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## Multicultural Therapy Practicum Involving Refugees: Description and Illustration of a Training Model

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# Multicultural Therapy Practicum Involving Refugees: Description and Illustration of a Training Model

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**Ben C. H. Kuo<sup>1</sup> and Anna Arcuri<sup>1</sup>**

## **Abstract**

Multicultural scholars have long noted the value and the need to incorporate multicultural counseling practica into diversity-social justice training. This article describes an ongoing, systematic model of multicultural therapy practicum in which clinical psychology trainees provide direct psychotherapy to community-referred, culturally and linguistically diverse refugee clients, under culturally grounded supervision. As a university–community collaboration, this practicum embodies the principles of multicultural counseling competencies, social justice, community outreach and service, experiential learning, and trauma therapy. In this article, we describe the target refugee population, the theoretical/conceptual bases, the learning conditions, the organizational structure, and the evaluative research of this practicum. Next, we present a former trainee’s narrative account of working with a male Afghan refugee from an autoethnographic qualitative framework to illustrate the dynamic learning process and the intricate cross-cultural interactions between the client and therapist. Finally, implications of this practicum for future practice and research on experiential multicultural training are discussed.

## **Keywords**

multicultural training, social justice, experiential, practicum, refugee

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There has been a proliferation of literature on multicultural counseling competencies (MCC) and social justice advocacy within counseling psychology in recent decades. However, the extent to which current multicultural-diversity curriculum for trainees translates into students' actual, demonstrated MCC and skills (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006) and integrates social justice values into counselor training (Pieterse, Evans, Risner-Butner, Collins, & Mason, 2009) remains a critical question. In fact, recent reviews have identified the prevalence of single, didactic-focused courses on culture and diversity, the absence of skills-oriented, hands-on, experiential multicultural training interventions, and the underrepresentation of coursework on social advocacy in most graduate programs (Malott, 2010; Priester et al., 2008).

In view of these concerns, there has been a limited, but growing body of research that has evaluated alternate modalities of cultural training for counselors, such as the "cultural immersion" intervention/program (see Hipolito-Delgado, Cook, Avrus, & Bonham, 2011; Nilsson, Schale, & Khamphakdy-Brown, 2011; Roysircar, Gard, Hubbell, & Ortega, 2005, for examples). Most of these interculturally and community-based diversity training interventions embody the principles of multiculturalism and social justice, and as such, represent significant progress in multicultural training. Although cultural immersion programs are timely and opportune in advancing current multicultural-social justice education, only a limited number of existing experiential training models occur within the context of trainees providing *direct therapy* and *counseling to therapy clients* under supervision in practicum settings. Specifically, the authors of this article found a handful of diversity-focused clinical practica descriptions based on an Internet search (i.e., one at the Department of Education, School, and Counseling at the University of Missouri-Columbia; one at the Department of Counseling and Clinical Psychology at Columbia University; one at the Counseling and Testing Center at Georgia State University). However, our literature search through psychology databases did not yield any published work or documentation on supervised multicultural practica devoted specifically to providing mental health services to diverse client populations with identifiable psychological or clinical concerns.

To address this gap in the literature, the present article aims to document and describe an ongoing multicultural therapy practicum established in 2007. The 8-month-long supervised clinical practicum, which is required of advanced doctoral students in clinical psychology, is an extension of a didactic multicultural course. The therapy practicum provides trainees the opportunity to offer direct therapy to culturally, linguistically, and religiously diverse refugee clients, under the supervision of the first author of this article.

The refugee clients, who typically report a history of trauma and torture, are referred for treatment by a local community agency. As such, the practicum represents a collaboration between the university and the referring community agency, as well as an outreach, service-based training model to help address the underserved mental health needs of the local refugee community. Accordingly, this multicultural therapy practicum derives and embodies the elements of multiculturalism, social justice, community outreach/service, experiential learning, and trauma therapy (Gorman, 2001; Vera & Speight, 2007).

The purpose of this article is twofold. First, we intend to delineate and describe the training objectives, content, and structure of this ongoing multicultural therapy practicum developed over the last 6 years. Second, we highlight the strengths, merits, and impacts of this practicum training on student trainees by presenting an illustrative case example. To these ends, the article will review (a) the relevant literature on experiential multicultural training and practicum; (b) the psychosocial and demographic characteristics of refugee survivors of torture and trauma—the target client population of this practicum; (c) the theoretical and conceptual bases for the practicum; (d) the learning conditions of the practicum in terms of its content, structure, and activity; and (e) the preliminary findings of the evaluative research of the practicum. These discussions are followed by a case narrative framed within the autoethnographic qualitative approach (Denzin & Lincoln, 2011), which is based on the second author's training experience with an Afghan refugee client. We conclude by considering the limitations, strengths, and implications of this multicultural practicum for future MCC education and research.

## **Literature on Experiential Multicultural Counseling and Social Justice Training**

The importance of incorporating multicultural counseling/therapy practicum into cultural training for counselors has long been advocated by various multicultural scholars (e.g., Abreu, Gim Chung, & Atkinson, 2000; Kuo, 2012; Smith et al., 2006). There has been an increasing body of evidence within the multicultural counseling training literature supporting the benefits of learning MCC through experientially based learning processes (Arthur & Achenbach, 2002; Heppner & O'Brien, 1994). Incidentally, a number of multicultural researchers and educators have recommended cultural immersion training (Kiselica, 1991; Pope-Davis, Breaux, & Liu, 1997) and supervised multicultural counseling/therapy practica as exemplary forms of hands-on, experiential learning for developing MCC among trainees (Abreu et al., 2000; Smith et al., 2006).

Recent research on social justice within counseling psychology further underscores the value of counselors' participatory learning through social action and direct engagement with marginalized communities and individuals (Constantine, Hage, Kindaichi, & Bryant, 2007; Vera & Speight, 2007). According to Fouad, Gerstein, and Toporek (2006), social justice work for counselors entails "helping to ensure that opportunities and resources are distributed fairly and helping to ensure equity when resources are distributed unfairly or unequally" (p. 1). From this standpoint, multicultural counseling education and community-level social advocacy training for psychologists and counselors are considered complementary and interconnected (Constantine et al., 2007; Pieterse et al., 2009). Examples of the fusion between multiculturalism and social justice in counseling training programs reported in the literature have included the "First Year Experience" reported by Goodman et al. (2004), the Refugee/Immigrant Mental Health Program reported by Nilsson et al. (2011), and the Multicultural Action Project reported by Hipolito-Delgado et al. (2011). These studies have provided preliminary evidence to support the efficacy of experiential, community-focused, service-learning based diversity training models.

In addition, Tomlinson-Clarke (2000) discussed the importance of student trainees directly engaging in live multicultural counseling practica and supervision within a therapeutic context. She stressed that multicultural practica afford students direct learning opportunities for "self reflection, thereby enhancing cultural self awareness and cultural self knowledge" (p. 229) as well as opportunities to understand how "beliefs and ways of interacting with others serve to enhance or interfere with the development of relationships" (p. 229). Kuo (2012) further contended that multicultural clinical practica may define the next critical step in advancing "best practice" in multicultural training. These assertions are consistent with empirical findings that have identified counselors' therapy and experience with culturally diverse clients as a strong predictor of their multicultural skills (Arthur & Januszowski, 2001) and their multicultural therapeutic relationship and awareness (Dickson & Jepsen, 2007).

