recognized that some of the barriers of language can be understood with non-verbal language, and that art expression may help translate emotion and needs when language may fall short. Current literature identifies that therapy across languages is challenging, where participants that worked with translators or interpreters identified how difficult it can be to develop the therapeutic relationship when there is a third entity confounding it. Participants working with Latin clientele in-particular remarked how the word for advice and counseling in Spanish are the same, *consejo;* participants stated this language discrepancy has become a barrier for misinterpretation of therapist role within the therapeutic relationship.

Gift giving and food sharing. When comparing ethical guidelines in relation to gift giving and food sharing most indicated the salient component is to discuss the intention behind the gift. Majority of participants recognized there is clinical good in accepting gifts and that in many cultures is considered culturally competent practice to accept the gift. However, many agency protocols seem to dictate when and how a

therapist can receive a gift. Regardless of ethic guidelines, the agency is dictating praxis, and not always doing so from a culturally competent frame. This was particularly evident in situations of food sharing.

Agency protocol. Agency protocols limited the discussion from exploring the participants' personal held beliefs regarding some questions. Agency protocol became a firmly held belief that either seems to not be questioned by the practitioner, or the practitioner recognized the protocol as unfortunate and felt they had little or no capacity to adapt the protocol. Participants who disclosed an obligation to their agency protocol tended to express a desire for more specific information as well as a detailed and narrow approach regarding cultural groups; where participants that spoke to the likelihood of clinical good seemed to have an observational approach that considered the client's worldview from a much broader context. The later group tended to project a sense of the multifaceted parts of the client's identity and of themselves, whereas the former group seemed to view the relationship from a hierarchal level.

Boundaries

Participants working with Latin members and communities collectively demonstrated the inherent flexibility needed to work with barriers, rather than against, in order to practice from a culturally competent perspective. Their praxis challenged ethical guidelines in boundary confusion. Where Latin communities are 'contact cultures' which value closer proxemics, as well as values in rapport, participants indicated they share some of their personal life with clients, such as weekend plans, support outside of the traditional counseling role, including documentation services, legal service connections,

and even play dates for children. Participants who worked with Latin communities unanimously stated they have accepted and shared food/drink with clients

Basic Helping Skills

Where the literature fell short was engaging in discussion about the importance of basic helping skills when working with migrant populations. Participants focused on attunement, resiliency, authenticity, and presence as key components to building the trust within the therapeutic relationship. Basic skills such as body positioning, active listening, structure and delivery of sessions, etc. appeared to be significant components of mental health relationships, regardless of demographic.

Limitations

Several limitations were presented within this research study. A larger sample of participants would have been ideal; the saturation point of 35 was not reached. In addition, discrepancy in licensure held by the participants varied, which offered a broad array of types of practice. This hindered more detailed and representative practices among art therapists. To gain a better understanding of how therapeutic professionals engage in building rapport with immigrant and refugee clientele a larger sample is required, including representatives across the country, and may be inclusive of migrant therapists. A sample inclusive of migrant therapists may have provided non-normative responses, in comparison to this study's findings, and therefore yielded alternative results. In addition, the methodology of the research design was based on grounded theory. This approach has inherent researcher bias, the researcher developed the questions to inquire of participants, conducted the interviews and developed follow up questions, and in addition, was the primary person analyzing the data.

Ideally, the perspective of the client would be incorporated into this study. Learning from the perspective of the client is a more direct way of understanding how the client perceives methods and gestures, rather than having this interpreted through the lens of the therapeutic professional. Further research on this topic is needed to better understand how trust and rapport are built among immigrant and refugee clientele from different cultural backgrounds.

While the researcher sees a need for the direct perspective of the migrant population in regard to their experience of building rapport, migrants are considered an 'at risk' population by the review board (Forster, 2013). Therefore the researcher did not feel her scope of practice and knowledge was adequate to engage this demographic directly for the current research purposes.

Future Research

The researcher found that the quality of interviews increased throughout the process. It is recommended that if a similar research design were conducted that preliminary pilot interviews are conducted to test out questions, adjust follow up questions, and to aid in the new researcher's comfort as well as efficiency. The research produced new questions to be answered:

- What are professionals doing to change agencies, how do they handle agencies that are not culturally competent?
- How is art giving agency to oppressed groups?
- What does art really do for people in a therapeutic setting?
- How do therapists work with issues of colonialism in sessions?

