**ORIGINAL PAPER**

# "Sometimes that Takes You Going the Extra Mile": The Role of Providers' Self-efficacy in Refugee Mental Health Services

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## Abstract

To achieve equity for refugee patients in mental health care settings, patient-centered, trauma-informed, and cultural humility practices have gained recognition; however, the use of these practices is not well defined. The implementation process of these practices may require providers' increased self-efficacy, motivation, and cultural intelligence (CQ). Overall, this study aims to understand training needs of health care providers to be able to provide refugee patients with culturally meaningful, patient-centered, and trauma-informed care. This is an explanatory sequential mixed-methods study and surveys (n = 20) were followed by in-depth interviews (n = 7) with health care providers. The results indicate that there is a positive relationship between providers' self-efficacy and CQ. The interviews revealed three major themes including sources of self-efficacy, the importance of trust-building, and creating trauma-informed healthcare systems. The findings suggest that a trauma-informed, patient-centered training focusing on self-efficacy and CQ enhancing activities for health care providers can improve mental health services for refugee patients.

**Keywords** Refugee patients · Self-efficacy · Cultural intelligence · Refugee mental health · Trauma-informed · Patient-centered

## Introduction

Given the importance of achieving health equity in preventive services, one population, among many other disadvantaged groups, whose preventive mental health care has not been fully provided or been mostly ignored is the newly arrived refugees and refugees in general. When refugees finally arrive in the United States, they are provided with services that aim for refugees to establish self-sufficiency as quickly as possible. The U.S. Refugee Act of 1980 sets the standards and identifies the considerations of the U.S. resettlement program. Although the conditions mentioned in the law (e.g., the achievement of economic self-sufficiency and English language training) require a good mental health status to be accomplished, the law does not necessarily address the needs for mental health services for refugees.

Newly arrived refugees must partake in a domestic medical screening evaluation within 90 days of their arrival (Florida Health, 2021). The Centers for Disease Control and Prevention (CDC) (2021) outlines guidelines for health care providers to follow during the initial contact with refugee patients upon their arrival to the United States. The CDC (2021) Refugee Health Guidelines encourage physicians to conduct a mental health screening for all newly arrived refugees; however, there is not sufficient information on the effectiveness of this screening process, number of referrals to community resources or mental health services, or the provider's specialty. In the guidelines that are revised in 2021, it is mentioned that "when resources are available for intervention, a more comprehensive screening should be considered" (CDC, 2021). It is not clear what happens if the resources are not available. As a result, there has been neither a standard provision of mental health services for refugees, nor a standard use of a screening process for mental health.

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Not delivering any mental health services for refugees during the first months of resettlement can adversely impact different aspects of their lives in a new country (Javanbakt et al., 2019). With more attention paid to mental health needs in the early stage of resettlement, daily functioning and long-term adjustment to the resettlement country might be improved through an early screening (Bogic et al., 2015; Porter & Haslam, 2005; Shannon et al., 2015). Research indicates that if training and best practices for screening are offered to providers who interact with refugees in health care settings, it would be possible to increase awareness of this issue, the number of referrals to services, and the evidence needed to apply for more grants and funding for those services (Shannon et al., 2016). Those trainings could also result in services that are more sensitive to the unique needs and concerns of this culturally diverse population (Rabin & Willard, 2014; Rhema et al., 2014; Shannon et al., 2015).

In this study, we aimed to address health care providers' training needs to provide refugees with mental health services that are trauma-informed and patient-centered. We also wanted to understand factors that facilitate communication between a refugee patient and a provider with a particular focus on the identification of the factors that help providers increase self-efficacy when working with refugee patients.

## Refugees in Central Florida

This study was conducted with health care providers in Central Florida. Central Florida was chosen as the research location since Florida, specifically the Central Florida area, is a hub for refugee resettlement. The number of refugees settling in Florida was steadily increasing until 2017 and had reached a high of over 60,000 new arrivals per year; however, in the last 3 years, that number has begun declining due to the implementation of stricter refugee admission policies (Florida Department of Children & Families, 2020). In the fiscal year 2020–2021, 1,306 new refugees and asylees had arrived in Florida (Florida Department of Children & Families, 2020). Of the 1,306 refugees and asylees who entered the state of Florida in 2020, about 12% settled in Orange County. An additional 3.3% settled in the surrounding counties, making the Central Florida area home to nearly 1,485 new refugees in fiscal year 2020. The majority of these refugees are from Cuba, Haiti, and Venezuela, although refugees from other countries, including Ukraine, Iraq, Burma, Egypt, Colombia, Nicaragua, the Democratic Republic of Congo, and Sudan resettle in Central Florida as well (Department of Children and Families, 2020).

