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Best Practices in Counseling the Balkan Population: Training for Mental Health Counselors

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Training for Mental Health Counselors

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Abstract

Balkan refugees in the United States have been shown to develop symptoms of anxiety, depression, PTSD, and low subjective quality of life after the Balkan wars and the stressors of immigration (Priebe et. al., 2009). Along with these potential mental health disorders, many of these refugees suffer with their mental health in other ways such as loneliness, low self-esteem, financial stressors, lack of understanding of the new cultural norms, language barriers, chronic fatigue, and more that all lead to developing maladaptive coping mechanisms (Keyes & Kane, 2004). Furthermore, most of these refugees do not seek mental health care and suffer in silence. Effective treatment methods for refugees, specifically Balkan refugees, are shown to be lacking. Some options may include various trauma therapies, group therapy, humanistic therapy, or rational emotive behavioral therapy. A review of the literature reveals a gap in mental health professionals understanding how to counsel this group of people. Because of this gap, a training has been developed for mental health counselors on teaching best practices for counseling the Balkan population. In this training, an overview of the history of the Balkan region, Balkan people, and the current research on mental health in Balkan refugees will be discussed. Along with this, the training will also aim to provide various strategies in counseling the Balkan population which includes how to build rapport and various therapies that can be used.

Keywords: Balkan refugees, post-traumatic stress disorder (PTSD), counseling

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Introduction

The purpose of this project is to explore various methods on counseling Balkan refugees and to gain a better understanding of this group of people. As counselors, it is important that we learn and understand the client in front of us. Fazel et al. (2005) concluded that one in ten refugees in Western countries has PTSD, one in twenty has major depressive disorder, and one in twenty-five has generalized anxiety disorder, with the probability that these disorders overlap with one another. For Balkan (or what I may refer to as Bosnian in this literature review) people, 40% reported feelings of chronic nervousness that developed into anxiety, depression, or PTSD (Carballo et al., 2004).

Mental health in this group of people is a serious issue and most do not seek help for it. Some that do seek help may find it difficult to find a counselor that is a good fit for them. Honoring diversity and promoting social justice are core professional values as defined in the American Counseling Association (ACA, 2014) along with social and cultural diversity addressed extensively in counselor education programs (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). This means that it is a counselor's responsibility to increase their comfort and competency in working with diverse populations, which includes refugees. This can be done by building rapport and utilizing various counseling techniques that are culturally appropriate for the client. Training counselors is a great first step in ensuring that the ones that seek help are receiving adequate counseling. The lack of research on this specific topic illustrates the importance of providing a training to counselors on the best practices in counseling the Balkan population.

Literature Review

Bosnian Culture

To understand a client that steps into your office, it helps to understand their way of life. For Bosnians, their culture is everything to them. If you were to speak to any Bosnian, most start off their story when they weren't Bosnian at all, rather Yugoslavian. Yugoslavia was the communist country that ruled a majority of western Europe until its fall in the late 1980s. Many Bosnians are fond of this time when Josip Tito ruled the nation. Citizens had food to eat, shelter, jobs, and the country was prospering, even hosting the 1984 Winter Olympics in Sarajevo (now the capital of Bosnia) (Fazlic, 2015). However, the country itself was the most heterogeneous country in Europe and even most of the world. Yugoslavia was broken up into six different ethnicities and within these six ethnicities, three major religions lived in them- Islamic, Catholic, and Orthodox. Although many of the citizens lived in peace, there was always underlying conflict with these different regions of religion dating back to this communistic time (Fazlic, 2015). After Tito's death in 1980, the country spent close to ten years in high tension until the Bosnian wars.

Religious identity is of great importance to Bosnians, if not the most important part of their identity. Depending on who you are speaking to, a Bosnian may identify themselves as a Bosniak (Muslim), Croat (Catholic), or a Serb (Orthodox) (Peljto, 2021). This grows confusing for most outside this region as a Croat and a Serb are not technically Croatian or Serbian, but rather Bosnian and they get this name from their religious ties. It is important to be mindful of which religion one is from, but most Bosnian refugees that settled in the United States are Muslim. This is because during the Bosnian wars, it was the Catholic Serbs that were attempting

to purge the nation of all Muslims so many of these Bosnian Muslims, also known as Bosniaks, fled to other countries for safety (Peljto, 2021).

Another important piece of Bosnian culture is that identity is important. “Identity is a historical value and a phenomenon that expresses the historical existence of particular human groups” (Filipovic, 2009). Many Bosnians pride themselves in their nationality and their religion, especially Bosnian refugees. Many Bosnian refugees in America keep up with traditions from back home, such as prayer or surrounding themselves with other Bosnians in their community. For many Bosnians that are still in Bosnia or assimilated elsewhere, community is also of importance. Oftentimes, Bosnians will spend hours each day visiting neighbors, friends or relatives. The Bosnian culture is a very social one and many get most of their emotional needs met through their communities and family members (Peljto, 2021). This form of culture is known as a collectivist culture, which is what many in the Balkans are. In a collectivist culture, members see themselves as part of an extended family and community structure. Interdependence is valued and is shown as a sign of dedication and loyalty to one’s group (Hays & Erford, 2017). Many in the Balkans have the lens of viewing things for the greater good of the group vs. the individual, which can tend to lead to all or nothing thinking. Oftentimes, the Balkan culture tends to have various beliefs ingrained in one another, such as: loyalty, honor, a “what will people say” way of going about life and one’s choices, and not bringing shame upon the family. This, in turn, makes many Balkans view healing as selfish and prioritizing one’s emotional and mental needs as selfish (Natalia & Fridari, 2022).

Regarding gender and social roles of the Bosnian culture, the status of men is always higher than the women. In the Bosnian culture, women are responsible for all domestic tasks, which often includes cooking, cleaning, and childcare. If a woman is working, it is often in

lower-paying roles than men. Since the devastations of the Bosnian war, it left many citizens in Bosnia poor, which is true even to this day. Prior to the wars, there was a normal social class and hierarchy of upper, middle, and lower class. But, since then, the wars have left even the richest, poor. Bosnia is the second poorest country of former Yugoslavia. So, the few better paying jobs that are now available in the country often go to men. Due to this, many women have moved back into the traditional role of a stay-at-home mother and caretaker of the home ("Culture of Bosnia and Herzegovina,", 2015). Like many other cultures in the regions surrounding the Balkans, there is often a patriarchal tradition that women are to serve the men. Geographical regions and the religion of many Balkans, Islamic, has contributed to this idea ("Culture of Bosnia and Herzegovina,", 2015).

Food and coffee are a staple of the Bosnian culture as well. Oftentimes, all these pieces of identity, community, and food go hand in hand. Many Bosnians will host others every day at various times of the day, multiple times a day. A Bosnian will always have coffee ready for their guests and food prepared to share with them. It is uncommon to enter a Bosnians home and you leave hungry and thirsty. Many Bosnians take pride in their nation's dishes and how their coffee is made and enjoy sharing this with others, whether they are Bosnian or not (Peljto, 2021). Food and coffee in Bosnia are derived from Turkish and Eastern European decent. Most dishes will have meat and/or cabbage in it, as these two are staples of many Bosnian foods. For example, *cevapi* are lamb and beef mixed sausages eaten on a flat bread called a *somun*, often paired with white onions and sour cream. Although not many Bosnians drink alcohol due to their religious beliefs, a popular alcoholic drink, a form of brandy called *rakija*, is one you may often see in the country ("Culture of Bosnia and Herzegovina,", 2015). Bosnians are the friendliest people you may ever meet, but behind all this they have suffered emotionally, mentally, and physically. It is

important that this piece does not go unnoticed, as Bosnians are ones that are great at hiding their pain in happiness.

