

RESILIENCE & RECOVERY AFTER WAR: Refugee Children and Families in the United States



Report of the APA Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees From Armed Conflict Residing in the United States

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APA Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees
From Armed Conflict Residing in the United States

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EXECUTIVE SUMMARY

Each year, tens of thousands of refugees flee their war-torn countries and communities and enter the United States. More than 40% are children. While the circumstances of their war experiences, their journeys to the United States, and the conditions in which they find themselves as new arrivals greatly vary, children displaced from war zones endure a tremendous amount of trauma, stress, and adversity that can impact their functioning and development (Birman et al., 2005; Lustig et al., 2004; Machel, 1996). These children and their families also demonstrate profound strength and resilience in their survival strategies, coping mechanisms, and abilities to adapt within what are often completely unfamiliar environments.

In this report, the American Psychological Association (APA) Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees From Armed Conflict Residing in the United States reviews the research on the psychosocial effects of war on children and families, identifies areas of needed culturally and developmentally appropriate research, and provides recommendations for culturally and developmentally informed practice and programs. Psychologists, in their roles within a variety of U.S. systems and institutions and in their work with other professionals, can be important resources in the lives of these war-affected children and their families and can work to enhance society's understanding of their experiences and needs. This report takes a social and ecological transactional approach that emphasizes the role of culture and individual, family, and community factors in healing and resilience and underscores the multiple risk and protective factors that affect refugee children's responses to their experiences as they develop and grow. A summary follows.

OVERVIEW

The field is only beginning to understand the full impact of armed conflict, displacement, and resettlement on children's development and overall well-being. Despite the risk for mental health sequelae after exposure to the unimaginable hardship and trauma associated with war, the literature and clinical experience suggest that war-affected children demonstrate tremendous resilience (Garmezy, 1988; Klingman, 2002). Individual, family, school, and community influences provide sources of both risk and protective factors that influence the psychosocial adjustment of children affected by armed conflict (Betancourt & Kahn, 2008).

Although there is a dearth of empirical studies documenting the effectiveness of available therapeutic interventions for war-affected children and families, the present literature indicates promising initiatives in individual treatment methods, family therapy, and group work in schools and other community settings. To address the diverse needs of this unique population, psychologists and other mental health providers must utilize various treatment models while upholding standards of care to the level of best practices. When working with refugee children and their families, the most effective practitioners provide comprehensive services, are culturally competent, and integrate evidence-based practice with practice-based evidence. Truly rich multicultural practice involves a process of community engagement that allows for dialogue, questioning, and adaptation of practice to fit a group's beliefs and values while still providing culturally informed, effective care. Psychology must examine and recognize the efforts of providers in the field working with this population (Birman et al., 2005), allowing clinicians the flexibility to utilize evidence-based techniques and protocols when possible, while incorporating "practice-based evidence"—clinical interventions and existing practices reported to be successful with war-affected children (Birman et al., 2005).

SPECIAL CONSIDERATIONS IN TREATMENT

Assumptions underlying clinical practice come from theory and treatment models developed in wealthy countries and Western culture; therefore, it is imperative they be critically examined in the care of culturally diverse refugee children and families. Psychologists must be aware of the often substantial power differential that exists in a relationship between refugee clients and professionals (Eth, 1992; Savin & Martinez, 2006) and maintain appropriate therapeutic boundaries. This is particularly important in cases involving human rights violations and other atrocities that may evoke strong transference reactions of dependency and gratitude in clients as well as powerful countertransference reactions in psychotherapists (Eth, 1992). When refugee community members are involved in outreach, interpreting, prevention, and mental health counseling, it is vital to ensure they uphold ethical practices, such as maintaining therapeutic boundaries and confidentiality in the context of a small or tight-knit refugee community. Informed consent may present particular challenges for refugee families, including cultural, educational, and linguistic differences between refugee clients and practitioners (Fisher, 2004; Vitiello, 2008) and the reluctance and/or fear of refugee families about signing legal forms and documents or not following the direction of an authority, such as the therapist or evaluator.

Service providers may find themselves challenged by the practices or beliefs of clients from different cultures that are in opposition to their own values. They are advised to seek supervision from within the field and from within the cultural community of their clients when faced with these tensions in order to determine how to proceed in an ethical manner that is respectful of cultural difference and consistent with the standards of practice of the field.

TRAINING

Given the constantly changing composition of refugee populations in the United States, providers' flexibility is paramount. Inflexible psychological services that narrowly address the needs of specific cultural groups will ultimately be insufficient. True engagement takes place within a context of listening, eliciting, and collaborating and can mean the difference between providing appropriate care that is ultimately accepted by refugee clients and care that is, at best, potentially alienating and, at worst, detrimental. There is a need to train psychologists on the processes and vocabulary of cultural identity, going beyond the simple facts of individuals' backgrounds and experiences.

Training for psychologists working with refugee populations should include nontraditional elements, such as interfacing and collaborating with other agencies, including cultural organizations not traditionally seen as "service providers" (such as community-based mutual assistance organizations) and working with language interpreters, cultural brokers, and paraprofessionals. These resources can engage refugee families in treatment and connect them to the larger community. The field of psychology should also encourage and support the training of refugees as psychologists to promote research and practice appropriate to the needs of refugee children and families and increase the cultural competence of the field as a whole.

Providers who treat war-affected refugee children and their families are at risk of secondary or vicarious traumatization, an area often underemphasized in clinical training. Stories of human atrocities and violence, often a part of the experiences of war-affected refugees, can lead psychologists to feel angry, burned out, depressed, or, in some cases, detached from their work. Without proper supervision and processing around this specific issue—the emotional toll of hearing stories from war zones and attempting to address war's human costs—psychologists are vulnerable to many overwhelming emotions and reactions. To minimize these difficulties, psychologists must learn self-care techniques during their training to work with war-affected children (Palm, Polusny, & Follette, 2004; Richardson, 2001; Trippany, Kress, & Wilcoxon, 2004).

RESEARCH: GAPS AND FUTURE DIRECTIONS

To date, the primary focus of much of the research on refugee youth and other war-affected populations documents psychiatric symptomatology related to exposure to potentially traumatic war-related events. In particular, there is considerable interest in examining the dose–effect relationship between exposure to violence and levels of distress, most often in the form of PTSD (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Stichick, 2001). However, there are other pressing and considerably more complex issues involved in the study and understanding of refugee populations.

Methodological Challenges

In order to deepen an understanding of the long-term effects of war on children and develop an evidence base on interventions for war-affected children and families, a wide range of methodologies is needed to identify and understand

cultural variations in well-being and distress (Betancourt & Williams, 2008), including qualitative methods (data in words), quantitative methods (data in numbers, often gained through survey research), and mixed methods (combining qualitative and quantitative methods in different sequences depending on the research questions at the heart of a study; Creswell, 2008). These three methods, plus community-based participatory methods and grounding assessments—an increasingly popular approach—provide unique approaches to understanding and working with these children and families. The same methodological challenges that pertain to identifying relevant mental health problems and syndromes apply to examining protective and promotive factors (e.g., social support, coping, and connectedness) within refugee groups, including recruitment and obtaining representative samples, the cultural validity of constructs, the cultural reliability and validity of instruments, solicitation methods and the use of multiple informants, accuracy of age information, and cultural variations in gender issues.

A Developmental and Longitudinal Perspective

The overwhelming majority of studies with war-affected and refugee children are cross-sectional, providing a one-time snapshot of the mental health and psychosocial well-being of study participants. One way to examine and understand the longitudinal and developmental trajectories of war-affected children is to consider the timing of research, incorporating a life-course perspective into protocols in order to examine long-term adjustment. A focus on cross-sectional symptom assessment also may be useful for understanding context during a certain instance of time, but it does not provide an opportunity to understand the impact of war and displacement on refugee children's evolving developmental capacities. It is important to assess impaired or endangered development in addition to more commonly studied patterns of psychiatric symptomatology. Finally, it may be useful to examine the relationship of symptomatology to development—that is, to what extent do symptoms of distress interact with and threaten children's current and future developmental achievements? Although longitudinal research is complex and resource intensive, it is essential in order to document the trajectories of risk and resilience among refugee children and families as they resettle in the United States.

Intervention Research and the Translation of Research to Practice

Tension exists between the need to provide services to war-affected refugees and the need to conduct rigorous intervention research. A great deal of the mental health care delivered to

refugees is not documented or studied in standardized ways and because of the lack of empirical data, treatments are often clinic-based and rely on the familiar strategies of psychotherapy and psychopharmacology, sometimes with accompanying case management services. In this way, mental health professionals may lose an opportunity to address the most commonly pressing psychosocial challenges for refugee families (Miller & Rasco, 2004). Clinic-based models of intervention are likely to be more effective in their impact on refugee children if complemented with various community-based services that link them and their families to key resources (Birman et al., 2008). Community-based interventions that foster the creation of new social networks at all levels of the social ecology could benefit the entire family, reducing isolation and lack of social supports. Families may also benefit from interventions that target specific ongoing resettlement-based stressors, as well as other family stressors such as domestic violence.

The integration of local/refugee paraprofessionals into treatment and research teams or as providers of care may address the cultural and human resource gaps given the diversity of refugee populations in the United States and the limited number of mental health professionals familiar with these populations. The effectiveness of paraprofessionals relative to trained mental health professionals is well established in literature on nonrefugee populations (Hubble, Duncan, & Miller, 1999). Several studies also indicate that well-trained and supervised local paraprofessionals can effectively deliver care to war-affected children (Bolton et al., 2007; Hubbard & Pearson, 2004). A critical role for researchers and practitioners lies in documenting the conditions under which paraprofessionals are most effective. Issues that bear exploration include the type of supervision most helpful to a paraprofessional, the delineation of mental health and psychosocial problems best suited to services from paraprofessionals, the models of intervention most effective when enacted by paraprofessionals, and the ethical and practical considerations of training paraprofessionals from within refugee communities.

Ethical Considerations

Ethical considerations are critical in the context of refugee research because of the inordinate power disparities and vulnerabilities that exist for refugee populations. Given their past experiences of war atrocities and political violence, it is particularly important to address issues of trust, disclosure, and the question of ownership of the narrative. Additional ethical considerations for researchers include balancing their rights with those of the participants; understanding the social, historical,

and cultural context of their research in the presentation and use of research findings; and identifying their own underlying political viewpoints (APA, 2002a; Estroff, 1995; Gomez et al., 2001; Morrow & Smith, 2000).

Implementing ethical requirements may call for increased creativity and flexibility on the part of the researcher and ultimately may create opportunities for improved research (Allden et al., 2009). When existing ethical guidelines are not sufficient or seen as less “ethical” in certain cultural groups, researchers must promote ethical research by developing appropriate and/or additional ethical approaches (Leaning, 2001). It is critical that individual participants feel free to participate or to not participate in research and that institutional review boards carefully examine the ethical dimensions of conducting research with traumatized, vulnerable populations. Addressing both individual and community consent in a refugee population may uphold ethical standards and create a more effective study (Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007).

CONCLUSION

War and armed conflict affect millions of people around the world each year, sending thousands into flight from their homes and their countries in the hope of escaping chaos and violence (UNHCR, 2007). In the midst of these refugees—some formally recognized by governments and welcomed into other countries and some fleeing without status and recognition—are thousands of children who have experienced and survived devastating and profoundly stressful events. Some witness the destruction of their homes and communities and experience threats and persecution, attacks, and killings. Their journeys from their home countries are often rife with violence and instability and characterized by long periods without the most basic childhood needs, such as proper nutrition, housing, and education. Some of these children travel alone and some with parents, caregivers, and other family members.

The APA Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees From Armed Conflict Residing in the United States created this report with

the objective of assisting the field of psychology in addressing the needs of war-affected children and families who came to the United States. Psychologists—in their roles as clinicians, researchers, educators, and advocates—have tremendous potential to assist the many children who arrive in the United States seeking safety after the violence and disruption of war.

RECOMMENDATIONS

Ensuring positive outcomes for refugee children and families requires stakeholders within the clinical practice, research, education, and public policy sectors to be culturally competent and cognizant of the various interacting factors that influence refugees’ mental health and adjustment upon resettlement, including:

- effects of migration and armed conflict
- acculturation
- risk and resilience
- cultural and religious beliefs and background
- age/developmental stage
- race/ethnicity
- gender
- socioeconomic status
- sexual orientation
- disability/medical needs
- characteristics of the family and host community
- language barriers/attainment

Stakeholders within each of these sectors must collaborate with each other, family members, and community members in order to improve the ethics, feasibility, and effectiveness of mental health care for refugee children and families.

The following recommendations focus broadly on ways that the field of psychology can address the needs of this population

Stakeholders within each of these sectors must collaborate with each other, family members, and community members in order to improve the ethics, feasibility, and effectiveness of mental health care for refugee children and families.

across practice, research, education, and policy domains. These recommendations require further communication and collaboration within the field of psychology and in interdisciplinary collaboration with other fields that are involved in the care and adaptation of refugee children.

Services and Supports

War-affected children may need supportive services to promote health and well-being after resettlement in the United States. Such services may address a range of needs, including basic daily living, education, and physical and mental health, across the numerous contexts in which these children function. Such services must be accessible and affordable, as well as culturally and linguistically appropriate.

To promote this standard of care, the task force recommends that APA:

- Support opportunities for sharing of practice methods and theories within the field of psychology that are developed to address the special needs of refugee children and families, recognizing that there may be methods of treatment that incorporate culturally syntonetic techniques into practice.
- Advocate for the implementation of school-based mental health programs and interventions that demonstrate clinical effectiveness with refugee children and adolescents.
- Support and advocate for federal policy initiatives that assist in the adjustment and self-sufficiency of refugee and war-affected children and families.
- Provide coverage for case-management services for war-affected refugee children and families that address basic needs and access to essential resources (e.g., medical, mental health, job placement, housing).
- Support the development of a range of services for unaccompanied refugee minors, such as mental health and medical services, adequate housing and provision of daily needs, school placement and support.
- Develop and disseminate culturally and linguistically appropriate evidence-based and evidence-informed practices for prevention, intervention, and treatment of mental and behavioral health problems among refugee children and families in both traditional and nontraditional settings (e.g., home-based, community-based, school-based, detention centers).

Research

To advance the knowledge base regarding the mental and behavioral health of war-affected children and families, the task force recommends that APA advocate for support of research that:

- Examines the broad range of war, displacement, and resettlement stressors that can affect the mental and behavioral health of refugee children and families and identifies culturally specific definitions of well-being, distress, and healing, as well as coping strategies that refugee children and families use.
- Examines the feasibility, adaptation, and efficacy of evidence-based interventions, including clinic-based, community-based, or school-based interventions, and evaluates practice-based evidence using rigorous scientific designs for use with refugee children and families. Research should include the role of factors that enhance treatment access, engagement, and retention for war-affected children and families.
- Uses qualitative, quantitative, and mixed methods in a complementary fashion to improve validity and cultural significance.
- Uses both longitudinal and cross-sectional design to identify trajectories of risk and resilience in war-affected children and families.
- Examines adaptational issues in refugee children such as language acquisition, identity development, acculturation, peer relationships, and mental health in relation to school and educational factors.

Education and Training

To improve and enhance training opportunities in refugee studies for graduate students and encourage training for and retention of professionals who work with refugee children and families, the task force recommends that APA:

- Continue to promote graduate training in multicultural practice and research.
- Advocate for federal policy initiatives for training in psychology such as:
 - *Graduate Psychology Education Program*: Supports the interdisciplinary training of psychology graduate students while the students provide supervised mental and behavioral health services to underserved populations (e.g., children and victims of abuse and trauma).
 - *Minority Fellowship Program*: Trains minority mental health professionals to provide culturally and linguistically

competent and accessible mental health and substance abuse services for diverse populations.

- Encourage training programs to include self-care and boundary management in order to prevent secondary traumatization in caregivers working with war-affected children and families.
- Encourage continuing education programs for practicing psychologists and mental health professionals to include instruction on multicultural practice and the importance of effective collaboration between psychologists and interdisciplinary resource agencies, community leaders, paraprofessionals, and cultural brokers to address the real-life needs of war-affected children and families.

Collaboration/Interface

To improve collaboration/interface between and among individuals, organizations, and systems that provide care to war-affected refugee children, the task force recommends that APA:

- Support opportunities for dialogue and formal collaboration between researchers and practitioners who work with refugee children in order to enhance the evidence base on effective treatment with this population and strengthen the effectiveness of clinical services being offered.
- Advocate for systematic collaboration and communication between the interdisciplinary systems (i.e., health care, education, legal/immigration, resettlement, social services) that provide services to refugee children and families in order to enhance service effectiveness, reduce redundancy of care, and create strong networks of support for this vulnerable population.
- Provide opportunities for collaboration and bidirectional training between psychologists and community leaders/paraprofessionals/cultural brokers.
- Engage in advocacy activities that are consistent with APA policy supporting the ratification of the UN Convention on the Rights of the Child by the U.S. Congress, which recognizes the rights of every child, including refugee children, to human dignity and the potential to realize their full capacities.

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INTRODUCTION



Each year, tens of thousands of children enter the United States, fleeing from countries and communities in which there was war, organized violence, or other armed conflict. According to the U.S. Refugee Processing Center (U.S. Department of State, PRM, 2009a), between 2004 and 2008, the United States admitted an average of 21,842 refugee children annually, with children constituting approximately 42.6% of total refugee admissions. Refugee children are sometimes accompanied by a parent or caregiver and sometimes arrive alone. In many cases they witnessed or directly experienced severe and shocking violence, and many lived within societies in which the basic social structures and systems were degraded or completely collapsed. In addition to children who enter as legal political refugees, some arrive without documented legal status, seeking asylum. While there is great variability in the circumstances of their war experiences, their journeys to the United States, and the conditions in which they find themselves as new arrivals, children displaced from war zones endure a tremendous amount of trauma, stress, and adversity that can impact their functioning and development (Birman, Ho et al., 2005; Lustig, Kia-Keating et al., 2004; Machel, 1996). These children and their families also demonstrate profound strength and resilience in their survival strategies, coping mechanisms, and abilities to adapt within what are often completely unfamiliar environments.

In this report, the American Psychological Association (APA) Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees From Armed Conflict Residing in the United States reviews the research on the psychosocial effects of war on children and families, identifies areas of needed culturally and developmentally appropriate research, and provides recommendations for culturally and developmentally informed practice and programs. Psychologists, in their roles within a variety of U.S. systems and institutions and in

their work with other professionals, can be important resources in the lives of these war-affected children and their families and can work to enhance society's understanding of their experiences and needs. The work of the task force reflects APA's role as an accredited nongovernmental organization of the United Nations committed to the spirit, purposes, and principles of the United Nations' (UN) *Convention on the Rights of the Child* (1989), Graca Machel's presentation to the UN General Assembly on her report *The Impact of Armed Conflict Upon Children* (1996), and the *Charter of the United Nations* (United Nations, 1945).

This report takes a social and ecological transactional approach that emphasizes the role of culture and community in healing and resilience. This social-ecological framework describes human development as the result of reciprocal interactions between individuals and their environments, varying as a function of person, context, culture, and time (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006). Interactions between the individual and the environment take place within nested levels or systems including the ontogenic level (individual), microsystem (family, school, and peers), exosystem (community and neighborhood factors), and macrosystem (societal and cultural belief systems) (Bronfenbrenner, 1979). The social-ecological framework underscores the multiple factors that affect refugee children's responses to their experiences of armed conflict, forced migration, resettlement, and acculturation (Lustig, Kia-Keating et al., 2004). Refugee youth are influenced by and always adapting within these multiple social and environmental contexts, each of which contains its own set of cultural norms, demands, and expectations. These contexts may provide varying levels of risk or protective factors—variables that detract from or enhance healthy adaptation—in the development of children (Bronfenbrenner & Ceci, 1994; Ehntholt &

Yule, 2006; Elbedour, ten Benschel, & Maruyama, 1993; Lustig, Kia-Keating et al., 2004).

This report emphasizes the central role of culture in research and mental health service provision for refugee children and families. In that vein, below are the APA multicultural guidelines (APA, 2002b) that advocate for cultural competence in the many roles and contexts in which psychologists work.

APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists

Guideline #1: Psychologists are encouraged to recognize that, as cultural beings, they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves.

Guideline #2: Psychologists are encouraged to recognize the importance of multicultural sensitivity/responsiveness, knowledge, and understanding about ethnically and racially different individuals.

Guideline #3: As educators, psychologists are encouraged to employ the constructs of multiculturalism and diversity in psychological education.

Guideline # 4: Culturally sensitive psychological researchers are encouraged to recognize the importance of conducting culture-centered and ethical psychological research among persons from ethnic, linguistic, and racial minority backgrounds.

Guideline #5: Psychologists strive to apply culturally appropriate skills in clinical and other applied psychological practices.

Guideline #6: Psychologists are encouraged to use organizational change processes to support culturally informed organizational (policy) development and practices.

This report addresses a number of areas pertaining to the lives of refugee children and their families resettled in the United States. First, the report explores the literature¹ on children and families affected by war and armed conflict, describing the known effects of these experiences and outlining areas in need of further research. Second, the report describes the current therapeutic resources and programs available to these children and families and discusses overarching principles of mental health care that emerged from research and practice with war-affected populations. Third, the report provides a critical examination of current research, identifying gaps that exist in understanding refugee children and families, provision of services and care to them, and empirical study of their experiences and their needs. The task force also makes recommendations that identify ways in which the field of psychology can bridge these gaps through research, practice, education, and policy efforts. Finally, throughout this report there are vignettes that illustrate the lived reality of the children who flee war and armed conflict and some of the programs developed to assist them. These stories capture the myriad struggles that these children and their families face, as well as the multiple ways that the field of psychology can assist in their healthy development and adaptation.

¹ This report is primarily based on available research involving samples of refugee populations resettled in the United States as specified in the task force's mission statement. In addition, international literature is cited where appropriate on areas where domestic research is still in its infancy. For example, research with refugee populations in Canada and Australia proved quite illuminating on certain topics. The task force used several databases that provided coverage of the social sciences, education, and biomedical literatures on refugee populations: PsycINFO, ERIC, MEDLINE, and Google Scholar. The following databases were also used to identify relevant, funded studies (both current and recently concluded): National Institutes of Health (NIH), Computer Retrieval of Information on Scientific Projects (CRISP), and the National Science Foundation (NSF).



OVERVIEW OF THE LITERATURE ON REFUGEE AND WAR-AFFECTED CHILDREN



This section draws on a developing, but still small, body of research that describes children² affected by war. As this report focuses on children and families affected by war who reside in the United States, research is specific to this group. At times, however, the extant literature is so sparse that research on other groups that might nonetheless inform an understanding of refugee children and families, such as studies of immigrants or refugees living abroad, is included. Due to the challenges in conducting research with refugee populations, there are also limitations across much of the literature, such as nonrepresentative samples and findings that are not generalizable beyond the particular cultural group of study. In addition, while this report focuses on children and adolescents under the age of 18, some of the research reviewed in this section includes adults.

Given the focus on children living in the United States, the discussed literature comes largely from a Western model of research and understanding. There are other vantage points from which to view issues related to adjustment of refugee youth beyond the scope of this report. This section highlights limited areas of study regarding refugee youth and notes the many knowledge gaps.

Theories that inform an understanding of child and adolescent adaptation to armed conflict include the developmental adaptation of a traumatic stress model (Pynoos, Steinberg, & Wraith, 1995) and a social-ecological model (Betancourt & Kahn, 2008; Bronfenbrenner, 1979). Pynoos and colleagues (Pynoos et al., 1995; Pynoos, Steinberg, & Goenjian, 1996) propose that in addition to the direct relationship between trauma and mental health, a range of additional variables (e.g., trauma reminders, temperament, prior traumatic

experiences, family functioning, and secondary adversities) impact children's adaptation to traumatic events in the proximal and distal aftermath of a traumatic event. These variables can be both risk and protective factors. Bronfenbrenner's social-ecological model (see Figure 1) provides a helpful framework for understanding these risk and protective factors in children's lives by identifying the presence of individual, family, and community systems that overlap and interact as children develop and grow. The following section reviews the existing literature and reports gleaned from psychology and other social sciences to inform an understanding of the multiple dimensions and factors influencing child and adolescent psychological adjustment to war and resettlement.

² For the purposes of this report, "children" are defined as children and adolescents under the age of 18. Wherever possible, the report cites literature that focuses on this age group. Cited literature that focuses on adult populations is identified as such.

