



# WALKING TOGETHER

A MENTAL HEALTH THERAPIST'S  
GUIDE TO WORKING  
WITH REFUGEES

*Produced by  
Lutheran Community Services Northwest*



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For almost a decade I have had the privilege of working with refugees and asylum seekers. Their strength, resiliency, kindness, and wisdom have profoundly transformed my life. They have my most deeply felt gratitude.

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# INTRODUCTION

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## WALKING TOGETHER

This guide is for mental health providers who have the privilege of working with refugees. It provides a foundational body of knowledge with an overview of both contextual and clinical considerations. It is not a substitute for therapeutic training.

*Walking Together* focuses on the most common diagnoses for refugees in the outpatient mental health setting: anxiety, mood and adjustment disorders.<sup>1,2,3,4,5</sup> It does not focus on persistent, severe mental illness, which would necessitate a different clinical approach. Nor does it address substance abuse and domestic violence within refugee populations. Both of these issues are serious, but given the limited space we are unable to explore them here.

It is important to note that this guide centers on work with resettled refugees in the United States. People who remain in danger within a country, reside in a refugee camp, or live in exile will have different treatment considerations, including safety, access to medical care, food security, presence of community, and access, or lack thereof, to traditional healing methods.

In 2014 there were more than 50 million displaced people worldwide (refugees, asylum seekers and internally displaced people), the highest number since the end of World War II.<sup>6</sup> Yet only a few countries allow for permanent resettlement of refugees.<sup>7</sup> The United States is one of these nations, resettling more refugees than any other country in the world. Since 1975, over three million refugees have been resettled in the U.S.<sup>8</sup>

Washington State is among the states receiving the most new refugees as well as secondary refugee migrants (those moving to the state after resettling elsewhere).<sup>9</sup> The vast majority of refugees coming to Washington today settle in King County.

The information in this guide is garnered from the experiences of staff and clients at International Counseling and Community Services (ICCS), which has worked with refugees in King County for over 30 years. An outpatient, licensed mental health program of Lutheran Community Services Northwest, ICCS works with more than 400 refugees and asylum seekers each year in its mental health program. It serves an additional 3,000 per year through partnerships and complimentary services such as English as a Second Language classes, nutrition classes, support groups, educational workshops, and more.

The recommendations in this guide are based on the approach that ICCS has discovered to be successful. In no way does this guide imply that the ICCS approach is the only, or best, means of promoting refugees' emotional health and well-being.

*Walking Together* draws heavily from material created by the Pathways to Wellness: Integrating Refugee Health & Well-Being project. Pathways is a partnership program between Lutheran Community Services Northwest, Asian Counseling and Referral Service, Public Health Seattle & King County, and Dr. Michael Hollifield of Pacific Institute for Research and Evaluation. The Pathways program offers a validated screening instrument to help detect emotional distress in newly arrived refugees. It also provides educational materials for refugee and provider communities. Many of these materials are cited in this guide, as are other helpful videos, publications and websites.

In addition, the content of this guide was greatly informed by meetings with over a dozen mental health workers whose practices focus on work with refugees. Many of these practitioners came to the U.S. as refugees or asylum seekers themselves. We also gathered input from refugees directly to ensure that

we addressed their most essential concerns. Both practitioners and refugee advisors then reviewed the content and offered their feedback and suggestions. Without the insights from these groups this guide would not have been possible.

The information contained here offers a general overview of issues and common understandings about mental health in refugee populations. It does not speak specifically about any one culture or belief system, nor does it contain any blanket truths. Not only is there great cultural and linguistic diversity among refugees in the world, including those resettled in the USA, but every refugee is unique. They have their own singular experience. Their family histories and family dynamics are distinctive. Their character traits are solely their own. As such, there can be no one-size-fits-all approach when it comes to mental health treatment for refugee populations.

Refugees are survivors. Their journeys here are testaments to courage, hope, faith, love and the resilience of the human spirit. We encourage providers to “walk together” with their refugee clients in helping them transition to their new lives. In this way, both providers and refugees learn from, and are inspired by, each other.

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- ① *Mental Health.* (2011, January 1). Retrieved November 9, 2014, from <http://refugeehealthta.org/physical-mental-health/mental-health/>
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  - ④ Savin, MD, D., Seymour, PsyD, D., Littleford, PhD, L., Bettridge, J., & Giese, MD, A. (2005). *Findings from Mental Health Screening of Newly Arrived Refugees in Colorado.* *Public Health Reports*, 120, 225–226.
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  - ⑥ *World Refugee Day: Global forced displacement tops 50 million for first time in post-World War II era.* (2014, June 20). Retrieved January 20, 2015, from: <http://www.unhcr.org/53a155bc6.html>
  - ⑦ *UNHCR Global Resettlement Statistical Report 2013.* (2013, January 1). Retrieved May 7, 2014, from <http://www.unhcr.org/52693bd09.html>
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**NO MAGIC BULLET**

Unfortunately, there is no one diagnostic or treatment methodology that applies to all refugees. Cultures and individuals vary greatly between and within populations. However, there is excellent ethnographic and public health research related to mental health in specific groups.

Therapists working with refugees, especially large numbers of clients from certain groups, would benefit from reading scholarly articles based on this research. With mental health being very subjective, these studies provide helpful empirical data which may lead therapists to important insights and ultimately enhance the quality of their care.

Clinics and health facilities may wish to provide continuing education credit to employees who take part in discussion groups focusing on ethnographic literature specific to culture and mental health. In this way, therapists would be encouraged to make time for this study despite their busy schedules.

International Counseling and Community Services hopes that this guide helps both providers and the clients they serve. We welcome input on how it can be improved or suggestions for additional sections. Feedback may be sent to [iccs@lcsnw.org](mailto:iccs@lcsnw.org).

*Walking Together* is open source and is free to be used as long as it is cited appropriately.

# SECTION 1

## WHO ARE REFUGEES?

Before engaging in mental health work with refugee populations it is important to define what the term “refugee” means and to better understand how refugees come to the United States. This context is critical to understanding the experiences and stressors that may lead to, or exacerbate, mental health symptoms in a refugee client.



## History of Refugee Movement

Refugees have been around almost as long as nations with borders, but international efforts to create a legal framework and process for caring for refugees did not begin until the first part of the 20th century.

In 1921, the League of Nations created the Office of the High Commissioner for Refugees and began efforts to find protection for those displaced and persecuted.<sup>10</sup> After World War II, these efforts intensified in response to the needs of millions of Europeans dislocated by war.<sup>11</sup> In 1951 the United Nations High Commissioner for Refugees (UNHCR) held the Convention Relating to the Status of Refugees and adopted the following definition. A refugee is someone who:

*“...owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country.”*

The UNHCR definition remains the accepted and working definition for refugees today. It distinguishes refugees from other immigrants by establishing that they have unique humanitarian concerns which warrant special protection efforts.

Refugees cannot return to their home country because doing so would result in further personal harm or persecution. While many governmental and non-governmental organizations (NGOs) work to aid refugees, the primary agency responsible for their protection is the UNHCR.

Currently, around two dozen countries in the world accept refugees for resettlement, with the United States taking the vast majority.<sup>12</sup> However, it is important to note that while developed nations often resettle refugees, 80% of the world's refugees reside in developing nations.<sup>13</sup> The 70,000 refugees the United States agreed to take in the 2014-2015 fiscal year represent just .005% of the more than 14-16 million refugees displaced globally each year.<sup>14</sup>

## WHAT'S THE DIFFERENCE?

### Immigrant

In general, immigrants are people who voluntarily choose to resettle to another country. Often they choose migration as a way of improving their economic, educational, or social standing. Immigrants are often divided into “documented” and “undocumented.” Being “documented” means that a person has gone through the official U.S. government processes for coming to the United States and has lawful permission to be here. Being “undocumented” means that a person is in the United States without permission because he/she crossed a border without authorization, overstayed a visa, or for another reason. There are some immigrants who flee their country due to harm or violence, but do not qualify as refugees or asylees under U.S. law because of technical or legal reasons.

### Refugees

Refugees are people who have had to leave their country because of fear of persecution or harm, often to save their lives. Refugees are resettled to the United States under the auspices of the Department of State and arrive after a complex and often lengthy process. ALL refugees in the United States are here legally and have work authorization.

### Asylees/Asylum seekers

Asylum seekers differ slightly from refugees. A refugee's humanitarian claim is decided before they are resettled in the United States. Asylum seekers are physically present in the United States and then have their humanitarian claim decided here. An asylum office or immigration court then determines the validity of the claim. If it is proven to be valid, they are then granted asylum status and are allowed to stay. Overall, 49% of asylum seekers were granted asylum in 2014, but outcomes varied widely depending on the immigration court.

*The most recent statistics from the Department of Justice on immigration can be found in their [Statistics Yearbook](#).*



## Refugees and the United States

The United States is known as a nation of immigrants, but from the beginning of European settlement the U.S. was also a nation of refugees. Ethnic and religious prejudice propelled many early settlers to make the perilous journey across the ocean. However, it was not until the middle of the 20th century that the U.S. set aside a special class of immigration for humanitarian concerns and began to differentiate between “refugees” and “immigrants.”

*“The word refugee is only a name.  
It doesn’t mean I don’t know  
anything. Sometimes I am talking  
to people and they think I am  
nothing because I am a refugee.  
They don’t know what I did before  
I came. Who I am. Some of us  
had more than the person we are  
talking to. We had a lot.”*

— A refugee client from Iraq on coming  
to the United States

In the wake of World War II, the United States Congress passed its first legislative act concerning refugees. The Displaced Persons Act of 1948 allowed for 400,000 displaced Europeans to be admitted to the United States.<sup>15</sup> Reflecting America’s Cold War stance against communism, in the 1950s and 1960s Congress allowed for individuals fleeing persecution under communist regimes to be admitted to the United States as refugees.<sup>16</sup> After the Vietnam War, there was another large influx of refugees, this time from Southeast Asia. Congress responded by passing the Refugee Act of 1980, which adopted the U.N. definition of refugees and standardized the process by which refugees are resettled to the U.S.

Each year, after consulting with Congress and the appropriate agencies, the president of the United States issues a [directive](#) that states the maximum number of refugees the United States will allow for resettlement. This number has varied annually from a post-Vietnam War high of over 200,000 to a low of 27,000 after September 11, 2001.<sup>17</sup>

## Refugee Resettlement

Refugees come to the United States through an administrative [process](#) that often takes years.

First it must be determined that a refugee cannot return home. Returning home – called repatriation – is often considered the best choice for an individual because they may be able to reclaim employment, housing, community, and an established social network.

If it is determined that a refugee, or refugee population, cannot return home, then integration is considered. Integration refers to a legal path of immigration into the country where the refugee is currently residing. This is often a neighboring country that shares a language and culture with the refugee’s own country, and as such it may be easier for the refugee to find employment and housing and to establish social ties.

Only if both repatriation and integration efforts fail is resettlement to a third country considered.<sup>18</sup>

Resettlement is the last option for many reasons. For example, there are not enough countries in the world which take refugees for resettlement. Currently there are over 50 million displaced people worldwide, roughly 14-16 million of them refugees.<sup>19</sup> The maximum number of refugees accepted for resettlement annually from all the countries that take refugees is around 120,000. This represents less than 1% of all refugees.<sup>20</sup>

In addition, resettlement is difficult. Refugees must move to a new country with a different language and culture. They must learn to navigate this new society, gain employment, and re-establish social networks. Refugees are often separated from family and friends, many of whom remain in refugee camps or in danger in their home country. While resettlement represents a meaningful opportunity, for most refugees it is also a demanding and stressful process.

The UNHCR prioritizes refugees for resettlement into three categories:<sup>21</sup>

- **Priority 1 (P1)**

These are individual refugees who have been identified and referred to the program by the UNHCR, a United States embassy, or a designated NGO.

- **Priority 2 (P2)**

These are groups of refugees that have been identified as of special humanitarian concern.

- **Priority 3 (P3)**

These are family reunification cases.

Resettlement is voluntary. Refugees fill out an application where they must detail specifics of their humanitarian claim. The next step is an official interview by a United States Citizenship and Immigration Services (USCIS) official. Refugees must meet the humanitarian criteria laid out by the United Nations. Refugees who have been involved in war crimes or have violated human rights are not eligible for resettlement.<sup>22</sup>

Applicants may include:

- Their spouse (this may include a same-sex spouse if they are legally married)
- Their children who are unmarried and/or under the age of 21
- In rare circumstances, other family members<sup>23</sup>

Once the humanitarian criterion is met, applicants undergo exhaustive security checks to ensure that they do not have a criminal background or pose a threat to the United States. One of the last steps before resettlement is a medical examination, which is done to protect the U.S. public from communicable disease. (Details of the medical examination process are available on the UNHCR website, <http://www.unhcr.org/pages/4a16b1676.html>.) Both the security clearance and the medical clearance must occur within six months of the refugee's departure.

Refugee resettlement in the United States is managed by the federal Office of Refugee Resettlement (ORR), which is an office of the Administration for Children & Families. Every year, after consultation with Congress, the president determines the maximum number of refugees who will be admitted to the United States in the next fiscal year, as well as the number from each region of the world.<sup>24</sup> (The president will sometimes allow those who have worked for the U.S. government or military to come straight from the country of origin without having to flee across a border. These are called Special Immigrant Visas or SIVs. SIVs receive the same benefits as refugees except SIVs can receive a green card shortly after arrival.)



Once a person has been approved for admission, travel arrangements are made through the International Office of Migration (IOM). Money is loaned to the refugee for the cost of travel and the individual or family is asked to begin paying back the loan starting six months after arriving in the U.S. Although these loans are interest-free and the payments are set in small amounts, the payments often remain a financial burden for refugees.

However, having refugees pay back travel costs helps the program be more financially sustainable and allows refugees an opportunity to establish credit in the United States.

All new refugee arrivals are received in the United States by one of nine federally contracted resettlement agencies. These agencies are also called Voluntary Agencies (Volags) and have a public/private partnership with the federal government, meaning that both the federal government and the resettlement agency raise funds to support the program. The agencies contracted in 2014 include:



Each week representatives of these agencies meet to review cases referred from overseas. Agencies try to match a refugee's needs with resources available in a local community. If the referred refugee has close relatives in a certain location, the refugee is likely to be placed in that community.<sup>25</sup>

Upon arrival in their new community each refugee receives a cash payment from the government to assist them in getting established in the United States. This money is called Reception and Placement money, or "welcome money." It is initially administered by the assigned resettlement agency and later managed by the refugee. In 2015, the amount is approximately \$1,975 per capita with a minimum of \$1,125 dedicated for direct client assistance. Up to \$850 can be used for the administrative expenses of the resettlement agency, which includes case management. The funds help the refugee secure housing, establish utilities, and acquire other basic needs like food, clothing, and furniture. Because funding is meager, resettlement agencies work to supplement government funds by raising money and resources to ease the resettlement process.

Newly arrived refugees may apply for federally-funded benefits, including cash assistance. These are the same benefits that are accessible to a U.S. citizen living in poverty. Some states have special programs with the goal of reducing dependence on welfare and moving refugees towards financial self-sufficiency. For example, Match Grant is a program that pays a new refugee's rent and utilities for four months while working closely with the refugee to find him or her a job as soon as possible. Resettlement agencies which participate must match the money provided by the Office of Refugee Resettlement (ORR) with cash and in-kind donations. A similar program is Wilson/Fish, which provides certain services and cash assistance to new arrivals in order to help them more quickly secure employment and achieve financial self-sufficiency. States and resettlement agencies will differ in which types of assistance programs they offer.

Refugees with minor children are eligible for Temporary Assistance for Needy Families (TANF). TANF is a means-tested assistance program that provides a variety of services including cash assistance, child care subsidies, employment supports, and other services.<sup>26</sup> Each state has broad discretion in determining benefit levels and assistance. Overall, TANF cash assistance levels are very low. In fact, in every state in the U.S., TANF benefits bring families to, at most, only half of the poverty line.<sup>27</sup>

TANF has a five year lifetime limit in Washington State. To find out more about TANF in Washington State click [here](#). To find out more about TANF in each state, including the average cash benefit, click [here](#).

Refugees without minor children are eligible for Refugee Cash Assistance (RCA) for eight months after arrival. Currently in King County the cash assistance is \$305 a month if the person is unmarried, while a married couple without dependent minors receives \$385 a month.

Resettlement agencies are committed to providing a specific set of services for refugees' first 90 days in the United States. These include, but are not limited to: finding housing, registering children for school, registering adults for English as a Second Language (ESL)/English Language Proficiency (ELP) classes, helping refugees find employment, applying for social security cards, and ensuring that refugees have an additional health screening shortly after arriving in the United States. These services are supplemented by additional ORR programs and grants to help refugees learn English, obtain employment, and navigate systems in the United States. Some resettlement agencies will also have grant-funded programs that allow for longer periods of case management, so that many refugees are engaged in services with resettlement agencies beyond the initial 90 days.

Refugees receive employment authorization when they enter the United States and are eligible to work immediately. Because reception and placement funds are limited, refugees are encouraged to work as soon as possible. While the employment search begins during the resettlement period, it often takes much longer to find employment, causing great financial stress.

Refugees may apply to be legal permanent residents (green-card holders) one year after being in the United States. They may also apply to become U.S. citizens five years after arrival. Refugees who gain Legal Permanent Residence (LPR) status or citizenship may file for certain relatives to join them in the United States. However, it may take many years for their relatives to gain permission to enter the U.S., and once they do enter they are considered immigrants, not refugees. Therefore, refugees may have multiple people in the same family with different immigration statuses and different public benefits eligible to them.

### What benefits are refugees eligible for? ~~~~~

Refugees are eligible for all means-tested state and federal benefits. These include benefits like Temporary Aid for Needy Families (TANF), federal food stamps, and Supplemental Security Insurance (SSI) if they are disabled or over the age of 65. Refugees are eligible for Medicaid, which is of particular importance to medical and mental health care providers. Refugees may also enroll in "Obamacare," meaning they can access medical benefits under the Affordable Care Act.

Refugees are eligible for federal benefits while other types of immigrants are not. Immigrants are barred from federal benefits until they have legally been in the country for five years (immigrants may



be eligible for some state benefits depending on the state). See the full scope of what federally funded benefits immigrants are eligible for at the [National Immigration Law Center](#).

### Typical Family of Four — An Illustration

		Total
<b>Reception and Placement Direct Assistance</b>		<b>\$4,500</b>
First, Last, Deposit	\$1,800	\$2,700
Utility Deposits	\$300	\$2,400
Phone	\$100	\$2,300
Furniture not donated	\$100	\$2,200
Clothing not donated	\$100	\$2,100
Household Items	\$100	\$2,000
Bus fare (one month)	\$50	\$1,950
Food until benefits begin	\$200	\$1,750

#### Month two

Income coming in until employment	\$585 in welfare	\$2,335
Expenses	\$1,250	\$1,085
Incidentals	\$100	\$985 at end of 60 days

#### Month Three

Income coming in until employment	\$585 in welfare	\$1,570
Expenses (rent and utilities)	\$1,250	\$320
Incidentals	\$100	\$220 at end of 90 days

This assumes no other expenses other than rent, utilities and a small amount for incidentals

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# SECTION 2

## THE REFUGEE EXPERIENCE

Refugees are survivors, and while strength and resilience propel them forward, most have experienced profound violence, fear, deprivation, and loss – all potential catalysts for mental health problems.



Not surprisingly, refugees are at a higher risk of developing mental health problems.<sup>28</sup> Common diagnoses include post-traumatic stress disorder (PTSD), major depressive disorder, and general anxiety or adjustment disorders. Refugees have been found to have 10 times the rate of PTSD as the general population.<sup>29, 30, 31</sup> For those who have been tortured—and estimates are that up to 35% of refugees have experienced this egregious form of violence—the risks of mental health distress are even greater.<sup>32, 33</sup>

Despite the need for mental health services, the chance of a refugee receiving effective treatment after arriving in the United States is small. There are numerous reasons for this. Already there is immense disparity in mental health care in the U.S., as ethnic and racial minorities tend to have less access to, and receive less benefit from, mental health services. This disparity has only grown in the last decade.<sup>34</sup> <sup>35</sup> For refugees the disparity is made worse because of language, stigma, a lack of culturally-responsive providers, and issues related to service delivery.

In this section we focus on how the refugee experience impacts mental health. In subsequent sections we discuss common barriers to treatment and propose some solutions that have been found helpful in the ICCS clinical setting.

## The Refugee Context

Knowing the client's context is critical in any mental health assessment. For example, if a therapist is doing an assessment on a woman with an acute fear of fire, the assessment will be different if:

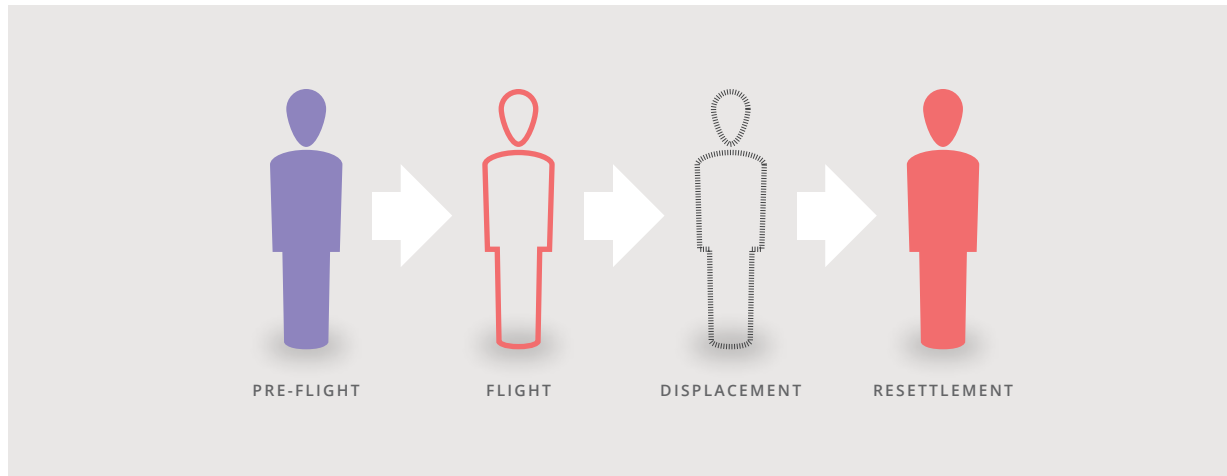
- The woman has recently developed this fear with no precipitating factors
- The woman developed this fear after recently being in a house fire
- The woman has had this fear since her house was destroyed by fire as a child
- The woman had this fear for a time as a child after her house was destroyed by fire, and it recently came back after an adverse event

To develop treatment approaches which are effective with refugees, it is necessary to understand the context of the refugee experience, keeping in mind, as mentioned earlier, that this experience varies enormously across individuals, families, communities and cultures. Therapists need to be aware of their clients' histories—for example, the unique experience of forced migration from one country to another due to war, persecution or oppression; the time in a refugee camp or exile; and the pressures of adapting to life in the United States.

