UNDERSTANDING MENTAL HEALTH PROFESSIONALS' PERSPECTIVE OF THERAPEUTIC ALLIANCE IN WORKING WITH UNACCOMPANIED CHILDREN: A GROUNDED THEORY APPROACH

A Dissertation

by

WENDY RIVERA

BA, The University of Texas at Brownsville, 2013
M. Ed., The University of Texas at Rio Grande Valley, 2016

Submitted in Partial Fulfillment of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in

COUNSELOR EDUCATION

Texas A&M University-Corpus Christi
Corpus Christi, Texas

August 2022

August 2022

UNDERSTANDING MENTAL HEALTH PROFESSIONALS' PERSPECTIVE OF THERAPEUTIC ALLIANCE IN WORKING WITH UNACCOMPANIED CHILDREN: A GROUNDED THEORY APPROACH

A Dissertation

by

WENDY RIVERA

This dissertation meets the standards for scope and quality of
Texas A&M University-Corpus Christi and is hereby approved.

Marvarene Oliver, Ed.D.
Chair

Jennifer Gerlach, Ph.D.
Committee Member

James Ikonomopolous, Ph.D.
Committee Member

Catherine Quick-Schumann, Ph.D.
Graduate Faculty Representative

August 2022

ABSTRACT

The number and trends of unaccompanied children immigrating to the U.S. has drastically changed throughout the years and many are placed in shelters while they remain in the custody of the Office of Refugee Resettlement (ORR). Unaccompanied children subject to traumatic experiences in their country of origin or throughout their journey present with high levels of adverse mental health. Despite this, there is limited literature exploring the mental health concerns of unaccompanied children or the experiences of mental health professionals serving unaccompanied children specifically unaccompanied children in ORR care. This study aimed to understand the perception of mental health professionals of establishing therapeutic alliance with unaccompanied immigrant children in an ORR shelter. Grounded theory methods were utilized to identify elements vital to the process of building therapeutic alliance with unaccompanied immigrant children. In this qualitative study data was drawn for 6 participants providing mental health services to unaccompanied immigrant children in ORR shelters in South Texas. The pressing elements identified were, policy impacts treatment, boundaries, limitations due to setting, cultural competency, creating a safe environment and impacts of COVID-19. Understanding how these elements present themselves and how to address them in the process of developing therapeutic alliance is crucial. Future research should include a specific focus on building therapeutic alliance in other ORR settings. More work can be done to educate communities and other mental health professionals about the efforts and practices necessary in building therapeutic alliance with unaccompanied immigrant children and addressing their unique needs.

Keywords: Unaccompanied Immigrant Children, mental health professionals, therapeutic alliance, Office of Refugee Resettlement, qualitative

DEDICATION

Por mis padres y para mis padres, que llegaron sin nada y me lo dieron todo.

ACKNOWLEDGEMENTS

Words cannot express my gratitude to my dissertation chair, Dr. Marvarene Oliver, who was incredibly patient and provided invaluable feedback throughout my journey. Many thanks to my committee, Dr. Jennifer Gerlach, Dr. James Ikonompolous, and Dr. Schumann, who generously provided their time, support, and guidance to make this possible. I would like to express my deepest appreciation to Dr. Ricard; thank you for making sure I made it to the finish line, for sharing so much of your knowledge, and for always having all the right and warm words in tough times. Also, I wish to acknowledge the help, advice, guidance, and generous support from the late Dr. Robert Smith. He helped and inspired so many students and counseling professionals.

I thank my cohort members and friends, Ben, Basilio, Krystin, and Nora, for all the late-night study sessions, countless emails, and their moral support. I moved to this town and started this program only knowing one person and finished this program with forever friends. To my friends in Corpus Christi and back home who encouraged me to apply and cheered me on even from a distance every step of the way, please know that all your messages, calls, and visits meant so much to me and kept me going. Thank you for demonstrating so much kindness listening to me go on and on about my dissertation and being my audience when I needed to rehearse my presentations.

Special thanks to the participants in my dissertation who so graciously took time to participate and provide their knowledge. Thank you for being a vital part in the healing process of unaccompanied immigrant children and helping them find the peace they yearn to have.

This endeavor would not have been possible without the support of my family. Thank you to my sisters who have always being in my corner and have helped me get to where I am today. To my nieces and nephews, thank you for your genuine interest in everything I do and being my motivation to keep going in efforts to be someone you can look up to and pave a way for you. May you always know everything is possible and may you never take for granted the sacrifices those before us made so we may have opportunities like this one. It is your turn to continue paving the way for those after us. To my person, thank you for answering all my late-night calls and hearing me out when it all got too heavy. Thank you for being my person to lean on and making sure I knew it would all be worth it in the end.

Finalmente, estoy eternamente agradecida con Dios que me ha brindado tantas bendiciones día tras día y con mis padres por inculcar en mi la importancia de la educación. Llegaron a este país con muy poco pero con muchas ganas y sueños en su corazón y ahora años después aquí estamos, mami y papi gracias por todos sus sacrificios y todos sus “échele ganas mija, usted puede”. ¡Si se pudo!

TABLE OF CONTENTS

Page

PART I: INTRODUCTION

Introduction

Unaccompanied immigrant children have become the focus of increased attention in the United States due to the notable number of children who have embarked on the treacherous journey to migrate to the United States. Immigrant youth, children who are foreign born or U.S.-born to immigrant parents and younger than the age of 18, accounted for one-fourth of the nation's 75 million children (Passel, 2011). There has been confusion and debate about how to describe individuals who migrate to the United States. The terms refugee, asylum seeker, and immigrant are often used interchangeably to describe individuals from other countries who seek to settle in the United States. In order to understand the experiences of unaccompanied minor children, it is important to have an understanding of who these children are.

A refugee is an individual who is forced to flee their home country as a result of war, violence, or persecution and who crosses an international border to seek refuge in another country (United Nations High Commissioner for Refugees [UNHCR], 2019). They migrate to a host country seeking safety. Similarly, the term asylum seeker refers to an individual who fled their home country due to persecution or a fear of persecution however, the individual is at the port of entry of a foreign country requesting protection, but their request has not been processed (UNHCR, 2020). The term immigrant refers to someone who makes a conscious decision to leave their home country to migrate to a foreign country with the intention of settling there and often enter the country illegally (Department of Homeland Security, 2018). Whether a refugee, asylee, or immigrant, a child who enters the country without a parent or legal guardian is referred to as an unaccompanied child. By statue, unaccompanied alien children are defined as those

under the age of 18 entering the country without a parent or legal guardian and who lack a legal immigration status (Congressional Research Service, 2019).

Through the years a big humanitarian response has arose from the thousands of unaccompanied children that arrive at the U.S.- Mexico border to seek refuge after enduring perilous journeys from their country of origin (Chishti & Hipsman, 2015). Many unaccompanied children endure significant trauma prior to, during, and after their journey including escaping violence, separation from their families, sexual abuse, and human trafficking (Crea et al., 2018; Riley et al., 2018). This trauma can have detrimental effects on the mental health of unaccompanied children. Despite the rising number of children migrating to the United States and needing care, there is not much known about the needs faced by unaccompanied children when they are placed in the Office of Refugee Resettlement (ORR) system or of a consensus in the field on best practices to meet their needs (Crea et al., 2018).

For many unaccompanied children, journeying to the United States is not an option but instead essential for their survival. Unaccompanied children's motives for migrating to the United States appear to be multifaceted, including reunification with family, education and economic opportunities, and violence in their country of origin (Ciaccia & John, 2016). Unaccompanied children expose themselves to further traumas, facing multiple dangers during their journey without their parents or guardians (Riley et al., 2018). Unaccompanied children apprehended at or near the U.S. border are detained by United States (U.S.) Customs and Border Protection (CBP) and then placed in the least restrictive and most humane settings possible as required by the Trafficking Victims Protection Reauthorization Act of 2008 (TVPRA; National Immigration Forum, 2018). Based on these agreements, youth entering the United States without the presences of a parent or legal guardian and illegally are found placement in shelters in the

Office of Refugee Resettlement (ORR) custody system within the Administration for Children and Families (ACF), a division operated by the U.S. Department of Health and Human Services (Department of Health and Human Services [DHHS], 2020). Unaccompanied immigrant children who are placed in ORR shelters receive integrative services including educational, medical, recreational, case management, and clinical services. The shelter they are placed in becomes their home while they await to reunify with family in the United States. All the services and staff providing those services become part of their day-to-day life.

The number of UIC migrating to the United States increased significantly over the years. In FY2011, 24,403 unaccompanied children migrated to the United States from Central America (Women's Refugee Commission, 2012). In 2014 U.S. government facilities saw a significant surge of UIC almost doubling the number of children received in 2013 (DHHS, 2014). The numbers have continued to rise with a noticeable 147, 975 United States Customs and Border Protection (CBP) Encounters with UIC for the fiscal year (FY) 2021 (U.S. Customs Border Protection, 2022). Despite the increase of unaccompanied children migrating into the United States, the literature does not report information regarding the mental health of these children nor about the importance of the therapeutic alliance with the population.

Statement of the Problem

In 2012, Shifter (2012) reported countries in Central America saw a rise in crime rates, systemic state corruption, and poverty. Youth in these circumstances are often subject to traumatic experiences both in their country of origin and in transit to the United States. Exposure to traumatic situations in the early years of an individual is linked with a range of adverse mental health concerns that can extend and present themselves in adulthood (Becker Herbst et al., 2018). Depression, post-traumatic stress disorder (PTSD), and anxiety are prevalent among

unaccompanied children (Huemer et al., 2009; Keles et al., 2018; Keller et al., 2017; Sotomayor-Peterson & Montiel Carbajal, 2014). In addition to the trauma unaccompanied children may experience before and during their journey, there are other obstacles they face once they reach the United States. The difficulties of integrating into a new and different place post-migration such as language barriers, stigma, socioeconomic factors, and lack of services may prevent refugees from seeking mental health services (Pejic et al., 2017). Unaccompanied children have continued to migrate to the United States at a steady rate and will likely continue to do so through the years (U.S. Customs and Border Protection, 2019). Even with the increased number of unaccompanied children migrating to the United States and the documented mental health concerns they experience, there are disparities in mental health service utilization. According to Garcia et al., (2011) some reasons for limited utilization of mental health services include economic determinants, lack of health insurance coverage, and their cultural beliefs about mental health problems. With minimal guidance to treat unaccompanied children and a scantiness of information of their unique needs and emotional concerns mental health professionals struggle to address the needs of the population. Identifying factors that help with building therapeutic alliance from mental health professionals in ORR settings will provide a foundation to the therapeutic alliance process.

Purpose of the Study

The purpose of this qualitative study is to utilize grounded theory methods to elicit ways helping professionals can engage and build positive therapeutic alliance with unaccompanied children from the perspective of mental health professionals in ORR shelters. There appears to be a gap in the literature about unaccompanied children in ORR emergency shelters or designed to assist professionals serving this population. The dearth of research creates barriers for

professionals working with unaccompanied children to know more about how to engage and foster a therapeutic alliance that may help them address their unique needs and emotional concerns. The relationship of mental health providers and unaccompanied children will be explored from the perspective of mental health providers serving the population. Handwerk et al. (2008) noted that therapeutic alliance has been conjectured to be an essential common aspect in producing improvement in therapy for participants and highlighted the importance of treatment alliance in therapy with children. Information regarding common emotional concerns of unaccompanied children in an ORR emergency shelters and current therapeutic practices that foster the therapeutic alliance will be collected. A qualitative design using grounded theories methods will be employed. The results of this study may lead to a better understanding of the needs and emotional concerns of unaccompanied children while in ORR and suitable practices and qualities to foster a therapeutic alliance to meet the needs and emotional concerns of unaccompanied children.

Research Question

The overarching research question for this study is: What is the process of developing therapeutic alliance among licensed mental health professionals who work with unaccompanied children in ORR?

Significance of the Study

Much has been written about the demographics of unaccompanied children from Central America immigrating to the United States and their reasons for migration (Chen & Gill, 2015; Chishti & Hipsman, 2015; Passel, 2011); however, a review of the literature revealed little research about UIC's in ORR shelters, particularly about their emotional concerns and the work of mental health providers. Specifically, the impact therapeutic alliance has in the work of mental

health providers in ORR shelters remains murky. Studies with youth in residential care and in emergency shelters have demonstrated the positive impact therapeutic alliance has on therapy outcomes (Eyrich-Garg, 2008; Handwerk et al., 2008). The study conducted by Eyrich-Garg (2008) outlined specific strategies found to be helpful in engaging adolescent girls in therapy as identified by participants. In their study Handwerk et al. (2008) reported that their findings were consistent with previous studies conducted in residential care settings, indicating that youth improved while they remained in therapy.

In the fiscal year 2017, 40,810 unaccompanied children were referred from the Department of Homeland Security to ORR and in the fiscal year 2021 the number significantly increased 147, 975 nationwide encounters (U.S. Customs and Border Protection, 2021). The data indicates that the number of unaccompanied children migrating to the United States has remained steady over the years. The results of this study will provide mental health providers working with this population with insight and guidance to address the emotional concerns of UIC by assessing the therapeutic alliance. In addition, the results will provide mental health providers with the information about important elements and attributes that may help them develop strategies to engage with unaccompanied children and improve therapy outcomes. It may also contribute as a foundation for further research to be completed about the population as well as provide licensing supervisors insight of therapeutic processes for licensees working with UIC population.

