

Adapting Clinical Services To Accommodate Needs of Refugee Populations

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The diversity of the refugee population in the United States requires practicing psychologists to respond by adapting clinical services to meet their mental health needs. However, the available literature on culturally adapted treatments is only a first step in guiding the process for adapting clinical services. This paper describes our experiences with designing and adapting a variety of clinical services for youth and families with refugee status. Guided by Sue's (2006) tenets for culturally competent service delivery, we discuss a therapeutic model of tiered service delivery used to deliver preventative services and treatment to refugee youth and adults. We discuss how we adapted treatments to help overcome access barriers to mental health treatment, and we provide specific examples of how existing treatments were used with refugee populations. In addition, we discuss information and approaches for how practicing psychologists can develop additional skills for working with refugee populations. We conclude by focusing on the need for our field to work toward improving access to mental health treatment for refugee youth and families and developing evidence-based treatments for this population.

Keywords: refugee, barriers to treatment, cultural competence, therapy

Delivering clinical services to a refugee population requires psychologists to develop cultural awareness, knowledge regarding cultures from around the world, and unique therapeutic skills. Refugee populations are considered differently than immigrant groups. Immigrant populations are generally viewed as people who voluntarily come to live in the United States, whereas refugees are populations who seek to escape conditions in their home country (Ogbu, 1997; Suárez-Orozco, 2000). Refugee populations are also

provided with legal protections from the United States government as part of their resettlement process. Presently, the United States is experiencing a dramatic change in population demographics that produces a different landscape for psychologists and educators working with refugee populations (Casas, 2010). Based on immigration statistics from the U.S. Department of Homeland Security, a total of 74,602 refugees were admitted to the United States in 2009—representing a 24% increase since 2008 and the greatest

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WE ACKNOWLEDGE the support of a Graduate Psychology in Education Training Grant provided to our program by the Health Resources and Services Administration of the U.S. Department of Health and Human Services, and the director of the clinical training program at this university, Dr. Susan Keane. Financial assistance for families accessing care was also provided by the Moses Cone Foundation CARES grant. The authors would like to express their appreciation for the academic–community partnership that guided the development and implementation of the interventions described in this article. The views described are those of our own as clinicians implementing our program. We are certain that much could be learned from collecting information from the adolescents themselves, and we will seek to include their stories in their own words in our future work, as our partnership and capacity for research with this community evolves. We especially thank the principal, school counselor, and social worker for their time and dedication to these youth and their families.

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number of refugee admissions in a decade (Martin, 2010). Sixty-eight percent of refugees admitted to the United States in 2009 were from Iraq, Burma, and Bhutan, and 34% were under 18 (Martin, 2010).

Due to the factors contributing to their resettlement in the United States, refugees are likely to have exposure to political violence, separation from family in countries of origin, and experiences of trauma both before and during the process of immigrating to the United States (Eisenman, Gelberg, Liu & Shapiro, 2003; Suárez-Orozco, 2000). For example, Eisenman and colleagues (2003) determined that over half of Latino primary care patients living in the Los Angeles area reported political violence experiences in their home country, with 8% endorsing experiences of torture. Individuals who experienced political violence were more likely to meet symptom criteria for posttraumatic stress disorder, endorse symptoms of depression and panic disorder, and experience chronic pain. Less is known, however, about how youth exposed to these issues are affected, and limitations associated with language barriers make research and treatment involving non-English or non-Spanish speakers quite difficult to implement (García Coll & Magnuson, 1997; Suárez-Orozco, 2000).

Responding to the needs of a diverse population of refugees is a vast and complex task. In many communities, few resources exist to support families raising children from diverse cultures who often do not speak English as their first language. In addition, there is a paucity of research describing the psychological experiences of refugee populations and the efficacy of associated mental health treatments. Moreover, most psychological research focuses more on immigrant and refugee populations and the problems they face and less on the awareness of how indigenous belief systems and practices may serve as protective factors for culturally diverse populations (Harwood & Feng, 2006). Recent work is expanding to focus on factors which contribute to the resilience of immigrant and refugee youth through the study of home, school, and community factors that could be enhanced to promote psychological health and adjustment (Casas, 2010; Winsler, Díaz, Espinosa, & Rodríguez, 1999).