## Barriers to Mental Health Services for Refugees

Across the literature, refugee health care barriers include different layers ranging from interpersonal barriers between patient and provider to structural barriers. Common interpersonal barriers include lack of trust in the provider and the system, dynamics and communication between the patient and the provider, challenges with interpreting and vocabulary, differing expectations for the visit, and low health literacy among refugees (Edward & Hines-Martin, 2014; Kotovicz et al., 2018; Yalim et al., 2019). Language barriers can prove to be a particularly challenging roadblock, even when mental health care providers utilize interpretation services, as many refugee patients have concerns regarding anonymity and fear that an interpreter from their local cultural community will break confidentiality (Gartley & Due, 2017).

Past and/or ongoing trauma can also create an important barrier for interpersonal connection between provider and patient (Sualp et al., 2021). Refugees have often experienced extensive trauma that may be unfamiliar to providers in the United States (Shannon et al., 2012). Most mental health services provided in the United States are not developed for use with refugee groups, many of whom have had higher rates of exposure to violence within their community, traumatic grief, psychosomatic symptoms, and phobias (Betancourt et al., 2017). It is essential for providers working with refugees to understand that the trauma refugees have experienced can be broken into premigration traumas, migration or transit traumas from the journey, and post-migration trauma related to adjusting to life in the United States (Butler et al., 2011).

Structural barriers include geographic accessibility, availability of the mental health staff, resources, and affordability; each of these factors plays a significant role in determining whether or not refugees will be able to utilize resources (Edward & Hines-Martin, 2014). It is common that refugees struggle financially, and they must work extended hours. This can create access and continuity issues when they need to reach mental health services (Sualp et al., 2021). The high cost of receiving services is considered a major structural barrier for refugee patients, as many do not have insurance; even when refugee patients do have health insurance, it often does not fully cover the cost of necessary services and requires out-of-pocket copays (Martinez et al., 2013; Ross Perfetti et al., 2019). Additionally, a lack of transportation is a common structural barrier for refugee patients that may result in missed or rescheduled appointments, but a lack of transportation is also reflection of a larger phenomenon of severe and widespread poverty amongst this population (Syed et al., 2013). Poverty/low-SES plays a major role in social determinants of health, and refugees' higher rates of poverty, as well as need for practical assistance, social stigma, and difficulty navigating the U.S. health care system, result in refugees not receiving or seeking necessary mental health services (Yun et al., 2015; Schlechter et al., 2020).
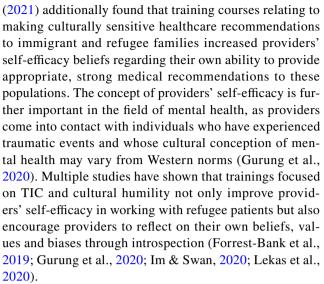
A transcultural, trauma-informed approach has been highlighted as a promising way to provide care, although this comes with its own set of challenges. Education and resources are needed for providers working with refugees in order to implement this approach (Wylie et al., 2018).

## Theoretical Framework

This study is informed by the patient-centered care (PCC) and trauma-informed care (TIC), which aim to provide a physically and emotionally safe environment and clear communication in service delivery among refugees, health care providers, and staff. PCC has been universally regarded by patients, providers, and healthcare organizations alike as a standard of high-quality healthcare (Robinson et al., 2008). This would be an appropriate framework to judge the quality of care given to refugees by individual providers and the healthcare system in general. It involves actions performed during service that contribute to the self-determination of the patient and strengthen the patient-provider alliance. The four main areas of PCC include understanding the patient's perspective, the psychosocial context of their experience, a shared understanding between patient and provider about the goals of treatment and creating a solution that aligns with the patient's values, and collaboration in decisions about the patient's health (Epstein et al., 2005). The use of this framework when working with refugee populations is useful in minimizing challenges and encouraging patient involvement in their care. In addition to PCC, TIC principles (safety, trustworthiness and transparency, collaboration and peer support, empowerment, choice, and intersectionality of identity characteristics) can guide health care providers to avoid institutional processes and individual practices that are likely to retraumatize refugees (Yalim & Kim, 2018). Honest and compassionate trauma-informed and patient-centered communication can foster a shared understanding and sense of safety between refugees and providers (SAMHSA, 2014).