Methodology

Qualitative Approach Using Grounded Theory Methods

Qualitative research is conducted to understand a specific how participants in a study work to address issues or concerns in particular situations or frameworks (Creswell and Poth,

2018). In addition, a qualitative approach is suitable to explore topics about which little is known. Merriam and Tisdell (2016) stated qualitative researchers undertake a qualitative study because there is an absence of theory, or an existing theory notably fails to explain a phenomenon. There is limited research concerning the therapeutic relationship of mental health professionals working with unaccompanied children in ORR shelters. Grounded theory focuses on generating or discovering a theory based on the mutual experience participants have had in a process in efforts that the theory may present avenues leading to explanations of a practice or frameworks for future research (Creswell & Poth, 2018). The current research does not aim to develop a theory; however, grounded theory methods are suitable for this the current study in that it looks to generate an understanding of elements MHPs working in ORR shelters view as essential in establishing a therapeutic alliance with unaccompanied children in ORR shelters.

Charmaz (2006) documented that grounded theory serves "as a way to learn about the worlds we study and a method for developing theories to understand them" (p. 10). Charmaz's stance on grounded theory is founded on the belief that theories are not discovered but rather constructed through our involvement and interactions with people. Similarly, the work of mental health professionals is humanistic in nature. They can create meaning with individuals they work with through their interactions. Furthermore, there is a dearth of information in the literature about the work of mental health professionals with unaccompanied children in emergency shelters. More research needs to be done to refine and expand the literature. Specifically, the significance of mental health professionals in ORR settings developing a therapeutic alliance with unaccompanied children has not received sufficient attention. A study exploring this phenomenon is prudent because it has been noted that therapeutic relationships in group settings are different than in traditional settings where a client seeks therapy services and may be seen on

a weekly basis (Duppong Hurley et al., 2015). Having an understanding of factors that contribute to foster the therapeutic alliance between mental health professionals and unaccompanied children in an ORR setting can be helpful to professionals in the field. Generally, grounded theory methodology is utilized when little is known about a phenomenon and is intended to produce a theory arising from the data that explains a process essential to the area being studied (Birks & Mills, 2015). In this perspective, the constructivist grounded theory approach suits the nature of this qualitative study.

Population and Sample

The best utilization of constrained assets while obtaining information- rich cases comes from purposeful sampling (Patton, 2014). Employing purposeful sampling entails identifying and selecting individuals who have extensive knowledge about a specific topic of interest(Creswell & Plano Clark, 2011). In the current study, I will utilize a population of mental health professionals who provide counseling services to unaccompanied children in ORR emergency shelters in South Texas. I will also utilize snowball sampling to allow participants to make referrals of other mental health professionals they believed fit the criteria for the study. This recruitment technique is utilized to identify other potential subjects with the assistance of research participants (Suri, 2011). Penrod, Cain, Starks (2003) asserted that purposive sampling within a frame of referrals generated through snowballing may provide depth and understanding.

Selection of potential participants will be based on criteria designed to elicit rich and detailed data concerning facets of building therapeutic alliance to unaccompanied children in ORR emergency shelters. Participants recruited for this study will be required to meet the following criteria: (a) be bilingual clinicians currently employed at a shelter serving unaccompanied children in South Texas, (b) be licensed to provide mental health services in the

state of Texas at a master's level and in good standing with their licensing board, and (c) possess a minimum of one year experience working with unaccompanied children in an ORR emergency shelter. The shelters where participants are employed house unaccompanied children ages 12 to 17.

Data Collection

Individuals with whom the researcher has established a trusting relationship through professional work in ORR shelters will be emailed to request participation in the study. Individuals are mental health professionals in ORR shelters. Individuals initially emailed will be encouraged to forward the recruitment email to individuals they believe meet the criteria to their personal emails after business hours. Participants will not be recruited through their employer. After receiving Institutional Review Board (IRB) approval, I will disseminate an email containing general information about the study to potential participants. In addition to the general information, a Qualtrics ® link will be provided; the linked document will include a consent document, demographic information document, and contact information for researcher. Potential participants will be assured that their participation in the study will be confidential and no identifying information will be revealed. Individuals who are interested in participating in the study will have the opportunity to contact the researcher about any questions they have about the study before consenting to participate.

All participants will engage in a semi-structured interview via Zoom Video Communications that is anticipated to last between 45 minutes and an hour. Interviews will be recorded through Zoom Video Communications and with an audio-recording device. After all the participants complete their individual interviews, recordings will be sent to a transcription service. Once the transcript is received, it will be analyzed, and I will contact participants to

request their feedback on identified initial themes. Participants will have two weeks to provide any comments or feedback they have on the developed themes including their thoughts on the accuracy on what they wish to communicate. Upon having completed all individual interviews participants will be invited to participate in a focus group session. There will be two focus group sessions conducted to accommodate to the availability of participants. The focus group will last approximately 45 minutes. Participants who agree to participate in the study will be encouraged to utilize a pseudonym during the focus group to protect confidentiality. I will write case-based memos after each interview and focus group reflecting on what I learn throughout the interviewing process.

Data Analysis

The purpose of this study is to generate a framework for future research outlining the therapeutic alliance between mental health providers and unaccompanied children in an ORR setting utilizing grounded theory methods. Charmaz (2014) identified strategies helpful in the process of collection and analyzing data. The process starts with the collection of rich data. In this study the data will be collected from participants who are employed as mental health providers at an ORR shelter in South Texas. The data collection and data analysis will be conducted simultaneously.

The notes and audio recordings will be cross-referenced to provide transcripts for qualitative analysis. Each participant's transcript will be analyzed utilizing initial coding followed by focused coding to identify individual themes. As I receive additional transcripts, I will analyze each in the same manner, comparing results of each with those previously analyzed. Coding involves data collecting and the process of finding meaning within the data (Corbin & Strauss, 2015). The process will continue with memo writing, theoretical sampling for saturation,

and sorting of categories. The use of constructivist grounded theory techniques will help to indicate when no new categories or concepts have emerged from the data. When I determine that the data is saturated, I will conclude data collection (Creswell & Poth, 2018).

Trustworthiness

Sikoila, et al. (2013) noted that a researcher may display trustworthiness in a qualitative study by ensuring credibility, transferability, dependability, and confirmability are present within the research. Credibility is the concept of demonstrating the truth of the research study's findings. To achieve credibility in this study triangulation and member checking methods will be utilized. Triangulation will be attained by collecting data in two ways: semi-structured interviews and the focus group. Member checking in the current study will involve sharing transcripts of interviews and initial identified themes with participants via encrypted e-mails to allow them to correct or elaborate upon the initial analysis. According to Lincoln and Guba (1985), member checks are essential for assessing trustworthiness. The method used in this study is designed to ensure that the findings are consistent with what participants intended to convey.

Transferability refers to the degree that results can be transferred to other circumstances or settings. Results in this study will utilize thick description that originates in the participants' own words to describe the individual and shared narrative about what is being studied so that readers can sense the ways in which the narrative overlaps with their own and other contexts (Tracy, 2010). The intention is to tell the story of therapeutic alliance within an ORR in such a way that readers can vicariously experience what the data demonstrates and relate to the experiences of participants (Ellis, 1995).

Dependability is related to the aspect of consistency. To achieve dependability in the study a thick, rich description of each process in the study will be provided. Confirmability is a

process to determine whether the researcher has been biased during the study. In this study confirmability will be established by utilizing a reflexive journal, memo writing, implementing triangulation of data, and providing a detailed description of the methods used in the study. The journal will be used as a tool to write notes on decisions made during the research process, reflective thoughts, and document my own experiences throughout the study. This audit trail helps ensure dependability and confirmability (Korstjen & Albine, 2018).

Definition of Terms

Unaccompanied Immigrant Child

For the purpose of this study an unaccompanied immigrant child is defined as a child under the age of 18 entering the country without a parent or legal guardian and who lacks a legal immigration status (Congressional Research Service, 2019).

Refugee

Refugee is defined as someone who has fled his or her country forcibly due to persecution, war, or violence and crosses an international border to seek refuge in another country ([UNHCR], 2019).

Immigrant

An immigrant is an individual who migrates to another country often to seek permanent residence for a variety of reasons (Department of Homeland Security, 2018).

Asylee

According to Homeland Security (2019, para.1) an asylee meets the classification of a refugee and is already residing the United States or is seeking admission at a port of entry and may apply for green card status one year after they have been granted asylum.

Mental Health Professional

For the purpose of this study a mental health professional is defined as an individual who possesses at least a master's degree in counseling or a related field and is licensed to provide mental health services at an independent level.

Office of Refugee Resettlement

The Office of Refugee Resettlement (ORR) is part of the U.S. Administration for Children and Families and is "dedicated to helping refugees, persons granted asylum, and their families" (The Administration for Children and Families, 2021)

Organization of Remaining Chapters

Chapter two consists of a review of the literature about the current study. Chapter three includes a detailed review of the methodology used in the study.

PART II: REVIEW OF THE LITERATURE

Literature Review

This chapter provides information of factors that impact unaccompanied children such as brief geopolitical information as it relates to unaccompanied children. Furthermore, the chapter introduces mental health concerns in unaccompanied children and presents a description of factors that contribute to the mental health of unaccompanied children. In addition, this chapter discusses literature of appropriate treatments when working with unaccompanied children. Finally, the chapter provides a brief exploration of therapeutic alliance.

Geopolitical Factors

In recent years certain geopolitical aspects have made the experience for immigrants and refugees including unaccompanied children a lot more complex. They have faced and overcome insurmountable odds as a result. According to Solomonov and Barber (2019), the political climate has had a significant effect on the lives of clinicians and clients, especially those clients who are part of marginalized communities. Ranjigar et al. (2019) noted that traumatic separations can have both short- and long-term neurodevelopmental consequences that can have mental health impact that lasts into adulthood.

As a matter of policy by the administration of 2018, the U.S. government separated countless parents from their children. In 2018, a “zero tolerance” policy was implemented toward illegal border crossing into the U.S. (Congressional Research Service, 2021). With this policy in place any adult entering the U.S. illegally was detained and prosecuted even when accompanied by minor children. The children were then labeled as unaccompanied children and referred to ORR shelters. According to the U.S. Department of Health & Human Services (2019), from April 2018 through July 2019 a total of 3,602 children were separated from their

parents at or between ports of entry. The president of the American Academy of Pediatrics (AAP) noted that that practice was considered a form of child abuse that had long-term effects and impacted the developing brains of children (Czeisler, 2018). These children carry stories of loss and trauma. The pervasive experience of parental separation has been documented to have a significant effect on the health and well-being of unaccompanied children (Crea at al., 2018). Children who experience traumatic separations are at risk for developing posttraumatic responses including nightmares, intrusive thoughts, self-destructive thoughts, plans, or actions (National Child Traumatic Stress Network [NCTSN], 2016).

Brané et al. (2015) noted that U.S. immigration laws do not take into account children's rights but are rather built on the foundation of enforcement principles, which has had had an overwhelming effect on the integrity of migrant families in the United States. Existing immigration policies such as those that terminate temporary protections against deportation create significant barriers for unaccompanied children and their families even outside of the immigration system. Immigrant children and their families may face living in conditions of poverty and lacking access to health among other things because some of those difficulties are determined by federal laws that restrict them from certain federal benefits (Brané et al., 2015). The migration itself, policies, and other factors such as being far from their host country and support systems can have other harmful effects on unaccompanied children.

Amid the coronavirus (COVID-19) pandemic, the administration of 2018 announced several immigration actions that affected unaccompanied children migrating to the U.S. In order to limit the spread of coronavirus, the U.S. Customs Border Protection (CBP) following Title 42 guidance suspended entry to immigrants illegally crossing into the U.S and is at the time of this writing repatriating them to their country of origin (U.S. Department of Homeland Security,

2020). Additionally, ORR stopped placing unaccompanied children in some shelters as a result of COVID-19 and were expelled to the country of last transit (Persaud, 2020; U.S. Customs and Border Protection, 2022). The challenges unaccompanied children face including those that are imposed on them may have adverse effects on their mental health.

Mental Health of Unaccompanied Children

The corpus of studies of immigrant Hispanic youth indicate that foreign-born youth commonly have an advanced rate of psychiatric disorders in comparison to youth who are born in the United States (Bridges et al., 2010). An internalizing disorder is a disorder that is focused inward and is often characterized by dimensions of worry, depression, and fear such as major depressive disorder, generalized anxiety disorder, or post-traumatic stress disorder (PTSD; Kumm et al., 2019; Patterson et al., 2018). For example, a study conducted by Glover et al. (1999) with Hispanic youth ranging from the ages of 11-18 revealed that Hispanic participants who were not born in the United States scored higher on the Child Behavior Checklist (CBCL) than Hispanic youth who were born in the United States. In another study with Hispanic adolescents ages 12-17., Mikolajczyk et al. (2007) found that youth who were not born in the United States and were less assimilated were at higher risk for depression compared to Hispanic youth born in the United States. The distinct events experienced by unaccompanied children affect their mental health. Turrini et al. (2017) reported that asylum seekers and refugees are exposed to stressful experiences during their forced migration and resettlement that make them susceptible to mental health conditions including PTSD, major depressive disorder, and generalized anxiety disorder. Hispanic youth who have experienced traumatic events are also at-risk to engage in substance use, experience higher levels of mistrust, identity confusion, and isolation (Asner-Self & Marotta, 2005; Bridges et al., 2010).

Factors Contributing to Mental Health Concerns

Many minors are exposed to trauma in their country of origin, in transit to the United States, and post-migration. The stressors they experience may have a negative impact on the mental health and well-being of UIC if not addressed. There are certain factors that should be considered when working to address mental health concerns with UIC.

Acculturative Stressors

The mental health functioning of immigrant children is affected for an array of reasons and may cause them to develop mental health disorders. Immigrant children are prone to significant risk factors due to difficult experiences in their country of origin, the migration process, and adjustment to a host country. To find and develop appropriate treatment guidelines to treat unaccompanied children it is important to gain some insight of the stressors that lead to a decline in their mental health.