Existing literature on culturally adapted treatments suggests that incorporating concepts from a client's culture of origin is indeed therapeutic. In a meta-analytic review involving 76 studies where treatments were adapted to reflect aspects of culture, Griner and Smith (2006) found evidence for including cultural concepts in treatment. Across all 76 studies the resulting average effect size was $d = .45$, indicating a moderately strong benefit of culturally adapted interventions. Additionally, the results suggested that treatments for specific cultural groups were four times more effective as compared to those offered to multiethnic groups. Lastly, in terms of understanding the role of language and therapy, Griner and Smith (2006) noted that for non-English-speaking populations, treatments that were done in a client's native language were possibly twice as effective as those done in English. Miranda and colleagues (2005) provided an extensive review of the effectiveness of evidence-based psychological interventions, such as cognitive-behavioral therapy and interpersonal therapy, for a variety of childhood and adult disorders. The review found greater evidence with African American and Latino populations, with fewer studies of Asian and Native American populations; however, this literature does not clearly address whether samples have refugee status.

Consistent with noted statistics on refugee populations, our midsized Southeastern city has experienced a marked increase in the cultural and linguistic diversity of local community members seeking or referred for mental health services. At our university-based psychology clinic, the number of refugee individuals receiving services has increased rapidly; over the past three years, our clinic has served refugees from countries including Iraq, Bhutan, Burundi, Somalia, Morocco, Liberia, Congo, Vietnam, Cambodia, and Mexico. Many of our clients of refugee status, as well as others in the community, are receiving general social services at community organizations like Lutheran Family Services, Church World Service, Catholic Social Services, and African Services Coalition, to name a few. In order to put into context how we adapted clinical services for refugees, we next provide a brief description of our clinic and its location, the team primarily involved in the service delivery, and the types of services available.

Clinical Staff and Services Provided

Our clinic is a training clinic for graduate students in an APA-approved doctoral psychology program. Under the supervision of doctoral-level, licensed clinical psychologists, graduate students provide a variety of individual, group, and assessment services. The clinic is located on a university campus, which can lead to transportation challenges for many clients. In 2008, the clinic received a small community foundation grant to provide services to underserved populations, including refugees. The grant coincided with an inquiry from a local school with a high percentage of refugees—300 students from over 30 ethnic groups who were recent arrivals to the United States—regarding our availability to offer group-based and individual services for their youth and families with mental health needs.

The specific team members who agreed to meet and adapt our clinical services for refugee populations consisted of two clinical supervisors and four graduate student therapists. Due to the school's request, the team initially focused on providing clinical services within the school to adolescent males and females from Iraq. Our training model involved selecting students to work in cotherapy teams, and we required students who joined the team to have completed a semester-long graduate seminar in multicultural issues in clinical psychology, taught by one of the supervisors. We also sought to include male and female therapists as the school-based groups would include both adolescent males and females. Finally, we attempted to recruit therapists with ethnically diverse backgrounds to the team—our initial team composition was 50% majority White background and 50% ethnic minority background (both with Middle Eastern countries of origin). We used 1 hour of supervision per week for service planning and 1 hour of supervision per week for live supervision once services were implemented at the school to examine how the adaptation process was working in practice.

The eventual set of therapeutic services that our clinic offered, and remain available at present, are the following: 1) group-based services offered at the school with refugee students, with an emphasis on preventative intervention; 2) individual or family therapy for refugee clients with specific psychological distress and more intensive need for services offered at the clinic or school setting; and 3) citizenship evaluations, where we conduct interviews and perform limited assessments to provide reports to be

used by the United States Naturalization Service about the likelihood of clients being able to pass the required tests for citizenship (most clients who have documented prior trauma and/or mental deficiency resulting in memory impairment are able to be exempt from a written citizenship test). Data from the 2009–2010 clinic records showed that 28 individuals in our clinic reported working with an immigrant or refugee client. Fifty-eight clients were seen for individual therapy, either at our clinic or at the school. Thirty-five clients participated in assessments at our clinic, including evaluations to inform citizenship applications.