As follows, a systematic effort to document and describe models of multicultural therapy practicum and supervision involving culturally diverse clients with psychological needs would be timely and highly desirable for the purpose of advancing current multicultural training practices. Against this backdrop, the ensuing sections detail the present refugee-serving multicultural therapy practicum.

## **The Clients: Characteristics of Refugee Survivors of Trauma and Torture**

Government-assisted refugees (GARs) are displaced individuals for whom the Canadian government has evaluated, accepted, and sponsored to settle in Canada as landed immigrants. Every year, an estimate of 7,500 GARs are being settled in Canada (Dossal & Hii, 2009). In 2012, a total of 2,315 GARs settled across six major cities in Ontario, Canada, including the city of Windsor (Citizenship and Immigration Canada, 2012a) in which the present multicultural practicum operates. In 2011-2012, Windsor received 266 GARs (Citizenship and Immigration Canada, 2012a). Importantly, most of these refugee newcomers are survivors of trauma and torture and hereafter, are referred to as “refugee survivors.” Refugee survivors include multinational and multilinguistic individuals and families from Afghanistan, Bhutan, Burundi, Colombia, Congo, Ethiopia, Eritrea, Iraq, Iran, Myanmar, Somalia, and Sudan, to mention a few. Many refugees have arrived from war-torn countries, lived in refugee camps for extended periods of time, and witnessed and experienced multiple forms of violence, torture, and trauma (Dossal & Hii, 2009). The preimmigration experiences of many refugee survivors represent among the most severe forms of social injustice and injury imaginable (Gorman, 2001). Consequently, a high degree of distress, psychological difficulties, and mental health needs are reported among refugees, particularly those who have witnessed and/or experienced violence prior to their resettlement in the receiving country (American Psychological Association [APA], 2010; The Centre of Victims of Torture, 2005).

Incidentally, recent reports on the mental health of refugees in Canada and the United States have highlighted an urgent need for culturally responsive clinicians and intervention services for refugee adults, children, and families (APA, 2010; Vasilevska, Madan, & Simich, 2010). The APA’s special task force on the Psychological Effects of War on Children and Families who are Refugees from Armed Conflict residing in the United States called upon psychologists to develop, promote, and advocate for culturally informed practices and research with refugees (APA, 2010). Recommendations include (a) the implementation of a comprehensive community-based model of interventions, (b) the delivery of care and services by culturally and linguistically competent clinicians and providers, and (c) the integration of evidence-based practice with practice-based evidence (APA, 2010). Nevertheless, refugees’ psychological and mental health concerns are underserved in their new host society (Marotta, 2003), which is another example of the ongoing social

inequality faced by refugees post-resettlement. Therefore, it is imperative that clinicians acquire cultural competencies to treat this population (Gorman, 2001; Marotta, 2003).

Refugee survivors are characterized by multiple diversity factors, including nationality, ethnic background, language, religion, sociopolitical history, education, and socioeconomic status (Dossal & Hii, 2009); diversity factors that are vastly different from the majority of graduate students in professional psychology programs in North America. The development and implementation of the present multicultural therapy practicum introduced in 2007 by the first author was motivated by social justice and multicultural ideals. The practicum was borne out of (a) the first author's response to a community-wide appeal made by a local refugee-serving community agency to local psychologists to provide pro bono psychological treatment to an increasing number of refugee survivors being settled in the Windsor-Essex area (further explanation on this point is provided in the later section on the history and the development of the practicum) and (b) the first author's impetus to offer "live" training opportunities for clinical graduate students to gain firsthand cross-cultural therapy experiences with refugee clients who are "culturally distant" from them.

## The Training Model: Theoretical and Conceptual Bases

Given the complex interplay of psychological, cultural, and sociopolitical issues faced by refugee survivors, expert scholars have identified specific knowledge and intervention skills needed by clinicians to effectively work with and treat this population. With respect to treatment approaches, Gorman (2001) outlined a social-political-psychological-cultural framework of psychological interventions with refugee survivors; the framework embodies the principles of *traumatology*, *multicultural counseling theories*, and *liberation theory*. Gorman conceptualizes political torture and trauma endured by refugee survivors as social, moral, and ethical injustice and injuries. Therefore, the treatment and the training approach grounded within this framework reflect the stances of multiculturalism and social justice work (Goodman et al., 2004). Based on this intervention model, clinicians assist refugee survivors through three stages to facilitate the healing process: *reestablishing safety*, *reconstruction*, and *reconnection*, as originally proposed by Judith Herman (1992).

The underlying instructional and philosophical bases of this multicultural practicum also reflect the tenets of experiential (e.g., Arthur & Achenbach,



2002) and service-based, outreach models of learning (Nilsson et al., 2011). As such, student trainees gain hands-on therapy experience while developing community outreach skills, which are essential to serve the larger multicultural communities. In addition, adopting a service-based outreach model while working with refugee survivors encourages trainees to engage in an “advocacy” role to help “empower” refugee clients.

Henceforth, these above elements constitute the underlying theoretical and conceptual assumptions and values of the current multicultural therapy practicum. These conceptual tenets are manifested in the course materials, treatment interventions, and supervision approach adopted for this practicum as described in the following sections.

## **The Practicum: Structure, Content, and Activity**

The Multicultural Counseling and Psychotherapy With Refugees Practicum is modeled on a two-semester (8 months/24 weeks; September to April), in-house clinical training practicum (see Table 1). As an in-house training practicum, all therapy sessions take place at the Psychological Services and Research Center (PSRC) located on the university campus. This practicum course is offered to 4th-, 5th-, or 6th-year doctoral students in the adult clinical track of an APA and Canadian Psychological Association (CPA) accredited clinical psychology MA and PhD program at the University of Windsor in Canada. It is part of a practicum training at the PSRC required of all clinical students in this track. At the time of writing this article, this practicum was into its sixth year of existence since 2007. The course was developed and has been instructed by the first author of this article since 2008. As a prerequisite, all practicum trainees must complete a full-semester (12 weeks), didactic multicultural and diversity course modeled on Sue and his colleagues’ Tripartite Model of MCC (Sue, Arredondo, & McDavis, 1992; Sue & Sue, 2008). The course emphasizes the development of students’ cultural awareness, knowledge, and skills, and exposes students to various social justice issues related to professional psychology. This multicultural training sequence with a didactic course followed by an experiential therapy practicum is considered optimal (Abreu et al., 2000).

