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# School and Mental Health Counselors: Recommendations when Working with Bosnian Refugees

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## **Introduction**

The recent influx of Bosnian immigrants differs from the traditional North European immigrants who came to the country in the late 1800s and early 1900s. The midwest region of the United States of America is experiencing unparalleled periods of ethnic diversification due to an influx of immigrants from Latin America and Eastern Europe who are coming to work in meat packing plants, farming, and related industries (Bloom, 2000; Grey, 1999). Various studies have shown that the new immigrants from Eastern Europe (e.g., Bosnia) arrive with health and psychological difficulties such as poor nutrition, poor dental health, depression, acculturation stress, post-traumatic stress disorder, and infectious diseases (Ackerman, 1997; Baylor University, 1999; Clemente, Clark-Hanify, & Collison, 2001). According to Clemente et al. (2001), many refugees from Bosnia who have experienced traumatic events related to ethnic cleansing come to the U.S.A. with psychological conditions that could challenge the most experienced school or mental health counselor.

*This study focused on perceptions about difficulties with acculturation for Bosnian refugees and their views on mental health counseling. It provides an overview of the Bosnian refugee dynamics in the United States of America and a description of the post-traumatic stress disorder (PTSD) as a condition faced by many refugees of war. Using a standard set of questions, two interviews were conducted with four school and mental health counselors to draw out emerging themes in counselor perceptions relating to the needs of this population. Implications and recommendations for mental health (community agencies) and school counselors are provided.*

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This article begins with a short overview of the Bosnian refugee dynamics in the United States of America and a description of the post-traumatic stress disorder (PTSD) as a condition faced by many refugees of war. The article then provides a description of several interviews conducted with school and mental health counselors from Iowa who have experience counseling Bosnian refugees. Finally, the article concludes with recommendations for counselors working with Bosnian refugees, including those who suffer from post-traumatic stress disorder (PTSD).

### **Mental Health Issues of Bosnian Refugees**

Because many states in the Midwest are experiencing a labor shortage related to the aging population, low fertility rates, and the out-migration of young workers, a rapid growth of ethnic diversification is expected as new immigrants arrive (Bloom, 2000; The Iowan, 2000). New immigrants go through a period of adjustment that can be influenced positively or negatively by factors such as level of trauma experienced, financial and educational level before immigration, amount of support and resources offer by the new community, and personal-social skills (U.S. Committee for Refugees, 1997).

A statistical report compiled by the Bureau of Refugee Services (1997) reported that Bosnian immigrants have multiple sources of stress that can originate from feelings of loss, social isolation, culture shock, and accelerated modernization. These sources of stress can lead to symptoms characterized by mood swings; sleep problems; and decreased memory, energy, and patience (Baylor University, 1999). As a result, school and mental health counselors who work with Bosnian refugee students must reconceptualize how services are provided to these immigrants and realize

that their needs may not be consistent with traditional strategies used for clients in the U.S.

The literature reveals that serious coping issues stem from psychiatric effects related to traumatic events of ethnic cleansing. According to Ackerman (1997), 65% of Bosnian refugees show some type of symptomatology related to post-traumatic stress disorder (PTSD), and 35% experience depression. The mental health status of Bosnian clients is intimately related to health issues that cannot be ignored, especially for those who arrive directly from refugee camps in Europe. During their residency in refugee camps, they are typically exposed to diseases such as measles, malnutrition, diarrhea, respiratory infections, malaria, meningitis, and hypothermia (The International Committee of the Red Cross & The Johns Hopkins School of Public Health, 1999). According to the Centers for Disease Control and Prevention (1999) and Ackerman (1997), refugees should receive a physical and mental health assessment within 30-90 days of arriving in their resettlement country. This assessment can serve as a mechanism to facilitate the adaptation process of newcomers. The following section provides a short description of the common symptoms and behaviors experienced by those suffering from PTSD.

### **Post-Traumatic Stress Disorder**

As the war escalated in the Balkans during the late 90's, many citizens left their home countries and sought refuge in other countries. Many of these individuals had experienced a variety of traumatic events. During the war, many refugees survived experiences such as: witnessing the savage killing of numerous individuals; anguishing over the disappearance of loved one(s); watching the destruction of their homes; living in refugee camps and/or leaving their

homes; and knowing that loved ones who stayed or were left behind might be killed in the war (Becker, Weine, Vojvoda, & McGlashan, 1999; Weine, Becker, McGlashan, Vojvoda, Hartman, & Robbins, 1995).