The culture that Balkans have also ties into stigmas on mental health. Typically speaking, most immigrants from areas in Eastern Europe, Asia, and the Middle East do not view mental health as a priority in their culture and have a lot of stigmas around the topic. For example, Middle Eastern culture values "concealing emotions, family honor, patriarchy, respect for authority, and hospitality" (Abdullah & Brown, 2011). Oftentimes, when one seeks mental health treatment, this goes against the values listed above. Acceptance of mental health treatment is very low in the Balkan culture, even for Balkan immigrants in more Western countries like the United States. Regardless of them being in a Western country that gives more exposure to mental health, they still carry stigma surrounding mental health (Matsuo, 2005). Bosnian immigrants in these Western cultures similarly uphold the Middle Eastern values listed above, given that Bosnia is near these regions and that many share the same religion of Islam with Middle Eastern countries. Most Bosnians are Muslim, so oftentimes they relate their experiences to religion. With this, they often seek comfort in their religion for a sense of understanding as to what has happened in their lives. They will often say phrases such as "this was Allah's plan" to cope (Matsuo, 2005). Islamic culture has many values that one must uphold, and some include emotional regulation, respect for authority, family honor, and hospitality (Abdullah & Brown, 2011). Balkans may view mental health the way that they do because if they are experiencing any distress or dysregulation, this inadvertently goes against the values that they feel they need to uphold. This can, in turn, suggest that mental health is viewed as a weakness in Balkan culture and the act of seeking treatment only further emphasizes that there is a weakness present in the individual (Abdullah & Brown, 2011).

Mental Health Issues with Bosnian Refugees

To understand the mental health issues of many Bosnian refugees, one must understand the difference between a refugee and a non-refugee. The refugee experience is one that can contribute to posttraumatic stress disorder, or PTSD. In the study by Hunt & Gakenyi (2005), they found that a refugees' experience was shown to be worse than a nondisplaced person. For example, Bosnians that were able to stay closer to their country and assimilate to a country that was similar in culture to theirs, such as Croatia or Slovenia, showed a lower risk of developing PTSD than Bosnians that had to flee to the west like America. Bosnian refugees that fled to a country that was geographically farther than theirs and had a totally different culture and language, were shown to be in more distress (Hunt & Gakenyi, 2005).

Outside of the experience that is assimilation, once a refugee settles into their new home, other difficulties emerge. In the study by Keyes & Kane (2004), belonging and adapting were the most notable issues for Bosnian refugees in America. As previously discussed, during the communistic time of Yugoslavia, many lived in harmony in their homes despite their religion and were taught that despite their differences, they were all the same. After, however, those norms were dismantled and in Bosnia it no longer felt like belonging when one could only feel belonging depending on what religion they were. This caused stress in many Bosnian refugees because the norms that they grew up with that they were all the same, suddenly was not true. After coming to America, many reported that belonging was difficult in a new country where they did not know the cultural norms or the language. This resulted in many Bosnian refugees feeling like they had to change their identity to fit into their new home. Most did not want to be viewed as different because when you were different in your old home post-war, there was a chance of death. Although that was not the case in their new migrated country, many still felt the

pressures of what may happen if they did not belong (Keyes & Kane, 2004). Another aspect that this study noted is the participants' feeling of insecurity of not knowing their new language perfectly. Many stated that this was an obstacle for them in life, despite that their English was nearly perfect. Having any trace of an accent created many worries for the participants in this study, such as finding jobs and just feeling normal. This also created a gap in being understood on a deeper level with American peers. Participants stated that since they did not have the words in English to articulate their true thoughts and feelings, they felt misunderstood and lonely (Keyes & Kane, 2004).

Another aspect in the study by Keyes & Kane (2004) was adapting. Having to adapt to their new homes and cope with their previous traumas and new culture caused great stress and even the feeling of being in survival mode. Adapting included things like finding a job to earn a living, learning their new country's customs and societal norms, improving their language skills, and trying to meet all other needs like making friends. Everything that Bosnian refugees had to adapt to led to learning coping mechanisms. Many participants reported that these coping mechanisms were things like dreaming, sleeping where they found solace, turning the shock and loss one felt into a game, numbness from their past experiences to help move on in their new country, or working long hours to not only make a living but to escape all the pain they felt in their past and present.

In the study conducted by Carballo et al. (2004), they looked at the mental health of displaced and non-displaced Bosnian refugees. The study found that over 25% of participants that were displaced from their homes suffered a loss of self-esteem and stated that they felt they were no longer able to play a useful role in their life after immigrating to their new country. 16% stated that they had lost all confidence in themselves and their abilities (Carballo et al., 2004).

Whereas, in the non-displaced population, only 11% felt a loss of self-esteem. Over 34% of displaced and 14% of non-displaced people stated that they felt depressed, along with both feeling an equal amount of chronic fatigue and “listlessness”. Over 40% of displaced people and 20% of non-displaced people reported feelings of chronic nervousness. These all led to participants developing sleep disorders, anxiety disorders, chronic stress, helplessness, low self-esteem, and difficulties coping. All of this along with the feelings of grief, PTSD (Spell this out the first time you use it), homesickness, loneliness in their new country, and so much more contribute to a Bosnian refugee’s overall mental health.

Post-Traumatic Stress Disorder in Bosnian Refugees

As previously discussed, post-traumatic stress disorder (PTSD) is the most prevalent disorder that Bosnians and Bosnian refugees are diagnosed with after the wars. In the study conducted by Fazel et al. (2005), they concluded that of their meta-analysis of 6,743 adult refugees showed that one in ten refugees in Western countries has PTSD, one in twenty has major depressive disorder, and one in twenty-five has generalized anxiety disorder, with the probability that these disorders overlap with one another. There are many physical and mental health effects that researchers have found in their studies that link many co-occurring disorders for refugees, such as anxiety, major depressive disorder, and PTSD.

Many Bosnian refugees experiencing prolonged PTSD can form maladaptive behaviors that can, in turn, develop into other disorders such as anxiety (Kashdan et. al., 2008). When PTSD goes untreated, people may begin to develop fears. These fears may begin as more external rather than internal, such as loud noises mimicking the sounds of gunfire. These fears can slowly begin to turn internal, often accompanied by avoiding unpleasant emotions, thoughts, and memories associated with the trauma. If this goes on for long enough, a person may begin to

develop anxiety as they continue to avoid anything unpleasant, external, or internal. Researchers often call this phenomenon experiential avoidance (Kashdan et. al., 2008).

In several research studies, participants showed one or more mental health disorders (Blackmore et. al., 2020, Priebe et. al., 2009, Kruse et. al., 2009, Selimbašić et. al., 2018). In the research study conducted by Blackmore et. al. (2020), 34% of their participants were diagnosed with PTSD, 31.5% were diagnosed with depression, and 11% were diagnosed with an anxiety disorder (either general, social, or separation anxiety). In another research study conducted by Priebe et. al. (2009), 83.7% of their participants were diagnosed with PTSD along with relatively low SQOL (subjective quality of life) scores.

Another research study conducted by Kruse et. al. (2009) showed that many participants experienced somatoform symptoms accompanied by PTSD. 81% of participants reported headaches, 79% reported backaches, 78% reported tachycardia, and 74% reported fatigue. With this data, several participants in this study were diagnosed with both PTSD and another somatoform disorder such as pain disorder, somatization disorder, and hypochondriasis.
In the study conducted by Selimbašić et. al. (2018), 120 Bosnian war veterans reported suffering twelve traumatic experiences on average during the war. The participants in this study suffering from PTSD most reported emotional numbness and intrusive thoughts, even twenty years after the war. These symptoms were accompanied by poor coping strategies such as projection, reaction compensation, and intellectualization. It is also important to note that this study discussed that these war veterans had low socioeconomic statuses and suffered from existential insecurity. This study aimed to show just how prevalent PTSD symptoms were after the war, even after twenty years and how many did not receive any mental health treatments post-war and just how that is still affecting them today.

