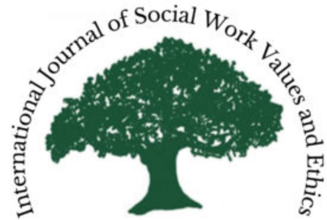

International Journal of Social Work Values and Ethics

Volume 19, Number 2 (2022)

ISSN: 2790-6345

DOI: 10.55521/10-019-200

www.jswve.org

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But Culturally Competent for Whom? Ethics and Cross-Cultural Dilemmas in COVID-Era Social Work

DOI: 10.55521/10-019-212

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Disney, L. & Carnes, S. (2022). But Culturally Competent for Whom? Ethics and Cross-Cultural Dilemmas in COVID-Era Social Work. *International Journal of Social Work Values and Ethics*, 19(2), 209-226. https://doi.org/10.55521/10-019-212

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Abstract

The COVID-19 pandemic has ushered in a new era of clinical social work practice, and related, new ethical challenges, particularly related to responsive, client-centered cross-cultural social work. As strengths-based practitioners seeking to support our clients' autonomy and self-determination, we often feel ethically bound to refrain from self-disclosure or providing concrete "advice," particularly around politicized, polarizing, or controversial issues. However, in our work as immigrant and refugee-serving practitioners, we have observed a strong desire from clients to receive clear advice and recommendations from the clinician related to COVID-19, particularly around vaccinations. Therefore, the proposed article will navigate these ethical conundrums while prioritizing the needs of culturally diverse clients who may see reluctance to provide opinions or guidance as relational failures. This article will evoke broader themes regarding the definition of culturally

competent practice, and the role that members of minoritized populations can – and should – play in defining the construct.

Keywords: Social work ethics, cultural competence, self-determination, refugee, COVID-19

Introduction

Individuals with refugee status represent a growing demographic in American society and will increasingly cross the paths of clinical social workers, necessitating culturally competent practitioners. Over three million persons with refugee status have been resettled in the U.S. since the Refugee Act of 1980, and more than 200,000 are expected to permanently resettle in the U.S. in 2022 (International Rescue Committee, 2022). Resettled individuals can benefit from clinical social work services given their high rates of some mental illnesses, the understandable resettlement challenges that come with making a new home in a foreign country, and the sociopolitical discrimination that many refugee populations face in the U.S. Yet, despite many potential benefits from service utilization, resettled refuges in the U.S. have historically engaged in clinical services at exceptionally low rates (Lamkaddem et al., 2014). Like other populations experiencing low income in the U.S., systematic barriers that prevent mental health service utilization include lack of insurance, transportation, and childcare. However, refugee populations in the U.S. also report cultural barriers including stigma and conflicting client and provider expectations, values, and beliefs, which prevent utilization of and satisfaction with mental health treatment (Disney & McPherson, 2020).

Meanwhile, the COVID-19 pandemic has ushered in a new era of clinical social work practice, and related, new ethical challenges, particularly related to cross-cultural and culturally competent social work practice. The need for clinical social workers to effectively navigate ethical issues when working with refugee populations becomes even more critical considering worsened mental health and mental health disparities for refugee and migrant communities during COVID-19 (Solà-Sales et al., 2021; Spiritus-Beerden et al., 2021). However, these ethical conundrums merit more in-

depth consideration even without the urgency of a global pandemic and have significant implications for general social work practice with minoritized populations, including but not limited to persons with immigrant and refugee status.

Prior to developing this article, we reviewed the National Association of Social Workers (NASW) Code of Ethics, along with literature that addresses the intersections of social work ethics, cross-cultural clinical practice, and COVID-19 vaccine hesitancy. Considering the nexus of culture and professional standards in clinical work, this article seeks to examine the specific ethical dilemma presented when resettled refugees request direct advice from their Western-trained therapists about COVID-19 vaccinations. A cross-cultural case illustration is presented, and relevant ethical issues are discussed. The case illustration is a composite of multiple clients and therapists and was developed based on the practice and supervisory experiences of one refugee-serving clinical social worker. We argue that prioritizing the NASW Code of Ethics standard of cultural competence should be the orienting principle when working across cultures.

Case Illustration and the Related Ethical Issues

The following case excerpts were developed to illustrate a common case discussion among refugee- and migrant-serving providers over the past two years: how should clinical social workers respond to clients whose cultural expectations are for the clinician to provide concrete advice on COVID-19 vaccinations?