War, encampment, persecution and forced migration have common psychological impacts and produce common coping skills. How “at risk” an individual might be to developing mental health issues depends on a number of factors, including individual temperament and early attachment. With exogenous depression, two major risk factors include loss and stress. PTSD is affected by the 1) intensity of the trauma experienced, 2) the frequency of the trauma(s), and 3) the duration of the trauma.

## Psychological Stages of Refugee Migration

Many researchers who study how the refugee experience impacts mental health utilize a framework of migration stages. Migration stages allow us to delve deeply into the multifaceted psychological impacts of the refugee journey.<sup>36, 37, 38</sup> Different authors and researchers divide the stages in different ways. For this guide we use the following structure:



Later in the section we explore these stages of migration through three refugee stories. While the people in these stories are not real, the stories themselves are accurate representations of typical experiences for someone in these particular refugee groups. There is also a worksheet that helps providers to think more deeply about the impact of the refugee experience on key psychological areas.

### Pre-Flight

Pre-flight is the event, or series of events, that cause a refugee to leave his or her country. This period of time is marked by instability, human rights abuses (personal and communal), high levels of violence, and/or targeted persecution. It can occur over a period of days or weeks, or even over generations.

Leaving one's home and country is one of the most difficult decisions a person will ever make. It is not as simple as moving from one geographic location to another. People must say goodbye to their jobs, land, family, friends, possessions, and everything else they are familiar with and step into the unknown.

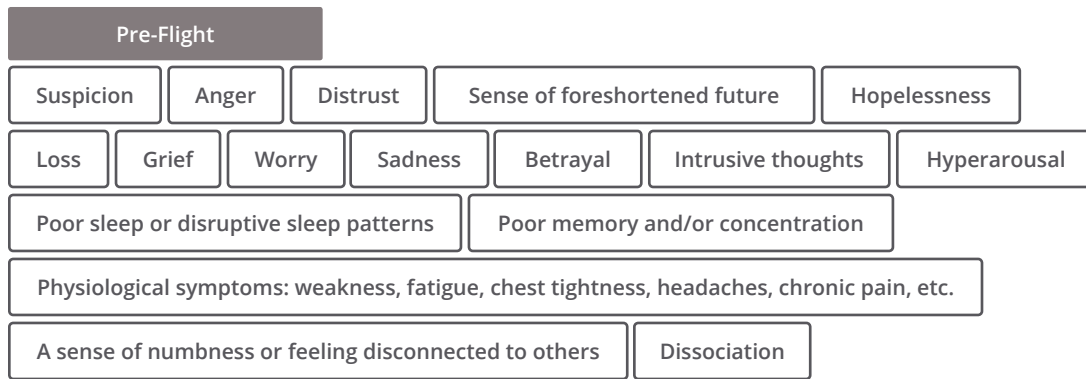
Stop for a minute and imagine your own home. Take an inventory of your favorite possessions and keepsakes. Think about all your friends and family. Whom do you go to when you need support? Who makes you laugh? Who are the people you share holidays and special events with? Think about your work and the education and time it took you to get to your current position.

Now, what would it take for you to walk away? If you had only a few minutes to prepare, what would you take with you? How would you feel if you had to leave all of this behind not knowing if you would ever return?

Even from this overly simplistic and brief exercise one can get a small glimpse into the magnitude of the decision facing refugees and the depth of their loss.

Because the decision is both complex and enormous, people often wait before leaving. In doing so, they endure a protracted period of persecution and/or violence. What ultimately pushes people into leaving is fear for their lives, or more commonly, fear for their children's lives.

Pre-flight experiences may differ widely, and thus may have widely varied psychological impacts. Some areas to consider are:



## Flight

Flight is the period of time between when a refugee leaves home and when they reach a place offering some degree of safety. For many refugees, safety is not assured until they have crossed a border. Refugees flee in many different ways – plane, foot, boat, car, horse, smuggled as human cargo, etc.

While flight can occur quickly (someone leaving their home and reaching a border within hours), it can also occur over a long period of time (walking hundreds of miles, moving from hiding place to hiding place, making multiple attempts to cross, etc.). Refugees can spend days, months and even years searching for a way to escape their situation, whether by trying to obtain a visa, crossing an open border, or paying someone to smuggle them across.

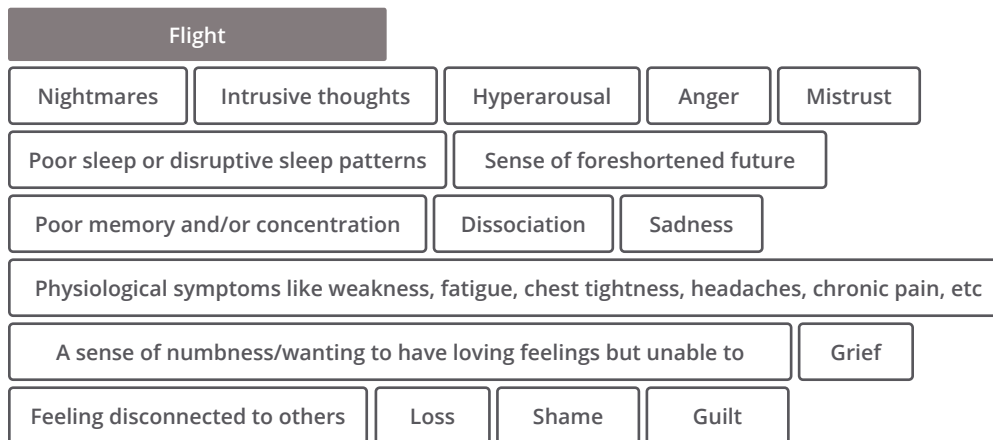
Because a violent event, or multiple violent events, often precede flight, some refugees must endure the journey injured, and with little or no medical care. If a refugee's journey is long, they may lack essential food and water and risk dying of starvation or dehydration. Many refugees flee with just the clothes on their back and thus may not have adequate footwear and clothing, putting them at risk of death or illness from exposure.

Refugees in flight often face great violence before reaching safety. Often they are hiding from authorities, soldiers, militia groups, or even local townspeople. They may risk being killed by wild animals such as lions and hyenas. It is not uncommon for fleeing refugees to be cheated by people who claim to offer them help, or set upon by thieves who take their meager belongings.

During this journey to safety there is not only great fear, but also great uncertainty as refugees leave behind the life they know and move into an unknown future. Their social fabric is torn apart, and they can rely on almost no one for help.



The psychological impact of flight is enormous. The effects may include, but are not limited to:



## Displacement

Currently about one-third of the world's refugees are encamped, while the rest live precarious existences in cities, villages, and towns.<sup>39</sup>

Refugee camps are run by the UNHCR or other Non-Governmental Organizations (NGO), which provide food, water, basic medical care and shelter. Many camps are quite large and can contain more than 100,000 people. The world's largest refugee camp, Dadaab in Kenya, currently has over 400,000 people, which is larger than the population of New Orleans.<sup>40</sup>

While camps are designed to be temporary in nature, most refugees, in fact, live in camps for an average of 17 years.<sup>41</sup> Some refugees are born and will die in refugee camps, and others may have spent their entire life in a camp before moving to the United States or other country of resettlement.

While camps may differ in services and resources, food and water are commonly inadequate and of unreliable quality. Food shortages or food scarcity is common, with acute and persistent malnutrition the result. One study conducted among Burmese refugees residing in camps along the Thai-Burma border found iron deficiency rates in children as high as 84%.<sup>42</sup>

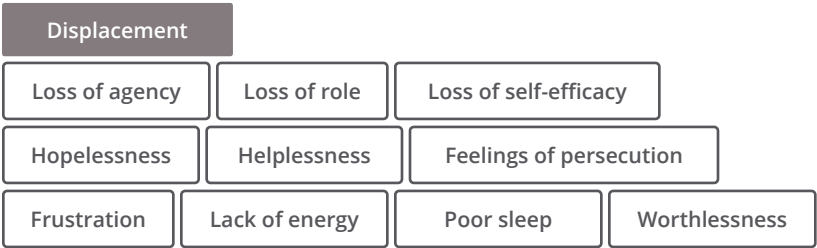
Many camps struggle with poor sanitary conditions, and thus disease and epidemics are commonplace. For example, in the aftermath of the Rwandan genocide an explosive outbreak of cholera in the refugee camp of Goma caused over 20,000 deaths in one month.<sup>43</sup>

Medical care is frequently insufficient to meet the needs of residents, and specialty care like gynecology is virtually non-existent. While most refugee camps do have schools, many struggle to provide basic necessities like pencil and paper and some camps do not offer education beyond primary school.

It is common for camp residents to not be allowed to leave the camp or work, and as a result people may have little to do. Violence is frequently endemic in camps because of boredom, frustration, and lack of oversight. Child abuse, domestic violence, and rape are unfortunately common. Locals may resent the camp residents, who they view as outsiders, and they may begrudge the food, medicine and shelter residents are receiving. Attacks on camps occur all too regularly and camp residents can be injured or killed in massacres or if the camp is set on fire.

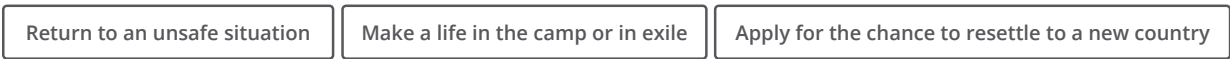
Refugees who live in exile (not in a camp) in another country face a different set of challenges. They are rarely allowed to work and often end up getting jobs “under the table” where they may be paid little or cheated out of pay. They are often charged exorbitant rates for rents, and cannot access education or medical care unless they pay. Because they may be in the country illegally, there is always the possibility they will be deported or even thrown in jail. In some tragic cases, war and civil unrest break out in the country of sanctuary, and the refugee is forced to flee again.

The length of time of displacement, conditions of displacement, and experiences during displacement all have an impact on individuals and families. These effects include:



## Resettlement

If a refugee is in a camp or in exile, and their country of origin is experiencing protracted conflict, they face a bleak choice:



Less than 1% of refugees will get the chance to resettle to a third country—that is, a country other than their country of origin or place of exile.

Most refugees who do resettle will complete a cultural orientation overseas prior to immigrating. However, this orientation cannot truly prepare them for the challenges they will experience after being resettled.

Many Americans believe that a refugee’s trauma is over once they arrive in the U.S., and in some ways this is true. Most are indeed physically safer after arrival, despite often having to live in neighborhoods which are more affordable but may also have higher crime rates. However, resettlement is still a huge challenge; most refugees experience extraordinary stress and upheaval starting and adjusting to life in the United States.

New arrivals have extremely limited monetary resources and must find a job quickly to survive. In many cases their previous profession or skills may not fit the employment market in the U.S. Refugees who were highly skilled professionals such as doctors and lawyers may be forced to start over as dishwashers, janitors, or factory workers. Those same jobs, while entry-level, may be challenging in different ways to someone who was previously a herder or farmer, or who has lived in a refugee camp for several decades.

The majority of refugees must also learn to speak English and navigate an entirely foreign, and deeply complex, system. Even if they come from an urban area with a developed infrastructure, the “how to’s”

of paying bills, taking public transportation, buying groceries, making medical appointments, and other routines of daily living will be substantially different in the U.S. than in their country of origin.

*“It’s not over. In South Sudan there is killing every day. I can’t even call my country. I will be too angry.”*

— Refugee client from Sudan

Actions that may have been accepted and normal in their home country, like leaving a 10-year old in charge of a baby, may not be accepted in the U.S. and may even be considered abuse or neglect.

What is considered of value and importance in American culture may be quite different than in the refugee’s culture, increasing his or her sense of marginalization and isolation. How people dress, talk, and interact, as well as what is deemed appropriate behavior for a parent, child, spouse, teacher or doctor, may also differ.

When individuals or families are resettled in neighborhoods or cities with few people from their community or culture, they lack some of the traditional social supports that would have previously helped them navigate and manage their responsibilities to themselves and their families.

While refugees are physically in the U.S., their thoughts are often with family and friends that remain back home or in camps. Loved ones may be facing grave danger from war, bombings, militia, or persecution. Some refugees have family in camps or resource-poor countries that are relying on them to send money home for food or medicine. In some sad cases, refugees are separated from family members and do not know whether they are alive or dead. Constant bad news and deep concern for their loved ones causes many refugees to live in a state of anxiety.

*“You have all these things. You lose everything. The things you saw and that happened to you, it is not human. Then you come to America and no one says, “Now take rest.” No, they say do everything, go to work, take care of yourself, take care of your family, learn it all. It is too much.”*

— A refugee client from Iraq discussing resettlement

Compounding their emotional stress, new refugees in the U.S. almost always live in poverty. They struggle with how to pay bills, make rent, and provide for their families. They often live in poorer neighborhoods and must find affordable transportation to get to work, shop, and obtain medical care.

Refugees have little social capital, meaning they have few, if any, informal social networks through which they can get information (who the good doctors are, where to find low prices for milk, bread, etc.), find reciprocal resources (like babysitting, ride shares, etc.), and connect to informal assistance. Financial obligations back home may further stress their precarious financial situation here in the United States. Indeed, many refugees feel like they are being pressured and stressed from both sides.

Because children often adjust and learn a new language more quickly than adults, household roles may shift. Children may become the only person in the home capable of making medical appointments, reading mail, and paying bills. Not only does this cause “parentification” of children, parents may lose their sense of authority and efficacy, leading to a loss of role and self-esteem.

Most refugees resettle with some expectation, however vague, of what life is like in the U.S. Almost always, refugees find that life is different, and harder, than they had imagined. With this realization often come



# COMMON THINGS A NEW REFUGEE WILL HAVE TO QUICKLY LEARN HOW TO DO:

## SKILLS

Get a job

Pay bills

Speak English

Read English

Use an ATM or EBT card

Deposit money

Take a bus

Understand and follow U.S. laws

Make a medical appointment

Find child care so they  
can go to work

Choose appropriate clothing and take  
precautions for the weather

Know when to call 911

Fill a prescription

Use appliances  
like a dishwasher,  
washing machine,  
stove, etc.

Take care of personal safety  
(locking doors and windows,  
smoke alarms, wall heaters,  
oven, etc.)

Learn how to mail a letter

Know whom to ask for help

Practice traffic safety (which  
side of the street to walk in, how  
to cross a road, obeying traffic  
signals, etc.)

Understand how the U.S. education  
system works if they have children

feelings of fear, anger, hopelessness, and regret. It is common for refugees to have a honeymoon period when first entering the U.S., followed by a period of disappointment and despair, and then eventually progress toward adjustment. The different phases of the transition can be summarized as follows:

#### HONEYMOON

In this phase refugees have typically just arrived in their new country and are very hopeful that their lives will soon improve.

#### CULTURE SHOCK

Confronting a huge array of challenges, refugees realize that life here is not what they thought it would be and is often much harder than they expected. Culture shock can happen at any time during the first year.

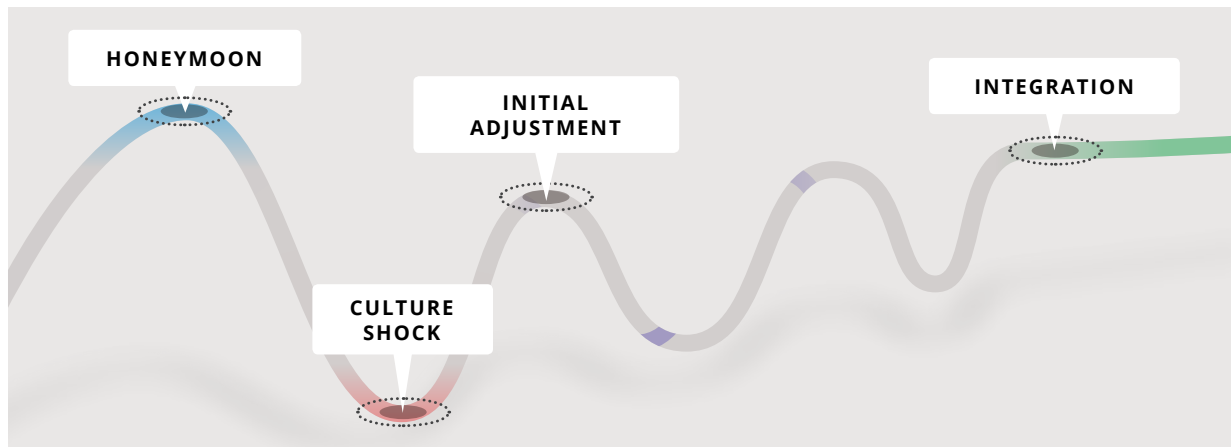
#### ADJUSTMENT

Refugees begin to adjust to the idea of being in the United States. Their new surroundings become more familiar and less scary. People learn how the “system” works and often find things here they like.

#### INTEGRATION

People begin to identify as being both American AND from their culture of origin.

This process of adjustment doesn’t have a fixed duration and **often reoccurs** many, many times over a person’s life. Refugees may feel they have adjusted and then a major life event happens such as a marriage, birth or funeral, throwing them back into culture shock and forcing another period of adjustment.



Resettlement is cited by refugees as profoundly traumatic and its impact on mental health may include but is certainly not limited to:

Resettlement						
Anxiety	Frustration	Anger	Disorientation	Isolation	Lack of motivation	Family problems
Memory problems	Fatigue	Confusion	Helplessness	Poor concentration	Poor sleep	
Inability to see oneself in the new environment			Difficulty relaxing; feeling comfortable			

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# CASE STUDY

## CONTEXT AND CLINICAL CONSIDERATIONS EXERCISE

Read each story. The worksheet that follows will help you explore how the client's experience may impact their current mental health. It will also highlight their strength and resiliency factors.

STORY OF

# ZAHRA



Zahra was born in 1969 in Diyala, Iraq. Zahra's family was of Shia Muslim faith, but not particularly observant. Her father was an engineering professor at the University of Baghdad. Her mother was an elementary school teacher. Zahra had two older brothers. She describes her mother as strict but loving, and her father as quiet and analytical. Both had high expectations of her. Zahra followed in her mother's footsteps by getting a college degree in education and working as an elementary school principal. She was a social person and had a lot of friends from all over the country. One of her best friends during her college years was a Kurdish classmate from Kirkuk. His name was Azad and he became like another brother and friend to the entire family.



Zahra met her husband while in college. Mohammed was 15 years older than Zahra and a Sunni Muslim. However, he was from a respected family with a similar background and both families supported the marriage. Mohammed had been conscripted into the Iran-Iraq War, which lasted from 1980 to 1988 and resulted in the deaths of more than half a million soldiers on both sides. While Mohammed had survived the war, he had been at the front for several years. He suffered from nightmares, and at times would isolate himself and go without talking for days. But Zahra was just grateful he was alive. She knew many young men who had died, including the older brother of her best friend and two of her cousins.

Mohammed worked as a hospital administrator and while not wealthy, the couple had a comfortable life. Over the next decade, Zahra and Mohammed had four children — three sons and one daughter.

In 1990 the United States began a military invasion of Iraq. Called Operation Desert Storm, the conflict was of short duration but the American bombings targeted Iraq's infrastructure. Water treatment plants, sewage treatment plants, telecommunications, and roads were destroyed. At the end of the war the U.S. withdrew, leaving Saddam Hussein in place but imposing sweeping international sanctions that blocked almost all imports and froze Iraq's foreign assets.

Under sanctions, food and medicine became much more difficult to get and Zahra and her family suffered along with the whole country. Her three year-old niece died from diarrheal disease because drinking water was no longer sufficiently purified (chlorine was being intercepted as a possible ingredient in weapons). The family thought about joining the mass exodus of professionals leaving the country, but decided against it. Neither Zahra nor Mohammed wanted to leave family and friends. They would wait this out together.

The United States invaded Iraq again in 2003. Bombs fell over a period of weeks causing widespread devastation. Zahra and her children, who ranged in age from 12 to 4, were terrified. Her husband remained at the hospital most days and nights since his staff were overwhelmed by the number of injured. Zahra was home with the children. They designated the small bedroom in the middle of the house the "safe room" because it was furthest away from the windows should they blow out. For a few weeks it seemed that they spent all of their time in this room, only venturing out for food or to go to the bathroom.

Despite the destruction and the fear of being killed in a bombing, Zahra felt hope. Now things would change. Saddam would be overthrown and the country would return to some level of normalcy. Unfortunately her hope was short lived. Diyala, which had always had a large number of both Sunnis and Shia families, exploded into sectarian violence. There were numerous car bombs and IED explosions. People were kidnapped and even targeted and shot on the street. Zahra kept her children home for weeks at a time because she found the streets too unsafe. One day in 2007 as she was walking to the store she heard a loud sound and then was thrown back several feet. A suicide bomber had blown himself up and 42 people were killed. Zahra remembers seeing the yellow orange dust from the bomb and hearing the screams. Zahra began to run. As she ran she saw an arm lying on the side of the road, and what looked like a foot.

Because her neighborhood was Shia and her husband was Sunni, Zahra's family began to be harassed. There were threatening notes left on their patio telling Zahra that the family should leave or her husband would be killed. Her husband took the threats seriously and even hired a guard to drive him to and from work, but he did not want to leave. He worried about where the family would go, and how they would survive financially once they got

there. One day Mohammed was on his way to work when another car cut him off. Armed gun men jumped out and started shooting at the car. Mohammed's driver sped away, but Mohammed was shot in the back and in the leg. He was taken to the hospital where he spent a few weeks before returning home. The family now talked seriously about leaving. They reached out to friends and family searching for a safe haven, but because of their mixed marriage and the high degree of sectarianism they could find no sanctuary. Zahra's family hesitated to take her in because her husband was Sunni. Mohammed's family hesitated because Zahra was Shia.

The final straw was when Zahra and Mohammed's oldest son Abbas, who was now 17, was kidnapped. He was held for a ransom of \$70,000. Zahra and Mohammed liquidated their savings to pay for his release. He was returned beaten and bloody, but thankfully alive. Zahra and Mohammed decided they could wait no more.

Zahra and Mohammed had hoped to fly to Turkey, which was the only country that would let people arrive by air without a visa. They first planned to go to Kirkuk to their friend Azad. The way to Kirkuk was safer, and from there they would fly to Turkey. When they called Azad his wife answered and told them that two months ago a group of terrorists kidnapped Azad and beheaded him. Zahra was shocked. She had lost one of her best friends and her way out of the country because no one without a sponsor in Kirkuk can enter the city. Now, flying to Turkey would mean the family would have to leave from the Baghdad Airport, and the way to the airport was not safe for Sunni people. They decided to flee to Syria where they could get a visa at the border. Mohammed used most of the family's remaining savings to hire a taxi driver to take the family of six. The road was almost deserted and they saw no other cars for hours. Zahra was terrified. They were very conspicuous and easy to target.