Subjective Quality of Life

In the research study conducted by Giacco et. al. (2013), they discussed the levels of subjective quality of life amongst Balkan people with PTSD. Oftentimes, people with PTSD show symptoms of intrusion, avoidance, and hyperarousal which have been shown to affect one's subjective quality of life (SQOL). Their study aimed to show whether various levels of PTSD correlated to changes in SQOL with the specific symptoms of intrusion, avoidance, and hyperarousal. They measured this by assessing a previous observational study called the CONNECT study. PTSD was measured by the Impact of Events Scale-Revised (IES-R) and subjective quality of life was measured by the Manchester Short Assessment of Quality of Life (MANSA). A follow-up reassessment of both the IES-R and MANSA was conducted after 12 months. Finally, they used descriptive statistics to summarize the characteristics. Their results proved correct and showed that people that had these three symptoms reduced over time did show higher levels of SQOL. This is to say, that when a person is experiencing PTSD, they often have this cluster of hyperarousal symptoms. The more recent the PTSD, the lower SQOL levels are. This is because these hyperarousal symptoms can affect SQOL. After a one-year follow-up in their study, SQOL levels appeared to increase as the hyperarousal cluster symptoms decreased. Their results also showed that lower SQOL may influence hyperarousal, but the other two, avoidance and intrusion, did not show significance in SQOL levels. This may be because sometimes people with PTSD use avoidance as a coping mechanism, which can reduce other symptoms of their PTSD temporarily.

In the research study conducted by Priebe et. al. (2009), they discussed how little research has been conducted in the Balkan areas on the long-term effects of PTSD, whether recovery can occur without treatment, or the PTSD worsens, and what their subjective quality of

life (SQOL) is like. These are all questions that many of the research studies found have been attempting to answer (Giacco et. al.,2013, Priebe et. al. 2009, Matanov et. al., 2013). Since little research has been conducted on a such a specific topic, this makes answering these questions all that more difficult. So, the researchers' aim of this study was to find out whether current PTSD in the Balkans is associated with lower levels of SQOL and the potential long-term outcomes of PTSD. They chose to assess PTSD at any point during the wars and then current PTSD by using the Clinician Administered PTSD Scale for Diagnostic and Statistical Manual of Mental Disorders-IV, or CAPS. SQOL was assessed using the Manchester Short Assessment of Quality of Life, or MANSA. The researchers used both logistical and linear regression models to analyze these scores. Their results showed that 83% of their participants met the criteria under CAPS for current PTSD and participants had an average score of 4.0 for SQOL under MANSA. These findings proved their original hypothesis of lower SQOL with higher levels of PTSD, like the results of Giacco et. al. (2013). Their results also showed if more recent experiences of PTSD occurred, lower SQOL was noted. They also found that higher recovery rates were shown in refugees that fled to Western Europe versus the people that stayed in the Balkan areas. These results are inconsistent with the findings previously discussed on Balkan adolescents (Betancourt et. al., 2012, Ehntholt and Yule, 2006), but it is important to consider that the studies discussed on Balkan adolescents showed higher rates of anxiety, depression, and various PTSD symptoms of those who were refugees compared to those who stayed in the Balkans. It would be important to note here that those studies did not directly compare PTSD in refugees and in those who stayed. This would be something interesting to look at in future studies of Balkan adolescents compared to Balkan adults when discussing SQOL and PTSD.

Matanov et. al. (2013) also used the CONNECT project in their research study, like Priebe et. al. (2009). The aim of their research study was to assess subjective quality of life (SQOL) and several other life domains in the war-torn Balkan regions that experience high levels of PTSD. They gathered PTSD levels of participants through the Life Stressor Checklist-Revised and then SQOL through the Manchester Short Assessment of Quality of Life (MANSA). Descriptive statistics and linear aggression were used to summarize the results of the participants. The average MANSA score for SQOL of the participants was 4.8, like Priebe et. al. (2009) at 4.0. The results of this study also showed that participants of older age, experiencing more pre-war, war, and post-war traumatic events led to lower SQOL. Having high levels of PTSD at the time of the study also showed lower SQOL. Interestingly, higher SQOL levels were associated with participants that had met with a friend in previous weeks, were married, and had higher education. Even after the researchers controlled for these variables, their findings continued to show that participants with PTSD showed lower levels of SQOL.

PTSD continues to be a leading factor in subjective quality of life for people in the Balkans or even Balkan refugees in other countries. Even after many years post-war, PTSD continues to be prevalent in the Balkan peoples' lives and affects them in many ways.

Treatment Options

As the research discussed previously in this literature review shows, many Balkan refugees suffer from post-traumatic stress disorder (PTSD). Along with this, they often have one or more other disorders accompanied by their PTSD and lower levels of quality of life. In the findings on treatment for the Balkan refugees, there has been minimal research done on effective psychotherapeutic treatments. In the study by Kruse et. al. (2009), Balkan participants received twenty-five hours of psychotherapy once a week for three months then once every two weeks.

This study utilized the first phase of the consensus model of trauma therapy. In this model, a therapist-client relationship is built, safety is developed, psychoeducation is provided on PTSD, cognitive restructuring is taught, progressive muscle relaxation was taught, skill-building regarding flashbacks, dissociations, negative behaviors, and more was taught, and finally self-care was taught. Their results showed an improvement in PTSD symptoms after treatment along with improvement on physical and mental component summary scales. It is important to note that this study focused on improving clients' ability to cope with their PTSD symptoms.

In the research study by Schwarz-Langer et. al. (2006), they utilized four different phases of treatment for thirteen Balkan participants that had PTSD. The first phase is meant to build security and trust between the participant and the therapist. The therapist utilized primarily cognitive behavioral techniques such as naming of symptoms and relaxation strategies. In the second phase, labeled as the self-control phase, the participants focus on coping and lowering levels of arousal. Again, the therapist used a cognitive behavioral technique of deep relaxation. The goal of this phase is to learn self-control, trust, and continue active participation by the client. The third phase, labeled as the remembering and grief phase, continues phase one's goal of a sense of security. Exploring what life was like before and after the trauma and then reconstructing said trauma is the goal in this phase. In this phase, behavior therapy techniques are used such as stimulus confrontation. Grieving is also encouraged in this phase and teaching the client(s) grieving psychoeducation. In the final phase, the reintegration phase, creating a new "self" is the goal. The therapist teaches the client how to actively, not defensively, approach triggering situations in their futures. Throughout the entire duration of treatment, all participants are taking medications accompanied by therapy. The results of the treatment showed positive improvement on sleep, hyperarousal, and intrusive symptoms.

In the research study by Urlic et. al. (2012), they utilized group therapy for Balkan participants in three phases, like Schwarz-Langer et. al. (2006). A notable difference in this study is that therapeutic treatment occurred during the Balkan wars, not after, where 32 mental health professionals had arrived to set up operations for mental health treatment. In the first phase, the goal was to set up a sense of safety, structure, and boundaries under constantly changing circumstances for the participants. Therapists identified a variety of traumatic reactions such as shame, sorrow, hatred, isolation, development of PTSD, denial, and projection. The severity of defense mechanisms during this phase were also observed, rationalization and projection being the most common. In the second phase, psychological treatments, interventions, and support was the goal. Therapists divided participants into groups depending on whether they were soldiers, women, or children. They focused on allowing group members to mourn and discuss their feelings with the rest of the group. In the third phase, the war had ended, and mental health treatment moved to centers that provided psychosocial help to those that continued to need it.

Hagl et. al. (2015) utilized dialogical exposure treatment using the Gestalt empty-chair method in a group of widowed Balkan women whose husbands died or were missing in the Balkan wars. Dialogical exposure was defined as combining both humanistic therapy and cognitive behavioral therapy, depending on the phase of treatment. It is a structured way of addressing and processing internal dialogues of a traumatic event that oftentimes leads to dysfunction. Since there is a sense of unfinished business, hence why many continue this internal dialogue, the empty-chair method of Gestalt is most appropriate in order to address this trauma. 119 women participated in this research study, 62 of which had husbands that were killed in the wars and 57 whose husbands were missing and never found. Questionnaires to assess baseline PTSD levels were the modified Bosnian version of the Posttraumatic Diagnostic Scale (PDS),

the Checklist War Related Experiences (CWE), and the General Health Questionnaire (GHQ). Twelve treatment groups were created and there were two forms, either the dialogical exposure group or the standard supportive group. Dialogical exposure treatment showed significantly better results in certain areas such as traumatic grief and avoidance but was not better in intrusion. The results also noted no statistical significance on what group recovered better than the other, but it was noted that more participants did recover more in the dialogical treatment group.