SOCIAL ECOLOGICAL MODEL

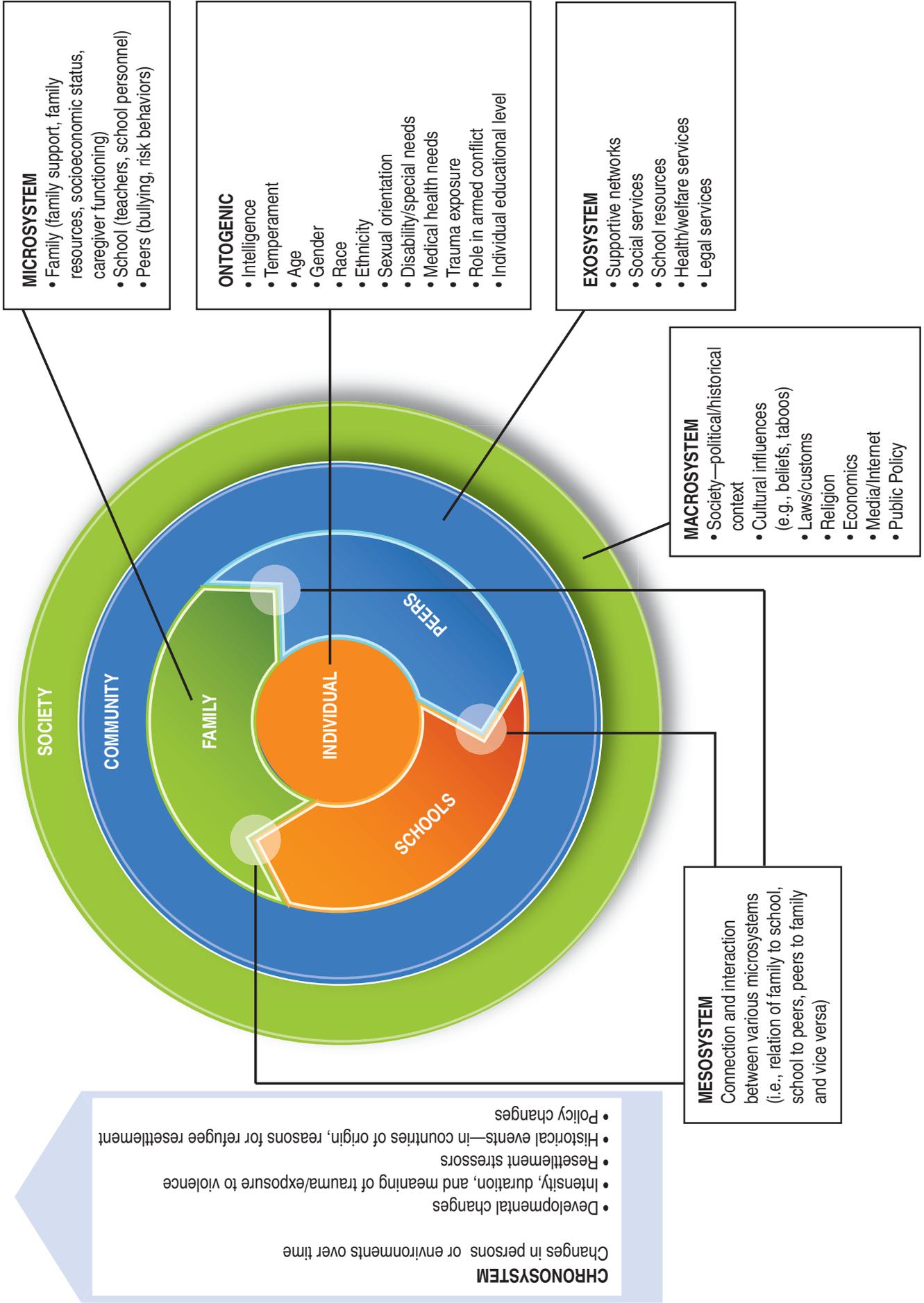


Figure 1: Social Ecological Model (adapted from Bronfenbrenner, 1979 and Betancourt & Kahn, 2008)

WAR AND DISPLACEMENT

Children arriving in the United States from countries affected by armed conflict and violence often experience multiple traumatic events and stressful circumstances prior to, during, and after their arrival (Lustig, Kia-Keating et al., 2004). In recent decades, civilians' involvement in armed conflict drastically increased, as evidenced by increased rates of civilian deaths, injuries, and incidents of direct exposure to violence (Machel, 1996; United Nations, 2007). These events affect children subjected to multiple losses and disruptions in their families and communities, exposed to situations of violence, threatened with injury and death, and in some cases physically harmed or tortured (Alayarian, 2009; Birman, Ho et al., 2005; Lustig, Kia-Keating et al., 2004; UN, 2007). In addition, a growing number of children are forced and recruited into armed service as child soldiers for fighting factions in conflicts throughout the world (Amone P'Olak, 2009; Betancourt, Simmons, Borisova, Brewer, & de la Soudière, 2008; United Nations, 2007). Across the globe, state- and government-sponsored forces, antigovernment rebels, terrorist organizations, and mercenary gangs commit direct acts of terror and violence and contribute to the degradation of social and civic structures (United Nations, 2007). Regardless of the differences in actors and methods of violence, these dangerous and disruptive conditions can have a devastating impact on children and their families and force many to become refugees.

In addition to direct exposure to violence and dangerous conditions from warfare, the experience of displacement and flight from their country of origin presents additional risks and threats to the safety of these children. Refugee children often experience secondary traumatic events associated with displacement, including loss of community and family, limited resources to meet basic needs (e.g., food, water, housing), health risks, lengthy and dangerous journeys to safety, and interim or long-term shelter without adequate resources (for summary, see Lustig, Kia-Keating et al., 2004). Children who experience forced migration are often separated from their family during their journey or may have already lost family members to armed conflict (Lustig, Kia-Keating et al., 2004). Their journey can be circuitous and haphazard and may involve travel across borders to one or more countries before resettlement. Living conditions along the way are substandard at best and dangerous at worst (United Nations, 2007). For example, millions of children and families are placed in refugee and internally displaced persons (IDP) camps where they often struggle with basic survival and safety needs. In addition to limitations of access to food, water, shelter, and medical treatment, these camps can present their own set of hazards and safety risks including crime, rape, and ongoing violence (Lustig, Kia-Keating et al., 2004; Machel, 1996; Wessells, 1997).

Refugee Children

Children who travel to the United States from regions affected by armed conflict arrive through multiple pathways and with varying statuses (i.e., refugee, unaccompanied minor, asylum seeker, or with undocumented status). Under U.S. law, those who enter through the formal refugee resettlement system qualify for refugee status. To obtain this status, applicants must (a) reside outside of the United States at the time of their application, (b) be considered of special humanitarian concern to the United States, (c) not be firmly resettled in any foreign country, and (d) meet criteria as a refugee as defined by the U.S. Immigration and Nationality Act (INA) Section 101 (a) (42) (Jefferys & Martin, 2008). The U.S. Immigration and Nationality Act conforms to the 1951 United Nations Refugee Convention, Article I, in defining a refugee as "a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail himself or herself of the protection of that country, or to return there, for fear of persecution." In addition, the INA allows the President of the United States to designate some nationalities that may be processed as refugees directly from their countries of nationality.

By the end of 2008, the United Nations High Commission for Refugees (UNHCR) estimated that globally there were approximately 15.2 million refugees and 827,000 asylum-seekers, 44% of whom were children under age 18 (UNHCR, 2009). Between 2005 and 2008, 43.5% of refugees resettled in the United States were under age 19 and 55.5% were under 25 (U.S. Department of Homeland Security, 2009b). Approximately 91% of these children (fiscal years 2005-2008) arrived in the company of biological or legally adoptive parents. Others traveled to the United States to reunite with caregivers or to join a relative newly designated as their caregiver (U.S. Department of Homeland Security, 2009a).

Trends in Refugee Resettlement in the United States

The United States has a long history of providing refugee status to populations driven from their homelands by war; political change; and social, religious, and ethnic oppression, having resettled over 2.7 million refugees since 1975, with average admissions of 81,500 refugees

annually (U.S. Department of State PRM, 2009b). Rapid and often unanticipated explosions of conflict and unrest around the globe and changes in U.S. public policy toward refugee resettlement drove the dynamic trends in refugee admissions between 1975 and 2008. Table 1 provides a brief summary of the patterns of refugee resettlement

Table 1: Periods of U.S. Refugee Resettlement (Refugee Council USA, 2009; U.S. Department of State, PRM, 2009c)

PERIOD	DOMINATED BY REFUGEES FROM	APPROX. POP.
Cold War (1948-1980)	Europe (two-thirds from former Soviet Union)	918,000
	Latin America and the Caribbean (primarily from Cuba)	100,000
	Southeast Asia (Vietnam, Cambodia, and Laos)	1,400,000
Balkans (1980-1992)	Europe	
	Former Soviet Union	155,000
	Former Yugoslavia (i.e., Bosnia and Herzegovina, Serbia, Montenegro (including Kosovo), Croatia, Macedonia, and Slovenia)	143,000
Civil Conflict (late 1990's-present)	Africa (primarily from Somalia and Ethiopia)	
	Somalia	65,000
	Ethiopia	43,000
	Near East and South Asia (primarily from Iraq, Iran, Afghanistan)	
	Iran	80,000
	Iraq	55,000
Afghanistan	38,000	

Determination of Refugee Status

Refugee status is determined on a case-by-case basis, and minor children may be eligible for refugee status as dependents (Jefferys & Martin, 2008). After the United Nations High Committee on Refugees (UNHCR) conducts a lengthy referral and screening process overseas, which sometimes lasts years, refugees who obtain permission to enter the United States are sponsored by a refugee resettlement agency. Refugees who enter the United States through this system are placed in any number of communities throughout the country, depending upon resettlement agency availability and employment and housing options. The federal government assists resettled refugees with housing, health care, vocational training, and cash vouchers through resettlement agencies. Refugees can apply for permanent residency after one year, unless they were admitted under conditions of “temporary protected status,” a temporary designation offered to individuals who are unable to return to their home country safely.

Most often, refugee children arrive in the United States with their parents or other guardian family members. For these children, the experience of resettlement is highly influenced by the experience of the whole family; parental adjustment and capacity are central factors in the children’s experiences. (Family factors affecting refugee youth adjustment are discussed in more detail in the Family Factors section below).

Unaccompanied Minors

A much smaller subset of refugee children enter the United States as “unaccompanied minors,” arriving without parents or caregivers (U.S. Department of Health and Human Services, Office of Refugee Resettlement [ORR], 2009). For example, beginning in 2000, the United States accepted a large population of Sudanese boys—often referred to as the “lost boys”—for resettlement (U.S. Committee for Refugees and Immigrants, 2001). Many of these children endured lengthy journeys to find safety without adult guardians, often traveling for years

in groups of peers and enduring multiple traumas and hardships, ultimately arriving in Kenyan refugee camps (U.S. Committee for Refugees and Immigrants, 2001). The United States then accepted some of these children for resettlement and foster care placements (U.S. Committee for Refugees and Immigrants, 2001). Since 1980, almost 13,000 minors have entered the Unaccompanied Refugee Minors program. At its peak in 1985, the U.S. Department of Health and Human Services' Office of Refugee Resettlement (ORR) provided protection to 3,828 children in care. Currently ORR has about 700 children in care in various states. While most unaccompanied minors are placed in licensed foster homes, other licensed care settings are used according to children's needs, e.g., therapeutic foster care, group homes, residential treatment centers, and independent living programs (U.S. Department of Health and Human Services, ORR, 2009).

Immigration officials often detain unaccompanied minors who have not received official sanction from the U.S. government to enter the country (Bhaba & Schmidt, 2006; Byrne, 2008). In 2007, approximately 7,000 children were detained (U.S. Committee for Refugees and Immigrants, 2008). Since 2003, the ORR has maintained federal custody of these children, placing them in shelters that range from nonsecure living facilities to secure detention facilities (Bhaba & Schmidt, 2006; Byrne, 2008). A small minority of these children are placed in foster care as they await the outcome of their legal cases (Bhaba & Schmidt, 2006). The vast majority of these children fled their homes in Central and South American countries (Byrne, 2008). There is no systematic review of these children's histories to determine how many of these youth experienced organized violence or war in their home countries. However, anecdotal reports show that many of the children fled violence. In addition, there are few studies examining the impact of detention on minors; however, research documents the deleterious impact of detention on the mental health of adult immigrants fleeing situations of violence (Keller et al., 2003). Research is warranted describing the rates of trauma exposure and impact of detention and other stressors and comparing the experience of foster care versus detention or shelter facilities for young people fleeing war zones. Policymakers can factor these effects into their decisions regarding unaccompanied minors who come to the United States.

Asylum Seekers

Some children, fleeing violence or persecution, enter the United States and file for asylum once on U.S. soil. Asylum seekers apply for refuge under the same INA guidelines for refugees outlined earlier. Asylum can be obtained either by applying within one year of entering the United States or in the context of removal proceedings (Jefferys & Martin, 2008). Children involved in the asylum process are either unaccompanied minors or dependents of parents seeking refuge in the United States. Seeking asylum involves an often lengthy, costly,

and stressful legal process developed without specific attention to the needs and rights of children (Bhaba and Schmidt, 2006).

Flight From Sudan

Since the late 1980s, civil war and genocide in Sudan led to the extensive destruction of the homes and villages across much of the southern region of the country. Children fled their burned villages in droves, often sent ahead by parents who hoped they would find safety. Other times they were the sole survivors of their families. An estimated 25,000 children undertook journeys of hundreds of miles, crossing deserts and savannahs, sometimes stalked by lions and hyenas. They finally arrived in the relative safety of a refugee camp in Ethiopia, only to be forced out again in 1991 as safety decreased. Again they fled, crossing over the Gila River, during which many drowned or were killed by crocodiles. Many arrived in Kenya where many lived for years at the Kakuma refugee camp. In 2000, the U.S. government began resettling these youth in the United States. Some of these refugees, now young men and women, spent the majority of their childhood and adolescence in flight from war and violence, unsure of whether they would ever see their parents or siblings again.

(Luster, Qin, Bates, Johnson, & Rana, 2009; U.S. Committee for Refugees and Immigrants, 2001)

Undocumented Children

Some children and families arrive and live in the United States without legal status, often unable to access adequate medical care, housing, employment, or government benefits. While assessing the number of undocumented children is difficult, it is estimated that 1.7 million children without legal status are living in the United States (Pew Hispanic Center, 2005), some of whom fled war in their home countries. The ongoing uncertainty of living without legal status, vulnerable to detention and deportation, may be particularly stressful for children who already experienced forced migration and loss of their home.

Family Reunification

Following a conflict in their home country, some children, traveling neither with family nor as unaccompanied minors, are brought to the United States to reunite with family members. Some are reuniting with a parent who moved to the United States prior to the onset of the violence. Others are reunited with parents or other relatives after separation during the war. Some children and parents presumed one another dead only to discover their loved ones living in the United

States. In many cases, the reunification involves family members who endured lengthy separations and disruptions to their relationships, as well as a range of frightening and traumatic events (Rousseau, Mekki-Berrada, & Moreau, 2001). While there may be great joy and relief at these reunifications, adjustment and stress often accompany such life changes.

Other War-Affected Youth

There are children born abroad in refugee camps or in the United States to families who recently fled armed conflict in their countries of origin. Although these children may not have experienced the direct conflict associated with war, many lived through the associated traumatic events and stressors of a childhood spent in a refugee camp (International Committee of the Red Cross [ICRC], 2004; Mollica, Poole, Son, Murray, & Tor, 1997; Rothe, 2005). The families and communities of those children born in the United States may still be struggling to adapt to their new lives and heal from the ravages of war (Spencer & Le, 2006). In addition, one or more family members may be victims of torture. The Center for Victims of Torture (2001) estimates that, at a minimum, a half-million survivors of torture reside in the United States, with between 5% and 35% of refugees being either primary or secondary survivors of torture; how many of these are children is not known. Living with a family member who survived torture can pose unique emotional and systemic challenges for a family, including children (Piwowarczyk, Moreno, & Grodin, 2000). Further research is needed to examine the needs and experiences of these children affected by their family's experience of refugee flight, torture, and dislocation.

Secondary Migration

Some refugee children experience secondary U.S. migrations and resettlements after entering the United States (ORR, 2006). Reasons for secondary migration include greater access to employment or training opportunities, greater access to welfare benefits, reunification with relatives, placement within a stronger ethnic community, or better climate (ORR, 2006). For example, beginning in 2001, many Somali families placed in larger cities such as Atlanta engaged in a secondary migration to Lewiston, ME, to access better housing, jobs, and safer neighborhoods and to join family and community members already resettled in this area (Blais, 2003). While these secondary moves ultimately may provide better opportunities and communities for these families, they do require refugee children to make yet another move and experience yet another transition.

THE EFFECTS OF WAR ON CHILDREN

There are multiple pathways by which young people arrive in the United States after fleeing situations of violence and armed conflict. For most of these children, the route out of a war zone is fraught with uncertainty and fear. Upon arrival in the United States, they and their families face challenging adjustments, sometimes with minimal access to support and resources.

The psychological literature describes a range of mental health and developmental sequelae associated with child and adolescent exposure to armed conflict. Comprehensive reviews of the literature on children exposed to war (e.g., Jensen & Shaw, 1993; Shaw, 2003; Stichick, 2001) and more specifically on refugee children (Athey & Ahearn, 1991; Keyes, 2000; Lustig, Kia-Keating et al., 2004; Rousseau, 1995) identify elevated symptoms of posttraumatic stress disorder (PTSD), depression, anxiety, somatic complaints, sleep problems, and behavioral problems in these children. Studies find high rates of exposure to traumatic events and a cumulative effect of multiple traumas, often referred to as a “dose effect,” such that higher rates of trauma are often associated with higher rates of PTSD, depression, and behavior problems (e.g., Ellis, MacDonald, Lincoln, & Cabral, 2008; Garbarino & Kostelny, 1996; Vizek-Vidovic, Kuterovac-Jagodic, & Arambasic, 2000).

This dose-effect relationship between war trauma and psychopathology—i.e., the finding that more frequent and severe trauma exposure leads to worse psychological outcomes—only partially describes the experience of war-affected children, many of whom demonstrate high levels of resilience and do not develop enduring patterns of distress (Bonanno & Mancini, 2008). Further, the dose effect cannot fully explain the complexity associated with the type or impact of specific traumas on individuals at different phases of their lives. For example, the experience of even one incident of sexual trauma in the context of war may constitute a profoundly traumatic and life-altering event for girls in terms of the impact on their worldview, relationship to their communities, and functioning.

In fact, prevalence rates are wide ranging in samples of war-affected children, with studies documenting rates of PTSD from 7%-75% (Allwood, Bell-Dolan, & Husain, 2002; Khamis, 2005; Kinzie, Sack, Angell, Manson, & Rath, 1986; Paardekooper, de Jong, & Hermanns, 1999; Papageorgiou et al., 2000; Rothe et al., 2002; Weine et al., 1995) and depression from 11%-47% (Kinzie, Sack, Angell, Clarke, & Ben, 1989; Papageorgiou et al., 2000; Servan-Schreiber, Lin, & Birmaher, 1998). Some literature suggests that these symptoms can both diminish and recur over time (Fazel, Wheeler, & Danesh, 2005; Rousseau, Drapeau, & Rahimi, 2003; Sack et al., 1993; Sack, Him, & Dickason, 1999) and that these symptoms may be related to other variables, such as family functioning, postwar stressors, resettlement

stressors, and discrimination (Ajdukovic & Ajdukovic, 1993; Ellis et al., 2008; Sack, Clarke, & Seeley, 1996). Despite the risk for mental health sequelae after exposure to unimaginable hardship and trauma, the literature and clinical experience suggest that war-affected children demonstrate tremendous resilience (Garmezy, 1988; Klingman, 2002).

While many published studies document the negative psychological sequelae associated with war trauma, some authors criticize the narrow focus on PTSD that dominates the field. This critique focuses on the fact that the diagnosis is a Western medical concept that posits disorder in the individual and assumes a universal response to trauma. In this way, the diagnosis does not reflect the social-political context of an individual's exposure to war trauma and also may not reflect cultural variations of distress and well-being (Boehnlein & Kinzie, 1995; Bracken, Giller, & Summerfield, 1995; de Berry et al., 2003; Summerfield, 1999). Others challenge the use of traditional Western measures of psychopathology and methods of assessment with children from a wide array of cultures and backgrounds (Birman & Chan, 2008; Hollifield et al., 2002). Further, despite frequent acknowledgement in the literature of the resilience of children who survive armed conflict, only a few studies specifically focus on understanding the factors that contribute to this resilience. Recent summaries of the literature suggest that contextual, social, family, demographic, and individual variables all contribute to resilient outcomes in war-affected children (Betancourt & Khan, 2008; Bonanno & Mancini 2008). Finally, Pynoos and others (1995) have argued more broadly that study of trauma in children must take into account developmental stage and processes. Despite an understanding of the elevated risk for mental health symptoms in war-affected children, the field is only beginning to understand the full impact of armed conflict, displacement, and resettlement on the developmental trajectory and overall well-being of children.

PSYCHOSOCIAL ADJUSTMENT

Individual, family, school, and community factors influence the psychosocial adjustment of children affected by armed conflict. As Bronfenbrenner (1979) describes in his model, these systems of social ecology do not function independently of each other; rather, they function transactionally. That is, they are parts of the child's world that are dynamically intertwined and that interact with one another, with each transaction potentially influencing the child's adaptation and functioning in one or another system.

Individual Factors

Development/age.

Children around the world experience war at all ages and stages of their lives within cultures and communities with varying expectations, norms, and values. Development, an important and complex consideration in understanding the needs of war-affected children (Coll & Magnuson, 1997; Hobfoll et al., 1991; Pine, Costello, & Masten, 2005), is one factor within a child's complex individual (ontogenic) system that interacts with other system components (e.g., gender, intelligence, physical capabilities) as well as other larger systems (e.g., microsystem, exosystem, macrosystem). War-related trauma can have multifaceted consequences for children, potentially impacting cognitive, emotional, moral, social, and physiological processes (Qouta, Punamäki, & El Sarraj, 2008).

There is some research on the impact of war in relation to children's developmental stages, but there is a need for greater examination of developmental processes across time and culture in war-affected children. Infants are wholly dependent on caregiver relationships for basic survival and security and therefore may be at particular risk if their attachment relationships and routines are disrupted by the violence of war (Pine et al., 2005; Punamäki, 2002). Preverbal infants and toddlers have fewer resources for recognizing and understanding the conclusion of frightening events and may therefore be more vulnerable to continued distress after trauma (Pfefferbaum, 1997). Conversely, infants' and toddlers' relative cognitive immaturity may provide a protective buffer for at least mild-to-moderate war-related traumas (Jensen & Shaw, 1993; Pine et al., 2005).

At 3–5 years old, children in many cultures are engaged in the developmental tasks of learning to regulate emotions and bodily functions, separate themselves for some periods of time from caregivers, and distinguish fantasy from reality. An environment of violence, unpredictability, and dislocation challenges small children's abilities to engage in these tasks and achieve mastery over them (Punamäki, 2002). For instance, young children from war zones are at risk for problems such as enuresis, separation anxiety, and physical destruction of objects (Chimienti, Nasr, & Khalifeh, 1989). Masten and colleagues (1990) argue that even temporary separation from caregivers during this developmental period can be highly stressful for children until they develop the cognitive capabilities to understand that the parent will return.

Middle childhood developmental tasks in many cultures center around the growing importance of peer relationships and the school environment (Durkin, 1995). War, displacement, and resettlement can interfere with these processes both in children's countries of origin,

where their fundamental relationships and activities may get ruptured, and during the process of resettlement, where they face a new culture and set of circumstances. Further, school-aged children may be more vulnerable to increased aggressive behavior—both physical and verbal—in the aftermath of war-related violence (Chimienti et al., 1989; Punamäki, 2002).

Some studies show that older children and adolescents experience a greater frequency of traumatic events during war than younger children, which may put them at greater risk for a dose effect (Macksoud & Aber, 1996; Nader, Pynoos, Fairbanks, Al-Ajeel, & Al-Asfour, 1993). Adolescents, often engaged in the developmental task of forming more intense and lasting interpersonal relationships, can have their sense of security and trust in others impaired by the violence they witness or experience during war (Punamäki, 2002). The insecurity adolescents experience and the disruption of their environment during war may thwart the normative tasks of individuation and development of autonomy that characterize adolescence in many cultures (Ellis et al., 2008). In addition, exposure to atrocities and violence prevalent in many war zones may distort adolescents' growing ability to think abstractly and develop a worldview and sense of morality (Punamäki, 2002). Conversely, older children may be more protected from negative psychological outcomes due to their increased cognitive understanding, greater number of outside resources, and ability to engage in a wider range of coping responses (Jensen & Shaw, 1993; Pine et al., 2005).

Overall, the evidence of psychological outcomes associated with age are mixed (Garbarino & Kostelny, 1996; Hobfoll et al., 1991; Schwarzwald, Weisenberg, Waysman, Solomon, & Klingman, 1993), suggesting that living through war as a child is part of a complex developmental process with multiple influential variables (Pynoos et

“Children’s psychological responses to trauma are comparable to that of adults with one exception: the children’s responses are mediated through a developing organism continuing to mature physically, cognitively, emotionally, and socially, and who is usually living within a family system.”

(Shaw, 2003, p.238)

al., 1995). Longitudinal studies examining war-affected children and their families across time that consider cultural norms and expectations would provide much needed insight into the needs of this population.

Temperament and preexisting conditions.

Little is known about the impact of preexisting temperamental presentations or psychological problems on the adjustment of refugee

children. Temperament may be related to adjustment to trauma (Bonanno & Mancini, 2008; Kruczek, Vitanza, & Salsman, 2008; Pynoos et al., 1995; Strelau & Zawadski, 2005). However, there is limited research on specific temperamental traits predictive of responses to childhood trauma. Punamäki (2002) proposes personality characteristics drawn from the resilience literature that may be protective for children from war zones, including flexibility, creativity, intelligence, and curiosity (Apfel & Simon, 1996; Qouta, Punamäki, & El Sarraj, 2001; Rutter, 2000).

As with adults, preexisting conditions may also impact children’s adjustment after war. Children with significant psychological problems that existed before the war may have more difficulty in the aftermath of the trauma they experience (Randall & Lutz, 1991). Pine and colleagues (2005), discussing the impact of war and terrorism on children, illustrate how pretrauma mental health functioning is linked to both internal and external risk factors that have an ongoing impact on the child:

Children with mental health problems may be particularly vulnerable in part because of associated inadequacies in their external protective systems (e.g., their parents may be less capable and protective) and in part due to endogenous factors. (p. 1786)

Posttraumatic stress may exacerbate existing psychological problems or a difficult temperament. Research is needed that examines children’s pretrauma competencies and inner resources, as well as vulnerabilities, in an effort to determine what affects their posttrauma outcomes.

Gender.

Studies of gender in war-affected, refugee, and immigrant children and adolescents suggest several differences in girls’ and boys’ war trauma experiences. Girls and women are more likely to experience sexual trauma, including sexual enslavement, mass and repeated rapes, and forced acts of sexual violence with family members (Machel, 1996; McKay, 1998; Women’s Commission for Refugee Women and Children [WCRWC], 2006). Girls may experience unique physical, psychological, and cultural effects of sexual violence, such as exposure to sexually transmitted diseases, reproductive impairment, and the stigma of being seen as “unmarriageable” (McKay, 1998). Girls are also more likely to exhibit internalizing and psychosomatic symptoms and to be affected by family and interpersonal stressors after war (Lien, Claussen, Hauff, Thoresen, & Bjertness, 2005; United Nations, 2007; Vizek-Vidovic, Kuterovac-Jagodic, & Arambasic, 2000).