Acculturative stressors have considerable impact on the mental well-being of immigrant adolescents and their families (Garcia et al., 2011). The acculturation process consists of an array of components that can be overwhelming for new immigrants. An accumulation of daily acculturative stressors can be strenuous for immigrant children. Stressors experienced by immigrants include significant life transitions, including learning a new language, culture, and identifying a social support system; and living with economic instability, while still attempting to maintain communication with family in their home country (Cervantes et al., 2013).

Acculturation can be especially taxing on unaccompanied children and adolescents. They must work to adapt to the culture concurrently with the American teen culture. The challenges of acculturation are particularly more stressing for Latino immigrant youth due to the sudden immersion in the new culture when they are enrolled in school (Gudiño et al., 2011). As they

begin to adapt to the culture by learning a new language, immigrant youth often serve as linguistic brokers for their immigrant parents. By helping their immigrant parents navigate through the American system, immigrant youth navigate between different cultures at a faster rate than their parents, which can in turn result in the roles being disrupted (Garcia et al., 2010).

Acculturative stress produced by a combination of acculturation aspects are risk factors for depression and anxiety in immigrants (Revollo et al., 2011) and drive adolescents to engage in maladaptive behaviors such as substance abuse (Unger et al., 2014). Keles et al. (2016) reported that unaccompanied refugees experienced general and *acculturation hassles* and further stated that the acculturation hassles explained 41% of the variance in depression. The stress associated with acculturation has been documented to be disruptive to mental well-being; however, it remains understudied for Hispanic immigrant youth.

Traumatic Experiences

Similarly, the traumatic experiences that immigrant youth endure can have an impact on their mental health. Immigrant youth are constantly exposed to traumatic experiences and are especially vulnerable to distress. Franco (2018) reported that when compared to other migrants, unaccompanied refugee migrants from Mexico and Central America, are at a higher risk to developing PTSD, and other psychological disorders such as depression and anxiety due to the exposure to traumatic events.

Many immigrant children have experienced multiple traumatic events. The United Nations High Commission for Refugees (2014) reported those traumatic events include sexual abuse, human trafficking, gang violence, and gang recruitment. In a study by Keller et al. (2017) asylum seeking immigrants from Central America were enquired about their exposure to significant traumatic events, such as violent acts; 32.2% reported a family murder, 45.4%

reported they received death threats, and 33% reported extortion. Immigrant youth from Central America often report experiencing or witnessing a traumatic event. Of 151 unaccompanied immigrant youth from Central America who were interviewed by the Women's Refugee Commission (2012), 77% identified violence in their country of origin as the driving factor for migration. Further, they reported they would make the journey to the United States again if necessary.

Exposure to traumatic experiences do not end for immigrant youth when they leave their home countries. The migration process is dynamic and consists of a pre-migration, in-journey, and a post migration phase. The stressors experienced in each phase of the migration process are factors present in migration trauma that provide information for their psychosocial history (Kirmayer et al., 2011)

Pre-migration. The events that unaccompanied immigrant youth experience during the pre-migration phase exposes them to an array of stressors. The push factors that cause them to flee their countries play a role in the exposure of traumatic events prior to migration to the United States, increasing their susceptibility to develop mental health illnesses. In addition to the violence in their home countries, economic hardships, and previous experiences with migration to the United States are amongst other factors that can be traumatic for immigrant Latinos and can cause chronic stress. (Perreira & Ornelas, 2013).

In-journey. The journey can often be in arduous conditions, especially for unaccompanied immigrant youth. Unaccompanied refugee minors are at risk of being assailed, experiencing sexual and physical abuse, and experiencing malnourishment from traveling through rough terrains during the treacherous journey (Franco, 2018). Despite the known dangers, many immigrant youths decide to travel to the United States. Unaccompanied children

migrate to the US by different means, many of them by boarding freight trains making them vulnerable to dangers and traumatic stressors, such as the likelihood of falling or being pushed off the freight train. Most immigrant youth have already been exposed to traumatic events prior to the journey and the exposure to trauma during the journey exacerbates it.

Post-migration. After the hazardous journey immigrant youth face unique stressors during the post migration phase. Upon entering the United States Southern border unaccompanied children are detained and taken into custody by US Customs and Border Protection. The environment in detention centers can have deleterious effects on immigrant youth. There have been cases of immigrant youth being separated from parents or legal guardians whom they were traveling with. The separation from family can lead to an increase of emotional distress. Family separation may have detrimental effects for immigrant children and may put them at higher risk of PTSD (Unterhithzenberger et al., 2015). Additional stressors are the fear of deportation and discrimination while trying to adjust to a new country. Exposure to violence in the home country and continued exposure to violence in the United States have been linked to have negative effects on the mental health for immigrants (Gudiño et al., 2011).

According to Garcia et al. (2011), mental health concerns such as anxiety, depression, and suicidal ideations were reported at higher rates in comparison to youth who identified as non-Latino however, their cultural beliefs were influential on their help seeking behaviors. Moreover, undocumented children have endured trauma pre-migration in the country of origin and in-transit to the United States making them vulnerable mental health concerns.

Disparities in Mental Health Care Utilization

In addition to the mental health concerns, the cultural influences are strong determinants of the mental health service utilization. Culture has an impact on the mental health service

utilization by unaccompanied immigrant youth. Specifically, cultural factors such as fear of deportation, a collectivist world view, cultural beliefs, and barriers due to their legal status (Arredondo et al., 2010; Bridges et al., 2010; Ciaccia & John, 2016; Crea et al., 2018; Garcia et al., 2011). Of Hispanic youth that identified with an increased need of mental health services, nearly 88% did not receive necessary care (Bridges et al., 2010). For many Hispanics, despite there being biochemical reasons for a number of mental health conditions, they still lean to cultural factors for explanations such as the belief that some mental health conditions are a result of magical or spiritual causes (Garcia et al., 2011). Such cultural beliefs can lead Hispanics to seek help from alternative services such as folk healers or herbalists which leads providers to perceive culture as a barrier to providing services and treatment (Bridges et al., 2010; Olcon & Gulbas, 2018). It is evident that cultural factors and knowledge about mental health influence the help-seeking behaviors of unaccompanied immigrant youth and their families. Although culture can often serve as a protective factor there are instances in which it can have adverse effects. Culture may become a risk factor when a strong emphasis to cultural values becomes onerous and causes individuals not to seek help or seek alternative cultural treatments (Gulbas & Zayas, 2015). Mental health illnesses that are not treated appropriately can have a long-lasting impact on their mental health that can extend well into adulthood.

Undocumented children who have endured traumatic experiences could benefit from mental health services. Unfortunately, many of them do not receive those services due to barriers they face. According to Ciaccia and John (2016), a common barrier for unaccompanied immigrant children and their caregivers is the fear of deportation due to lack of legal status. The lack of legal status prevents them from seeking health care and at times they turn to home remedies instead. They are in a country with more opportunities but are limited regarding

opportunities due to lack of legal status. Individuals who can attain a legal status may qualify for benefits such as Medicaid; however, without legal status they are ineligible and are excluded from federal benefits offered through the Affordable Care Act (Ciaccia & John, 2016). Chen and Vargas-Bustamante (2011) noted that although some mental health conditions can be properly treated and controlled with adequate treatment many immigrants face lack of mental health care access in comparison to individuals who are born in the United States.

Latino cultural factors contribute to disproportionate utilization of mental health services in comparison to native born individuals. The stigma that surrounds mental health is a significant factor and it poses an issue in seeking mental health services. The experience of immigrant youth is that they do not make the decision to seek mental health services rather their parents are the ones who make that decision (Gudiño et al., 2011). However, the mental health stigma may discourage parents from seeking help if they do not deem the concerns as serious. Within Latino families, *familiasmo*, a collectivist worldview, is present (Arredondo et al., 2014) which may steer them to deal with a presented concern as a family instead of turning to the help of a mental health professional. For Latino men, machismo, a masculine force view, is determinant in them seeking mental health services as they may view seeking mental health services as a sign of weakness (Garcia et al., 2011). Postponing the process of reaching out for mental health help may cause their symptoms to worsen. The story of many Latino youth is that they do not receive the mental health care they need (Garcia et al., 2011). For many that do seek help, they may not always receive the help they require and 60 to 75% who access services only attend the first session (Andrade & Viruell-Fuentes, 2011). There continues to be a vast disparity in the mental health care utilization between Latino immigrant youth and individuals who are more in the United States.

Treatment for Unaccompanied Children

Despite the increase of Hispanic unaccompanied children traveling to the United States and the documented exposure to traumatic events, there continues to be a gap in literature discussing appropriate cultural treatments for this vulnerable population. Many of the needs of unaccompanied children, including mental health needs, are documented well in other countries within Europe, but research on the experience and treatment for Hispanic unaccompanied children in the United States is currently limited (Crea et al., 2018).

Most mental health services for children and adolescents who have experienced trauma were not originally developed for refugees (Betancourt et al., 2017). Specifically, many unaccompanied children who reunify in the US find there is a dearth of bilingual mental health professionals, extensive wait times in clinics, and providers who are not willing to work with individuals without a legal status (Roth & Grace, 2015). There are significant indicators that Hispanic unaccompanied children can benefit from tailored treatments that culturally address their unique needs. Studies with refugee minors have yielded results indicating that treatments including trauma-focused cognitive behavioral therapy (TF-CBT), and narrative exposure therapy (NET) were proven efficacious in treating PTSD and other stressors (Tyer & Fazel, 2014).

Therapeutic Alliance

Therapeutic alliance, a cooperative working relationship between a mental health professional and client, is a topic that has been commonly researched in adult psychotherapy (Horvath et al., 2011). In contrast, the literature focusing on therapeutic alliance with adolescent clients is limited but purports therapeutic alliance is an important factor in therapy (Capaldi et al., 2016; Eyrich-Garg, 2008; Handwerk et al., 2008; Kazdin & McWhinney, 201 8). Holmes

(1998) noted that having a strong working alliance aid in the process of developing self-exploration and increasing self-awareness, to emerge and continue unhindered in therapy.

Building a strong working alliance with a therapist is beneficial specifically when treating clients who have experienced trauma. Unaccompanied children traveling to the United States often experience trauma and are susceptible to mental health issues. It has been recognized that individuals who are victims of physical abuse, sexual abuse, or experience neglect struggle to develop a positive therapeutic alliance (Eltz et al., 1995; Stovall-McClough & Cloitre, 2006). Based on these outcomes, mental health professionals have highlighted the importance of placing a strong emphasis on developing a therapeutic alliance prior to implementing techniques (Everly & Lating, 2004). A strong therapeutic alliance can aid in the therapeutic process and outcomes (Duppong Hurley et al., 2015; Solomon et al., 1995). Specifically, having a strong therapeutic alliance has been linked to improving PTSD symptoms in adolescents (Capaldi et al., 2016).

For many children who have endured trauma, the therapeutic relationship may be the most meaningful and safe relationship they have experienced. Saxe et al. (2007) described *signals of care* as strong attachment relationships because they work to respond when a child is confronted with signals of danger. They reported that living in social environments and systems of care that comprise of signals of care can help minimize danger responses in children with traumatic backgrounds and noted that relationships are an important part of the trauma system which is made up of the emotional regulation and social environment components. In essence, the quality of the relationships the child is a part of determine the child's ability to regulate emotion when faced with danger. More importantly, Saxe et al. (2007) documented four reasons that working with children who have experienced trauma requires a solid therapeutic relationship: (a) the feeling of being cared for is essential for the child to engage in the

treatment, (b) information interchanged within the therapeutic relationship may offer the child the opportunity to understand how interpersonal signals work and apply them within other relationships in their lives, (c) the experience of feeling cared for can be transformative for the child, and (d) the emotions experienced by the clinician can provide benefits to the transformation of a traumatized child. Therefore, it is important that ORR mental health providers focus on alliance building with this population. In addition, this information suggests that specific therapist traits may contribute to a strong therapeutic alliance.

The therapeutic relationship between unaccompanied children and ORR mental health providers is unique and therefore requires further exploration. Duppong Hurley et al. (2015) noted therapeutic relationships in group care vary from those in outpatient settings given that treatment providers do not just meet with youth once or twice a week in a traditional manner but rather are on site and available as needed. For unaccompanied children in ORR care, the shelter is their home and mental health providers are a part of that environment. The Office of Refugee Resettlement (ORR) mental health providers are available around the clock toto provide mental health services as needed rather than the conventional way of parents taking their child for weekly appointments. Specific to therapeutic alliance in residential care, Eltz et al. (1995) identified that youth who had a history of experiencing maltreatment had lower therapeutic alliance scores in comparison to youth did not have a history of maltreatment. Along with this factor it is important to recognize the experience youth have adjusting to a new setting and individuals they meet, including those who are mental health providers.

The ORR residential service shelters differ from other settings in that the expected length of stay for children varies based on the reunification process. Each case receives a category

based on the verified relationship the child has with the person seeking to sponsor them. Categories are defined by The Administration for Children and Families (2022) as follows:

- Category 1 cases are children reunifying with a parent or legal guardian.
- Category 2A cases are children seeking reunification with an immediate family member who previously served as a caregiver.
- Category 2B cases are children reunifying with an immediate family member who was not the child's primarily caregiver.
- Category 3 cases are children working to reunify with a distant relative or unrelated adult individual.
- Category 4 cases are in which a sponsor is not identified.