### **Participants**

Each year, the multicultural therapy practicum is comprised of four or five senior PhD students in the clinical psychology program. Prior to enrolling in this practicum, trainees have typically completed two therapy courses (e.g.,

**Table 1.** Time-Based Structural Summary of the Multicultural Therapy Practicum.

Schedule	Training activities and tasks (trainees and practicum supervisor)	Therapy referral and case support procedures (case managers and program director)	Evaluation research <sup>a</sup>	
			Trainees	Refugee client
Week 1	Didactic Seminar <sup>b</sup> <ul style="list-style-type: none"> <li>Theoretical bases of training and supervision: multicultural counseling, traumatology, and experiential service-based learning</li> </ul>	Identification of potential refugee clients for referral by case managers (CM)	Complete the pre-practicum questionnaire <sup>c</sup>	
Week 2	Didactic seminar <sup>b</sup>			
Week 3	Didactic seminar <sup>b</sup>			
Week 4	Didactic seminar <sup>b</sup>			
Week 5	Onsite community visit at the Multicultural Council (MCC)	Orientation meeting between trainees and MCC staff		
Week 6	Training workshop on "Therapeutic Use of Interpreter" delivered by a professional interpretation trainer	Client screening and referral from CMs to practicum supervisor		
Week 7	Didactic seminar <sup>b</sup> Client screening and assignment to trainees by practicum supervisor	Liaison and arrangement for appointment, interpreter, and transportation for clients by CMs		

*(continued)*

**Table 1. (continued)**

Schedule	Training activities and tasks (trainees and practicum supervisor)	Therapy referral and case support procedures (case managers and program director)	Evaluation research <sup>a</sup>	
			Trainees	Refugee client
Week 8 to Week 24	Regular weekly therapy session with refugee client Weekly group supervision involving viewing session tapes, group discussion/consultation, and supervisor's feedback • Individual supervision on need basis	CMs provide ongoing logistics support to refugee clients and to therapist trainees over the course of the therapy	Complete critical incident journals weekly and rating of therapy alliance tri-weekly	Complete rating of session outcome weekly and therapy alliance tri-weekly <sup>d</sup>
Week 25	Individual evaluation of trainee's therapy competence by supervisor	Year-end partnership feedback meeting among trainees, supervisor, and MCC staff	Complete the post-practicum questionnaire <sup>c</sup> and the final reflection paper	Complete exit interview questions <sup>d</sup>

<sup>a</sup>A 3-year research project.

<sup>b</sup>Topics ranging from vicarious traumatization to PTSD to therapy models.

<sup>c</sup>Measures including the Multicultural Counseling Inventory, the Multicultural Counseling Self-Efficacy Scale, the Multicultural Counseling Social Desirability Scale, and a demographics sheet.

<sup>d</sup>Refugee clients completed the scales/questions with the aid of language interpreters/aids.

cognitive behavioral therapy, psychodynamic therapy, or emotion-focused therapy) and several off-campus therapy and/or assessment practica. The practicum instructor/supervisor is a full-time tenured faculty at the university in which the practicum is offered and a registered psychologist in the province of Ontario. He is a first-generation Asian Canadian immigrant and has a PhD in counseling psychology with research, teaching, and clinical expertise

in the areas of cross-cultural psychology and multicultural counseling. As previously noted, the client population for the practicum includes refugee survivors who are considered “government-assisted refugees.” Refugee client referrals are conducted by case managers at an immigrant- and refugee-serving community agency, the Multicultural Council of Windsor-Essex. Refugee clients were identified and referred on the basis of having significant or specific psychological and emotional issues (e.g., signs of posttraumatic stress disorder [PTSD], past experiences with violence or trauma, adjustment difficulties, depressive symptoms). Finally, trained language interpreters or language aids, needed to support therapy with refugees are hired and reimbursed by the Multicultural Council.

### *Didactic Seminars*

The multilayered nature of this training model involving service-based learning and a university–community collaboration calls for the integrated use of diverse and unconventional mediums and approaches of instruction. Table 1 presents a time-based overview and summary of the various components of this practicum model. The key components of the practicum are highlighted next.

The course begins with 7 weeks of pretherapy didactic seminars. Participation in seminars require students to complete a reading list and present topical issues related to clinical work with refugee survivors. Seminar topics include the nature, sequelae, and recovery process for refugee survivors of torture and trauma, refugee-specific PTSD symptoms, clinical treatment models associated with refugee survivors, therapeutic use of language interpreters, refugee cultural adjustment and acculturation issues, and secondary or vicarious traumatization of therapists. However, student trainees are reminded that refugee clients’ presenting issues at the actual therapy may vary considerably in nature from health to pragmatic to emotional and psychological concerns and sometimes can be a combination of several issues. In addition, logistic, procedural, and ethical issues unique to the university–community partnership involving multiple interdisciplinary care providers (e.g., boundary and confidentiality issues) are discussed in seminars and in group supervision throughout the course of the academic year.

To help trainees overcome specific challenges associated with language barriers between refugee clients and trainees, one didactic seminar specifically focuses on teaching trainees to work with language interpreters within the context of therapy. This 2-hr training workshop on the “Therapeutic Use of Interpreters” is facilitated by a professional trainer who teaches language interpretation at a local college (see Table 1; Week 6). Trainees are also

shown previously video recorded therapy sessions to help prepare them to manage therapy with an interpreter. This aspect of learning characterizes a challenging yet distinct and integral part of the multicultural practicum experience.

### *Community Collaboration and Partnership*

The APA Task Force on the Psychosocial Effects of War on Children and Families who are Refugees From Armed Conflict Residing in the United States (2010) recommends that psychologists' provision of psychological treatment to refugee populations must be built on a close interface and collaboration with community-based cultural agencies. The joint and interconnected university–community collaboration in the current multicultural therapy practicum is evident in the following ways. First, student trainees participate in a prearranged onsite visit and orientation at the Multicultural Council (see Table 1; Week 5). During this visit, student therapists are introduced to the program coordinator and the refugee resettlement program case managers, and are oriented to the agency and its refugee and immigrant services. Through this outreach and exchange, trainees are made aware of the collaborative working relationship between the university and the community partners and various participants' respective roles in this therapy practicum. Second, the university–community partnership obliges (a) the university, via the multicultural practicum, to provide psychological treatment to refugee clients to address their emotional, mental health, and adjustment issues, and (b) the Multicultural Council to offer support for the settlement and day-to-day subsistence needs of refugee clients, including financial aid, education (ESL classes), transportation, employment assistance, and medical care. Third, at the conclusion of every practicum, the Multicultural Council staff, the student therapists, and the practicum instructor participate in a joint year-end partnership feedback and evaluation session. This meeting provides all participants with an opportunity to review and provide feedback about the collaborative practicum and the working relationship between the psychology department and the partner agency, as well as an opportunity to discuss avenues to improve future treatment services.