Due to such exposure to violence, there are concerns that the Balkan population which has resettled in the United States is at a higher risk for developing post-traumatic stress disorder. According to the DSM-IV (American Psychiatric Association, 1994), post-traumatic stress disorder (PTSD) is the development of symptoms after exposure to a traumatic event or stressor. A diagnosis of PTSD requires that the person responded to the event with an "intense fear, helplessness, or horror" (Criterion A1) (p. 424). Additional diagnostic criteria for PTSD include: re-experiencing the trauma; avoiding triggers associated with the event experiencing a numbing of affect; and feeling a sense of increased arousal. The symptoms must be present for over a month and cause significant distress and/or impairment in functioning.

Children are extremely vulnerable to the impact of trauma; in fact, PTSD is three times more likely to occur if a trauma victim is under the age of 11 (Pelcovitz & Kaplan, 1996). However, a similar study conducted by Becker et al. (1999) revealed that Bosnian adolescents who have resettled in the United States have a relatively low rate of PTSD. Analogously, Becker et al (1999) and Weine et al (1995) indicated that children experience less cultural disruption than adults. On the other hand, Clemente, Clark-Hanify, and Collison (2001) revealed that Bosnian youth encounter cultural and linguistic challenges that impede a healthy cultural transition. Since the Bosnian immigration is a new phenomenon and research studies with this population are limited and conflicting, it is too early to assume that all refugees will successfully

adapt to the North American culture. Furthermore, there are no longitudinal studies with this population indicating whether the effects of transition to the U.S. or the success of children and youth in the educational system.

### **Research Purpose and Design**

This study was designed to gather information from counselors who have significant experience in counseling Bosnian refugees in order to better understand the treatment needs of this population. The following research questions guided the study: (a) How much compatibility exists between the evaluation methods used by North American counselors for psychological evaluation and the mental health needs of the Bosnian population?; (b) What are the most challenging situations for school and mental health counselors when working with Bosnian immigrants?; (c) What are some of the ethical, legal, and linguistic issues that counselors must take into account when working with this population? This study was intended to provide an operational foundation for mental health and school counselors who may interact with Bosnian refugees in schools or community agencies.

The design of this study followed standard procedures of qualitative design suggested by Bogdan and Biklen (1992).

### **Method**

#### **Counselor Participants**

This study involved interviewing four counselors; two of whom were school counselors (one male and one female) and two of whom were mental health counselors (one male and one female). All counselors interviewed were European American (White). The counselors were selected because of their past work with Bosnian clients. Due to the location of their

respective agencies or schools, each counselor had worked with Bosnians clients and other immigrant clients or students. The experience of the counselors ranged from 4 to 10 years. All the counselors had either a school counseling certification or a mental health license except for one mental health counselor who was a National Certified Counselor (NCC) completing the clinical hours for licensure.

### **Interviews**

The school counselors were interviewed individually by the researcher who is an assistant professor in School and Mental Health Counseling at the University of Northern Iowa. The researcher is a Latino male who has been involved in previous studies with Bosnian and Latino clients in the community of Waterloo, IA and has previously worked as a school counselor and in mental health settings in Oregon and Puerto Rico. The mental health counselors were interviewed by a Latina female who was a mental health counselor in the community serving as a research assistant during the interviews. She has been involved in previous studies with Bosnian children and adolescents. Questions were oriented toward their respective professional areas, school and mental health counseling. All interviews were conducted in the participants' respective schools or agencies.

The same set of questions was used for each of the four interviews in order to provide structure and continuity to the interviews. The interview questions were generated as an extension of the research questions and revolved around the participants' perceptions about the following themes: professional competency, quality of communication and interaction, multicultural challenges, language differences, legal and ethical issues, and conceptualization of psychopathology.

The first set of interviews ranged in time from one hour to one and a half hours; the time spent interviewing was nine hours. The second set of interviews ranged from thirty to forty-five minutes. A total of fourteen hours were spent in both sets of interviews

### **Transcription and Analysis**

During the first session, the counselors were interviewed using the guideline questions. After this interview, the session was transcribed and analyzed, and emerging patterns were codified into categories. The second interview was used to verify these categories with the counselors and to discuss any inconsistencies found during the first interview. Therefore the initial interview session was audiotaped and then transcribed, while the second interview session was also audiotaped but not transcribed. Taping and analysis of the second interview complemented the first interview; and conclusions were drawn based upon the integration of both interviews.