The application of PCC-related skills in healthcare settings is often associated with health care providers' confidence and beliefs in their capabilities (Zachariae et al., 2015). Bandura (1997) defined an individual's confidence in their own ability to complete tasks or achieve goals as self-efficacy. In order for health care providers to successfully meet the full needs of refugee patients, they must develop self-efficacy in their ability to work and communicate with diverse populations, understand past traumatic experiences, and make culturally meaningful recommendations for healthcare interventions. Young et al. (2020) found that, among nurses receiving a training targeting self-awareness and knowledge on refugees, those nurses with low transcultural self-efficacy may not consider cultural factors that impact health behaviors and outcomes due to their own lack of confidence. McFadden et al.

(2021) additionally found that training courses relating to making culturally sensitive healthcare recommendations to immigrant and refugee families increased providers' self-efficacy beliefs regarding their own ability to provide appropriate, strong medical recommendations to these populations. The concept of providers' self-efficacy is further important in the field of mental health, as providers come into contact with individuals who have experienced traumatic events and whose cultural conception of mental health may vary from Western norms (Gurung et al., 2020). Multiple studies have shown that trainings focused on TIC and cultural humility not only improve providers' self-efficacy in working with refugee patients but also encourage providers to reflect on their own beliefs, values and biases through introspection (Forrest-Bank et al., 2019; Gurung et al., 2020; Im & Swan, 2020; Lekas et al., 2020).

To achieve equity in healthcare settings, patient-centeredness and cultural humility practice have gained recognition in the last two decades; however, their implementation and use across different groups and settings are not well defined. There are overlaps in how patient-centeredness and cultural humility are operationalized, and what both approaches achieve such as emphasizing the patient's uniqueness and perspective, sharing power, effective communication, and consideration of sociocultural context (Saha et al., 2008; Zachariae et al., 2015). Implementation of the aspects of these approaches require developing capabilities, gathering knowledge, and practicing skills. In recent years, Cultural Intelligence (CQ) as a concept has been studied in healthcare settings globally, which can allow health care providers to practice the aspects of PCC and cultural humility in a more personalized way (Luquis, 2021). The concept was first introduced by Early (2002) in the business field and defined as "a person's capability to adapt effectively to new cultural contexts and it has both process and content features" (p.274). This intelligence approach focuses on engaging with knowledge, learning, motivation, and behaviors (Luquis, 2021). The facets of CQ consist of knowing what and how to do (cognitive), having the tools to exert effort (motivational), building a behavioral repertoire to respond to the multicultural interaction (behavioral), and developing strategies to overcome new social contexts attributable to intercultural interactions (metacognitive) (Early, 2002). Using this framework as a tool in healthcare settings can increase providers' humility and capabilities in engaging with patients from different cultural backgrounds.

Based on this theoretical framework, research questions that inform this study are: How much do health care providers feel competent to work with refugee patients? How is self-efficacy associated with cultural intelligence among health care providers? What are ways to enhance the skills and competencies of health care providers to promote

culturally meaningful, patient-centered and trauma informed care for refugee patients?

## Methods

An explanatory sequential mixed methods design was used to understand health care providers' perspectives and experiences in working with refugees. This is a type of design in which the quantitative (QUAN) data is collected and analyzed first and then those findings inform the qualitative (QUAL) data collection and analysis (Creswell & Clark, 2017). The study protocol was reviewed and approved by the university's Institutional Review Board (IRB) before the data collection began.

### Sample and Data Collection

Purposive and snowball sampling strategies were used to reach the providers. The study inclusion criteria were: (1) serving as a provider in a healthcare setting in Central Florida and (2) seeing refugee patients in their healthcare environment. The QUAN phase of the study (n = 20) consists of physicians (n = 2), social workers (n = 6), administrators (n = 9), and academic staff (n = 3) from health clinics and agencies in Central Florida who provide refugees with health services (Table 1). The goal of the QUAN data collection is to identify providers' level of self-efficacy and cultural intelligence and their effect on their patient-provider alliance in health care settings and provision of mental health services. The following measures were used for QUAN data collection:

*The Self-Efficacy in Patient Centeredness Questionnaire (SEPCQ):* The SEPCQ was electronically administered to participants to understand their ability to relate to and communicate with patients (Zachariae et al., 2015). It is a 27-item reliable and valid instrument for assessing patient-centeredness self-efficacy in both medical students ($\alpha = 0.92$) and physicians ($\alpha = 0.95$) (Zachariae et al., 2015).