In summation, more research was noted in general on immigrants and refugees in mental health relationships/systems. Looking at how therapeutic professionals define common terms such as respect, empathy, listening, attunement, etc. and how they know they have reached these within the relationship may yield results that further reveal best practices. Finally, gaining the perspective of the clients themselves in regard to how they felt they would best build trust, would offer an invaluable addition to the research. Gaining this knowledge can then inform a more comprehensive and culturally competent practice that can be reflected in the code of ethics across the helping professions.

When this question was brought to participants in the interview process, a common expressed desire was for detailed information of specific nationalities and their cultural preferences when working in a therapeutic capacity. In addition participants were eager to have more evidence-based practices with the migrant population as well as praxis focused research.

Conclusion

While a larger sample size may be conducive to more comprehensive results, the research study produced clarity on discrepancies of theory versus praxis. While ethical codes serve as guidelines to therapeutic relationship building the agency protocol tends to be the ruling entity delineating therapeutic professional's actions within the therapeutic space. Additional research needs were identified by all participants and a common desire is to look into delineation of specific cultural groups and how to adapt practice to fit individual needs.

Developing skills related to attunement in physicality and verbal interactions, in addition to authentically being present for the sessions, provides a less threatening

environment and therefore, the potential to build a positive therapeutic relationship. It is imperative to see the multifaceted identity of the client and therpaist, learning their story and taking time for this to unfold rather than imposing time and structure to space. While participants recognize the clinical good that is inherent in accepting some gifts or food offerings, many have learned to decline these gestures. I would like to propose further explanation within the ATCB *Code of Professional Practice,* as well as AATA *Ethical Principles for Art Therapists* in regard to gift giving and food sharing to include a consideration for the clinical good that may result from accepting these items from clients. In addition it may be helpful to have a proposal from these nationally recognized ethics committees that practitioners could utilize to recommend amendments to agency protocols.

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Apendix A

IRB Paperwork

Madeline Brenner

From: Linda L. Skelton <lskelto@siue.edu>
Sent: Thursday, April 10, 2014 3:46 PM
To: Madeline Brenner
Cc: E. Goebl-Parker
Subject: IRB approval - Madeline Brenner

To: Madeline Brenner:

Your proposal to conduct research involving human subjects entitled: "How do /Therapeutic Professionals Navigate the Conflict of Ethics and Therapeutic Rapport with Migrant Clients?" IRB # 14-0407-2 approval period 4/10/14-5/31/15, was received by the Institutional Review Board (IRB), reviewed and approved on April 10, 2014. Your protocol was designated exempt from further IRB review according to the federal regulations on human subjects research as allowed in 45 CFR 46.101 (b) (2).

No further action is required unless you change your methods or duration dates, or alter your interactions with participants. In these cases you must contact the Graduate School's Office of Research and Projects at lskelto@siue.edu to update your protocol and to determine whether further protections are warranted. You are also responsible for reporting any unanticipated events involving risk to participants or others. See http://www.siue.edu/orp/research-forms.shtml#irb_misc_forms for more information and to view our Federal Wide Assurance (FWA) Document.

Thank you for cooperating with the Institutional Review Board. If you have any questions about your research with human subjects, please contact Linda Skelton in the Graduate School at lskelto@siue.edu.

Sincerely,

P

P. Ann Dirks-Linhorst, Chair
Institutional Review Board

Linda L. Skelton
Research Administrator/Ethical Compliance
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Southern Illinois University Edwardsville
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Apendix B