For the fiscal year 2019, the average expected stay for children was sixty-six days (U.S. Department of Health and Human Services, 2020). According to Florsheim et al. (2020) therapeutic alliance gains from intake to 3 months between youth and staff in a residential correctional setting predicted improvement in youth outcomes. Mental health providers may only get to meet with youth in care a limited number of times depending on their length of stay. In a study by Duppong Hurley et al. (2013) therapeutic alliance was assessed with youth in residential group homes over the span of 12 months or until they discharged from services, and they noted that ratings of the therapeutic alliance began fairly high when services began, then declined, and steadily went back up. They suggested the findings were in line with the experience of many youths in a residential care setting noting that it takes time to adjust however, with time their experience improves. The length of stay of unaccompanied children in an ORR emergency shelter is subject to change

Another important factor that may hinder the therapeutic alliance is that children are not the ones to initiate therapy; rather, they attend therapy at the request of a parent or another adult because of seeming concerns (Handwerk et al., 2008). As a result, youth may be reluctant to open up or attend therapy. The relationship of unaccompanied children in ORR care and mental health providers differs in that the youth's parent are not in the U.S. and ORR services are already in place for all unaccompanied children admitted into care. Working with adolescents may also present other challenges. Because the developmental focus of teens is self-reliance, it may be more difficult to engage them in treatment when compared to adults and children (DiGuiseppe et al., 1996). Engagement in therapy is a factor important to therapeutic alliance. Engaging clients in therapy has been said to be the first step in forming a working relationship and absence of engagement may cause changes in therapy such as lack of or minimal participation in treatment (Coatsworth et al., 2001; Robbins et al., 2003). In addition, other factors such as attitude, beliefs, and knowledge about mental health services may be vital aspects relating to the therapeutic alliance. For example, Constantine and Kwan (2003) noted that self-disclosure from the therapist can be used in efforts to develop the therapeutic alliance addressing demonstrating cultural competence and other cultural factors as well as establishing therapist expertise. In a study by Majumder et al., (2019) with unaccompanied refugee minors in a setting in England it was found that factors such as the youths' perception of the practitioner and their characteristics as well their perceptions of therapies were identified as barriers in the therapeutic process. For youth in the study some of their perceptions were related to their cultural influences. Therefore, it is important that mental health providers are capable of providing culturally responsive treatment as it may aid with therapeutic alliance. Additionally, Bickman et al. (2012) found that clinician's modification to the working relationship with patient was predictive of the

severity of youth symptoms in an outpatient setting. Therapist attributes throughout the therapy process are essential to the therapeutic process.

Slight research on therapeutic alliance has been done in alternative settings such as ORR emergency shelters. Research exploring the therapeutic alliance between unaccompanied children and mental health providers in ORR emergency shelters is prudent to identify therapist qualities that may help with the unique emotional needs of unaccompanied children Further research may also help identify perceived barriers that clinician experience in relation to therapeutic alliance in an ORR setting.

Conclusion

The literature regarding the importance of therapeutic alliance between mental health professionals in an ORR setting and children is not well documented. The literature is even more scarce for unaccompanied children in an ORR setting. Unaccompanied children migrating to the US and cared for in ORR shelter is a topic that has obtained a lot of attention especially during the current administration. The plight of their journey and the trauma they endure has been documented in other contexts; however, more is still needed. A review of the literature indicated that unaccompanied children endure many hardships in their country of origin, during their journey, and upon reunifying with family in the US that can have a significant effect on their mental health and revealed that young children are best understood and helped recover in the context of supportive and predictable relationships. However, there is not much known about the significance of therapeutic alliance from the perspective of mental health professional in ORR settings. As such, this study endeavors to fill the gap in literature by exploring the therapeutic relationship of mental health providers and unaccompanied children in an ORR setting.

PART III: METHODOLOGY

Methods

This chapter offers an outline of the grounded theory model to be employed in the current study as well as an overview of the process to be utilized. The focus of this study is to utilize grounded theory methods to examine the therapeutic alliance process from the perspective of mental health professionals providing services to UIC and generating a framework for future research.

Design Rationale

Qualitative research can be helpful to explore a topic that is not well defined or understood. Qualitative research involves practices that make the world visible and locate the observer in the world (Denzin & Lincoln, 2011). The intent of qualitative inquiry is to understand the characteristics of a situation and the meaning brought by participants concerning what is happening to them at the moment (Patton, 2015).

The importance of the therapeutic alliance between mental health providers and children in ORR care has not been sufficiently researched. A review of the literature reflected minimal research about the work with unaccompanied children from a therapeutic context. Creswell and Poth (2018) noted qualitative research is conducted because there is a need to study a group and there are inadequate theories about certain populations.

Grounded theory inquiry allows the opportunity to move beyond description to generate a theory that may explain practice or provide an outline for future additional research (Corbin & Strauss, 2007). The essence of a grounded theory design is that the substantive theory is generated from participants who have experienced the problem (Merriam & Tisdell, 2016). The researcher works to generate this theory from the data as it is being collected. While the current

research is not intended to develop a substantive theory, it was advantageous to utilize grounded theory methods in this study to understand the process of the therapeutic alliance.

Design Methodology

Grounded theory qualitative design was initially developed by two researchers, Barney Glaser and Anslem Strauss, in 1967 (Kenny & Fourie, 2015). Charmaz (2014) adopted the methodological strategies of the classic grounded theory but not the epistemology (Wertz et al., 2011). Unlike Glaser and Strauss, Charmaz advocated for a social constructivist perspective recognizes diverse local worlds, world views, and actions instead of a single process (Creswell & Poth, 2018). A constructivist grounded theory is one that is constructed from data from past and present involvements and interactions with people, perspectives, and research practices. The focus of this study is to generate and develop more refined concepts rather than further explore existing ones. Researchers who utilize constructivist grounded theory assume that data and analyses are social constructions and therefore, the entirety of the analysis is situated in time, space, culture, and experienced condition (Crossetti, et al., 2016). The constructivist theory approach by Charmaz provides flexibility in guidelines, greater emphasis on theory developed that is based on the researcher's view, and a greater focus on the meaning of the phenomenon to the participants within the context rather limiting it in only on the setting (Bernard & Ryan, 2010). Specific to this study, the Office of Refugee Resettlement (ORR) ensures every UIC receives therapeutic services as needed; however, not much is known about the therapeutic relationship in this context. Thus, constructivist grounded theory methods are appropriate for this study in order to explicate the perspectives of MHPs working with unaccompanied children concerning therapeutic alliance

Role of the Researcher

The researcher plays an essential role in qualitative research study. In a qualitative study the researcher is considered a key instrument in completing the study (Creswell & Poth, 2018). This unique position allows the researcher to engage with participants in depth. The researcher immerses in the study with intent to gather rich data and understand the experiences of participants. Being a qualitative researcher means stepping into the world of the participant and immersing oneself their world via interactions with participants or extensive interviewing (Kopala & Suzuki, 1999).

Creswell and Poth (2018) stated that qualitative study requires researchers to commit to spending a significant amount of time in the field collaborating with participants in efforts to develop and "insider" perspective. When this study will be conducted, I will be employed providing mental health services at an ORR shelter in South Texas; therefore, my role as a researcher will be an insider. An insider researcher conducts research with a population of which they are also a part (Kanuha, 2000) so that the researcher shares similarities such as experiences, language with the study participants (Asselin, 2003). The insider role allows for complete acceptance from the participants and may aid in collecting data with greater depth. Participants in the study might be more open to talk about their experiences of their role and in their role because there is an assumption that they feel heard, seen, and understood (Dwyer & Buckle ,2009).

Lens of the Researcher

Remaining objective specifically when utilizing grounded theory methodology is key as the theory is being developed. Sikoila et al. (2013) noted that a grounded theory researcher does not approach the study with pre-conceived theories to test; instead, they turn their attention to

how people interact with what is being studied. Given my role as an insider it was important that I remained objective and unbiased to ensure the participants' perspectives, thoughts, and voices were represented in the final study.

I worked to examine my own personal experience as it related to that of participants and the lens through which the data would be collected and examined. My first job after completing my undergraduate degree was as a case manager at an ORR shelter for unaccompanied children. My role was to coordinate with the child in care, their family, and program stakeholders to ensure the safe and timely reunification of the child with family in the United States. This was my first experience working with unaccompanied children. It was through this role that I learned of their plight in their home countries and the reasons many of them sacrificed so much to migrate to the United States. It was also through this role that I learned about their hopes and dreams to better their lives. More importantly, it was through this role that I learned of the limited information available for those working with the population and of the obstacles many children could potentially face upon reunification.

During the time I worked as a case manager I was also working on completing my master's degree in counseling. Working with unaccompanied children helped me think about things differently. I wondered how certain therapeutic approaches, techniques, and assessments would be applicable to unaccompanied children when they were being discussed in class. I focused on bringing attention to the population through the work I did. Thankfully, having attended a university located in a border town the topic was not uncommon and some professors had even taken part in advocating for unaccompanied children through their work. When I completed my studies, I had the opportunity to transition from my role as a case manager to a clinician. As a clinician I was responsible for providing mental health services to unaccompanied

children. By that time, I had been working with unaccompanied children for three years; however, I was introduced to a completely new side of it and with that I found new meaning to working with unaccompanied children.

That same year I was accepted into the counselor education doctoral program. Throughout the program I focused on researching and learning more about the topic. Much of the information I found is related to the demographics and legal aspects of unaccompanied children. I found very little on their mental health or the work of mental health professionals in ORR settings. Through reviewing literature, I learned that a former student had focused her research on clinicians' experiences working with unaccompanied children. I, therefore, decided to expand on that by focusing my research on the therapeutic alliance between mental health professionals and unaccompanied children in an ORR setting. I wanted to learn about the process of developing a therapeutic alliance from the perspective of the clinicians working with the children and work to produce a framework for future research which is why I opted to utilize grounded theory methods in this qualitative research. It was also important to me that the data collected and generated represented the stories of the participants and not my own even with the personal experience I have working with unaccompanied children.

Research Question

The overarching research question for this study is: What is the process of developing therapeutic alliance among licensed mental health professionals who work with unaccompanied children in ORR?

Participants

In a grounded theory study, it is important to locate a homogenous sample, a sample comprised of individuals who have commonly experienced an action or process related to the

central phenomenon (Creswell & Poth, 2018). Mental health professionals providing therapeutic services to unaccompanied children in ORR emergency shelters in South Texas will be recruited for this study via email. The mental health providers recruited will be from two separate ORR shelters in South Texas. Each facility houses unaccompanied children ranging from ages 12 to 17 years old and provides medical, mental health, case management, educational, and recreational services to all unaccompanied children. Participants for this study will be recruited based on the following criteria: (a) each participant is currently employed at an ORR shelter in South Texas providing bilingual mental health services to unaccompanied children, (b) all participants will be required be licensed to provide mental health services in the state of Texas and in good standing, this includes individuals who are licensed in clinical mental health counseling, social work at a masters level, marriage and family therapy, or psychology and, and (c) each participant will be required to possess a minimum of one year experience working with unaccompanied children in an ORR shelter as a licensed professional.

Recruitment

An email outlining details of the study will be sent to individuals with whom the researcher has established a trusting relationship through work in ORR shelters to identify a homogenous sample. Snowball sampling will be implemented by asking them to forward the email to potential participants they believe fit the criteria to obtain information-rich cases (Creswell & Poth, 2018). The email will include a Qualtrics link for those who were interested in participating where they will be able to provide consent to the study. Potential participants will be invited to attend a video conference call through Zoom Video Communications to learn further details of the study. They will be informed their participation in the study will remain confidential.

It is significant to note that at the time of this study the corona virus (COVID-19) pandemic required social distancing order (Centers for Disease Control and Prevention [CDC], 2020). The virus resulted in some professionals working from home to safely practice social distancing. Due to COVID-19 social distancing protocols, no face-to-face meetings will be held and instead, video conference calls were held with those who are interested in learning more about the study. Individuals who agree to participate will submit digital consent through Qualtircs. Keeping in mind safety measures, the interviews and focus groups for this study will be conducted via video call utilizing Zoom Video Communications.

Data Collection Methods

Participants will provide demographic information and consent via Qualtrics. Each participant will participate in an individual semi-structured interview (See Appendix D). All interviews will be conducted via Zoom Video Communications. Additionally, participants will attend a focus group session via Zoom Video Communications. Two separate focus group sessions will be conducted to accommodate to participants' schedule and availability. The interviews and focus group will be recorded through Zoom Video Communications. An audio recorder will be used as a backup to account for any technical issues. All audio recordings will be digitally saved in a password protected file folder on a password protected laptop in the interviewer's household. No identifying information will be on the audio recordings. The themes identified from the interviews will be shared via e-mail with participants to obtain their feedback. The e-mail and the attached document will be password encrypted to address confidentiality. There are no other members residing in the household and therefore only the interviewer will have access to the stored data.

Trustworthiness

In qualitative research there are different strategies for achieving trustworthiness. In order to have trustworthiness credibility, transferability, dependability, and confirmability need to be established (Lincoln & Guba, 1985). Sikoila et al. (2013) noted the quality of a study employing grounded theory methodology can be improved by increasing the trustworthiness of the research. In efforts to increase the quality of this research there was a strong focus on fulfilling the guidelines to establish strong trustworthiness.

Credibility will be achieved in this study by using member reflections and triangulation. Member reflections will be obtained by emailing participants transcriptions of their individual interview and focus group as well as overarching themes identified. Participants will have the opportunity to expand if needed. Member reflections is a method employed to improve the qualitative credibility in diverse ways and moves past just the objective of ensuring the researcher got the information correct (Tracy, 2010). Member reflections in this study will be used to allow participants the opportunity to elaborate in order to have data that is rich and has depth. Through the process of member reflections in this study participants will have the opportunity to offer feedback on the accuracy of the data collected from their individual interview and focus group interview. Triangulation will be another technique used to ensure credibility. Triangulation consists of the researcher making use of multiple and different sources for validating the accuracy of the study (Creswell & Poth, 2018). The sources of data collected will be transcriptions of the semi-structured interviews and transcriptions of the focus group. The triangulation of data will aid to prevent researcher bias and to maintain consistency and integrity. In qualitative research, trustworthiness predicts that if there are similarities in two or more sources of the data then the conclusion is more reliable (Denzin, 1978).