*Cultural Intelligence Scale (CQS):* The CQS is a 20-item scale with four-factor model including metacognitive cultural intelligence (CQ) ($\alpha = 0.76$), cognitive CQ ($\alpha = 0.84$), motivational CQ ($\alpha = 0.76$), and behavioral CQ ($\alpha = 0.83$) (Ang et. al., 2006). Earley and Ang (2003) state CQ as a concept understands why some individuals are more effective than others when interacting with individuals from other cultures and manage culturally diverse situations effectively. As they defined CQ as an individual's capability to function and manage effectively in culturally diverse settings, it is an appropriate variable to study the effectiveness of refugee patient-provider alliance.

Based on the findings from the QUAN data, a list of open-ended questions was developed to conduct semi-structured

**Table 1** Sociodemographic characteristics of participants

| Characteristic | n | % |
|---|---|---|
| Gender | | |
| Female | 16 | 80.0 |
| Male | 4 | 20.0 |
| Age group | | |
| 18–25 | 1 | 5.0 |
| 26–35 | 2 | 10.0 |
| 36–45 | 2 | 10.0 |
| 46–55 | 11 | 55.0 |
| 56–65 | 3 | 15.0 |
| 65 + | 1 | 5.0 |
| Race | | |
| Asian | 3 | 15.0 |
| Hispanic/Latino | 5 | 25.0 |
| Black/African American | 2 | 10.0 |
| White/Non-Hispanic | 7 | 35.0 |
| Other | 3 | 15.0 |
| Education | | |
| Associate degree | 1 | 5.0 |
| Bachelor's degree | 3 | 15.0 |
| Master's degree | 8 | 40.0 |
| Doctoral degree | 7 | 35.0 |
| Other | 1 | 5.0 |

in-depth interviews with the health care providers who directly see refugee patients. Some of the questions are: what would be factors that influence provider's self-efficacy (in other words, belief and confidence in your skills and knowledge)? Any other factors that facilitate communication between the provider and the refugee? What are the barriers in refugee mental health services? As a provider, how do you navigate these barriers? How do refugees navigate these barriers? How can we reduce the likelihood of re-traumatization in health-settings?

Health care providers were individually interviewed (n = 7), and each interview lasted an average of 45 min. The participants consisted of program directors (n = 3), providers (case manager and clinical social worker; n = 2), health services manager (n = 1), and scheduling coordinator (n = 1). All participants worked and interacted with refugee patients closely in a health care setting. As following the social distancing guidelines in place due to COVID-19, interviews were held on Zoom, a video communication tool.

Informed consent was obtained from all participants in the study. In QUAN part, the consent form was attached to the beginning of the survey, so the participants were informed about the purpose of the study and make their decision based on the information they were introduced. In QUAL part, verbal consent was obtained from each participant in the beginning of the interview and a copy of

explanation of research was emailed to all participants. A $20 gift card was given to each participant to appreciate them taking the time from their busy schedule to fill out the survey. The participants who were interviewed individually received a $30 gift card at the end of the interview.

## Data Analysis

The data analysis process began with analyzing the QUAN data and the results informed the QUAL data collection and analysis. The QUAN data was collected through a Qualtrics survey between October 2020 and April 2021. The survey responses transferred from Qualtrics into SPSS Version 26 (IBM, 2021). After cleaning the data and excluding missing responses SPSS was utilized to generate descriptive statistics (See Table 1). Histograms and charts were generated to examine the data distribution regarding sociodemographic characteristics of participants. Correlation analysis was conducted to examine the relationship between scales (CQS and SEPCQ) and their subscales.