Somewhere near the border they joined other cars stopped at a checkpoint. Soldiers were checking passports. The man in the car next to them handed his passport to the checkpoint guard, and as Zahra looked the guard asked the man to get out of his car. Without ceremony the guard put a gun to the man's head and shot him, leaving him a crumpled, bleeding body next to his car. The guard approached their car. Zahra had heard that there were fake checkpoints controlled by the militia. Her knees began to shake. Was it a Sunni checkpoint or a Shia checkpoint? If it was Sunni, she would probably be okay as they almost always only checked the husband's ID. If it was Shia, they would almost certainly be killed. She put her hands on her knees to keep them from shaking. Her daughter had her head in her lap and was whimpering. Her husband got out of the car and handed the guard his passport. She looked down, holding her breath, waiting for the sound of a shot. But instead of a shot she heard the car door open and her husband quietly get back in. They drove on, eventually reaching the Syria border where they were issued a visa for 30 days.

Zahra and her family registered with the United Nations High Commissioner for Refugees and rented a small apartment and Mohammed began to look for a job. Because he was Iraqi, he could not find a job in his previous field. Mohammed eventually found a job in construction that just barely covered their rent. Zahra and Mohammed did not have enough money left to send the children to private school, and because of their immigrant status free school was not open to them. Zahra began to teach the children at home, getting them up early and making them get dressed just like a regular school day. Abbas had been a good student back in Iraq, but since the kidnapping he had trouble



concentrating and seemed uninterested in school work. Zahra and Mohammed talked and decided it would be better if he found work along with Mohammed. At least this would keep him occupied and away from the street gangs.

Their tenuous but safe existence in Syria continued until 2011 when civil war broke out. By now the family truly had no money left and no way to get out of the country. They were trapped in Damascus, and every day they lived in a constant state of fear. There was no one they could trust. Secret police, wearing civilian clothes and armed with guns, were everywhere. Every day and every night there were sounds of explosions and gun shots. The water became contaminated and the only safe water was bottled, but it was expensive. Food became hard to get and incredibly expensive. There was no more construction and Mohammed and Abbas lost their jobs. The situation became desperate. At one point Zahra sold her wedding ring for food. Safety was just a dream.

In 2013 Mohammed got the news that the family had been approved for resettlement. He and Zahra cried with relief. They would finally be safe. Unfortunately, Abbas could not come with the family. He was now too old to join them and had to have his own resettlement case. The hardest day of Zahra's life was the day she had to leave him. Damascus was not safe. Being an Iraqi was not safe. There was nothing to do but wait and hope he survived.

The now five-person family was resettled in the United States. They moved into a three-bedroom apartment with a rent of \$1,000 dollars a month. After registering the younger children in school, Zahra, Mohammed and their oldest daughter began to search for work. Three months after arriving in the USA, and despite help from their resettlement agency, only Mohammed had been able to find work. He worked as a stock boy in a large warehouse and made a little above minimum wage, bringing home about \$1,000 a month. It was barely enough to pay the rent and utilities. Zahra worried constantly about Abbas. Some nights she couldn't sleep at all.

Zahra and Mohammed had trouble connecting with their neighbors, even the Iraqi ones. It seemed like the sectarian problems in Iraq had also come to the U.S. They were afraid to tell people their story, afraid to talk about Abbas. Who knew whom people were connected to back home? Maybe somebody would have Abbas kidnapped and try to get money out of them because they were in the U.S. now. Maybe people would think they were traitors. Maybe they would disapprove of their Sunni/Shia marriage. It was better to just keep everything to themselves.

Mohammed worried about his children. He noticed that children in the United States were not very respectful towards adults. Some of the outfits he saw on girls, even young girls, were scanty and he considered them immoral. He hated watching American television. Muslims were always portrayed as terrorists, and when Iraq was mentioned it was as if Americans were the only ones who had lost anything. His country and his life were smashed. Everything he worked for meant nothing now. He felt he had done everything right. Gone to school, served his country, worked a good job, and saved for retirement. But now there was nothing left.

Zahra saw her husband's despair, and felt her own. She was glad the youngest were in school. She was grateful they were safe. But until Abbas joined them and she could see him and know for sure he was safe, she could not start her life here. This part of her heart was still in Syria, and still in danger.

# THE REFUGEE JOURNEY AND ITS IMPACT

Think about the story you just read and then write down your thoughts about the impact in each of these areas on the main person in the story:

	Pre-Flight	Flight	Encampment	Resettlement
Trust				
Self-esteem				
Self-efficacy				
Safety				
Belonging/ Community				
Fairness/Justice/ Equity				
Role/Place				
Hope/Future orientation				

Demonstrated resiliency and strengths:

# THE REFUGEE JOURNEY AND ITS IMPACT (CONT.)

Now think about influencing factors that may either compound or mitigate the impact of the previous page.

## Influencing Factors

Early attachment/family of origin

Developmental age when events occurred

Intensity, frequency, duration of trauma

Loss

Nutritional deprivation

Physical health

Current stressors

Hope/Future orientation

STORY OF

# SANJAY



Sanjay was born in 1976 in the country of Bhutan. Generations earlier his family had moved from Nepal to the lowlands of southern Bhutan. Sanjay and his family were proud to be Lhotshampas, or “southern people,” and had retained their distinct Nepali language, culture, and customs.

Sanjay was the oldest of five children. His mother was a homemaker while his father was a farmer on a small farmstead that had been in the family for generations. Sanjay and his family were Hindu and their faith was a central part of their life. Sanjay’s hero was his father, a respected leader in his community. His father was consulted on both family and community matters, and it was not uncommon for Sanjay to find neighbors in their home seeking his father’s advice.



In the late 1980s, when Sanjay was an adolescent, the government of Bhutan (which was dominated by the Drukpa ethnicity) enacted a policy of “Bhutanization” under the slogan “One Nation, One People.” Sanjay’s family and other Lhotshampas were told they could no longer wear their traditional clothing or speak their language. Not long after that, officials came to their village and demanded that all the Lhotshampa people provide tax receipts to prove they owned their land and that they had been in the country before 1958. If a family could not produce these receipts they were considered illegal aliens and would have to leave the country.

Sanjay’s father joined other neighbors in protesting the government’s new policies. After one such protest in 1992, Sanjay’s father did not come home. For two months, the family did not know if he was alive or dead. Late one night Sanjay heard the door open and his mother gasp and cry. He came into the living room and saw his father—thin, disheveled, bruised, and bloody. Later Sanjay would find out his father had been imprisoned, hung upside down, and beaten on an almost daily basis. His father told the family to pack some rice and a few belongings. Within an hour they had fled for the border.

Leaving on foot, Sanjay and his family joined two other families from his village who were trying to reach the border with India. The family stayed off the main road, walking in the jungle to stay hidden. They constantly feared deadly snakes and being set upon by thieves who attacked travelers in the jungle. It was the rainy season and several times they had to cross swollen and dangerous rivers. They walked 14 hours each day, sleeping when they could no longer walk and eating what meager food they had.

Sanjay’s mother carried his youngest brother on her back for most of the journey. His father was still not strong enough. He watched his mother struggle and felt helpless. He tried to calm his younger siblings’ fears and keep their spirits up even though they were tired and hungry. Twenty times a day his little sister begged to stop. She cried constantly. He felt like shaking her but knew it wasn’t her fault. She was only seven and the journey was hard.

After two days they reached the border. They knew that local residents were not friendly to outsiders and that the police could arrest them and take all of their possessions, so they intentionally went to a village where there were a high number of Nepali families. There they were lucky enough to find a sympathetic family that would allow them to stay one or two nights. The family told Sanjay’s family that India would not be safe for them and urged them to join other Lhotshampa in crossing the border into Nepal. The Lhotshampa families pooled their resources and hired a truck driver. On their second day in India they boarded a truck and set off for a 36-hour journey toward the border.

Along the way they worried about being stopped by police or robbed by bandits. Fortunately, they reached the border without incident. The Nepalese officials at the border had everyone disembark from the truck and then began asking them many questions: Who were they? Why were they here? What were their names, ages, and professions? How many children did they have? Had they committed a crime? After what seemed like hours of questions the Nepalese border guards put the families on a truck that would take them to the refugee camp.

Sanjay and his family finally felt safe as they travelled to the camp. When they arrived it was late in the day and there was no chance to register or get food rations. They grabbed their meager belongings and made a makeshift camp site in a grassy area under the open sky. The next day Sanjay and his family registered as refugees. They were given a ration

card for food and some utensils for cooking. They were also assigned a camp site and were given some bamboo and a tarp to make a shelter. That day Sanjay, his father, and other camp residents worked to build a shelter for Sanjay and his family.

Camp residents were not allowed to leave the camp. If they did so they risked arrest or being beaten up by locals, who resented the camp residents. Some men did leave and some even found work “under the table,” but frequently they returned to the camp having been cheated out of their pay or robbed on the way home.

Inside the camp there was little to do, but there was school. The classes were basic and included students of every age, which sometimes made it difficult to be challenged or learn. Sanjay’s family had always valued education, so he and his brothers and sisters attended school when it was in session. Sanjay liked to learn. He looked forward to the times when the camp handed out pens and hated it when his pen ran out of ink, for he knew it would be some time before he would get another.

The first year was by far the hardest, especially getting used to the hunger. Every few weeks Sanjay’s family would line up to get their ration of rice, oil, vegetables, and salt. The family would eat 2-3 small meals a day. This way, they had something in their belly but would not run out of food too quickly before the next ration. Yet Sanjay was always hungry. He often went to school with nothing but hot tea in his belly. Sanjay watched his younger siblings grow hungry as well. His youngest brother, like many others, now had the round and distended belly that signaled malnourishment. Sanjay hated that he had no soap, or even a toothbrush or toothpaste. He had no shoes or jacket, either, and so he suffered when the weather was cold. During rainy season it was often windy and the tarp covering Sanjay’s shelter often flapped open, letting in rain. Sanjay hated those nights because he would have to sleep with the tarp over his body in an attempt to stay dry.

The lack of food was coupled with a lack of sanitation. Epidemics of diarrheal disease, cholera, tuberculosis, and typhoid were frequent. There was some medical care in the camp, but it was very basic and insufficient to meet the need. In the first year alone Sanjay knew five families that had lost a child.

Camp residents cooked outside over an open flame, and the second year Sanjay was there a fire broke out, destroying part of the camp. Twenty-two people died.

In 2002, when Sanjay had been in the camp for ten years, he got married. His wife became pregnant and Sanjay feared she would die in childbirth. He knew many women who had, and he was very afraid. Fortunately his wife survived and they were blessed with a beautiful baby boy.

In 2007 people started to hear the news that refugees were being resettled from Nepal to the United States. Some people in the camp were fiercely opposed to resettlement because it meant giving up their land rights in Bhutan. Sanjay and his wife discussed it. They wanted more for their son than the life in the camp, and they weren’t sure they would ever get to return to Bhutan. Sanjay had already been in the camp for 15 years. He did not want to die in the camp. Sanjay and his wife decided to register for resettlement without telling anyone. They went through multiple interviews and background checks in secret, since they didn’t want to raise suspicions among the anti-resettlement forces in the camp.

About a year after registering, Sanjay got the news that they had been approved. He would be going to the U.S. and could now tell his family that he and his wife and son would be leaving. Sanjay's family had also registered, but their resettlement application had not yet gone through. He knew he would have to leave his parents and the rest of his family in the camp and had no idea when, or if ever, he would see them again.

Finally the day of departure arrived. He and his wife had packed all their belongings in one suitcase. His family and friends walked him to the bus that would take them to the transit camp. His wife began to cry. The goodbyes would be harder on her, for her father was old and sick. He had not filed for resettlement and she knew she would likely never see him again.

It took two-and-a-half days of flying to get to the United States, and when Sanjay and his family arrived they were exhausted. They were met at the airport by their resettlement worker who took them to their first apartment in the U.S. After a night's sleep the resettlement worker returned to begin orienting Sanjay and the family to their new life.

Sanjay was surprised by the U.S. Surprised and scared. The streets were very busy and he was afraid cars would hit him when he crossed. He had to take two buses to get to work and he worried he would get off at the wrong stop. Since he did not speak or write English, he also worried that he would get lost and not be able to find his way. His work schedule changed every week, making it harder for him to go to school. He worried that if he did not go to school and learn English he would never get a good job. His work was physically hard and Sanjay was often exhausted. Even though he worked full time, he could barely make his rent and twice was unable to pay his utilities. He worried constantly about money and how he would pay the bills. Maybe they will even put me in jail, he thought.

Sanjay knew that his family would be better off financially if his wife worked, but she had not taken the move well and rarely left home. She cried almost every day and sometimes spent entire days in bed. Recently they had had an argument and she accused Sanjay of taking her away from her father and bringing her to a place where they could end up homeless on the street. Sanjay thought about taking a second job. He knew this meant he would have to quit school and stop learning English, which would likely limit his ability to get a better job in the future. He wasn't sure what to do. Maybe coming to the U.S. had been a mistake.

# THE REFUGEE JOURNEY AND ITS IMPACT

Think about the story you just read and then write down your thoughts about the impact in each of these areas on the main person in the story:

	Pre-Flight	Flight	Encampment	Resettlement
Trust				
Self-esteem				
Self-efficacy				
Safety				
Belonging/ Community				
Fairness/Justice/ Equity				
Role/Place				
Hope/Future orientation				

Demonstrated resiliency and strengths:



## THE REFUGEE JOURNEY AND ITS IMPACT (CONT.)

Now think about influencing factors that may either compound or mitigate the impact of the previous page.

### Influencing Factors

Early attachment/family of origin

Developmental age when events occurred

Intensity, frequency, duration of trauma

Loss

Nutritional deprivation

Physical health

Current stressors

Hope/Future orientation

STORY OF

# ESTHER



Esther was born in 1997 in the North Kivu area of the Democratic Republic of Congo. The North Kivu region had been engulfed in war since 1994 as a result of spillover from the Rwandan genocide. Millions of people would die in this conflict.

Esther was only seven when she saw her entire family slaughtered. It was just after dusk when armed men broke into the house and began raping and murdering. She saw her father shot in the head and her mother grabbed by two men. The men had not seen Esther, and she took the opportunity to slip out the back door. Esther hid in some bushes near the house, lying down in the dirt. From there she saw the soldiers leave the house

and set it on fire. She saw the flames consume the house and all of her family—her mother, her father, and her two young brothers. Her neighbors' homes were set ablaze, too. She saw her cousin Paul run out of his house on fire and watched as two soldiers raised their guns and shot him as he ran. Afterward they laughed and patted each other on the back.

Esther lay there the entire night afraid to move, even wetting herself because she was afraid to rise up and squat. She saw the soldiers leave as the remains of the village smoldered.

At dawn Esther heard the sounds of people moving. Slowly a few villagers came out of the bushes. Esther saw her best friend's grandmother, Ruth. She ran to her, wrapping her arms around that soft familiar body and collapsing in tears. Ruth patted Esther's back for a few minutes and then took her by the hand. They joined about a dozen other villagers and began to walk toward a border and the hope of safety. Along the way they met other survivors until there were about 30 of them.

They walked for more than two weeks with almost no food or water. They hid in the jungle, sometimes sucking water from the puddles in the mud, sometimes eating grass. They stayed off the main paths, afraid of the militia who would surely slaughter them. Esther found that she was more hungry than scared. She thought about food constantly. When she wasn't thinking about food she thought about her mother's face at the moment when the soldiers grabbed her. She wondered if she was dead before they set the fire. She hoped so. Sometimes Esther prayed to God. She did not pray for her family, for she knew they were dead. She did not pray to survive. She prayed that an animal wouldn't eat her. She had heard the large cats in the night, and she knew they were stalking the group. She imagined the animal leaping from the tall grass, its jaws around her leg as it dragged her off into the bush. When she imagined these things she held Ruth's hand, which always made her feel safe.

Ruth had not talked for the entire trip and she had a blank look on her face, but she took care of Esther. She gave her what little food she could find and pushed her forward. She took part of the hem of her dress to make bindings for Esther's feet after they became bloody from walking. She slept with Esther at night, pulling her into the curve of her body to protect her.

After two days they saw a small river and on the other side was another country. They would have to get across to reach safety. Esther did not know how to swim. The group waited until it was dark and then slowly crept toward the river. Suddenly a shot rang out and then many shots. People began to run and scream. Esther could not see anything and did not know where she was. She began to run. She felt a tug on her arm. She was still holding Ruth's hand and Ruth was pulling her toward the water, forcing her ahead. And then Esther was in the water, with Ruth still holding her arm. Somehow she found herself on the other side. She started running from the river's edge when suddenly she saw a shadow coming towards them. She began to scream, but this time it wasn't the militia, but a border guard. They had made it across.

Ruth and Esther were taken to a camp in a desolate and dry area. It had a barbed-wired fence around it and guards posted every day to keep people from coming in and going out. They registered at the camp and were given a ration card and a tarp. The tarp was supposed to be used for their shelter, but there was little else to build with. She and Ruth slept in the open, pulling the tarp over them as a blanket. Esther noticed that other people would take small sticks and bind them together with string and cloth, making a kind of

frame on which they draped the tarp. She and Ruth began to find every sturdy stick they could, and within a day they had their own shelter.

After Esther had been in the camp a year, the camp started a school. She was so excited. Here was something to do every day. The school had no pencils or books, but the teacher was good and she could do sums in the dirt.

What little food the camp had was often moldy or bug-ridden. The water was terrible and already two cholera epidemics had passed through the camp. Many people died, including two girls from school.

While Esther and Ruth avoided cholera they were not spared malaria. She and Ruth had malaria more times than they could count, but so did everyone else they knew. Esther would sleep next to Ruth and hold her hand while she was suffering from fever, wiping her brow and telling her she would be okay. Ruth was her mother now, and daughters took care of their mothers.

When Ruth was well she would sometimes slip past the guards, who had become more lax over the years, and comb the area nearby for firewood, which was scarce in the camp. One time Ruth returned from such a trip with a large welt on her forehead, a black eye, and bruises on her neck. She did not talk for more than a week. Esther did not ask what happened. She knew. Ruth had been raped by locals who looked for women alone. It happened all the time.

When Esther was 14, after seven years in the camp, someone from the UNHCR came to the camp and told the refugees that orphaned children might get a chance to study in the United States. Ruth urged Esther to go and take this opportunity. Esther wanted a new life in America, but she did not want to leave Ruth. Ruth insisted. "You will die in this camp if you do not go," she said. Esther relented and filed for refugee status. A year and a half later, she was told that she had received resettlement and would be going to the U.S. to join a new family.

Esther was now 15. She knew she would never see Ruth again, but she also knew she could work in America and send her money. She could help Ruth get medicine and food. She could hire a girl to take care of her.

Esther was scared but excited about her new life in the United States. The home she was placed in was beautiful. She had her own room and her own bed. She had more than enough food to fill her stomach. She told her social worker the second day she was there that she needed to get a job as soon as possible, but the social worker told her that at 15 she was required to go to school. She would need to concentrate on her studies, learn English, and adjust to life with her new family. She could work later, but not now. Esther became angry, shouting at the social worker that she had to work and that she would not have come to the United States if she knew she could not work.



# THE REFUGEE JOURNEY AND ITS IMPACT

Think about the story you just read and then write down your thoughts about the impact in each of these areas on the main person in the story:

	Pre-Flight	Flight	Encampment	Resettlement
Trust				
Self-esteem				
Self-efficacy				
Safety				
Belonging/ Community				
Fairness/Justice/ Equity				
Role/Place				
Hope/Future orientation				

Demonstrated resiliency and strengths:

# THE REFUGEE JOURNEY AND ITS IMPACT (CONT.)

Now think about influencing factors that may either compound or mitigate the impact of the previous page.

## Influencing Factors

Early attachment/family of origin

Developmental age when events occurred

Intensity, frequency, duration of trauma

Loss

Nutritional deprivation

Physical health

Current stressors

Hope/Future orientation

# SECTION 3

## BARRIERS TO CARE

People have an amazing ability to heal, and despite the extreme violence and stress that many refugees experience the majority do not need mental health treatment.<sup>44</sup>

They draw on their faith, traditional healing methods and community connections to rebuild their lives.

However, because of the high degree of trauma and stress both before and after migration, about one-third of refugees do develop major depression or post-traumatic stress disorder.<sup>45</sup> (Again, it should be noted and admired that two-thirds do not!) These refugees would benefit from some form of mental health treatment designed to help them come to terms with the past and cope with their current challenges.

This guide recognizes that treatment via counseling within a community mental health clinic is not the only, or necessarily the best, solution to emotional distress in refugee populations. Other kinds of interventions may happen within refugee communities, religious institutions, community-based organizations, or ethnic-specific self-help organizations. Nevertheless, when mental health clinics offer appropriate, culturally-responsive care, they can play a critical role in reducing the symptoms of emotional distress and furthering a refugee's adjustment.

Unfortunately, while refugees have a greater need for mental health services, they utilize these services at a disproportionately lower rate.<sup>46,47,48</sup> The reasons are multifaceted and include stigma, contextual gaps in understanding what mental health in the U.S. is, and a lack of culturally responsive services.

### Individual and Community Barriers to Mental Health Treatment

#### LACK OF CONTEXT

Many refugees come from countries with little if any mental health infrastructure. This means that there is little if any access to effective counseling, medication, or treatment. If a mental health infrastructure does exist, it is commonly a psychiatric institution for those with persistent, severe mental illness.

In many countries there are few laws to protect the human rights of those with mental illness. People may be forcibly detained without due process for an indeterminate period of time –sometimes the rest of their life. The condition of these institutions and the care given to their patients is often deplorable, with poor sanitation, over-medication of patients, and forced restraint. It is not uncommon for the mentally ill to endure terrible abuse.<sup>49</sup> People may be forcibly chained, starved, beaten, or even placed in cages like animals.<sup>50</sup>

*“Where I come from there is normal  
and there is crazy. That’s it.”*

— Refugee client from Somalia

If, in these countries, having a mental health issue is a sign that you lack faith or have committed a misdeed in a past life, then it would be wise to keep those issues hidden. If treatment is only for those with severe mental illness, then mental health issues would naturally be associated with being “crazy.”

In some places there is no concept at all of “mental health.” It is not that the term equates with crazy, but there are simply no other words in the refugee’s language to explain what it means. Alternatively, the symptoms of a recognized mental health disorder like depression are known by another name but may not be considered a mental health issue at all.

### DIFFERENCES IN CAUSALITY

Many refugees understand health and wellness in ways that are distinctly different from Western medical perspectives. While most Western countries adhere to a bio/psycho/social worldview of mental health, other countries and cultures attribute mental health problems to other causes, including:

- Supernatural forces like witchcraft, the “evil eye,” curses, and spirits
- Religious issues like lack of faith, or a test from God
- Humoral issues like lack of balance in the body (hot and cold), too much bile, or poor blood
- Personal or karmic inheritance resulting from misdeeds in a past life or family history
- Personal weakness; admitting to mental distress may be considered weakness or lack of strength

Because of the above perceived causes, mental health issues often carry a stigma, and those with mental health problems may be shunned or ridiculed, barred from marrying, receiving an education, or getting a job.