By contrast, some research suggests boys are more likely to be exposed to direct nonsexual violence (e.g., shootings) during war, experience a greater frequency of traumatic events, and be involved

in the conflict themselves as perpetrators or child soldiers (Allwood et al., 2002; Macksoud & Aber, 1996; UN, 2007). These studies, however, may not capture the experience of sexual trauma, which male children and adolescents may be less likely to report. Furthermore, in resettled communities, there has been no examination of refugee boys' risk for retraumatization and/or conduct problems related to exposure to community violence, gangs, and other community pressures characteristic of adolescent boys in the United States.

After resettlement, cultural expectations may further differentiate the experience of refugee boys and girls. Resettled girls may experience more family pressures related to changes in family roles, acculturation, and sexual norms (Warikoo, 2005). For example, in many cultures girls play central roles in caregiving and household duties (Suárez-Orozco & Suárez-Orozco, 2001; Warikoo, 2005). These roles and norms may create tension when a family is resettled in the United States, where expectations can exist for girls to attend school regularly, pursue higher education, and work outside the household (Vasquez, Han, & De Las Fuentes, 2006). Tension may also develop for immigrant girls navigating American adolescent activities such as dating, which may conflict with their family or cultural expectations (Suárez-Orozco & Suárez-Orozco, 2001). In response, families may monitor the activities of their female children more closely (Suárez-Orozco & Suárez-Orozco, 2001). However, restrictions imposed by families, as well as the cultural affiliation demonstrated by girls' close connection to their families, may in fact serve a protective role for refugee and immigrant girls (Suárez-Orozco & Suárez-Orozco, 2001). By enacting the roles and duties within their homes and families, girls may exert and maintain a strong sense of cultural identity (Warikoo, 2005). For example, parental monitoring and girls' adherence with parental expectations may explain immigrant girls' higher educational achievement as compared to immigrant boys in the United States (Portes & Rumbaut, 2001).

In contrast, boys may experience both familial pressure and freedom to engage with the world outside the family through social activities, job seeking, or education, thereby forcing engagement with their new community at the expense of their cultural identity (Suárez-Orozco & Suárez-Orozco, 2001; Warikoo, 2005). Further research exploring the pressures and protective processes associated with cultural expectations of boys and girls is needed, with recognition that gender may interact in complex ways across different cultures.

Sexual orientation and gender identity.

Little formal research addresses the unique needs of lesbian, gay, bisexual, and transgender (LGBT) refugee children. In clinical settings, some services are in place for assisting youths seeking asylum based on persecution due to sexual orientation or gender identity; some of these youths may also be fleeing war zones or situations of organized violence. The International Gay and Lesbian Human Rights

Commission (2007) found a wide range of cultural norms and values around the world in terms of sexuality and gender identity and a high prevalence of persecution of LGBT individuals. There is also significant variability in the legal rights accorded to LGBT individuals depending on country of origin (Amnesty International USA, 2009). One qualitative study of gay Hmong refugee adults found that while the affiliations of family, clan, and religion buffered against the effects of racism in new communities, these same factors led to greater risk of rejection and discrimination based on sexuality (Boulden, 2009). Research on the experiences and needs of LGBT refugee children and adolescents, particularly at the intersection of the multiple cultures in which they live, is required.

Race and ethnicity.

The United States has a long history of oppression and maltreatment of racial and ethnic minority groups due to the values ascribed to social constructs of race and ethnicity. Consequently, these are likely important factors affecting the adjustment and mental health of refugee children and families upon their resettlement in the United States. Once they are in the United States, these families who have experienced significant trauma and dislocation must then cope with additional stressors and cultural differences (Dachyshyn, 2006). The additional presence of racial and ethnic discrimination upon resettlement poses additional risks to their adjustment and well-being.

Unique Challenges for Refugees of Color

In the last decade, the proportion of refugees of color entering the United States from sub-Saharan Africa (approx. 28%) and Asia (approx. 23%) steadily increased, constituting just over half of all entrants (U.S. Department of State, PRM, 2007).

In many cases, these refugees relocate to states where they become members of a tiny racial minority (e.g., between 2000 and 2004, North Dakota had the fourth highest per-capita distribution of refugees [U.S. Department of Health and Human Services, ORR, 2004] in a state that is 89.9% White, 5.4% American Indian and Alaskan Native, 1.9% Hispanic, 1.0% Black, and 0.8% Asian [U.S. Census Bureau, 2008b]). The experience of resettling in a new community can be difficult and challenging when refugees become members of a marginalized racial minority. However, it cannot be presumed that the racial homogeneity in some refugees' countries of origin precludes experience of prior discrimination. Often, refugees are members of marginalized ethnic minority groups in their native countries. Discrimination may also occur between different racial minority groups or between newly arriving refugees and established minority groups. Many refugees may arrive unprepared to confront conditions of racism and discrimination. For refugees fleeing persecution or feared persecution due to their race or ethnicity, experiences of discrimination may also function as traumatic reminders. In racially diverse states such as Florida, which has the highest per-capita distribution of refugees (60.8% White, 20.6% Hispanic, 15.9% Black, 2.3% Asian, and 0.5% American Indian and Alaskan Native [U.S. Census Bureau, 2008a]), refugees may live in minority enclaves where the pace of assimilation into larger society and socioeconomic achievement over time is mediated by race (Zhou, 1997).

The construction of racial or ethnic identity is a complex process for any child or adolescent, and research shows that a positive racial/ethnic identity boosts self-esteem, which can serve as a protective factor against the stressors of discrimination for ethnic minority children and adolescents (APA, 2008c; Phinney, Chavira, & Williamson, 1992). One study with Somali children in the United States found that the development of bicultural competencies and relationships allowed them to draw support from their own ethnic community (parents and coethnic peers) as well as the host community (teachers, counselors, and mainstream peers). Such biculturalism allowed them to avoid "psychological discontinuities," i.e., the difficulties that individuals encounter in learning to effectively navigate cultural differences, while developing high self-esteem and positive ethnic identity (Kapteijns & Arman, 2004, p. 23). This, in turn, lessened the impact of experiences of discrimination by mainstream society as well as other stressors (Kapteijns & Arman, 2004).

Many research questions remain regarding the impact of race and ethnicity on the mental health of refugee children. For instance, how do refugee children balance the development of racial and ethnic identities with the other multiple developmental tasks they must perform as they grow up? Also, the largest percentage (43%) of refugees in the United States is Eastern European (U.S. Department of State, PRM, 2007). Research studies could examine the differing processes of integration, assimilation, and acculturation for Eastern European refugee children compared with refugee children who are members of other visible minority groups.

Acculturation.

Acculturation refers to the process of adaptation, or lack thereof, that occurs when two cultures come into contact with one another (Berry, 1980). This process of adaptation is one of the central tasks for refugee children. Berry (1980) proposes a bidimensional model of acculturation, resulting in four types of acculturation: assimilation (adopting the new culture exclusively), integration (maintaining one's own culture and adopting the new), marginalization (not being strongly identified with either culture), and separation (maintaining one's original cultural identity exclusively). Acculturation may be marked by language(s) spoken, an individual's ethnic identity, or the degree to which individuals participate in cultural activities. Although there has been progress in understanding acculturation as a complex process rather than merely the task of assimilating into the new culture, an important future direction for research is recognizing these dimensions—language, identity, behavioral engagement, and participation—and their interplay within and between an individual's various cultures (Trickett & Birman, 2005).

There is a demonstrated relationship between racial discrimination and psychological distress, low self-esteem, internalizing and externalizing behaviors, and poorer school performance among children of color (Sellers, Copeland-Linder, Martin, & Lewis, 2006). Also, perceived racial discrimination constitutes a significant stressor which can jeopardize the mental health of refugees resettling into new communities (Noh, Beiser, Kaspar, Hou, & Rummens, 1999). In fact, experiences of discrimination are strongly associated with symptoms of PTSD and depression among refugee children (Ellis et al., 2008).

The process of acculturation is highly relevant to the adjustment of refugee children. Some research found worse outcomes associated with adolescent refugees who demonstrate a marginalized style of acculturation and more positive outcomes associated with integration, though this bears further exploration given the complexity and multiplicity of factors involved (Kovacev & Shute, 2004). Padilla and Perez (2003) note that acculturation is also influenced by the degree to which the host community stigmatizes members of a particular group and argue that both contextual factors and the individual's perception and cognition related to this stigma must be considered.

Theories of social identity can inform an understanding of the process of acculturation for refugee children, although most of these theories do not specifically address the impact of the experience of war on patterns of identity development and affiliation. One aspect of social identity posits that as individuals become increasingly identified with a particular social group, they become more likely to view this group in a positive light, which in turn contributes to their psychological well-being (Turner, Brown, & Tajfel, 1979). However, such identification with their original group may also contribute to negative views and beliefs about other groups, a dynamic that may be heightened by the experience of war.

Acculturation may also be understood through the lens of intersectionality, which suggests that social identity is constructed of multiple dimensions that may include constructs beyond cultural identification, such as gender or socioeconomic status, and that the intersection of these social identities profoundly shapes individuals' experiences (Crenshaw, 2005). This perspective may be particularly useful for understanding acculturation and adjustment among refugees where gender roles are divergent between the culture of origin and resettlement. As described previously, acculturating away from a culture of origin may have very different implications for stress and adjustment for girls than for boys (Suárez-Orozco & Suárez-Orozco, 2001).

A nuanced understanding of acculturation, i.e., one that considers the multivariate and transactional processes involved, is essential for understanding refugee youth adjustment. For example, the individual impact of living through violence and war on cultural identity and relationship to homeland has not been examined. Additionally, although the stress associated with acculturation is often the focus of research, the experience of migration and navigation of several cultures can also

be a positive experience and source of maturation that still needs to be explored (Coll & Magnuson, 2005).

Resilience and coping.

The term "resilience" is often used in discussions of the adaptation of war-affected children who resettle in the United States. Although many definitions of resilience exist in the literature, at its core, resilience involves the positive adjustment of individuals under conditions of significant adversity (Luthar, Cicchetti, & Becker, 2000; Masten, Best, & Garmezy, 1990; Rutter, 1990). The development of resilience is a dynamic process that takes place within and through the multiple social ecological contexts of children's lives. As described earlier, refugee children and their families are exposed to severe forms of stress through their experience of war-related trauma, displacement, separation and loss, and resettlement. Within this context, resilience describes the remarkable presentation of many of these children who overcome these adversities and lead healthy, productive lives in school, in their families, and in their communities.

Very few studies explicitly focus on understanding the protective processes that contribute to resilient outcomes in refugee children resettled in the United States (Betancourt & Khan, 2008). The social-ecological model illustrates that there are multiple layers of opportunity for protective processes in the lives of war-affected and refugee children (Betancourt & Khan, 2008; Luthar et al., 2000). Betancourt and Khan (2008) identified several factors shown to contribute to resilience in war-affected children living in conflict or postconflict settings, including individual factors (e.g., intelligence, coping, emotion regulation), attachment relationships and social support, caregiver mental health, access to child care and schools in war-affected regions, religious institutions and affiliations, and cultural values and practice. A study of refugee children living in Sweden found that good family relations, emotional expression, peer relationships, and prosocial behavior were related to the absence of PTSD symptoms in both children of torture survivors and refugee children whose parents were not victims of torture (Daud, af Klinteberg, & Rydelius, 2008). Another study of unaccompanied minors living in Britain demonstrated the importance of social support systems and caregiver relationships in findings of resilience in these youth (Hodes, Jagdev, Chandra, & Cunniff, 2008). While these studies focus on children resettled in countries other than the United States, they point to important factors

to consider in future research with refugees resettled in the United States. Among Afghan refugee children living in the United States, ethnic differences associated with higher parent education, language acquisition, and less exposure to war-related violence were associated with more positive outcomes in children (Mghir, Raskin, Bhugra, & Krause, 1999). Sense of school belonging was also related to better psychological outcomes in Somali refugee adolescents resettled in the United States, regardless of their level of past trauma exposure (Kia-Keating & Ellis, 2007). Throughout this review, additional protective processes can be elucidated from studies demonstrating factors associated with higher or lower levels of psychopathology in refugee youth. However, future research is needed to fully explore the role of specific protective processes and the interplay of individual and external factors in understanding resilience in these children (Masten et al., 1990).

Coping is among the individual factors considered important in understanding resilience in war-affected children. Coping with the traumatic and frightening events of war may tax and drain children's inner resources, resulting in a reliance on fewer and less-effective coping strategies (Kocijan-Hercigonja, Rijavec, Marušić, & Hercigonja, 1998; Punamäki, Muhammed, & Abdulrahman, 2004). On the other hand, some children demonstrate remarkably high functioning after severe trauma, illustrating the protective power of individual coping strategies in the face of adversity (Halcón et al., 2004). Studies linking relationships between specific types of coping strategies and posttraumatic stress symptoms (e.g., Durakovic-Belko, Kulenovic, & Dapic, 2003; Gavrilovic, Lecic-Tosevski, Knezevic, & Priebe, 2002; Kuterovac-Jagodic, 2003) suggest that coping strategies may be important mediators or moderators of the link between children's exposure to conflict and psychosocial adjustment (e.g., Jensen & Shaw, 1993; Pynoos et al., 1995).

There are a number of coping strategies identified in refugee children (Qouta, Punamäki, & El Sarraj, 2008), including cognitive restructuring (e.g., Khawaja, White, Schweitzer, & Greenslade, 2008), prayer (e.g., Halcón et al., 2004), and seeking emotional expression through social support (e.g., Khawaja et al., 2008). Recent studies suggest that religion is an integral part of coping and adaptation for some adult refugees (Ai, Peterson, & Huang, 2003; Ai, Tice, Huang, & Ishisaka, 2005; Khawaja et al., 2008; Sachs, Rosenfeld, Lhewa, Rasmussen, & Keller, 2008). Additional studies are needed to better understand the specific experiences of refugee children resettled in new cultures, the strategies they use to cope with these multiple stressors, the role of cultural norms, and associated psychological outcomes in these children. Coping strategies utilized by refugee children and their effectiveness vary by culture. Increased knowledge about coping strategies associated with resilience in refugee children would assist in the development of culturally syntonic (i.e., consistent

with the cultural values, norms, and traditions of the individual) recommendations for enhancing adaptation and healing.

Language.

Language is central to adaptation to a new culture. Refugee children and families resettled in the United States are placed in a new environment where they may be unfamiliar with the language and the cultural nuances associated with use of the language. Therefore, the experience of language acquisition can affect children's adaptation to war-related trauma and resettlement (Suárez-Orozco, Suárez-Orozco, & Todorova, 2008). Language acquisition may serve as a protective factor for children who acquire new language skills more quickly. For example, Halcón et al. (2004) found that language fluency was associated with lower symptoms of PTSD in young adult Somali and Oromo refugees. Portes and Rumbaut (2001) found evidence that fluent bilingual immigrant children demonstrated better adjustment and less conflict with their parents as compared to less fluent peers. Thus, proficiency in multiple languages may contribute to positive interpersonal outcomes and indicate cognitive flexibility (Portes & Rumbaut, 2001; Suárez-Orozco & Suárez-Orozco, 2001). However, there may be implications for children who demonstrate decreased fluency in their first language, as this may interfere with communication with family members who only speak the primary language. This dynamic may contribute to a loss of social support within the family setting (Wong Fillmore, 2005).

The challenge of learning something as fundamental as a new language places additional burdens on refugee children. Second languages typically take students between 6 and 7 years of teaching and practice to master (Snow, 1993), with multiple factors, including age, formal education in the first language, and immersion in a school, influencing the rate of second-language acquisition (Collier, 1995). Through their attendance at school, refugee children may be the first in the family to develop functional English skills, and, as such, they may assist their parents in basic adaptational tasks in the community. The child's facility with language may in fact disrupt the more culturally normative pattern of the parent-child relationship. As children take on the role of communicators for their parents, they may become parentified, overly burdened, or generally required to be more mature than other children their age (Portes & Rumbaut, 2001; Puig, 2002). They may be exposed to information and concerns that otherwise might not be relevant for their consideration. This may also contribute to conflict with parents, e.g., older children or adolescents may feel less inclined to defer to parents' authority if they are themselves empowered in ways in which their parents are not. Conversely, other research demonstrates positive outcomes of language brokering by immigrant children for their parents in terms of improved academic performance, social competence, and self-efficacy (Buriel, Perez, De Ment, Chavez,

& Moran, 1998; Kuperminc, Jurkovic, & Casey, 2009). Clearly, further research with refugee children is needed to examine the relationship between language acquisition, mental health, and adaptation. This kind of examination could assist educators and policymakers as they develop educational programs and resources for non-English speaking students in schools, including refugees.

Disabilities/medical needs.

Disabilities and medical problems that a child had before the war and those that developed due to exposure to war can affect the refugee child's postmigration psychosocial adjustment. According to the 1996 *UNICEF Report on Children and Armed Conflict*, approximately 6 million children had been injured or permanently disabled by armed conflict in the prior decade (Machel, 1996). Exposure to violence increases risk for physical injuries and impairments and increases the risk of injury or abuse for those already considered disabled (UNHCR, 2001). Further, the societal disruptions associated with armed conflict, displacement, and refugee living conditions present additional risks to the well-being of these youth (UNHCR, 2001). Refugee children may experience malnutrition or receive inadequate health or rehabilitative care before leaving their home countries or refugee camps (Browner-Elhanan, 1997; UNHCR, 2001). Children are at risk for acquiring infectious diseases during conditions of flight and displacement and, as a result, may suffer long-term consequences of these infections (Westermeyer & Wahmanholm, 1996). Parental disease and malnutrition can lead to a higher risk of birth complications, and lack of adequate nutrition and stimulation for infants can lead to developmental delays (UNHCR, 2001). The dissolution of community and civic structures that occurs during war may result in limited resources and supports for disabled children, as well as isolation or an experience of being "hidden" from others (UNHCR, 2001).

The long-term adjustment of refugee children living with disability in the U.S. is an unexplored area of inquiry. Studies of Western samples of children and adolescents living with disability or chronic illness suggest that these conditions can play an important role in self-concept and identity formation (e.g., Gill, 2001; Seiffge-Krenke, 2001; Shields, Taylor, & Dodd, 2008). Intellectual disability has been linked to a vulnerability to stress and use of less-effective coping strategies (Janssen, Schuengel, & Stolk, 2002). The experiences of refugee children may be further determined by cultural, community, and family perceptions of disability. The concept of "disability" can vary widely based on culture, socioeconomic status, and religious beliefs, and attitudes within refugee communities toward individuals living with disabilities may reflect these variations (Rogers-Adkinson, Ochoa, & Delgado, 2003; UNHCR, 2001; Welterlin & LaRue, 2007). Some types of disability or physical difference may be viewed within some cultures as negative and shameful, as a special gift or positive sign, or as some combination of these beliefs (Rogers-Adkinson

et al., 2003). For example, children with visible physical injuries or scars from war violence may elicit unwitting reactions from family or community members who see their injuries and are reminded of the traumatic events of the war. In contrast, in some immigrant groups, the view of disability may in fact be more positive and less stigmatizing than perceptions of disability in the U.S. (Greeson, Veach, & LeRoy, 2001; Welterlin & LaRue, 2007). The stress associated with living with disability has been compared to the stress experienced by ethnic minority groups living in the U.S. (Shapiro, 1993), suggesting a possible cumulative effect for refugee children with disability. The culture of origin, as well as perceptions of disability in the resettlement community, may determine the expectations, access to resources, and experiences of discrimination or shame for refugee children.

Disability within the school setting may lead to additional academic and social challenges for students who already may be struggling to learn a new language, adjust to a new school system, overcome educational gaps, and otherwise adapt to school expectations within the U.S. For instance, refugee children who are deaf may not have learned any formal sign language and might simultaneously need to learn American Sign Language, reading, and writing in English (Akamatsu & Cole, 2000). Formal assessment of the cognitive abilities of deaf refugee children may be difficult (Akamatsu & Cole, 2000).

Limited understanding of how to access health care or having differing cultural approaches to illness and healing may also inhibit families' use of medical care once families are resettled (Browner-Elhanan, 1997). Children with physical injuries, such as burns, limb amputations, scars, and other physical sequelae of violence from the war, need access to appropriate medical evaluation, ongoing care, and rehabilitation. Overall, refugee children with disabilities and medical problems require coordinated, interdisciplinary care in order to meet their multifaceted needs and facilitate their physical and psychological recovery (Akamatsu and Cole, 2000). Research is needed on the unique needs of disabled refugee and war-affected children and what practices and programs best address these needs.

Many developing countries experiencing armed conflict and war also struggle with high rates of HIV infection (Spiegel et al., 2007). The direct or indirect impact of HIV infection in families and children from high-risk areas must be considered by caregivers. Research with adult refugees shows that the negative psychological sequelae of exposure to war are associated with increased risky sexual behavior (Steel et al., 2003). For child or adult refugees, several factors may hinder receiving appropriate care for HIV/AIDS, including stigma, belief systems regarding healing, or concerns that a positive diagnosis might affect legal status. Foreign-born sexually active high school students are less likely to use condoms than their nonimmigrant peers (Browner-Elhanan, 1997), suggesting that risky behavior for HIV infection warrants special attention among refugee youth. While there is little research examining

issues related to HIV/AIDS and refugee children, further research is needed to identify best practices for strengthening prevention and education efforts and understanding and affecting behaviors and attitudes in refugee communities.

Family Factors

The adjustment of war-affected children is necessarily linked to the experiences, functioning, coping strategies, and adaptation of their families. In addition to the stress of war and flight, refugee children may experience separation from family and witness the intimidation, abuse, or death of caregivers and loved ones. These disruptions, traumas, and shifts in roles and responsibilities can lead to increased levels of conflict and stress within refugee families (Athey & Ahearn, 1991; Hobfoll et al., 1991; Weine, Muzurovic et al., 2004). In addition, resettled children are sometimes reunified with family members with whom they have had little contact for long periods (ICRC, 2004). The literature provides little empirical data about the stress of reunification and the renegotiation of these child-caregiver relationships; however, clinical experience suggests that these changes challenge refugee families.

Refugee families must learn to function in new cultures with the added burden of finding adequate resources for their most basic needs. These resettlement stressors are linked to increased rates of depression and PTSD symptoms among children (Miller, Weine et al., 2002; Steel, Silove, Bird, McGorry, & Mohan, 1999). Adults who are highly educated or former professionals in their country of origin may now face the difficult and sometimes humiliating experience of finding employment in a society that does not recognize their educational background or work experience (Miller, Worthington, Muzurovic, Tipping, & Goldman, 2002; Yakushko, Backhaus, Watson, Ngaruiya, & Gonzalez, 2008). A loss of status may particularly affect families with unrealized expectations of a better life or elevated social standing in the United States, but to date no known research examines how these unrealized expectations may affect their adjustment. The psychological and economic stress of this transition not only affects adults, but also their children, who must live with these changed circumstances.

As discussed earlier, differences in rates of acculturation within resettled refugee families are common (e.g., Birman, 2006; Weine, Feetham, et al., 2004). Children often adapt to new language

and cultural norms more quickly than their parents, leading to intergenerational misunderstandings, tensions between old and new cultures, and challenges to identity development (e.g., Suárez-Orozco & Suárez-Orozco, 2001; Weine, Feetham, et al., 2004). Changes to established family roles and family dynamics may leave parents lacking in authority or confidence (Suárez-Orozco & Suárez-Orozco, 2001). While intergenerational stress and role realignment are not unique to refugee families, further exploration is warranted to determine whether the added stress of the war experience makes refugee families more vulnerable.

Family members' mental and physical health also has an impact on children's psychological health. Multiple studies of refugee and war-affected populations identify maternal mental health problems and adjustment difficulties as risk factors for increased internalizing and externalizing behaviors in children (Ajdukovic & Ajdukovic, 1993; Almqvist & Broberg, 1999; McCloskey, Southwick, Fernández-Esquer, & Locke, 1995; Miller, 1996; Smith, Perrin, Yule, & Rabe-Hesketh, 2001). These well-documented findings demonstrate a principle confirmed in many clinical settings: Following adversity, parental functioning has a powerful impact on the well-being of children (Masten et al., 1990). Additionally, unaccompanied minors arriving in resettlement countries without caregivers are at relatively greater risk of experiencing symptoms of depression and anxiety and behavioral problems than accompanied minors or those who reconnect with family members (Derluyn & Broekaert, 2007; Kinzie et al., 1989), suggesting the protective nature of having some form of family remain intact after war.

One of the less-acknowledged stressors in resettled, war-affected refugee families is the secondary trauma of domestic violence and child abuse/neglect. Families under increased economic and social stress and living in social isolation are more vulnerable to incidents of violence in the home (Gelles, 1985). Although cultural norms and presumed fears of disclosure make these issues difficult to study, evidence suggests that partner violence in refugee homes may contribute to increased risk for psychological distress in female victims (Nilsson, Brown, Russell, & Khampahkdy-Brown, 2008). The impact of family violence on refugee children is also under studied in the literature. The cumulative effect of multiple traumas is well documented (e.g., Garbarino & Kostelny, 1996; Macksoud & Aber, 1996), and using the Pynoos and colleagues' (1995) model, domestic violence or child abuse is likely to serve as both another source of trauma and

a reminder of war-related traumas. Witnessing threats and/or actual violence toward a parent puts children in these homes at increased risk for trauma-related sequelae, including an increase in feelings of insecurity, fear, and anxiety.

Several factors may block access to resources for refugee women and children in violent homes, including cultural and language barriers, presumed cultural values and norms, fear and uncertainty related to immigration status, and dependence on the batterer (Keller & Brennan, 2007; Pan et al., 2006). The Violence Against Women Act (1994; subsequently reauthorized in 2000 and 2005) was introduced to allow immigrant spouses and children of U.S. citizens or lawful permanent residents to petition for permanent residency independent of their abusive spouses.

Despite the multiple stressors on war-affected families, research and clinical evidence indicates remarkable resilience in resettled families and their communities as they cope with the aftermath of war (Lustig, Kia-Keating et al., 2004). For example, communities with extended kinship networks may provide consistent caregiving to children in the community who lost parents or caregivers. Despite concerns about acculturation differences leading to parents' overreliance on children for activities such as translation (Athey & Ahearn, 1991), one recent study suggests that using adolescents as cultural brokers is related to greater family adaptability and does not interfere with family cohesion (Trickett & Jones, 2007). Further, well-functioning families provide a protective function in the lives of refugee children affected by severe trauma (Ajdukovic & Ajdukovic, 1993). While poor parental functioning is linked to greater difficulties in refugee children, refugee parents model resilience to their children in many ways, including adapting to a new culture, providing for their families, and sending additional economic support to family members still living in their country of origin.