### **History, Development, and Support for this University–Agency Collaboration**

The prospect of the present multicultural practicum began in 2006, 1 year prior to the inception of the project, when the Victim Services-Multicultural Liaison coordinator of the Multicultural Council wrote a letter requesting

registered psychologists in the Windsor area to provide pro bono psychological services to the increasing number of refugee survivors of torture being received by the agency. The coordinator described personal stories and common psychological needs faced by refugee survivors in the letter. Upon receiving this letter, the faculty instructor of the practicum (the first author) was profoundly impacted and inspired by the appeal. This prompted his idea to integrate the respective resources and expertise of the community agency and the university to meet the mental health needs of local refugee survivors, as well as the need for multicultural and social justice training for clinical graduate students. Subsequent to acquiring the support of his home psychology department, particularly from the department head and the clinical training director, working closely with the agency's liaison coordinator, and holding several meetings between the university department personnel and Multicultural Council, the practicum was created and launched in September 2007.

Canada's Immigration and Refugee Protection Act (IRPA) established in 2002 mandates the government of Canada to provide assistance and support to GARs (Citizenship and Immigration Canada, 2012b). As such, the Multicultural Council receives ongoing funding from the Resettlement Assistance Program and the Client Support Services Program available through the Ministry of Citizenship and Immigration Canada to finance the social services they provide to GARs in the Windsor area (Citizenship and Immigration Canada, 2012b). Available services include (a) offering GARs social assistance income for their basic needs (e.g., rent, transportation, household items) for 1 year after arrival in Windsor and (b) providing orientation services and training to assist GARs in resettlement and meeting their basic and immediate needs (Citizenship and Immigration Canada, 2012b). These government social assistance programs provide funding for the necessary resources associated with treatment, particularly the Multicultural Council case managers, clients' transportation to and from therapy appointments, and language interpreters or language aids for therapy. Trained language interpreters are available through the agency's Translation and Interpretation Services, which offers services in 50 languages for a fee. At the university end, the faculty instructor receives two course teaching credits (one for each semester) for managing, coordinating, teaching, and supervising this 8-month therapy practicum. All therapy sessions take place at the in-house clinic of the psychology department, with supporting clerical staff already in place. Therefore, there is no additional cost to the university or the department in administering the present multicultural practicum.

The faculty instructor's previous work experience in social services and immigrant settlement services sector affords him a basic working knowledge

with ways to work and collaborate with community-based agencies. The university–agency collaboration is further strengthened by the faculty instructor’s direct involvement in various service and advocacy roles in addition to the practicum, both with the collaborating agency and the larger Windsor-Essex multicultural communities. For instance, the faculty instructor had previously written letters to funding bodies in support of the provision of services available at the Multicultural Council, served as a mental health consultant/advisor for the agency, participated in the agency’s service provision and evaluation focus group, and delivered a training workshop on adjustment and mental health issues of immigrants and newcomers to social workers, immigrant settlement workers, and ESL teachers across social services agencies in the Windsor-Essex and surrounding areas. The instructor’s visibility and active presence in the community seems to have imparted him a degree of credibility and expertise with the community and likely has contributed to a positive, enduring working relationship with the partner agency.

### *Client Referrals and Provision of Psychotherapy*

To facilitate client referrals, the practicum instructor/supervisor contacts and provides the Multicultural Council case managers with screening criteria to help identify refugee clients who are appropriate for treatment (e.g., adult clients who have expressed willingness to receive psychological help; clients who are not currently suicidal or suffering from psychosis or addiction problems). The practicum instructor reviews each client referral that is forwarded by the case managers to assess each client’s suitability for treatment and training purposes prior to assigning the client to a student therapist.

Once a refugee client is assigned to a therapist, the therapist initiates contact with the case manager in the agency. The case manager briefs the therapist on additional information available about the client relevant to treatment. The case manager acts as the crucial intermediate individual who coordinates the therapy appointment, the client’s transportation, and any language interpreter services, if necessary. The effective flow of this communication is predicated on consistent communication between the therapist trainee and the case manager through phone calls and emails. In addition, the case manager typically accompanies the client for the first treatment appointment to help address any additional questions or issues that the client may present at the onset of treatment. Administratively speaking, the faculty instructor oversees the overall operation of the practicum in conjunction with the partner agency. He interfaces directly with the program director of the Multicultural Council on a regular basis and attends to organizational and procedural matters, including monitoring individual trainee’s caseload and the client waitlist,

and managing any miscommunication or difficulty among the trainees, the case managers, and the program director.

Trainees are able to provide a maximum of 17 weeks of treatment to refugee clients. Longer term treatment that extends beyond the academic year is available to refugee clients under exceptional circumstances in which the client requires extended care or services. Students typically work with one or two refugee clients on a weekly basis. Therapy sessions are scheduled for 90 min to accommodate the necessary time for in-session language interpretation. All sessions are videotaped on a DVD camcorder for training and supervision purposes. An overarching goal of the early sessions involves the establishment of a therapeutic relationship between the client, the interpreter, and the student therapist. During the first session, limits of confidentiality are addressed and treatment consent forms are completed. Subsequently, the therapist conducts an intake assessment based on a standard screening questionnaire developed specifically for this practicum with refugee survivors. Therapists inquire about refugee clients' past and present psychological and psychiatric conditions, family history, medical history, migration experiences, religious background, sociopolitical circumstances, and past incidences of torture or trauma.

Throughout the duration of treatment, trainees work collaboratively with each client's case manager to advocate for the client's individual needs and this constitutes an example of trainees' learning about social advocacy work (Vera & Speight, 2007). This close working relationship between therapist trainees and case managers is an important bedrock of this practicum, as refugee newcomers often require a number of basic needs (e.g., financial assistance, housing, medical care) and face greater systemic, cultural, and language barriers compared with nonrefugee populations (APA, 2010; Sue & Sue, 2008). Subsistence needs are often profoundly distressing to refugee survivors and can easily exacerbate their preexisting psychological and emotional difficulties, and consequently, the case management and support provided by the Multicultural Council is imperative for positive treatment outcomes.

### *Supervision*

Two-hour, weekly, group supervision is scheduled as part of the current practicum. Adopting this 2-hr group supervision format is partly a function of the time commitment associated with the instructor's teaching assignments. However, additional individual supervision and support is available from the practicum supervisor on an as needed basis and upon the trainees' request. The main objective of the supervision sessions is to support the professional development of trainees while concurrently ensuring that refugee clients



receive appropriate treatment services. Supervision is grounded on and incorporates various perspectives, specifically MCC, social justice, experiential service-based learning, and traumatology. Student therapists are required to discuss their therapy work with their clients and present segments of their videotaped therapy sessions during each group supervision meeting. They are intended to promote trainees' development in clinical skills, cultural responsiveness, and personal awareness and growth. Supervision meetings also incorporate the development of case conceptualizations and problem solving in a group format to help facilitate peer supervision and consultation skills.

Based on our experiences over the years, this 2-hr group supervision model has worked well for this practicum and the trainees' needs. Although the refugee clients receiving treatment all reported a history of trauma and/or torture, their presenting psychological problems nevertheless vary considerably. Presenting concerns have included medical and health issues, cultural adjustment and acculturation difficulties, intergenerational parenting challenges, loss and bereavement issues, and trauma incidences, to mention a few. The weekly scheduled group supervision, coupled with additional individual supervision as needed or requested is sufficiently flexible to address the varying degree of supervision needs among the student therapists, which correspond to the nature and the intensity of their clients' presenting concerns.