Counseling Refugees

Counselors are taught cultural competence in their schooling and how to empower clients of diverse backgrounds. Honoring diversity and promoting social justice are core professional values as defined in the American Counseling Association (ACA, 2014) along with social and cultural diversity addressed extensively in counselor education programs (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2016). This means that it is a counselor's responsibility to increase comfort and competency in working with diverse populations, one of these diverse populations is refugees.

One of the first and most important things that a counselor must do with every client, regardless of if they are a refugee, is build rapport. A counselor cannot move forward in the counseling process until rapport is built. In the study by Eltaiba (2014), she discusses how to build rapport with Muslim refugees. As previously discussed, many Bosnian refugees in America will more than likely be Muslim. It is important to ask your client what their religious beliefs are, and to what extent, if they feel comfortable answering to gain a better sense of your client's identity and world. This is essential to building a professional relationship with the client as this topic is one that will come up often in session if the client is religious. Many Muslims use their

religion to cope with their mental health issues, so it is important to familiarize oneself with their religion and be open to discussing and learning more about it, along with creating a safe space for the client to talk about their religion.

Eltaiba (2014) discusses the importance of empowering Muslim clients and to help them understand their multiple identities and any discrimination they may face. Narrative therapy is a great tool to use for many Muslim refugee clients as it helps them tell their story through their lens and provides the counselor with a better understand of their client and how they view their world and themselves. By listening to a client's story, the counselor in turn shows respect to the client by listening to them without interference. This piece of telling their story will be a steppingstone for future goal setting in sessions. Another important aspect of building rapport as outlined in Eltaiba (2014) is that a counselor does not assume to share their client's knowledge of their culture, even if the counselor comes from the same or similar culture. Ensuring that the counselor provides acceptance of their client's culture and religion through clear communication often when the opportunity arises is important, this can be done verbally or nonverbally.

Another area to build rapport with the client is to explain the counseling relationship to them. Most refugee clients are very unfamiliar with counseling and the counseling process, so creating clear understandings of what the process looks like will help the client understand the expectations of counseling and may ease any anxieties they have about it. Another thing to note in this part is debunking any myths the client may have of counseling such as a "quick fix" and that the counselor "fixes all of their problems" and what professional boundaries may look like (Eltaiba, 2014).

A Muslim refugee client may also have hesitations towards the counseling process because of their religion. Many Muslims steer away from seeking professional help for their

mental health problems due to stigmas surrounding mental health from their religion. In Islam, anything that may be wrong in one's life can be attributed to Allah's will. It is important for a counselor to understand the way their client views their mental health issues and other issues in their life, whether it is from a religious or cultural standpoint. This can help the counselor know how best to treat their client, such as using excerpts from the Quran to help them move through their struggles or teach them various coping skills (Eltaiba, 2014). Most importantly, a counselor should ensure that their client always feels safe and comfortable throughout the counseling process.

In the study by Lonn & Dantzler (2017), they discussed the utilization of Maslow's Hierarchy of Needs when counseling refugees. As discussed previously, refugees in their new homes may face uncertainty and adjustments in education, employment, housing, access to and acquiring food, and managing the ongoing stressors of acculturation. Counselors can play a key role in helping mitigate pre- and post-migration trauma, loss of social and economic status, and other mental health concerns (Lonn & Dantzler, 2017). Research shown in this article states the need for counselors to now adopt a holistic and advocacy-based counseling approach, part of which is addressing practical needs for the client. This article notes that a humanistic approach to counseling refugees is best suited as the principles of this theory consider the full range of human experiences and dignity (Lonn & Dantzler, 2017). Along with this, the use of Maslow's Hierarchy of Needs can help conceptualize the complex needs of the client.

In Maslow's Hierarchy of Needs, there are six areas of need in a pyramid, which are in order of lowest to highest: physiological, safety, love and belonging, esteem, self-actualization, and self-transcendence. One cannot move up in the pyramid until the previous need is fulfilled. When using Maslow's Hierarchy of Needs, a counselor gets a big picture of where the client is

now at in their life. This can help the counselor get to know their client and build rapport, along with identifying and addressing areas of immediate need for the client. This also helps the counselor be able to advocate for the client if they are aware that the client's physiological needs are not being met, such as access to food, and finding resources and places that the client may get food and fulfill that need. Using Maslow's Hierarchy of Needs can also give some direction for the counselor on what specific mental health areas need to be addressed. This could be finding out that when discussing the belonging and love needs, the counselor finds out that their client feels depressed because of all the friends and family they left behind in their home country. This offers a guide for the counselor to decide which area needs to be addressed immediately and which can be addressed later (Lonn & Dantzler, 2017). However, it is important to note that Maslow's Hierarchy of Needs has been widely known as a Western concept and has an inherent cultural bias, so being aware of these limitations will help a counselor decide if this counseling strategy may be useful for their client.

Bemak & Chung (2017) utilized the Multiphase Model of Psychotherapy to counsel refugees. In this model, there are five phases. Phase I is mental health education. In this phase, a counselor provides psychoeducation to their client, specifically on the counseling process. Phase II is individual, group, or family psychotherapy. During this phase, psychotherapeutic interventions happen that are appropriate for the client. A counselor should be aware of various theories and interventions to use that may be most appropriate for their client. Phase III is known as cultural empowerment. In this phase, the client is taught to overcome cultural barriers and learn to empower and advocate for themselves. In phase IV, known as indigenous healing, the counselor teaches the client to merge Western and indigenous healing methods. In phase V, also known as the social justice and human rights phase, counselors become social advocates for their

clients and discuss any injustice or human rights violations the client has faced (Bemak & Chung, 2017). This mode of counseling may work well for some counselors depending on the client that they are seeing, however it is not one of the most well-known interventions out there for counseling refugees.

Another great counseling option that can be used when working with Balkan refugees, or even anyone from a different culture, is rational emotive behavioral therapy. Rational emotive behavioral therapy, or REBT, is a great therapy to use as it does not stress mental illness. In REBT, the practitioner is viewed as a "teacher" and thus it makes the process of helping more appealing to some. The basic theory of REBT states that the practitioner never disputes or argues with clients' strong preferences, desires, and goals, all of which are considered "rational" in REBT (Corey, 2017). The A-B-C framework from REBT is a great tool that can be used to assist clients in disputing irrational beliefs.

Conclusion

Bosnian refugees have endured a lot in their lifetime. This includes war, displacement, assimilation, mental health struggles, low subjective quality of life, and mental health disorders such as PTSD, anxiety, and depression. A Bosnian refugee may have a hard time reaching out for help based on their religious and cultural beliefs. Additionally, there is little research on effective treatment options for refugees in general suffering from PTSD due to the complexity of their situations. Although it may seem impossible for Bosnian refugees to process all the struggles they have gone through, they find a way to do so, and they do it in a new culture and country with a new language. Although Bosnian refugees are notoriously resilient, they still need help. This is why it is important for all counselors to familiarize themselves with counseling refugees in general, but specifically Bosnian refugees. A culturally competent counselor may be

critical in the healing process for a Bosnian refugee client. For this to happen, exposure and education on this topic is important for counselors. It is also important for counselors to learn and be aware of appropriate techniques and therapies that may be best used for clients from this region. As a result, a training for counselors on how to counsel the Balkan population is of the utmost importance.

Training

This training will identify best practices in counseling Bosnian refugees. This training is a lecture and discussion-based training which will be conducted via Zoom to reach as many audience members as possible and to make it easily accessible for counselors to attend. Qualifications to give this training include a master's level degree in counseling or a related field (i.e., social work) and experience working with the Balkan population. The audience of this training will be mental health counselors or similar professionals interested in learning how to better counsel the Balkan population. This includes, but is not limited to, clinical mental health counselors, social workers, and family and marriage counselors. The purpose of this training is to help counselors navigate various options on counseling Balkan people along with a history and information on Balkan people to further provide understanding for counselors on these types of clients. Goals for this training include gaining a better understanding of Balkan people and to learn best regarding counseling them. At the end of the training, there will be a post-training questionnaire asking participants how effective they felt this training was in preparing them to counsel people from the Balkans.