We developed a tiered system (least intensive to most intensive) to help identify the appropriate type of service based on the clients' needs; some clients participated in multiple services. For example, the school-based support groups were offered as preventative interventions and provided general information to newly arriving refugee students. Specifically, school-based group therapy was used to "support" the acculturation and adjustment to America for youth who had particularly difficult migration histories and were referred by their school counselor. If students continued to show distress either during or after the groups, they were eligible to receive individual services (often continued at the school, but sometimes the location moved to our clinic). Additionally, parents of students or other adult refugees in the community often self-referred to our clinic after they learned that we offered low-cost services and used language interpreters. The tiered system or menu of services reflects the observation that some refugee populations need assistance with acculturative stress, while others require more intensive, trauma-focused treatment that would be most appropriate for a clinical mental health setting.

Culturally Competent Treatment

Overcoming Service Access Barriers

In considering the factors that impact refugees arriving in the United States, we were concerned about multiple barriers to accessing mental health treatment. Access to mental health treatment for low-income populations and ethnic minority groups is often hampered by limited financial and transportation resources (Snell-Johns, Mendez, & Smith, 2004), varying attitudes toward receiving treatment from mental health professionals (e.g., Sood, Mendez, & Kendall, 2010; Surgeon General, 1999), and increased dropout rates once treatment has begun (Kazdin & Mazurick, 1994). Thus, traditional clinical services need to be adapted in order to maximize treatment access and success for racial and ethnic minority groups (Snell-Johns et al., 2004), especially refugee youth and families experiencing significant language and cultural barriers.

Our first strategy for adapting clinical services for refugee youth and families centered on forming culturally competent academic—community partnerships. An academic—community partnership exists when individuals with scientific training, often from a university, partner with community organizations to promote change within the identified community (Pokorny et al., 2004). Such a partnership increases the likelihood that the services will be appropriate for the community members (e.g., Beeker, Gunthier-Gray, & Raj, 1998; Pokorny et al., 2004), and helps to ameliorate potential mistrust in mental health providers. Mistrust might be a significant barrier for refugee populations, particularly if models of

help-seeking in the country of origin involve seeking assistance from religious leaders, healers, or medical doctors, as opposed to psychologists (Sood et al., 2010).

Our partnership consisted of the local school serving refugee students, members of agencies offering language interpreter services, cab companies offering transportation assistance, and other community organizations, such as Lutheran Family Services. We also partnered with local experts at our university to learn more about the history and culture of our specific treatment populations such as Iraqi youth. In developing these relationships, we sought to reduce barriers to treatment for the refugee community and minimize potential mistrust of mental health professionals by anchoring clinical services within the community. These partnerships were in place during our work with the school-based group for adolescents from Iraq. The success of the groups (all youth attended the initial group sessions, and the boys' group had even stronger attendance than the girls' group) created future opportunities to develop additional therapy groups for adolescent refugees from Africa and Central America; individual therapy services for refugee youth and families from countries such as Bhutan, Burundi, Vietnam, Cambodia, and Mexico; and assessment services for individuals from countries including Serbia and Vietnam.