Transferability denotes the pertinence of a set of findings to another setting (Sikoila et al., 2013). In this study transferability will be achieved by providing a thick description of the research and the participants. A detailed description of a phenomenon enables readers to determine the extent to which conclusions drawn can be applied in and to other settings, circumstance, individuals, and times (Amankwaa, 2016).

The process of auditing the research is helpful in establishing both dependability and confirmability (Cresewell & Poth, 2018). Dependability will be achieved by having an external researcher that is not involved in the research process examine an audit trail of the processes and product to obtain the reliability of the findings (Morrow, 2005). To achieve dependability, I will consult with my committee chair as the data is being collected and analyzed. Confirmability consists of demonstrating that the findings in the study are the result of the participant' responses and not resultant from researcher bias. Confirmability in this study will be met by maintaining an audit trail to help with triangulation. The audit trail will consist of a step-by-step description of the steps that were taken throughout the research process including raw data, written field notes, process notes, and reflexive notes (Lincoln & Guba, 1985). The notes will be maintained in a reflective journal throughout the process of the study to document steps taken and decisions made, in particular after interviews and as the data is being collected and coded simultaneously. The trustworthiness will be enhanced following the strategies Sikoila et al. (2013) outlined such making use of audit trails, peer reviewers, triangulation of data sources, and sharing transcripts of the individual interviews and developing elements and categories with participants.

Data Analysis

Constructivist grounded theory utilizes thorough procedures for analyzing data. This process is comprised of three phases of coding: (1) initial coding; (2) focused coding; and (3)

theoretical coding (Creswell & Poth, 2018). Essentially, this process consists of moving the raw data through levels of coding that ultimately lead to a theory being constructed. The data will be analyzed utilizing this method. According to Bryant and Charmaz (2007) in grounded theory the researcher does not wait until the data are collected to commence analysis; instead, the analysis must commence as soon as possible. Data will be analyzed during the initial data collection period, individual interviews, and continued by utilizing the developed understanding of the phenomena to gain further insight of the phenomena later in the data collection process, focus group. Ideas, concepts, and categories identified during the initial coding process will reduce the raw data to categories that characterized the research topic. The purpose of initial coding is to compare data to identify similarities and differences. Upon finishing each individual interview, the recording will be sent to a transcribing service, Go Transcript, to have interview transcribed. While waiting for the transcript of the interview I will begin listening to recordings to identify initial categories and other significant data that comes up. The second part of the coding process will be focused coding in which the codes were more selective than those identified during initial coding. Charmaz (2006) explained focused coding meant utilizing the most significant and/or frequent previous codes to filter through large quantities of data. This part of the coding procedure will be utilized to help narrow down the data. After receiving the transcript from each interview information will be reviewed in depth to identify selective categories. The codes that are identified will then be followed in the theoretical coding process. During this part of coding the theoretical codes that emerge will specify possible interconnections between the categories identified during focused coding.

It is important to note that throughout the coding process I will complete memos as the codes emerge and document ideas, thoughts about the meaning of codes, and steps taken during

the coding process. Memo writing will be helpful to make comparisons between the data and formulate questions that needed to be answered as the data was collected and analyzed. Birks and Mills (2015) consider memo writing to be an analytic process that is crucial to ensure quality in grounded theory. Throughout the process I will also send the transcripts and analysis of the datato the participants via email requesting feedback to ensure accuracy of the results.

REFERENCES

Amankwaa L. (2016) Creating Protocols for Trustworthiness in Qualitative Research. *Journal of Cultural Diversity, 23(3), 121–127.*

Asner-Self, K., & Marotta, S. (2005). Developmental indices among Central American immigrants exposed to war-related trauma: Clinical implications for counselors. *Journal of Counseling & Development, 83,* 162–171. https://doi.org/10.1002/j.1556-6678.2005.tb00593x

Asselin, M. E. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Staff Development*, 19, 99-103.

Becker Herbst, R., Sabet, R. F., Swanson, A., Suarez, L. G., Marques, D. S., Ameen, E. J., & Aldarondo, E. (2018). 'They were going to kill me': Resilience in unaccompanied immigrant minors. *The Counseling Psychologist*, *46*(2), 241-268. doi:10.1177/0011000018759769

Bernard, H. R., & Ryan, G. W. (2010). *Analyzing qualitative data: Systemic approaches.* Sage.

Birks, M., & Mills, J. (2015). *Grounded theory: A practical guide* (2nd ed.). London: SAGE Publications.

Bryant, A., & Charmaz, K. (2007). *The Sage handbook of grounded theory*. London: SAGE Publications.

Centers for Disease Control and Prevention. (2020). *How to Protect Yourself & Others*. https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage.

Charmaz, K. (2006). *Constructing grounded theory.* Sage

Chen, A., & Gill, J. (2015). Unaccompanied children and U.S. immigration system: Challenges and reforms. *Journal of International Affairs,* 68(2), 115–133.

Children entering the United States unaccompanied: Section 2. The Administration for Children and Families. (2022, March 8). Retrieved May 3, 2022, from https://www.acf.hhs.gov/orr/policy-guidance/children-entering-united-states-unaccompanied-section-2

Chishti, M., & Hipsman, F. (2015). The child and family migration surge of summer 2014: A short-lived crisis with a lasting impact. *Journal of International Affairs, 68*(2), 95–114. Retrieved from https://manowar.tamucc.edu/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=102305759&site=ehost-live&scope=site

Ciaccia, K. A., & John, R. M. (2016). Unaccompanied immigrant minors: Where to begin. *Journal of Pediatric Health Care,* 30(3), 231.240.

Congressional Research Service. (2021, February 2) *The Trump administration's "Zero Tolerance" immigration enforcement policy* (CRS Report No. R45266) Retrieved from Congressional Research Service website: https://sgp.fas.org/crs/homesec/R45266.pdf

Corbin, J., & Strauss, A. (2007). Basics of qualitative research: Techniques and procedures for developing grounded theory (3rd ed.). Sage.

Corbin, J., & Strauss, A. (2015). *Basic of qualitative research: Techniques and procedures for developing grounded theory.* (4th ed.). Sage.

Crea, T. M., Lopez, A., Hasson, R. G., Evans, K., Palleschi, C., & Underwood, D. (2018). Unaccompanied immigrant children in long term foster care: Identifying needs and best

practices from a child welfare perspective. *Children & Youth Services Review*, *92*, 56–64. https://doi-org.manowar.tamucc.edu/10.1016/j.childyouth.2017.12.017

Creswell, J.W., & Plano Clark, V.L. (2011) *Designing and conducting mixed method research.* (2nd ed.) Sage.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches*. Sage.

Crossetti, M. O., Goes, M. G., & de Brum, C. N. (2016). Application of constructivist grounded theory in nursing research. *The Qualitative Report*, 21, 48-53. https://nsuworks.nova.edu/tqr/vol21/iss13/5

Denzin, N.K. (1978). *Sociological methods: A sourcebook* (2nd ed.) McGraw Hill.

Denzin, N. K., & Lincoln, Y. S. (2011). Introduction: The discipline and practice of qualitative research. *The sage handbook of qualitative research* (4th ed.). Sage.

Department of Homeland Security. (2022, April 18). *Nationwide encounters*. U.S. Customs and Border Protection. Retrieved May 4, 2022, from https://www.cbp.gov/newsroom/stats/nationwide-encounters

Dwyer, S. C., & Buckle, J. L. (2009). The Space Between: On Being an Insider-Outsider in Qualitative Research. *International Journal of Qualitative Methods,8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Ellis, C. (1995). Final negotiations. Philadelphia: Temple University Press.

Everly, G. S., Jr, & Lating, J. M. (2004). Personality-guided therapy for posttraumatic stress disorder.: American Psychological Association.

García, C., Gilchrist, L., Vazquez, G., Leite, A., & Raymond, N. (2011). Urban and rural immigrant latino youths' and adults' knowledge and beliefs about mental health

resources. *Journal of Immigrant & Minority Health*, *13*(3), 500-509. doi:10.1007/s10903-010-9389-6

Gulbas, L. E., & Zayas, L. H. (2015). Examining the interplay among family, culture, and latina teen suicidal behavior. *Qualitative Health Research*, *25*(5), 689–699. https://doi-org.manowar.tamucc.edu/10.1177/1049732314553598

Handwerk, M., Huefner, J., Ringle, J., Howard, B., Soper, S., Almquist, J., … Father flanagan's boys' home. (2008). The role of therapeutic alliance in therapy outcomes for youth in residential care. *Residential Treatment for Children & Youth*, *25*(2), 145–165. https://doi-org.manowar.tamucc.edu/10.1080/08865710802310152

HHS Office, & Public Affairs. (2019, November 27). Latest UAC Data – FY2019. Retrieved from https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/latest-uac-data-fy2019/index.html.

Huemer, J., Karnik, N. S., Voelkl-Kernstock, S., Granditsch, E., Dervic, K., Friedrich, M. H., & Steiner, H. (2009). Mental health issues in unaccompanied refugee minors. *Child & Adolescent Psychiatry & Mental Health*, *3*, 1–10. https://doi-org.manowar.tamucc.edu/10.1186/1753-2000-3-13

Journal of Multicultural Counseling and Development - Wiley Online Library. (2020). Retrieved June 21, 2022, from https://onlinelibrary.wiley.com/page/journal/21611912/homepage/productinformation.html

Kanuha, V. K. (2000). "Being" native versus "going native": Conducting social work research as an insider. *Social Work*, 45, 439-447.

Keles, S., Friborg, O., Idsøe, T., Sirin, S., & Oppedal, B. (2018). Resilience and acculturation among unaccompanied refugee minors. *International Journal of Behavioral Development*, *42*(1), 52-63. doi:10.1177/0165025416658136

Keller, A., Joscelyne, A., Granski, M., & Rosenfeld, B. (2017). Pre-migration trauma exposure and mental health functioning among Central American migrants arriving at the US border. *PLoS ONE, 12*(1), 1–11. https://doi-org.manowar.tamucc.edu/10.1371/journal.pone.0168692

Kenny, M., & Fourie, R. (2015). Contrasting classic, straussian, and constructivist grounded theory: Methodological and philosophical conflicts. The qualitative report, 20, 1270-1289. http://nsuworks.nova.edu/tqr/vol20/iss8/9

Kopala, M., & Suzuki, L. A. (1999). *Using qualitative methods in psychology*. (M. Kopala & L. A. Suzuki, Eds.). Sage Publications, Inc

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. *European Journal of General Practice*, *24*(1), 120–124. https://doi: 10.1080/13814788.2017.1375092

Lincoln, Y.S. & Guba, E. (1985), *Naturalistic Inquiry.* Sage.

Morrow, S. L. (2005). Quality and Trustworthiness in Qualitative Research in Counseling Psychology. *Journal of Counseling Psychology*, *52*(2), 250–260. https://doi-org.manowar.tamucc.edu/10.1037/0022-0167.52.2.250

Nctsnadmin. (2018, June 27). *Children with traumatic separation: Information for professionals*. The National Child Traumatic Stress Network. Retrieved May 4, 2022, from https://www.nctsn.org/resources/children-traumatic-separation-information-professionals

Olcoń, K., & Gulbas, L. E. (2018). “Because that’s the culture”: Providers’ perspectives on the mental health of latino immigrant youth. *Qualitative Health Research,* 28(12), 1944–1954. https://doi-org.manowar.tamucc.edu/10.1177/1049732318795674

Passel, J. S. (2011). Demography of immigrant yuth: past, present, and future. *Future of Children*, *21*(1), 19-41.

Patton, M.Q. (2002), *Qualitative research and evaluation methods*, (3rd ed.), Sage.

Patton, M. Q. (2015). Qualitative research and evaluation methods (3rd ed.). Sage.

Pejic, V., Alvarado, A. E., Hess, R. S., & Groark, S. (2017). Community-based interventions with refugee families using a family systems approach. *Family Journal*, *25*(1), 101–108. https://doi-org.manowar.tamucc.edu/10.1177/1066480716680189

Penrod, J., Preston, D. B., Cain, R. E., & Starks, M. T. (2003). A discussion of chain referral as a method of sampling hard-to-reach populations. *Journal of Transcultural Nursing*, *14*(2), 100. https://doi-org.manowar.tamucc.edu/10.1177/1043659602250614

Ranjbar, N. (2019). Psychiatric--legal partnerships addressing family separation at the border and the long-term effects of trauma. *American Journal of Family Law*, *33*(3), 325–337.

Riley, A. H., Tellez Lieberman, J., Ataiants, J., Cohen, C., Reidy, M. C., & Chilton, M. (2018). Unaccompanied children at the United States border, a human rights crisis that can be addressed with policy change. *Journal of Immigrant & Minority Health*, *20*(4), 1000–1010. https://doi-org.manowar.tamucc.edu/10.1007/s10903-017-0577-5

Shifter, M. (2012). *Countering criminal violence in Central America*. Council on Foreign Relations Press.

Sikolia, D., Biros, D., Mason, M., & Weiser, M. (2013). Trustworthiness of grounded theory methodology research in information systems. *MWAIS 2013 Proceedings*, 16. Retrieved

from http://aisel.aisnet.org/mwais2013/16

Solomon, P., Drain, J., & Delaney, M.A. 1995. The working alliance and consumer case management. *Journal of Mental Health Administration,* 22, 126–134.