Slide One

Time: 1 minute

Script: Trainer should introduce themselves and their credentials.

Slide Two

What is the purpose of this training?

- The purpose of this training is for you to leave feeling more confident in what direction to take when counseling people from the Balkan region.
- To gain a better sense of understanding of Balkan people and what struggles they may be facing when entering your office

Time: 1 minute

Script: Trainer should discuss the purpose of this training, as stated above.

Slide Three

Background of the Balkan Culture

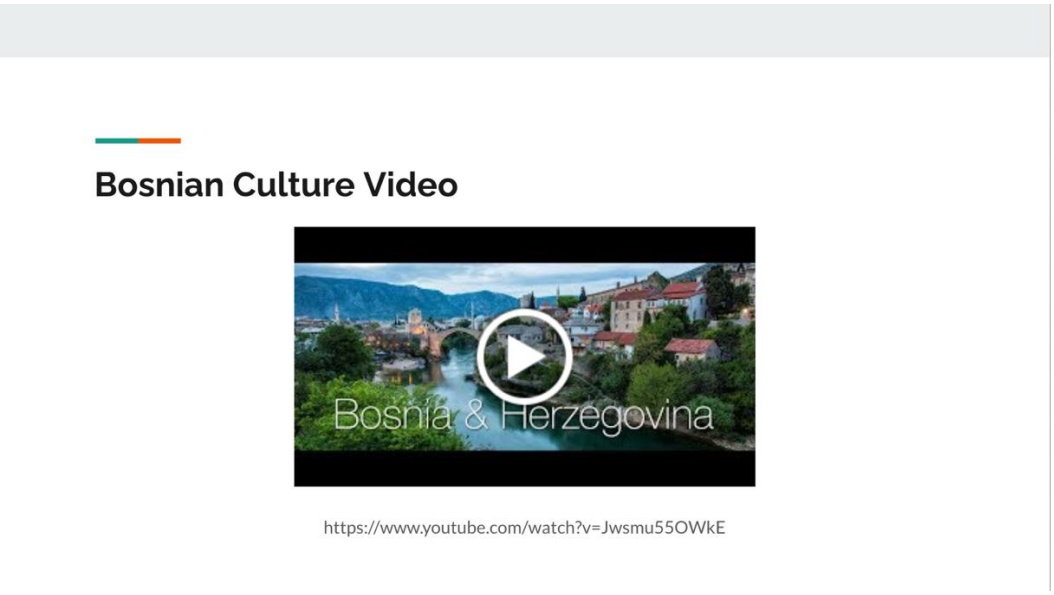
- What we now refer to as "Balkan" was once the country of Yugoslavia
- Food and coffee
- Religious identity
- Gender and social roles
- Stigma surrounding mental health

(Abdullah & Brown, 2011)
("Culture of Bosnia and Herzegovina,", 2015)
(Fazlic, 2015)
(Matsuo, 2005)
(Peljto, 2021)

Time: 10 minutes

Script: Trainer should discuss the history of the Balkan people, which includes former Yugoslavia. Trainer should mention the fall of Yugoslavia which resulted in the Balkan wars. Trainer should move onto discussing the food and drink of Balkan people and the symbolism behind it- community and identity. Trainer should also discuss religious identity and its importance in a Balkan person's life. This should include a discussion on the various religions that encompass the Balkan region- Catholic, Muslim, and Orthodox. Trainer should discuss the collectivist culture of the Balkan people. Trainer should move onto discussing gender and social roles. Finally, trainer should discuss stigma surrounding mental health in the Balkan culture and how it relates to their religious views. Trainer should use the research articles located at the bottom left-hand corner to assist in this discussion.

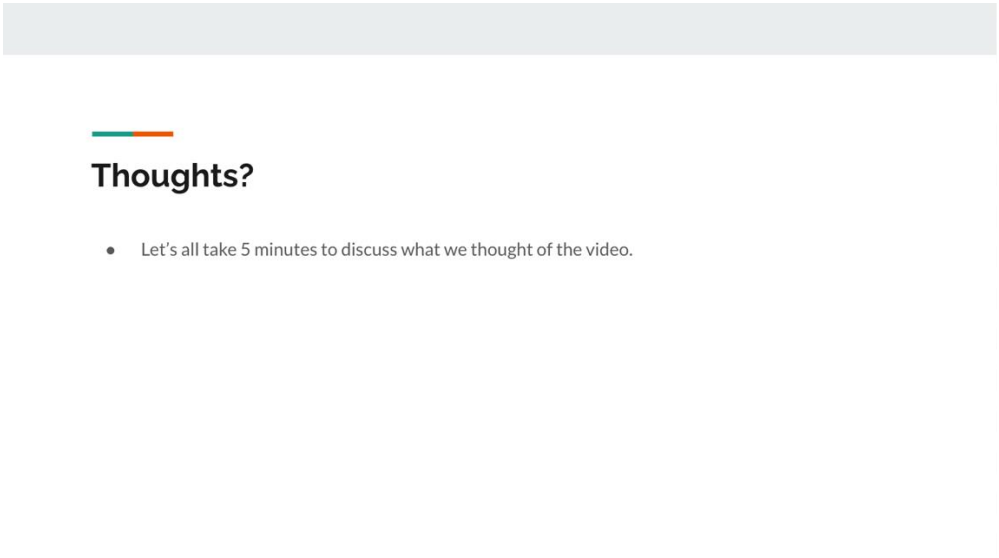
Slide Four



Time: 10 minutes

Script: Trainer should play this 10-minute video related to Balkan culture.

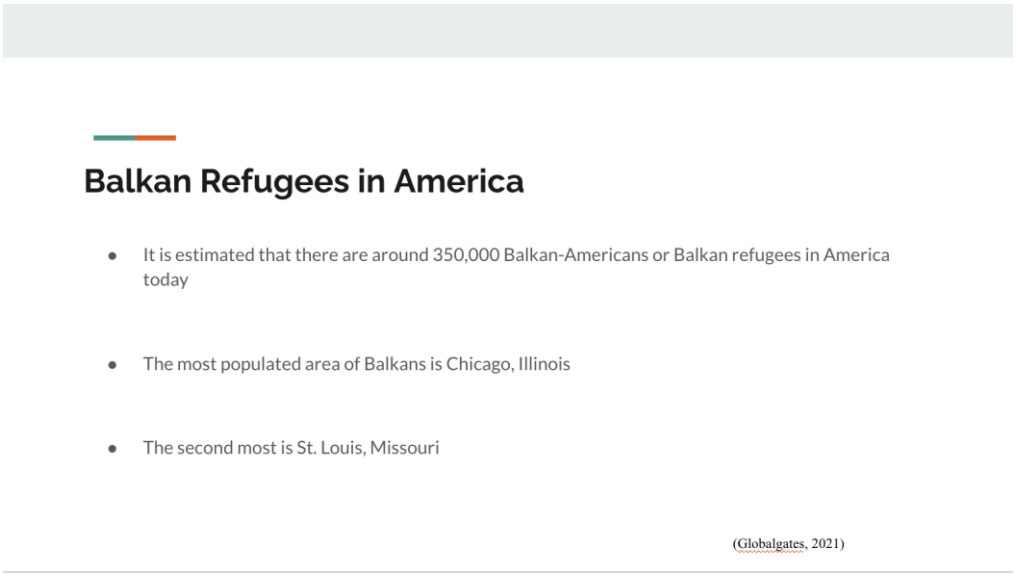
Slide Five



Time: 5 minutes

Script: Trainer should provide a 5-minute open discussion regarding what they discussed on Balkan culture and the video just watched.