#### WHAT IS WORLDVIEW?

A worldview is a set of beliefs that help us make sense of the world around us and guide us in how we should act in that world. Of particular importance to health care providers is that worldviews influence how an individual interprets or explains their experience or symptoms. A refugee client may have a worldview distinctly different from their provider’s and therefore may have a different perspective on how to approach or resolve an issue. It is important for providers to not only remember this, but also to remember that modern medicine, including psychiatry, is part of a Western worldview.

### HISTORY OF PSYCHIATRIC ABUSE

It is important to recognize the role of psychiatry as a tool for political oppression. Human rights abuses by psychiatrists have occurred all over the world, with authoritarian regimes using psychiatry to stifle dissent. Refugees who come from countries where mental health systems have aided in persecution are likely to view mental health in the U.S. with great suspicion and fear.<sup>51</sup>

### FEAR OF COMMUNITY GOSSIP

Refugees may come from countries where confidentiality is not guaranteed and is not the norm. If an interpreter is in the session, then confidentiality may be even more in doubt. Refugee communities are small. When clients and interpreters share a community, the client may fear that information from the session will make its way back into the community. For this reason, the client may prefer a family member or close friend to be the interpreter, which in turn causes its own set of challenges and issues. (See Section 7, Working with Interpreters.)



**WORRIES ABOUT IMPACT OF SEEING A THERAPIST**

Refugees may have a limited understanding of the ways that counseling might help them. The pressures of daily life may lead many to question how sitting down and “just talking” to a stranger can have any impact on the issues they are facing. As survivors, many refugees have had to rely on their own resources and may feel that going to counseling is an admission that they are “weak” or unable to manage their own life.

For almost all refugees, getting citizenship in the U.S. means safety and permanence, both of which have been missing from their lives. Some refugees will worry that receiving mental health treatment will negatively impact their ability to become a U.S. citizen, gain employment, or take advantage of other opportunities.

In addition, if a client is involved in an abusive relationship or undergoing a divorce, they may worry that seeing a mental health provider will mark them as “unfit” for parenting and make it less likely for them to secure or maintain custody of minor children.

**CONFUSION ABOUT CLIENT AND PROVIDER ROLES**

Because many countries do not have an established psychiatric infrastructure there is often confusion about client and provider roles. Refugees may view the therapist as a friend or natural helper. He or she may call the therapist “my sister” or “brother” and ask the therapist over for a meal or a special event. It is important for Western therapists not to assume that clients are deliberately crossing boundaries. Remember, this type of professional relationship may be unknown in the client’s country of origin.

Many refugees are also uncertain how to act in the session, or what to reveal or not reveal. Officials in the past may have misused information, or not been transparent about its use. Therefore, some refugees may hide certain information because they are unsure what role the provider plays in the system. This is not being deceitful, but protective.

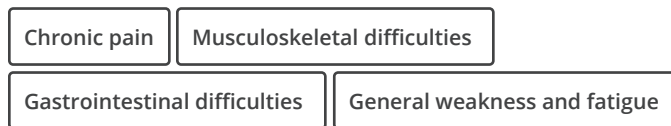
Refugees may not want to talk about the past, or be frustrated that the therapist continues to talk about mental health when they are having difficulty paying rent, getting employment, or understanding how to take the bus. They may express irritation that there is “all talk and no action.”

**TRAUMA-INFORMED LENS**

It is important for providers to have a trauma-informed lens when working with refugees and be aware of common issues in those who have survived complex trauma, including memory problems, confusion, and disrupted timelines. Knowing how trauma impacts an individual’s mind and body is critical to assessment, engagement and treatment. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides a [clearinghouse](#) on trauma informed care where providers may learn more about a trauma-informed approach, interventions, and training.

### HIGH SOMATIZATION

Refugees tend to have more unexplained physical symptoms than the general Western population.<sup>52</sup> This may be because of stigma, uncertainty about the role of the therapist, or because a refugee's worldview may not separate the mind and the body. In truth, the mind and body are linked. Trauma experiences and stress cause physiological reactions that can manifest in a variety of ways that may not be well-understood by modern medicine. There is emerging research that the strain placed on the body by trauma and violence is high and can contribute to hypertension, diabetes, body and joint pain, and other physical symptoms.<sup>53</sup> Common physical problems trauma survivors report include:



Ongoing stress and fear can also suppress the immune system, making the client more susceptible to a variety of illnesses.

As a first step, therapists must make sure that physical symptoms are assessed by physicians. Refugees will generally come from countries that lack a medical infrastructure and they may have underlying physical conditions which should be ruled out. It is not uncommon for chronic and other diseases to be affecting a refugee's overall health.

If an identifiable medical problem is not found, the therapist should explain to the client how emotional distress can cause symptoms that affect the body. At the same time, the therapist must be careful from ascribing these bodily symptoms wholly to emotional causes. It is not uncommon in our clinic to have a client who has had multiple concussions from bomb blasts to have persistent headaches with no found medical cause, or to have a client who has been gang raped by soldiers to have persistent lower abdominal pain with no found medical cause. However, it is not unreasonable to believe that there still may be an underlying, but poorly understood, physiological reason for this pain.

### Barriers within the U.S. Mental Health System

While stigma, shame and fear may prevent refugees from seeking or accepting mental services, the U.S. mental health infrastructure also hampers access and treatment. The mainstream mental health model in the United States is predicated on Western culture and is deeply rooted in a complicated bureaucratic system.

### INDIVIDUALISTIC VS. COLLECTIVISTIC WORLDVIEWS

In the U.S., mental health treatment tends to focus on the thoughts, perceptions, and desires of the individual client. However, many refugees come from more collectivist cultures. In worst- case scenarios, the therapist can label the client as “enmeshed” or “overly dependent” and insert these issues into therapy.

Therapist Perspective	Client Perspective
What do you want?	What is best for my family?
What are your hopes and dreams?	I must fulfill the role my family gave me.
It is your life!	My life is the product of all my ancestors and their sacrifices.
You have to take care of yourself first.	If you do not put your family before you, then you are selfish and immature.

Much of mainstream psychotherapy is also focused on processing feelings. Many refugees have lived in survival mode for decades. Being vulnerable enough to “feel” can be a liability in an environment in which staying alive requires suppressing one’s emotions and maintaining toughness.

#### LACK OF STABILITY

New arrivals often lack any degree of stability in their lives. They are uncertain about how to navigate the system, they may be unemployed, and they are almost certainly financially stressed. The ongoing challenges of acculturation make it difficult to establish the sense of safety necessary to address a refugee’s symptoms or do therapeutic work.

Refugees may also still have family and friends who are in harm’s way. They may be receiving frequent bad news about people they love, which can fuel depression and retrigger traumatic stress.

*“I avoid the phone. I avoid the news. Sometimes I even avoid all the people from my country. I don’t want to know what has happened or who has been killed. Bad news always. You know, it is not over. I don’t think it will ever be over.”*

— A refugee client from Sudan discussing how current events in his home country still affect him

“Talk therapy” can seem impractical to a survivor with a heavy trauma history who is facing acculturation challenges, bad news from home, and an inability to make rent or find a job.

#### UNFAMILIAR TERMS

Words that are commonly used in the United States may have no meaning, or a different meaning, in other languages. “Counseling,” “depression,” “therapy,” “mental health” and other terms may not have equivalent words or equivalent concepts in cultures where mental healthcare professionals and services do not exist. Simple questions and statements such as, “Do you think it would be helpful to see a therapist?” or “We can’t find anything physically wrong with you; it may be depression,” may be met with confusion and misunderstanding.

#### COST TO THE CLINIC

Many mental health systems are chronically under-resourced and stretched thin, and working with refugees can be both staff- and time-intensive. While many refugees have strong circles of interdependence, many of those natural networks are fractured when they come to the U.S. Refugees often have complicated needs in addition to mental health issues, and addressing and/or untangling these situations requires time and phased treatment planning.

Mental health providers in the U.S. are also overwhelmingly English-speaking, which requires clinics to use an interpreter. Using an interpreter means that the session will address half as much because everything must be said twice. This lengthens time in service and costs clinics money. The cost may be beyond a clinic’s financial reach and discourage clinics from working with this population.

**ADMINISTRATIVE OBSTACLES**

A clinic’s administrative processes may hinder a refugee from accepting or sustaining services. Many clinics do initial phone screening and ask highly personal questions designed to ensure that the client qualifies for service and/or that their clinic is appropriate for the client’s symptoms. Most refugees are

*The United States also has a history of psychiatric abuse. Historically, psychiatric institutions were dismal places with poor sanitary conditions, brutal treatment, and little effective care. It was only when institutions in the U.S. put in place more humane and effective treatments that stigma and shame were reduced. Even now there remain abuses, and conditions such as schizophrenia still carry significant stigma.*

reluctant to share private information over the phone when they do not know the person or how the information will be used. In addition, some of the normal pre-screening questions—such as “Are you hearing voices?” or “Have you been thinking of killing yourself?”—reinforce preconceived stigmas around mental health.

Many clinics also send administrative forms and consents ahead of time, or have clients arrive early to fill out these forms. It is unlikely that a clinic will have the forms translated into

the refugee’s language, making it impossible for clients to complete these forms before the first session. Clinics may have to go over each form in person, adding extra time and often frustration to the initial meeting.

**INFRASTRUCTURE BARRIERS**

Depending on a refugee’s insurance, diagnosis and other factors, mental health treatment may or may not be covered.

Getting to appointments is also likely to be an obstacle given that new arrivals are unlikely to have transportation and may not know how to reach the clinic by bus. Even if refugee clients do know how to use the bus, bus fare may be prohibitive to those refugees on a very low income.

If a new arrival is employed they are most likely in an entry level job. Such jobs have schedules that change frequently, making it hard to commit to appointment times.

If a client repeatedly cancels or does not show for appointments because of a job schedule, or a missed or late bus, the clinic may label the refugee as “non-compliant” or not engaged in treatment and may discontinue working with them.

**INDIVIDUAL PROVIDER BARRIERS**

Mental health providers are often unsure about how to best deliver services to refugee populations. While they may have received cultural competency training, most training focuses on the diversity of

*“I am afraid this therapy is to make me forget the past. I don’t know about the therapist. He will never understand. Never get the full idea. No one will ever feel the pain except those that suffer it.”*

— A Somali refugee client discussing the fear of “forgetting”

the U.S.-born population (African-American, Asian-American, etc.) and rarely focuses on the complexity of delivering services to the foreign-born. When training does encompass foreign-born clients, it often creates overly broad categories such as “Asian” or “African,” which does little to inform a provider about a particular culture and the variations within that culture. For

example, an upper-class doctor from the dominant ethnicity of a country may have little in common with a pre-literate farmer from a remote hillside tribe within that same country.

Refugees bring with them trauma stories which can be extremely disturbing. Many involve incident after incident of brutal violence on a scale unheard of in the United States. Few therapists are prepared emotionally or therapeutically for this level of trauma. Therapists may feel overwhelmed and wonder what they could possibly offer someone who has experienced such horrific events. In some cases, they may harbor doubts that it is possible to recover at all.

Most therapists are not trained on how to work with interpreters and find sessions with an interpreter clunky and hard to manage. They may dislike that the initial emotional connection is more between the client and the interpreter, instead of between themselves and the client.

Because many refugees are not certain what counseling is, and because they face extraordinary stress and pressures in starting over in the U.S., they are likely to ask the therapist to assist them with understanding the system or accessing basic needs. While offering this support is critical to establishing trust and stabilizing clients in order to do deeper, more therapeutic work, many therapists are not trained for case management, nor do they respect its role in the therapeutic process. Getting to the mental health portion of the treatment may by necessity take longer and require considerable patience. This delay may leave therapists feeling frustrated that they are not fully treating the client’s mental health.

**CAUSALITY**

Refugees and therapists may ascribe different causes to symptoms. What heals and what hurts may also be different depending on a person’s beliefs and where they come from. A U.S.-born therapist is likely to ascribe cause to a bio/psycho/social framework, while a refugee client may ascribe cause to any number of beliefs including karma, humors, spirits, and more. What one believes causes a symptom dictates what one believes will cure the symptom.

If a client and a therapist ascribe different causes to the symptoms, but the treatment plan is only geared to the therapist’s framework, the relationship is unlikely to be successful.



### KLEINMAN'S EIGHT QUESTIONS

Dr. Arthur Kleinman is a renowned anthropologist and psychiatrist who developed eight questions providers can ask to better discover their patients' explanatory model of illness. Kleinman's eight questions provide a framework for better understanding how people may view their illness or symptoms, what they believe causes it, how it affects them, and what might lead to recovery.

The eight questions are:

- ① What do you call your problem? What name does it have?
- ② What do you think caused your problem?
- ③ Why do you think it started when it did?
- ④ What does your sickness do to you? How does it work?
- ⑤ How severe is your sickness? How long do you expect it to last?
- ⑥ What do you fear most about your illness?
- ⑦ What are the biggest problems that your illness has caused for you?
- ⑧ What kind of treatment do you think you should receive? What are the most important results you hope to receive from treatment?

### ABSENCE OF FAITH INCLUSION

Refugees often come with a faith that is central to their life. Whether it be Islam, Christianity, Buddhism, Judaism, Hinduism, or another religion, this faith has usually provided strength and sustenance during incredibly difficult times. Some progress has been made on recognizing the importance of faith in healing, but overall the current U.S. mental health system does a poor job of integrating faith systems into treatment. Such faith systems are often crucial to clients' recovery and resiliency.

**TRYING TO “FIX” THE PROBLEM**

Numerous participants in the refugee advisory group spoke about their frustration with Western therapists who wanted to “fix” them, especially after only short-term therapy. Said one refugee from Gambia, “I can’t forget it. It didn’t just happen then, it became a part of me. You know [speaking of the therapist] we did not come from the same problem. Mine will take time.” Another advisory member from Djibouti said, “It makes me feel like more of a problem, more of a failure when I can’t get better fast like they want me to.”

When treating clients therapists should try to improve functionality, decrease distress and offer emotional support while at the same time respecting the individual’s timeframe. It is not only difficult, but perhaps unethical, to expect clients to recover within a pre-determined period of time, considering that they have survived genocide, trauma, ethnic cleansing, and war, as well as the fracturing of their social system.

This combination of community and provider barriers makes it less likely a refugee will access services, remain in services, or benefit from services. However, there are effective strategies to reduce barriers, increase engagement, and provide effective treatment to refugees. Tactics on how to create a shared understanding of services, combine traditional and mainstream interventions, and reduce clinic impediments are discussed in the next section.

## SPECIAL CHALLENGES FOR REFUGEE YOUTH AND THEIR FAMILIES

Acculturation differences often cause a generational gap between refugee parents and children, which can produce challenges at home. Children learn English more quickly than parents and will often assume the role of interpreter. They may be asked to read all the mail and decide what pieces of mail are important. They may assist in paying the bills. They may even interpret for parents at critical appointments like those with a physician, at a bank, or even with the authorities. This can cause additional stress and pressure on youth, and may also lead to parents feeling ineffective as their role is diminished.

Many countries do not welcome active involvement of parents in school. Refugee parents coming from those countries may not understand that parental involvement in schools is highly prized in the U.S. Parents who don't speak English or are pre-literate may not be able to assist children with their homework, school forms, or college applications. Unable to turn to their parents for help, youth may feel at a disadvantage when it comes to school activities, homework, or preparing or applying for college.

Children and young adults generally become more assimilated and adapt to the United States more quickly than their elders. Parents can have a hard time accepting this change as they would prefer that their children maintain the traditional roles and cultures of their home country. Parents may feel loss or even betrayal as they see their children becoming "Americanized" and taking on cultural attributes different than their own. This may cause conflict in the home with the older and younger generation having different beliefs around what is normal, expected, or desirable.

Youth may feel like they don't quite belong to either the culture of their parents or to the culture of their U.S.-born school peers. This can lead to struggles with identity and feelings of isolation.

All of the challenges above are in addition to normal developmental challenges.

There has been considerably more research and publication about PTSD than about treatment and interventions that support refugee youth and families after resettlement in the U.S. [Bridging Refugee Youth and Children's Services \(BRYCS\)](#) is a website devoted to ensuring the successful development of refugee children, youth, and their families by increasing information sharing and promoting collaboration at the local, state, regional, and national levels. BRYCS has a comprehensive list of publications, practice tips, and guides to support this effort.

## SPECIAL CHALLENGES FOR GERIATRIC REFUGEES

Older refugees have unique challenges when resettling to the United States. Refugees 65 and older are unlikely to work and may be solely dependent on their family or the government for financial support, making them more dependent and vulnerable.

Elders may have previously lived in neighborhoods or villages dense with friends and family. Conversation and community may have been right outside their home. Now in the U.S., most of their extended family and friends may remain overseas. Friends and family that live in the U.S. may reside in different states or cities. Even if they reside in the same city, they may live miles away and the elder refugee may lack the transportation options to visit.

Many refugees live in urban areas and on heavily trafficked streets. Walking busy streets to get groceries, visit friends, or participate in an activity like ESL may seem scary and daunting to an older refugee. In their country of origin a family member may have been assigned to remain at home to help the elder with chores, cooking and travel. In the U.S. every adult family member may work, leaving the elder at home alone all day which contributes to feelings of isolation and loneliness. Substantial time alone with few meaningful activities can also increase rumination on the past, leading to increased emotional distress.

The older a person is, the harder it is to learn a new language. Not knowing English makes it difficult to navigate a new environment, thus increasing an elder's isolation. English is required to become a U.S. citizen, and elders may have trouble passing the U.S. citizenship test. If they do not become a citizen within seven years of entering the U.S., they will no longer be eligible to receive SSI, leading to a complete loss of stable income.

As people age they also tend to develop both acute and chronic diseases. These diseases can lead to pain and discomfort, making it hard to leave home or engage in outside activities. Pain is also a contributor to depression, making refugee elders particularly vulnerable to depressive disorders. In traditional societies, elders may be viewed as teachers, community authorities, and wise-leaders from whom individual, family and community advice is sought. For a variety of reasons they may lose this position of privilege in the U.S., leading to a loss of role and diminished sense of purpose and esteem.

For many refugees, even while they adjust to life in the U.S. they entertain thoughts of going home again. This may not mean returning home forever, but at the very least, it means visiting friends, family and familiar places. If a refugee is old and/or ill, they may know that they will never see their home, family, or friends again. After death, there may be no one to perform traditional rites or rituals and they may not be buried in the land of their birth or ancestors. This realization brings with it special loss and grief.

While it is hard for every age to adjust to a new culture, it is particularly hard for the elderly. However, it also may be harder for refugee elders to accept counseling or medication because of entrenched misunderstandings and stigma around mental health. Regular support groups, congregant meals, and planned excursions are effective and accepted ways to reduce isolation and depression in refugee elders while increasing feelings of connection.

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# SECTION 4

## OVERCOMING OBSTACLES

While the barriers to receiving effective mental health treatment are great, there are approaches that help mitigate these obstacles. Below are steps therapists can take to improve the relationships they have with their refugee clients, as well as changes that clinics and clinic management can make that help to lower barriers.

## Individual Level

### BUILD A SHARED UNDERSTANDING

The ways we discuss our services or talk about mental health may hinder or motivate someone to enter or continue therapy. Given that refugees come from places that may be lacking mental health infrastructure, and that mental health may be equated with being crazy, it is important to begin the first session by creating a shared understanding. At ICCS, we have found that this is most successful when it includes the following elements:

- Setting the context (who you are and what you do)
- Addressing misperceptions of mental health in the U.S.
- Normalizing struggles and reducing stigma
- Connecting to concrete benefits
- Allowing the client to choose whether or not to enter services

One client from Sierra Leone said it this way:

*“I need an explanation before I can accept.”*

Below is script for a therapist who is meeting a client for the first time to do an initial assessment:

*“Hi, my name is Mary. It is really nice to meet you. Thank you for coming in today. Can I get you some tea or water? Did you have any trouble finding us? Again, my name is Mary and I am a therapist here. A therapist is someone who talks to you about things that may be bothering you and helps you create a plan for making those things better. I work here at name of agency. Name of agency is a mental health clinic. I know that in many places in the world mental health means “crazy” but that is not true in the United States. In the United States mental health covers a wide range of feelings and emotions - from being sad all the time, to not being able to sleep at night, to even feeling like life is not worth living. It is common for many refugees to have these types of problems because of all the terrible things they have been through, and because it is very hard starting over in the United States. What happens to us in life has an impact on our mind and on our body. What we try to do here is figure out how to make problems like these better so that someone can better care for themselves and their family, and make life easier in the United States. Does it sound like our services would be helpful to you?”*

There are some who believe “mental health” should not be mentioned, or the fact that the clinic is a mental health clinic should be obscured. However, we believe it is important to always be open and transparent with clients. It is our job to educate clients so that they have a greater understanding of U.S. systems and can make the choices they want. This respects and affirms their ability to choose what is right for them. If a client is not told the nature of the clinic, and later finds out, it can also break trust in the relationship.

### EXPLAIN CONFIDENTIALITY AND ITS LIMITS

Explaining confidentiality in concrete, understandable terms helps build trust with new clients. Providers should let clients know that there are significant repercussions including fines and loss of employment should therapists break confidentiality. Including any interpreters present in this confidentiality helps diminish concerns about community gossip.

*“Everything that you tell me is private with very few exceptions. That means that I cannot tell people what you say, or even that you are in services, without your permission. If I break your privacy without your permission I could get in a lot of trouble. I could lose my job and the agency could get fined a lot of money. That is true for the interpreter too. Interpreters must also keep everything private or risk losing their jobs.” (You may ask the interpreter to please say this directly to the client.)*

Therapists are required to not only explain about confidentiality, but also the limits of confidentiality. This can be a difficult to address with refugees because they must include discussion of both suicide and child abuse. For many refugees, suicide is forbidden and highly stigmatized. In addition, refugee communities often have deep-seated fears, based on pervasive rumors, about the U.S. child protection system. Therapists must discuss the limits of confidentiality without implying that they suspect the client of misbehavior.

*“There are some times when we do have to break privacy even if a client does not want us to. We break privacy when someone is in danger or may lose their life. For example, if a client were to tell me that they are going to leave today and go jump off a bridge and kill themselves, I would do everything in my power to save them. Even if they did not want me to, I would call 9-1-1. Or if a client tells me that their next door neighbor is seriously hurting a child, a disabled person, or very old person, I would have to report it because children, people who are disabled, and very old people cannot protect themselves.”*

**TALK IN TERMS OF SYMPTOMS, NOT DIAGNOSIS**

Words commonly used in the U.S. like depression, treatment, and insomnia may not have equivalent meanings in other languages. These words may also contain stigmatizing elements in other cultures. It is better to talk in concrete symptoms which are easier to understand. Some examples:

Term	Concrete Example or Symptom
Insomnia	Not being able to sleep
Depression	Sadness
Frequent tearfulness	Crying all the time
Anxiety	Too many worries; too many thoughts
Panic	Sudden feeling of fear
Treatment	The plan to make things better
Assessment	Asking questions so I can learn more about you and what is bothering you
PTSD	How trauma and violence affects your mind and body

It’s also important not to talk in acronyms. While people in the U.S. may know what DSHS, SSI, or TANF mean, many newcomers do not.