Sotomayor-Peterson, M., & Montiel-Carbajal, M. (2014). Psychological and family well- being of unaccompanied Mexican child migrants sent back from the U.S. border region of Sonora-Arizona. *Hispanic Journal of Behavioral Sciences*, *36*(2), 111–123. https://doi-org.manowar.tamucc.edu/10.1177/0739986314523560

Stovall-McClough, K. C., & Cloitre, M. (2006). Unresolved attachment, PTSD, and dissociation in women with childhood abuse histories. Journal of Consulting and Clinical Psychology, 74(2), 219.

Suri, H. (2011). Purposeful sampling in qualitative research synthesis. *Qualitative Research Journal*, *11*(2), 63–75. doi: 10.3316/qrj1102063

Trafficking victims protection reauthorization act safeguards children. National Immigration Forum. (2018, October 17). Retrieved May 3, 2022, from https://immigrationforum.org/article/trafficking-victims-protection-reauthorization-act-safeguards-children/

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16,* 837-851. doi:10.1177/1077800410383121

Tyrer, R. A., & Fazel, M. (2014). School and community-based interventions for refugee and asylum seeking children: A systematic review. *PLoS ONE*, *9*(2), 1–10. https://doi-org.manowar.tamucc.edu/10.1371/journal.pone.0089359

U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement. (2016). Unaccompanied children’s program. Retrieved

from http://www.acf.hhs.gov/sites/default/files/orr/orr_uc_updated_fact_sheet_1416.pdf

Wertz, F. J. (2011). *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry*. Guilford Press.

"Zero Tolerance" Immigration Enforcement: Administration policy on border crossing. (2018). *Congressional Digest*, *97*(7), 4–8.

APPENDIX A RECRUITMENT EMAIL

Hello,

My name is Wendy Rivera, and I am a doctoral candidate at Texas A&M University-Corpus Christi in the Counselor Education and Supervision program. I am currently conducting a qualitative study to explore the therapeutic alliance process from the perspective of mental health professionals serving unaccompanied immigrant children in an Office of Refugee Resettlement (ORR) setting. Participation in this study is voluntary. You may decide not to participate or withdraw at any point. Your participation in this study will remain confidential.

If you are interested in learning more about this research study and participating in the study, please click the link below.
https://tamucc.co1.qualtrics.com/jfe/form/SV_5nzEkMeo2BEyC4l
If you know other individuals who meet the criteria and think they would be interested in participating in the study, please feel free to share this email with them.

I am available to answer any questions or concerns you may have regarding the study. You may reach me at wrivera@islander.tamucc.edu or at (956) 372-0413.

Thank you for your help.
Wendy Rivera, M.Ed., LPC
Doctoral Candidate, | Department of Counseling and Educational Psychology
Texas A&M University- Corpus Christi

APPENDIX B DEMOGRAPHIC INFORMATION

Please do not include any personal identifiable information on this form. Information collected on this form will not be linked to your responses in this study and will not affect your participation in this study.

For the following items please select the response that you identify with and fill in the blank for those necessary.

Gender:

☐Male ☐Female

☐Prefer not to answer ☐Other: Click here to enter text.

Age:

Click here to enter text.

Race or Ethnicity:

☐White ☐American Indian or Alaskan Native

☐Black or African American ☐Asian

☐Native Hawaiian and Pacific Islander

☐Hispanic, Latino, or Spanish

☐Middle Eastern or North African

☐Other Click here to enter text. ☐Do not wish to answer

How long have you provided mental health services to unaccompanied children?

Click here to enter text.

Are you fully licensed (with good standing) to provide mental health services in the state of Texas? ☐Yes ☐ No

☐No

Please identify your professional license:

☐Licensed Professional Counselor

☐Licensed Marriage and Family Therapist

☐Licensed Master Social Worker

☐Licensed Psychologist

☐Other – Please specify: Click here to enter text.

APPENDIX C INFORMATION SHEET

UNDERSTANDING MENTAL HEALTH PROFESSIONALS' PERSPECTIVES OF THERAPEUTIC ALLIANCE IN WORKING WITH UNACCOMPANIED CHILDREN: A GROUNDED THEORY APPROACH

Introduction

The purpose of this form is to provide you with information about a qualitative research study that may help you decide whether or not you choose to participate in this study. Please read the information in this form and ask questions about anything you do not understand. You were asked to participate in this study because you are over the age of 21 and able to provide consent to participate in the study. Criteria for individuals able to participate in this study can be found below.

Why is this research being done?

The purpose of this research study is to utilize grounded theory methods to elicit ways mental health professionals who work in Office of Refugee Resettlement (ORR) shelters approach and build the therapeutic alliance process with unaccompanied children in these shelters. Objectives of this qualitative study include (a) to gain an understanding of the process of the process of developing therapeutic alliance when working with unaccompanied immigrant children; (b) to understand specific qualities and skills used by mental health professionals to foster therapeutic alliance; and (c) to obtain information regarding potential barriers mental health professionals perceive in establishing therapeutic alliance in an ORR setting.

Who can be in this study?

To be a part of this research study you will need to be a clinician in good standing in the state of Texas who is working with unaccompanied immigrant children in an ORR setting.
To be eligible to participate in this study, you

- must be 21 years of age or older
- must hold a master's or doctoral degree in social work, counseling, marriage and family therapy, or psychology
- must be currently licensed and in good standing as a social worker, counselor, marriage and family therapist, or psychologist
- must have a minimum of one year of experience providing mental health services to unaccompanied immigrant children in an ORR setting.

What will I be asked to do?

If you choose to participate in this study you will be asked to complete a one-page demographic form and an individual interview. After the individual interview you offered the opportunity to provide feedback via email on initial identified themes in your interview. Last, you will be invited to participate in a focus group. The interview seeks to gain information about the therapeutic alliance process when working with unaccompanied immigrant children in an ORR setting. The focus group also seeks to gain information about the therapeutic alliance as well as participants' feedback about the researcher's initial findings.

Should you choose to participate in this study the average expected time for your participation will be five minutes or less to complete the demographic form, 45 minutes to an hour to complete the individual interview, and approximately one hour to complete the focus group. If you choose to provide email feedback regarding your initial interview, the estimated time that might take is 15 minutes, although you will be welcome to provide as little or as much feedback as you wish. The maximum anticipated time is 2 hours and 20 minutes. The individual interview and focus group will be recorded.

What are the risks involved in this study?

This research involves minimal risks or risks that are no more than what you may experience in everyday life. The main risk may include:

- Your participation will involve collecting information about you. There is a slight risk of loss of confidentiality. Your confidentiality will be protected to the greatest extent possible. You do not have to give any information to the study that you do not want to give. Pseudonyms will be used in the study to protect the identification of participants.
- If you choose to participate in this study, your interview will be audio recorded. Any audio recordings will be stored securely in a password-protected file. Any recordings will be kept until it has been transcribed. After transcription and verification of the transcription's accuracy, the recording will be permanently deleted.

What are the alternatives to being in this study?
Instead of being in this study, you may choose not to be in the research study.

What are the possible benefits of this study?
There may be no direct benefit to you from being in this research study. By being in this study, you may help researchers learn more about establishing therapeutic alliance with unaccompanied immigrant children in ORR settings in the future. Benefits to society could involve mental health professionals learning more about the therapeutic alliance process when providing mental health services to this vulnerable population in a unique setting. Due to a high number of unaccompanied immigrant children migrating to the United States and being referred to ORR centers the therapeutic alliance process needs to be explored.

What will I receive if I am in the study?
You will not receive any payment for participating in this study.

Do I have to participate?
No. Your participation in this study is completely voluntary. You may decide not to take part in this study or withdraw at any time. If you choose not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled.

What if I change my mind?
You may quit at any time. There will be no penalty or loss of benefits to which you are otherwise entitled.

You may decide not to participate or quit at any time without your current or future relations with Texas A&M University-Corpus Christi or any cooperating institution being affected.

What about protecting my information?
This study is confidential.

When information collected about you includes identifiers (like name, email, and phone number) the information is confidential.

Your information will be protected in the following ways:

- The interview once transcribed will be anonymized (a process by which identifying information is removed) by using pseudonyms (a fictious name). The interview recording will be deleted after transcription.
- All research records will be kept securely.
- Research records will be seen only by authorized research team members.
- We will share your information only when we must, will only share the information that is needed, and will ask anyone who receives it from us to protect your privacy.
- No identifiers linking you to this study will be included in any report that might be published or presentation.

Once data analysis is complete, any remaining identifiers will be removed from the research data. Your information collected as part of this research, even after identifiers are removed, will not be used or distributed for future research studies.

Who can I contact with questions about the research?
You may call Wendy Rivera (Doctoral Candidate Researcher) at 956-372-0413, or email wrivera@islander.tamucc.edu with any questions. You may also contact Dr. Marvarene Oliver at Marvarene.Oliver@tamucc.edu.

Who can I contact about my rights as a research participant?

You may also call Texas A&M University-Corpus Christi Institutional Review Board (IRB) with questions or complaints about this study at irb@tamucc.edu or 361-825-2497. The IRB is a committee of faculty members, statisticians, researchers, community advocates, and others that ensures that a research study is ethical and that the rights of study participants are protected.

CONSENT TO PARTICIPATE

To participate in this research study, click the following link _____ to begin completing the demographic form. By following the link and completing the demographic, you are agreeing to participate in the study. By participating in this study, you are also certifying that you are 18 years of age or older.

If you do not agree to participate in the research study, please exit this form and do not fill out the demographic form.

APPENDIX D INTERVIEW QUESTIONS

1. Tell me about how a skilled mental health professional would establish a therapeutic alliance with unaccompanied immigrant children in an ORR setting.

Follow up question. Examples: Could you say more about that? What do you mean by that?

2. Based on your experience, what skills have you observed are more or less effective in helping build the therapeutic alliance with unaccompanied children?

Follow up question. Examples: Could you say more about that? What do you mean by that?

3. What qualities do you believe a mental health professional working with unaccompanied children should possess to aid in the therapeutic alliance process?

Follow up question. Examples: Could you say more about that? What do you mean by that?

4. Tell me about any challenges you have encountered when working to build a therapeutic alliance with unaccompanied children in an ORR shelter?

Follow up question. Examples: Could you say more about that? What do you mean by that?

5. Tell me about any ways establishing a good therapeutic alliance aids unaccompanied children in therapy while in care.

Follow up question. Examples: Could you say more about that? What do you mean by that?

6. Tell me about how having a good therapeutic alliance may help unaccompanied children after they discharge.

Follow up question. Examples: Could you say more about that? What do you mean by that?

7. Tell me about building therapeutic alliance when conducting telehealth sessions.

Follow up question. Examples: Could you say more about that? What do you mean by that?

8. What do you think all mental health professionals should learn regarding establishing a therapeutic alliance with unaccompanied immigrant children in an ORR setting?

Follow up question. Examples: Could you say more about that? What do you mean by that?

9. What else about establishing a therapeutic alliance with children in ORR would you like to share?

APPENDIX E INTERVIEW FOLLOW-UP EMAIL

Hello,

The attached document contains initial themes that were identified from the information you provided during your individual interview. Please provide any comments or feedback you have about the themes I developed, including the extent to which you think I have accurately captured what you wish to communicate. I want to be sure I am representing your thoughts correctly.

Please respond within two weeks of this email, even if to simply indicate you agree. You can give as much or as little feedback as you wish. If I do not hear from you by that time, I will move forward with my interpretation of our interview.

Thank you for your consideration.

Wendy Rivera, M.Ed., LPC
Doctoral Candidate,| Department of Counseling and Educational Psychology
Texas A&M University- Corpus Christi

APPENDIX F FOCUS GROUP EMAIL INVITATION

Dear participant,

I would like to invite you to take part in a focus group (small discussion group) on Sunday, October 3, 2021, at (**6:00 PM**) or on Tuesday, October 5, 2021, at (**6:30 PM**) via Zoom Communications about the initial findings from the interviews about your experience in building therapeutic alliance with unaccompanied immigrant children. The focus group should last no longer than one hour.

The focus group will provide you and other participants the opportunity to share your perspectives about my tentative findings as you talk with me and each other. Please respond to this email confirming your interest and letting me know which group you prefer to attend. I will then send a link for the Zoom meeting to your email.

If you have any questions regarding the focus group you can reach me at wrivera@islander.tamucc.edu or at (956) 372-0413.

Thank you again for your willingness to participate in this research.

Wendy Rivera, M.Ed., LPC
Doctoral Candidate| Department of Counseling and Educational Psychology
Texas A&M University- Corpus Christi

PART V: PROJECT REPORT

Changes to Research

There were no changes made to the research design. The overall concept of the study remained the same.

Target Journal

The manuscript was written for the Journal of Multicultural Counseling and Development, a journal from the Association for Multicultural Counseling and Development. The Association for Multicultural Counseling and Development is a division of the American Counseling Association.

"The Journal of Multicultural Counseling and Development (JMCD) is concerned with research, theory, and program applications related to multicultural and ethnic minority interests in areas of counseling and human development" (Journal of Multicultural Counseling, 2020, para. 1). The Journal of Multicultural Counseling and Development is a peer reviewed journal that publishes quarterly. The journal does not specify a page limit and should follow Publication Manual of the American Psychological Association (7th ed.) or the Chicago Manual Style.

This journal was most appropriate for this manuscript as the focus of the study matches the overall scope of the journal. The research at hand focused on the experiences of mental health professionals providing services to UIC, a population from diverse cultural backgrounds, in efforts to identify best counseling practices. Readers may find information applicable to their practice and informative.