Case Illustration

"Mrs. Haddad" is a 45-year-old Syrian woman with refugee status who has been in therapy for several months for resettlement-related depression. Mrs. Haddad, her husband, and four of her children, all under the age of 20, were resettled in the U.S. approximately one year ago. Mrs. Haddad has several medical conditions, including autoimmune disease, celiac disease, diabetes, and obesity. To be culturally appropriate and responsive, the clinical

social worker uses a comprehensive approach to mental health treatment that combines a recognition of the social policy contexts that impact Mrs. Haddad, case management services that support her resettlement, and traditional talk therapy (Miller & Rasmussen, 2010; Watters, 2001).
Mrs. Haddad often brings questions about resettlement and acculturation to therapy sessions, such as how the healthcare, school, and legal systems in the U.S. function. Since Mrs. Haddad's English is limited, though improving, Mrs. Haddad will also often ask her therapist for assistance in scheduling medical appointments and understanding written documents from healthcare providers, as well as support with general medical case management needs. Mrs. Haddad's therapy sessions are often the only certain time that Mrs. Haddad will have an in-person interpreter with whom she is comfortable and who understands the dialect clearly. Mrs. Haddad's therapist recognizes this and looks to Mrs. Haddad to 'set the agenda' for sessions.

During a session, Mrs. Haddad asked if her therapist thought she ought to get a COVID-19 vaccine. The following represents four excerpts between Mrs. Haddad and her therapist during separate therapy sessions over a two-week period.

Therapy Session Excerpt #1

> Therapist: "How have you been feeling lately, Mrs. Haddad?"
>
> Mrs. Haddad: "I have been worried about getting COVID-19…Do you think I should get the COVID-19 vaccine?"
>
> Therapist: (*surprised that Mrs. Haddad did not already have a COVID-19 vaccine, given her medical conditions and risk for severe illness if she did contract COVID-19*). "Well, I am not a medical doctor…have you spoken with your doctor about the COVID-19 vaccine?"
>
> Mrs. Haddad: "My doctor said, 'I recommend the vaccine, but it is your choice.'"

Ethical Issues in Therapy Session Excerpt #1: Self-Determination and Communication

Let us consider each piece of the therapist and Mrs. Haddad's exchange. Mrs. Haddad directly asked her therapist for advice about an urgent medical

issue. Her therapist avoids the direct question, likely to support the client's right to self-determination, and to stay in her professional role as a mental health, not physical health, provider. However, in her response, the therapist should consider whether she has prioritized her Western beliefs about professional roles over her client's beliefs about the roles of a trusted helping professional.

Additionally, the cultural communication style of Mrs. Haddad must be considered. In his seminal work on cross-cultural communication, Hall (1976) highlighted the inextricable linkage of meaning and context, with context shaping communication styles and patterns across diverse cultures. As described by Salleh (2005), high-context and low-context communication styles can be compared across four primary domains: directness of message conveyed, use of non-verbal communication, emotions in a close relationship, and use of analogous language. Summarizing these two styles, a high-context communication style is characterized by indirectness, emotionality, and relational closeness, use and importance of nonverbal cues (and related, intuition), and use of analogous language, or language that requires inference and interpretation to "fill in the blanks" (Hall, 1976). Conversely, low-context communication involves directness, rationality, direct communication instead of verbal cues, and use of specific and precise language (Hall, 1976). As suggested by Hornikx and Le Pair (2017), individuals accustomed to low-context communication styles may struggle to decipher implicit messages and meaning when engaged with individuals from high-context cultures. Further, individuals accustomed to high-context communication styles may inaccurately infer implicit messages and meaning when engaged with individuals from low-context cultures. Hall and Hall (1990) identified Middle Eastern, African, Asian, and South American cultures as primarily high-context, while European and Northern Americans were understood as embracing a low-context style. Given that most – but not all – individuals with refugee status engage in a process of migration from the high-context Global South to low-context North America and Europe (United Nations High Commissioner for Refugees [UNHCR], 2021),

consideration of communicative disconnect is an essential component of culturally responsive practice.

Considering divergent communication styles and the risk for communicational misunderstanding, we now consider how Mrs. Haddad might interpret her medical doctor's response about whether she should get the vaccine: "it's your choice." Those trained in Western medicine may interpret the doctor's response as a pro-vaccine stance that also supports the client's self-determination (Zwi et al., 2017). However, individuals from high-context communication cultures, such as Mrs. Haddad's culture of origin, may interpret the doctor's response as exactly the opposite – as anti-vaccine stance or vaccine hesitancy due to the lack of a clear and consistent directive. Similarly, the therapist's lack of a clear pro-vaccine directive may similarly be interpreted by the client as an implicit anti-vaccine message.