To expand upon understanding provided by QUAN result, QUAL data were collected and analyzed. The in-depth interviews were conducted over three weeks in July 2021. They were partially transcribed by a feature on Zoom Cloud. To ensure the accuracy of the transcripts, the second author listened to the recordings while following along with the transcripts and made necessary corrections. Two researchers independently analyzed the transcripts, using an open- and focused-coding approach guided by the principles of Grounded Theory (Glaser & Strauss, 1967). The analysis started with open coding, which involves identifying labels for each line or segment of the data. In the focus coding phase, the researchers concentrated on the most frequent of the initial codes and started to develop themes. As coding continued, codes were grouped based on their associations through constant comparison (Charmaz, 2014). The researchers met to discuss emerging themes and each other's interpretations.

## Findings

### Quantitative Findings

The sample consisted of participants with years of experience ranging from 1 to 35 with an average of 16 years of experience. A majority of the participants were female (n = 16). The participants were highly educated, as 75% of the participants had either master's or Doctorate degree.

There was a positive relationship between providers' self-efficacy and CQ (0.94). Providers who had a higher level of knowledge about the culture of the patient felt more confident about their helping process and effectively dealt with communicative challenges in healthcare settings. In addition, we observed a high positive correlation between subscales of the scales. The correlation between the cognitive component of the CQS and total SEPCQ and its subscales was very high (See Table 2). The correlation between the behavioral component of CQS and SEPCQ subscales was still significant; however, it was a lower correlation compared to other subscales. Only the correlation between dealing with communicative challenges, a subscale of SEPCQ, and behavioral component of CQS was not significant.

There was no association between the number of years working with refugees and self-efficacy nor CQ.

### Qualitative Findings

Based on the interviews with health care providers, the following themes emerged: Sources of self-efficacy, the importance of trust-building in provider-patient communication, and creating trauma-informed healthcare systems.

#### Sources of Self-efficacy in Health Care Providers

The interviews revealed that health care providers' increased self-efficacy is a critical component to improve

**Table 2** Correlations with confidence intervals

| Variable | Total Self Efficacy | Exploring patient perspective | Sharing information and power | Dealing with communicative challenges |
|---|---|---|---|---|
| Total CQ | .94* | .85* | .83* | .78* |
| | {.77, .98} | {.59, .95} | {.47, .95} | {.39, .94} |
| Behavioral | .75* | .77* | .65* | 44 |
| | {.23, .93} | {.41, .92} | {.09, .90} | {-.18, .81} |
| Cognitive | .92* | .71* | .74* | .91* |
| | {.71, .98} | {.29, .90} | {.26, .92} | {.72, .97} |
| Metacognitive | .82* | .52 | .89* | 85* |
| | {.41, .95} | {-.01, .82} | {.64, .97} | {.55, .96} |
| Motivational | .85* | .85* | .73* | .60* |
| | {.48, .96} | {.58, .95} | {.25, .93} | {.05, .80} |

*p < 0.05

communication and trust between refugee patients and providers. A provider who is knowledgeable about refugees' backgrounds and their unique needs feels more confident about their helping process. Increased self-efficacy in providers can create a more welcoming healthcare environment for refugee patients. In this environment, a refugee can feel heard and more likely to adhere to their treatment plan and follow their provider's instructions. Participants discussed how being informed about refugees can increase providers' self-efficacy and, consequently, refugees' health outcomes:

> The physician, you'd probably get better outcomes and better responses from the patient you're working with, and when you're kind of getting those good responses out of patients, and they're opening up to you, and kind of engaging, and a good conversation… Definitely, I think, patients are very happy when you know something about where they came from, and their culture, and it just leaves a better overall interaction… (Scheduling Coordinator)

Exploring refugees' health beliefs, cultural expectations, and psychosocial contexts requires spending extra time with refugee patients. According to the medical providers in this sample, students in health care professions need to observe providers who practice communication skills with refugee patients. This role modeling process can allow students to understand how to interview with a refugee and explore their cultural perspectives and health beliefs.