School Factors

Many war-affected children arrive in the United States with limited formal education. The societal breakdown associated with war and displacement, as well as limited educational resources in refugee camps or resettlement communities, often results in large educational gaps for refugee children (WCRWC, 2004). Once resettled in the United States, children are usually placed in the educational system according to their age. Although access to public education may be seen as a resettlement benefit, children face multiple challenges once placed in the U.S. educational system. Those without formal schooling must adapt to a new culture and language while learning the fundamentals of school attendance and participation. These children must function in an environment with same-age American peers who attended school for many years. Families must adjust to societal

expectations regarding parents'/caregivers' roles in their children's education (Rousseau & Guzder, 2008). Parents may be unfamiliar and uncomfortable attending school conferences and assisting with homework. Language barriers may further inhibit communication between parents and school professionals.

School performance is an important indicator of how well refugee children function after their migration experience. Several authors note that refugee children are more vulnerable to learning problems than other children (Rousseau, Drapeau, & Corin, 1996; Sack, Richard, Kinzie, & Roth-Ber, 1986). The psychological difficulties that result from war-related experiences may affect children's learning and school performance. For example, both depression and PTSD negatively affect concentration and attention (Davis & Siegel, 2000; Thabet, Abed, & Vostanis, 2004). Children's premigration learning disabilities may not be easily identifiable because of cultural and language differences, lack of formal schooling experience, and parents' hesitation to access unfamiliar educational resources in a new community. Poor behavioral or academic functioning at school may indicate that a child is struggling emotionally. Teachers, school psychologists, and guidance counselors are essential resources for refugee children's adjustment to school and the identification of learning or emotional difficulties (O'Shea, Hodes, Down, & Bramley, 2000). School psychologists can play a critical role in identifying refugee children in need of mental health services, evaluating educational or trauma-related needs, and consulting with school administration and staff regarding ways to promote acceptance of refugee students.

Schools may also provide a less-stigmatizing setting for the provision of mental health screening and services. Within many refugee communities, mental illness is highly stigmatized and families seek to protect their children from this stigma by avoiding mental health services (Lauber & Rossler, 2007; Ng, 1997). Providing these services within schools allows children to receive services in a more culturally accepted system (Ellis, Lincoln et al., in press). Thus, schools are important for both mental health promotion and intervention for refugees.

Education can also serve as a protective function for refugee and war-affected children. In a study of Somali youth resettled in the United States, a greater sense of school belonging was associated with less depression and a greater sense of self-efficacy (Kia-Keating & Ellis, 2007). In a study of Iraqi refugee children in Sweden, teacher identification of fewer peer relation problems was related to fewer PTSD symptoms, suggesting that peer relations in the school setting may be either a protective factor or a marker of resilience (Daud et al., 2008). Higher ethnic identification is associated with more positive school outcomes among immigrant adolescents (e.g., Bankston & Zhou, 1997; Gibson, 1988; Ogbu, 1991), although more recent studies did not find this (Trickett & Birman, 2005). Further research is needed

to examine how school factors may interact with identity development, peer relationships, and other aspects of acculturation to create positive adjustment in refugee children.

Schools Aiding Refugee Youth

Because schools can be less-stigmatized settings in which to provide mental health services, they are the focus of many creative mental health promotion programs (Rousseau & Guzder, 2008). Project SHIFA (Supporting the Health of Immigrant Families and Adolescents) is a school-based mental health program for Somali adolescents in the Boston Public School System. This program includes community outreach, school-based groups, and, for youths with significant mental health needs, mental health treatment using a trauma-systems therapy model. Built out of partnerships with community organizations, this program demonstrates excellent rates of treatment engagement. Similarly, World Relief in Chicago piloted a program implementing trauma-focused cognitive behavioral therapy (CBT) in schools, and, in combination with case management, teacher training, parent training, and other wraparound services. Project Tamaa, based in Philadelphia, developed a curriculum focused on teachers and staff to help them better understand how to support the success of refugee students. These programs demonstrate how school settings can achieve high engagement of refugee children in needed mental health services (for additional information on these programs, see <http://www.healthinschools.org/Immigrant-and-Refugee-Children/Caring-Across-Communities.aspx>).

community with higher representation of native-language speakers is related to decreased fluency in English among immigrant adults (Chiswick & Miller, 1996; Ying, Han, & Wong, 2008). But a study of adolescent refugees from the former Soviet Union living in the United States did not find this to be the case (Birman, Trickett, & Buchanan, 2005). Other critical dimensions influenced by resettlement community characteristics include degree of acculturation and experiences of discrimination (Birman, Trickett et al., 2005; Ying et al., 2008). Again, the direction of influence is unclear; while some studies of immigrant children suggest that immigrant ethnic enclaves promote strong identity with immigrants' culture of origin (Birman, Trickett et al., 2005; Ying et al., 2008), others find adolescents more likely to reject their ethnic identity in closed communities as compared to moderately integrated communities (Zivkovic, 1994). The degree to which the dominant culture accepts or discriminates against newcomers of different cultural groups is an important factor in the culture of a community. Padilla and colleagues (2003) note that individuals' perceptions of acceptance and stigmatization within the dominant community influence their level of acculturation. Ellis and colleagues (2008) argue that stigmatization within the host culture may directly affect the mental health and adjustment of refugee children. The interplay of culture, degree of acculturation of the resettled community, and characteristics of the host community are complex; additional research examining the interrelations of these characteristics and their relation to child adjustment is needed. Community psychologists, with expertise in creating services for vulnerable populations not typically served in mental health settings, may be particularly able to assist in needs assessment and development of community-based interventions for refugee families.

The level of social support that refugee children and families perceive from their host community may also play an important role in psychological adjustment. Studies of war-affected children suggest that higher levels of social support are related to fewer psychological symptoms, whereas absence of support is related to PTSD and internalizing symptoms (Betancourt & Khan, 2008; Brajša-Zganec, 2005; Kuterovac-Jagodic, 2003). In a study of Lebanese families, Farhood, Zurayk, Chaya, and Saadeh (1993) found that a reduction in social networks was related to depressive symptoms in children, whereas perceived social support mediated the impact of war-related stress on adolescent depression and interpersonal relationships. Although fewer studies of resettled refugee children focus on social support, a review of studies involving Southeast Asian refugee children identified social support as an important variable in the adaptation of these children (Fox, Cowell, & Montgomery, 1994). Unaccompanied children may be among those most in need of social support systems in their resettled communities, given their lack of family support upon arrival. A study of unaccompanied asylum-seeking children

Community Factors

While research has focused on how refugees' characteristics and experiences relate to adjustment, less is known about how differences in resettlement communities affect the adjustment of children. Resettlement communities in the United States are far from monolithic; they vary along a number of dimensions, including density of refugees already resettled, ethnic and racial diversity, job opportunities, community safety, attitudes toward immigrants and refugees, dominant religious beliefs, and availability of resources. Historically, patterns of refugee resettlement shifted from a dispersion model to one that concentrates refugees from a particular ethnic group together (Patrick, 2004). Living in an area with high concentrations of their own ethnic group, or ethnic enclave, may be particularly important to shaping the experience and adjustment of children, although the direction of influence does vary. There is some evidence that living in a host

in Britain found that low-support living arrangements were, in fact, related to symptoms of PTSD (Hodes et al., 2008). Mels, Derluyn, and Broekaert (2008) also identified social support as an important factor in unaccompanied boys' self-esteem and efforts to cope with stress; in particular, they identified the importance of social support resources accessed through ethnic communities and their local asylum center.

Finally, ongoing exposure to community violence affects many refugee children even after resettlement (Ellis et al., 2008). The cumulative effect of being exposed to continued violence may ultimately overwhelm coping and resilience for some refugee children (Garbarino & Kostelny, 1996), thus, the negative effects of exposure to armed conflict must be understood in the context of continued exposure to violence *post*-resettlement. Community factors that promote positive adjustment or prevent the accumulation of risk are important areas of intervention to inform community-level prevention programs.



MENTAL HEALTH SERVICES FOR REFUGEE AND WAR-AFFECTED CHILDREN



A REVIEW OF THE LITERATURE

There are several excellent reviews of treatment options for war-affected children and their families (Barenbaum, Ruchkin, & Schwab-Stone, 2004; Birman, Ho et al., 2005; Ehntholt & Yule, 2006; Lustig, Kia-Keating et al., 2004; Yule, 2002). Various therapeutic models and techniques address the effects of exposure to war in children. These interventions include individual psychotherapy, family therapy, group treatment, and school-based services, and they represent a range of orientations and approaches, including psychodynamic, supportive, cognitive-behavioral, and expressive arts and movement therapies (Barenbaum et al., 2004; Betancourt and Williams, 2008; Birman, Ho et al., 2005; Ehntholt & Yule, 2006; Harris, 2007; Lustig, Kia-Keating et al., 2004; Perret-Éatipoviæ, 1999; Yule, 2002). While research on the efficacy of such treatments with refugee populations is still relatively limited, there are many clinicians³ working in the field adapting and combining some of these interventions in order to provide effective clinical care to war-affected children. This *practice-based evidence* can provide guidance to practitioners and researchers working to assist these populations (Birman, Ho et al., 2005).

³ For the purposes of this report, the terms *clinician*, *service provider*, and *practitioner* are interchangeable and refer to individuals working in settings providing services to refugee children and families. In addition, the terms *clinical* and *therapeutic* refer to professional services provided to refugee children designed to address problems in functioning or adaptation or to prevent the development of such problems. These terms refer to the work of service providers in the field of psychology and in other human service fields, such as social work, medicine, and education. Additionally, the *Mental Health Care Principles* are intended for a variety of psychologists and service providers working with refugee children and families in multiple settings and are not exclusively intended for clinical psychologists or private practitioners.

Individual Approaches

While there are few studies on mental health treatment for war-affected children, there is some evidence of the effectiveness of individual treatment with children affected by traumatic stress from other types of events (Taylor & Chemtob, 2004). Two reviews of the treatment of traumatized children conclude that a variety of therapeutic approaches are effective in reducing symptoms in children (ages 0–18 years) with traumatic stress reactions (Cohen, Berliner, & Mannarino, 2000; Silverman, Ortiz, Viswesvaran, Burns, Kolko et al., 2008; Taylor & Chemtob, 2004). In general, a number of common factors that characterize effective practitioners, regardless of their training or technique, contribute significantly to good therapeutic outcomes, including a high degree of empathy, tolerance for strong emotions, capacity to gently confront clients when needed, and lack of defensiveness (Hubble, Duncan, & Miller, 1999). Thus, the power of a positive therapeutic relationship—across a range of orientations—to impact children’s lives should not be underestimated.

Cognitive-behavioral therapy (CBT) techniques are frequently used in therapeutic work with war-affected children. CBT, with its emphasis on mastering negative emotions, thoughts, and actions with analysis and adjustment of dysfunctional cognitions and behaviors, can be well suited to address fear, helplessness, and anxiety often found in war-affected children (Murray, Cohen, Ellis, & Mannarino, 2008). Trauma-focused interventions such as testimonial psychotherapy (Lustig, Weine, Saxe, & Beardslee, 2004; Weine, Kulenovic, Pavkovic, & Gibbons, 1998), eye movement desensitization and reprocessing (Oras, de Ezpeleta, & Ahmad, 2004), and narrative exposure therapy (Neuner, Catani, et al., 2008; Onyut et al., 2005) involve some component of CBT exposure techniques. In exposure therapy, children or adolescents are assisted in tolerating gradual

exposure to the remembering and retelling of traumatic memories. This therapy is effective for decreasing the hyperarousal and avoidance symptoms that are part of PTSD and demonstrated initially positive results when utilized in randomized controlled studies with refugee youth (Catani et al., 2009; Neuner, Catani, et al., 2008). Depending on children's age and degree of exposure to trauma, revisiting traumatic memories may take place through storytelling, drawing, play, writing, or other structured age-appropriate formats (Porterfield & Akinsulure-Smith, 2007). Other CBT methods used with war-affected children (in both individual and group treatments) include strengthening coping strategies using, for example, visual imagery and relaxation techniques (Ehnholt, Smith, & Yule, 2005).

CBT therapy protocols developed for traumatized children involve a combination of techniques and methods. Trauma systems therapy (TST; Saxe, Ellis, & Kaplow, 2007) is a phase-based model of care that builds children's emotional regulation skills while simultaneously targeting and reducing social environmental stressors that contribute to emotional dysregulation. TST integrates individual interventions with services in the home and at school and community levels and was adapted for use with Somali refugee adolescents in Boston. Recent results show success in reducing barriers to access and encouraging treatment for traumatized adolescents (Ellis, Miller, Baldwin, & Abdi, S., in press). A trauma-focused cognitive behavioral therapy (TF-CBT) protocol for traumatized children was developed combining many of the techniques mentioned above in a short-term structure and including therapeutic work with parents (Cohen, Mannarino, & Deblinger, 2006). While not specifically designed for refugee children, this therapy was researched and effective with a range of traumatized children (Cohen, Mannarino, Berliner, & Deblinger, 2000).

While there are no controlled medication trials conducted on war-affected children, there is evidence that therapeutic interventions for traumatized children may be supplemented with psychopharmacological treatment for greater symptom reduction (Cohen, Perel, Debellis, Friedman, & Putnam, 2002). While psychopharmacologic treatment of refugee children who may have PTSD falls outside the scope of this report, it is recommended that psychologists understand the psychobiology of PTSD, as well as the risks and benefits of medication that is available for and currently used with children with PTSD (Cohen, 2001; Cohen, Mannarino, & Rogal, 2001; Donnelly, 2003; Donnelly, Amaya-Jackson, & March, 1999; Marmar, Neylan, & Schoenfeld, 2002). Refugee patients may not be familiar with medicalized treatments of psychological distress, and clinicians need to be aware of the salience of these cultural differences, rather than simply assume that refugee patients will accept a recommendation for medication. There is limited research available on how racial and ethnic differences moderate response to psychopharmacological treatment and influence treatment choice

and adherence among refugee children (Kinzie & Friedman, 2004). In fact, typical participants in the majority of studies available on psychopharmacological treatment of children are White males (APA, 2006). Further research is needed on the use of medication with war-affected children and on issues of attitudes and compliance with these regimens in a refugee population.

Family Approaches

There are few studies of family-based interventions for the refugee family, although there are case descriptions of clinical interventions with refugee populations (Arrendondo, Orjuela, & Moore, 1989; Bemak, 1989; Walter & Bala, 2004; Westermeyer & Wahmanholm, 1996). Family members who have lived through a war together may still have vastly different ways they remember, process, and deal with these traumatic events. These differences may be based on issues such as developmental stage, role in the family, and individual issues, such as whether a family member was injured, disabled, or otherwise exposed to more trauma during the war than other family members. Family-based interventions targeted at improving the emotional functioning of war-affected children and their families can address many aspects of the refugee family's experience, including surfacing the family members' shared experiences and differing perspectives on the war, flight, and acculturation; identifying family patterns of coping and communication; and assisting in the process of making meaning of the family's history. Family therapy can provide an environment which addresses each family member's well-being and adaptation, thereby providing the clinician a fuller picture of the family context. Clinicians who work with refugee families may take on several tasks over the course of family therapy, such as restoring a sense of equilibrium and parental executive functioning, enhancing empathy between and among family members, and allowing opportunities for making meaning through shared expressive exercises (Porterfield & Akinsulure-Smith, 2007).

Weine and colleagues engaged extensively with refugee communities in family-based education and support programs and argue that the "family beliefs" of the refugee family are the core values and meanings that influence how family members respond to their life after war (Weine et al., 2006; Weine et al., 2003; see box). These authors argue that understanding the specific family beliefs framework of a community will contribute to the development of preventive interventions that will resonate with and be effective for the population. Dybdahl (2001) utilized a group psychoeducational model to enhance the parental and emotional functioning of mothers in refugee families. Given the finding that parental mental health is a predictor of how well refugee children function, clinicians working with refugee children need to be aware of the adaptation of the parents (Almqvist & Broberg, 1999; Hosin, Moore, & Gaitanou, 2006). More research is needed to

determine the efficacy and feasibility of family-based interventions for war-affected children and families.

A Family-Focused Framework for Development of Services for Refugees

Weine and colleagues (2006) used the Youth Coffee and Family Education and Support (CAFES) intervention to develop a conceptual framework for family-focused preventive interventions using family beliefs as a way to formulate social and cultural interactions. Youth CAFES is a multifamily education and support group for Bosnian refugees in Chicago focused on families of middle and early adolescents (ages 11–15 years), which aims to facilitate family processes that prevent risky behaviors, truancy, and school dropout. It was conducted in community settings and facilitated by trained and supervised Bosnian laypersons. The group sessions' topics were organized around families' and youths' priorities and concerns, urban adolescents and their families, school life, city life, family talk, family values and beliefs, and planning and celebrating the future together.

The family-beliefs framework consisted of four realms and specified processes by which refugee families adapt and apply their beliefs concerning youths (obliging family, keeping tradition, working hard, and living through children). There were also contextual factors—related to home country and country of refuge—interacting with these family beliefs and the ways in which families adapted their beliefs through interactions with these contextual factors. Home country-related factors were: Bosnian and Muslim traditions, family togetherness, and war memories. Refugee-related factors were: economic opportunities, American culture, and disappointing schools.

The family-beliefs framework offers a way to consider interactions between war traumas and transitions (on social, cultural, economic, familial, and psychological levels). The Youth CAFES intervention provides a model of a family-focused preventive intervention that is socially and culturally specific.

(Weine, Feetham, et al., 2006)

School-Based and Community-Based Group Approaches

Given that the school setting is one of the first and most influential service systems that refugee children encounter, it is crucial that interventions for war-affected children utilize the resources offered

in the educational environment (Kia-Keating & Ellis, 2007; Persson & Rousseau, 2009; Rousseau & Guzder, 2008; Rousseau, Lacroix, Singh, Gauthier, & Benoit, 2005). In creating a safe and stable environment for war-affected children, schools can provide a welcome contrast to the disruption that these children endured in their countries of origin and during their resettlement journey. Schools provide an accessible environment in which refugee children can be reached before psychosocial and mental health problems develop or worsen (Betancourt, 2005). School personnel can be essential in identifying the mental health needs of war-affected children and referring them for appropriate services (Fazel, Doll, & Stein, 2009). Furthermore, school psychologists within these educational settings can provide direct interventions for this population, such as teaching effective ways to handle stress and providing support and guidance around issues of acculturation. In addition, schools can provide the setting for clinical services, such as group interventions and creative art and expressive treatments that would likely be less accessible to refugee children in traditional clinical settings (Akinsulure-Smith, 2009; Fazel & Stein, 2002; Gordon, Staples, Blyta, & Bytyqi, 2004; Hodes, 2002; Layne et al., 2001; Lustig, Kia-Keating et al., 2004; Woodside, Santa Barbara, & Benner, 1999).

There is little systematic research on therapeutic group interventions used in schools and other community settings to facilitate the adjustment of refugee and war-affected children (Akinsulure-Smith, 2009; Layne et al., 2001; Schwartz & Melzak, 2005; Shakoor & Fister, 2005; Tucker & Price, 2007). Goals of group therapy can include fostering hope, normalizing experiences and reactions, imparting information, creating interpersonal learning opportunities, and allowing for catharsis (Yalom, 1995). In addition, group work can provide an opportunity to decrease the sense of alienation often created by war and create a sense of belonging and connection. One study of school-based CBT group therapy with refugee youth in high school found modest improvements in symptoms after the group therapy and some decrease in PTSD symptoms (Ehnholt & Yule, 2005). Layne et al. (2008) reported improvement in functioning in two groups of Bosnian high school students who participated in different tiers of intervention in their school—a classroom-based psychoeducation and skill-building intervention and a higher-intensity group treatment component. It must be noted that for refugee youth in the United States, there is not always the “critical mass” of students available in a school or community to provide opportunities for group- or classroom-based interventions. Therapists must carefully consider the composition of a school-based group when placing children or adolescents together who are from different countries or even from different cultural backgrounds (ethnic, religious, tribal) within the same country. Therapists should be aware of the basic geopolitical history that may influence refugee patients' feelings and opinions about other groups. While more systematic

research is needed in order to determine the most helpful components of group therapy, many clinicians find that a group model allows participants to process their experiences within an environment that is less threatening than a one-on-one clinical contact. In addition, group therapy can create opportunities for collaboration between group members and the “teaching” of cultural norms to the practitioner, an experience that can provide group members with feelings of mastery and expertise. Further research is needed to determine the efficacy of group therapy for war-affected young people.

A Group Psychoeducational Treatment for Retraumatized Refugees

An alternative New York City public school implemented a psychoeducational group treatment for older students (ages 17–23 years) with a history of refugee trauma, war, and human rights abuses after these young people experienced further traumatization by the 9/11 attacks. The goals of this 7-week-long intervention were to provide emotional and behavioral stabilization and symptom relief through trauma education and stress-management skills training. Counselors and teachers identified participants for the intervention after they reported difficulties, such as intrusive thoughts and images of events surrounding 9/11, increased anxiety, poor concentration, and insomnia. The coping skills introduced were drawn from cognitive behavioral therapy literature (Fazel & Stein, 2002; Lustig, Kia-Keating et al., 2004).

Seven adolescent students from Sierra Leone, Haiti, Yugoslavia, Guinea Bissau, Bosnia, Colombia, and Albania participated. These nations all have collectivistic cultures for which the group intervention provided a good fit. Over the 7-week-long intervention, the participants shared present and past personal traumatic experiences and learned stress-management techniques such as progressive deep muscle relaxation, a thought-stopping technique, breathing retraining, and a positive memory exercise. The participants reported that the techniques helped them to manage psychological distress (with deep muscle relaxation identified as being the most effective), and they all reported symptom reduction.

Although the interventions derived from a Western orientation, the diverse cultural backgrounds of the participants became an integral part of the group process. Throughout the intervention, they were encouraged to share coping skills that were part of their cultural heritage. The group sessions always included discussion of ways to use cultural resources to reduce the participants' symptoms. The participants expressed appreciation of the social ties they developed with each other and reported that they found the group to be a safe space in which to verbalize their fears and concerns.

(Akinsulure-Smith, 2009)

Expressive Arts Approaches

Across the varying modalities and orientations of therapy, creative art and expressive treatments are often utilized with traumatized refugee children (Miller & Billings, 1994; Rousseau & Heusch, 2000; Rousseau, LaCroix, Bagilishya, & Heusch, 2003). Visual art and drawing exercises may be well suited for recently arrived refugee children with limited English-language skills and younger children who may not tolerate a direct discussion of traumatic events. In addition, older children embarrassed about their experiences or hesitant to talk directly about themselves may find that symbolic expression techniques, such as storytelling or drama activities, help them share and process their traumatic experiences through displacement (Fitzpatrick, 2002; Porterfield & Akinsulure-Smith, 2007; Rousseau, Singh, Lacroix, Bagilishya, & Measham, 2004). Rousseau and colleagues implemented several school-based programs utilizing creative expression and the arts for refugee and immigrant children across different developmental stages (Rousseau, Benoit, Gauthier, Lacroix, Alain et al., 2007; Rousseau, Lacroix, Singh, Gauthier, & Benoit, 2005). These innovative programs involved the use of sand-tray play with preschoolers, storytelling and drawing with school-age children, and drama therapy with adolescents. The authors reported some symptom reduction and improvements in social adjustment, self-esteem, and academic performance in children participating in the programs. Other creative and expressive formats used with war-affected adolescents include dance/movement therapy (DMT). Harris (2007) noted improvement in group cohesion in a group of resettled Sudanese adolescents after their participation in a dancing and drumming program. While many clinicians utilize creative expression techniques in a range of settings and report positive results, there is still a need for systematic study of the effectiveness of these interventions with war-affected children (Barenbaum et al., 2004; Birman, Ho et al., 2005; Lustig, Kia-Keating et al., 2004; Yule, 2002).

Special Populations

There are several groups of war-affected children whose experiences warrant special consideration in terms of evaluation and treatment.

Children and families in detention.

Very few studies document and explore the impact of detention on unaccompanied war-affected minors or on children and their families in the United States. Despite the UNHCR recommendations (1999) that governments should not detain minors seeking asylum, a study by Physicians for Human Rights (PHR) and the Bellevue/NYU Program for Survivors of Torture (2003) noted that most unaccompanied minors detained by U.S. Immigration and Customs Enforcement (ICE) are held in detention facilities alongside juvenile offenders. Research documents short- and long-term psychological distress and mental

health risks associated with the detention of previously traumatized refugee children and families (Lawrence, 2004; Steel, Silove, Brooks, Momatrin, Alzuhairi, & Susljik, 2006). In addition, a study by Amnesty International (2003) noted that the rights of unaccompanied children held in U.S. detention are frequently violated. Amnesty International called for an end to the policy of routinely detaining unaccompanied children and argued for safeguards of these children's rights, including the provision of appropriate legal representation, least restrictive settings standards for their placements, and humane treatment across the settings in which they are placed. Current research on the impact of detention on infants and young children in the United States is very limited; however, Australian research documents deleterious effects, including incontinence, food refusal, stuttering, and other behavioral and attachment problems in young children in detention (Silove, Austin, & Steel, 2007).

A recent study by the WCRWC and the Lutheran Immigration and Refugee Service (2007) estimated that the U.S. government has the capacity to detain 600 immigrant men, women, and children on a daily basis. Their report recommends discontinuation of the detention of families in penal institutions and calls for the development of nonpenal, homelike facilities for those families who cannot be paroled. In addition to the prison-like confines of some U.S. detention centers, this study found numerous disruptions to family functioning of refugee families placed in this type of detention, including inadequate time for educational activities, separation of caregivers and children, and loss of autonomy and executive control for parents over their families (WCRWC & Lutheran Immigration and Refugee Service, 2007).