## **Evaluation Research of the Practicum: Preliminary Findings Based on Exploratory Analyses**

To better understand and assess the efficacy of this diversity practicum on trainees' clinical and cultural development, a research component has been integrated into the training program since fall 2010. This 3-year, grant-supported mixed-methods design (i.e., collecting quantitative and qualitative data; see Table 1) evaluation study of the practicum is currently being conducted by the course instructor and his research team. The project intends to examine the process and outcome of three consecutive cohorts of trainees' learning experiences by (a) administering pre- and post-practicum questionnaires that assess changes on measures of MCC, multicultural self-efficacy, and the quality of the therapist–client working alliance, and (b) collecting trainees' weekly "critical incident journals" over the course of the practicum, with a focus on their cognitive, affective, and behavioral changes. Quantitative data based on refugee clients' perceptions of the quality of therapy and their therapeutic working relationship with their therapists is also being collected after each therapy session.

Here, we present some preliminary findings based on the exploratory analyses of the data collected from the first two cohorts of participant trainees (2010-2011 and 2011-2012). Given the ongoing nature of data collection,

these results should be viewed as preliminary and treated with tentativeness. The sample of trainees includes nine participants, one male and eight females ranging between 25 and 31 years of age. However, due to an incomplete post-questionnaire by one female participant, the quantitative analyses were based only on eight participants, whereas the qualitative analyses were based on all nine participants. All participants self-identified as “White/Caucasian” in terms of their racial background; seven indicated that they were Canadian born and two indicated that they were born outside of Canada.

For quantitative analyses, participants completed pre- and post-practicum questionnaires which included the Multicultural Counseling Inventory (MCI; Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Self-Efficacy Scale-Racial Diversity Form (MCSE-RD; Sheu & Lent, 2007), a demographic sheet, and other measures that were part of a larger study. For the qualitative analyses, the participants additionally completed and submitted weekly “Critical Incident Journals” as part of the required course assignment, following each therapy session with their refugee clients. Some aspects of the following results have been reported in conference papers by the first author and his research team (Kuo, Rodriguez-Rubio, Batoul, & Prada, 2013; Rodriguez-Rubio, Kuo, & Batoul, 2012).

### *Quantitative Results*

A series of *t* tests were conducted to examine the changes in the participants’ pre- and post-scores on the measures of MCC at the start and the end of the practicum. Based on the measure of the MCI, trainees ( $n = 8$ ) reported significantly higher overall scores on the measure,  $t(7) = -3.050, p < .05, r = .08$ , between pre- and post-practicum. Specifically, a significant increase was found in the scores of the Multicultural Counseling Skills subscale of the MCI between pre and post,  $t(7) = -4.829, p < .05, r = .24$ . Similarly, participants scored significantly higher on their overall scores of multicultural self-efficacy as measured by the MCSE-RD,  $t(7) = -12.292, p < .05, r = .73$ , since the beginning of the practicum. In particular, trainees reported significantly higher scores on all three subscales of the MCSE-RD: the Multicultural Intervention,  $t(7) = -9.683, p < .05, r = .60$ , the Multicultural Assessment,  $t(7) = -6.549, p < .05, r = .15$ , and the Multicultural Counseling Session Management,  $t(7) = -5.451, p < .05, r = .63$ .

### *Qualitative Results*

Given our interest in trainees’ reflective learning in this practicum, we conducted qualitative analyses of the participants’ ( $n = 9$ ) first five journal entries

(i.e., the first five therapy sessions with refugee clients). There were two reasons for selecting these initial journal entries for this preliminary analysis. First, at this exploratory phase, the research team was interested in the trainees' learning during the early stage of developing therapy and working relationship with their refugee clients. Second, the number of journal entries collected from the participants ranged from 6 to 19 (i.e., a few clients discontinued therapy after 6 sessions). Therefore, using the first five journals captured the therapy and practicum experiences of all the participants at this early phase of learning and therapy experience.

In terms of the analytic methodology, the research team adopted the thematic content analysis approach as described and recommended by Braun and Clarke (2006) to analyze the qualitative journals. Braun and Clarke defined thematic analysis as "a method for identifying, analysing, and reporting patterns (themes) within data" (p. 6). Adhering to their recommended approach, the journals were carefully analyzed by the first author's research lab/team (one PhD student and two post-undergraduate volunteers) by following these steps: (a) scanning through the journals for general ideas and themes for the first read, (b) reviewing the journal entries and looking for "meaning units" (meaningful phrases/sentences) in the second read, (c) sorting meaning units into categories, (d) naming/labeling consistent categories while identifying new categories, and (e) finally grouping similar categories into key themes. From this process, two salient themes and their subthemes were extracted from these journals.

The first theme pertains to trainees' awareness and recognition of the uniqueness of working with multicultural clients. Trainees described an active process of attuning to the differences between their multicultural refugee clients and their other clients who do not identify as racial and ethnic minorities (Theme 1). Differences were noted between these two groups of clients, particularly in terms of (a) refugee clients' expectation of and expression in therapy (Theme 1a), (b) refugee clients' understanding of therapy and its process (Theme 1b), (c) added importance of incorporating a cultural framework in working with refugee clients (Theme 1c), and (d) specific skills needed to work with refugee clients (Theme 1d). For example, a female trainee wrote the following reflection in her journal, after an in-session therapy interaction in which an Afghan client posed a direct and challenging question:

I was not expecting these questions and thus, I was initially caught off guard. I thought, it's interesting that other clients (non multicultural clients) have never asked me such questions before. I think I responded in a way that I would not respond with other clients and I integrated my cultural experiences to help explain

my position. I feel like in these sessions, and at this moment in particular, my answers are more personal or less cookie cutter answers. I think this experience helped me practice my skill to speak my beliefs, describe my stance, which includes more self-disclosure than I typically engage in with other clients. It drew my attention to the client's awareness and thoughts of being a refugee client, from another culture, and essentially, not the same as me, a white therapist. It highlighted that the client sees us as different and the client perhaps wonders how much someone with such different experiences (growing up in Canada) can understand him.

The second theme relates to participants' awareness of refugee clients' culture compared with their own personal culture (i.e., Canadian; Theme 2). Under this theme, the trainees commented on (a) cultural divergence between refugee clients' country of origin and their own Canadian perspective (Theme 2a); (b) clients' experience of working with White, Canadian therapists (Theme 2b); (c) relevance of acculturation and acculturative stress in conceptualizing clients' issues (Theme 2c); and (d) the commonalities shared between the refugee clients and themselves despite cultural differences (Theme 2d). As an illustration, upon hearing a 41-year-old Iraqi refugee client's complaint about insomnia due to her belief that the content of her dreams will become reality, a female trainee described the following:

I was thinking to check if this is a psychotic feature or a culturally specific belief and wondering how can I discriminate between the two options. In Canadian culture, beliefs in psychic skills are usually subject to in-depth evaluation, but in other cultures, there is support and understanding of such "gifted" people who are given the position of power in society . . . I took the Multicultural class and I remember discussing how tricky it is to not pathologize a behavior that falls out of the Western norms without assessing how it fits in the proper cultural context. This encounter just brought the issue to a more concrete level, showing me the difficulty of culturally sensitive assessment. It also showed me that working collaboratively with the client, I can learn about the specific cultural views and I can use them to formulate a clinical judgment.