**KNOW THE LANDSCAPE BUT ASK THE INDIVIDUAL**

It is essential that providers know something about a client’s country and culture. A small amount of research can help a provider better understand where someone is from, what the prevailing beliefs and customs are, and what conflict or reason likely precipitated their leaving their country. Still, no amount of preparation can substitute for getting to know the individual client.

The truth is that people differ tremendously in every culture. Age, social class, economic status, and educational attainment are highly variable, as is adherence to prevailing cultural norms. See the below illustration for differences in three individuals from Iraq:

Term	Client 1	Client 2	Client 3
Age	22	35	78
Gender	Male	Female	Male
Education	No School	PhD	High School
Ethnicity	Arab	Kurdish	Turkmen
Employment History	Farmer	Professor	Retired Businessman
Religion	Mandean	Muslim	Muslim

In the above individuals, client #2 may have more similarities to a highly educated female from another country than the other two clients from their own country.

To build a respectful clinical relationship, it helps to be curious and genuinely interested in the client. Providers should not be afraid to ask a client to explain, or to admit their ignorance on a subject. This not only allows providers to better understand their client, it helps empower the client and promote a sense of equality in the relationship.

To find out more background information on refugee communities in the U.S., visit the [Community Orientation Resource Center](#).

**TAKE CULTURE INTO ACCOUNT**

Culture is an intricate and layered subject that can be defined in many different ways. For the purpose of this guide we define culture as the patterns, behaviors, cognitive constructs, beliefs, and understandings about the universe shared by a group of people. People from a common culture often feel like they “fit” with each other, while also feeling like they are distinct from another group.

It is important to remember that culture is not static or universal. Culture changes over time and contains subcultures. A 70-year old and a 17-year may share a culture, but are likely to have different subcultures within that culture. Nor is culture universal. Imagine a bell curve. The large curve in the middle is how most people would “type” or “stereotype” a particular culture, but within that culture are wide differences on either side.

Critical assessment of one's own culture, identity and orientation to the world is important for providers working across cultures. This is particularly important for therapists from the dominant U.S. culture (white, U.S.-born, middle class) who are often exempted from this examination because the dominant culture is subconsciously seen as the "norm" by which other cultures are compared.

Everyone has a culture and examining one's own culture is the first step in successful cross cultural work. Some areas of examination include:

Area	Mainstream U.S View	Other Views	External Indicators of this View
Time	Rigid adherence to and observation of time	More relaxed view of time	Timeliness; adherence to a schedule; comfort with a schedule
Authority and Power	Less hierarchy or distance between people at "the top" and people at "the bottom"	Significant distance between people authority and others	Offering an opinion without being asked; telling a person of higher authority you disagree; making a complaint
Task vs. Relationship	The task is the most important	The relationship is the most important	Time spent before "getting down to business"; having a personal as well as business relationship
Individual vs. Collective	The power of the individual is predominate	The power of the group matters most	What is considered in decision making
Locus of Control	Within a person's power to act or influence their future	The future is outside a person's control; fate	Self-efficacy
Role	The individual defines their role; who they want to be	The role an individual plays is assigned to them by family or community	Personal choice



There are many other dimensions of culture than the ones above, and it is a good idea for a therapist to spend some time reading about those dimensions and how they fit into the different aspects of their own culture. While there are a great many theories and much research in the field of intercultural studies, ICCS has found the work of Professor Geert Hofstede to be particularly useful. Hofstede divides culture into six dimensions:

- **Power Distance (PDI)** – A rigid hierarchy of roles versus a relatively flat hierarchy of roles
- **Individualism versus Collectivism (IDV)** – Individual needs versus the needs of the group or community
- **Masculinity versus Femininity (MAS)** – Ego-oriented versus relationship-oriented
- **Uncertainty Avoidance (UAI)** – Tolerance of ambiguity and uncertainty versus need for certainty and concrete action
- **Long Term Orientation versus Short Term Orientation (LTO)** – Desire to live in the “here and now” versus desire to see “now” as a product of history and desire to plan for future generations
- **Indulgence versus Restraint (IND)** – Freedom versus control

Hofstede’s cultural dimensions are well worth exploring, and further information about his work may be found at his website linked [here](#).

In addition, SAMHSA has produced a free publication called “Improving Cultural Competence: A Treatment Improvement Protocol” which may be downloaded [here](#).

#### COMBINE TRADITIONAL AND WESTERN APPROACHES

What people believe is causing their symptom or problem often dictates what will be an effective solution. Treatment plans are generally more effective if the therapist can utilize what the client believes will work, along with evidenced-based interventions. Asking clients what they believe is causing their problem and what they think will make it better is a good way to elicit this information. One way to do this is for providers to let the client know that they are open and accepting of different beliefs. For example, a therapist could state the following:

*“Some clients who come here believe that their forgetfulness and sleep problems are caused by spirits, a curse, or even lack of faith. Do you have any beliefs like that which you think may be causing your problem or making it worse?”*

Section III of the new Diagnostic and Statistical Manual of Mental Disorders (DSM-5) has a revamped discussion of culture, including an entire section devoted to cultural formations. This section contains questions designed to further therapists’ understanding of their clients’ worldviews as well as an explanatory model of their symptoms. The interview questions can be found [here](#).

Case Study

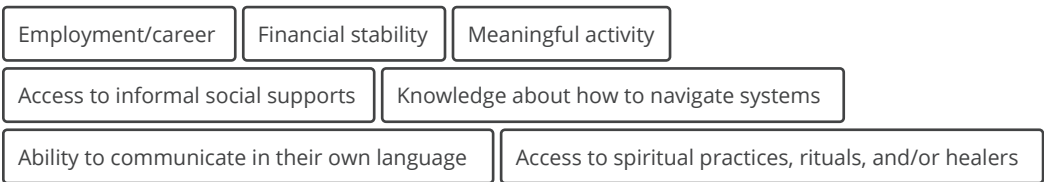
Asha is a 38-year old woman from Somalia who has been experiencing nightmares, intrusive thoughts, poor sleep, and panic attacks for the last several years. The symptoms have gotten worse over the last four months and have been so debilitating of late that Asha has quit work and is only sleeping two hours a night. The therapist believes that Asha’s problem is post-traumatic stress disorder caused by witnessing extreme violence in Somalia and being raped multiple times in the refugee camp. The therapist believes that Asha would benefit from trauma-focused therapy and medication. However, when the therapist asks Asha what she thinks is causing the problem Asha says “jin,” or an evil spirit, and that only an imam or religious leader at a mosque could help.

See the table below to see the multiplier effect of combining interventions.

Intervention	Outcome
Western-Only Intervention	Asha comes a few more times to counseling, but doesn’t understand why the therapist wants to talk about her past. She also doesn’t take the medication. She doesn’t understand why she would take medication for what is a spirit problem.
Traditional-Only Intervention	Asha feels better after going to see an imam and having an exorcism, but the relief is only temporary. The symptoms return and Asha approaches the imam again.
Western and Traditional	Asha agrees to take medication and go to therapy while she also gets connected to an imam for an exorcism. She feels better after the exorcism, and also has begun to sleep better. Now that she is sleeping better, she has more energy and asks the imam about volunteering at the mosque. He agrees and she begins to go to the mosque every week to volunteer. Her visits to the mosque allow her to meet people and make new friends. Through one of these friends she is connected to a job at a restaurant. Even though Asha still struggles, and thus far refuses to do any trauma-focused therapy, she continues to come to counseling weekly and appreciates the support and encouragement she gets from her therapist.

INCORPORATING CASE MANAGEMENT – RESTORING LOSS

Conflict, persecution, and migration to a new country damages refugees’ psychosocial fabric and inflicts tremendous losses, which may include:



The therapist may also be the only person that the client knows and trusts to help them navigate the U.S. system or find resources. The client may live in an apartment complex surrounded by other new arrivals, no longer connected to a resettlement agency nor to any community-based organizations. With no one else to turn to, the client may bring housing forms, cell phone bills, and even junk mail into the

clinic for the therapist to read and explain. In effect, therapists may find themselves in the role of case worker as much as mental health provider.

Yet many therapists do not integrate case management into their practice. It may be because of a high caseload or because the clinic or insurance company discourages “non-therapeutic” (i.e., non-reimbursable) interventions. Many therapists also dislike casework, believing that casework is

*“When I ask for help, don’t tell me the steps. Show me the path. Walk with me.”*

— A refugee client from Burundi talking about what she desires in a therapist

beneath their training and skill set. While helping a client access rent assistance or make a medical appointment may seem like “case management,” in reality it is helping a refugee restore a loss caused by displacement. In addition, it is difficult and at times inappropriate to focus on psychological issues when a client is facing a large external stressor like eviction. Another benefit of including casework/resource and referral is that it allows time for refugees who are unfamiliar with counseling to

build trust in the process and their therapist. The close interdependence of mental health with other life domains demands that all of a client’s challenges be incorporated into the treatment plan.

### Clinic Level

Clinic systems can help or hinder someone from accepting services or remaining in services. Below are helpful suggestions for clinics on how to improve their systems and processes to better work with refugee clients.

- Clinics serving refugee clients should keep the treatment team as small as possible. The U.S. often values efficiency over relationships. This means that many medical and mental health systems are set-up like a small assembly line – one person handles calls, another does intake, and still another provides counseling. With refugees, however, the fewer people the client has to work with and talk to, the better.
- At ICCS, we strive to have the initial phone call done by either the intake specialist or the assigned therapist. While we do ask why the caller would like to come to our clinic, we avoid questions such as “Are you hearing voices?” which may reinforce stigma and misconceptions. At the initial interview—the point of engagement—we try to have the assigned therapist present.
- Providers need to learn how to work with interpreters effectively. Working with an interpreter is a skill that can be developed through education and practice. For an overview on how to work with interpreters, see Section 7.
- If using an interpreter, try to request the same interpreter every time. Having a different interpreter in each session is stressful to the client, who must re-establish trust over and over again. If a provider feels that they, the client, and the interpreter all work well together, the provider should ask for the interpreter’s name and availability. Providers can ask the interpretation agency if it possible to establish a regular schedule with a particular interpreter.
- Hire staff from the communities being served. This increases the cultural and linguistic capacity of the clinic, builds trust with communities, and allows important community input into clinic practices.
- Providers should become familiar with other supporting services such as English as Second Language classes, citizenship classes, and employment support, and connect clients to these resources as needed.

- Providers should become familiar with local Mutual Assistance Associations (MAA). These ethnically-based organizations play an invaluable role in providing support and community connection to refugees. Most established refugee communities, especially those in an urban setting, will have an MAA.
- Clinics should invite feedback and input on their services from clients and community leaders as well as from employees who may come from a refugee background themselves. Doing so has two benefits: it gives clients a voice in developing and improving services and promotes community awareness of mental health issues.

# SECTION 5

## ASSESSMENT

Effective assessment must happen first if there is to be effective treatment later. In addition to routine queries, it is helpful to include additional questions for refugee clients. These questions allow the therapist to gain a more holistic picture of the client, as well as gather more information regarding the client's migration experience.



Before starting an assessment the therapist should spend some time explaining who they are, what they do, and what mental health means in the U.S. This is the first step in creating a positive relationship with the client and can take anywhere between 15 and 30 minutes. Because of this, and because an interpreter may be involved in the session, the initial assessment should be scheduled for no less than two hours, or divided into two 1.5 hour sessions.

While it is important to understand what trauma(s) the client has endured and the challenges they face, it is also important to get an understanding of the client that goes beyond their experience as a refugee. For being a refugee is not the client's only story: they are also mothers, fathers, brothers, artists, athletes, and so much more. (For more on the danger of a single story, see Chimamanda Ngozi Adichie's powerful [TED talk](#).) By concentrating only on the trauma, losses, and stresses of the client, providers run the risk of reducing the person to being "just a refugee," or someone to be pitied rather than seen with dignity. Because of a lack of English, and because most aspects of their new community are unfamiliar, some refugees may already feel unintelligent, incompetent and incapable. They may begin to feel diminished and one-dimensional. Consequently, therapists should help by anchoring clients in their many strengths and dimensions, and then incorporating those attributes into the subsequent treatment plan.

Therapists should also strive to understand the client's current stressors. Many times U.S.-born therapists believe that arrival in the U.S. equals "safety and security," but in fact new arrivals face difficult post-migration stressors which must be attended to in order to do deeper therapeutic work.

Here are some questions therapists may consider including in an initial assessment or incorporating into the ongoing assessment that occurs as a part of counseling. Therapists should not feel that they have to include all of the questions below, and they should certainly not include all of them in the initial session. How long the client is in therapy, the client's presentation, the treatment plan, and other factors should guide therapists in choosing which questions to ask and when. In addition, the order in which the questions are listed below is not a recommended order. Some therapists prefer to start with the present while others prefer to start with the past. In many cases, the client will begin the session wherever they are most comfortable starting.

Many of the routine questions that therapists might ask in the United States may be considered pejorative to refugee clients. Refugee clients may believe that you are asking them these questions because you suspect them of this activity. This is especially true of drugs and alcohol. It is helpful to let clients know at the beginning of the assessment that you are required to ask certain questions of everybody, and that asking these questions does not imply that you believe the client is engaging in these activities. A helpful script might be:

*"I will be asking lots of questions today. It helps me to get a complete picture of who you are and what problems you might be having. This will also help us come up with a plan for how we might make things better. Some of these questions I have to ask everyone because it is required. I want you to know that just because I am asking a question does not mean that I am assuming anything about you or your life."*

## Family History

### WERE BOTH PARENTS ALIVE DURING CHILDHOOD? IF DECEASED, FROM WHAT? WHAT AGE WAS THE CLIENT?

This is an important question for a number of reasons. Obviously a parent dying represents a tremendous emotional loss, but the loss of a parent can also be the catalyst for many other life changing events. When a parent dies there is often a loss of family earning power. In some cases, especially in developing countries, this can leave the remaining family struggling for survival. If a client's parent(s) dies during childhood, and especially if that parent was the breadwinner, it is good to follow-up with additional questions like, "After your father died, was your mother able to provide for the family? Did you have enough to eat? Were you able to stay in your home?" It is not uncommon at our clinic to hear of families who were once middle class reduced to poverty after a parent's death; or, for a parent's death to result in a child of 12 or 13 going to work to support the family.

The remaining parent may also choose to marry again, which can cause children to live in blended families or to be given to another relative to raise. Changes in living circumstances often have distinct – sometimes positive, sometimes negative – consequences for an individual.

Lastly, it is also important to assess how the parent died. If they died as a result of violence, then that historical violence is worth noting. If they died of a chronic illness, it may have implications for the client's own health care.

### SIBLINGS AND FAMILY ROLE

In many refugee communities children often play roles in the family that carry with them specific expectations. The oldest son often has the role of helping parents financially support the family. The oldest daughter may be expected to marry first and if her younger siblings get married before her, there may be significant distress. The youngest daughter may be expected to care for elderly parents.

It is helpful to know how many siblings the client has, the birth order of the client, and the nature of the client's relationship with their siblings. Are their siblings alive or dead? If they are dead, how did they die? If they are alive, do they remain in danger?

### OVERALL CHILDHOOD EXPERIENCE

A childhood with secure attachments and few adverse experiences is a good predictor of resilience.<sup>55,56,57</sup>

A childhood with few positive attachments and many adverse events often compounds subsequent traumas. It is important to ask the client to describe their childhood and any major events during childhood, both positive and negative. If the client had an abusive childhood, or one marked by neglect, it often takes longer to recover from subsequent traumas.

## Personal History and Temperament

Personal and developmental history is crucial for any mental health assessment. With refugees the following considerations are helpful:

### EDUCATIONAL OPPORTUNITIES

Did the client have the opportunity to go to school? This information can help the therapist better understand the challenges a client may face in ESL or in employment.

**PREVIOUS EMPLOYMENT**

What was the client's previous occupation? This information gives the therapist insights into the client's previous class and standing in the community and helps the therapist better understand any current employment challenges. For example, if a client was previously a high ranking government official then working as a dishwasher may be psychologically difficult because of the change in class standing. Conversely, if a client was encamped for twenty years and has never been employed, then there may be unique difficulties in finding and sustaining employment.

**PRE-MORBID FUNCTIONING AND TEMPERAMENT**

Temperament refers to the characteristics and personality an individual is born with, and includes innate attributes like being introverted, extroverted, calm, anxious, nervous, etc. It is important to know how the client describes themselves before they experienced trauma, or before coming to the United States. Have they always had these symptoms/problems? If yes, are the symptoms worse or better after coming to the U.S.?

For example, if a client states that they have always been a sad person, but that they are sadder after coming to the U.S., then the clinical assessment may lean more toward endogenous depression made worse by current stress. If the client says that until the war they were known as a happy and fun person, but since the war they have been sad all the time, then the clinical assessment leans more toward exogenous depression.

**STRENGTHS AND RESILIENCE**

Focusing on strengths and sources of resilience helps both the client and the provider focus on the client's inherent inner resources. It is from these resources that the client will have the power to address current challenges. As providers gather information from the client they should pay careful attention to displayed strengths - resourcefulness, courageousness, patience, etc. – and find opportunities to acknowledge and build on those strengths in treatment.

Asking "What has helped you to survive so far?" assists the therapist in knowing how the client views their resilience. Whatever the answer, it is good to incorporate their response into the assessment, subsequent therapy, and/or the treatment plan. For example, if a client believes that their survival was due to God, then strengthening their connection to prayer or a faith community would be wise. If they believe that they survived because of their children, then understanding the current relationship with their children is important. If the client believes they survived because they were well connected, then how might that lack of connection in the U.S. increase their vulnerability?

**FUTURE ORIENTATION**

Asking the question "Do you think things will get better?" helps the therapist assess the future orientation of the client. Future orientation helps clients set goals and move forward, and is critical in adjusting to a new community and culture. A particular diagnosis or condition, or the current circumstances in the client's life, may be affecting their capacity to envision a meaningful future to their lives. Lack of future orientation is also an indicator that they may be experiencing more difficulty than expected in adjusting to the U.S.

## Migration Experience

Many providers may be uncertain whether their client is a refugee or immigrant. The following questions have been helpful in learning more about the client's migration experience.

### HOW LONG IN THE U.S.?

It is important to know how long someone has been in the U.S. so that the therapist can be sensitive to the client's current level of stress and adjustment and to appropriately pace the treatment plan so as to not overwhelm the client. In addition, this information provides insight into the client's coping and adjustment. A client who does not know how to pay a bill after three months in the U.S. differs considerably from a client who does not know how to pay a bill after 13 years in the U.S.

### FLIGHT

This period of time is heavily associated with trauma. It is important to know what caused the client to flee and how they got out of their country. A good way to approach this is saying, "What made you leave your country?" Often clients will say "the war" or "the government." If they do, follow up with moderately probing questions like, "Was there a particular event that caused you to flee?" It is good idea to get a general idea of why the client left, while saving in-depth trauma work for subsequent sessions.

### CAMP/EXILE EXPERIENCE

Questions related to the camp experience include: "Were you in a refugee camp? If so, for how long? What were the conditions in the camp like? Were you with family members or alone? Did you feel safe?"

If the client was in exile: "Were you forced to live in the country illegally? Were you allowed to work? Did you or your children have a chance to go to school? Were you able to see a doctor or receive medical care?"

### HOW WOULD THEY DESCRIBE THEIR LIFE BEFORE THE WAR/VIOLENCE OR EVENTS THAT CAUSED THE DISRUPTION? HOW WOULD THEY DESCRIBE THEIR LIFE IN THE USA?

Take note if the client's circumstances have improved by coming to the U.S. or gotten worse. For those who now have better access to food, medical care, improved housing, etc. the emotional adjustment to the U.S. is generally easier. Those who see their circumstances reduced – who now have safety but a lower standard of living – often have a more difficult emotional adjustment.

Food insecurity, starvation and dehydration are major traumas and should be asked about in any trauma assessment. This is where "knowing the landscape" can be particularly helpful. Elderly clients from the Ukraine likely experienced the "Hunger Times;" death from hunger and dehydration was a regular feature of the journey of the Sudanese "Lost Boy;" lack of adequate food in the Bhutanese refugee camps resulted in widespread nutritional deficiencies.

In our experience, not being able to access food and water is a significant and enduring trauma. People who have experienced it remember the feelings of hunger vividly, and may even have residual behavior like hoarding or over- or under-eating as a result. If they have had to watch family or friends die due to lack of food or water, this trauma is even more acute.

## Causality

Causality is covered more in depth in other sections, but it is critical that every assessment include the client's own thoughts and beliefs regarding their symptoms. This helps the therapist incorporate the client's worldview into assessment and treatment planning. Questions may include:

- What do you think is causing (list symptoms here)?
- What do you think will make (list symptoms here) better?

See the [DSM-V Cultural Formulation Interview](#) for a series of questions designed to enhance cross-cultural clinical understanding.

## Current Stressors

### FINANCES

As discussed in previous sections, most refugees have a stressful adaptation to life in the U.S. One of the largest stressors on a client is finances. Asking clients how much money they have coming in every month and how much their rent is will generally give the therapist an accurate snapshot of the client's financial pressures.

### SEPARATION FROM LOVED ONES

Worries about friends and family often complicate treatment by increasing anxiety and re-triggering traumatic stress. It is important to know if the client has friends and family members whom are still in danger in their home country. If so, it may be important to quickly focus on coping skills as these situations are often prolonged and difficult to resolve.

Clients may also have friends and family who are facing other worries like illness or lack of resources. For example, a client's mother may have terminal cancer and the client is unable to return to their home country. Or a client's brother may depend on the client sending him money so the family can eat or get medical care. These stressors can cause feelings of frustration and helplessness. If a client is unable to meet the obligations to the family, or perform important rituals, roles and functions, then the client's self-esteem and self-perception may be negatively impacted.

Some therapists also find it helpful to do a culturagram when working with refugee clients. Dr. Elaine Congress created the culturagram to help providers individualize treatment and improve services across cultures. The culturagram charts:



- ① Reason for relocation
- ② Legal status
- ③ Time in community
- ④ Language spoken at home and in the community
- ⑤ Health beliefs
- ⑥ Impact of trauma and crisis events
- ⑦ Contact with cultural and religious institutions, holidays, food, and clothing
- ⑧ Oppression, discrimination, bias , and racism
- ⑨ Values about education and work
- ⑩ Values about family – structure, power, myths and rules

An example of the culturagram and an interview with Dr. Congress about its use may be found [here](#).

### PROGRAM TIP

What if the client shows up to the intake with members of their family?

If this happens, it often indicates that the family sees the client's current situation as a "family problem" or that the family is already providing important support. It can also indicate that there may be a desire to "censor" the information shared by the client or there are issues of power and control within the family that are unknown to the therapist.