Committee Commentary and Candidate Response

After dissertation proposal presentation members of my committee provided feedback and suggestions. Feedback and suggestions were discussed with the dissertation chair for

additional guidance prior to making any changes. No changes were made to the research design. The feedback is included below:

Committee Commentary	Candidate Response
1. Word overarching research question differently [Gerlach, Smith]	The research question was reworded to reflect the purpose of the study.
2. Include terms and definitions to chapter 1.	I added common terms and definitions to Ch.1.
3. Highlight the sample of the study, mental health professionals providing services to UIC to tie in the study and sample [Smith]	I added information about sample population
4. Overall, more depth and expansion in Ch. 2 sections [Gerlach]	I added additional information related to UIC, results of studies cited, numbers/statistics of UIC updated, and other policy factors throughout chapter 2.
5. Include interview protocol Ch. 3 [Gerlach]	I added participant interview information
6. Grammatical and style recommendations [Gerlach, Smith, Oliver]	Changes were made throughout dissertation

Abstract

The purpose of this study was to understand the experiences of mental health professionals building therapeutic alliance with unaccompanied immigrant children (UIC) in an Office of Refugee Resettlement (ORR) setting. Data collected from six participants from individual interviews and focus groups was utilized to generate elements essential to the process of developing therapeutic alliance with UIC in ORR shelters. Grounded theory analysis methods were used to develop elements. The elements identified important in the process of developing therapeutic alliance with UIC in care include (a) policy impacts treatment, (b) boundaries, (c) limitations due to setting (d), cultural competency (e), creating a safe environment (f), and impacts of COVID-19. The findings outline unique aspects of ORR that impact the treatment and other factors important to know when working with UIC. Findings from this study may be useful for other mental health professionals working with UIC and supervisors providing supervision to mental health professionals providing counseling to UIC. Future research should include aspects of building therapeutic alliance in other ORR settings. More work can be done to educate communities and mental health professionals in other settings about the unique needs of UIC and the work that mental health professionals in ORR settings do to meet those needs.
Keywords: Unaccompanied Immigrant Children, mental health professionals, therapeutic alliance, Office of Refugee Resettlement, qualitative

Understanding Mental Health Professionals' Perspective of Therapeutic Alliance in Working with Unaccompanied Children

The number of unaccompanied immigrant children (UIC) migrating to the United States (U.S.) has significantly increased through the years. United States Customs and Border Protection (CBP) Encounters with UIC for the Fiscal Year (FY) 2021 was documented at the high number of 147, 975 nationwide, many of them migrating from Central America (U.S. Customs and Border Protection, 2022). By statute, unaccompanied alien children are defined as children under the age of 18 entering the country without a parent or legal guardian and who lack a legal immigration status (Congressional Research Service, 2019). Following their detainment, the general process for UIC entering the United States is to undergo an initial health screening and receive placement at a Health and Human Services shelter where they remain until a sponsor in the United States is identified with whom they can be placed pending outcome of the immigration process. Many of them endure a treacherous journey to the United States.

A substantial number of UIC endure significant trauma prior to, during, and after their journey including escaping violence, separation from their families, sexual abuse, and human trafficking (Crea et al., 2018; Riley et al., 2018). The trauma experienced by UIC pre-migration, during the journey, and post-migration may have detrimental effects on their mental health. Despite the alarming rate of UIC that continue migrating to the. United States and needing care, there is not much known about the mental health needs, best practices, or process needed to be able to meet the unique needs of UIC.

The purpose of this qualitive study was to utilize grounded theory methods in efforts to understand the experiences of mental health professionals developing the therapeutic alliance process with unaccompanied immigrant children in an ORR setting. The data consisted of a

semi-structured interviews and a focus group to learn from the experiences of mental health professionals treating unaccompanied immigrant children in an ORR setting. The overarching research question was, “What is the process of developing therapeutic alliance among licensed mental health professionals who work with unaccompanied children in ORR?” The study was conducted with the intention of gaining an understanding of the unique needs of unaccompanied immigrant children in the therapeutic process.

Method

Grounded theory methods were employed to conduct this qualitative study. While the intent of this study was not to generate theory, this methodology was appropriate because it allowed be to look beyond descriptions and consider common elements or process in the practice of mental health professional working with a specific population within a specific organizational context (Corbin & Strauss, 2007). The core of a grounded theory design is characterized by generating a theory from participants who have experienced the problem (Merriam & Tisdell, 2016). While no attempt was made to generate a specific theory, I worked with data collected from participants working in the field with the identified problem to identify common elements noted previously. The interviews in this study were used to gather data about building the therapeutic alliance process with unaccompanied children within an ORR context. The focus group allowed participants to expand on initial elements and provided the opportunity for additional data to be gathered.

Purposeful sampling was used to ensure information-rich cases were identified. Snowball sampling was implemented to allow participants to make referrals in efforts to recruit more participants. A total of 6 participants were identified for this study. 5 of those participants were females and there was 1 male participant. Participants ranged from ages 29-46 and identified as

Hispanic, Latino, Spanish. The range that participants had been providing mental health services in an ORR setting at time the study was conducted was between 1.5 – 3 years. Of the 6 participants 3 were Licensed Professional Counselors (LPC) and 3 were Licensed Master Social Workers (LMSW).

Data Collection

Data in this study was collected from participants through individual interviews and a focus group. Participants were given the opportunity to choose their pseudonyms to ensure confidentiality. Of the six participants, five picked their pseudonyms and one asked that I pick the pseudonym. All interviews were conducted via Zoom Communications due to participant location and as a precautionary method due to COVID-19. The individual interviews lasted between 23 minutes and 47 minutes. The interviews were semi-structured in which pre-generated questions were used, with follow-up questions used as needed obtain additional information from participants. A total of two focus groups were held on different dates to allow participants to accommodate to participants schedule and availability. Out of the six participants only five were able to participate in the focus group. Participant unable to participate was deployed due to influx of minors. One focus group consisted of two female participants and the second consisted of three participants, one male and two female participants. The questions for the focus group were generated based on the common themes identified from the individual interviews. Six interviews for participants and two focus groups were recorded and transcribed.

Data Analysis

A constructivist grounded theory detailed analysis procedure was used to identify elements from data collected. The analysis procedure consisted of moving the raw data through levels of coding starting with the initial coding. The data analysis commenced as soon as the

individual interviews were conducted, I listened to audio of each interview. I read and re-read transcripts of each interview, identifying distinct concepts and categories that addressed the overarching research question. I the utilized focused coding to reduce the categories identified during initial coding into more selective elements. I then examined possible connection between the elements identified in the previous step. Elements identified during individual interviews were written out and sent to participants to request their feedback; all six participants responded with no changes requested to be made. The data collected from the focus groups allowed for the comparison of elements and provided more in-depth insight of the elements. Memos were made throughout the analysis process to record my thoughts about how to organize and categorize data.

Findings

Data from individual interviews and a focus group resulted in identification of six elements that impact development of therapeutic alliance in the ORR facilities in which they worked.

Policy Impacts Treatment

Participants noted that policy impacts treatment, including the process of building therapeutic alliance. Policies may be specific to a particular location or a result of laws and regulations; whatever the original source of the policies, they play a role in how a clinician builds therapeutic alliance. Policy factors identified by these participants include timeframes, confidentiality, requirements to obtain specific types of or additional information, and services offered per policy.

Timeframes

Participants noted that the length of stay of unaccompanied immigrant children varies by reunification category for each case and not the mental health needs of clients. Mari explained it succinctly when she said, “Category 1s [minor reunifying with a parent or legal guardian], especially right now, they are speeding those cases up, so we don’t get to develop much relationship.” Touching on what Mari shared Bailey stated, “Compared to the ones that stay there longer you actually develop a relationship getting to know their goals and stuff like that.” Kelly described ambiguity of the time mental health professionals will have to address trauma when there is a disclosure due to timeframes stating:

> As a clinician, is then how deep do I dig or search for all these feelings or emotions or trauma, and how much time am I going to have to process if I open this big old can of repressed or past history and then they tell me, "Hey, we're going to submit the case next week." Whoa, I just opened a big old can of worms kind of thing.

During her interview Mary explained that the reunification process affects how effective therapy services can be due to time limitations stating, “It affects how effective we are as a clinician and whether they get anything at all out of the clinical services, because I guess we’re dependent on that [reunification status].” Mary’s statement, “We’re in the hands of the type of reunification the child has” demonstrates how impactful policy timeframes are to the process of building the therapeutic alliance.

Confidentiality

Participants indicated that there are many things mental health professionals working in ORR settings must share with stakeholders; thus, confidentiality is limited more than it would be if a minor were seen in another setting, which can impact development of therapeutic alliance.

Mari shared, “When you’re engaging a child during intake and they disclose something . . . that’s not necessarily confidential. We have to report it automatically to the government because of policy. It kind of affects your relationship.” Mari, in describing an experience she had with a minor after a case manager discussed a disclosure with him, stated, “I’ve been confronted by a minor once and it was very hard to rebuild our relationship or the trust. I lost it. I lost a client basically.” Blue elaborated that some unaccompanied immigrant children have told him, “I wish I could tell you things, but I know that somehow it’s going to affect me. That really poses a hesitation on [sic] the client.” Unaccompanied children hesitate to disclose because they know what they share does not remain confidential and can potentially affect their case. Participants noted it is important to explain the specifics of the limits of confidentiality when building therapeutic alliance with unaccompanied immigrant children.

Requirement to Obtain Additional Information

Participants shared that policy affects the information and details they need to obtain from minors when there is a disclosure of traumatic events. Sandra explained that policies require counselors to further inquire about traumatic events children disclose. She stated:

> I don’t know [that] . . . it is ethical . . . or therapeutic for the child if it’s going to worsen the situation if we keep inquiring about traumatic events, but due to all our policies and requirements we are encouraged to inquire [about] details and dates about these traumatic events.

Mary echoed what Sandra shared, stating “You have to keep asking them and asking them about what they said. I can definitely see how that can affect the therapeutic relationship.” Some participants described that doing so feels as though they are being intrusive. Mari shared

> Sometimes I feel like I’m intrusive . . . finding out more and investigating about their

> trauma or history of something and normally would want for the client to disclose when they are ready . . . I feel like they weren't ready to disclose so it affects us building the relationship . . ..

Services Offered per Policy

Participants explained that, by policy, unaccompanied immigrant children receive an array of services while they are in care in an ORR shelter. Participants emphasized in other settings individuals commonly seek counseling services, unlike in ORR shelter where services are automatically provided upon enrollment. During the focus group Blue stated, "It's not like they're looking for counseling, so it's kind of like a mandatory." Mary shared a similar sentiment and adding that often clinical services are no longer needed for continuity of care, "and you just have to continue on for the sake of the policies and the child gets bored here."

The policy factors were emphasized by participants as having an impact when building or maintaining the therapeutic alliance. Participants noted they work to maintain the integrity of the policies implemented but would like to have some more flexibility to foster the therapeutic alliance. Participants shared that mental health professionals working in an ORR setting must be aware of how policies may affect the therapeutic alliance process and be prepared to find alternatives while still adhering to the policies.

Boundaries

Participants explained that establishing boundaries in an ORR setting is essential in the process of building therapeutic alliance. The boundaries may differ depending on the shelter, but there was an emphasis on how they aid the development of therapeutic alliance. The data reflected two different types of boundaries described by participants: boundaries due to setting and boundaries due to culture.

Boundaries due to Setting

Participants explained that the setting is unlike other settings as an ORR shelter operates 24/7. Participants noted that setting boundaries is important in the process of fostering therapeutic alliance to ensure boundaries are not blurred. Bailey pointed out that with the children being in care a shelter that operates around the clock it is imperative to know your boundaries and described residents being observant stating:

> They know what you are driving. They're there all the time. Always being closed about your personal life, so it can focus on them. That's what I'm saying, like boundaries. They do ask a lot, because they're bored, too. I guess they're looking for a friend.

Kelly reiterated that the "children" are in the shelter all day every day until they are discharged to their families. She stated that, as a result, the children start learning the schedules of the workers. Kelly noted that counselors need to be intentional with the boundaries they set. Kelly described boundaries stating, "I think the setting gives itself, for boundary, a problem. Not a problem, but just the kids start to ask for you to see them and then seeing them every day, or seeing them every other day when in reality, if you have clients in the community, how often are you scheduling their session compared to a child who is there every single day? Then the clinician is accessible at a moment's notice, right?" She added, "We're trying our best to establish a positive and strong therapeutic alliance, but we just have to be very cautious of not enabling their dependency or enabling them because then we're not going to do them any good."

Boundaries due to Culture

Some participants shared during their interviews and again during the focus group that it is important to set boundaries because some of the residents are not familiar with boundaries due

to cultural norms. From female participants there was an expressed need to set boundaries and be firm with boundaries when working with male unaccompanied immigrant children. Bailey stated, "Knowing your boundaries – I think that's number one." Mari agreed and noted,

> They haven't grown with those boundaries, or maybe they haven't been brought up with the same idea, or maybe like Bailey says, it's their culture. We do have teenagers who are married, that have various kids, so they already come with the mindset that they're adults. Sometimes with those boundaries they get confused. We've had a lot of incidents where minors are writing letters to clinicians or they're basically declaring their love, so they confuse the relationship or the service that we're trying to provide.

Blue, the only male participant, discussed how culture plays a role in the boundaries differently for him when working with female residents stating, "Due to their culture, they're not allowed to be with a male maybe, especially if you don't know the person." Blue described that he has observed female residents be shy not providing eye contact and very reserved at times during session and he understands he has to take his time and respect the boundaries the resident has because of their culture.

Limitations due to Setting

As participants expanded on elements important to facilitation of therapeutic alliance when working in an ORR setting, they noted limitations that are a result of the setting itself. The limitations varied from shelter to shelter as participants in this study were employed in different shelters. Limitations vary with the site for instance availability of space to conduct therapy sessions and safety restrictions impacting therapeutic sessions.