Therapy Session Excerpt #2

> *Continued from previous conversation, excerpt #1, Mrs. Haddad asks the therapist about her own vaccine decision*: "My doctor said, 'I recommend the vaccine, but it is your choice.' What about you, did you take the vaccine?" This question was directed to the therapist.

Ethical Issues in Therapy Session Excerpt #2: Self-Disclosure

How should the therapist respond to Mrs. Haddad? Historically, personal self-disclosure in individual therapy has been highly discouraged, primarily due to the potential for skewing the patient-provider dynamic and focus. In this case illustration, the therapist may err on the side of caution and make the choice to avoid self-disclosure rather than risk imposing personal preferences and values, shifting the focus to the therapist, or crossing a professional boundary (Alsina, 2020). However, the therapist should also consider whether they are meeting the needs of culturally diverse clients who may see reluctance to provide opinions or guidance as relational failures, stymying the therapeutic alliance.

A growing body of empirical work has highlighted the utility of thoughtful, well-timed provider self-discloser as a tool for strengthening

existing therapeutic relationships and increasing feelings of closeness between the client and provider (Henretty & Levitt, 2010). Particularly salient to work with individuals experiencing refugee status, Barnett (2011) found self-disclosure to be a powerful moderator of power differentials in clinical practice with diverse populations. Empirical work evaluating therapist self-disclosure of health information is limited, although there is evidence on the effectiveness of medical professional self-disclosure of health information. Related to the COVID-19 pandemic and vaccine hesitancy, Durand et al. (2021) identified specific benefits of collaborative processes around healthcare decisions, such as the decision to vaccinate, in which both client and medical professional play an active role in brainstorming and sharing information. Cannity (2022) suggested that mental health providers who do *not* disclose when asked specific questions about opinions on vaccination, preferring instead to demur or refrain from directly answering vaccine-hesitant clients' requests for input or guidance, may inadvertently galvanize vaccine-hesitant beliefs.

Therapy Session Excerpt #3

> *This conversation occurred the week after the previous excerpts. Mrs. Haddad brings up the COVID-19 vaccine again this session.*
>
> Mrs. Haddad: "I saw my doctor yesterday."
>
> Therapist: "How did your appointment go?"
>
> Mrs. Haddad: "Ok…Doctors here (in the U.S.) are so busy."
>
> Therapist: "Doctors here can be very busy… I remember from last session that you had some questions about the COVID-19 vaccine. Were you able to ask your doctor about any questions or concerns you might have had?"
>
> Mrs. Haddad: "No, I didn't ask anything. The doctor did not mention the vaccine again."
>
> Therapist: "I wonder what keeps you from asking questions that you have?"
>
> Mrs. Haddad: "Where I am from, patients don't ask doctors questions."
>
> Therapist: "Here (in the U.S.), you can ask doctors questions. What do you think it would take for you to ask the questions that you have?"

Therapist uses an empowerment approach and continues to process client's internal barriers to agency.

Ethical Issues in Therapy Session Excerpt #3: Empowerment and Client Agency

In this excerpt, the therapist conceptualizes the clinical problem as a lack of client self-advocacy skills and uses an empowerment approach with the goal of increasing client agency. Yet could it be possible that this "empowerment" approach is colored with paternalistic overtones? Instead of responding to the client's implicit communication that her doctor is not meeting her expectations (Renkens et al., 2022), the therapist suggests the value-laden construct that Mrs. Haddad lacks internal agency and needs to develop self-advocacy skills. The therapist might consider that asking direct questions to a medical professional could feel inappropriate or disrespectful for Mrs. Haddad, and that Mrs. Haddad is currently dissatisfied with her doctor's low-context communication style which feels impersonal, uncaring, and rude to Mrs. Haddad. Moreover, if Mrs. Haddad expects her medical doctor to provide direct guidance about her medical needs, regardless of patient-led questions, which professional expectation must be revised for truly culturally competent practice? While Mrs. Haddad's therapist displays cultural competence in recognizing Mrs. Haddad's use of interpretation services during their session for case management needs, the therapist fails to recognize Mrs. Haddad's use of interpretation services during their session for goals outside of the treatment plan (i.e., in this case, obtaining direct health information). From Mrs. Haddad's perspective, she is using the resources available to her, when they are available to her, which *is* emblematic of personal agency.