One strategy is to have a both/and approach that includes the family, respects the client's privacy, and independently determines the level to which the client would like family and friends to be involved.

One way of doing this is to include the entire family at the beginning of the session where the therapist introduces themselves and explains services. After this the therapist can excuse the family and talk to the individual alone about the degree to which he or she wants family members included in subsequent therapy sessions.

There may be high stigma in many refugee communities around suicide. Despite this, refugee clients do experience suicidal ideation and a suicide assessment is an important part of any initial and ongoing assessment.

At our clinic we find it helpful to engage a two-step process in asking about suicide.

*Step 1:*

*“Have things ever been so hard or so bad that you felt you wanted to die or did not want to live anymore?”*

Refugee clients may express being “tired of life” or that they are “done with life.” This is often because of extensive trauma over a long period of time. Expressing these thoughts does not necessarily indicate suicidal ideation, but if a client says “yes,” go to Step 2.

*Step 2:*

*“Have you ever wanted to end your life or kill yourself?”*

If the client says yes, a therapist should then move into a more comprehensive and full suicide assessment. Be careful not to use terms like “keep yourself safe” which has a specific meaning in the United States (not hurt yourself), but may not be easily understood by refugee clients.

It is also important to note that how the client presents in the room should not dissuade the therapist from inquiring about suicide. At ICCS, we have had numerous cases where the client seems stable and future oriented with a pleasant and positive demeanor while still endorsing active suicidal ideation. Alternately, we have had clients who appear significantly distressed and decompensated who express no suicidal ideation at all. In our experience, client presentation is a poor indicator of suicidal thoughts.

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- <sup>(55)</sup> Svanberg, P. (1998). *Attachment, resilience and prevention*. *Journal of Mental Health*, 7(6), 543–578. Retrieved March 28, 2015, from <http://informahealthcare.com/doi/pdf/10.1080/09638239817716>
  - <sup>(56)</sup> Krzysztof, K., Moore, K., Howard, S., & Buchwald, P. (2014). *The Relationship of Attachment to Resilience and their Impact on Perceived Stress*. In *Stress and anxiety: Applications to social and environmental threats*. (p. 73). Logos Verlag Berlin.
  - <sup>(57)</sup> Nolte, T., Guiney, J., Fonagy, P., Mayes, L. C., & Luyten, P. (2011). *Interpersonal Stress Regulation and the Development of Anxiety Disorders: An Attachment-Based Developmental Framework*. *Frontiers in Behavioral Neuroscience*, 5, 55. doi:10.3389/fnbeh.2011.00055

## EXERCISE

Below are two clients both referred into a clinic by their primary care physician. Both are experiencing the same set of symptoms:

- Headaches and stomach pain; no known medical cause has been found
- Not wanting to socialize, see friends, do things outside of the home
- Sleeping 4 hours or less a night
- Increased irritability toward family members
- Depressed mood most of the day, every day with frequent tearfulness
- Feeling numb inside; unable to feel connected or have loving feelings

### Case # 1:

G\_\_ is 29 year old woman from the Congo. She grew up in a rural area of the Democratic Republic of Congo with four siblings. Her parents were farmers and very poor. She says she did not have enough to eat growing up. Her father died when she was seven of unknown causes and her mother began to do the farming so the family could eat. She was the oldest and so she took care of her younger siblings. She never went to school and never learned how to read or write. Her mother died when she was 16, shot by some soldiers who came to her village. She fled with the three younger siblings over the border to a refugee camp in Uganda. She lived in the camp for 10 years where camp conditions were brutal. She got cholera twice and typhoid once. There was little medical care and both times she feared she would die. She got married at 23 to a respected older man in the camp. She had three children, one died at six months of unknown causes. She came to the USA two years ago with her husband and two children. Her siblings are still in the camp awaiting resettlement. She works full time as a housekeeper, but her husband has been unable to find work. She feels that she was one of the “lucky ones” who survived and that “God has blessed her with this chance” and she cannot figure out why she is not happy.

### Case #2:

S\_\_ is a 43-year-old man from Iraq. He grew up with two brothers in a large urban city. Both of his parents were professors at the local university. He went to college and graduate school and had a well-paying job before the war, a nice house, and even a housekeeper and a driver. He married in his late twenties to a woman who was a lawyer. They have one child. When the war started S\_\_ began working for the U.S. military as a bilingual interpreter. Because of his association with the military he was targeted for killing and several attempts were made to kidnap him. One brother is missing and he does not know if he is alive or dead. The other brother is in Baghdad taking care of his elderly parents. He and his wife and child fled to Syria where they lived illegally for four years before coming to the United States. He used up his entire savings living illegally in Syria. He is currently unemployed as is his wife. He spends most of the day at home and has quit looking for a job. Lately he has been wanting to return to Iraq even though he is still targeted for death.

Compare and contrast the cases. How might a provider conduct each client’s assessment? What questions would guide that assessment? How might the assessment and subsequent treatment plan look different with each of these clients?

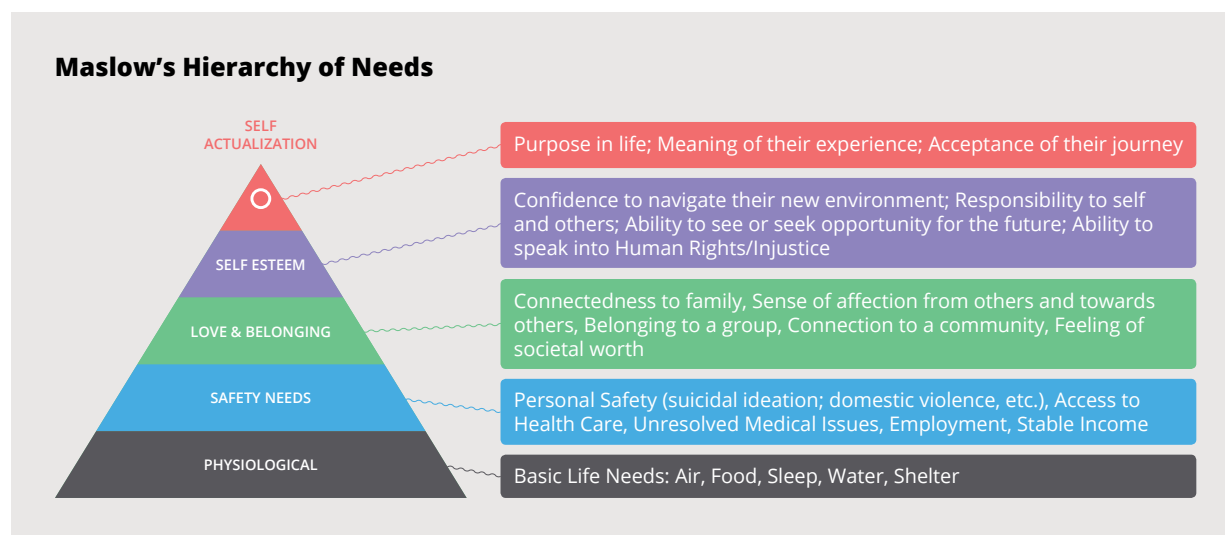
# SECTION 6

## TREATMENT PLANNING

A treatment plan is more than an intervention—it is a framework or structure for how the therapist and client will work together to decrease symptoms and increase functioning. Treatment plans are living documents and should be revisited and revised frequently as new information becomes known or as circumstances change.

## A Phased Approach

Newly arrived refugees can overwhelm providers and systems with the number and complexity of their needs. It is critical to prioritize care. Toward this goal a good resource is Maslow's Hierarchy of Needs. Abraham Maslow, an American psychologist, developed this hierarchy in 1943 to explain human motivation. It was developed as a psychological theory, not for treatment planning, nor was it developed with refugees in mind. However, the basic principles are helpful. ICCS has modified it slightly to better match the client needs we see at our clinic.



Most new-arrival refugees in the United States will have the majority of their physiological or life sustaining needs met. This may not be the case for refugees fleeing from harm or living in camps with unreliable sources of food and water. It may also not be true for asylum seekers in the U.S. who may be homeless or lack access to food until they file for asylum or obtain employment authorization.

There are three things in the Physiological and the Safety Needs tiers that ICCS highly prioritizes: 1) sleep, 2) risk of bodily harm, and 3) shelter.

Helping clients who experience poor or little sleep is almost always listed as one of the first treatment goals. Sleep is a physiological imperative and no matter the culture people can understand and support improved sleep. Sleep problems can cause or exacerbate many of the same symptoms as both PTSD and depression, including trouble with focus and concentration, impaired mood, heightened irritability, and even mild hallucinations. It can also contribute to high blood pressure, diabetes and a weakened immune system. ICCS has found improving sleep to be an important, concrete goal that works well cross-culturally and has important clinical outcomes.

Reducing the risk of bodily harm from active suicidal ideation or domestic violence should be prioritized, as the client's life may be at stake. Homicidal ideation or the intent to harm others should also be addressed immediately, although we have found such thoughts to be rare among our refugee clients.

Counseling becomes very difficult for clients who are, or feel they are about to become, homeless. New arrival refugees have sought sanctuary in the United States, usually after living through a period of



profound insecurity. They typically have few community connections, low English-speaking skills, and little understanding of how to navigate the U.S. system. They may not have the choice to move in with family, “couch surf,” or even live in their cars (most don’t have cars)—the options that can often help U.S.-born people stay out of homelessness, at least temporarily. The prospect of living on the street or in a shelter is terrifying for new arrivals, and rightfully so. Those at risk of losing their housing usually feel extreme fear and vulnerability, and for this reason this issue must be prioritized in treatment planning.

At ICCS we have found some practitioners are attracted to the “meaning making” portion of doing trauma-work with refugees, while minimizing the importance of physiological and safety needs. Providers should remain focused on restoring losses, building the client’s sense of self-efficacy and supporting the client in mastering his or her new environment. Following a phased treatment approach will ensure that trauma-focused therapy is initiated at the appropriate time.

Therapists need not work exclusively on one area before moving on to another. They can, and in many cases should, be working on several areas at a time. For example, a treatment plan can include helping a client improve their sleep while at the same time connecting them to community.

When creating a treatment plan with a client, it is also imperative to ask the client about their goals or hopes for treatment. The words “goals” and “objectives” are often not well-understood, and it may be more helpful to ask, “What are you hoping will get better by coming here?”

The provider should go over each part of the treatment plan with the client. They should tell the client what to expect during therapy and confirm that they and the client are working toward the same objectives. For example:

*“You said your sleep is your biggest problem. I think that is important too. I would like to see you go from sleeping just one hour a night to eventually sleeping through the night. It may take a while to get there so in the next month, I’d like to see you increase your sleep by at least two to three hours. You said you didn’t want to try medication, so I think the first step in helping you sleep more is going to be looking more closely at what is keeping you from sleeping. We are going to look at how much caffeine you drink and when, if you are looking at the computer, video games or TV before bed, and other things that may be making sleep more difficult. We will then try to see if we can change anything so you can get some more sleep. Does that sound like a good place to start?”*

It is helpful for therapists to think about using short, medium and long term goals. Being new to the United States, many refugees do not know what timeframe is reasonable. Some common beliefs we have seen include expecting to feel immediate relief after taking an SSRI, getting housing within a week or two after submitting a housing application, or having symptoms resolve after a few counseling sessions. Inevitably, misunderstandings around how long things normally take lead to feelings of frustration and disappointment.

Identifying short-, medium- and long-term goals, and then educating clients about how long it can take to achieve those goals, helps the client regulate their expectations and feel more successful. For example, many clients need and desire low-income housing. King County, where our clinic is located, has a wait list of three to four years for low income housing. Therefore, appropriate goals might be the following:

**Short Term:** Apply for low income housing

**Medium Term:** Teach client how to independently check on housing status

**Long Term:** Move into low income housing

## Interventions

There is no one, or best, therapy to treat mental health conditions arising from armed conflict, persecution, oppression, torture and war. Interventions should be based on a number of factors including:

- **Symptoms** A diagnosis does not dictate the appropriate intervention – symptoms do. For example, while avoidance of crowds and intrusive thoughts are both indicative of PTSD, avoidance of crowds would benefit from In Vivo, while intrusive thoughts would benefit from Exposure. Ask the client which symptoms are most disruptive and find the appropriate intervention for that symptom or symptom cluster.
- **Timing** New-arrival refugees face a multitude of pressures and new responsibilities. In their first few months in the United States they must learn how to navigate the system, get employment, begin learning English, and much more. The amount of information they are processing on a weekly, daily and hourly basis is vast. Providers must consider timing when thinking about which intervention(s) to employ. If the client is in the beginning of resettlement, it may be best to focus on coping and symptom stabilization rather than trauma-focused therapy.
- **Provider training** Providers should practice within their scope of training and experience. This is especially true when employing trauma-focused therapies. Without appropriate training and supervision, a therapist could re-traumatize a client and make symptoms worse.
- **Causality** The client's views about what is causing symptoms and the best way to address symptoms is vital and should be integrated whenever possible. For example, providers can integrate relaxation/ breathing techniques with five times a day prayer for Muslims, or employ behavioral activation by encouraging regular church/mosque/temple attendance. It is important for providers to move forward in this area with both honesty and humility, recognizing that many clients do not believe that Western mental health interventions, while evidenced-based, are the most helpful to them.
- **Client's journey** The vast majority of providers will not have lived through the type of complex trauma that a refugee client has endured. Providers could, and should, suggest interventions that they feel will help the client. They should discuss the evidence for the proposed intervention and what symptoms the intervention targets. However, if a client does not want to engage in that intervention or does not feel ready for that intervention, then the provider must cede to the clients wishes. The provider should humbly acknowledge that there is little consensus about what recovery from genocide, war, or other mass atrocities should look like. The client should be trusted to determine their own timeline and to choose their own interventions. This is their healing journey, not the provider's.

At the same time, clients may avoid moving into revealing details of their trauma or moving towards trauma therapy because of fears of being overwhelmed. The therapist will need to apply good judgment as to whether the client is avoiding the proposed interventions out of fear, or is in fact not yet ready for trauma therapy.

## TREATMENT PLANNING WORKSHEET WITH REFUGEES

Physiological Needs	Issues/Symptoms	Interventions
Food		
Clothing		
Housing/Shelter		
Bodily Harm (SI, DV, etc.)		
Sleep		
Safety	Issues/Symptoms	Interventions
Access to Medical Care		
Unresolved Medical Issues		
Employment		
Ability to Pay Bills		
Substance Abuse/Addictions		
Legal Issues		
Trauma Symptoms		
Stable Housing		
Love & Belonging	Issues/Symptoms	Interventions
Family Relationships		
Connection to Community		
Adjustment to the U.S.		
Group Membership		
Societal Worth		
Self-Esteem	Issues/Symptoms	Interventions
Speaking Into Human Rights/Injustice		
Meaningful Activity		
Confidence Navigating Systems		
Opportunity/Future Goals		
Self-Actualization	Issues/Symptoms	Interventions
Purpose		
Meaning Making		
Reconciliation of the Past		

There are concerns that many evidenced-based practices are based on Western-concepts of trauma, mental health, and healing, and that most intervention studies have not been done with non-Western populations. While these criticisms are valid, there are a number of interventions that have been investigated and proven to be effective with resettled refugees, including pharmacological, psychosocial, psychotherapeutic, psychoeducational, and community-based interventions.

Cognitive Behavioral Therapy (CBT) is the most-studied of the interventions and has proven to be effective at reducing distressing symptoms and increasing functioning. CBT includes a number of therapeutic techniques. Those most often used with refugees include:

- Behavioral Activation
- Prolonged Exposure/In Vivo
- Narrative Exposure Therapy
- Cognitive Coping
- Cognitive Processing Therapy

Support groups and group therapies have been proven to be effective interventions with refugee populations.<sup>59,60,61</sup> Groups can have a number of different purposes including improved clinical and preventive outcomes as well as stronger social connections. Moreover, groups are extremely flexible and can be adapted to fit the unique experiences of refugee clients. They can also be used to address collective trauma, which is a limitation of most Western therapies. Pathways to Wellness: Integrating Refugee Health & Well-Being has a free eight-week support group curriculum that may be useful with newly arrived refugees in a number of different settings. It can be requested [here](#).

Expressive art therapies like weaving, art, poetry, dance and music are positive and meaningful activities which offer non-cognitive ways to process trauma and opportunities for socialization.<sup>62</sup> They also provide alternative avenues of communication and utilize different parts of the brain by leveraging creativity for healing.

Eye movement desensitization and reprocessing (EMDR) has been proven to be effective in decreasing trauma symptoms with Western populations, and there are some limited studies suggesting that EMDR can be used effectively with traumatized refugee populations.<sup>63</sup>

Complementary and alternative interventions like t'ai chi, qigong, meditation, acupuncture, and reiki have been shown to decrease trauma symptoms in refugees and survivors of torture. They may also be used as traditional healing methods in the client's country of origin, which can make them especially appealing for clients worried about the stigma of mental health treatment.<sup>64,65</sup>

Community-oriented interventions like peer support specialists, mentorship, and community-based support programs are helpful in preventing mental health and adjustment problems among new arrival refugees. Moreover, they can provide assistance throughout the adjustment period and beyond.<sup>66</sup>

**CULTURAL BROKERS**

Ideally treatment would be led or co-led by someone from the same culture who speaks the same language. If the therapist is not from the same country or culture, the therapist should employ a cultural broker. Cultural brokers are knowledgeable about the beliefs, customs, values and health-care systems from the client's country, and about how to navigate systems in the U.S. Ideally they are trusted by the community and may be able to help ease the distrust or discomfort community members may feel in accessing services. They are critical in bridging the gap between providers and clients and should be included as a vital part of any treatment team.

There is copious literature that points to the therapeutic benefits of clients telling their trauma story.<sup>67,68,69,70</sup> Those who have suffered traumatic events often struggle to make sense of what happened. Survivors may have gaps in their memory, disorganized memories, or experience great distress when remembering the incident(s). Sometimes the horror, shame, or disgust at what they have seen or experienced is overwhelming and difficult to verbalize.

*“In counseling, for the first time, someone looked at me like I was a human being. Like I mattered.”*

— A refugee client from Sierra Leone

Therapists have many guided and structured storytelling techniques at their disposal, including Narrative Exposure Therapy, psychodrama, family storytelling, and storytelling through art. [Dr. Richard F. Mollica](#), a pioneer in the field of refugee mental health, has published extensively about storytelling to promoting healing in clients, while at the same

time promoting connection and understanding in providers. His work on trauma storytelling with refugees is both profoundly moving and educational for practitioners, and is highly recommended.

This above is not a comprehensive list of therapeutic interventions, but instead a starting place. Whatever the intervention or treatment plan, therapists should employ great humility and patience when working with refugee clients. They should anticipate that progress may be slow and should not be afraid to ask for clarity when it is needed. Therapists should be genuinely curious and allow the client to teach them. Above all, they should build on the client's demonstrated strength and resilience and trust the client's wisdom, insights and ability to heal.



**SCREENING TOOLS**

A mental health screening instrument for refugees needs to be efficient and sensitive to a range of common psychiatric diagnoses, primarily anxiety, adjustment, and depressive disorders. Screening instruments should be relatively short and capable of being used in a wide variety of settings. Because of a dearth of validated screening instruments, Lutheran Community Services Northwest (which is the parent agency of ICCS) joined with Asian Counseling and Referral Services, Public Health Seattle & King County, and Dr. Michael Hollifield to create the Refugee Health Screener-15 (RHS-15). The RHS-15 is a free, public-use instrument that helps detect refugees who are likely to have significant emotional distress. It is not meant to be diagnostic, but instead help find those who may need additional support and get them connected to care. The RHS-15 is designed to be used in combination with introductory and referral scripts that provide psychoeducation and cultural bridging. To find out more about the RHS-15, download the free [RHS-15 Replication Packet](#).

**DIAGNOSTIC OR DIAGNOSTIC PROXY MEASURES**

Diagnostic or diagnostic proxy measures may help guide therapists during assessments and ensure that clients meet diagnostic criteria to make a proper and complete diagnosis. Some measures can also be utilized to measure progress or outcomes.

The [Harvard Trauma Questionnaire \(HTQ\)](#) and the Vietnamese Depression Scale (VDS) are specific to posttraumatic stress disorder (PTSD) and depression, respectively, and were specifically designed for use with refugee populations. The New Mexico Refugee Symptoms Checklist-121 (NMRSL-121) assesses the broad range of persistently distressing somatic and psychological symptoms in refugees, and is a reliable and valid predictor of traumatic experiences, PTSD, anxiety and depression in both Kurdish and Vietnamese refugees.

Other scales developed for specific illness states in Western populations have been adapted for use with refugees. For example, the Hopkins Symptom Checklist-25 (HSCL-25) has been adapted for several populations including Indochinese and Bosnian refugees and assesses clinically significant anxiety and depression. The Posttraumatic Symptom Scale-Self Report (PSS-SR) is a reliable predictor of a PTSD diagnosis and has been positively evaluated in both Kurdish and Vietnamese refugees.

**HELP! I AM STUCK IN CASE MANAGEMENT MODE**

Case management often occupies the early sessions of therapy for new arrivals. If a clinic does not have dedicated case managers, here are some tips to prevent getting stuck in case management mode:

- ① From the first session, the provider should frame how long they will be doing case management and when they will switch to other concerns. *"Right now I can tell that finding a medical provider is really important to you because of your high blood pressure. I think that is important too and I can work with you to find a clinic close to your home and set up an appointment. After that is done, I would like us to work on improving your sleep."*
- ② Providers should engage in a landscape analysis. Is there anyone else in the client's circle of family and friends that can help them with ongoing case management? Are there other agencies that providers can connect the client to?
- ③ When necessary, providers should mentor the client. Clients need to learn the skills to navigate their new environment. It is a worthy investment of time for providers to teach clients a skill if that skill is important in reaching a goal in the treatment plan.
- ④ Set an agenda for the session. *"I want to read the letters you brought in, but I also want to check in on your sleep and sadness. Let's work on the sleep and sadness for thirty minutes and then I will read the letters."*

Remember, case management efforts should dovetail nicely with the existing treatment plan. If they do not, providers may want to re-examine the treatment plan and ask themselves why they are doing this particular case management. For example, a therapist helping a client understand how to pay the rent leads to a client's increased safety and stability. Helping a client pick out a cell phone plan does not.

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# SECTION 7

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## WORKING WITH INTERPRETERS

The best encounter is one where there is no language barrier between provider and client; ideally each client would have a trained therapist that speaks his or her language. Unfortunately, this is often not possible and an interpreter must be used.

Working with interpreters is a skill that can be developed with a little knowledge and practice. By following the following tips, providers can help create a favorable atmosphere even with a third person in the counseling room.