A recent U.S. Immigrations and Customs Enforcement report (2009) made extensive recommendations for modifying the U.S. detention system, including "unique provisions" for families in detention (Schriro, 2009, p. 3). In addition, in January 2010, ICE began automatically considering for parole those arriving asylum seekers who do not represent a flight risk and have a credible fear of persecution. Parole temporarily authorizes asylum seekers to enter the United States without being formally admitted or granted immigration status. The new policy does not, however, detail what will happen to the families already held within the detention system. The psychological needs of the population of refugee children who escape war only to find themselves detained in the United States warrants further examination, as does the role that psychologists can play in assisting detained families during and after their detention.

Children of torture survivors.

A small body of literature focuses on the unique needs of children whose parents were tortured (Daud, af Klinteberg, & Rydelius, 2008; Krogh & Montgomery, 1993; Montgomery, Krogh, Jacobsen, & Lukman, 1992). The few studies examining the experiences of children of

torture victims note a range of difficulties for these children, including behavioral and cognitive impairments, such as PTSD, anxiety and depressive symptoms, psychosomatic symptoms, and sleep disorders (Daud et al., 2008; Krogh & Montgomery, 1993; Montgomery et al., 1992). Given that parental functioning is linked to the adaptation of refugee children, it is important to focus on the needs of families with a potentially highly traumatized parent. Krogh and Montgomery (1993) emphasize intervening in an entire family system affected by torture, rather than focusing on individual family members. Thus, families in which there is a parent who experienced torture may require specialized family intervention or support focusing on returning family members to prior levels of functioning and enhancing children's sense of well-being (Daud et al., 2008).

Child soldiers.

A growing body of literature documents the severely traumatic experiences endured by children forced into the roles of child soldiers (Bayer, Klasen, & Adam, 2007; Betancourt, Agnew-Blais, Gilman, & Ellis, 2009; Betancourt, Borisova et al., in press; Boothby, 2006; Kohrt, Jordans, Tol, Speckman, Maharjan et al., 2008; Wessells, 2009). In 2001, the first *Global Report on Child Soldiers* reported more than half a million girls and boys were abducted or forcefully conscripted into government forces and armed groups in 87 countries (Coalition to Stop the Use of Child Soldiers, 2009). Children affiliated with fighting forces often serve as porters, cooks, servants, human shields, and sexual slaves and are forced into direct combat and the commission of atrocities, such as killing and sexual violence (Amone-P'Olak, 2009). Despite the threats to mental health and development posed by such extreme war-related trauma, very little information exists about the most effective interventions for former child soldiers. Those who work with child soldiers emphasize thorough assessment, which considers trauma exposures and current stressors and individual, family, and community protective resources that may also contribute to resilience (Betancourt et al., 2008; Betancourt & Kahn, 2008; Stark, 2006). In fact, former child soldiers within the treatment population of the United States may face many of the same resettlement stressors and acculturative stressors that characterize the general population of refugees and immigrants as discussed in this report. The literature documents some successful interventions for former child soldiers using dance therapy, school-based support programs (with remedial educational focus), narrative exposure therapy, and group interpersonal therapy (Betancourt, 2008; Betancourt et al., 2009; Bolton, Bass, Betancourt, Speelman, Onyango et al., 2007; Ertl, Pfeiffer, Schauer, Neuner, & Elbert, 2008; Harris, 2007).

Although there is a dearth of empirical studies documenting the effectiveness of available therapeutic interventions for war-affected children and families, the present literature indicates promising initiatives in individual treatment methods, family therapy, and group

work in schools and other community settings. In order to address the diverse needs of this unique population, psychologists and other mental health providers must demonstrate flexibility with treatment models while upholding standards of care to the level of best practices.

MENTAL HEALTH CARE PRINCIPLES: COMPREHENSIVE, CULTURALLY COMPETENT, AND INTEGRATIVE BETWEEN EVIDENCE-BASED PRACTICE AND PRACTICE-BASED EVIDENCE

Three principles of mental health care are well documented in the research and clinical literature on the needs of refugee children and families reviewed in this report: the necessity of comprehensive services, the importance of cultural competence in practitioners, and the need to integrate evidence-based practice with practice-based evidence. Below, a discussion of these mental health care principles is followed by case vignettes⁴ and “practice points” (i.e., specific examples of ways to enact the principles). This list of practice points is not meant to be exhaustive or linear in terms of a temporal progression of interventions, but rather, illustrative of some of the ways practitioners can use these principles with war-affected children or families.

Mental Health Care Principle 1: Use Comprehensive, Community-Based Services

Several authors emphasize the importance of developing comprehensive services for war-affected refugee children (Barenbaum et al., 2004; Birman et al., 2008; Hodes, 2002; Lustig, Kia-Keating et al., 2004; Yule, 2002). Comprehensive services are designed to increase service use by underserved populations and to address a broad range of needs and stressors in the population. Birman et al. (2008) noted that creating outreach services to clients and providing care in accessible and nonstigmatizing locations facilitates service utilization. The National Child Traumatic Stress Network (NCTSN) Refugee Trauma Task Force reviewed several methods aimed at engagement and retention of refugee clients, including telephone contact to introduce a set of services and direct problem-solving around issues of work and child care that might interfere with accessing services (Birman, Ho et al., 2005). Birman and colleagues (2008) described the FACES program's (see box below) use of service locations in the community, in clients' homes, and in schools in order to maximize the program's accessibility and comfort for participants.

⁴ These case vignettes are fictional and are not intended to depict any actual person or event.

International FACES Program:

A Comprehensive Community-Based Services Model for Refugee Children and Families

Birman and colleagues (2008) conducted a collaborative study of International Family, Adult, and Child Enhancement Services (FACES), a comprehensive, community-based mental health program that works with refugee children and their families, with the goal of gathering “practice-based evidence” about effective services for this population. The International FACES model uses a multidisciplinary and multiethnic team approach (i.e., clinicians partner with ethnic mental health workers/paraprofessionals); different services are provided according to a team-designed plan. Ethnic mental health workers serve as cultural brokers/interpreters. Team members provide services such as case management, which can address basic survival needs and adjustment challenges. Team members interface with other service providers (e.g., teachers, advocates, other mental health professionals) and provide services at a variety of locations, including homes, schools, and other community locations.

FACES clinicians provided services to multiethnic (34 different ethnic groups), multinational (32 countries), and multilingual (26 languages) participants. Mental health assessment showed that the largest proportion of children was diagnosed with PTSD (over 25%), followed by depressive and adjustment disorders. Clinical services included individual and group therapy, family therapy, parent guidance, and expressive arts therapies. Services were individualized and intensified for those whose needs were perceived as greater. Participants matched with a service provider according to language stayed in treatment longer, but did not necessarily have better clinical outcomes. Over time, children receiving services showed improvement, but improvement was not a function of the quantity of services provided. The authors conclude that issues such as intensity of service delivery and ethnic and linguistic matching between providers and clients must be examined in relation to clinical effectiveness of services for refugee children.

Another component of comprehensive care for refugee children is addressing daily life adaptation and problems—sometimes called a “holistic” approach—as opposed to solely focusing on mental health symptoms (Ehnholt & Yule, 2006, p. 1202). Given the numerous stressors on individuals facing resettlement in a new country—including language, work, education, financial issues, and cultural adaptation—it is important for clinicians working with refugee children to recognize the primacy of these issues. Miller and Rasco (2004) argue that since

stressful environmental and social conditions can create and maintain psychological distress, interventions for refugee children must address and have an impact on these conditions. Ehnholt and Yule (2006) describe their focus on practical problems when working with refugees and emphasize how this work can lead to the creation of a trusting, safe relationship between a client and clinician, also known as a therapeutic alliance. Alternatively, the use of a case manager or social worker, who focuses on the daily needs and concerns of a refugee family, may provide stability so that the family can later address its mental health needs with a trained clinician (Birman et al., 2008).

Many authors advocate for community-based intervention as part of a comprehensive services plan (Layne et al., 2008, Weine, 2008). Community-based interventions typically involve individuals or groups of individuals receiving supportive information or care in a normalizing, nonpathologizing context, such as a school or community center.

Hodes (2002) recommends a “tier-based” model of services for refugee children’s mental health needs. In this model, most members of the target population receive services in broader, community-based interventions with specific, trauma-focused treatment required for the most symptomatic and impaired members of the community. Layne and colleagues (2008) describe a school-based program for children in Bosnia in which a classroom-based program provides a first tier of services comprising psychoeducational information about reactions to trauma and grief and a skill-building component based on handling negative emotions. The program provides specialized intervention at the second tier for teens with severe trauma and grief reactions and referral to mental health services at the third tier for the most symptomatic teens. Others advocate for the use of tier-based approaches to intervention and prevention among traumatized children (Murray et al., 2008; Weine, Feetham, et al., 2004).

The National Center of Trauma-Informed Care (NCTIC) similarly calls for a “public health framework” in the formulation of services for refugee children. This model focuses primarily on culturally competent, trauma-informed community and preventive interventions, in which psychoeducation and skill-building in relation to trauma sequelae are used. Trauma-specific treatment modalities are then used in the smaller number of cases where there is the most severe need (Blanch, 2008).

Practice points: Comprehensive services.

Case 1. *A Liberian mother who is a political asylee brings her 9-year-old daughter and her 11-year-old son to a busy emergency room in Boston. The children recently arrived in the United States from a refugee camp in Ivory Coast, where they lived with their grandparents for the past 5 years. The children’s father, a political activist, was killed during the civil war in Liberia, and their mother, fearing that she too was being targeted, fled alone to the United States. The mother, during her emergency room (ER) intake, reports tearfully that she is afraid her*

children might have tuberculosis (TB) and that, because she cannot pay for their medical care, she has kept them at home since their arrival. She also says that she cannot afford to feed them. A physical exam reveals that the children are malnourished and have not been out of their apartment for 2 months. The ER staff calls in a child protection worker and a psychologist for consultation.

Practice Point 1: Assess postdisplacement basic needs. In this case, the mother engages in behavior with her children motivated by fears, worries, and her economic situation. There may be a later opportunity for the clinician to address fears and worries, but medical and nutritional needs are the first priorities at this point. It is important for clinicians to recognize that families displaced due to war are likely to be economically disadvantaged, even when they have refugee status or political asylum. In fact, many refugees' economic and survival stressors supersede their concerns about psychological distress, making them less likely to seek mental health care (Birman, Ho et al., 2005; Westermeyer & Wahmanholm, 1996). A starting point for the psychologist in this case is a direct assessment of the family's basic daily needs—health care, food, clothing, housing, transportation, and so forth. By demonstrating a real interest in the family's problems to the mother, the psychologist may begin building a treatment alliance.

Practice Point 2: Assess resettlement stressors. The psychologist should explore additional stressors present in this family's life. A family recently resettled in the United States may be coping with flight- and resettlement-related stressors beyond economic issues, such as vocational stressors, legal issues, educational needs, language and acculturation issues, and discrimination (Ellis et al., 2008; Murray et al., 2008; Weine, 2008). These stressors may be more difficult to address by referral to an agency in the community, but they may have a profound impact on the children's and mother's functioning and should be considered as the clinician identifies goals and develops a treatment plan with the mother. Asking this mother the following questions in an open-ended way can yield helpful and important information:

- *Tell me about your life in the United States. How are you doing?*
- *How has your (and your children's) life changed since you've come to the United States?*
- *What are you finding difficult in terms of your life here?*
- *How has life been since your children arrived?*
- *What is going well for you and your family?*
- *What is helpful to you?*
- *What situations would you like to improve in your life here?*
- *What are some of the differences between your (and your children's) life now and your (and your children's) life before you came here?*

This kind of open exploration may allow the mother to provide a picture of her and her children's adaptation in the United States, including positive and negative factors and cultural differences.

Practice Point 3: Assess resource availability. Having explored the basic daily needs and resettlement stressors of the family, the psychologist should assess the resources not yet accessed for or by the family. Refugee families may be unfamiliar with a host of services (e.g., public assistance, special education, legal aid) and agencies (e.g., religious and charitable organizations, ethnic/cultural organizations) that may provide some support for the presenting problem. For example, this mother may not realize that the state child health insurance program would cover tuberculosis screening. The mother may never have explored cultural or community organizations providing social contact for Liberians that could decrease her and her children's social isolation. Cultural or community agencies can identify food pantries and direct the mother on how to use them. Efforts to connect the mother with these services may help her feel more secure and trust the psychologist. Speaking with the agency prior to referring a client will help the psychologist assess the agency's resources, cultural sensitivity, and other relevant information.

Practice Point 4: Engage and collaborate with the community. Due to the child protection agency's involvement in this case, it is essential that the psychologist and the child protection caseworker collaborate on assessment and intervention. When possible, clinicians should be part of the outreach to the community resources available to children and families. Collaborating with other agencies prevents redundancy of care as well as miscommunication and misunderstanding between and among agencies and the client. For example, after learning about the mother's adaptational stresses and adjustment as a recent asylee, the psychologist may communicate with the child protection worker and enhance the worker's understanding of the mother's situation. The involvement of a child protection agency may be extremely frightening for this mother, who was separated from her children for several years. A child protection worker's lack of familiarity with the issues facing a war-affected family can lead to inappropriate or misguided interventions. The psychologist can serve as a bridge between this mother and the child protection agency.

Practice Point 5: Work directly with the war-affected child's school when possible. In this case, the psychologist is working with recently arrived children who have no school involvement. This is an important area for immediate intervention because schools are an essential part of refugee children's involvement in their new culture. Children's healthy adaptation is inherently linked to how they perceive and function within their school environment. More so than other professionals, school personnel generally spend more time with children and are an excellent resource for clinicians seeking to understand the experience of refugee children (O'Shea et al., 2000;

Rousseau et al., 1996). School psychologists' training makes them uniquely qualified to assess and address children's social, cognitive, emotional, and academic functioning and needs within the school environment. In this case, it is likely that the child protective services agency will play a role in connecting the children to an appropriate school setting. However, the psychologist should actively reach out to teachers, guidance counselors, and others involved in the children's education. The hospital psychologist should refer the children to an onsite school psychologist, if there is one at the school. If the hospital psychologist is engaged in ongoing treatment of these children, he or she could be in regular contact with the children's school, receiving updates on their functioning and giving feedback to the schools on their emotional and psychological needs.

Mental Health Care Principle 2: Provide Culturally Competent Services

Effective clinical services for war-affected refugee populations must reflect cultural competence (Brown, 2008; Fong, 2003). The NCTSN defines cultural competence as "the capacity of programs to provide services in ways that are acceptable, engaging and effective with multicultural populations" (Birman, Ho et al., 2005, p. 12). Numerous frameworks emerged from community, clinical, school, and counseling psychology that outline culturally competent care in a variety of contexts (APA, 2002b; Marmol, 2003; Mason, Benjamin, & Lewis, 1996; Nastasi, Moore, & Varjas, 2004; Pedersen, 2003; Vargas & Koss-Chioino, 1992; Vera, Vila, & Alegria, 2003). While these models were not specifically developed in relation to war-affected children, they can provide guidance to clinicians working with this population. For example, Pedersen (2003) warns against cultural encapsulation—that is, working within a counseling context as if the clinician possesses the only valid set of cultural assumptions and without regard or respect to the historical roots of the client's cultural background. Birman, Ho et al. (2005) outline several methods for building cultural competence in care providers, such as training on cultural issues, employing providers from the background of a target population, and using paraprofessionals to work with clinicians on cases.

Inherent in the notion of culturally competent care is the concept of identifying needs and creating culturally syntonetic clinical services (i.e., consistent with a population's values, beliefs, and practices; Gonzalez & Acevedo, 2006). Miller and Rasco (2004) articulate one aspect of culturally competent service provision—understanding cultural notions of well-being, distress, and normal development within an ethnocultural group:

An understanding of local views related to human development and social expectations provides an important context for understanding psychosocial distress and well-being and can

help to prevent serious misunderstandings when developing interventions with culturally diverse populations. (p. 401)

With an understanding of these concepts, a clinician can design interventions that integrate cultural beliefs and norms about well-being and health with Western approaches and techniques (Betancourt & Khan, 2008; Eisenbruch, 1990; Miller & Rasco, 2004).

Clinicians working with war-affected children can use the principles of culturally competent care to guide their treatment planning. Specifically, careful query regarding the cultural and faith-based beliefs, values, and rituals central to refugee families may provide openings for clinicians to integrate these beliefs and practices into the treatment. There are several excellent examples of clinical care in which indigenous practices, beliefs, or rituals are incorporated into clinical services for war-affected individuals (Jaffa, 1996; Schreiber, 1995; Stark, 2006).

D. E. Hinton, Hinton, Pich, Loeum, and Pollack (2009) provide an exceptionally thorough analysis of the content and meanings of nightmares in a population of Cambodian refugees with PTSD. These authors provide examples of how, with a deep engagement and understanding of the meanings of certain nightmares to these clients, clinicians used normalization and psychoeducation to decrease the fears and anxiety associated with the nightmares and to open discussion on the use of medication in a culturally syntonetic way (D. E. Hinton et al., 2009).

The development of culturally competent care with refugee populations entails more than a training module or collection of "facts" about an ethnic or racial group's beliefs. Truly rich multicultural practice involves a process of community engagement that allows for dialogue, questioning, and adaptation of practice to fit a group's beliefs and values while still providing culturally informed, effective care.

Practice Points: Culturally competent services.

Case 2. *The father in a Hmong family of six from Laos who lives in subsidized housing in Minnesota informs the family's resettlement caseworker that they must immediately be moved because of the presence of spirits in their home. The father notes that the spirits are targeting their 7-year-old daughter because she witnessed someone die in the refugee camp in which they lived in Thailand. The father believes that a malevolent spirit is in their home because of what the girl witnessed, and he feels that the girl is damaged. The caseworker calls a psychologist who worked previously with members of the Hmong refugee community on a school-based program and informs the psychologist that it would be very difficult to move the family from this subsidized apartment without creating serious financial strain for the family.*

Practice Point 1: Demonstrate openness to and respect of cultural beliefs. It is incumbent on psychologists to attempt to understand and respect the deeply held beliefs and traditions of clients, even if they are opposed to psychological principles from the “host” culture or do not share the culture’s beliefs. A social-ecological perspective posits that individuals’ and families’ problematic behaviors and actions can often be understood as a “poor fit” between their current environment and their resources (Miller & Rasco, 2004, p. 376, see box quote). This does not mean that clinicians must demonstrate a blanket acceptance of all behaviors and beliefs of clients from different cultures. For example, the enactment of cultural beliefs or behaviors that violate the rights or autonomy of others is an area in which psychologists may provide careful and thoughtful challenges to cultural traditions within the context of a positive therapeutic relationship. However, it is recommended that psychologists attempt to genuinely understand and respect the values, norms, and traditions of refugee families’ cultural background in order to engage effectively and work collaboratively to improve children’s functioning.

Practice Point 2: Assess linguistic and cultural components of mental health symptoms. The psychologist should carefully assess this child’s and family’s functioning, allowing the caregiver and child to report in their primary language, using trained interpreters whenever possible. In addition, the psychologist should carefully explore the language used in describing this family’s worries and concerns and should frame questions in a language that matches the father’s when possible (e.g., “*You say something is not right with your daughter’s soul. What do you mean? Can you help me understand what is happening with her soul?*”). Once a clinician is aware of the language or terms used to describe a child’s development or symptoms, the clinician can use this same language in mirroring what was heard and what can be done (e.g., “*I hear that you are worried about the presence of a spirit in your home that is bringing something bad to your daughter and your family. You say you have to move away to fix this situation. I am worried that if you move, you will have other problems that will also be difficult to solve. Perhaps I could help you with this situation by helping you figure out another way to solve this problem. I see that it is very important to you*”). Using this kind of query and reflection, the psychologist can understand presenting problems through the lens of the client’s cultural context rather than only through the Western clinician’s lens.

Practice Point 3: Elicit client-focused goals and strategies. Once the psychologist explores the meanings and origins of the problem, it may be useful to determine the family’s or caregivers’ goals, as well as what they have thus far done to deal with their situation. Walter and Bala (2004, p. 510) call this the “co-creation” of therapeutic goals between the traumatized refugee family and the clinician. In Case 2 presented above, the father’s fear and worry about his daughter’s

“Psychological problems often reflect a poor fit between the demands of people’s settings and the adaptive resources to which they have access. Ecological interventions should seek to alter problematic settings, create alternative settings better suited to people’s needs and capacities, or enhance people’s capacity to adapt to existing settings.”

(Miller & Rasco, 2004, p. 376)

safety and well-being may make him feel that moving the family from the apartment is the only solution. The psychologist can validate this while also linking to the real limitations of that solution (e.g., “*I hear that you want to move immediately to get away from this spirit because you are very worried about your daughter. I am worried that the refugee agency cannot accommodate you in another apartment and so I am wondering if there is another way to help your family with this problem. If you were back in your country, what would you do about this?*”). Eisenbruch (1990) presents a sensitive and detailed method for eliciting the meanings in refugee clients’ beliefs about ghosts, spirits, and dreams. In the case presented above, because the father was identified as having the concern about the child and the home, it would be useful to elicit the mother’s perspective as well. The development of treatment goals should be a collaborative process in which clinicians share their perspective on the presenting problems while eliciting the clients’ goals and hoped-for solutions as well.

Practice Point 4: Engage with cultural “brokers” in the community. Clinicians may need to reach out to religious leaders, interpreters, or others in the community who can provide guidance about cultural norms and practices (APA, 1990; Blanch, 2008; Miller, Kulkarni, & Kushner, 2006). In this way, the psychologist in this case may obtain more information about the family’s beliefs and ways to address the situation in their home community. It is essential that clinicians follow principles of confidentiality and informed consent in these communications. A religious leader, healer, or shaman may educate the psychologist and provide guidance in approaching this family’s problem. For example, a healer in the community may perform a cleansing ceremony in the family’s home to address their beliefs about the presence of spirits. Clinicians must explore these practices to understand their meanings and functions and inform additional treatment planning (Betancourt & Khan, 2008).

Mental Health Care Principle 3: Integrate Evidence-Based Practice With Practice-Based Evidence

Mental health care providers working with refugee and other war-affected children should follow the principles of practice and ethical care recommended in the psychological assessment and treatment of all children (APA, 2008a). APA has defined evidence-based practice in psychology as follows:

Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences. . . The purpose of EBPP is to promote effective psychological practice and enhance public health by applying empirically supported principles of psychological assessment, case formulation, therapeutic relationship, and intervention. (APA Council of Representatives, August 17, 2005)

When working with children, an “evidence-based orientation to practice” consists of assessment, intervention, and ongoing monitoring. A clinician should conduct these three elements “in a scientifically minded manner and informed by clinical expertise” as well as remain attentive to “the developmental processes and contexts of care that are critical for children and adolescents” (APA, 2008a, p. 38).

Thus, clinicians should use evidence-based treatments with this population when possible, i.e., rigorously evaluated interventions deemed safest and most effective. However, since few treatment effectiveness studies have been conducted with war-affected children, it is necessary for psychology to examine and recognize the efforts of providers in the field working with this population (Birman, Ho et al., 2005). These caregivers can provide “practice-based evidence”—reports of clinical interventions and existing practices successful with war-affected children (Birman, Ho et al., 2008). This type of evidence—gleaned from real-world settings—can then inform future scientific study of treatment methods for refugee and war-affected children.

The notion of practice defined by complementarity between evidence-based practice and practice-based evidence can guide clinicians working with refugee and other war-affected children. Specifically, clinicians must be properly trained in well-researched methods and core competencies of effective clinical practice for treating trauma in children, such as CBT used with refugee children (Birman, Ho et al., 2005; Blanch, 2008). However, clinicians can enhance their knowledge of working with this population by learning about other existing mental health practices successful with refugee children and families in their communities, in the United States, and around the world.

Clinicians must be flexible, utilizing evidence-based techniques and protocols when possible, while incorporating other methods developed to meet the unique needs of war-affected refugee children. This delicate balance requires creativity and rigor and, in some cases, collaboration with others who tackled similar issues. For example, clinicians should proceed carefully when considering the use of unfamiliar methods of intervention and should not assume they can infringe upon or simply co-opt culturally unique rituals or beliefs. Conversely, clinicians who rigidly adhere to protocols and treatment plans devised for populations with very different cultural backgrounds, beliefs, and values may lose opportunities to intervene effectively with war-affected children or families.

Practice Points: Integration of evidence-based practice with practice-based evidence.

Case 3. *An 8-year-old boy from Kosovo is enrolled in a New Jersey public school shortly after arriving with his parents and four brothers and sisters as refugees to the United States. The boy is referred to the school psychologist because he is having trouble learning, refuses to remain in his chair during his classes, and frequently fights with other children. The school psychologist asks the parents to come in for a meeting to discuss the boy's behavior. The mother comes and brings a friend to interpret for her and cries for much of the meeting. She tells the psychologist that the family lost their home in the war when soldiers came and set their village on fire. She also describes the 8-year-old boy as having witnessed an attack on his 17-year-old brother in which Serbian soldiers came into the home, held the brother down, and poured boiling water from the stove onto his face. The mother describes how the family fled on foot to a refugee camp after this attack while the older brother traveled to Switzerland, where there were other relatives and better medical care. The mother cries while talking to the school psychologist about how much she misses her oldest son and expresses anger at her youngest son for acting up when the family is out of danger and finally in a safe place.*

Practice Point 1: Assess history of war trauma exposure with care and patience. Clinicians should always assess children's exposure to trauma with care and sensitivity, given the potential to overwhelm and retraumatize children and their caregivers. Writing from their perspective as clinicians who worked with refugee families (practice-based evidence), Walter and Bala (2004) argue that clinicians working with refugee children and families should be particularly aware of this, given that they may not understand the cultural meaning of discussing and revisiting past traumas within the context of the family's background.

In the above example, the school psychologist must show sensitivity to the mother's experience of being asked about her family and the events they endured during the war. Open acknowledgment of

the difficulty of describing painful and frightening events may assist the mother (e.g., *“I realize that talking about what happened to your family in Kosovo is very difficult and it is hard to talk to someone you do not know about something so private and personal. It would help me to know about your son’s experience so that I can try to help him do well here at our school, but first I would like to know if that is something you are comfortable talking about.”*). Allowing the mother to describe, at her own pace, what she feels is important may provide her with a feeling of control and diminish her distress. In addition, processing how she is feeling after talking about the war experience may provide her with emotional closure at the end of the meeting (e.g., *“We talked about a lot of very difficult memories today. You helped me understand your family’s experience. How do you feel after all of this talking?”*).