Therapy Session Excerpt #4

> Mrs. Haddad: "My son asked my husband and I if he should get the COVID-19 vaccine. My husband said that it is not safe, that it can change his DNA. I'm not sure this is true; we saw a video on Facebook about it, but I don't know. We also heard that the vaccines are being tested on us (refugee community), and that is why there is a gift card if we get it."

> Therapist: "How frustrating not to know what information is trustworthy…you know, I also had concerns about vaccine safety, would you like to hear what my doctor shared with me?"

Ethical Issues in Therapy Session Excerpt #4: Responding to Misinformation

Therapists should be careful when responding to misinformation presented by clients because the experiences of "correcting" and "being corrected" can have implications for the therapist-client relationship. Being corrected can potentially cause feelings of disempowerment or embarrassment, reify existing power imbalances between provider and client (and non-refugee and refugee), and derail the focus of the session. Yet, there are times when therapists should consider the harm of *not* correcting misinformation. In this case illustration, the therapist was concerned about the impact of Mrs. Haddad's misinformation about vaccine safety and vaccine testing on Mrs. Haddad's health. Additionally, the therapist was sensitive to the U.S. social inequities that prioritize the delivery of public health information for English language citizens.

The Code of Ethics (Section 6.04) states that social workers' have ethical responsibilities to broader society: "Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people" (NASW, 2017). The need for accurate and trustworthy COVID-19 vaccine information provided in languages other than English is pressing, with implications far beyond refugee populations. Social media networks can be important sources of health information for resettled refugee populations who may lack access to robust public health information. However, resettled refugee populations are also disproportionately impacted by misinformation circulating on social media platforms and are thus more likely to hold vaccine hesitancy beliefs. Since the largest social media networks - Facebook, Instagram, and Twitter - use primarily English-based computer algorithms to filter out misinformation, COVID-19 and COVID-19 vaccine misinformation runs rampant on social platforms in other languages (Goldsmith et

al., 2022). Therapists should demonstrate cultural responsiveness by being aware of these social justice issues, and the related deleterious implications for the health of refugee clients and broader public health.

The therapist in this excerpt can use self-disclosure to correct misinformation while also normalizing the frustrations of not knowing which news sources are trustworthy. The therapist also displays cultural competence by being sensitive to the client's mistrust of the government and state – a valid feeling given many refugees' experiences of state-sanctioned persecution and violence, and a reasonable concern given the client's current unfamiliarity with U.S. systems.

Cultural Competence as an Orienting Principle

The case illustration above is intended to spark critical consideration of the specific ethical issues presented when a refugee client asks about COVID-19 vaccination in the clinical setting. Our positionality as refugee and migrant-serving providers is that cultural competence should be the orienting principle when working cross-culturally. This inevitably means that in ethical dilemmas involving cultural competence and self-determination, cultural competence would be prioritized, and that self-determination and other ethical issues would be considered within the cross-cultural context.

The NASW Code of Ethics states that self-determination is an ethical standard: "Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals" (NASW, 2017). Self-determination in practice is the degree to which the therapist decides to intervene or let the client make their own choices (Akbar, 2019). Self-determination as a concept is both subjective and difficult to operationalize, which is in part why there has been much discussion related to the construct. The literature discusses ethical dilemmas and limits to self-determination in certain circumstances, such as when a client is mandated, or when a client's choice is not supported by the law (Akbar, 2019). However, there is little discussion in the literature about when self-

determination is culturally incompatible with a client's personal preferences, values, or needs.

The NASW Code of Ethics similarly states that Cultural Competence is an ethical standard (1.05c), "Social workers should demonstrate awareness and cultural humility by engaging in critical self-reflection (understanding their own bias and engaging in self-correction); recognizing clients as experts of their own culture; committing to life-long learning; and holding institutions accountable for advancing cultural humility" (NASW, 2017). This explicit commitment to cultural humility and ongoing learning and reflection is certainly essential to moving the needle of responsive practice forward, as is its recognition of clients as the experts on their own cultures. However, this tenet, as well as the Code of Ethics in general fail to explicitly identify clients – particularly those from marginalized and minoritized populations – as experts not only of their own cultures, but also of their own needs. For example, in the case illustration, does Mrs. Haddad need to be "empowered" to ask her vaccine questions to her doctor, or does her doctor need to be culturally competent and anticipate her questions and needs, and provide complete, direct medical information and guidance? Many patients in the U.S. have adapted to managed healthcare systems by asking rapid-fire questions during a 15-minute appointment time slot – this is an opportunity for social workers to "hold institutions accountable" for being culturally responsive, rather than putting the onus on the client, who may feel particularly uncomfortable in such settings. As clinical social workers, do we recognize when our clients are engaging agencies even when the mechanisms or goals do not resemble our own picture of empowerment? Clinical social workers who are working cross-culturally can be at risk of approaching cultural factors, such as communication styles, as barriers to be overcome. Critical reflexivity can be a safeguard measure for the clinical social worker.