#### **KNOW THE LANGUAGE OF THE CLIENT**

This may sound simplistic, but it is common for therapists to order the wrong language, which leads to confusion. Many refugee clients come from areas that have multiple ethnicities and languages, but are known as one specific refugee group. For example, new arrivals coming from Burma/Myanmar are often known as “Burmese” refugees. This could lead someone to order an interpreter that speaks Burmese. However, refugees coming from Burma speak many different languages including Karen, Kachin, Chin, and more. Always ask the client what their native language is.

#### **USE A PROFESSIONAL INTERPRETER**

Unless the client indicates otherwise providers should always use a professional, qualified interpreter either on the phone or in person. In-person interpreters are generally between \$30 and \$50 an hour while phone interpreters are between \$1.00 and \$2.00 a minute. A good rule of thumb is to order an in-person interpreter for encounters over 30 minutes, or if the encounter is expected to be complex.

For commonly interpreted languages, order the interpreter at least 48 hours before the session. The rarer a language is, the more time the agency will need. A week is recommended for harder to find languages like Lingala, Kirundi, Kenyarwanda, Mandinka, etc. Providers may have to rely on telephonic interpretation for rare or hard to serve languages, or emergent appointments. In some cases, telephonic is preferable, since in new arrival or small refugee communities the only available interpreters may be individuals that the client knows, which can increase concern about confidentiality and decrease willingness to share information.

Providers should not attempt to communicate with the client if they’re only able to comprehend the client’s language at a rudimentary level. Many idiomatic phrases in languages are regionally based, or popular only among certain age groups, and so there’s room for confusion. Unless a provider is a native speaker or has had formal language training, it is unlikely that the provider will understand the cultural nuances that a qualified interpreter will.

#### **MATCH INTERPRETER AND CLIENT GENDER**

Whenever possible, try to match the gender of the interpreter and the client. Providers must do this at the time of the request. This is highly important when working with clients who may have a history of sexual assault, or whose culture segregates men and women (i.e., some forms of Judaism and Islam that have separate worship for men and women). This seems to be less critical for men who may be used to women being in a “helper” role than for women who may be forbidden from discussing certain issues in front of a male.

Sometimes age may matter as well. An older client may not feel comfortable discussing confidential or personal matters with a much younger interpreter, especially in cultures where age equals authority and respect. Some clients may feel that discussing difficult issues demonstrates a “weakness” or “loss of face.” Some clients may not feel it appropriate to discuss issues concerning children or sexual trauma with a young female interpreter who has never been married or does not have children. (Many available interpreters are those who have arrived young and been educated in the U.S. school system or colleges.)

**MATCH COUNTRY AND CULTURE WHERE POSSIBLE**

Many languages have multiple dialects. While the language may be similar, full comprehension is hard. For example, Arabic is the official language of 26 countries. While people from Iraq and Sudan both speak Arabic, the dialects differ substantially. Where possible ask for an interpreter from the client's country of origin.

It is also important to consider multiple other issues that may or may not be present. Was there just a civil war in the client's country and is there a risk of getting an interpreter from an ethnicity that may cause distress to the client (i.e., Rwanda with Hutus and Tutsis)? Or, is the client from a culture where caste is an issue? Does the client have an issue like sexual identity or suicidality that may be highly discriminated against in their cultural community?

While these issues are difficult to mitigate, it is important to pick up on both verbal and non-verbal cues in the session that may indicate there is a problem. Visible anger, distrust, and simply not speaking to the interpreter are some clues that the interpreter and client may not be best-matched. In these cases, it is helpful for providers to ask the interpreter to wait outside for a minute while they connect with a phone interpreter to ask the client directly if there is an issue. If this is not possible to do in the session, the provider can use a phone interpreter to call the client later and inquire if there was an issue.

The pre- and post-session with the interpreter can also help explore these issues and help to better understand some of the context of what the client said during the session.

**CONDUCT A PRE-SESSION**

Providers should meet for a few minutes alone with the interpreter before the session. They should give the interpreter permission to let them know of any cultural nuances they might be missing, or if a misunderstanding might be taking place. Providers may also let the interpreter know of any sensitive subject matter that might come up in the session (i.e., rape, torture, death of a child) so that they can emotionally prepare. Lastly, providers should share with the interpreter any other critical information about the session that may impact their interpreting. For example, if the provider is going to be doing an evaluation on a client referred in for possible schizophrenia, it is important to let the interpreter know that the presentation of the client may be unusual or that the client may not be "making sense." Otherwise, the interpreter is likely to be confused during the session and struggle with how to interpret appropriately. Providers need to ask interpreters to interpret word for word and not "adjust" the message to make sense. It is important in a mental health assessment for providers to know if the client is swearing, speaking emotionally, not answering directly, etc. Discordant speech may help to diagnosis a condition or indicate a reaction to a medication.

Providers should encourage the interpreter to take notes if needed.

Providers should ask the interpreter for the correct pronunciation of the client's name.

Sample script:

*"Hi, my name is \_\_\_\_\_ and I am a mental health therapist. Today will be my first session with this client and I will explain services to him, have him sign some forms, and then gather information about what is bothering him. I wanted to let you know that the client's son did die in the war in violent circumstances so this may come up in the session. If at any time*



*I am misunderstanding what is happening in the session, or I am doing something wrong culturally, I encourage you to let me know. Because I want the client to understand everything in the room, it is important you let the client know that you are stopping to explain something to me. If I don't understand something, I will also stop and ask further questions. All of this will be interpreted for the client so they do not think we are having a private conversation about him. Do you have any questions?"*

#### DURING THE SESSION

Therapists should build in extra time for the session. Everything will take longer with an interpreter because it must be said twice. If intakes are normally 90 minutes, it would be wise to set aside a minimum of 120 minutes. For counseling sessions, providers may be bound by a typical 50-minute session. If this is the case, they should adjust their expectations for how long the client will be in services as they will likely be accomplishing less in each session.

Providers should begin the session by introducing everyone in the room, discussing confidentiality, and explaining that everything said in the room will be interpreted. By doing this, they set-up the session for the greatest success and pro-actively address the most common concern of clients, which is privacy within the community.

Sample script:

*"Hi, my name is \_\_\_\_\_ and I am a therapist here. Mr. \_\_\_\_\_ is a professional interpreter from Agency X. Both Mr. \_\_\_\_\_ and myself are bound by strict laws of confidentiality, meaning that if we talk about things without your permission, or tell people what was said in this room without your permission, we could get in a lot of trouble. We could be fined, lose our license, or even our job. Today Mr. \_\_\_\_\_ will interpret what you say and what I say. He is going to interpret everything said in the room so both you and I can have a good understanding of everything that is happening. Please ask any questions you may have at any time."*

Providers and interpreters should be positioned side-by-side so that the client only has to look in one direction. This eliminates both the provider and the client from having to turn their head back and forth like watching a tennis match.

Providers must maintain appropriate eye contact and speak to the client. They should not say to the interpreter, "Tell Mr. \_\_\_\_..." or "Ask Mrs. \_\_\_\_". Instead, they should talk to the client directly which helps develop both rapport and connection with the client. Note: If the client tends to avoid eye contact or seems uneasy, the provider may adjust their line of sight to look slightly higher or lower to help client avoid discomfort. (Direct eye contact may be culturally inappropriate for some based on gender, age or culture.)

Providers should speak in short sentences, and pause frequently to give the interpreter time to process the concept and to interpret.

Providers should avoid stopping in mid-sentence because the interpreter may not grasp the entire thought and therefore have a hard time interpreting.

Providers need to be aware of and avoid idiomatic speech ("by the skin your teeth," getting fired," etc.) and acronyms (SSI, DSHS, TANF, etc.). These often are difficult to convey and to understand.

At least once in the first part of the session the provider should stop and ask the interpreter if they are speaking clearly enough, or speaking too fast.

Not every word or concept has a direct equivalent in another language. Therefore, what the interpreter says may not match the length of time the provider spoke. However, if it becomes extremely disproportionate or does not appear to match the client's demeanor, a provider should inquire further. For example, if the provider asks the client if she is having nightmares and the client talks for several minutes and is clearly distressed, and then the interpreter simply interprets "No," then something has likely been missed in interpretation. In that case a provider can firmly but gently say to the interpreter, "Please tell me what Ms. \_\_\_\_ said word for word."

Where possible, clinics and providers should have written material in the client's own language. [Healthy Roads Media](#) is often a good source of written material on health and mental health topics in multiple languages and formats.

#### POST-SESSION

After the session, providers should spend a few minutes following up with the interpreter. They should ask for feedback on what they can do better when working with an interpreter, and ask if there are specific things they should know about the client's culture that could improve their work. Finally, if there was difficult subject matter brought up in the session, providers should ask the interpreter how they are doing. Many interpreters have shared experiences with the clients and some sessions may trigger memories or difficult emotions.

Providers should never ask the interpreter their opinion. For example, asking the interpreter if the client is telling the truth, or what they think the real problem is. This is outside their scope of work, puts the interpreter in a difficult position, and is disrespectful to the client. If the interpreter independently begins to give his/her opinion, the provider needs to explain how important that it is that they only analyze the client's content at face value, and that they only need information that comes directly from the client.

Sample Script:

*"Thank you for your help today. Is there anything that I could have done better to make the interpretation go more smoothly in the session? (Wait for answer) Is there anything I should know about the client's culture that would help me serve the client better? (Wait for answer) I know the client talked about the death of her child during the war. I know that was difficult to hear. Are you doing OK? (wait for answer and offer resources if necessary)."*

**CAUTION**

Do not use family and friends as interpreters. This can compromise the client's confidentiality, and in many cases, the client will not disclose critical information. This is not necessarily because the client is keeping "secrets" from family, but is more likely because the client does not want to worry or distress family with the depth of their symptoms, or retell painful and shared memories in front of family or friends.

The family or friend is also untrained in interpreting and will likely have a distinct opinion about what the client should disclose or what they need. This can lead to "offside" conversations where the family/friend may offer their opinion directly to the client and/or discourage the client from disclosing certain information. They may also omit information or summarize or "correct" the content.

Family and friends are not bound by the same laws regarding confidentiality and there is an increased risk that the details of the clients' case would be shared with other family, friends or the community at large without the client's permission.

If the client insists on a family member or friends to do the interpreting, it is critical that a therapist:

- Discuss confidentiality and why it is important
- Tell the client and family/friend that everything said must be interpreted for the best outcomes and that they should indicate if they feel unable to interpret any terminology or content
- Chart that they offered professional interpretation and that the client declined (this is critical because of both liability and professional standards).

It is helpful also to determine if the client has truly given permission to have this family member/friend to serve as an interpreter. Providers are advised to speak to the client separately with a qualified interpreter (with a telephonic interpreter or at a later time) to verify that they prefer an "ad hoc" interpreter. Sometimes a family member or friend may be insisting without the client's permission or desire, or there may be family issues or dynamics that are unknown.

**PROGRAM TIP**

Once a program or agency gets a client density in a certain population, they may consider hiring a bilingual case manager or paraprofessional. Interpreters are expensive and leave after the session. They cannot be used to make follow-up phone calls or help clients new to the United States navigate the system. Once a program has a certain number of “encounters” or clients within a certain language group, a bilingual staff person makes financial sense and improves the quality of care. They can contact clients in between sessions to follow up on medication adherence, side effects, or teach the client how to navigate systems. They can be also trained to run support groups which are often very effective for clients coming from more collectivist cultures.

The bilingual staff person usually knows the community and culture and can help educate staff, thereby improving the overall competency of the program. The ethnic/language community that the staff is hired from will know that a member of “their own” works at the agency. By choosing a staff person who is respected by the community a program can deepen trust with a community that may be unfamiliar with the U.S. mental health system.

The program not only should, but must, train the bilingual staff member in critical competencies including confidentiality, mandatory reporting, policies and procedures, etc. This ensures the quality of services and also allows the bilingual staff person to develop deeper knowledge of U.S. mental health care. The staff member is then able to share their familiarity and knowledge of the mental health care system with their community, helping to improve community-based understanding and reduce the stigma against mental health care. Ideally, the staff member would be encouraged to further their education and become a trained therapist themselves, thereby broadening the linguistic and cultural capacity of the field.

Often an ethnic community is further segmented into clans, tribes, regional areas, family groups. Bilingual staff should know that no preference must be made to any particular sub-group in the community, so that care is perceived as fair, equal and available to all.

Type	Duties	Cost per hour	# of hours/ week	Cost
Interpreter	Interpret during session	Estimated at \$45	7	\$315
Bilingual Staff/ Paraprofessional	Interpret during sessions; provide feedback to staff to improve competency; check in on medication adherence or side effects; run groups; lead educational workshops; teach clients how to navigate the system	Estimated at \$16	PT (15 hours per week)	\$240

Note regarding translation: Many interpreters are not able to do translation, which is a different skill set than interpretation. They may not have enough literacy in their home language or English. Do not expect an interpreter to be able to “sight translate” or do emergent translation on the spot without having a conversation about whether they agree, or are able to translate, prior to the request. If a provider regularly gives written instructions regarding medication or other important health issues, they will want to have translations professionally done to enhance comprehension and to lessen liability. Developing language specific materials is critical to any program and it should be considered in overall program budgets.

# SECTION 8

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## MEDICATION ADHERENCE

This section is for both prescribers and therapists. While most therapists do not prescribe medications, they may be working closely with a provider who does.



## Successful Medication Adherence Strategies in Refugee Populations

Medication is only one possible treatment option, but it can be an important one. For refugees who are experiencing acute mental health problems, serious problems in functioning, or for whom other interventions are not working, medication can be beneficial. However, studies show that medication adherence in refugee populations is often a challenge.<sup>71</sup> Up to 61% of refugees do not take their medication as prescribed, which is considerably higher than the general population.<sup>72</sup>

The reasons for non-adherence are multi-faceted:

- Many refugees are from places that have poor health infrastructure. People may only go to doctors when they are very ill. When medication is effective in those cases it can seem clear and dramatic. Psychotropic medications, especially those used for depression or post-traumatic stress disorder, may work slowly or not have an immediate and noticeable impact. Therefore, many refugees may feel like they are not working at all.
- Many psychotropic medications are also taken over long periods of time, sometimes for the rest of a person's life. Many refugees believe that if a medicine works, it will "cure" them of the problem and they would no longer have to take the medicine. The fact the medicine does not cure the problem may be equated with it not being effective.
- The modality of the medications used in the U.S. may be different than the modality in the refugee's country of origin. Many countries use injections instead of pills. The injection may be administered once for the "full dose" of medicine, whereas pills are usually taken every day. The combination of having to take a pill every day and not feeling dramatically different may cause some individuals to feel that the medication is not working.
- Refugees may believe their mental health issues have a different root cause. While prescribers see the issues through the lens of the biomedical model, some refugees may view their problem through a different lens or belief system. Refugees (and of course many others) may attribute their current depression, anxiety, or other symptoms to things like bad karma, a lack of balance in the body, a curse, evil spirits, or even a lack of faith in God. The belief about what is causing any problem generates the solution. When a provider and a client have differing beliefs about causation, the likelihood of non-adherence increases. See below for an illustration.

**CASE SCENARIO : ROSE**

Rose is a 36-year old Congolese woman. She fled the DRC with her family after her father was shot and their home burned down. Rose spent 15 years in a refugee camp before coming to the United States. She was married at 17 and had seven children, two of whom died in infancy. She has been in the United States for approximately six years. Rose is a homemaker and spends most of her time caring for her five children. About two years ago, Rose's husband died of cancer. Since that time, Rose reports that she has days where she cannot get out of bed and feels weak and "heavy." She reports crying frequently and being "tired of life" although she does not endorse suicide. She states that she has lost 20 pounds because food no longer tastes good. In the last several months, she has quit meeting with friends and leaves the house infrequently. She says "I just want to be left alone now."

The prescriber believes Rose is suffering from depression. Given the severity (losing 20 pounds; not getting out of bed) and the length of time (more than two years), the prescriber believes that an anti-depressant medication along with therapy would be helpful.

Rose heard from a neighbor that a curse had been placed on her family. The curse not only caused her husband to get cancer, but also has made her very ill as well. She fears she will die like her husband. Already, she is tired and weak.

Rose believes her problems are caused by a curse. Therefore, removal of the curse would cure her. Given Rose's belief system it is unlikely that she would take the medication unless she and the prescriber had a frank discussion that tried to find a mutual and complimentary solution.

- If a client is new to the U.S., and did not have access to medical care or medication before arrival, multiple issues may have been diagnosed shortly after arrival in the U.S. Suddenly, the client has gone from taking no medications to being prescribed three, four, or even more medicines. This may seem like "too much" or "too many medications." Often refugees will say that there were fine before, and they don't understand why the doctor thinks they are so sick now.
- Many refugees expect health ailments to be either "cured" as in complete remission. The chronicity of mental health conditions including depression and PTSD is often not understood. In many refugee cultures, traditional healers promise "a cure" and this is often how success is gauged in treating health conditions.
- The client may not understand how to use a pharmacy, or what a prescription is. In some countries medication is given directly by the physician, or medication is only prescribed within a hospital setting. An illustration of this is that several years ago there was a case of a Karen (Burmese) man who was not taking the medication his primary care physician prescribed. The medical condition was significant and the physician was concerned enough of that he asked a community health outreach worker to visit the client in the home. When the worker asked why he was not taking the medication, the client appeared angry and said, "He did not give it to me! He only gave me a piece of paper!" The worker explained that the paper was a prescription and that he needed to take the paper to the pharmacy and that the

pharmacy would give him the medication. Several days later the worker returned and the client still did not have the medication. He had given the pharmacist the paper just like the worker had said, but nothing had happened. The worker then had to explain to the client that he had to wait for the prescription to be filled. The next time the worker contacted the client he had received the medication and was taking it as prescribed.

- Pharmacies do not have interpretation or translation. This can cause several issues, including:
  - The client may not be able to read the instructions for how to take the medication, and therefore will choose to not take it as opposed to take it incorrectly.
  - The client may have had an experience where the pharmacist attempted to discuss a medication with them. Without an interpreter, the pharmacist appeared frustrated, talked loudly, or used gestures. This interaction made the client worried that there was something important about the medication that he/she should know (and there could be), and without knowing what it is, it would be better not to take it.
  - The pharmacy may have attempted to tell the client that the medication was not ready or not covered by insurance. Without an interpreter, the client only knows that they did not get their medication.
- Transportation may be a barrier. If the pharmacy is at a location other than the clinic, the client might not know how to get there or may not have the extra income for the bus.
- Because of poverty, clients may not be able to afford the medication if there is a co-pay, or if the medication is not covered by insurance.
- Clients may worry that the medication being prescribed is addictive. This is especially true if people are from countries where available medication that impacts mood is addictive, such as valium.
- Refugee clients, like most other clients, worry about potential side effects of new medications. Or they may have experienced side effects and are not willing to continue taking the medication until the side effects lessen or remit.

### Helpful Strategies

- The first step in prescribing medication to a new client is to have the client bring in all of their current medications to their first appointment. In this appointment, at which a prescriber should be present, the prescriber should ask the client what the medication is for and how they use it. This helps give the prescriber a more complete picture of the client's health status, and enlightens the prescriber about the client's current level of knowledge regarding their medical conditions and medications.
- Prescribers should allow enough time in the session to educate the client about what the medication is and how it works. Providers should use simple and concrete terms. If possible, a provider should use drawings or illustrations to help the explanation.
- Providers should explain the chronicity of many mental health issues; meaning that there may not be a "cure." People may feel better but not completely so. Symptoms may rise and fall depending on other factors like stress, loss and physical health. Taking medications and/or going to counseling is unlikely to lead to a permanent state of "happiness." Treatment instead is more likely to help increase functioning and decrease symptoms of distress. Refugees are likely to stop taking their medicines when expectations are not met, so keeping expectations realistic is important to maintaining adherence.

- Assess the client's state of readiness to take medications by determining their fears, misconceptions, or concerns about the medication. (See International Counseling and Community Services Medication Survey at the end of this section).
- Consult with a cultural broker or seek outside cultural consultation. Many clients see visions of the dead, believe that have "second sight," talk to their deceased loved ones, and even hear the voice of loved ones. These "symptoms" may be based in a culture or religion and not imply a problem. Also, those coming directly from war zones often feel like they are being followed or see shadows, which is likely more indicative of hypervigilance than paranoia or psychosis. Lastly, many clients have been persecuted, often by government or people in official capacities. They may be more suspicious than a U.S.-born client, and can be mislabeled as paranoid. Cultural brokers or cultural consultations with people from the same country, culture, or conflict can provide important information on what may be within, or outside, the range of "normal."
- Have someone (therapist, cultural broker, interpreter) write medication instructions in the client's own language. If possible, have them write the instructions directly on the prescription bottle.
- Try to find information regarding diagnosis or medication in the client's own language. [The National Network of Libraries of Medicine](#) has a comprehensive list of medical information in different languages.
- Be willing to compromise. Clients, especially those new to counseling, may want to see if other interventions work first. This shows reasoned and responsible decision-making and should be supported unless safety or other concerns outweigh the client's desire. If the prescriber and the client decide to pursue other interventions, it is helpful to have an agreed upon time frame for progress and indicators.

*"I think it's great that you want to give counseling a chance to work before you decide to take medications. That tells me that you are really thinking about what you need and what's best for you. What about this? What if we give counseling three months to see if it works? Does that seem like a good amount of time? (Client agrees.)*

*Now that we know how much time to give counseling, let's talk about how you will know if you're feeling better. What are some of those signs? (If client cannot think of anything, add some ideas based on their symptoms like sleeping more hours per night or crying less.)*

*Now let's talk about what happens if things get worse or they don't get better. Would you agree to come back and see me if things get worse, or don't get better in three months so we can talk about medication again?"*

Taking medication is ultimately the client's choice. If a prescriber is pushy or insistent about a medication, the client will often agree to take it, but in actuality will not do so. This creates a lack of transparency which is likely to leave both parties frustrated and unsatisfied.

- Some clients may take the medicine only when they feel sick. They may believe this is working well for them and that they are getting benefit from the medication this way. Educate them about how the medication works and ask them to experiment with taking it every day for 4-6 weeks (longer for antipsychotics) and then compare which way works best for them – on a p.r.n. basis (meaning as needed, which is what they've been doing), or every day (which is what you suggested).
- Consider ethnic and racial differences when prescribing. The Federal Drug Administration recognizes that racial and ethnic subgroups may metabolize and/or respond to medications differently.<sup>73</sup> Sometimes these racial and ethnic differences suggest a lower load-dose.

- Clients may be using herbal or other medications that interfere with prescribed medications. If clients are new arrivals, ask them if they brought medicine with them. If they have been in the U.S. longer, ask them if they are receiving medications from home, are taking traditional or herbal remedies, or are buying supplements or other medication from local shops. When prescribers ask about this they should do so in an open and affirming manner so that the client is more likely to be forthcoming. For instance:

*“Many of our clients also take medications from back home, herbal remedies, or other nutritional supplements. If you are taking any of these it is fine, but it is also important for me to know so I can make sure it doesn’t conflict with the medication I am prescribing.”*

- Try not to use the word “try.” Psychotropic medication is often trial and error, and providers may have to adjust multiple times to get the right medication and the right dose. Because of this, providers often use the word “try.” As in, “Let’s give this medication a try.” Refugee clients consistently tell us that when providers say that they suspect that he or she doesn’t really know if the medication will work and thus is “experimenting on them” or using them “like a guinea pig.” It is better if providers say something firm, while at the same time being transparent about possibly adjusting medication in the future.