Practice Point 2: Use normalization and psychoeducation.

Normalization of and psychoeducation about common symptoms and reactions are widely utilized by those who develop treatment protocols (evidence-based practice) for children affected by war and violence (Birman et al., 2008; Dybdahl, 2001; Layne et al., 2001, 2008; Pynoos & Steinberg, 2006), as well as in clinical settings with war-affected children (practice-based evidence) (Elklit, 2001; Novkovic, 2000). Normalization involves engaging with children and families by acknowledging the profound stress of what they experienced—in this case example, witnessing the direct victimization of the oldest son, experiencing the loss of their home, being separated from a loved one, and having to adapt to a new culture—as well as the fact that many people in similar circumstances had reactions like their own. For this mother, normalization could help her feel that her child’s behaviors are understandable and are not unexpected after all that the family endured and help her see that there are ways to address his difficulties (e.g., *“I know you are upset about your son’s behavior, but I want you to know that many children who have been through war show some signs of upset or worry. Your family has been through very difficult events and your son’s reactions might be coming from the fact that he is still having upset feelings. There are ways that I think we can help him feel better and behave better.”*).

Psychoeducation involves the more specific review and explanation of symptoms and reactions common in people who have experienced trauma (Wessely et al., 2008). With this mother, the clinician could discuss the boy’s difficulty in sitting still in class as possibly a reflection of the hyperarousal characteristic of PTSD. His aggression with his peers could be related to his fears that others are going to harm him, given what he witnessed happen to his brother. In a school setting, this boy’s presenting of learning problems, impulsivity, and hyperactivity may warrant an evaluation for attention and concentration capabilities and a possible learning disability as well. Hypotheses about the origin of children’s difficulties should only come after thorough assessment of their functioning and history, and

clinicians should be careful in drawing direct causal links between behaviors and events, given that there are many factors that can influence children’s functioning. However, it can still be useful to help parents see that their children’s behaviors and emotions are likely related to their life experiences and stressors. For the mother in this case, this kind of normalizing and educating may make her feel less frustrated by her son’s acting-out and more empathic of his experience.

Practice Point 3: Maintain a strength-based focus and acknowledge resiliency. Walter and Bala (2004) describe a clinical method (practice-based evidence) used with parents and children to analyze what the family did to cope with the stresses of war and resettlement. Implicit in this conversation is recognition that families naturally develop strategies and ways of dealing with adversity, many effective in some way for that family. The clinician’s elicitation of these strategies serves to underscore those effective for the family while providing an opening to find alternatives for those strategies that no longer serve the family’s needs (Walter & Bala, 2004). Recent intervention studies (evidence-based practice) incorporate a “strength-based emphasis,” that is, a focus on the war-affected family’s adaptive and successful coping strategies and resiliency processes (Betancourt & Khan, 2008, Betancourt & Williams, 2008). Pynoos, Steinberg, and Wraith (1995) argue that a focus on building resilience in a family exposed to violence can restore children’s sense of a “protective shield” in their lives.

“Discussing the effects of parental strategies used to help children can lead to strengthening the parental competency either by stabilizing the chosen support or jointly searching for alternative possibilities.”

(Walter & Bala, 2004, p. 505)

For the clinician in the case above, asking the mother about what helped the family thus far may provide important information about family members’ functioning and problem-solving capabilities (e.g., *“You have clearly done a lot to get your family out of a dangerous situation. Tell me how you did that and what helped you. How did your children help you and each other in that difficult time?”*). For this overwhelmed mother, an exploration of what she and her children did successfully may help her move forward handling a different set of stressors. Genuine exploration of the strengths and capabilities of the refugee family in the face of unimaginable fear and hardship can also enhance the clinician’s empathy and respect for the family.

Practice Point 4: Use trauma-focused treatments flexibly when needed. Some war-affected children may require more extensive clinical intervention and attention. When possible, clinicians should use empirically evaluated, trauma-informed methods of symptom reduction and promotion of healthy adaptation, recognizing that many clinical methods used with other traumatized populations may also be appropriate for war-affected children (Blanch, 2008). Cognitive-behavioral therapy techniques are used in a number of treatment protocols with war-affected children (Birman et al., 2008; Layne et al., 2001, 2008). These methods are discussed earlier in this section and include exposure therapy techniques, cognitive processing and appraisal, relaxation, and problem-solving techniques. Some authors note the need to adapt certain CBT techniques to the special circumstances of war-affected children (practice-based evidence). For example, Birman et al. (2008) describe the need for adaptation of exposure methods that operate from a premise of addressing one traumatic memory at a time. Children who live through war often witness and experience multiple, severely traumatic events, thereby making it nearly impossible to “parse out” specific trauma memories and reminders one at a time.

Careful assessment of the history and current difficulties of the boy above may result in a recommendation for a trauma-focused intervention to address his memories of the attack on his brother. The clinician could use narrative exposure techniques to assist him in habituating to the emotional responses to the memory and creating a consistent autobiographic narrative (Schauer, Neuner, & Elbert, 2005). Practice-based evidence suggests that clinicians can apply this technique to refugee children with good effect (Schauer et al., 2004). Creating an advice book for other children who lived through frightening events may foster a feeling of mastery for the boy while allowing processing of his own experience. In terms of his school environment, the clinician could develop with the teacher a behavioral program for the boy, with rewards for achieving targeted goals, such as staying in his seat and keeping his hands to himself. The clinician would need to work carefully with the mother to develop and explain the goals and rationale of each of these interventions, as they may be unfamiliar to her.

SPECIAL CONSIDERATIONS FOR PSYCHOLOGISTS WORKING WITH WAR-AFFECTED CHILDREN

Ethics in Clinical Practice With Refugee Children and Families

The *APA Ethical Principles of Psychologists and Code of Conduct* (2002a) provides a comprehensive guide for ethical conduct for psychologists. Therefore, this report highlights just a few issues for ethical considerations in clinical practice with refugee children and families.

Assumptions underlying clinical practice come from theory and treatment models developed in wealthy countries and Western culture; therefore it is imperative that they be critically examined in the care of culturally diverse refugee children and families. For example, the Western medical model frames adversity and suffering in terms of psychopathology rather than as a legitimate response to stress and upheaval (Summerfield, 2000). A psychologist may experience pressure to emphasize vulnerability and victimization over resilience in the clinical formulation of a refugee client’s condition in order to request other services or support an application for asylum (Watters, 2001). This kind of emphasis then suggests that the individual’s reaction to war and organized violence is abnormal rather than an expected response to severe trauma.

It is important that psychologists be aware of the often substantial power differential that exists in a relationship between refugee clients and professionals and that they carefully monitor their own political and social inclinations in the context of psychotherapy with refugees who may have direct experiences with armed conflict and/or torture (Eth, 1992; Savin & Martinez, 2006). Maintaining appropriate therapeutic boundaries is an important component of ethical practice, particularly in cases involving human rights violations and other atrocities that may evoke strong transference reactions of dependency and gratitude in clients and powerful countertransference reactions in psychotherapists (Eth, 1992). Conversely, individuals who experienced direct persecution or violations of their human rights may experience a stance of unwavering neutrality from a practitioner as a minimization or denial of the injustice of what was done to them. The power of a therapist to bear witness to clients’ suffering and take a stand as to the injustice and criminality of it cannot be underestimated (Lustig, Weine, Saxe, & Beardslee, 2004).

Refugee community members are often involved in outreach, interpreting, prevention, and mental health counseling to improve cultural competence in a clinical team. Ethical dilemmas can easily arise, for example, when the only available interpreter in a particular language is someone who has a personal relationship with the

refugee child and family (Bjorn, 2005). Therefore, it is vital to ensure that community members involved in the provision of clinical services uphold ethical practices, such as maintaining therapeutic boundaries and confidentiality in the context of a small or tight-knit refugee community.

As with other kinds of clients, when offering therapeutic services to refugee children and families, clinicians must obtain informed consent from parents or legal guardians (Alkhatib, Regan, & Jackson, 2008; Redding, 1993). There may be barriers to effective communication regarding informed consent, such as cultural, educational, and linguistic differences between refugee clients and practitioners (Fisher, 2004; Vitiello, 2008). Also, individuals who escaped situations of persecution or interrogation may experience fear about signing legal forms and documents, as well as about the ramifications of not following the direction of an authority, such as the therapist or evaluator.

Despite these barriers, practitioners must impart basic information about the risks and benefits of treatment to children or families, the limits of confidentiality, and the rights of the patient (Alkhatib et al., 2008). Legally, the age of children or adolescents can become an important factor in determining who gives ultimate consent to treatment and to whom information can be released. For children from cultures in which exact age and birth date are not recorded, this kind of information may not be clear. Practitioners must follow state law and ethical guidelines to the fullest extent possible when grappling with these issues in a situation of consent with refugee children or adolescents.

Finally, a continuum exists between the approach of ethical relativism, which embraces all cultural values and practices, and ethical universalism, which holds that there are fundamental principles that all people, regardless of their culture, should follow (Brannigan, 2000). Service providers may find themselves challenged by the practices or beliefs of clients from different cultures that are in opposition to their own values. They are advised to seek supervision from within the field and from within the cultural community of their clients when faced with these tensions in order to determine how to proceed in an ethical manner that is respectful of cultural differences and consistent with the standards of practice of the field.

Training

Psychologists can play a unique role in helping war-affected refugee children and families, but they also face challenges, and it is useful to enhance training in several areas that are not typically part of psychological education. For many clinical psychologists trained in specific symptom-reducing intervention techniques, the emphasis on broader, community interventions, as compared to individual or even family therapy methods, may seem somewhat unorthodox. While

“traditional” therapeutic training in psychotherapy techniques and orientations may be helpful and appropriate for some of these children (i.e., the most highly symptomatic and impaired), such specific “case-based” conceptualizations may not be applicable to many war-affected children, youth, and families. Families’ awareness of mental health issues may take time and may not necessarily be the most pressing issue.

As discussed earlier, a tier-based approach places a premium on recognizing a family’s migration experience and considering daily adaptation needs while using community-based, nonstigmatizing resources, such as faith-based organizations, ethnic and cultural community groups, and non-Western leaders and healers. This may require clinical psychologists to search for and advocate within these unique community organizations, activities that are traditionally more the domain of community psychologists or social workers. Thus, psychological training that emphasizes the psychologists’ roles in interfacing and collaborating with other agencies, including cultural organizations not traditionally seen as “service providers” (e.g., community-based mutual assistance organizations), may be useful for clinicians working with war-affected families.

Psychologists may not be familiar with the cultural norms and values and the geopolitical experience of war-affected children’s and families’ community of origin. Yet this information is essential to clinicians’ cultural competence in dealing with recently arrived refugee families. Although psychology graduate programs, internships, and continuing education courses improved dramatically over the last decade in their prioritizing of cultural competence in psychologists’ training, there is still a need to train psychologists on the processes and vocabulary of cultural identity, going beyond the simple facts of individuals’ backgrounds and experiences.

As discussed in the introduction to this report, the nature of the cohorts of refugees resettling in the United States is dynamic and ever-changing. Developing inflexible psychological services that narrowly address the needs of specific cultural groups will still ultimately be insufficient given the constantly changing composition of refugee populations. Engaging with, learning from, and respecting the cultural background and meanings of war-affected families’ experiences is a process that does not take place by following a multicultural “equation” or “cookbook.” Rather, true engagement takes place within a context of listening, eliciting, and collaborating and can mean the difference between providing appropriate care that is ultimately accepted by refugee clients and care that is at best potentially alienating and, at worst, detrimental.

Another area underemphasized in traditional psychology training is working with language interpreters, cultural brokers, and paraprofessionals—resources frequently needed in work with children from war zones. Training in competent and respectful communication with children and families while using language interpreters is necessary for psychologists doing this work. Cultural brokers can often serve multiple purposes; not only interpreting, but also engaging families in treatment, connecting them with the larger community, and providing consultation to practitioners regarding culture.

In fact, given the paucity of clinicians providing mental health services to refugee children and families and the limited number who speak the diverse languages characterizing refugee groups resettling in the United States, the use of paraprofessionals as frontline care providers or members of treatment teams holds great promise. The involvement of paraprofessionals potentially strengthens the cultural competency of the workforce and increases the likelihood that families will remain engaged in much-needed mental health services. The potential role of psychologists in the training and supervision of paraprofessionals is an area that needs further exploration.

Finally, the field should encourage and support the training of refugees as psychologists. Increasing the representation of refugees within the field of psychology may promote research and practice appropriate to the needs of refugee children and increase the cultural competence of the psychology field as a whole (see box).

Training Refugees to Become Clinicians

An innovative model of encouraging refugees to join the mental health profession was implemented at Boston University School of Social Work. Through their Building Refugee and Immigrant Degrees in Graduate Education program (BRIDGE), refugees and newcomers who are potential social work school applicants are mentored over the course of a year in the preadmission and application skills needed to be accepted into social work graduate school (Boston University, 2009). Once accepted in the master's in social work program, they are provided with preparation for the transition into graduate training, mentoring during their graduate studies, and career development counseling after they graduate. Similar programs to encourage and support the professional development of potential psychologists from refugee communities could greatly benefit both the individuals involved and psychology as a whole (Boston University, 2009).

Secondary Trauma

Psychologists and other professional care providers who work with war-affected children face a particular risk often underemphasized in training in human service settings—that of secondary or vicarious traumatization. Stories of human atrocities and the violence that are often a part of the experiences of war-affected refugees may overwhelm and upset clinicians. Compounding this is the fact that the children are witnesses and, in many cases, direct victims of this violence. This awareness can lead psychologists, even with the best clinical training, to feel angry, burned out, depressed, or in some cases, detached from their work. Without proper supervision and processing around this specific issue—the emotional toll of hearing stories from war zones and attempting to address war's human costs—psychologists are vulnerable to many overwhelming emotions and reactions. To minimize these difficulties, psychologists must learn self-care techniques during their training to work with war-affected children (Palm, Polusny, & Follette, 2004; Richardson, 2001; Trippany, Kress, & Wilcoxon, 2004).



RESEARCH REGARDING REFUGEE AND WAR-AFFECTED CHILDREN AND FAMILIES: GAPS AND FUTURE DIRECTIONS

As discussed earlier, research documents high levels of exposure to war-related traumas in refugee children (Kinzie et al., 1989; Locke, Southwick, & McCloskey, 1996; Mollica et al., 1997). These experiences can have profoundly adverse effects on refugee children's mental health—for example, the development of depression and behavior problems (Mollica et al., 1997), anxiety disorders such as PTSD (Ellis et al., 2008; Kinzie et al., 1989), and a range of other adjustment difficulties (Barenbaum et al., 2004; Lustig, Kia-Keating et al., 2004). Upon resettlement in the United States, refugee children's adjustment to a new culture and context brings with it a host of social, emotional, and acculturative stressors. More research on the long-term psychosocial consequences of war and displacement on these children and their families, as well as on the efficacy of interventions and programs designed to aid them, is greatly needed.

To date, the primary focus of much of this research on refugee youth and other war-affected populations documents psychiatric symptomatology related to exposure to potentially traumatic war-related events. In particular, there is considerable interest in examining the dose–effect relationship between violence exposure and levels of distress, most often in the form of PTSD (Barenbaum et al., 2004; Stichick, 2001). Some of the findings from this research were discussed earlier in this report. However, there are other pressing and considerably more complex issues involved in the study and understanding of refugee populations, including methodological approaches and ethical challenges.

METHODOLOGICAL CHALLENGES

In order to deepen an understanding of the long-term effects of war on children and develop an evidence base on interventions for war-

affected children and families, researchers must address a number of methodological issues pertaining to qualitative, quantitative, and mixed-methods research. Valid measurement is important for understanding distress and impairment, and for identifying risk and protective factors. The same methodological challenges that pertain to identifying relevant mental health problems and syndromes apply to examining protective and promotive factors (e.g., social support, coping, and connectedness) within refugee groups.

Sampling

The widespread use of samples drawn from clinical populations—that is, children demonstrating adaptational problems or reactions that require clinical care—in studies of refugee children represents a considerable methodological challenge (Kinzie et al., 1989; Sack et al., 1993). Although clinical studies provide critically important information regarding the challenges and needs of highly distressed refugee children, they are not designed to reveal the distribution of mental health and adjustment problems in the general population of refugee children in the United States. This kind of information is still needed, but reliance on clinical studies may lead to a skewed picture regarding general levels of the severity and persistence of distress reactions among refugee children. This phenomenon is seen in the literature on the mental health of children of Holocaust survivors; whereas earlier studies using clinical samples suggested high rates of distress, later studies using representative nonclinical samples found rates of disorder comparable to the general population (Kellerman, 2001), although specific vulnerabilities to stress did exist for some in this population.

A representative general population survey of refugees is virtually impossible to obtain. First, it is very difficult within the United States to identify refugee ethnicity and background because neither school

records nor refugee entry records capture ethnicity and background. In addition, broad surveys of refugees generally tend to have very low participation rates (Allodi, 1989). Other sampling methodologies that encourage broad-based participation need to be identified; in addition, techniques pursued in other forms of research on “hidden” or hard-to-reach populations must be given greater consideration in research on refugees (Heckathorn, 1997; 2002). The efforts of the federally sponsored National Child Traumatic Stress Network (NCTSN), which has several member centers serving a large number of refugees, present promising new opportunities for applied research. Nonetheless, the difficulty of translating and validating measures for numerous diverse refugee populations and obtaining widely representative community samples remains a challenge to ongoing research of refugee children and families.

Cultural Validity of Constructs

The valid and meaningful assessment of mental health constructs within and across different cultural groups and settings is a major challenge to research on the mental health of war-affected children and families. To conduct valid and culturally meaningful research, the field must further its understanding of how different cultural groups vary considerably in their views regarding psychological well-being, distress, and healing (see *APA Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* for a discussion of multicultural issues in assessment in the context of research). Contributions from cultural psychology and anthropology can be particularly instructive on this topic (see Kleinman’s work on the “category fallacy”; Kleinman, 1987).

In addition to identifying culturally specific expressions of well-being and distress, researchers must contend with a cross-cultural challenge of critically examining constructs developed in Western societies before applying them to children from non-Western countries now living in the United States. Behaviors may be viewed as problematic in one context but normative in another and thus lack the same significance. Focus groups or key informant interviews (interviews with individuals likely to be knowledgeable about a particular topic of interest) about the items that reflect constructs of interest may be one way to explore whether the research is measuring locally meaningful constructs. In addition, researchers must recognize that constructs relating to cultural norms, including what are considered adaptive and maladaptive behaviors, are dynamic and change over time, suggesting that the ongoing reassessment of these constructs is needed.

Culturally Different Views of Psychological Well-Being, Distress, and Healing

Jo de Berry and colleagues (2003) documented the ways in which Afghan parents understand children’s mental health largely in terms of *tarbia* or moral development within an Afghan Islamic framework. Parents are likely to become very concerned when their children display signs of bad *tarbia*, such as behaving inappropriately in social settings (e.g., showing disrespect toward adults, using inappropriate language, dressing in ways that violate cultural expectations, or interacting with children of the opposite sex in ways considered unacceptable); in fact, parents may be more likely to engage in help-seeking behavior in cases of bad *tarbia* than when children show signs of internalized distress (anxiety, depression). From an intervention standpoint, such data are invaluable, since Afghan parents may be far more likely to avail themselves of mental health services when those services are framed in terms of culturally salient concerns (i.e., good and bad *tarbia*) than in Western psychiatric terms such as PTSD that they may not regard as requiring outside assistance.

Cultural Reliability and Validity of Instruments

Few instruments used commonly in research were validated with refugee children or validated and standardized for the specific refugee groups being studied (Birman & Chan, 2008; Hollifield et al., 2002). This is important for several reasons. First, clinical cut-off points developed on the basis of research with Western child populations may lack validity when used with children from non-Western societies. Acknowledging this limitation, which many studies do, is important, but must be emphasized in relation to the generalizability and interpretation of findings.

Second, as discussed earlier, the symptoms and syndromes that constitute Western scales may lack validity in some non-Western populations. Again, in some cases, researchers will acknowledge the potential limitations of such scales for refugees, but more commonly, they simply use Western measures without critical examination of their cross-cultural validity. This disregard is frequently seen in the assessment of PTSD among refugee children. Despite the fact that the PTSD diagnosis (which was officially identified as a diagnosis in 1980) was originally developed based on clinical experience with U.S. veterans of the Vietnam war, the construct is widely and sometimes uncritically assessed with many different populations, including children. Research with refugee children from diverse ethnocultural backgrounds must emphasize assessing cultural variations in the experience and expression of traumatic stress (Summerfield, 1999).

An NCTSN task force is developing a new diagnostic classification that might better capture the complexity and developmentally specific symptom picture associated with chronic childhood trauma for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (van der Kolk, 2005). In the context of this potential new diagnosis, there is a continued need to be attentive to cultural issues and to make certain that the diagnostic criteria are valid for diverse populations.

Finally, even when culturally specific measures are developed, they may still lack validation with the relevant population, and therefore their use would remain questionable. The validity of new measures can be assessed in a number of ways, such as through examination of a new measure's correlation with similar existing measures, assessment of its relationship with theoretically related constructs, or assessment of its capacity to reliably discriminate among groups of children expected to differ on whatever construct the measure is intended to assess (Bolton & Tang, 2002; Miller, Omidian et al., 2006). For example, a new measure assessing refugee children's social functioning should reliably discriminate between children identified by parents or culturally competent teachers as functioning well or poorly. Alternatively, Phan, Steel, and Silove (2004) illustrated their use of the multitrait-multimethod approach to instrument validation (Campbell & Fisk, 1959) in their development of the Phan Vietnamese Psychiatric Scale.

Solicitation Methods and the Use of Multiple Informants

Much of the literature on refugee children and families relies on self-reports. However, the methodological literature shows a range of variability in the recall of past events, differences between caregiver and child reports, and gender differences in symptom reporting in different refugee groups (Montgomery, 2008). Also, many psychological measures rely on Likert-type scales, which can be conceptually challenging in groups with limited literacy and minimal exposure to multiple-choice-style questions. Participants differ in their comfort level in reporting certain indicators of distress along a number of demographic factors (e.g., gender, literacy). Problems also occur because of differences in how different cultural groups view indicators of distress and dysfunction; these differences can result in varying interpretations of standard survey questions (Roberts, Wass, Jones, Moss, & Sarangi, 2005; Weisz, Sigman, Weiss, & Mosk, 1993).

The type of solicitation method used in research can have an impact on results. For example, a respondent may provide different responses to the same topic depending on the method used for assessment. In one study, Burundian participants reported elevated levels of somatization on a standardized quantitative measure but infrequently mentioned somatic symptoms in open-ended questions (Yeomans, Herbert, & Forman, 2008). In addition to examining culturally valid ways of soliciting consistent and accurate responses, this issue highlights another relatively neglected area of research:

developing and testing different ways for reconciling inconsistencies.

Research studies demonstrate that there is limited cross-informant agreement between refugee children and parents and raise questions about whether various informant ratings represent qualitatively different constructs (Goldin, Levin, Persson, & Hägglöf, 2003; Montgomery, 2008). Drawing from research in Thailand, Africa, and the United States, Weisz et al. (1993) suggest that cultural differences in parent-child agreement in reporting of emotional and behavioral problems may result from a "threshold effect" (i.e., different cultures use different criteria to discern behaviors indicating mental health problems in children). Often, these reports may differ depending on whether the problems examined are more internalized (e.g., anxiety, depression) or externalized (e.g., conduct problems or aggression). To address this, the use of multiple informants is recommended in mental health research on children (Earls, Guiseppe, & Carlson, 2008; Kraemer et al., 2003).

Age and Gender

Other methodological challenges may also arise in the assessment of children and families who flee war and organized violence. For instance, refugees may originate from regions of the world where the accuracy of reported information may not be reliable. For example, children may not know their precise age, either because birth records were never available or were lost or because they come from societies where precise knowledge of one's age is not a priority. Also, the normative tasks and challenges of developmental stages may vary across cultures, making it important for researchers to be cautious in applying developmental norms from one culture onto another. For example, there is cultural variation in expectations of family obligation and the role of adolescent family members; immigrant adolescents may feel obligated to contribute financially to the family's livelihood, in contrast with European American cultural expectations of increased independence and autonomy at this developmental stage (Fuligni & Pedersen, 2002).

Gender issues also vary across different cultural groups regarding war and resettlement stressors, risk and protective factors, and mental health outcomes, suggesting that in some instances male and female experiences overlap, whereas in other instances, they are quite distinct. Ethnographic and anthropological research shows that gender shapes the life experiences of many refugee children in important ways. For example, boys and girls may have different types or levels of trauma exposure, and gender can influence the operation of protective factors in the mental health of refugee children (Kuterovac-Jagodic, 2003; Llabre & Hadi, 1997). In addition, cultural expectations frequently differ for boys and girls and can lead to very different experiences of acculturative stress after resettlement (see Gender section for further discussion of these issues). However, few studies examine gender

differences in outcome and functioning in refugee and war-affected children, particularly in relation to developmental trajectories of risk and protective factors.

Disability

As discussed in prior sections of this report, refugee children are often at greater risk of exposure for personal injury. Certainly, abuses that target children during war, such as the abduction of child soldiers (Betancourt, Brennan, et al., in press), are associated with increased and intense exposure to physical and sexual abuse as well as forced use of drugs and alcohol. Such war-related exposures have lasting emotional and physical consequences. Certainly issues like traumatic brain injury, physical scarring, and a range of other physical disabilities bear further understanding in the cognitive and emotional functioning of children who have suffered abuse or injury due to war. Further research on such topics is greatly needed.

MIXED METHODS

A wide range of methodologies is needed to identify and understand cultural variations in well-being and distress (Betancourt & Williams, 2008). This kind of research requires a fundamental alteration of the more common investigative frameworks (i.e., rather than approaching culture as a set of assumptions generated through a Western lens, researchers must use more creative methodologies to understand the worldview and language of refugee populations). Using multiple methods will address these complex issues and fill research gaps (Betancourt & Khan, 2008). These methodologies include:

- qualitative methods (data in words),
- quantitative methods (data in numbers, often gained through survey research), and
- mixed methods (combining qualitative and quantitative methods in different sequences depending on the research questions at the heart of a study (Creswell, 2008).