Together these mixed-methods findings, though preliminary, are nonetheless notable and encouraging and lend some initial empirical support to proponents of multicultural practicum training (e.g., Abreu et al., 2000; Smith et al., 2006). In particular, the quantitative results suggest that through this practicum-based model of multicultural training, trainees reported that they significantly improved their multicultural counseling skills, as well as their sense of self-efficacy specifically with respect to their multicultural intervention, assessment, and session management skills with culturally diverse clients. These results are consistent with previous studies that found actual counseling experience with multicultural clients to be predictive of

counselors' multicultural skills, relationship, and awareness (Arthur & Januszowski, 2001; Dickson & Jepsen, 2007). As further revealed by the trainees' qualitative journals, critical improvements on their multicultural skills are likely linked to their heightened sense of cultural and self awareness, which is developed throughout their *in vivo* therapy process. Of note, trainees reported that their cultural and self awareness consequently helped inform their subsequent therapy interventions with refugee clients. This modality of learning obliges trainees to persistently face, respond, and connect with their refugee clients, and to actively engage in self-reflection and problem-solving over the course of the practicum.

### **Autoethnographic Case Illustration: A Therapist Trainee's Reflective Narrative**

To complement the foregoing conceptual and structural discussion of this multicultural therapy practicum and to further illustrate the experiential dimensions of this training model as highlighted in the qualitative findings above, the following section presents a case example. It is based on a former therapist trainee's cross-cultural therapy work with BA, a refugee client from Afghanistan. Methodologically, this case example is construed and communicated in a manner akin to the interpretive qualitative method known as "autoethnography" (Anderson, 2006; Chang, 2008; Denzin & Lincoln, 2011). Ellingson (2011) defined autoethnography as "research, writing, story, and method that connect the autobiographical to the cultural, social, and political through the study of a culture or phenomenon of which one is a part, integrated with relational and personal experiences" (p. 599). Ellis and Bochner (2006) stated that the intent of autoethnography is to motivate change "Autoethnography wants the reader to care, to feel, to empathize, and to do something, to act" (p. 433). As such, autoethnography gives credence to a researcher's (a) "story" and subjective reality; (b) self-examination and reflexive analysis; (c) emotional experiences; and (d) sociocultural and political lens, beliefs, and positions in the research process (Anderson, 2006; Ellingson, 2011).

Embedded in the autoethnographic framework, the present case illustration is written for the purpose of the current article. It is generated based upon the second author's retrospective analysis of her 12 critical incident journals (described in the last section) completed following each therapy session with her Afghani refugee client during the practicum and her final reflection paper submitted for the practicum course as an assignment. These data serve as her "self-reflective data" in autoethnography and are grounded in "introspection, self-analysis, and self-evaluation" (Chang, 2008, p. 95). Therefore, the first

person “I” is used in the following case description to reflect the personal account of the therapist.

In addition, to enhance the illustrative purpose of this case example, the narrative is being linked to the two key themes identified from the qualitative analyses reported in the last section. Hence, pertinent content of the case example that corresponds to the qualitative themes and subcategories identified under the qualitative results section above is highlighted throughout the case description using specific notations (e.g., “Theme 1a”).

### ***Brief Background of the Therapist and the Client***

At the onset of the multicultural practicum, the therapist—a female of Italian descent—was a 4th-year PhD student in clinical psychology; she had completed therapy coursework in cognitive behavioral and psychodynamic therapy. The client’s demographic and background information have been modified to protect his identity and the initials “BA” will be used throughout this case illustration. The treatment protocol included 12 sessions that spanned over a 3-month period. All sessions were interpreted between English and Turkish by a trained female language interpreter.

The client, BA, is a man in his mid-20s who arrived in Windsor, Canada, from Istanbul, Turkey, a few months prior to the onset of treatment. He was born and raised in Afghanistan and is the youngest of six children. BA’s parents died in a tragic car accident when he was 12 years of age. During his late adolescence, BA was held captive by the Taliban and forced into a Taliban military training camp, from which he later barely escaped under a barrage of gunfire. BA was initially referred to and presented to therapy to address his uncontrollable emotional and behavioral outbursts, namely, anger, rumination of thoughts, and feelings of guilt due to his behavior. He also reported disturbed sleeping patterns, nightmares, intrusive thoughts and images, a sense of foreshortened future, and difficulties with concentration, symptoms that are consistent with PTSD. Of note, during early therapy sessions, BA demonstrated inappropriate affect, for instance, he smiled when he discussed the death of his loved ones.

I, the therapist, used the traumatology and trauma therapy framework initially proposed by Judith Herman (1992) and later extended by Gorman (2001) to help guide BA’s case conceptualization and treatment process. According to this conceptual framework, refugee survivors’ healing can progress through three stages in therapy: *safety*, *reconstruction*, and *reconnection*. The ensuing case illustration is discussed within this framework.

## *Establishing Safety*

During the first session, BA appeared tense and uneasy as his hands were clenched together and his body language was closed. Keeping Gorman's treatment framework in mind, I found that socializing BA to the therapeutic process and openly discussing concerns related to confidentiality and his treatment expectations helped foster a sense of safety, instill a sense of hope, and enhanced my credibility as a treatment provider, which is highly valued among multicultural clients (Sue & Sue, 2008). Providing psychoeducation about PTSD and discussing common reactions to trauma during the initial phase of treatment seemed beneficial to BA as the information helped normalize his PTSD symptoms (Themes 1a and d). Throughout this process, I came to realize that it was equally important to educate the interpreter about the therapeutic process, to invite the interpreter to ask questions, and to clearly outline each participant's role in therapy to help create a sense of comfort for the interpreter (Theme 1d).

In this initial relationship building stage, I learned to become more attuned to cultural issues and nuances as I worked with BA. For instance, I adopted a more direct style of communication in session. Unlike most White European Canadian clients that I have worked with, BA tended to be more direct in session, and he frequently inquired about my beliefs related to the influences his culture had on his behavior (Themes 1a and 1b; Themes 2a and 2b). Interestingly, over time, his directedness helped me become increasingly more comfortable with discussing important cultural issues and stereotypes in a candid manner, and offering honest and direct feedback to him as his therapist.

Unexpectedly, conducting therapy with the aid of an interpreter was an eye-opening learning experience for me, as it was reassuring and fascinating to witness how well the interpreter was able to convey the affective tone and the broader meaning underlying our verbal expressions (Theme 1d). Her ability to match our affective tone was definitely a critical element that helped me to develop a therapeutic alliance with BA despite our language gap. The interpreter seemed to become a "voice" in sessions. The rapport established between the interpreter and me provided the interpreter the opportunity to independently discuss any emotional reactions she may have experienced secondary to the content that she was exposed to in session.