The ethical considerations of this case illustration would be lacking if we did not discuss the overlay of power when working cross-culturally. Interestingly, power is not explicitly mentioned in the Code of Ethics – "personal privilege" is included, as part of the cultural competence ethical

standard (1.05b), "Social workers must take action against oppression, racism, discrimination, and inequities, and acknowledge personal privilege" (NASW, 2017). We argue that providers' decisions about the cultural communication style they employ constitutes an exercise of power, as are decision-making processes around responding to ethical dilemmas in the clinical setting. In the clinical setting, the therapist often holds the power to decide whose communication style is accommodated and which ethical standards are prioritized, with power dynamics shaping value-laden treatment processes. The Western clinical profession values a person-centered approach, yet some refugee clients may value a professional-centered approach where providers provide clear advice and recommendations, particularly around topics where the clinician may be viewed as having greater expertise. When we demur instead of answering our clients' questions, are we prioritizing our own comfort behind the guise of "cultural humility," or what our clients need/find comfortable? Do our clients perceive our silence on important matters as stonewalling, or respectful acknowledgement of their autonomy?

Additionally, related to power dynamics in the helping relationship, the very concept of "empowerment," in which social workers are presumed to supply resources, skills, or perspectives to previously lacking clients, is susceptible to paternalistic values and power imbalances reminiscent of the medical model era of practice. In social work, "empowerment" involves supporting clients to bring about individual change and gain power over their lives, often through the development of specific skills and capacities (Payne, 2005; Ninacs, 2008). Empowerment-focused social workers run the risk of crossing from "empowering" to "power over" clients when therapist and client have divergent beliefs about what client skills and capacities need developing. Related, Wendt and Seymour (2010) highlight how providers may unwittingly replicate societal power imbalances and hierarchies by conceptualizing themselves as "empowerers," reifying their position as power-holder and giver in the therapy office.

Lastly, we question - could the very construct of empowerment – with its normative emphasis on personal responsibility and individual power

(Rivest & Moreau, 2015) -- be antithetical to collectivist, low-context cultural ideas, societal norms, and values about well-being? The therapist's choice to utilize an empowerment approach is a belief system that values the individual above the collective. For the collectivist client, the belief system is that the therapist *is* responsible for using their specific skills and capacities to help the client – by providing trusted information, or by advocating from or collaborating between one (mental health) professional to another (medical) professional. Instead of "empowering" clients, our goal should be to respect *their* autonomy and *their* identification of needs (for example, obtaining information from a trusted helping professional about the vaccine) as more important than *our* perceptions of what we think cultural humility should be.

Conclusion

This article examines the intersections of ethical issues, cultural and communicative differences, and power dynamics in the therapy office, with significant attention paid to the professional values and ethics ensconced in the NASW Code of Ethics. As strengths-based practitioners seeking to support our clients' autonomy and self-determination, we often feel ethically bound to refrain from providing concrete "advice," particularly around politicized, polarizing, or controversial issues. However, in our work as immigrant and refugee-serving practitioners, we have observed a strong desire from clients to receive clear advice and recommendations related to COVID-19, particularly around vaccinations. While social workers are trained to prioritize both client self-determination and culturally competent practice, the previous case excerpts highlight the discrepancy that may exist between classroom discussions and real-world practice in a post-COVID-19 world. Social work education should provide students with opportunities to critically examine complex, current clinical scenarios, and related dynamics of power, with careful consideration of the NASW Code of Ethics – and its limitations – as a framework for ethical practice (Larkin, 2007).

According to the NASW Code of Ethics purpose statements, "The NASW Code of Ethics does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict" (NASW, 2017). While the consideration of existing professional norms and standards is an essential component of preparation for effective clinical work, we argue that cultural competence should be considered an orienting value of the highest order, particularly when working with diverse populations such as immigrants and refugees. The case illustration presented underscores the nuances of defining culturally competent practice, as well as the critical role that members of minoritized populations such as refugees *can* – and *should* – play in shaping the construct. Providers must look to their diverse client populations to define what culturally competent practice looks like *for them*, and how they believe their unique needs could be most effectively met.

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