Overview of Ethic Guidelines

Overview of Ethic Guidelines

Ethical code/guidelines	ACA	ATCB	AATA	AAMFT
Food	none	none	none	none
Gifts	**A.10.f** Receiving Gifts: counselors understand challenges of accepting gifts, recognition some cultures small gifts are a token of respect and gratitude. Think of Tx relationship, monetary value, motivation for giving, counselors' motive for want to accept or decline	**3.4.7** Art therapists understand the challenges of accepting gifts from clients and recognize that in some cultures, small gift are a token of respect and showing gratitude. When determining whether or not to accept a gift from clients, art therapists take into account the therapeutic relationship, the monetary value of the gift, a client's motivation for giving the gift, and his or her own motivation for wanting or declining the gift.		**3.9** Marriage and family therapists attend to cultural norms when considering whether to accept gifts from or give gifts to clients. Marriage and family therapists consider the potential effects that receiving or giving gifts may have on clients and on the integrity and efficacy of the therapeutic relationship.
Bartering	**A.10.e** only if no exploitation or harm, client must request, accepted practice by professionals in the community, cult implications, discuss concerns with clients and document in written contract	**3.4.6** Art therapists may barter only if the relationship is not exploitive or harmful and does not place the art therapist in and unfair advantage: if the client requests it; and if such arrangements are an accepted practice among professionals within the community. Art therapists should consider the cultural implications of bartering and discuss relevant concerns with clients and document such agreements in a clear written contract.	**11.5** Art therapists may barter only if it is (a) not clinically contraindicated, (b) not exploitative to the client, and (c) an acceptable community standard or practice where the client and art therapist reside. Bartering is an agreement entered by the client and the art therapist to exchange art therapy services for a type of non-monetary remuneration by the client, such as goods or services. **11.6** Art therapists aspire to offer equal access to art therapy services to those clients who are unable to pay full fee, and where possible, offer a sliding fee scale to accommodate such need.	**8.5** Marriage and family therapists ordinarily refrain from accepting goods and services from clients in return for services rendered. Bartering for professional services may be conducted only if: (a) the supervisee or client requests it; (b) the relationship is not exploitative; (c) the professional relationship is not distorted; and (d) a clear written contract is established.
Dual Relationship	**A.6.b** extending counseling boundaries: consider risks and benefits, (attending clients ceremony, wedding, purchasing a service by a client, visiting a clients ill family member... appropriate professional precautions such as informed consent, consultation, supervision, and documentation to ensure that judgment is not impaired and no harm occurs **A.6.c** documenting boundary extensions do so prior to interactions with rationale, potential benefit, anticipated consequences, show attempt to remedy any harm should it have occurred	**3.3.2** make best efforts to abide entering into non-tx or non-prof relationships with current or former clients family members or other persons known to have a close personal relationship with client **3.3.8** Art therapists must insure that they do not engage in personal, social, organizational, or political activities which might lead to a misuse of their influence.	**1.4** art therapists refrain from entering into multiple relationships with client if they could reasonably be expected to impair competence or effectiveness, risk exploitation or harm: multiple relationships that would not reasonably be expected to cause impairment or risk exploitation or harm are not unethical	**1.3** Marriage and family therapists are aware of their influential positions with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid conditions and multiple relationships with clients that could impair professional judgment or increase the risk of exploitation. Such relationships include, but are not limited to, business or close personal relationships with a client or the client's immediate family. When the risk of impairment or exploitation exists due to conditions or multiple roles, therapists document the appropriate precautions taken.

Apendix C

Sample Leters to Particpants

Draft of initial letter inquiring about participation in the research:

Dear _____,

My name is Madeline Brenner; I am a current graduate student in the Art Therapy/Counseling program at Southern Illinois University Edwardsville. I will be conducting a practice-led, semi-structured interview research study to explore the ethic conflicts and therapeutic rapport when working within a migrant demographic. You have been identified, either by myself, an acquaintance, or on your own accord, as someone who may be interested in participating.

The aim of the research is to inquire of thirty-five professionals from the United States and Canada on their perspective of how ethics affect their ability to develop a therapeutic rapport with immigrant/refugee clientele. The interviews will be conducted through Skype or recorded phone call to ensure consistency with each participant. The interview may run between 30-90 minutes.

If you are interested in participating please contact me by any of the means listed below. In addition if there is someone you know who may benefit the study and might be interested in participating I would be happy to reach out to him or her as well.

Additional questions and concerns can be directed toward myself (contact information is provided below) or my thesis chair for this project, Shelly Goebl-Parker, Department of Art Therapy Counseling at Southern Illinois University Edwardsville at (618)- 650-3196 or egoeblp@siue.edu.

Thank you in advance, and I am looking forward to hearing from you.

All my best,

Madeline Brenner
Art Therapy/ Counseling Student
Southern Illinois University Edwardsville
mabrenn@siue.edu
236-3557

Apendix D

Sample Questions

List of Sample Questions

- What is your experience working with migrant clients?
- Please describe the training you have? What is involved in achieving these__
  - degree?
  - specializations?
  - Credentials?
  - Certificates?
- How many years experience do you have working with this population?
- What type of relationship do you develop with migrant client(s)?

- How do you feel therapeutic alliance/rapport is best built?
  - What tools and skills would you suggest a student develop before working with migrant populations?
  - What barriers are frequent in your line of work?
  - What barriers or moments of disconnect have you encountered that are not as common, or that you were unprepared for? What differences do you see in your practice from others in your field?
  - What do you do when/if a client invites you to dinner at their home?
  - What process do you encounter when a client wants to offer a gift?
  - Describe other conflicts with ethics.

- What additional research do you feel could be beneficial to the field in regards to migrant populations?
- How has group/individual treatment sessions impacted the client's experience and success?
- What is your opinion on co-leadership?
  - What is your experience of working with an interpreter or translator?