Treatment Preparation: Drawing Upon Sue's Tenets

Our clinical team drew upon Sue's (2006) tenets of *awareness*, *knowledge*, and *skills* to prepare for service delivery. Culturally competent treatment emphasizes the professional's level of *awareness* regarding how culture impacts mental health and therapy, *knowledge* of the target culture and issues impacting refugees, and *effective skills* for working with members of a cultural group and/or refugee population (Sue, 2006). According to Sue (2006), psychologists who operate using "scientific mindedness" (p. 239) act in accordance with culturally competent practice, because they rely on accumulative evidence and creative ways to develop and test hypotheses, as opposed to working from initial assumptions about culturally diverse populations. In his paper, Sue (2006) also emphasized the need for culture-specific expertise in working with particular groups or populations. Because "scientific mindedness" (p. 239) and culture-specific expertise are so challenging to define and operationalize, examples for professionals regarding how to acquire such skills are needed within the literature (Sue, 2006). Therefore, we describe our team's efforts to prepare for the school-based group for adolescent males and females from Iraq. Our preparation efforts were ongoing, as we continued to increase our awareness and knowledge and develop our skills prior to and during the interventions. Based on its perceived effectiveness (empirical data are not yet available), our clinic used culturally adapted versions of Sue's (2006) model to provide services to other refugee groups.

Awareness and gathering knowledge. Our team engaged in a 6-week planning process prior to conducting the group that involved a series of conversations, identification of resources, and unpacking of assumptions and goals for the groups. Through weekly discussions, we attempted to increase our culture-specific awareness and knowledge about important issues. We researched and read information about Iraqi culture, with a particular focus on increasing our knowledge related to its history, religious sects and beliefs, and gender roles. In addition, we consulted with other

faculty experts, including some who had traveled to the region and worked with United Nations officials responsible for relocating refugee families. Finally, we attended a half-day conference on refugees in our state and listened to refugees relay their stories of migration and adjustment to America. The planning steps proved to be especially important throughout the duration of services, as it eventually informed our session topics. Because the groups took place at a local school, we met with the school social worker and counselor to learn more about each group member, their route to the United States, and how they were adjusting to the school. Many of the youth were only residents in the United States for weeks or months before attending this particular school, with some refugees never attending any formal school in their homeland. We learned that many recent refugees from Iraq had experienced and/or been threatened with violence and death. Also, many of the students from this region lived in refugee camps or sought asylum in Syria and Jordan before arriving in the United States.

An equally important step in the development and delivery of services was our effort to continuously reflect upon our own assumptions related to working with a culturally diverse group of adolescent males and females. For example, we discussed if presenting group rules in both English and Arabic would be consistent with the practices of the school and showed the group members we respected their ability to learn and speak multiple languages. At weekly team meetings, supervisors encouraged discussions regarding the internal challenges related to discrepancies between our own worldview and that of the group members. We agreed to challenge each other and examine how our experiences were related to our own assumptions. Not only did the discussions help increase our awareness of how our own beliefs might influence the group process, but they also reminded us that the journey toward culturally competent practice is an ongoing one. We also incorporated a model of live supervision, as opposed to relying on the reports of the student clinicians, which allowed the therapists to more freely focus on conducting the groups, while the supervisors took detailed process notes regarding group content to analyze further in later supervision meetings (Helms & Cook, 1998).

Skills. To identify and utilize effective therapy skills, we drew upon the literature to inform our session topics and activities. However, it quickly became clear that there is a paucity of research available to guide the development of groups for adolescent refugees from Middle Eastern nations and also refugee populations generally. Therefore, we planned to use culturally adapted versions of the session topics outlined in Barrett and Sonderegger's (2001a, 2001b) "Non-English-Speaking Background Life Skills Program for New Arrivals." The session topics focus on how moving to a new country impacts one's emotional well-being, challenges encountered by cultural differences, family changes associated with the move, methods of coping with one's current circumstances, as well as positive aspects of change. The team chose the listed topics because they believed the topics were consistent with techniques utilized in cognitive-behavioral therapy, and had elements of challenges that could be relevant to developing new coping skills to be utilized while navigating a new American culture. Although the topics provided a useful platform for discussion, the team recognized the need to be flexible and occasionally modified planned session content for emergent issues that seemed more applicable to the group's current needs. For example, one group session focused generally on females' choices for intimate rela-

tionships in the United States as compared to Iraq, which surfaced after one participant raised a concern about possible dating partners.