Slide Six



Time: 1 minute

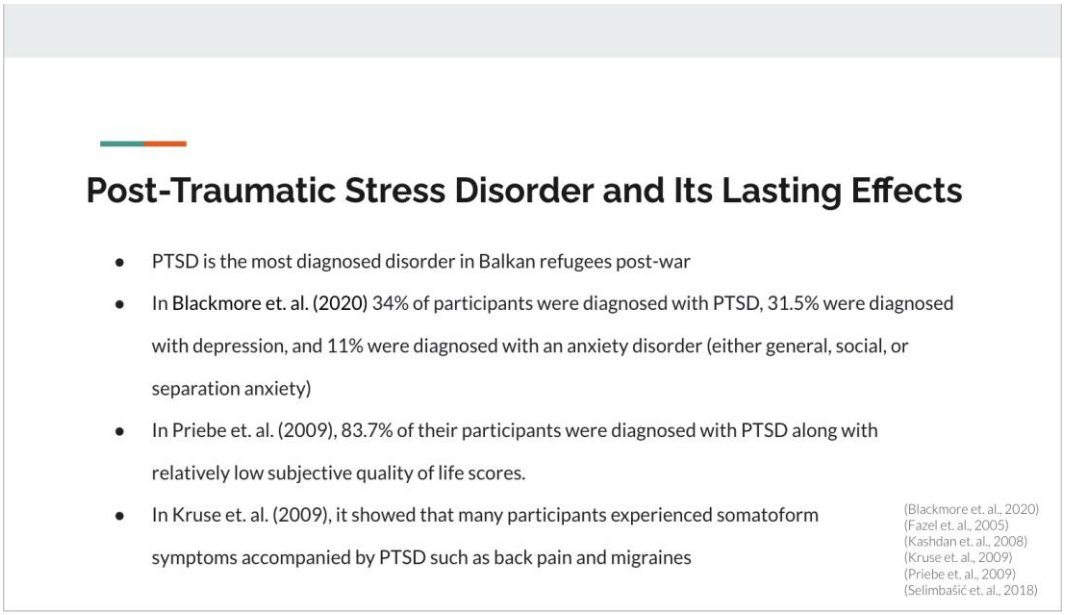
Script: Trainer should discuss current statistics on Balkans in America listed above from the website Globalgates.

Slide Seven

Time: 5 minutes

Script: Trainer should discuss content above from the research studies by Carballo and Keyes and Kane regarding belonging and adapting and displaced and nondisplaced refugees. Trainer should apply these research studies on the mental health of Balkan refugees.

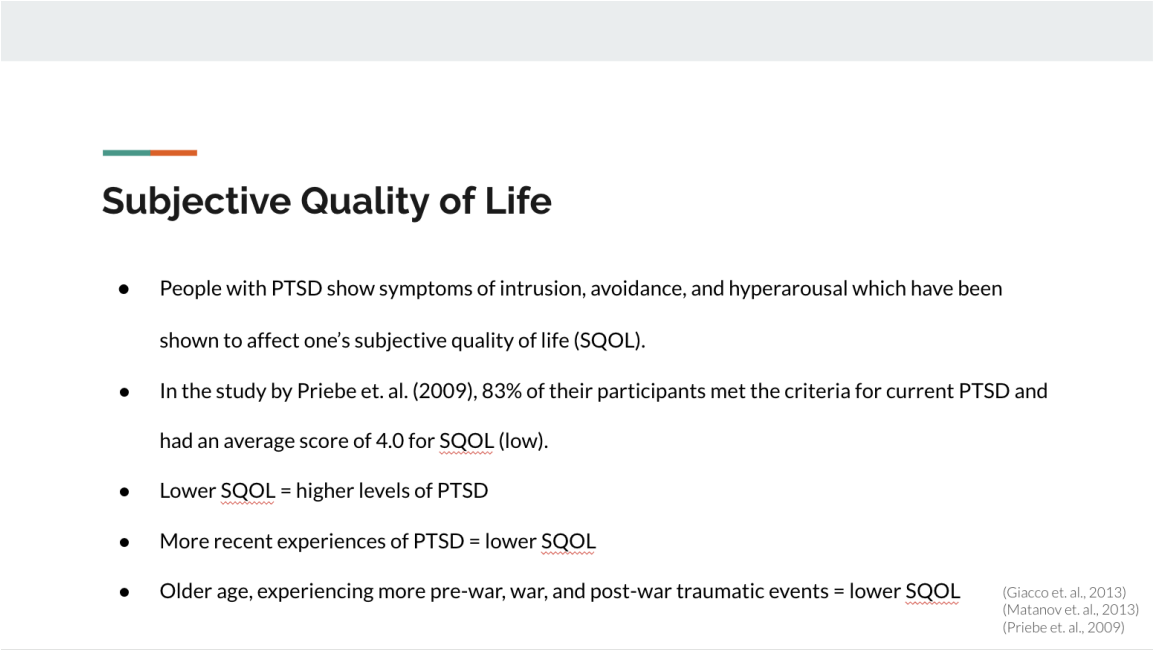
Slide Eight



Time: 5 minutes

Script: Trainer should discuss post-traumatic stress disorder in the Balkan population along with its many co-occurring disorders. Trainer should use the research articles listed at the bottom right-hand corner when discussing this information. The information on the PowerPoint slide should be highlighted when discussing.

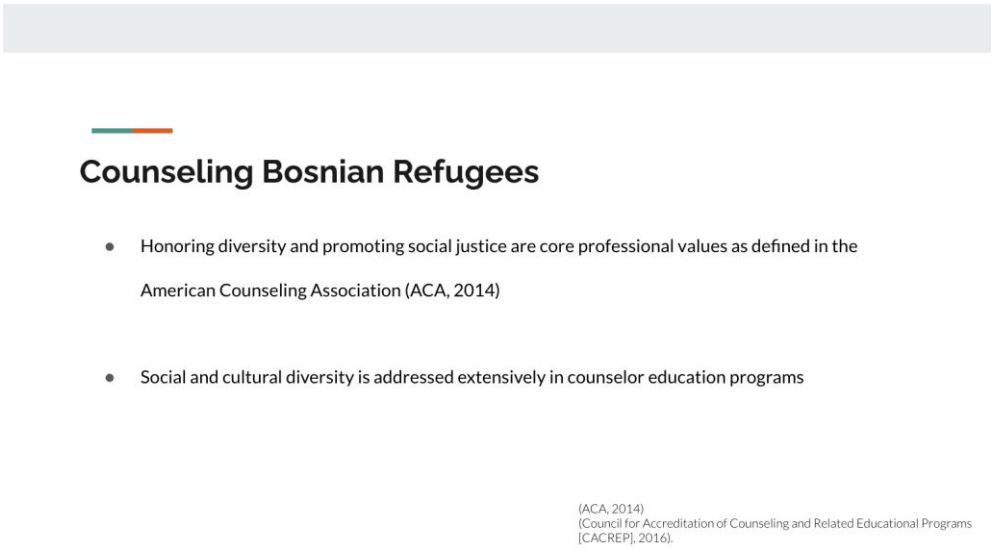
Slide Nine



Time: 3 minutes

Script: Trainer should discuss subjective quality of life in the Balkan population by using the references from the bottom right-hand corner. Trainer should highlight the information on the PowerPoint slide during this discussion.

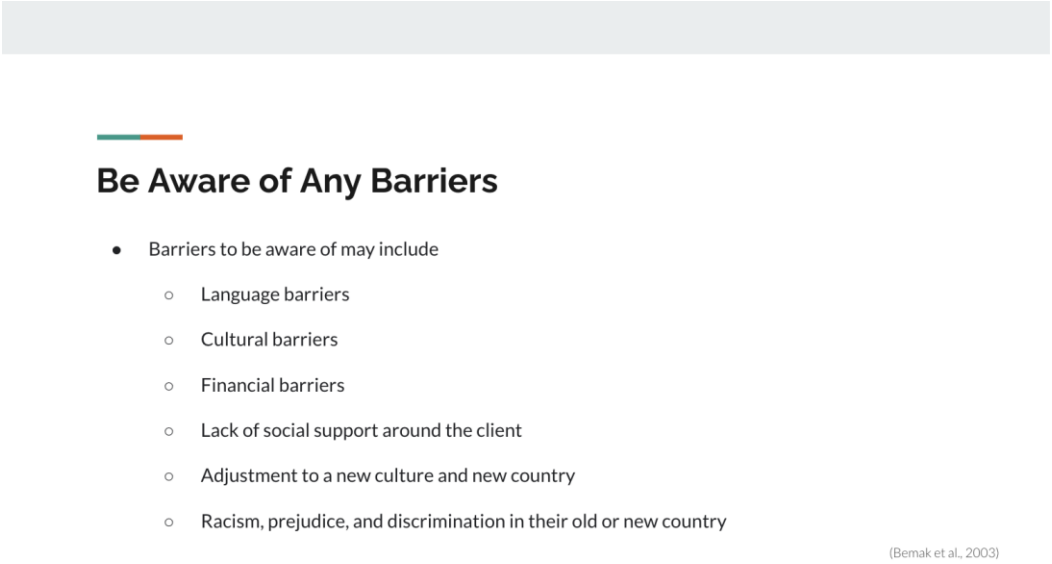
Slide Ten



Time: 2 minutes

Script: Trainer should discuss best practices regarding counseling Bosnian refugees. Trainer should do this by discussing the ACA Code of Ethics and CACREP standards of honoring diversity and promoting social justice as outlined in the ACA Code of Ethics and CACREP.