> Getting to see the Med students and get to see the physician close out the interview, see what they would do in that situation in the future, see how they talk to the patient and see. Each time they're learning a little bit more about how to properly interact with the patient, so I think that helps. (Student Director)
> Nobody starts crying for no reason, something is wrong, so they (providers) need to ask them (refugee patient). Any medical providers, when somebody's coming to talk to you, you need to take time to observe. (Health Service Manager)

Developing a shared understanding that aligns with the patient's values, needs, and beliefs requires providers' increased motivation and efforts to educate themselves on refugee patients. Providers can learn through hands-on experiences what it truly takes to help patients improve their wellbeing, which usually means going the extra mile:

> We have to build them up to be secure and feel confident that they can do what they have to do, and sometimes that takes you going the extra mile and pulling the string and taking them there physically, you know. And that requires a lot of resource. (Clinical Social Worker)

Additionally, a couple of participants reported practicing greater empathy and compassion for refugee clients would increase providers' motivation to listen to and learn about refugees:

> …Empathy is a huge part of medicine and if you're not able to understand where they came from, and why they're here, then you might get frustrated with little things a little bit more easily than you would have otherwise, you might have just had less patience. (Program Director)
> Anybody in health care needs to have the human side with them, okay so we can teach somebody in nursing school the meaning of kindness. (Health Services Manager)

Developing the skills of empathy among health care providers can have an empowering effect on refugee patients:

> The opportunity to tell the story is very cathartic for them and to have somebody listen and understand and empathize, you know, and validate their experience. (Clinical Social Worker)

### The Importance of Trust-Building in Provider-Patient Communication

Refugee patients show mistrust of health care providers as a result of past experiences and traumas in their home country and after resettling in a new country. The participants discussed the trust issues in healthcare and how they can be overcome through clear and open communication:

> There initially seems to be like a lot of mistrust of the health care providers … I think you just have to be open to listening to their concerns and trying to establish trust. (Program Director and Professor)
> Making sure our students introduce themselves very clearly, they actually wear a badge that says 'medical student' in large letters. Patient knows right away that there are students, and then we make it very clear up front they're going to talk to the students first, but then they're going to see the physician, right after. (Program Director and Professor)

Making efforts to learn about refugees and their expectations, values, and beliefs facilitates communication between the provider and the refugee patient.

> …you really ruin their trust and that's something that's very difficult to obtain in the first place, with a lot of them. Just kind of being aware of little things like that, so that you can establish trust and continue it long term, because you're not just treating their symptoms, you're treating the person, and the person has values

and morals and beliefs that might be different to yours. (Student Director)

The participants reported that including refugees in the decision-making process empower refugee patients and foster mutuality between the provider and the refugees.

Create open communication, not only between the staff members, look between the staff members and patients, so they kind of know they're in charge of their life, they're in charge of their health care, they know that they know their story best. And they make the final decisions. (Scheduling Coordinator)

A consistent follow-up process is also important to gain the trust of refugees in healthcare systems. It increases their feelings of care:

…someone is reaching out to them and that's how we have, you know, the same patients coming back or bringing other members of their family that qualify for refugee status, etc., I think that that's gone a long way. (Program Director and Professor)

Along with the principles of cultural humility, being comfortable with asking questions to refugees about their experiences and cultural understandings and avoiding assumptions would contribute to open communication between the provider and the client:

We have to be very careful about our judgments about things, about what we think is going on, and really remember me that a client is the best source to understanding and don't make assumptions. And I think we have the tendency to do that… (Program Director)
All refugees have been through some kind of trauma, but I feel like it's not necessarily something everyone is taught or learned and it's not a lens I guess every clinician uses. But it can be really important when working with this group of people because of how it can affect like their mental and physical health. (Scheduling Coordinator)

## Creating Trauma-Informed Healthcare Systems

The interviews with the providers indicated a need for TIC-focused training for providers. According to the TIC principle of intersectionality, cultural and gender issues need to be acknowledged and practiced more in healthcare environments through actions such as meeting refugee patients' requests for same-gender providers and being aware of ethnic, religious, and dialectic diversity within refugee groups:

Training for medical providers to make them more sensitive and competent and into dealing with dif-

ferent ethnic groups… how we make them feel welcome in the American system, in the American healthcare system. (Health Services Manager)
… Just thinking about cultural things, you know, if sometimes women would prefer to be pair with a woman provider, because it makes them more comfortable. (Scheduling Coordinator)

Understanding historical issues is also important to have an intersectionality lens in healthcare practices:

Knowing the history a little bit and understanding where they came from, what their why they had to leave, I think that that's very important to know when you're talking to these patients, because you could say something that might be offensive or just inadvertently. (Student director)
In order for healthcare to be more cognizant of it, they need to understand the back end of the story, right? That all you're seeing is that African woman sitting in your treatment room, but you don't know the story, you don't know how she got here, you don't know. (Program Director)

Participants reported the importance of providing refugees with physical and psychological safety in healthcare systems. Asking about immigration status, the use of interpreters, and physical conditions need to be considered to ensure safe services for refugee patients.