In sum, the use of scientific mindedness, combined with other training on the use of cognitive-behavioral techniques, resulted in a therapeutic approach of using specific topics to elicit culturally relevant material from the students. We were also open to allowing the youth to address unique issues that we did not necessarily anticipate. Overall, we observed clinical content in two different, but related, areas—culture-of-origin issues and issues related to refugee status and acculturation. For the first, many of the youth were experiencing distress because of loss of their home culture (e.g., foods, places, people who were no longer part of their daily lives). For the second, refugees experienced acculturative stress (Hovey & King, 1997)—difficulties in their adjustment to life in American society, including economic and social stressors. By maintaining a focus on both coping with loss of the culture of origin, and dealing with the stress of living in a new culture, the groups were able to foster a sense of hope and resilience in many of the youth. Specifically, several group members reported that the opportunity to recount their histories and learn coping strategies and problem-solving skills suited for living in American culture provided them a sense of security and hope as they encountered daily stressors and challenges. The group members also noted that they were more aware of community and academic supports, contributing further to their sense of hope. Our therapeutic focus was also in line with the school's approach for working with these refugee youth.

In addition to therapy skills, our clinical team aimed to increase our skills in working with interpreters and using culturally appropriate clinical assessments. The next sections describe our experiences in these domains.

Training and Use of Interpreters

We sought training about working with interpreters in a mental health setting from an expert at a center at our university who offers second language interpreter training. She presented the traditional view that interpreters should be neutral and impartial conduits of information, repeating in turn what the therapist and client say. Although limited in scope, the available literature suggests that interpreters can be successfully used in cognitive-behavioral treatment (e.g., d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007). For example, Miller, Martell, Pazdirek, Caruth, and Lopez (2005) interviewed therapists and interpreters working in refugee mental health treatment centers. The results suggested that therapists considered the relationship among client, therapist, and interpreter a three-person alliance; therapists likely consult the interpreter about their thoughts on clinical material and use them as cultural consultants. Moreover, interpreters often reported feeling the emotional impact of hearing painful stories of war-related trauma and loss.

Like Miller et al. (2005), our experience suggests that mental health interpreting is a complex and dynamic process that can have an emotional impact on the interpreter. For example, one interpreter appeared tearful as a client described a particularly painful experience where someone in the family was killed. Another interpreter was enthusiastic about a party held at the culmination of group treatment and provided traditional food from her native

country of Jordan. We found that routinely conducting 30-min, pre- and posttherapy briefing and debriefing sessions with interpreters was essential to successful treatment, as it helped them process any emotions associated with their participation in the session. The sessions also provided us an opportunity to learn more about the cultural context of some session material (e.g., expectations for males and females in Middle Eastern culture). We hope the literature related to the use of interpreters in a mental health setting will expand in order to better understand this aspect of care for a diverse refugee population.

One key strategy to assist with locating potential interpreters is to develop a relationship with local interpreter agencies and/or other groups serving large numbers of refugees (e.g., Lutheran Family Services). Therapists who are not aware of interpreter resources may be able to find these professionals in larger cities or university communities, particularly when interpreters are unavailable within the local community. Sometimes, costs associated with interpreting can be negotiated so that the psychologist, agency, and client are not facing a situation where expenses are a treatment barrier. Also, depending on the uniqueness of the language spoken, we had the experience of searching statewide through a variety of community agencies in order to find an appropriate language match. We have also had experiences where this match was not possible, so the client was referred to another city for services; of course, this situation is not ideal, but it does occur and is consistent with recommendations to provide services in the client's own language rather than engage in limited English communications.

Assessment

During our treatment preparation before the group intervention, we sought to assess the group members for any clinically significant internalizing or externalizing symptoms, as well as current adaptive functioning. We believed that a thorough assessment would allow us to cater the group intervention to meet the group members' needs.