## *Reconstructing the Experience*

Having achieved a firm positive working relationship with BA, I gradually began to introduce him to trauma work. First, I provided a rationale to explain

the purpose and advantages of dealing with painful memories and reconstructing a new trauma “narrative” (Themes 1b and 1d). We reconstructed his experience related to his parents’ death. Specifically, we processed the image of his mother’s damaged skull due to her car accident and the buried and unattended grief reactions he experienced subsequent to the incident. We explored his deep-seated cultural beliefs related to gender roles, particularly that men should not cry or appear weak/vulnerable (Theme 1c).

I noticed that BA was only able to speak about his trauma experiences at the Taliban training camp after he finally felt safe and understood (Theme 2d). During the seventh session, BA described his experience of being captured by the Taliban and forced to remain in a Taliban military training camp. In this session, BA began to account the torture that he endured at the camp, including having water thrown on him and then being whipped on his hands and feet, as well as his nuanced emotions, including feeling tricked, trapped, anxious, and powerless. We promptly processed these painful memories and his related experiences such as his overwhelming conviction that he was going to die, as well as his courage, which eventually led to him to escape from the Taliban military camp.

I was struck by the degree to which BA’s sense of safety and trust, and our therapeutic alliance affected his willingness to open up, reconstruct his traumatic experiences, and intensively engage in the therapy process (Theme 2d). At one point, BA commented in English: “O.K., I have a friend!” At this stage of treatment with BA, I became acutely aware of our nonverbal behavior, including our affective presentation, tone of voice, and the manner in which he depicted different stories (Theme 2a and 2b). Upon reflection, I realized that the cross-cultural therapy sessions with BA incorporated a “high-context” communication style (i.e., a communication style that heavily relies on environmental cues and nonverbal messages; Sue & Sue, 2008) more than my therapy sessions with European Canadian clients (Theme 1; Theme 2a and 2b). Serendipitously, I learned to communicate in a more concise and understandable manner. In retrospect, providing responses in an accessible and colloquial way helped reinforce my ability to teach and describe psychology concepts, such as PTSD to not only to BA but also to my European Canadian clients (Theme 1).

### ***Reconnecting to Recover***

According to Herman’s (1992) trauma therapy, the final phase of treatment involves the survivor establishing a sense of self as a whole person, integrating the trauma experiences into his or her life history, gaining hope and empowerment for the future, and forming new connections with people and



communities. Over the course of therapy, I learned that the reasons BA was emotionally distant from others stemmed from his belief that “bad things” would happen to those he grew close to and his cultural values to not impose on and inconvenience others (Theme 1c). As such, we focused on identifying challenges that may potentially interfere with his ability to form future positive relationships with others.

In my work with BA, I made conscious decisions about how directive I ought to be, how much of an “expert position” I ought to assume, and how much self-disclosure I would provide in-session (Themes 1a and 1b; Themes 2a, 2b, and 2c). Overall, these stances contradict the teachings of mainstream training of counseling and psychotherapy (Theme 1). I found it particularly interesting that I spontaneously changed my therapy approach from a more tentative style to a more directive one because BA did not respond well to my initial nondirective counseling approach with him (Themes 2a and 2b). Taking the 4-month long didactic multicultural class prior to this multicultural practicum was helpful to prime my expectations and understanding related to the use of self-disclosure with multicultural clients. However, actually working with BA helped contextualize this knowledge and highlighted that culturally diverse clients may have different expectations about the role of mental health professionals and the nature of the therapeutic relationship (Themes 1a and 1b).

### *Termination of Therapy*

Discussions related to termination with BA were initiated during the 10th session with the ending of the academic semester. Our termination work focused on consolidating BA’s therapeutic gains, exploring his concerns related to ending treatment, and discussing his future goals and aspirations. BA demonstrated behavioral and emotional changes as a result of therapy. For instance, BA stated that he researched PTSD symptoms online and that he experienced a significant reduction in his PTSD symptoms since the onset of his treatment. Further to that, BA was no longer readily angered, preoccupied with thoughts about his past, or constantly worried about his future. BA also reported feeling calmer, “energized and better,” and more open to talking with others.

Upon reflection of my work with BA and my peers’ work with their refugee clients, I can identify a number of clinically and culturally relevant gains. Cognitively, this therapy experience piqued my interest and increased my awareness of issues in Afghanistan. I started watching more documentaries, reading about history, culture, and war, and researching the Taliban and issues related to refugees. I was struck by the amount of trauma and

challenging life experiences that our refugee clients have lived through in comparison with our nonrefugee, Western clients (Theme 1). My practicum experience with refugee clients challenged my biases (Theme 2) and subsequently helped me adjust my view of refugees and culturally diverse individuals more generally.

Clinically speaking, particularly with respect to my cultural competencies, the experiential, hands-on nature of this multicultural practicum encouraged me to be flexible in session, to adapt to BA's treatment expectations, to take on a more directive role in session, to feel comfortable providing "on the spot" feedback in session, and to trust and appreciate the therapeutic process and relationship (Theme 1d). This strengthened my belief and allegiance to humanistic and multicultural theories.

Pedagogically speaking, I found the safe, supportive, and collaborative approach of group supervision adopted in this practicum well suited for multicultural training. These characteristics of supervision were particularly helpful given the novelty of working with cross-cultural clients and the challenges that arose from working with refugee survivors specifically. In my opinion, our learning seemed to occur on an individual basis by directly working with cross-cultural clients and vicariously by watching other trainees' video recorded sessions, and discussing clients' case conceptualizations and treatment plans. Socratic questioning that was typically used by the supervisor, including asking trainees about our treatment goals and plans in upcoming sessions, encouraged our thinking, planning, clinical development, and case conceptualization skills. All and all, this multicultural supervision approach encouraged my ability to trust the therapy process.

## Discussion

Multicultural counseling scholars have emphasized the need to develop actual multicultural skills and relationships through experiential training and to integrate social justice curricula into graduate training programs (Constantine et al., 2007; Pieterse et al., 2009; Vera & Speight, 2007). As such, the multicultural therapy practicum described in this article offers a concrete, alternate model of diversity training for psychology and counseling trainees that extends the strengths of emerging research on cultural immersion education programs (e.g., Nilsson et al., 2011; Roysircar et al., 2003; Roysircar et al., 2005).

Goodman and colleagues (2004) noted that an effective multicultural-social justice training intervention should allow psychology and counseling students to expand their learning across three levels: (a) the *macro* level: government, policy, and social norms; (b) the *meso* level: community and organization; and (c) the *micro* level: individual. Using this framework,

several benefits associated with this practicum-based multicultural training can be identified. At the macro level, this practicum sensitizes trainees to international events and global issues related to war, conflicts, human rights, and refugees within Canada and abroad. Trainees acquire knowledge on policies, laws, regulations, and resources relevant to refugees, such as the Canadian immigration policy on refugees and immigrants.