Qualitative methods provide an opportunity to better understand local terms and cultural norms of mental distress and well-being, local syndromes, and meanings of what is “normal” and “abnormal” (Betancourt, Speelman, Onyango, & Bolton, 2009). Research on refugees and war-affected populations to date demonstrates that culture is not a uniform construct, and although expressions of distress across cultures share similarities (D. E. Hinton & Good, 2009), there are also important differences (Miller, Kulkarni, & Kushner, 2006). Once researchers use qualitative methods to identify locally salient indicators of well-being and distress, or positive and negative functioning, they can then incorporate these common indicators into

new or existing measures and validate these measures in the local population (Betancourt et al., 2009; Bolton & Tang, 2002; de Jong & Van Ommeren, 2002; Miller et al., 2006b; Van Ommeren et al., 1999). By incorporating and focusing on local symptoms and syndromes, researchers can also develop interventions that respond to locally recognized disorders and use local strengths. Such an approach has the potential to encourage engagement and retention of war-affected populations in mental health services (Bernal, 2006; Miller, Kulkarni, & Kushner, 2006).

Fernando, Miller, and Berger (2009) recently used this approach to identify common indicators of well-being and distress among Sri Lankan children in the ethnically diverse eastern district of Sri Lanka. They used parent interviews and child focus groups to identify key indicators of functioning. Although there was certainly significant overlap with indicators of positive and negative mental health found in Western measures, items reflecting social or interpersonal functioning (e.g., behaving in culturally expected ways at home, in the community, and at school) were particularly salient, in contrast to Western measures that focused heavily on intrapersonal or intrapsychic states (e.g., feeling sad or worried).

An increasingly popular approach is the use of grounding assessments of war-affected populations within local cultural contexts in order to develop culturally appropriate assessment tools. A grounding approach involves the sequential pairing of qualitative methods with traditional quantitative instrument techniques (Betancourt et al., 2009; Bolton & Tang, 2002; Miller, Omidian et al., 2006). Qualitative methods include focus group surveys, key informant interviews, and freelistings, in which participants identify as many indicators as they can of a particular construct (e.g., all the ways in which one can tell that someone was affected by war, all the things one must do in order to function well, or all of the things that are stressful on a daily basis). Another example of new methodology that shows promise in research with refugee children is the use of photo elicitation methodology to examine both their visual (using their photographs) and verbal narratives to identify key factors in their psychological adjustment and well-being (Kia-Keating, 2009).

COMMUNITY-BASED PARTICIPATORY METHODS

The use of community-based participatory methods has increased, involving refugee communities as equal and active participants throughout the research process. For example, female Guatemalan refugees in southern Mexico collaborated with local researchers to conduct a survey in the refugee camps located along Mexico’s border with Guatemala. The survey focused on diverse issues related to women’s well-being in the camps, and the active participation of

camp residents themselves guided and implemented all phases of the study (see Garcia, 1996). Complementary strategies that Western researchers can use to broaden their cultural understanding include reading historical accounts, watching and listening to videos, attending local cultural events, and developing a cultural advisory board (Ellis, Kia-Keating et al., 2007; Kia-Keating & Ellis, 2007).

Community participatory research with refugees is a particularly useful methodology to allow the joint negotiation of ethical practices at every phase of the research process and the shared discussion of research findings with refugee communities that participate in research (Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007; R. Hinton, 2000; Löfman, Pelkonen, & Pietila, 2004; Macaulay et al., 1999). In a study of Somali adolescents and their families resettled in the United States, these methods allowed the Somali community to play a crucial role in enhancing the reliability and validity of the investigation by providing their cultural expertise (Ellis et al., 2007). The research team used an approach highly informed by community participatory research, which included interviewing leaders within the community prior to initiating the research, hiring staff from within the community, developing an advisory board made up of Somali leaders from different parts of the community, and partnering with local agencies. This active involvement of the community allowed for careful review and oversight of research questions and protocols, promoted participation in the study, and ultimately led to increased community involvement in using study findings to inform the development and implementation of mental health services for Somali adolescents.

An Example of the Uses of Qualitative Research Methods to Perform a Needs Assessment and Address Domestic Violence Among Resettled Refugee Families

In order to design an innovative collaborative project to address domestic violence among Somali, Latino, and Vietnamese immigrant and refugee communities residing in San Diego, California, the Ahimsa for Safe Families Project conducted 120 interviews completed by a team of bilingual and bicultural outreach workers, which included 40 members from each of these three immigrant communities, with equal numbers of children and adult males and females (Pan et al., 2006). They utilized a community advisory board to review and approve a structured interview guide, also translated into Somali, Spanish, and Vietnamese. In addition, the staff conducted seven focus groups and 20 interviews with social service providers from domestic violence/sexual assault services, law enforcement, and immigrant and refugee service providers. This comprehensive needs assessment pointed to the concerns about intergenerational and partner violence. In particular, participants raised the issue of parent-child conflicts and differences in child-rearing practices in the United States as compared to their countries of origin. Key findings from these communities included major concerns around acculturative stress (e.g., increased conflicts as women and children acculturate), gender equity, economic stressors, and adolescent violence and delinquency (e.g., runaways, gangs).

Culturally specific intervention strategies included parenting classes, education, services for children, and the use of culturally aware outreach workers. All three communities discussed the importance of giving attention to religious (Muslim, Buddhist, and Christian) teachings in mental health approaches. Using these findings, Ahimsa collaborated with the Rotary Club, Horn of Africa, and the International Rescue Committee to offer sewing classes to Latino and Somali women, both as an educational and economic opportunity toward increased self-sufficiency (the women themselves then developed a sewing cooperative and home-based businesses) and as encouragement toward cross-cultural communication. Lessons learned from the project include: (a) the usefulness of a focus on “family harmony” rather than using stigma- and culturally bound words such as domestic violence, (b) the importance of providing assistance outside of the scope of the research project to be responsive to community needs and build a positive reputation in the community, and (c) the value of hiring and training bilingual/bicultural staff from each target community toward developing trust and building strong inter-cultural relationships (Pan et al., 2006).

A DEVELOPMENTAL AND LONGITUDINAL PERSPECTIVE

The overwhelming majority of studies with war-affected and refugee children are cross-sectional, providing a one-time snapshot of the mental health and psychosocial well-being of study participants. Thus, there is still a need to examine and understand the longitudinal and developmental trajectories of war-affected children. One way to address this limitation is to consider the timing of research, incorporating a life course perspective into protocols in order to examine long-term adjustment. Little is known about the natural course of refugee children's distress reactions. To what extent and under what conditions do patterns of distress diminish (or worsen) over time as refugee children adjust to life in the United States? What factors either facilitate or impede this attenuation of distress?

Additionally, a focus on cross-sectional symptom assessment may be useful for understanding context during a certain instance of time, but it does not provide an opportunity to understand the impact of war and displacement on refugee children's evolving developmental capacities. It is important to assess impaired or endangered development in addition to more commonly studied patterns of psychiatric symptomatology.

Finally, it may be useful to examine the relationship of symptomatology to development—that is, to what extent do symptoms of distress interact with and threaten children's current and future developmental achievements?

There are very few longitudinal studies on this topic to date. In one of the few longitudinal studies of refugee children in the United States, Kinzie et al. (1986, 1989) found that despite considerable levels of trauma and depression, the Cambodian children they studied nonetheless managed to perform in school quite effectively, suggesting that academic abilities remained intact despite high levels of internal distress. This finding underscores the need for broader assessments that include developmental capacities, as well as longitudinal designs to assess patterns of distress and impairment over time. In the Kinzie et al. (1986; 1989) studies, levels of PTSD and depression remained fairly constant over a period of several years, suggesting these problems were a constant as the child developed.

Longitudinal research on war-affected children in Sierra Leone also observed relatively stable levels of indicators of depression, anxiety, hostility, and confidence over time (Betancourt, Borisova et al., in press). In contrast, in a study of trauma reactions among Palestinian children, Thabet and Vostannis (2000) found that levels of PTSD dropped markedly once the intensity of the violence abated, suggesting that PTSD in their sample was less of a persistent disorder than a transitory response to ongoing exposure to violence.

Although longitudinal research is complex and resource intensive, it is essential in order to document the trajectories of risk and resilience among refugee children and families as they resettle in the United States. Additional resources could address a number of pressing research questions about refugee children and families such as the following:

- Which flight-related stressors affect the well-being of war-affected children and families?
- How do postmigration stressors affect these war-affected children and families once they are resettled?
- Which issues characterize the process of psychosocial adjustment in relation to different types of social ecology, as experienced by refugee children?

For instance, at the individual level little is known about the struggles that refugee children may face with cultural identity, particularly as shaped by age, gender, and race. At the family level, there is more to be learned about the role of within-family stressors, such as parental conflict and intimate partner violence, parental demoralization and trauma, economic stress, poor housing conditions, and the role of early stimulation and nutrition on development in the children of refugees. At the community level, research should examine the postconflict resettlement environment to determine which factors may exacerbate past trauma reactions (Layne et al., 2009). For example, more research is needed to examine community stressors (e.g., neighborhood violence, discrimination, prejudice, poor-quality schools, schools that are unresponsive to unique refugee needs). Little is known about how these factors relate to refugee children's mental health and ongoing development or how they affect a young person's capacity to cope with traumatic war exposure.

Future research should also examine mediating and moderating factors related to child refugee mental health and psychosocial development. Mediating factors are variables that explain the relationship between two other variables. For example, the impact of war is at least partly mediated by the massive social and physical disruptions it creates (Fernando et al., 2009). Moderating factors are variables that influence the strength of the relationship between two variables. For example, moderating factors, such as living with family members, weaken the negative impact of war and exile on the mental health of Cambodian youth in the United States (Kinzie et al., 1986). Research is needed to illuminate and explore the resources that exist within children's social ecologies that can promote positive adaptation and healing from war-related trauma and loss. Few studies examine positive resources or assets for war-affected children and families (Betancourt & Khan, 2008; Kia-Keating & Ellis, 2007).

INTERVENTION RESEARCH AND THE TRANSLATION OF RESEARCH TO PRACTICE

The interventions evaluated for use among war-affected and refugee populations in the United States vary considerably in their methods of intervention and in the quality of services provided. Because of the lack of empirical data regarding effective refugee-focused interventions, treatment models are often implemented with refugee children and families without an adequate empirical basis. More often than not, treatments are clinic-based, relying on the familiar strategies of psychotherapy and psychopharmacology, sometimes with accompanying case management services. Unfortunately, because few refugee clinics systematically evaluate the impact of their services, little is known about the extent to which such interventions are helpful to program clients. There is evidence, however, that therapy and medication, when not accompanied by efforts to address basic survival and resettlement issues, fail to show a significant impact on mental health (Miller, 1999). When solely using clinic-based services and methods, mental health professionals may lose an opportunity to address the most commonly pressing psychosocial challenges for refugee families (Miller & Rasco, 2004). For example, there is growing evidence that social isolation and a lack of social support are significant stressors affecting refugee families, who lost their entire social network when they were displaced (Bennett & Detzner, 1997; Miller et al., 2002; Silove et al., 1997; Tribe & De Silva, 1999).

To the extent that isolation and a lack of support adversely affect refugee families and thus elevate stress levels for children in those families, interventions that entail community-based programs and foster the creation of new social networks at all levels of the social ecology are likely to be helpful to these families. The role of clinical-based services would likely be adjunctive in such situations (i.e., the reduction of distress through clinical care may help the individual to access and use other community-based interventions and resources more effectively). For refugee families, community-based intervention—even if it is targeted toward adults—could have benefits for the entire family, as it reduces isolation and lack of social supports.

Clinic-based models of intervention are likely to be more effective in their impact on refugee children if complemented with various community-based services that link refugee children and their families to key resources (Birman et al., 2008). Treatment that takes place within a clinical setting can be useful for addressing the effects of war-related trauma exposure, but families may also benefit from interventions that target specific ongoing resettlement-based stressors, as well as other family stressors such as domestic violence. These interventions are likely to require collaboration with various types of community agencies and resources.

As discussed earlier, in situations where professional mental health care may cause stigma, interventions with distressed refugee children may be most effectively implemented in community settings, such as schools, where the stigma may be absent or lessened (Birman et al., 2008). Research is needed to examine the conditions under which clinic-based versus community-based (e.g., school-based) interventions are more effective, and the specific ways these interventions improve or affect a refugee family's functioning.

Intervention research with resettled refugee populations may require broad-based community outreach to engage and recruit families. In addition, conducting a methodologically rigorous intervention study within a framework of community-based research is challenging, particularly in the case of refugee populations for whom an appropriate comparison group is difficult to identify. Randomization procedures can be complicated in the context of insular communities where social networks are of primary importance. The questions of whether and to whom the results can be generalized are often uncertain, given the relatively small number of refugee children and families who typically access a mental health service or participate in an intervention study.

In addition to building a repertoire of evidence-based interventions, researchers must document and operationalize practice-based evidence—that is, the practices that psychologists working with refugees document as successful. Tension exists between the need to provide services to refugees and the need to conduct rigorous intervention research. One challenge contributing to this reality is that in order to improve study designs, researchers must operationalize interventions in discrete and replicable ways, thus allowing them to study the effectiveness of specific intervention aspects and therefore requiring fidelity to a treatment model. However, as evidenced in the section on Practice, a great deal of excellent mental health care delivered to refugees is not documented or studied in these standardized ways.

The integration of local/refugee paraprofessionals into treatment and research teams or as providers of care may address the cultural and human resource gaps given the diversity of refugee populations in the United States and the limited number of mental health professionals familiar with these populations. The effectiveness of paraprofessionals relative to trained mental health professionals is well established in literature on nonrefugee populations (Hubble et al., 1999). Several studies also indicate that well-trained and supervised local paraprofessionals can effectively deliver care to war-affected children (Bolton et al., 2007; Hubbard & Pearson, 2004). A critical role for researchers and practitioners lies in documenting the conditions under which paraprofessionals are most effective. Issues that bear exploration include the type of supervision most helpful to a paraprofessional, the delineation of mental health and psychosocial

problems best suited to services from paraprofessionals, the models of intervention most effective when enacted by paraprofessionals, and the ethical and practical considerations of training paraprofessionals from within refugee communities.

Supervision of Paraprofessionals in Intervention Research With War-Affected Youth

In a clinical trial of an adapted version of group interpersonal therapy to serve war-affected children and adolescents in Northern Uganda, skilled and dedicated clinical supervisors were essential to support the paraprofessional staff who provided the intervention. The intervention involved 16 weekly group meetings, lasting 1.5–2 hours each. Facilitators guided the group in sessions focused on improving depressive symptoms and functioning by identifying the interpersonal problem(s) most relevant to their depression and assisting participants in building skills to manage those problems. Weekly group and individual supervision was important in order to sustain fidelity to the evidence-based intervention model being implemented (Group Interpersonal Therapy, IPT-G) and to ensure appropriate response to new needs of participants as they arose (such as the participants who demonstrated comorbidities or other problems that required further attention). Such constant and thoughtful supervision was essential to ensuring fidelity to the IPT-G model for the purposes of research while also ensuring that high-quality mental health services were delivered to these war-affected youth.

In both global and domestic settings, the implementation of mental health interventions by paraprofessionals requires close attention by committed supervisors. Clinical supervision to support intervention facilitators and troubleshoot problems as they arise is essential to avoid staff burnout and maintain an adequate quality of mental health care for children and families. Supervision and clinical consultation are necessary not just during formal trials of interventions but also any time that agencies are implementing mental health services for people in difficult circumstances (Betancourt et al., 2009).

ETHICS IN RESEARCH WITH REFUGEE CHILDREN AND FAMILIES

From the point of view of the refugees, the professional has everything—a fixed place in society, a voice, status, money, etc.—which has been lost to them. (Summerfield, 2000, p. 9)

Ethical considerations are critical in the context of refugee research because of the inordinate power disparities and vulnerabilities that exist for refugee populations. Researchers must articulate how a study may contribute to improving the lives of participants and/or the larger community, and the potential risks of participation. In addition, ethical issues related to the involvement of children in research apply to refugee children and are intensified by the power dynamics inherent in work with this vulnerable group. Given their past experiences of war atrocities and political violence, it is particularly important to address issues of trust, disclosure, and the question of ownership of the narrative. Also, balancing the rights of the researcher with the rights of the participants is a crucial ethical issue. Ethical practices for researchers also include understanding the social, historical, and cultural context of their research in the presentation and use of research findings, as well as their own underlying political viewpoints (APA, 2002a; Estroff, 1995; Gomez et al., 2001; Morrow & Smith, 2000). The status, identity, and position of researchers in relation to the culture and population they are studying are important considerations.

Ethical practices and the selection and use of methods are intrinsic to each other (Dyregrov, Dyregrov, & Raundalen, 2000; Ellis et al., 2007; D. E. Hinton & Good, 2009). A research protocol that does not maintain strict methodological standards will more likely lead to inaccurate conclusions that could subsequently cause harm and inadvertently promote false understandings. Similarly, a research study that does not adhere to the highest ethical standards is at risk of losing the trust of a community, which could lead to a failure to engage participants or obtain honest responses to questions. In addition, when communities participate in research but do not share in the dissemination of findings, distrust and misunderstandings can be exacerbated.

Although these issues are fundamentally no different in refugee research than in other research, there are unique challenges posed by research with refugee communities. Implementing ethical requirements may call for increased creativity and flexibility on the part of the researcher and ultimately may create opportunities for improved research (Alden et al., 2009). When researchers fail to explore and recognize the ways in which community members perceive their research and its potential benefits or harm to their community, significant obstacles to trust and access may arise (APA, 2002a; Miller, 2004).

Certain guidelines may be contraindicated or seen as less “ethical” in certain cultural groups, and this calls for a reexamination of Western-derived ethical guidelines. When existing ethical guidelines are not sufficient—for example, in the case of obtaining voluntary informed consent in the face of cultural, educational, and/or linguistic barriers—it is the researchers’ responsibility to promote ethical research by developing appropriate and/or additional ethical approaches (Leaning, 2001). For example, as discussed in the Mental Health Services section, the intention behind individual informed consent practice may not have the same meaning to someone from a more collectivistic orientation, within which group members make cooperative decisions and/or have a structure that relies on community leaders or elders. Therefore, an individual-based consent may not provide the same protection for the refugee’s well-being (Eth, 1992; Kuczewski & McCrudden, 2001).

The validity of informed consent is further complicated when refugees come from countries where governments use coercion and violate human rights. It is a particularly challenging issue with traumatized refugee populations, given that the sociopolitical climate from which they were forced to flee was unlikely to uphold individual rights. In these situations, it is even more critical that individual participants feel free to participate or to not participate in research and that institutional review boards carefully examine the ethical dimensions of conducting research with traumatized, vulnerable populations. Addressing both individual and community consent in a refugee population may uphold ethical standards and create a more effective study (Ellis et al., 2007).

In summary, there are numerous methodological and ethical challenges to conducting relevant and valid research with refugee families and children, including:

- Standard assessment tools used to screen children at risk for mental health disorders or adjustment problems, which may not be appropriate for refugee children from diverse cultural backgrounds (Birman & Chan, 2008; Hollifield et al., 2002);
- Sampling and solicitation methods used on Western populations that pose problems with diverse refugee populations;
- Ethical issues pertaining to power inequities and inadequate involvement of refugees in the design of studies and dissemination of research results;
- Lack of empirical research to guide clinical interventions by mental health service providers for refugee children;

- Limited data regarding the most effective level of intervention (i.e., child, family, school, community) and when different levels of intervention will have the most impact;
- Paucity of evidence to determine which interventions are likely to be efficacious within and across particular refugee groups due to lack of systematic evaluation of refugee-focused interventions (Birman, Ho et al., 2005); and
- The critical need to identify protective factors that can serve as the targets of both intervention and prevention programs for child refugee populations (Lustig, Kia-Keating et al., 2004).

Mental health services that build on—rather than disregard—existing strengths in the community and that are grounded in refugees’ own cultural belief systems are more likely to result in better treatment outcomes (Miller, Kulkarni, & Kushner, 2006; Summerfield, 2000).

It is not enough to publish research findings; rather, researchers and practitioners must collaborate in order to integrate findings and clinical practice. It is critical to ensure the translation of research to practice and incorporate knowledge about the unique needs of refugee children into evidence-based practices, such as those endorsed by the APA Task Force on Evidence-Based Practice With Children and Adolescents and the National Child Traumatic Stress Network. The gains made in science need to be translated more quickly to improve the feasibility, ethics, and effectiveness of mental health care for refugee children and families.



CONCLUSION



War and armed conflict affect millions of people around the world each year, sending thousands into flight from their homes and their countries in the hope of escaping chaos and violence (UNHCR, 2007). In the midst of these refugees—some formally recognized by governments and welcomed into other countries and some fleeing without status and recognition—are thousands of children. Each year, the United States gives refuge to some of these children, either as formal refugees or as asylees. In 2008, of the over 60,000 refugees who came to the United States, approximately 21,000 of them were under the age of 18. Similarly, of the almost 23,000 individuals granted asylum, approximately 1,200 were under the age of 18 (U.S. Department of Homeland Security, 2009a).

It is unknown how many children arrive in the United States undocumented and without legal immigration status, either alone or with family, to escape situations of armed conflict and war. What is known about children who come to the United States after experiencing war and flight is that they have often experienced and survived devastating and profoundly stressful events. Some witnessed the destruction of their homes and communities and experienced threats and persecution, attacks, and killings. Their journeys from their home countries are often rife with violence and instability and characterized by long periods without the most basic childhood needs, such as proper nutrition, housing, and education. Some of these children traveled alone and some with parents, caregivers, and other family members.

The APA Task Force on the Psychosocial Effects of War on Children and Families Who Are Refugees From Armed Conflict Residing in the United States created this report with the objective of assisting psychologists—whether they are researchers, clinicians, educators, or advocates—in meeting the needs of war-affected children and families who came to the United States. The report reviewed the

research on the effects of war on children, discussed treatment models used and principles of care for this population, and discussed new directions for empirical study of this community.

This report uses a social-ecological approach that underscores the transactional nature of human development as children interact within and react to the varying environmental and cultural contexts in which they exist. Thus, the report examined individual factors that affect the functioning of children after war, such as exposure to trauma, age and developmental stage, gender, race and ethnicity, resilience and coping processes, language, and disability. Research examining the role of family factors, such as familial disruption, acculturation, parental functioning, and domestic violence was reviewed. The report reviewed the contexts of school and community, where refugee children may encounter the challenges of academic adjustment, language acquisition, cultural adaptation, and discrimination but may also build new social supports and shape new facets of their identity.

This report examined some of the mental health services provided to refugee and war-affected children both within and outside of the United States. Individual, family, and group treatment modalities were used, and there is a small but growing evidence base regarding effective treatments. There is also a body of literature from within the community of practitioners working with refugee children on the existing practices—also called practice-based evidence—used on the front lines of work with this group. Those working with and evaluating mental health care for refugee children repeatedly endorse the use of comprehensive, community-based services with this population. Some argue these services, provided in locations and formats accessible to refugee families and focused on the variety of needs and problems of such families, are a better match for these communities than clinic-based, pathology-focused models of care.

The importance of cultural competence in care is also underscored in the literature about clinical work with refugee children and families. Active engagement with and exploration of cultural values, history, and conceptions of well-being and distress are recommended.

Finally, this report discusses a complementary approach between evidence-based practice and practice-based evidence. In this approach, clinicians use core competencies and best practices of treatments shown to be effective with war-affected children, such as CBT techniques and protocols, while integrating methods that emerged from practice literature and are unique and salient to the needs of the refugee child and family. The report discussed the importance of drawing on the strengths and resilience of the refugee family, with an emphasis on recognizing successful coping strategies they used thus far to cope with the stressors of war and displacement.

The report also discussed the research examining the experiences and needs of war-affected children and discussed methodological challenges and new directions. Issues of sampling, instrument design, and mixed-methods assessment were discussed, with an emphasis on creating opportunities for strengthening cultural validity and reliability of constructs and instruments. The report underscored the need for research that is culturally engaged in order to discern local meanings of well-being, distress, and resilience, as well as to strengthen community involvement and participation in the research.

The report recommended the integration of research findings and clinical practice so as to create models of care that are grounded in evidence and guided by real-world feasibility and practicality for this community and discussed ethical issues in terms of both research and clinical work with war-affected and refugee children. For those working with this vulnerable group, issues of power differential and cultural difference must not be underestimated.

Psychologists—in their roles as clinicians, researchers, educators, and advocates—have tremendous potential to assist the many children who arrive in the United States seeking safety after the violence and disruption of war. Therefore, this report concludes with recommendations in the areas of practice, research, education and training, and public policy that will address some of the gaps that exist in the understanding of and service provision to refugee children and their families.

RECOMMENDATIONS



PREAMBLE

Ensuring positive outcomes for refugee children and families requires stakeholders within the clinical practice, research, education, and public policy sectors to be culturally competent and cognizant of the various interacting factors that influence refugees' mental health and adjustment upon resettlement, including:

- effects of migration and armed conflict
- acculturation
- risk and resilience
- cultural and religious beliefs and background
- age/developmental stage
- race/ethnicity
- gender
- socioeconomic status
- sexual orientation

- disability/medical needs
- characteristics of the family and host community
- language barriers/attainment

Stakeholders within each of these sectors must collaborate with each other, family members, and community members in order to improve the ethics, feasibility, and effectiveness of mental health care for refugee children and families.

The following recommendations focus broadly on ways that the field of psychology can address the needs of this population across practice, research, education, and policy domains. These recommendations require further communication and collaboration within the field of psychology and in interdisciplinary collaboration with other fields that are involved in the care and adaptation of refugee children.



SERVICES AND SUPPORTS

War-affected children may need supportive services to promote health and well-being after resettlement in the United States. Such services may address a range of needs, including basic daily living, education, and physical and mental health, across the numerous contexts in which these children function. Such services must be accessible and affordable, and culturally and linguistically appropriate.