Traditionally, clients are administered structured assessments, like questionnaires with multiple-choice, likert, or true/false response formats that are normed on the appropriate population. However, there is a paucity of culturally relevant assessment measures available that would be applicable for the diverse refugee population our clinic serves. Moreover, researchers (e.g., Okawa, 2008) emphasize the importance of the clinical interview over questionnaires with highly structured response formats (e.g., multiple choice, true/false, or likert) due to psychometric concerns, such as scale equivalence, or the "cultural comparability of the scales" (Marsella, 2001, p. 281). Thus, given the difficulty in identifying psychological assessments appropriate for non-English-speaking clients, assessments that are free-response or narrative in format may be preferred (e.g., Esquivel, Oades-Sese, & Olitzky, 2008).

Following these recommendations, we adapted our traditional structured assessment methods to include semistructured, free-response, and narrative formats that asked clients to "tell us the story of their life." We also used assessment to focus the individuals on the present and future, and suggest that getting extensive details about prior trauma is only necessary to inform the current treatment, given that the group members received short-term preventative interventions that did not allow for thorough and indi-

visualized process and exposure work following trauma. We initially incorporated these additional assessment formats in our adolescent groups, and then applied them to all services with diverse refugee populations at our clinic. Moreover, we have begun to reconsider how to measure change over the course of treatment for refugee youth and families. In discussions of these cases, several therapists from our clinic reported that consistent attendance, low attrition, a strengthened bond between the client and therapist, more frequent in-session laughter, increased understanding of mental health treatment, and utilization of coping skills are better indicators of progress than traditional assessment methods. For example, a client reported that the therapist's discussion of mindfulness of the present was similar to an African proverb. Another client compared deep breathing techniques for stress reduction to massaging the temples to relax. Yet another client talked about accepting his family's experience during war and focusing on his dreams for the future, an anecdote we felt was consistent with an adaptive coping style we had modeled.

More in-depth research will help us determine whether these in-session behaviors generalize to out-of-session treatment gains. We also need to increase our knowledge of how traditional diagnostic methods, including behavior rating scales and clinical interviews such as structured interview modules used for assessment of PTSD or depression, can be utilized to inform treatment and measure change for the clients. Finally, we need to better understand how to measure the therapeutic relationship in situations where an interpreter is involved in order to determine further how the interpreter helps or hinders the therapeutic relationship.

Implications for Clinical Practice

As we reflect on the success of our initial experiences with a diverse refugee community, we anticipate more work on the horizon. The increasing presence of refugee populations in the United States requires psychologists to respond by designing and implementing appropriate clinical services for these groups. The development of such services will facilitate growth and use of an evidence-based practice model for refugee populations. Although research in culturally adapted treatments is expanding, there continues to be a paucity of literature on the effectiveness of evidence-based clinical treatments to guide this process. Indeed, a broad literature search using *PsycINFO* and the keywords "cognitive behavior therapy" and "refugee" yields 24 peer-reviewed hits compared to a search using only "cognitive behavior therapy" which yields 7,950 hits. The field's growth in this area rests upon embracing Sue's (2006) tenets of attention to multicultural *awareness, knowledge, and skill*.

Casas (2010) stated that it is essential for the American Psychological Association to revisit its *Resolution on Immigrant Children, Youth and Families* (American Psychological Association, 1998) in order to improve mental health resources for the immigrant population. Specifically, this resolution, published over 10 years ago, stated that the American Psychological Association:

- promotes and facilitates psychologists' acquisition of competencies, including relevant cultural knowledge, attitude, and skills in providing services to and conducting research on immigrant children, youth, and families;
- advocates and promotes efforts to increase the availability of and access to educational, health, mental health, and social ser-

vices for immigrant children, youth, and families (American Psychological Association, 1998, para. 11).

These principles embody the spirit of our work and the purpose of this paper. In particular, our own experience suggests that a strong academic–community partnership is a useful component that facilitates culturally competent service delivery, and thus the advent of an evidence-based practice model for refugee groups, particularly with regard to reducing barriers to treatment and promoting trust of mental health providers. Use of a tiered approach, which offers preventative, acculturation-focused services in combination with more intensive, trauma-focused treatment, also proved useful.