*“For certain types of diseases there may only be one medication that works, but problems with sleep, sadness, and worries are a little different. There are lots of different medications we can use. The important thing is to get the one that works best for you. Based on your symptoms I would recommend using “X.” “X” has been proven to....(connect to client’s symptoms – increase sleep, reduce worries, help people feel less sad, etc.). Six weeks will give us enough time to see if this medication is indeed the right one for you. If at six weeks you are not feeling better or the medication is causing other problems, then I will either change the dosage or change the medication.”*

- Keep the medication regime as simple as possible. Many refugees believe that Americans take too many medications (and they are right). While their symptoms may indicate that they need an anti-depressant, sleep medication, and medication to reduce nightmares, be aware that giving them all three may overwhelm them and cause them to take none.
- If a client is particularly worried about side effects, consider prescribing a lower dose and increasing slowly. The fewer side effects the client has, the more likely they are to stay adherent.
- Don’t assume the client will report side effects. While most U.S.-born clients know to call a doctor’s office if they are having side effects, many refugee clients do not. They also may fear that they would be labelled as “complaining” or “non-compliant.” Providers should check in, and check in frequently, with any client on a new medication. Providers should also let clients know ahead of time that they will be doing this so they can feel reassured. “I will call you in two days to see if you are having any problems with the medication.”
- If the client agrees to take medication, providers should ask them to bring the medication to the next appointment. This allows the prescriber to visually examine the medication and see if it is being taken as indicated, or at all. It’s often not a good idea for providers to ask clients directly “Are you taking your medication?” especially if the prescriber can see from medication bottles that they are not taking them as prescribed, or if they know the client has not picked up refills. Clients may say they are taking medications to save face or to please the provider. It is more helpful to ask in a way where the client can tell the truth more easily. Examples:

*“Sometimes it is hard to take the medication every day. About how many days a week have you been taking it?”*

*“I see that you last refilled your medication a while ago. Was it difficult for you to get to the pharmacy, or did you decide the medication wasn’t helping very much?”*

- Providers should try not to get frustrated if the client is not taking the medication. This should be instead viewed as an opportunity to better understand the client’s point of view regarding medication, any concerns they have about taking medication, and their attitude toward mental health care in general.
- Where possible, providers should integrate the client’s explanatory model into their approach.

**Let’s revisit Rose, whose situation was described above.** ~~~~~

*Prescriber: So you believe that all your problems are caused by a curse?*

*Rose: (nods)*

*Prescriber: Is there anything you can do to get rid of the curse?*

*Rose: I don’t think so. It has to be a special person to do it.*

*Prescriber: And you can’t find a person like that here?*

*Rose: I don’t know.*

*Prescriber: Have you tried?*

*Rose: I don’t want to tell people about the curse.*

*Prescriber: Is there anyone you would feel comfortable asking about this?*

*Rose: I don’t know. Maybe.*

*Prescriber: It sounds like it is really important to you to get this curse lifted. It sounds like it would help your health improve.*

*Rose: I could do it if I was home.*

*Prescriber: Is there any way it could be done in your home country on your behalf?*

*Rose: No, I have to be there.*

*Prescriber: If you found the right person here, could it be done?*

*Rose shrugs*

*Prescriber: Well, I think it is worth a try. It seems like the curse is really affecting you. What about this? What if, with your permission, I made some calls and tried to see if I could find out if anyone here that lifts curses. Would that be OK?*

*Rose: OK.*

*Prescriber: Do you think you could ask two or three people too?*

*Rose: I don’t see anyone any more.*

*Prescriber: That does make it hard. I do think though that you have better connections than me. Could you even ask one person?*

*Rose: I guess. Maybe by the phone.*

*Prescriber: That would be great! I will also see what I can find out. I may have to get more information from you about the curse and what is needed to lift it so I can ask the right questions.*

*Rose: OK*

*Prescriber: In the meantime, I am still really concerned about how sad you are. You are losing a lot of weight and not sleeping. Even to fight this curse you will need some strength. There is a medication that works well on sadness and sleep and I would like you to use it while we work on getting the curse lifted.*

*Rose: I don’t know. It might not work until the curse is gone.*

*Prescriber: You might be right. But I think it is important to do both right now – take the medication and work on getting the curse lifted.*



- Prescribers should avoid using the word “psychiatric” which can have the same connotation as “crazy” for many refugee populations.
- It is important for prescribers to coordinate with the client’s therapist, including having the therapist in the session where possible. Therapists provide valuable information on the client’s treatment goals, current interventions, and overall functioning. Ideally the therapist is from the same culture or country as the client and can also act as a cultural broker.
- Because refugees often have frequent comorbid physical issues, as well as higher rates of somatization, it is important for prescribers to have contact with the client’s primary care physician to coordinate care.

One of the most important factors in a refugee client taking, or continuing to take, a medication is the relationship between the prescriber and the client. If the relationship is good, prescribers will know which symptoms are most bothersome to the client’s target systems, understand their explanatory model, and appreciate how they view medication.

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- <sup>(71)</sup> Bener, A., Dafeeah, E., & Salem, M. (2013). *A study of reasons of non-compliance of psychiatric treatment and patients’ attitudes towards illness and treatment in Qatar. Issues in Mental Health Nursing, 34*, 273–280. <http://dx.doi.org/10.3109/01612840.2012.745039>
- <sup>(72)</sup> Sawada, N., Uchida, H., Suzuki, T., Watanabe, K., Kikuchi, T., Handa, T., & Kashima, H. (2009). *Persistence and compliance to antidepressant treatment in patients with depression: A chart review. BMC Psychiatry, 9*(38), 1–10. <http://dx.doi.org/10.1186/1471-244x-9-38>
- <sup>(73)</sup> Yasuda, S., Zhang, L., & Huang, S. (2008). *The Role Of Ethnicity In Variability In Response To Drugs: Focus On Clinical Pharmacology Studies. Clinical Pharmacology & Therapeutics, 417–423.*

INTERNATIONAL COUNSELING AND COMMUNITY SERVICES

# CLIENT MEDICATION SURVEY

to Assess State of Readiness to Take Medications and/or Adhere to Medication Regimen)

Client Name

Client ID

Date

**What do you feel is causing your problem?** (verbatim response from client when possible)**Cues:**

When possible use specific symptom like:

"trouble sleeping", "nightmares",  
"crying", "angry outbursts",  
"witnessing car bombing", etc.**Do you feel that medication would help with this?** ☐ Yes ☐ No

If "NO", please state the reason:

**Cues:**

You can ask:

"Can you tell me more about why not?"

"What do you think would be helpful?"

"What do think will outweigh the benefits of medications?"

**Are you willing to take medication for this problem?** ☐ Yes ☐ No

If "NO", please state the reason:

**Cues:**

Many of our clients are uncertain about medication. You can ask:

"Can you tell me more about why you don't want to take it so I can better understand?"

"Can you share reservations you have about taking medication?"

**If you do not feel better in a few months, can we discuss medication again?**☐ Yes ☐ No

If "YES"

Have you ever taken medication before?

☐ Yes ☐ No

Was it helpful?

☐ Yes ☐ No

Was it pills or injections?

☐ Pills ☐ Injections ☐ Other: \_\_\_\_\_

If they have taken pills, have you ever taken pills every day before?

☐ Yes ☐ No**Do you have any worries about this medication?**

Client Name

Client ID

Date

# SECTION 9

## VICARIOUS TRAUMA

Therapists working with refugees hear almost unimaginable tales of brutality, suffering and horror. They're told of incredible injustices and human rights abuses that may never be righted. They must watch as clients try to come to terms with the past while simultaneously struggling with the pressures of adaptation, poverty, and marginalization.

Therapists who work regularly with refugees will also become aware of the inequalities, prejudices, and problems within the U.S. They are also likely to work with people who may be refugees because of U.S. policies and interventions.

If the therapist is from the same country or culture as the client, these feelings may be intensified, and their own trauma may be re-triggered.

Therapists also often feel inadequate to address the vast needs and complex trauma of their refugee clients. It is common to hear from therapists, "I don't think I'm really helping."

Working with such intense trauma material can also lead to feelings of isolation. Therapists are bound by privacy and cannot discuss specifics of their clients and cases with family and friends. The work they do can be viewed as dark and disturbing, and many therapists feel unsure of how to talk about their work without sounding depressing.

In addition, therapists will begin to perceive the world in a new way. They will know people who have been affected by what's happening in the news. Sometimes the stories their clients tell will contrast radically with the how the same stories are portrayed in the media, and this can be frustrating and upsetting.

The vast majority of therapists working with refugees will come to have a deep respect and affection for their clients. They will hear these same clients vilified in the news and in social media. "Why are we letting these people into our country?" and "They should go back to where they came from!" are sentiments that appear in virtually every comment section in every story these days about immigrants.

It is normal for therapists to feel at times helpless, angry, shocked, and distressed. If those feelings go on for an extended period of time, or begin to negatively affect functioning, the therapist may be suffering from vicarious trauma.

New therapists may be particularly prone to vicarious trauma because they have not yet developed the coping mechanisms needed to sustain them in the work, and because they have not yet seen for themselves that clients can and do get better.

### Tips for Managing Vicarious Trauma

Here are some tips for preventing or lessening the effects of vicarious trauma:

#### ① Have positive activities outside of work that nurture or bring joy

Many therapists must balance their professional work with being a parent, adult child, spouse, friend and more. In all of these roles, they must also give of themselves. It is not uncommon for therapists to find themselves constantly "giving" and rarely "getting."

Picture a bucket full of water. If water is constantly being scooped out, and no more water is coming in, eventually the bucket will run dry. It is important for therapists to have "water" coming in. This water should not be another obligation or "have-to" but something joyful that brings comfort or gives energy.

## ② **Have regular clinical supervision**

One hour a week is the minimum. Supervision should include not just administrative tasks, but also the time and space for the therapist to process their feelings and concerns.

## ③ **Don't be the last person to hold the story**

If a therapist hears a particularly traumatic, violent, or disturbing story have one or more people at work who are also bound by HIPAA be available to hear the story. By sharing the story, someone else helps "hold the story" which reduces feeling of isolation.

## ④ **Don't be afraid to be silly, trivial or laugh**

This work is intense and therapists can become so passionate about it that they fill their recreational time with reading books about refugees, seeing movies about refugees, monitoring news stories about international events, etc. It can seem frivolous to watch a slapstick comedy, read a romance novel, or take a photography class. However, these "reality escapes" can provide much needed respite from the demands of therapy work.

## ⑤ **Practice good nutrition and exercise**

Physical and emotional health influences each other in profound ways, and exercise and proper nutrition play a key role in preventing vicarious trauma and burn-out.

## ⑥ **Know the early signs of burn-out**

Increased irritability, crying more frequently, having nightmares about the client's stories, and feeling numb or detached when hearing client stories are symptoms of burn-out that is already quite advanced. It is important for therapists to know the early signs or symptoms, which may be milder and harder to recognize. Early signs may include innocuous things like binge watching television, hoping that clients don't show up for appointments, and craving sweets.

## ⑦ **Engage in counseling yourself**

An unfortunate fact is that many agencies where therapists work do not provide robust mental health treatment plans. Therapists may in fact have fewer mental health options than their clients. In addition, therapists may be more particular when seeking a therapist, desiring one who is more highly trained than themselves, or one who is an expert in treating other therapists. But if they can find it, ongoing supportive therapy can help therapists process how their work is affecting them, allowing them to be more available to their clients.

## ⑧ **Practice religion, faith, spirituality or other form of meaning-making**

This work can lend itself to an existential crisis, where therapists can begin to question the purpose, meaning and value of life. Having an avenue to explore these difficult questions helps. For many it is religion or faith. For others, it is a spiritual practice that is not necessarily connected to a faith. For others still, it is their own individual views and beliefs about life and existence.

While working with refugee clients carries with it risks of vicarious trauma, it also comes with tremendous rewards. Most therapists say the work is life-changing, leaving them incredibly grateful for their own life and in awe of the resilience of the human spirit.

**CLINICS HAVE RESPONSIBILITY TOO!**

Clinics must also take real steps to help prevent vicarious trauma in their staff.

Efforts should include:

- ① **Ensuring proper and adequate supervision.** Clinical supervision should be one hour a week minimum. Staff should have the opportunity to seek outside consultation if they are working with an especially difficult case (traumatic brain injury, developmental delay, etc.), new population, or co-morbid condition. Supervisors should assist staff in finding these consultants.
- ② **Support ongoing education and training.** Therapists should be encouraged to identify areas in which they need to further develop therapeutic skills. Training dollars should be in the budget and dedicated to support this growth.
- ③ **Keep caseloads reasonable.** Don't forget to include staff meetings, trainings, supervision, case management and paperwork when determining total workloads.
- ④ **Have regular staff meetings to share information and give staff an opportunity to support each other.**
- ⑤ **Allow staff to diversify their work.** Would the therapist like to run a group, give a workshop, or do outreach? Do they have an interest in other therapeutic modalities? Are there other things they want to do that add value to the clinic?
- ⑥ **Seek feedback.** Give staff a chance to provide input on the services being offered and the overall direction of the clinic.



# CONTRIBUTORS

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## Contributors

### Ranj Abdulsamad, BSN, AAC



Ranj Abdulsamad is a cross-cultural counselor at International Counseling and Community Services. He received his bachelors in nursing from the University of Kirkuk in Iraq. Ranj worked for seven years as a certified nurse in the emergency department of the main hospital in Kirkuk before becoming a safety officer for United States Citizenship and Immigration Services (USCIS) in the Kurdistan region. Ranj also acted as an interpreter for numerous foreign journalists as they covered the war and sectarian fighting in Iraq.

### Lakew Adnew, ARNP



Lakew Adnew is originally from Ethiopia and came to the United States in 2004. He began his nursing career as a CNA and continued on to become an LPN, RN, and eventually an ARNP. He has worked in both outpatient and inpatient mental health settings and practices a client-centered approach to medication management. Lakew's professional goal is to continue to develop his cross-cultural ARNP work with America's immigrant, refugee and asylum population.

### Lorin Boynton, MD



Lorin Boynton has worked as a psychiatrist with refugees and immigrants in the International Medicine Clinic at Harborview for the past 17 years. In this setting she has been able to learn about and appreciate the profound role of culture and spirituality in the context of psychiatric illness. Lorin is from South Africa and attended medical school at the University of Cape Town. Lorin also serves as an associate professor in the Department of Psychiatry, University of Washington.

### Janet Brodsky, MSW, LICSW



Janet Brodsky has been in social work since 1978 and is a specialist the field of traumatic stress counseling. She earned her master's degree in social work at the University of Washington in 1986 and was a therapist at Harborview Center for Traumatic Stress from 1990 through early 2003. Her own practice, South Bay Counseling, continues to provide trauma-specific therapy, consultation and training locally and regionally. Janet has a passion for assisting under-served communities, including refugees and people affected by discrimination.

**Beth Farmer, LICSW**

Beth Farmer is a licensed clinical social worker in Seattle. She received her undergraduate degree from Texas Christian University and her master's degree in social work from the University of Washington. Beth has worked for over 20 years in the field of social work, focusing on women's reproductive health, international trade, and, in the last decade, work with refugees. She currently directs International Counseling and Community Services and is also the manager of the Northwest Health and Human Rights program, which provides legal assistance and medical and mental health care to survivors of torture. Beth has won numerous awards for her work including the Robert Wood Johnson Community Health Leaders Award.

**Michael Hollifield, MD**

Michael Hollifield received his MD with thesis honors from the University of Washington and completed dual residency training in Family Medicine and Psychiatry at the University of New Mexico (UNM). He has served as faculty at UNM and the University of Louisville and is currently the director of the Program for Traumatic Stress at the VA Long Beach Healthcare System, associate professor at the University of California at Irvine, and guest scientist at the Pacific Institute for Research and Evaluation. He served as evaluation director for the Pathways to Wellness project, which has helped to improve detection of and care for refugees with emotional distress. Michael has been NIH-funded to improve measurement of trauma and health in refugees and to develop novel interventions such as acupuncture, imagery rehearsal therapy, and cognitive behavioral therapy for post-traumatic stress disorder. He has helped establish clinics and programs for refugees in New Mexico and Kentucky, for children who were orphaned during civil war in Sierra Leone, and for disaster survivors in Sri Lanka.

**Mustapha Hydara, DNP, ARNP**

Mustapha Hydara is a psychiatric nurse practitioner with many years of experience working as a psychiatric nurse prescriber to refugees in an outpatient mental health setting. Originally from Gambia, Mustapha is currently a treatment team leader at Fairfax Hospital, an inpatient psychiatric facility located in King County, Washington. Mustapha received his doctorate of nursing practice (DNP) from the University of Washington.

**Andrew Kritovich, LMHC**

Andrew Kritovich was born in Lviv, Ukraine, and came to the USA as a religious refugee in 1999 together with his family. He holds a master of arts degree in counseling psychology from Northwest University. Andrew has more than 20 years of experience working in a variety of settings focusing on counseling, client advocacy and community empowerment for refugees, immigrants, minority populations, inmates of the penitentiary system, individuals without permanent housing, victims of domestic violence, people struggling with substance abuse, and other vulnerable populations. He is currently clinical director at International Counseling and Community Services. Working for many years with clients of different ethnic, religious and racial backgrounds, Andrew has developed a sensitive multicultural approach in addressing clients' needs. He is fluent in Ukrainian, Russian and English.

**Maliha Mirza, MSW, MHP**

Maliha Mirza is a cross-cultural mental health counselor. She completed her master's degree in social work at the University of Washington and has extensive professional experience working with refugees, including multicultural counseling. Her therapeutic focus is on helping new refugees adjust to life in the United States by employing trauma-focused therapy and cross-cultural communication. Maliha was born in Afghanistan and lived as a refugee in Pakistan before coming to the United States as a refugee. She is fluent in English, Dari, Farsi, Urdu, and Hindi.

**Susan Heffner Rhema, PhD, LCSW**

Susan Heffner Rhema has a PhD from the Kent School of Social Work, University of Louisville, where her thesis was entitled, "Predicting Emotional Distress in Recently Arrived Adult Refugees." She has lived and worked in Africa and Latin America. Currently in private practice, Susan specializes in recovery from severe trauma, working extensively with refugees, survivors of torture and victims of human trafficking.

**Risho Sapano, MA, AAC**

A native of Sudan, Risho Sapano is a cross-cultural therapist with International Counseling and Community Services. She has over 13 years of experience providing culturally and linguistically appropriate counseling, advocacy and case management services for refugee and immigrant communities which have experienced violence and trauma as a result of war or domestic abuse. Risho is a former board member of the Washington State Coalition against Domestic Violence and is the founder and board president of Mother Africa, a nonprofit organization that helps African refugee and immigrant women in Washington State reach their highest potential. She earned her master's degree in international development and social change from Clark University in Worcester, Massachusetts. Risho is fluent in Arabic and English.

**Christie Schmid, LICSW**

Christie Schmid is currently the clinical manager of Trauma Services at International Counseling and Community Services. She is a licensed clinical social worker with a certificate in global mental health from the Harvard Program in Refugee Trauma. Christie has focused on trauma counseling and advocacy with individuals and communities surviving war, torture and gender-based violence. Prior to this work she participated in international human rights and peacekeeping efforts with communities experiencing conflict and oppression around the world.

**Sasha Verbillis-Kolp, MSW, CSWA**

Sasha Verbillis-Kolp is a social worker with secondary coursework in international development and forced migration studies. Recently, she served as the evaluation coordinator for the Pathways to Wellness project where she helped develop the Refugee Health Screener-15 (RHS-15). As the Pathways Portland program coordinator she focuses on community-level interventions for refugees that promote emotional health and well-being through alternative therapies. These include adjustment support groups as well as activities which incorporate traditional arts and urban agriculture. She also provides culturally appropriate clinical assessment and treatment planning.

**Tsegaba Woldehaimanot, MSW, Youth Counselor**

Tsegaba Woldehaimanot holds a master's degree in social work from the University of Washington and has over seven years of experience in the field of mental health, including work as a mental health therapist providing therapeutic services to children and adults. Tsegaba was born in Sudan where her family had taken refuge after fleeing their homeland of Eritrea because of war and violence. She and her family later migrated to the United States as refugees. Tsegaba has long been interested in issues of emotional distress in refugee populations and how communities can best meet those needs. Tsegaba currently works at Asian Counseling and Referral Service (ACRS) as a youth counselor. Previously, she was the outreach coordinator for the Pathways to Wellness project.

**Junko Yamazaki, MSW, LICSW**

Junko Yamazaki is the director of the Children, Youth and Families Program for Asian Counseling and Referral Service (ACRS), the largest pan-Asian multi-service center in the Pacific Northwest. There she oversees the operations of children and youth mental health counseling, refugee mental health, youth development, youth job/college readiness training, and parenting education. Junko is a licensed mental health counselor and a state certified minority health and geriatric mental health specialist. She has over 30 years of experience in providing mental health services, consultation and training, and managing human services programs for multilingual/multicultural populations. Junko was born in Japan and is fluent in Japanese and English.

**Kelly Yotebieng, MPH**

Kelly Yotebieng holds a master's degree in public health and is currently working on her PhD in medical anthropology at The Ohio State University. Her research focuses on cultural concepts of distress and healing practices among urban refugees in Central Africa. Kelly has experience implementing programs to address health and wellness in extremely resource-limited settings through her 10 years of living and working in the Democratic Republic of Congo and Cameroon. Her work included providing alternative approaches to behavioral health such as art, music and yoga.

In October 2013 she worked with a refugee resettlement program in Columbus, Ohio, to ensure the successful start up of a mental health screening, referral and support program for newly arriving refugees. She is bilingual in French and English and also speaks intermediate Lingala and Cameroonian Fulfulde.



# GLOSSARY

**CBO** – Community Based Organization

**ICCS** – International Counseling and Community Services

**IDP** – Internally Displace Person

**IOM** – International Office of Migration

**MAA** – Mutual Assistance Association

**NGO** - Non-Governmental Organization

**ORR** – Office of Refugee Resettlement

**RCA** - Refugee Cash Assistance

**RHS-15** – Refugee Health Screener-15

**TANF** – Temporary Aid for Needy Families

**UNHCR** - United Nations High Commissioner for Refugee

**USCIS** - United States Citizenship and Immigration Services

**Volag** – Voluntary Agency (Refugee Resettlement Agency)

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# WALKING TOGETHER

A MENTAL HEALTH THERAPIST'S  
GUIDE TO WORKING  
WITH REFUGEES

*Produced by  
Lutheran Community Services Northwest*