They're scared to access services, they believe accessing any type of services, that can impact their immigration status, so they are afraid, so they wait until the end to access the emergency room. And by then it's too late. (Health Services Manager)
Have a clean and safe, have a clean waiting room and make sure someone's there to greet them, or sometimes you could leave the door open for the interview you have with the patient, because they might feel unsafe in a room with one other person. (Scheduling Coordinator)

While ensuring refugee patients' psychological safety, the principles of TIC also emphasize psychological safety for providers. When a provider's wellbeing is promoted, burnout, distress, and other psychological issues among healthcare providers can be preventable. A psychologically safe environment for both refugee and provider is a need to fully meet TIC principles:

So, it's not just training the providers, you know, on their on their skill sets and all the stuff that they have to do, is training them on how to take care of themselves. (Clinical Social Worker)

Supervision and peer-support can help providers develop new skills, reduce biases, manage challenging situations, and make tough decisions about refugee patients:

> We have a positive regard for that person as sitting across from us and we check our biases as we're doing the work, we're not robots and address it, address it in the room, if you can address it with a colleague, address it with a supervisor, you gotta start talking about that stuff. (Program Director)
> "Finding enough practitioners that are open to that, you know, that are open and just understand the world, you know, so that they can, you know, be as flexible as they possibly can to kind of mold services so that they fit the needs. (Clinical Social Worker)

Collaboration and mutuality between different agencies and professions need to be fostered through interdisciplinary health teams and community partnerships to implement TIC principles into healthcare systems:

> We had a referral system where say, for instance, if we feel that one of our patients need any mental health assistance. We had, you know, multiple agencies, we had a flyer where these agencies were referred to, and then there was a referral process. (Case Manager)
> The clinic is run by several medical students, along with a partnership that involves students from pharmacy and, most recently psychology department, and we have several faculty members of volunteer right now it's limited to once a month. (Program Director and Professor)

## Discussion

In this study, we aimed to understand the factors that facilitate communication between a refugee client and a health care provider and explore the ways that can potentially strengthen the providers' beliefs in their skills and competencies for patient care. Findings suggest that health care providers who have a higher level of CQ feel more confident about their helping process. According to Bandura's Self-Efficacy theory (1997), the influential sources of self-efficacy include mastery experiences (performance outcomes), vicarious experiences (observing others), social (verbal) persuasion (encouragement/discouragement), and emotional states (wellbeing and managing challenging situations). The sources of self-efficacy defined by the health care providers in this study are in line with Bandura's Self-Efficacy Theory (1997). Particularly, observing experienced health care providers in working with refugee patients, mastering the skills in provider-patient communication, and being informed about the refugee groups are

influential sources of self-efficacy of health care providers. It is important for providers to become educated about cultural norms and beliefs of the population they are serving. Being informed about refugees' backgrounds and exploring their unique needs can foster a shared understanding between refugees and providers. According to the QUAL study findings, practicing empathetic and compassionate attitude towards refugee patients contributes to providers' self-efficacy.