As described in this paper, providing culturally competent services is an ongoing process that often requires more work on the part of therapists and supervisors compared to traditional clinical services. However, it is our experience and belief that this work is rewarding and should be a central component of training and professional development. Our team spent significant time in developing cultural awareness and knowledge in order to provide effective therapy. However, our own personal growth was a significant byproduct of these experiences. For example, the school staff and students invited us to attend “Cultural Night” at the school (during which various groups presented ethnic songs and dances from their culture of origin) and treated us to a singing performance in Swahili by a group of African male refugees. Taking part in these events outside of our workday allowed us to have greater appreciation and understanding of the cultures around the world that help define the individuals who are now part of our local community. We believe that understanding one’s role in a community as a therapist and professional will contribute to professional growth.

A specific list of lessons learned would be too lengthy to generate; however, we offer these specific observations to guide others who seek to implement services for refugees.

1. Because of the numerous access barriers, therapists interested in assisting this population need to consider strategies for reducing barriers to accessing assessment and treatment services. In our community, establishing partnerships with a local school and marketing our clinical services through partnerships with refugee-serving agencies proved to be effective. Use of a tiered system of services allowed us to serve a broad range of clients and presenting problems, while providing more intensive services when necessary.

2. Consult with refugees in the community, agencies serving populations of refugees during the resettlement process, and other experts regarding the culture of origin to better understand the issues refugee clients may face upon arrival to America. Understand that migration does not affect all family members the same, and that often the youth fare better than adults due to the ability to attend American schools, which assists with the acculturation process.

3. Working with populations who have experienced trauma is difficult and sometimes painful for clinicians. Read about trauma in order to prepare for the content and challenges in working with refugees who have experienced trauma. Practitioners with specific experiences and training related to trauma and victimization may be uniquely prepared to expand their practice into working with refugees during resettlement into the United States.

4. Locating and working with mental health interpreters is necessary for offering services. Use pre- and postmeetings with interpreters to review issues that occur in session and use the interpreter to understand any cultural discrepancies that occur in treatment. In addition, working with mental health interpreters can involve financial expenses for practitioners or clients; however, mental health interpreters may be willing to offer reduced rates or work pro bono, given that they may have heightened awareness of the challenges refugees face, and thus, have personal interests in providing services to refugee populations. Developing a partnership with another agency working with refugees could be a win-win for the psychologist and other professional groups who share concerns for this population.

5. Prepare to adapt clinical measures to assess change in the clients. Asking open-ended questions of the clients, such as “What have you learned in this session?” or “How did the coping skills help you at home?,” may be useful in understanding the impact of treatment. Consider how existing measures (e.g., assessments of PTSD) can be supplemented by some other assessment techniques.

6. Explain the purpose and context of therapy to the clients, and assure them that help-seeking is one way to assist them with coping with the demands of their new life in America. Review carefully the rules of confidentiality and the limits of confidentiality, as many refugees are not aware of the services that psychologists can provide. It may also be helpful to agree on the role of the interpreter in the session and to discuss any guidelines you are obligated to follow as part of your ethical code and the rules of the clinical practice/agency.

Conclusion

Preparing professionally for working with refugee populations who have come to America is a pressing need in our mental health system. Refugee populations may experience common problems associated with adjustment to life in America and acculturative stress; however, they may also present for treatment with unique situations based upon a difficult history of migration to this country and problems in their home countries. Professionals with experiences in working with populations who experience trauma and who are interested in cultural and contextual influences on psychological adjustment would be uniquely suited to expand to practice serving refugees. A willingness to establish local community partnerships, to discuss the process of working with refugees, and to embrace the challenges associated with learning about cultural competence will facilitate greater awareness and skill, as described and emphasized in Sue’s tenets of multicultural practice. In sum, we plan to study further best practice approaches to assisting refugee youth and families who are coping with grief and loss along with strategies for working effectively with interpreters and refugees.

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