To promote this standard of care, the task force recommends that APA:

- Support opportunities for sharing of practice methods and theories within the field of psychology that are developed to address the special needs of refugee children and families, recognizing that there may be methods of treatment that incorporate culturally syntonetic techniques into practice.
- Advocate for the implementation of school-based mental health programs and interventions that demonstrate clinical effectiveness with refugee children and adolescents.
- Support and advocate for federal policy initiatives that assist in the adjustment and self-sufficiency of refugee and war-affected children and families.
- Provide coverage for case management services for war-affected refugee children and families that address basic needs and access to essential resources (e.g., medical, mental health, job placement, housing).
- Support the development of a range of services for unaccompanied refugee minors, such as mental health and medical services, adequate housing and provision of daily needs, school placement and support.
- Develop and disseminate culturally and linguistically appropriate evidence-based and evidence-informed practices for prevention, intervention, and treatment of mental and behavioral health problems among refugee children and families in both traditional and nontraditional settings (e.g., home-based, community-based, school-based, detention centers).

RESEARCH

To advance the knowledge base regarding the mental and behavioral health of war-affected children and families, the task force recommends that APA advocate for support of research that:

- Examines the broad range of war, displacement, and resettlement stressors that can affect the mental and behavioral health of refugee children and families and identifies culturally specific definitions of well-being, distress, and healing, and coping strategies that refugee children and families use.
- Examines the feasibility, adaptation, and efficacy of evidence-based interventions, including clinic-based, community-based, or school-based interventions, and evaluates practice-based evidence using rigorous scientific designs for use with refugee children and families. Research should include the role of factors that enhance treatment access, engagement, and retention for war-affected children and families.
- Uses qualitative, quantitative, and mixed methods in a complementary fashion to improve validity and cultural significance.
- Uses both longitudinal and cross-sectional design to identify trajectories of risk and resilience in war-affected children and families.
- Examines adaptational issues in refugee children such as language acquisition, identity development, acculturation, peer relationships, and mental health in relation to school and educational factors.

EDUCATION AND TRAINING

To improve and enhance training opportunities in refugee studies for graduate students and encourage training for and retention of professionals who work with refugee children and families, the task force recommends that APA:

- Continue to promote graduate training in multicultural practice and research.
- Advocate for federal policy initiatives for training in psychology such as:
 - *Graduate Psychology Education Program:* Supports the interdisciplinary training of psychology graduate students while they provide supervised mental and behavioral health services to underserved populations (e.g., children and victims of abuse and trauma).
 - *Minority Fellowship Program:* Trains minority mental health professionals to provide culturally and linguistically competent and accessible mental health and substance abuse services for diverse populations.
- Encourage training programs to include self-care and boundary management in order to prevent secondary traumatization in caregivers working with war-affected children and families.
- Encourage continuing education programs for practicing psychologists and mental health professionals to include instruction on multicultural practice and the importance of effective collaboration between psychologists and interdisciplinary resource agencies, community leaders, paraprofessionals, and cultural brokers to address the real-life needs of war-affected children and families.

COLLABORATION/INTERFACE

To improve collaboration/interface between and among individuals, organizations, and systems that provide care to war-affected refugee children, the task force recommends that APA:

- Support opportunities for dialogue and formal collaboration between researchers and practitioners who work with refugee children in order to enhance the evidence base on effective treatment with this population and strengthen the effectiveness of clinical services being offered.
- Advocate for systematic collaboration and communication between the interdisciplinary systems (i.e., health care, education, legal/immigration, resettlement, social services) that provide services to refugee children and families in order to enhance service effectiveness, reduce redundancy of care, and create strong networks of support for this vulnerable population.
- Facilitate opportunities for collaboration and bidirectional training between psychologists and community leaders/paraprofessionals/cultural brokers.
- Engage in advocacy activities consistent with APA policy (in its role as a UN NGO) by supporting the ratification of the Convention on the Rights of the Child by the U.S. Congress, which recognizes the rights of every child, including refugee children, to human dignity and the potential to realize their full capacities.

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APPENDIX A: GLOSSARY

Armed conflict/war. Armed conflict falls into three general categories: state-based conflict, non-state conflict, and one-sided violence. *State-based conflict* refers to what most people intuitively perceive as “war”: fighting either between two states or between a state and a rebel group that challenges it. It usually results in at least 25 battle-related deaths in one calendar year. *Non-state conflicts* are viewed much like state-based ones, with the exception that in these conflicts, none of the warring parties can be a state. Such conflicts are also included if they reach the 25 battle-related deaths threshold. *One-sided violence* involves the use of armed force by the government of a state or by a formally organized group against civilians which results in at least 25 deaths in a year.

Uppsala University. (2008). *Uppsala Conflict Data Program: Definitions*. Retrieved from www.ucdp.uu.se/database.

Asylee. Asylees are individuals who, on their own, travel to the United States and apply for/receive a grant of asylum. These individuals do not enter the United States as refugees. They may enter as students, tourists, businessmen, or even in undocumented status. Once in the United States, or at a land border or port of entry, they apply to the U.S. Department of Homeland Security (DHS) for asylum, a status that acknowledges that they meet the definition of a refugee and allows them to remain in the country. Individuals granted asylum are eligible for Office of Refugee Resettlement (ORR) assistance and services.

U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement. (2008). Retrieved from <http://www.acf.hhs.gov/programs/orr/about/whoweserve-2.htm>

Culture. *Culture* is defined as the belief systems and value orientations that influence customs, norms, practices, and social institutions, including psychological processes (language, caretaking practices, media, educational systems) and organizations (media, educational systems). Inherent in this definition is the acknowledgment that all individuals are cultural beings and have a cultural, ethnic, and racial heritage. Culture has been described as the embodiment of a worldview through learned and transmitted beliefs, values, and practices, including religious and spiritual traditions. It also encompasses a way of living informed by the historical, economic, ecological, and political forces on a group. These definitions suggest that culture is fluid and dynamic and that there are both cultural universal phenomena and culturally specific or relative constructs.

American Psychological Association. (2002). *Multicultural guidelines on education, training, research, practice, and organizational change for psychologists*. Retrieved from <http://www.apa.org/practice/guidelines/multicultural.pdf>

Immigration and Nationality Act of 1952 (INA). This major body of law includes provisions relating to immigration and nationality. It has been amended several times, most prominently in 1965, 1976, 1978, 1980, 1986, 1990, and 1996.

U.S. Citizenship and Immigration Services. Retrieved from <http://www.uscis.gov/files/article/8%20Glossary.pdf>

Internally displaced persons (IDPs). These are persons or groups of persons who have been forced or obliged to flee or leave their homes or places of habitual residence—in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or human-made disasters—and who have not crossed an internationally recognized state border.

UN Office for the Coordination of Humanitarian Affairs. *Handbook for Applying the Guiding Principles on Internal Displacement*. Retrieved from http://www.reliefweb.int/ocha_ol/pub/IDPprinciples.pdf

Key informant. The term *key informant* is generally associated, though not exclusively, with qualitative research in which a researcher employs interviewing of knowledgeable participants as an important part of the method of investigation. During the often-extended period of fieldwork that such research requires, a particular subject may become an especially useful source of information, be repeatedly interviewed, and thus earn designation as a key informant. It is not unusual in field research that at any particular time an investigator might have several informants who could be identified as performing in that role. Key informants can extend the investigator’s reach in situations where he or she has not, or cannot, be a direct observer, and they can illuminate the meanings of behavior that the researcher does not understand. They can also serve as a check on the information obtained from other informants.

Blackwell Encyclopedia of Sociology. Retrieved from http://www.blackwellreference.com/public/tocnode?id=g9781405124331_chunk_g978140512433117_ss1-1

Posttraumatic stress disorder (PTSD). PTSD is an anxiety disorder that develops in some individuals after exposure to one or more

extremely traumatic events involving actual or threatened death or serious injury or a threat to the physical integrity of self or others. For a diagnosis of PTSD, the disturbance must last for at least 1 month and must cause significant distress or impairment in social, occupational, or other important areas of functioning. Three symptom clusters (reexperiencing, avoidance/ numbing, and hyperarousal) describe the clinical features of PTSD. First, the traumatic event is persistently reexperienced. Second, such reexperiencing and reactivity leads to persistent avoidance of cues associated with the traumatic event. Third, persistent symptoms of increased arousal or anxiety that were not present before the trauma also cause disruption in the lives of those with PTSD.

Encyclopedia of Psychology, Vol. 6. Retrieved from <http://psycnet.apa.org/books/10521/079.pdf>

Refugee. A *refugee* is a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of persecution because of his or her race, religion, nationality, or membership in a particular social group or political opinion; and is unable or unwilling to avail him or herself of the protection of that country or return there for fear of persecution. Individuals granted refugee status overseas by the DHS are brought to the United States for resettlement by the U.S. Department of State. Voluntary agencies and ORR through their programs assist with their resettlement and integration into the United States. Refugees are eligible to receive ORR benefits and services from the first day they arrive in the United States.

Office of Refugee Resettlement. Retrieved from <http://www.acf.hhs.gov/programs/orr/about/whoweserve.htm>

Removal. This is the expulsion of an alien from the United States. This expulsion may be based on grounds of inadmissibility or deportability.

U.S. Citizenship and Immigration Services. Retrieved from <http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=3ab48fa29935f010VgnVCM1000000ecd190aRCRD&vgnnextchannel=b328194d3e88d010VgnVCM10000048f3d6a1RCRD>

Temporary protected status. Establishes a legislative basis for allowing a group of persons temporary refuge in the United States. Under a provision of the Immigration Act of 1990, the Secretary of Homeland Security may designate nationals of a foreign state to be eligible for TPS with a finding that conditions in that country pose a danger to personal safety due to ongoing armed conflict or an environmental disaster. Grants of TPS are initially made for periods of 6 to 18 months and may be extended depending on the situation. Removal proceedings are suspended against aliens while they are in Temporary Protected Status.

U.S. Citizenship and Immigration Services. Retrieved from <http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=b46ca4491c35f010VgnVCM1000000ecd190aRCRD&vgnnextchannel=b328194d3e88d010VgnVCM10000048f3d6a1RCRD>

Unaccompanied alien child. An unaccompanied alien child is one who has no lawful immigration status in the United States; has not attained 18 years of age; and with respect to whom there is (a) no parent or legal guardian in the United States or (b) no parent or legal guardian in the United States is available to provide care and physical custody.

Office of Refugee Resettlement. Retrieved from <http://www.acf.hhs.gov/programs/orr/about/whoweserve-6.htm>

Undocumented immigrant. This is a noncitizen who has been unlawfully admitted to the United States or who has violated the terms of his/her lawful admission.

U.S. Citizenship and Immigration Services. Retrieved from <http://www.uscis.gov/files/article/8%20Glossary.pdf>

RELEVANT APA RESOLUTIONS AND POLICY STATEMENTS

- Reaffirmation of the APA Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and Its Application to Individuals Defined in the United States Code as “Enemy Combatants”— <http://www.apa.org/about/governance/council/policy/torture.aspx>
- Resolution Against Genocide— <http://www.apa.org/international/resources/Resolution.pdf>
- Resolution on Children’s Mental Health— <http://www.apa.org/about/governance/council/policy/child-mental-health.aspx>
- Resolution on Immigrant Children, Youth, and Families— <http://www.apa.org/about/governance/council/policy/immigrants.aspx>
- Resolution on the Psychological Needs of Children Exposed to Disasters— <http://www.apa.org/about/governance/council/policy/children.aspx>
- Resolution on UN Convention on the Rights of the Child— <http://www.apa.org/about/governance/council/policy/rights-child.aspx>
- Resolution on UN Convention on the Rights of the Child & Optional Protocols – <http://www.apa.org/about/governance/council/policy/child-rights.pdf>
- Resolution on Violence Against Children by Governments— <http://www.apa.org/about/governance/council/policy/governments.aspx>

MENTAL HEALTH RESOURCES

APA Presidential Task Force on PTSD and Trauma in Children and Adolescents—www.apa.org/pi/families/resources/task-force/child-trauma.aspx

This task force produced a suite of products for mental health professionals and policymakers regarding the basics of trauma in children and adolescents, ways in which to help children and their families cope and recover, and pitfalls to avoid upon encountering trauma and PTSD in children and adolescents.

Bellevue/NYU Program for Survivors of Torture—www.survivorsoftorture.org

The Bellevue/NYU Program for Survivors of Torture provides comprehensive medical and mental health care and social and legal services to survivors of torture and war traumas and their family members.

Boston Center for Refugee Health and Human Rights—www.bcrhhr.org

The center provides comprehensive health care for refugees and survivors of torture and related trauma, coordinated with legal aid and social services. The center provides training to agencies and professionals to conduct clinical, epidemiological, and legal research and to advocate for the promotion of their health and human rights.

Center for Multicultural Human Services—www.cmhsweb.org

The center assists mental health workers in meeting the needs of clients who have a culture and/or language barrier to treatment. The center is dedicated to bridging the gap between diverse client populations and mainstream mental health provider organizations.

Center for Victims of Torture (CVT) —www.cvt.org

The CVT offers national technical assistance through resources, training, and networking opportunities specifically targeted to specialized torture treatment centers. CVT also provides a series of publications for practitioners who work with refugees and survivors of torture.

Disaster Response Network (DRN)—www.apa.org/practice/drnindex.html

APA’s DRN is a national network of psychologists with training in disaster response who offer volunteer assistance to relief workers, victims, and victim’s families after man-made or natural disasters in the United States and territories. DRN members use their professional judgment and training to help disaster victims cope with extremely stressful and often tragic circumstances. Members help problem solve, make appropriate referrals to community resources, advocate for workers’ and victims’ needs, provide information, and listen. They also focus on providing general emotional support and helping people marshal their own successful coping skills.

Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma- Exposed Populations in Clinical and Community Settings—http://itspnyc.org/perspectives_guidelines.pdf

The Task Force on International Trauma Training of the International Society for Traumatic Stress Studies developed consensus-based guidelines for training in mental health and psychosocial interventions for trauma-exposed populations in the international arena.

Harvard Program in Refugee Trauma (HPRT)—www.hpert-cambridge.org

The HPRT is a multidisciplinary program that has been pioneering the health and mental health care of traumatized refugees and civilians in areas of conflict/postconflict and natural disasters for over two decades.

Immigrant & Refugee Mental Health—<http://www.mcgill.ca/tcpsych/clinical/child>

This website provides research on the mental health of ethnocultural communities in Montreal. It is part of the Montreal Center of Excellence in Immigrant Studies, sponsored by Citizenship Canada and the Social Science Research Council of Canada.

National Child Traumatic Stress Network (NCTSN)—www.nctsn.net

The NCTSN is a SAMHSA-funded collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children (including refugee children) and their families across the United States.

SAMHSA Refugee Mental Health Program—www.refugeewell-being.samhsa.gov

This program provides refugee mental health consultation and technical assistance. SAMHSA also responds to refugee admissions emergencies and provides technical assistance to increase collaboration between refugee service agencies and mental health providers.

GOVERNMENTAL AGENCIES

Bureau of Population, Refugees, and Migration (U.S. Department of State)—www.state.gov/g/prm

This bureau coordinates U.S. international migration policy within the government and through bilateral and multilateral diplomacy. It has responsibility for formulating policies on population, refugees, and migration and for administering U.S. refugee assistance and admissions programs.

Office of Refugee Resettlement (ORR) (U.S. Department of Health and Human Services)—www.acf.hhs.gov/programs/orr

ORR advises the Secretary of Health and Human Services on matters relating to refugee resettlement, immigration, and repatriation. ORR plans, develops, and directs implementation of a comprehensive program for domestic refugee and entrant resettlement assistance. This site indexes ORR regulations, information on welfare reform, and Medicaid information.

U.S. Citizenship and Immigration Services (USCIS) (U.S. Department of Homeland Security)—www.uscis.gov

USCIS oversees lawful immigration to the United States and decides upon the petitions and applications of potential immigrants (i.e., immigrant visa petitions, naturalization petitions, and asylum and refugee applications).

INTERNATIONAL ORGANIZATIONS

International Organization for Migration (IOM)—www.iom.int

IOM is dedicated to promoting humane and orderly migration for the benefit of all. It does so by providing services and advice to governments and migrants. IOM works to help ensure the orderly and humane management of migration, promote international cooperation on migration issues, assist in the search for practical solutions to migration problems, and provide humanitarian assistance to migrants in need, including refugees and internally displaced people.

Refugees International—www.refintl.org

Refugees International is a private advocacy organization serving refugees, displaced populations, and other vulnerable groups around the world.

United Nations High Commission for Refugees (UNHCR)—www.unhcr.org

This UN agency leads and coordinates international action to protect refugees and stateless persons and resolve refugee problems worldwide. Its primary purposes are to safeguard the rights and well-being of refugees and ensure that they can exercise the right to seek asylum and find safe refuge in another state, with the option to return home voluntarily, integrate locally, or resettle in a third country.

RESETTLEMENT AGENCIES

Church World Service—www.churchworldservice.org

The Immigrant and Refugee Program of the Church World Service

resettles about 8,000 refugees and entrants in the United States each year and also helps meet the needs of people in protracted refugee situations and refugees returning home.

Episcopal Migration Ministries—www.episcopalchurch.org/emm.htm
Episcopal Migration Ministries uses a network of 30 offices in 26 dioceses and volunteers to perform advocacy and provide refugee resettlement services.

Ethiopian Community Development Council (ECDC)—www.ecdcinternational.org
ECDC manages the resettlement and placement of refugees from Africa, Eastern Europe, Latin America, the Caribbean, the Near East, and Southeast Asia through a network of independent community-based organizations around the country. ECDC's participation in the Matching Grant program, a public/private partnership, provides financial incentives to refugees to become self-sufficient during their first 120 days in the United States.

Hebrew Immigrant Aid Society (HIAS)—www.hias.org
The HIAS Refugee Resettlement Program is dedicated to the successful resettlement of refugees, regardless of ethnicity, religion, or place of birth. It works with government agencies and international and local organizations to ensure all refugees receive the services guaranteed to them under U.S. law. HIAS also works with a team of local affiliate agencies to provide refugees with direct services such as English lessons, vocational training, and other necessary activities that ensure refugees can successfully adapt to life in the United States.

International Catholic Migration Commission (ICMC)—www.icmc.net

ICMC works in the area of forced migration, responding to the immediate needs of refugees, internally displaced persons, and forced migrants and focusing on the most vulnerable within these populations.

International Rescue Committee (IRC)—www.theirc.org

The IRC supports newly arrived refugees by providing immediate aid, including food and shelter, housing, job placement and employment skills, clothing, medical attention, education, English-language classes, and community orientation. The IRC's resettlement network also provides comprehensive immigration services to assist refugees and asylees on their path to becoming permanent residents or U.S. citizens.

Lutheran Immigration and Refugee Services (LIRS)—www.lirs.org
LIRS mobilizes action on behalf of uprooted people to see that they receive fair and equal treatment, regardless of national origin, race,

religion, culture, or legal status.

U.S. Committee for Refugees and Immigrants (USCRI)—www.refugeesusa.org
USCRI's network of field offices *develops and implements a variety of programs to help refugees* meet their immediate needs upon arrival, gain self-sufficiency within their first year of resettlement, overcome past trauma and grief, develop new support systems, and prepare for long-term adjustment and success.

U.S. Conference of Catholic Bishops—www.nccbuscc.org/mrs/refprog.htm
The U.S. Conference of Catholic Bishops resettles nearly one-fourth of all refugees admitted to the United States each year through a concerted effort of program support and assistance to a network of over 100 diocesan refugee resettlement offices and collaboration with other national resettlement and governmental agencies.

World Relief—www.worldrelief.org

World Relief offers legal support, job training, and English classes to immigrants including refugees. Their legal services clinic in Baltimore, MD, reaches out to thousands of clients each year—helping them fill out paperwork, joining them at hearings, and ensuring they understand their rights and responsibilities. World Relief is also engaged in advocacy for immigration and refugee policy.

TECHNICAL ASSISTANCE/SERVICES

Catholic Legal Immigration Network, Inc. (CLINIC)—www.cliniclegal.org/resources/citizenship-civic-participation-project

The CLINIC operates a citizenship and civic participation project for refugees that provides technical assistance to service providers and voluntary agencies. CLINIC also operates an asylee information referral hotline that provides a single, centralized source of accurate information in 19 languages about service eligibility and programs across the country that assist asylees with the resources they need for a smooth adjustment and early self-sufficiency.

The National Partnership for Community Training (NPCT) for Immigrant Service Providers—www.acf.hhs.gov/programs/orr/resources/npct.htm

The primary goal of the NPCT is to develop and improve the capacity of local community service providers throughout the nation to identify,

refer, assist, effectively serve, and, with existing resources, provide appropriate treatment and rehabilitation for torture survivors. A second goal of the project is to advance and disseminate best and promising practices related to treatment and intervention for survivors of torture.

U.S. Conference of Catholic Bishops, Bridging Refugee Youth and Children Services (BRYCS)—www.brycs.org

BRYCS provides technical assistance activities to support service providers for refugee children, youth, and their families. BRYCS provides one-on-one consultations, training, conference presentations, and access to the only website focused specifically on migration and child welfare.

ADVOCACY

Kurdish Human Rights Watch (KHRW)—www.khrw.com

KHRW provides programs and activities related to the displacement of Kurds, including refugee, immigrant, and mentoring services.

National Coalition for Haitian Rights—www.nchr.org

This coalition of Haitian religious, labor, and human rights organizations seeks to assure that Haitian asylum applicants receive fair hearings in the United States and to educate the U.S. public about the political and economic causes of the Haitians' flight from their homeland.

National Immigration Forum—www.immigrationforum.org

The forum advocates and builds public support for public policies that welcome immigrants and refugees and that are fair and supportive to newcomers in the United States.

The Organization for Refuge, Asylum, and Migration (ORAM)—www.oraminternational.org

ORAM is the first nongovernmental organization to focus exclusively on refugees and asylum seekers fleeing sexual or gender-based violence.

Southeast Asian Resource Action Center—www.searac.org

The center facilitates the relocation of Southeast Asian refugees into American society and the development of nonprofit organizations led by and for Southeast Asians.

Women's Refugee Commission—www.womensrefugeecommission.org

The Women's Refugee Commission advocates vigorously for laws, policies, and programs to improve the lives and protect the rights of refugee and internally displaced women, children, and young people—bringing about lasting, measurable change.

LEGAL SUPPORT

American Bar Association—http://www.abanet.org/publicserv/immigration/legal_services_directory_map.shtml

This directory lists free or low-cost immigration legal service providers throughout the country.

American Immigration Law Foundation—www.aifl.org

The foundation is dedicated to increasing public understanding of immigration law and policy and the value of immigration to American society and to advancing fundamental fairness and due process under the law for immigrants.

Asylum Law.org—www.asylumlaw.org

This web-based resource provides information about asylum law in the United States and internationally with links to human rights websites to research country conditions. It also has a database ranking immigration judges on frequency of asylum grants.

Center for Gender and Refugee Studies (CGRS)—<http://cgrs.uchastings.edu>

CGRS strives to impact the development of law and policy to protect women fleeing gender-based violence by providing training and technical support to attorneys, tracking and monitoring gender asylum decisions, engaging in appellate litigation, participating in national policy strategizing, educating the public through the media, and participating in international conferences. CGRS has a variety of resources available to attorneys who are litigating gender-based asylum cases, including domestic violence, female genital mutilation, rape, and sexual orientation issues.

National Children's Center—www.refugees.org/article.aspx?id=1260&subm=75&area=Participate&

The National Children's Center is a partnership between the U.S. Committee for Refugees and Immigrants and American Immigration Lawyers Association. The center finds pro bono attorneys for unaccompanied immigrant children. The center welcomes referrals through its confidential online referral system. The center also is recruiting immigration attorneys to mentor pro bono attorneys inexperienced in immigration law. The National Children's Center maintains a resource library for attorneys representing immigrant children. The resource library has information about Central American gangs, including articles, reports, and a list of experts.

National Immigration Law Center (NILC)—www.nilc.org

NILC seeks to protect and promote the rights and opportunities of low-income immigrants and their family members. NILC staff specialize in immigration law and the employment and public benefits rights of

immigrants. They also conduct policy analysis and impact litigation and provide publications, technical advice, and trainings to a broad constituency of legal aid agencies, community groups, and pro bono attorneys.

INFORMATION CLEARINGHOUSES

Center for Refugee Studies—www.yorku.ca/crs

The center conducts research on refugee issues; informs public discussion, policy development, and practice innovation by international, governmental, advocacy, and service organizations; and supports teaching in refugee and migration studies.

Refugee Studies Centre—www.rsc.ox.ac.uk

The centre's objectives are to carry out multidisciplinary research and teaching on the causes and consequences of forced migration; disseminate the results of that research to policymakers, practitioners, and within the academic community; and to understand the experience of forced migration from the point of view of the affected populations.

ReliefWeb—www.reliefweb.int

ReliefWeb is an electronic clearinghouse for those needing timely information on humanitarian emergencies and natural disasters—designed specifically to help the humanitarian community improve its response to emergencies.

UNHCR Refworld—www.unhcr.org/refworld

Refworld contains a vast collection of reports relating to situations in countries of origin, policy documents and positions, and documents relating to international and national legal frameworks. The information has been carefully selected and compiled from UNHCR's global network of field offices; governments; international, regional, and nongovernmental organizations; academic institutions; and judicial bodies.

DATA AND STATISTICS

Office of Refugee Resettlement Data—<http://www.acf.hhs.gov/programs/orr/data/index.htm>

This site provides information on state profiles, refugee arrival data, annual reports to Congress on refugee resettlement, anti-trafficking initiatives, and refugee repatriation.

UNHCR Statistics—www.unhcr.org/pages/49c3646c4d6.html

UNHCR provides data, trends, an interactive data visualization platform, and statistical reports on refugees, asylum seekers, returned refugees, and internally displaced and stateless people around the world.

U.S. Department of Homeland Security—Yearbook of Statistics on Refugees and Asylees—

www.dhs.gov/files/statistics/publications/YrBk08RA.shtm

This site provides statistics on refugee arrivals and individuals granted asylum on an annual basis.

Worldwide Refugee Admissions Processing System (WRAPS)—

www.wrapsnet.org

This database is used to process and track the movement of refugees from various countries around the world to the United States for resettlement under the U.S. Refugee Admissions Program (USRAP).