According to the QUAN findings, self-efficacy and CQ are highly correlated. These findings show the importance of being informed about refugee patients' cultural backgrounds in providers' beliefs in their abilities when working with refugee patients. While CQ may consist of some similarities with cultural humility, it concerns 'learned capabilities' (Livermore, 2011 as cited in Luquis, 2021). As the metacognitive component of CQ suggests, development of an advanced level of comfort and managing patients' expectations when interacting with different cultural groups are important skills to facilitate patient-provider communication. In addition, motivation is a very critical component of CQ. According to Luquis (2021), CQ includes self-confidence and inherent motivation. Providers can be asked if they have the desire and confidence to work with refugees and people from multicultural groups and/or be in cross-cultural situations despite the difficulties that may arise during this interaction. Health care providers who have curiosity and confidence to interact with refugee patients can serve more patient-centered services. As emerged in the interviews, this desire or confidence is explained as "going an extra mile", or in other words, health care providers putting forth an additional effort to become informed about multicultural groups different from their own, is critical to increasing providers' self-efficacy as well as facilitating relationship between the patient and the provider. According to Earley (2002), the behavioral component of CQ is capability to adapt appropriate verbal and non-verbal actions to engage cross-culturally. This adaptation process may involve learning from experienced providers, being flexible, and willing to adapt to the cross-cultural situation (Luquis, 2021). Again, providers' motivation is a critical source for them to exhibit appropriate behaviors. Then the question becomes how providers' motivation can be increased so that not only will they be willing to learn about the socio-cultural background of refugees, but also use the knowledge and skills they learned when communicating with their refugee patients. Banerjee and Firtella (2017) suggest that multicultural education and training in health sectors should go beyond cultural competence and take into consideration the culturally based cognitive and learning styles of providers. Reflective exercises can help providers see how their cultural outlook may change due to cross-cultural interaction. Additionally, encouraging role modeling in health care settings and at health profession
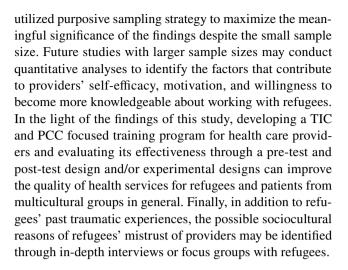
schools can help to increase hands-on experiences of students and providers.

In the current study, the behavioral component of CQ and SPECQ's subscale of dealing with communicative challenges were not correlated. In SPECQ, the items about dealing with communicative challenges include the provider's emotional reactions and being aware of their own feelings, which do not necessarily focus on behavioral actions; but internal processes when interacting with a refugee patient. There is also no association between the number of years working with refugees and neither self-efficacy nor CQ. Im and Swan (2020) found a similar finding in their study with providers working with refugees in healthcare settings. According to these findings, the amount of previous experience working with refugees may not necessarily build competencies to respond to refugees' needs, which implies the training gaps for the providers.

This study also sheds light on the trauma-informed training needs for current and future health care providers. The principles of TIC and PCC can guide health care providers to avoid miscommunication and practices that are likely to cause retraumatization for refugees. Retraumatization can occur when a provider is not sensitive to cultural differences of a refugee patient or does not know how to deal with cross-cultural situations. Training programs for health care providers that are informed by the TIC and PCC principles can facilitate communication between a provider and a refugee patient, increase providers' knowledge of refugees' background and trauma, and accordingly their motivation and self-efficacy. Increasing providers' awareness of historical, gender, and cultural issues through education, supervision, peer-support, and role modeling can foster a trauma-informed healthcare environment for both refugees and providers. Further, TIC principles of trustworthiness and transparency, empowerment, and collaboration and mutuality can encourage providers to take control of the cross-cultural situation and foster their belief in abilities to take the right actions for their refugee patients (Barros-Lane et al., 2021).

## Limitations and Future Research

Although this study has important findings to improve communication between providers and refugee patients in healthcare settings, there are several limitations that are important to consider. When the data collection was conducted between late 2020 and early 2021, it was difficult to identify and reach health care providers who work with refugee patients due to their busy schedules as a result of the COVID-19 pandemic. Providers who work with refugees became a hard-to-reach population, which resulted in a small sample for this study. Since certain characteristics were defined through the inclusion criteria, this study

utilized purposive sampling strategy to maximize the meaningful significance of the findings despite the small sample size. Future studies with larger sample sizes may conduct quantitative analyses to identify the factors that contribute to providers' self-efficacy, motivation, and willingness to become more knowledgeable about working with refugees. In the light of the findings of this study, developing a TIC and PCC focused training program for health care providers and evaluating its effectiveness through a pre-test and post-test design and/or experimental designs can improve the quality of health services for refugees and patients from multicultural groups in general. Finally, in addition to refugees' past traumatic experiences, the possible sociocultural reasons of refugees' mistrust of providers may be identified through in-depth interviews or focus groups with refugees.

## Conclusion

This study underlines the importance of health care providers' increased self-efficacy, motivation, and CQ to better serve refugee patients in health care environments. Open and compassionate communication can foster a shared understanding and sense of safety between refugees and providers. It is evident that trauma-informed, patient-centered trainings focusing on self-efficacy and CQ can enhance providers' motivation to have a more meaningful interaction with refugee patients. These educational interventions can improve refugee health and mental health services and contribute to achieving health equity not only for refugee patients but also patients from different cultural groups in general.

## Declarations

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