Some participants reported not having a proper space to hold counseling sessions impacted the process of building the therapeutic alliance when meeting with unaccompanied

immigrant children. Bailey reported it was difficult to work on building a strong therapeutic alliance because the shelter she worked at did not have designated offices for mental health professionals to conduct their sessions. She described the setting she worked in stating,

> We have clear pods that we see our minors, where we do our clinical session. Sometimes, if they break down, they want to cry because some of the stuff they say is rough, a lot of them are not going to want to be crying where another minor is going to see them because then they're going to get made fun of.

She noted that it is difficult to talk about sensitive topics while working on building the therapeutic alliance because the minors do not feel comfortable being in a space where others can see them. She added that it would be different if they had an office where those sessions could take place. Mari shared a similar experience

> We have to do it in open areas, visible where the cameras are visible where all the staff is. It's not always very private and I know that it doesn't offer the most comfortable setting or where they can feel that we are going to keep everything confidential because there's people passing.

Safety measures implemented in ORR shelters were described to pose as a limitation in building therapeutic alliance. Mary, who worked in a different shelter, described that due to safety precautions mental health clinicians are limited to the activities they can do to help build rapport with UIC. When describing challenges Mary noted,

> I guess a lot of it is the limitations of what we're able to provide the child because of safety means within the facility. Like, say, we're not able to do certain activities, we're not able to provide them certain tools or things like that because of safety precautions.

From information shared by participants it is evident that the process of building the therapeutic alliance with UIC in an ORR shelter requires for mental health professionals to be prepared to operate with certain limitations.

Cultural Competency

The majority of the UIC whom participants serve are from Central America. The UIC have diverse backgrounds and cultures. Participants noted it is important to be knowledgeable about cultural factors to aid in fostering the therapeutic alliance with UIC and protect against not creating barriers.

Mental Health Cultural Views

Unaccompanied Immigrant Children come from an array of countries, often having different views on mental health and women in the field. During the focus group Mary talked about how machismo, a strong sense of masculine pride, can affect building the therapeutic alliance when working with male UIC. Mary stated,

> A lot of the times the we're the first counselor that they've spoken to and culturally, it's something . . . that we hear, especially machismo and things like that, that they might not be open or receptive to just being completely vulnerable from the get-go, so it's slowly building that therapeutic alliance, winning their trust, and just letting them know that it's okay to express themselves and to talk about anything that might be on their mind.

She added that machismo also affects the therapeutic relationship when female counselors work with male UIC, stating,

> We have to really watch when we're pairing them with a female clinician on how they're [UIC] treating them, and if they are able to build that therapeutic alliance with them, because a lot of times they have no interest whatsoever in speaking to them.

Bailey touched on same topic of machismo noting that it makes it plays a factor in building therapeutic alliance when male residents do not want to partake in session because they do not want to talk about their emotions stating, “We go into that culture stuff like boy’s shouldn’t cry, boys shouldn’t open their feeling and stuff like that.”

Language Barriers

All participants emphasized that understanding the language and being able to communicate in UIC native language is crucial to building the therapeutic alliance. Participants in this study work with UIC primarily from Central America who speak Spanish and often a dialect. Participants stated that being bilingual is a factor that is important in simply being able to communicate with UIC. Kelly shared,

> Being bilingual, I think is a very important quality. I think that when somebody is not fluent in Spanish, it really affects that rapport, and just that therapeutic alliance is very hard to strengthen if the person’s not—because I’ve seen it. I’ve seen where the children request a change of clinician because of that barrier. It’s difficult to communicate with them.

Mari confirmed, and said,

> Knowing the language is something that we really have to be able to do . . . we can’t assume that we know their language perfectly because their language doesn’t translate the same way to words that we do use here in the valley, specifically, in Spanish.

Other participants shared similar experiences and added that it is important to be prepared to work with interpreters. Mari noted that when a UIC speaks a language other than Spanish an interpreter may have to be called in. Mari stated,

> I've had minors from Africa, from Romania, from France . . . they're not the typical unaccompanied minor that we serve that speak Spanish. Then we're having to use translators and we put the translator on the phone and then the kids will express that the translation is not the same to the language that they use. I don't know if it's a variant of the language or the dialect and so they don't always translate into what we're actually saying. It's very hard to build rapport there because of using a third person.

It is evident that cultural factors play an important role in building the therapeutic alliance specifically when working with UIC. Participants shared it is important to know the language, more often Spanish, but it is also important to be prepared to access other resources when building the therapeutic alliance.

Safe Environment

The element of safe environment was one that participants stressed. Participants explained creating a safe environment for UIC specifically upon arriving to the shelter is vital in the process of creating therapeutic alliance. All six participants shared that it is important to explain to UIC what their role as mental health professionals is and what the process at the shelter will look like, many of them using words such as "transparent" and "honest". Participants stated that it may be difficult for an UIC to be in a new place away from their family and it is imperative to meet their need of safety to help build a therapeutic alliance with them. When discussing how she establishes therapeutic alliance, Sandra shared it is important to make the children feel comfortable from the very beginning. She said, "One of the things that I take my time is welcoming them and just explaining to them they are in a safe place." Mari talked about how having particular qualities will help building therapeutic alliance, "being genuine with them

and transparent all the time, that you'll be able to build a better relationship with them no matter what." Mary emphasized that being honest about what your role is and the services that will be provided to them helps build rapport and engage UIC in the services.

Additionally, participants explained that creating a safe environment helps build therapeutic alliance which in turn may result in positive treatment outcomes. Kelly noted it helps UIC have someone to talk about how they are feeling, to advocate for the UIC, and "learn skills that will go with them when they leave." Mary echoed what Kelly expressed stating,

> They are more open to what we're sharing with them . . . it snowballs into, okay, now that they have less stress or they know how to manage their stress better, they're more willing to engage in other activities or take more opportunities that the shelter has. The findings mark that creating a safe space expands to other parts of therapeutic alliance process.

COVID-19

This study was conducted during a pandemic and participants noted the process to developing therapeutic alliance with UIC changed in more ways than one. During the pandemic mental health professionals in some ORR settings transitioned to providing telehealth sessions for precautionary measures. Mari shared that when the shelter she worked at initially transitioned to telehealth sessions UIC were not very receptive to it, noting, "it was very difficult to form that alliance in the beginning because they weren't open to it." Other participants shared similar experiences about the initial transition and explained that for new UIC telehealth was the norm and they adjusted quickly. Mary explained, "I think the children coming in right now, who have only ever received counseling services virtually, they are not as impacted. Where I saw the biggest gap, or the biggest issue was when COVID started."

Participants shared other changes resulting from COVID 19 that impacted the process of building therapeutic alliance. The factors include not having privacy due to UIC quarantining with other children in care, technical difficulties while facilitating telehealth sessions, and conducting sessions in person while wearing full PPE gear. When discussing privacy during quarantine Mary stated,

> We are now struggling with the lack of privacy, the lack of just ability to really sit down, take your time, build that relationship. We've seen too where it affects the child's willingness to open up especially about traumas and things like that because of not being able to take minors out from a symptomatic area.

Sandra noted that technical difficulties disrupt the process of building therapeutic alliance when attempting to find good connection, "Sometimes I've had to end session and reschedule for another time, that way the child can be placed in a different part of the building so that—I feel it break that therapeutic alliance." Participants shared different experiences when facilitating sessions in PPE gear. Kelly described what it's like meeting with UIC for face-to-face sessions now.

> There we are with the goggles or face mask they really can't see who you are, and they can probably just see our eyes but not even because the glare in the glasses…. I can only imagine that they can't see my expressions whenever I am talking to them.

Discussion

This qualitative study was conducted to gain an understanding of the process of mental health professionals building therapeutic alliance with unaccompanied children in an ORR setting. The response from participants helped generate suggested elements essential in the process of building therapeutic alliance. The elements from this study may provide guidance to

mental health professionals in ORR settings and other mental health professionals interested in providing mental health services to unaccompanied immigrant children.

The elements identified in the data from mental health professionals highlight the importance of what it entails to build therapeutic alliance in an ORR shelter with a population with unique needs. The findings of this study indicate there are core components of a therapeutic relationship that must be drastically adjusted compared to building a therapeutic alliance in a conventional setting such as private practice. Mental health professionals are often focused on meeting policy standards and setting a specific set of boundaries, creating added layers in working on the therapeutic relationship. They must have full understanding that the limits of confidentiality vary based on policy and that their first session with the UIC may be the last because the timeframes of their length of stay are established by the category of the case. In addition, they must be prepared to obtain additional information that in another setting might be sought later in the counseling process all while focusing on building therapeutic alliance. There is no outlined process to building therapeutic alliance with unaccompanied children in an ORR shelter; however, participants in this study also shared that understanding limitations posed based on the setting and cultural factors are key in being able to foster the therapeutic relationship. Not having a private designated area to conduct counseling sessions or having full comprehension of the UIC's primary language are also components that mental health professionals in this study stressed can impact building of therapeutic alliance.

Mental health professionals in this study also noted that the use of alternative treatment modalities such as telehealth there were required as a result of COVID-19 impacted building of therapeutic alliance. The shelters where participants worked transitioned to telehealth during pandemic. Participants shared that typical element of communication such as nonverbal

expressions and body language were difficult to assess with masks on and only being able to see the client's face during sessions. Although some participants were again able to conduct in-person interviews at the time of the focus group, all noted that making a connection in session is different when you are wearing full PPE gear and unable to make simple eye-contact or share a smile. Moreover, participants stressed that technical difficulties can often happen in the middle of session, creating a dent in the process of therapeutic alliance. In addition, for many UIC, it was their first time to not only speak to a mental health professional but also utilize a technology device such as a laptop or iPad. Participants shared how telehealth processes at their shelter continue to be adjusted as the pandemic brings about changes. Telehealth for mental health professionals in ORR settings cannot be overlooked as transitions within each shelter continue to happen.

The experiences of these mental health professionals provide an initial conceptualization of elements or processes important to and impacting development of therapeutic alliance with UIC who are in an ORR facility. With the unprecedent number of unaccompanied immigrant children migrating to the U.S. having information about the therapeutic relationship is not only important to mental health professionals currently providing services to the population but to mental health professionals who may encounter unaccompanied immigrant children in other settings after they reunify.

Implications

The findings of this study suggest recommendations for MHPs working with UICs as well as for supervisors working with individuals seeking licensure who are providing mental health services to UIC as they accrue hours. While establishing a strong therapeutic alliance is key in the therapeutic relationship process, it vastly differs in developing the process with UIC in

ORR shelters. Due to policies and facility procedures, there are aspects of the process of developing therapeutic alliance that need to be considered. Understanding how policies and procedures may affect therapeutic alliance is key.

Some participants in this study referenced how building therapeutic alliance in an ORR setting differs from doing so in other settings such as private practice. Due to the setting, there may be some limitations and policy may bring about abrupt changes to the treatment approaches. Programs may consider including specific factors that may impact treatment and how to address them during new employee trainings for mental health professionals. On a larger scale, policy changes placing emphasis on the mental health services may be suggested. Trainings and policy changes can benefit mental health professionals providing services to UIC as well as UIC in care in ORR shelters. Furthermore, Licensing supervisors providing supervision to licensees in the setting may benefit from trainings as to how to provide guidance to licensees who provide mental health services in ORR settings.

The findings of this preliminary study provide avenues for future research to elicit best practices to meet the needs of UIC and enhance the therapeutic approaches of mental health professionals providing services to UIC in an ORR setting.

Limitations

The qualitative study had limitations. The participants consisted of 5 females and only 1 male and therefore cannot be generalized to the experience of all mental health professionals providing services to UIC. Additionally, the sample size consisted of 6 participants and large sample size may yield different elements. Facilities in which participants are employed in may differ in size of the facility meaning they may operate differently and pose different limitations for mental health professionals. Moreover, the participants were employed in an ORR shelter

part of the residential services division and other ORR programs such as Staff Secure, Residential Treatment Centers (RTC), Transitional Foster Care (TFC), Therapeutic Foster Care, Long Term Foster Care (LTFC), Unaccompanied Refugee Minors (URM) facilities may operate differently and have different policies and procedures.

References

Congressional Research Service. (2021, February 2) *The Trump administration's "Zero Tolerance" immigration enforcement policy* (CRS Report No. R45266) Retrieved from Congressional Research Service website: https://sgp.fas.org/crs/homesec/R45266.pdf

Corbin, J., & Strauss, A. (2007). Basics of qualitative research: Techniques and procedures for developing grounded theory (3rd ed.). Sage.

Crea, T. M., Lopez, A., Hasson, R. G., Evans, K., Palleschi, C., & Underwood, D. (2018). Unaccompanied immigrant children in long term foster care: Identifying needs and best practices from a child welfare perspective. *Children & Youth Services Review*, *92*, 56–64. https://doi-org.manowar.tamucc.edu/10.1016/j.childyouth.2017.12.017

Department of Homeland Security. (2022, April 18). *Nationwide encounters*. U.S. Customs and Border Protection. Retrieved May 4, 2022, from https://www.cbp.gov/newsroom/stats/nationwide-encounters

Merriam, S. B., & Tisdell, E. J. (2016). Qualitative Research: A guide to design and implementation (4th ed.). Jossey Bass.

Riley, A. H., Tellez Lieberman, J., Ataiants, J., Cohen, C., Reidy, M. C., & Chilton, M. (2018). Unaccompanied children at the United States border, a human rights crisis that can be addressed with policy change. *Journal of Immigrant & Minority Health*, *20*(4), 1000–1010. https://doi-org.manowar.tamucc.edu/10.1007/s10903-017-0577-5