Data were analyzed by highlighting common themes of the transcription manuscript and codifying (labeling) by categories. Following qualitative guidelines documented by Borg, Gall, and Gall (1993) and Bogdan and Biklen (1992), these codes were catalysts to further explore inconsistencies in the previous interview or to pursue in-depth issues regarding a topic during the second interview. The data were qualitatively analyzed in order to find commonalities, themes, and trends, as well as distinctive experiences among the interviewees. Categories were clustered into codes, subcodes, and themes depending on the degree of interdependence (Strauss & Cobin, 1990).

### **Results**

As a result of the analysis of these interviews, the author and the research

assistant identified a number of themes and consolidated these themes into categories. This section will describe each category yielded by the qualitative analysis of our interviews. The study results are reported according to the themes that were synthesized into categories.

### **Communication Patterns and Language**

The most pressing issues for all counselors interviewed appeared to be related to difficulties in conveying ideas to Bosnian clients. As one school counselor expressed: "I took French in high school and college but never expected to be exposed to a language such as Serbio-Croatian in Iowa. I have had to rely on interpreters, especially when dealing with newcomers."

Counselors also expressed some degree of frustration when trying to explain a concept that does not have a direct translation from one language to the other such as love, which has more variations in Serbio-Croatian than in English. Therefore, long explanations are needed in order for the client(s) to comprehend the idea.

In contrast to the Anglo-Saxon (North American) model of behavior that promotes restraint and calm, even during the discussion of the most passionate topics, interviews reported that Bosnians are more open in exhibiting their emotions as decisive elements of strength and conviction.

### **Social and Legal Principles**

Due to the fact that Bosnian social and legal standards differ so much from North American standards, interviews reported that they have taken a very strong psychoeducational approach in order to educate their clients. Also, because some clients have been exposed to traumatic events during the war, many continue using coping skills that are no longer needed. As an illustration, government institutions are used as a last resource by some Bosnian

immigrants, in view of the fact that in their native country many government agencies were unreliable. One counselor expressed: "I had taken for granted my cultural, social, and legal knowledge regarding the American culture and did not realize that it was completely foreign and unsound for my Bosnian clients. This has forced me to avoid any kind of assumption, even if it sounds too elemental."

### **Counseling and Mental Health**

All counselors expressed that every Bosnian client they have seen had been referred and that none of them visited their offices by their own volition. One mental health counselor said: "their perception toward mental health professionals is based on the concept of extreme psychopathology and not a developmental or an acculturation issue. Therefore, the first couple of sessions must be used to normalize their fears and contest those negatives stereotypes toward the profession."

Also, counselors expressed their apprehension when diagnosing Bosnian clients based on the DSM-IV and have opted to perform extended intakes and utilize more often the glossary of culture-bound syndromes section of the manual.

### **Children's Needs**

According to both school counselors' experiences, Bosnian students are accustomed to a more traditional method of teaching. Collaboration among student peers and group activities are new concepts for them. However, Bosnian children adapt quickly to the US system of education and are willing to learn the language. One school counselor said: "They like to experience education to the fullest. Also, I have noticed that they like to keep using their native Serbio-Croatian language as much as possible in school when they are among other Bosnian children. Different from other



immigrant children that I have seen in the past, they are not embarrassed to use their language in front of English-speaking students. That speaks a lot of their pride regarding their cultural heritage and language.”

### **Ethical Issues**

All counselors expressed a high degree of hesitation when making decisions that could affect their client’s legal, social, and educational future. One counselor said: “ I am aware that if I follow a treatment plan based on a diagnosis as I understand it, without taking into consideration variables such as culture, language, and past events that occurred in Bosnia, I could do more harm than good. Also, I am conscious of the potential legal and social implications that a diagnosis could have when it is inappropriately used.”

Consultation seemed to be the common denominator for all the counselors when a decision had to be made. Therefore, a conscious analysis of the cultural context took precedence over some of the ethical standards as have been portrayed in the counseling profession.

### **Discussion**

The initial counseling session will determine the quality of the relationship and will facilitate the assessment and plan of action in any counseling context, whether it is with an international-non-English speaking client or a native speaker. The following is a list of communication strategies that could be utilized with Bosnian refugees in order to ensure a positive first impression, a successful relationship, and counseling outcome.

### **Recommendations for School and Mental Health Counselors on Improving Communication and Assessment**

The initial counseling session will determine the quality of the relationship and will facilitate the assessment and plan of action in any counseling context, whether it is with an international-non-English speaking client or a native speaker. The following is a list of communication strategies that could be utilized with Bosnian refugees in order to ensure a positive first impression, a successful relationship, and counseling outcome.