Slide Eleven



Time: 2 minutes

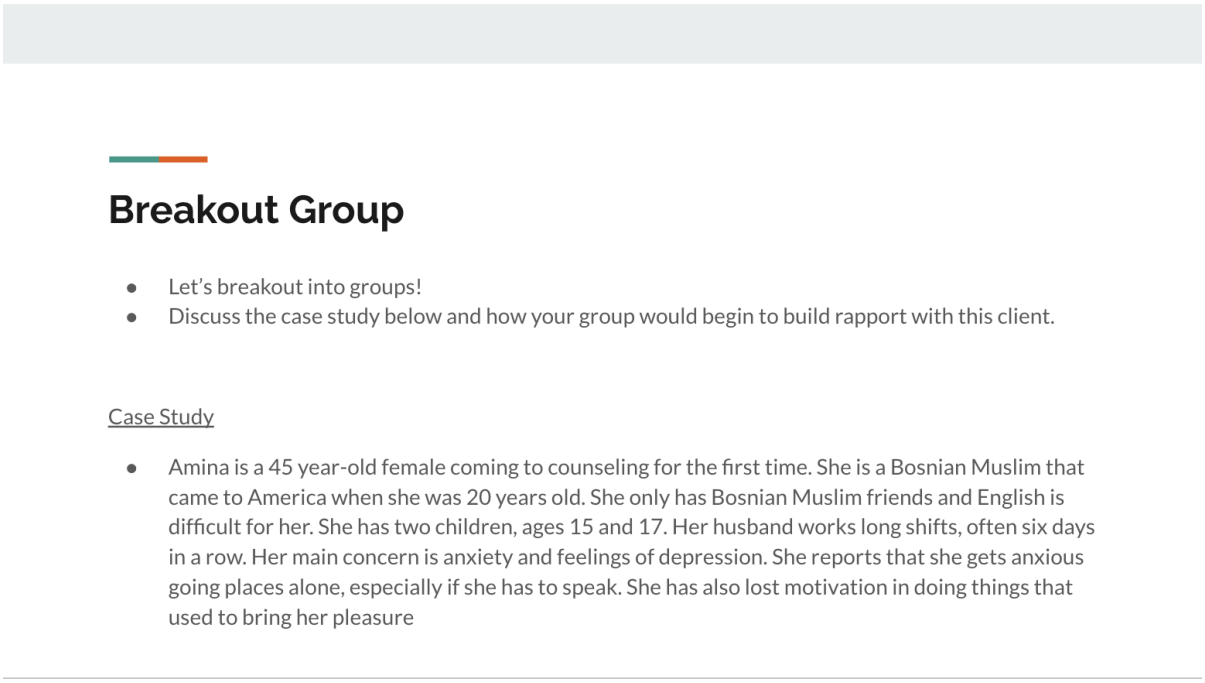
Script: Trainer should discuss the potential barriers a Balkan client may face, as listed in the PowerPoint slide. This information can be found in the research study by Bemak to guide the trainer.

Slide Twelve

Time: 7 minutes

Script: Trainer should discuss rapport building by referencing the research study by Eltaiba. Trainer should highlight the information on the PowerPoint slide when discussing.

Slide Thirteen

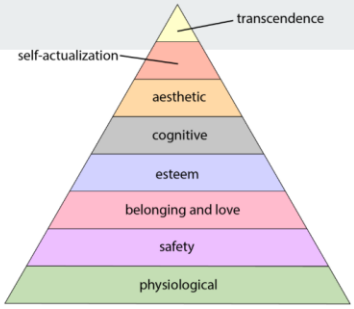


Time: 25 minutes

Script: Trainer should explain the group exercise, as shown above. Trainer should emphasize that there is no right or wrong method, but rather to work on building rapport. Trainer should use their own discretion on how much time to provide for the breakout groups. Once the breakout groups return to the main group, trainer should guide a large discussion by having each group share what they did.

Slide Fourteen

Maslow's Hierarchy of Needs



- Refugees in their new homes may face uncertainty and adjustments in education, employment, housing, access to and acquiring food, and managing the ongoing stressors of acculturation
- Counselors should adopt a holistic and advocacy-based counseling approach
- When using Maslow's Hierarchy of Needs, a counselor gets a big picture of where the client is now at in their life
- Helps a counselor advocate for their client
- Be aware of the cultural bias related to Maslow's Hierarchy of Needs

(Lonn & Dantzler, 2017)

Time: 5 minutes

Script: Trainer should discuss Maslow's Hierarchy of Needs in relation to counseling Balkan refugees. Trainer should use the research article by Lonn and Dantzler to help guide this.

Slide Fifteen

Narrative Therapy

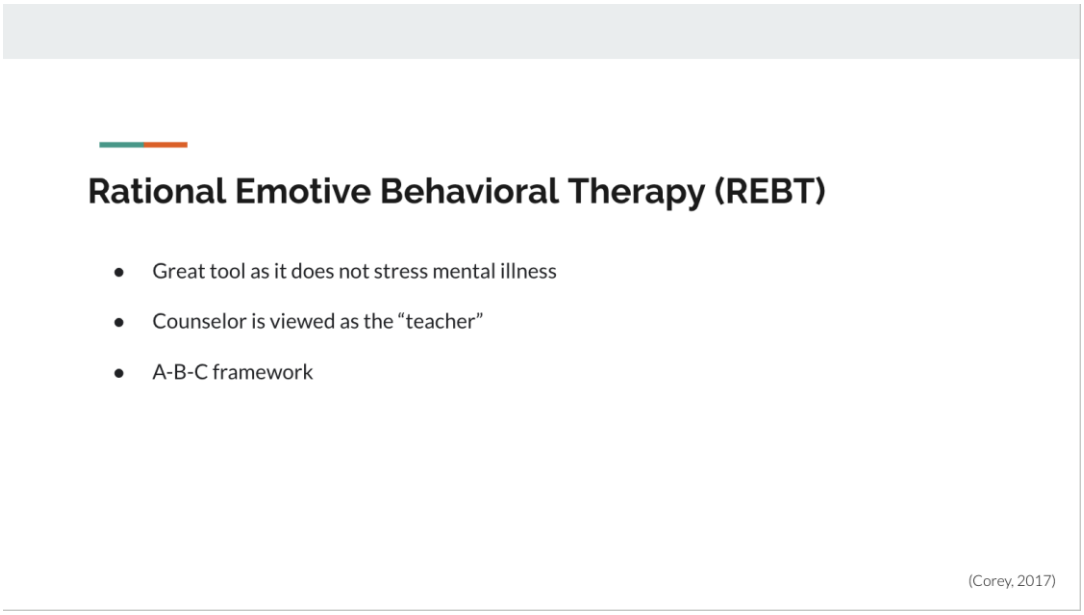
- Great tool to use for many Balkan clients as it helps them tell their story through their lens and provides the counselor with a better understand of their client and how they view their world and themselves.

(Eltaiba, 2014)

Time: 1 minute

Script: Trainer should discuss Narrative therapy in relation to counseling Balkan refugees. Trainer should provide a brief description of what Narrative therapy is and why it is ideal to use for refugee clients. The research study by Eltaiba can assist in this.