At the meso, programmatic level, this practicum takes the trainees outside of the classroom and into the community. In this regard, the benefits of this multicultural practicum include (a) providing trainees with a distinct learning environment to develop multicultural competencies through the direct provision of psychological services to culturally diverse clients; (b) offering a practical training-based mental health service and outreach for extremely underserved refugee newcomers; (c) promoting effective university–community collaborations and learning opportunities; and (d) implementing comprehensive multicultural interventions that embody teaching, training, service, and research. These characteristics are well reflected in the underlying philosophy, and the structure and content of the practicum, as outlined in this article. It is noteworthy that this refugee-serving multicultural practicum training model has been highlighted in a recent report by the Centre of Addiction and Mental Health in Toronto, Canada (Vasilevska et al., 2010), as an innovative example/model of a university–community “strategic partnership” that can help bridge the psychological and mental health needs of refugee newcomers.

Finally, at the micro, individual level, this multicultural practicum can have a broad and lasting impact on trainees’ professional and personal development, as evidenced through the preliminary data analyses based on the current practicum evaluation research and the case narrative. The current findings based on our mixed-methods approach are encouraging as they lend preliminary support that trainees’ multicultural skills, feelings of self-efficacy, and awareness of cultural issues in therapy increase after involvement in direct services to refugee clients. Moreover, multicultural counseling scholars have contended that hands-on intervention experiences with diverse clients, in conjunction with a supportive and culturally grounded supervision approach can result in students’ learning that extends across cognitive, behavioral, emotional, and relational domains (Kiselica, 1991; Tomlinson-Clarke, 2000). Indeed, in the case illustration, the therapist trainee identified the growth in her (a) awareness and attention toward client–therapist cultural differences (e.g., sociopolitical history, cultural beliefs, communication styles, nonverbal behaviors), (b) appreciation and ability to achieve and maintain a therapeutic alliance with the client, (c) responsiveness and flexibility in adjusting the therapy approach by incorporating diverse and multiple intervention skills, (d) capacity to assimilate trauma therapy with multicultural

principles, and (e) interest in cultural diversity and social justice issues related to refugees globally, and (f) motivation to work with diverse clients in the future. Clearly, these cultural and clinical learning opportunities were unlikely to occur within a conventional cognitive-focused multicultural course venue.

### *Challenges and Limitations*

Despite the many rewards associated with implementing and refining the current multicultural therapy practicum, we have learned and identified a number of technical challenges pertaining to conducting and maintaining this community-based practicum over the last 6 years. These obstacles characterize many typical challenges related to engaging in social advocacy work in the larger community as noted by others (Goodman et al., 2004). First, even though this practicum bears no direct financial costs to the participants, administering and managing the practicum is a time and resource intensive endeavor. A significant amount of time and commitment is required to coordinate the various components and multiple stakeholders of this practicum—the university psychology department, the practicum supervisor/instructor, graduate student trainees, refugee clients, interpreters, case managers and the program director at the referring agency. Hence, a strong and determined leadership on the instructor/supervisor's part is imperative to ensure smooth and continuous implementation of the practicum year after year.

Second, a successful service-based multicultural practicum is contingent on a strong working relationship between the university department and the collaborating community partner. In addition, a sustainable university–community project is predicated on continuous support and commitment to the project from each partner's respective administration. This is particularly important because each collaborating partner holds different organizational mandates and interests (i.e., the university primarily aims to address the students' training needs; the community agency primarily aims to meet the clients' service needs). Therefore, it is essential that both collaborating partners constantly communicate, evaluate, and negotiate their shared values and goals during the process.

Third, pragmatic issues frequently faced by refugee clients (and community clients in general), external to the therapy present a particular obstacle for providing mental health services to this population. Typical challenges can include clients' need for transportation to and from therapy, child care issues during therapy, concomitant medical and health problems, financial strain, and between-session communication difficulties between clients and therapists due to language barriers, just to name a few. These multiple psychosocial and structural obstacles can negatively affect refugee clients'

commitment or ability to attend therapy regularly. While there is no simple way to resolve these logistic concerns, creative and proactive problem solving, open communication, and a close working relationship among the referral agency, interpreters, trainees, and the practicum supervisor can significantly help to keep the impact of these barriers to a minimum.

As an example for this university–agency negotiation and problem solving, at the conclusion of the 2011–2012 academic year, the Multicultural Council announced that funding for refugee clients' transportation to and from therapy sessions (e.g., cab fares) was going to be ceased due to a significant funding cut to the resettlement services program. Realizing the gravity of not providing transportation for refugee clients and the adverse effect this decision would have on the operation of this practicum and this therapy service, the course instructor vehemently advocated to protect against this cut. In subsequent meetings and conversations, the university faculty and the agency's program director participated in ongoing discussions in which they refocused and reaffirmed their shared commitment to prioritize refugee clients' welfare despite the adverse economic circumstances. Together, they discussed alternative funding possibilities from various private sectors and ways that both organizations can help to reduce the cost of operating this joint service-based project. Creative solutions were agreed upon; the program director realigned the program budget for the upcoming year and the course instructor advocated for free on-site campus parking for interpreters and case managers when they accompany clients to the sessions. Consequently, the transportation service for refugee clients was fortunately preserved.

On this note, from a training standpoint, it is equally important for trainees to recognize that these pragmatic and logistic issues presented by refugee clients and the associated issues related to partnering with social services agencies accurately reflect the typical challenges that are introduced when working with community-based client populations. As such, the experiences and skills learned in negotiating and managing these issues for treatment purposes should be framed and viewed as an inherent aspect of trainees' cultural learning (The Centre for Victims of Torture, 2005).

## **Implications for Future Training and Research on Multicultural Counseling and Therapy**

The present article intends to systematically document and describe a model of experiential multicultural training. It represents a promising alternative to existing didactic-only cultural coursework as it involves psychology trainees and culturally diverse clients in a formal, supervised therapy practicum. From this perspective, this article contributes to the current multicultural counseling training and social justice literature by offering an authentic example of a

multicultural therapy practicum—a multicultural training method that has been long advocated and aspired by multicultural scholars and educators (Smith et al., 2006). The practicum detailed in this article serves as one potential model or exemplar for multicultural counseling educators and researchers who are considering similar practicum-based diversity training opportunities for their students. For instance, similar practicum models can be implemented with the involvement of local, culturally diverse client populations, such as international students, ESL students, immigrant newcomers, migrant workers, and so on. It is hoped that this article will generate further dialogues, discussions and inquiries related to best practices for multicultural counseling training and supervision.

This article bears implications for research as well. An emerging body of empirical research on multicultural counseling training through cultural immersion interventions was identified and discussed in the current article. This development points to the discipline's increasing acknowledgment of the need for more comprehensive and experientially-based cultural training and the desire to empirically understand the facilitative ingredients of experiential training in promoting MCC (Sammons & Speight, 2008). That is, as Malott (2010) poignantly concluded in her recent review of multicultural coursework, the pertinent question to be addressed is now “which specific training components are essential in cultivating multiculturally competent helping professionals” (p. 60). Clearly, additional and more thorough research is needed to verify the utility of this and other experiential models of multicultural counseling training.

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