1. *Be present.* Bosnian clients, like any other refugee, want to know that a person who is caring and understanding is there and willing to listen to their unique experiences.
2. *Focus and relax.* Since working with a person whose first language is not English demands additional psychological-intellectual energy, the counselor ought to make an extra effort to clear her/his mind and pay attention to the conversation. Being relaxed and natural does not imply being inattentive but instead requires having one’s mind and body clear of distractions.
3. *Pre-plan your strategy.* Decide in advance what information is necessary to be compiled or provided. Gathering or providing unnecessary information slows down the counseling relationship.
4. *Engage in self-disclosure and demonstrate eagerness to learn.* Ordinarily Bosnian Muslim names have a Middle Eastern identification, usually based on Islamic or Turkish roots. As a way of illustration, most Bosnian family names end in –ic, which means “child of.” Similarly, female first names have a tendency to end in –a or –ica. Counselors could start establishing a conversation by asking the meaning of their names and their position within the

family genealogy. By demonstrating one's interest in learning about the individual, the counselor can set the stage for an exchange of information. Next, the counselor could disclose some personal information regarding his/her family that could relate to the client. Acknowledging the importance a client's Bosnian cultural heritage and family name brings a different dimension to the counseling session.

5. *Be specific and explain yourself multiple times.* Communicate in an explicit manner with your Bosnian client. Do NOT assume that the client understands you immediately. Explaining your ideas more than one way will allow your client to have a clear picture. Bosnian individuals are attentive and courteous people, and may say they understand even when they don't. They may either want to avoid embarrassment or may not want to make you work harder. To deal with this, ask for feedback or use summaries. Short-intentional paraphrases with a closed question at the end help to maintain the conversation on "track" and without misunderstandings. Using long summaries could be confusing for the Bosnian clients, instead short summaries are recommended.
6. *Attend to body language.* Bosnian clients rely on body language to express emotions and important facts. For example, rolling their eyes and lifting both hands could either mean disgust or gratitude. The context of the conversation determines the meaning of the expression. Observe their eyes and expression to verify if they are following you. Observing the way Bosnian clients manifest their ideas through their body language can serve as a mechanism to compensate for the lack of language command.

7. *Use of interpreters.* Use caution when selecting an interpreter. Avoid family members if possible due to ethical issues. If you decide to use an interpreter, arrange a pre and post meeting with him/her to set a plan and to debrief the content of the session. Arrange the chairs in a triangle position with both, the interpreter and client, situated in front of you. Encourage the client to look at you as opposed to the interpreter.

### **Recommendations Regarding Bosnian Clients Suffering Post-Traumatic Stress Disorder**

Besides being in a new country with a different language, culture, and people, some Bosnians have to deal with the emotional consequences of war and ethnic cleansing. The following recommendations for counselors deal with Bosnian clients who present signs and symptoms of PTSD.

1. *Personal boundaries.* Traumatic experiences alter people's personal boundaries. In spite of the fact that Bosnians tend to be physical when experiencing joy and affection, caution ought to be exercised regarding touching or closeness.
2. *Personal freedom.* Some Bosnian clients have suffered imprisonment and torture; therefore, the idea of being trapped is still a vivid one. Providing reassurance that they can leave the office at any time is reassuring.
3. *Affective responses.* Emotional numbness and "flat affect" could be present. It should not be mistaken with apathy or unwillingness to work. Freezing emotions has often helped them to go through difficult experiences during the war. Consequently, do not assume that a lack of appropriate



- responses to the therapeutic process signify resistance to counseling.
4. *Do not force the counseling process.* Many Bosnians were forced to do things against their psychological or physical will. It is recommended to ask permission to talk about painful events and to avoid forcing the counseling process.

## Conclusions

The United States of America is experiencing a unique period of ethnic/racial diversity. Immigrants coming from Latin America, Asia, Africa, and Eastern Europe have typically left their countries due to economical or political oppression. Many of these immigrants arrive in the United States of America with psychological and physiological needs.

Due to the unique cultural and psychological needs of the Bosnian population, school and mental health counselors need to be aware of their own counseling beliefs and strategies when working with this population in order to increase their effectiveness. Longitudinal research studies need to be conducted with this population of new immigrants in the United States of America. A variety of studies, qualitative and quantitative, could serve to develop a consistent frame of operation for counselors to operate from in the future.

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