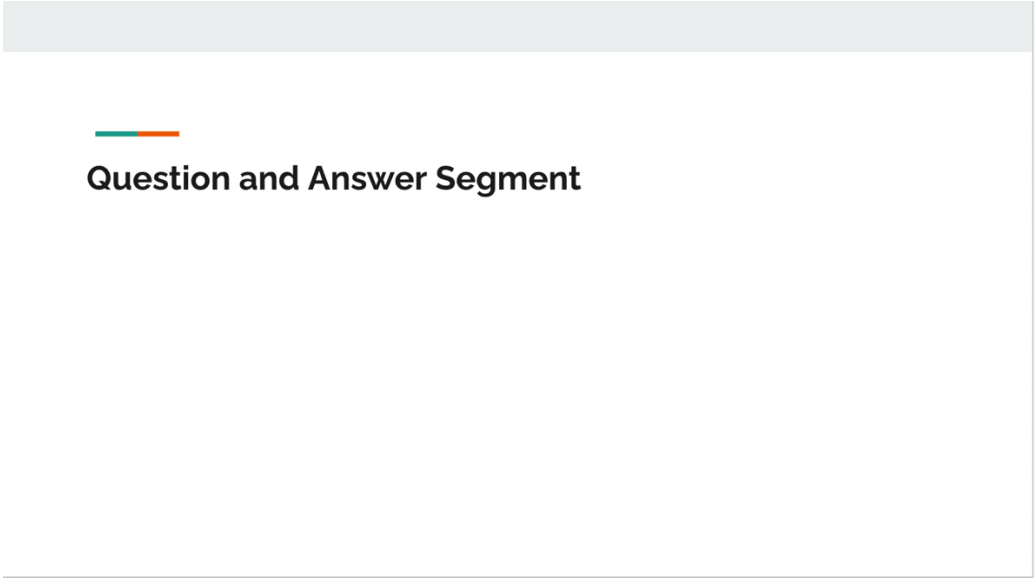
Slide Sixteen



Time: 1 minute

Script: Trainer should discuss rational emotive behavioral therapy and how it can help in counseling Balkan refugees. Trainer should provide a brief description of what REBT is, how it may be used, and why it works well for refugee clients. The textbook by Corey can assist in this.

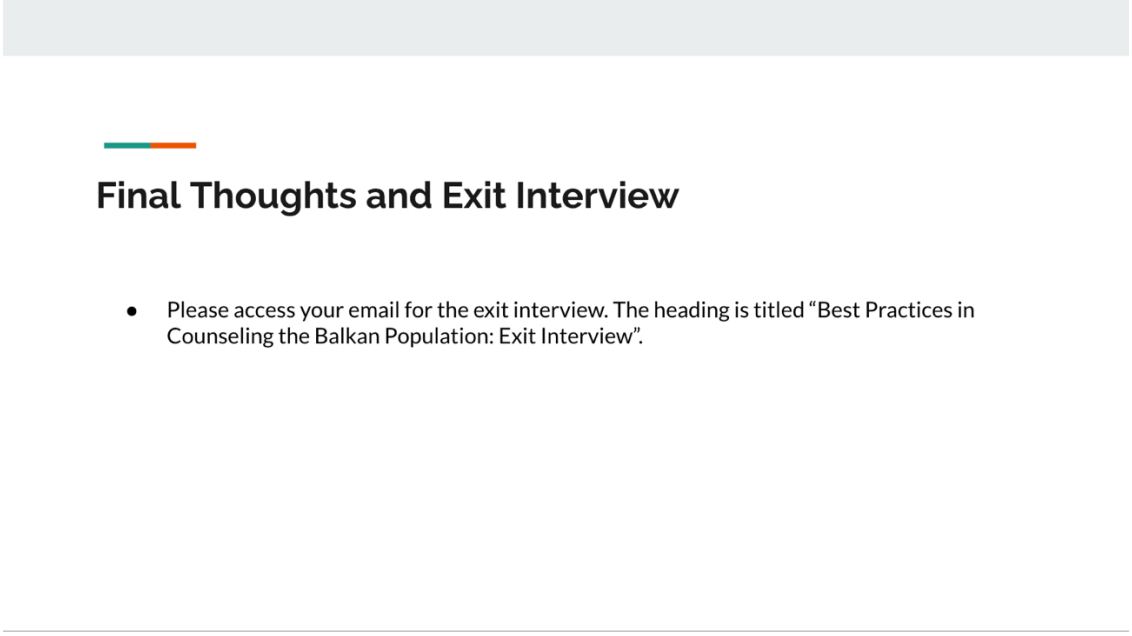
Slide Seventeen



Time: 15 minutes

Script: Trainer should provide 15 minutes for participants to ask any questions they may have.

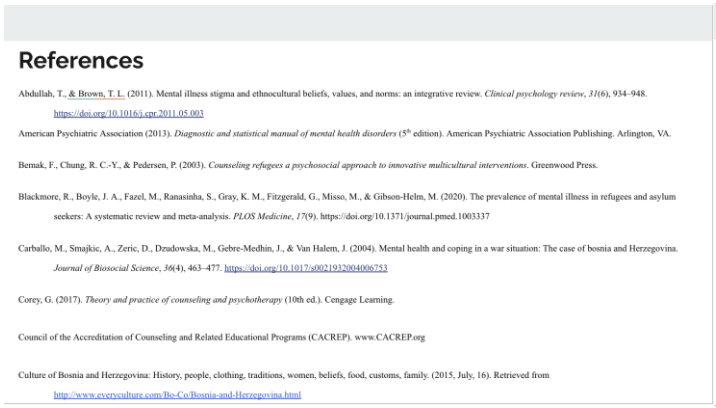
Slide Eighteen



Time: 5 minutes

Script: Trainer should thank participants for coming. Trainers should provide instructions on exit interview and where participants can find it. Trainer should wait for all participants to submit an exit interview before leaving.

Slides Nineteen- Twenty-One



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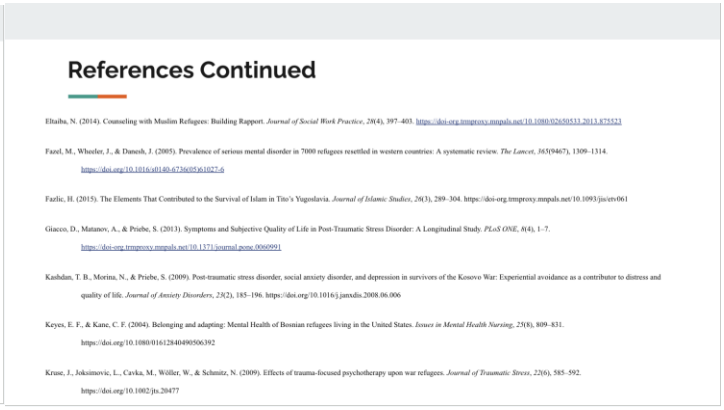

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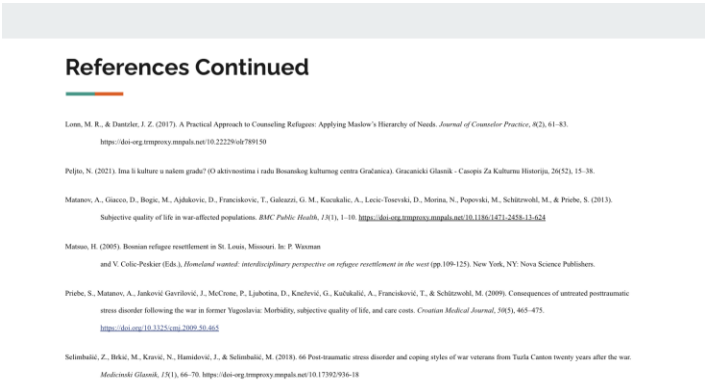

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Time: 0 minute

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Appendix 1

Exit Evaluation Survey

1. What did you enjoy about today's training?
2. What is something you did not enjoy about today's training?
3. What is something you would have liked more information on from today's training?
4. How would you rate your overall learning experience today?
5. How could we improve the learning experience?
6. How would you rate the overall course delivery from today's speaker?