

The National Alliance for Multicultural Mental Health

A program of Immigration and Refugee Services of America



Lessons from the Field: *Issues and Resources in Refugee Mental Health*

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I. Introduction

Many refugees are models of successful adjustment and achievement. For others, the process of adjustment is long, difficult, and does not always end in success. Resettlement staff can overlook the psychological consequences of the refugee experience if they are not familiar with mental health issues in addition to the pressure to move new arrivals quickly toward self-sufficiency. Teachers and others who work with refugees are usually unaware of the traumas many refugees have experienced and how the consequences of these traumas may affect their ability to function well in a school or work environment. We can help refugees make a faster and smoother transition to life in the United States if we build on the refugees' strengths (including individual, family and community strengths), support their efforts to cope, and connect them with the resources they need. In some cases it may also be important to recognize the psychological problems that are a result of severe traumas and to make appropriate referrals.

The National Alliance for Multicultural Mental Health was founded in 1997 by Immigration and Refugee Services of America together with three leading refugee mental health agencies:

- Heartland Alliance for Human Needs and Human Rights, Chicago, IL
- Center for Multicultural Human Services, Falls Church, VA
- Center for Victims of Torture, Minneapolis, MN

The overall purpose of this collaboration has been to enhance the responsiveness of resettlement and mainstream providers to refugee mental health needs by providing technical assistance at the national level to a broad range of service providers and organizations. Alliance members provide on-site trainings and consultations on refugee mental health to organizations across the United States, are available for consultation by telephone and email, and have produced one to two regional training conferences per year. Each conference has drawn about 200 attendees from over 30 states, including Hawaii and Alaska. Conferences been held in St. Louis, Boston, San Francisco, Washington, DC, and Miami.

This on-line publication, *Lessons from the Field: Issues and Resources in Refugee Mental Health* is a work in progress. These articles represent some of the best practices of the professional staff of the Alliance member agencies. Each article is preceded by a short biographical statement on the author, and contact information is included in the agency descriptions at the end of this publication. The publication is intended to familiarize those working with refugees with issues of mental health and to offer the Alliance as a resource for information and consultation.

In 1999, the Alliance expanded to six agencies and IRSA, and has continued to provide on-site technical assistance, regional training conferences. The NAMMH will also produce an electronic information service twice yearly, focusing on best practices and information and resources in refugee mental health. Newest members are:

- Victims Services/*Solace*, New York City
- International Institute of Boston
- International Institute of New Jersey, Jersey City

Through our experience in this field, we have found that a diversity of approaches works best in addressing the adjustment and mental health needs of refugees. The Alliance provides a broad range of approaches, training, and experience and represents some of the best work in the field. We hope that you will continue to check our website www.refugeesusa.org for our newsletter and updates and will contact us for more information.

II. Mental Health and Well-Being

by

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Andrea V. Link, MSW, MA received her Master of Social Work from Catholic University in 1996 and her Master of Arts in Liberal Studies from Georgetown University in 1998. Ms. Link has extensive experience working for international refugee organizations. She worked as a grant/research Director for Southeast Asia for Refugees International. At the International Organization for Migration she was the Project Liaison Consultant for Afghan Programs in London, England and Senior Operations Assistant/Afghan Medical Program with the same organization in Washington, DC. Locally, she has advocated for child's rights in individual abuse/neglect cases through the Family Division of the District of Columbia Superior Court. Currently, she is the Associate Director for the Program for Survivors of Torture and Severe Trauma at the Center for Multicultural Human Services in Falls Church, VA.

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Outline

- A. Definition of Mental Health
- B. Mental Health in Cultural Perspective
- C. Dimensions of Health
- D. Finding a Path to Building a New Life and Sense of Well-Being

A. Definition of Mental Health

The World Health Organization has defined health as a state of complete physical, mental, and social well-being, rather than merely the absence of disease.

Mental health, then, refers to optimal well-being and should be viewed holistically, as an interaction between body, mind, and the social realm. The concept of mental health used in this manual is based on the WHO definition. This concept of holistic mental health consists of six components:

- Physical
- Social
- Psychological
- Vocational
- Intellectual
- Spiritual

The holistic model of health provides an especially effective model for the refugee population because it goes beyond physical or mental health to incorporate the clients' cultural and religious values. The word "holistic" derives from "holism," meaning that whole entities are greater than and different from the sum of their parts.

When applying concepts of mental health to refugees, field workers should remember the concept of mental health represents a cultural ideal. For example, in the United States, being assertive and open about what one wants is generally considered healthy, and an indication of high self-esteem. However, in other countries, such behavior may represent other less-desirable qualities, such as immaturity. The meanings of non-verbal communication, such as eye contact and personal space, differ widely across cultures. Behavior considered appropriate with members of the other sex, the elderly, or children may be quite different, depending upon the culture.

To increase cultural sensitivity:

1. Find out as much about the country of origin as possible. What are the political system and recent history and what experiences are refugees likely to have undergone?
2. Review cultural values, family structure, and appropriate behavior for members of this group and society.
3. Keep in mind that each refugee is an individual and may have quite different values and aspirations from other refugees from the same culture. What is her ideal of "successful adjustment"? What was most important to him in the past? What makes her feel good, whole? What are his goals for successful resettlement?

Some of the refugee's goals may need to be renegotiated according to the realities of life in this country. However, understanding what has created a sense of happiness and well-being for the refugee in

the past can provide an important starting point to rebuilding their life in the present. This approach will also help to build a trusting relationship with the refugee, and he or she will be more likely to be open about experiences and feelings.

The following sections describes each dimension or component of mental health or successful adjustment in greater detail.

*See the article on Three Cultures for examples of useful information for a field worker about Kurdish, Somali, and Bosnian refugees.

B. Dimensions of Health

The first step in helping newly arrived refugees adjust to their new country is to help them meet their basic needs. However, since our definition of mental health includes optimal well-being in several dimensions, meeting basic needs is not enough in itself to promote mental health. A healthy life encompasses many of the factors described below. The lengthy list may make resettlement workers feel as overwhelmed as the refugees themselves. Yet, by working with each refugee family to categorize and set priorities in meeting their needs (See Figure I), resettlement workers can feel more in control and be able to pass this sense of control on to the families with whom they work.

The holistic model of mental health with its six components provides a useful framework for resettlement workers to think about fostering mental health in refugees who have suffered multiple traumas. Initially, one component may take priority over another in an effort to meet basic needs. For example, it will be difficult for a person to think about diet and exercise to stay physically fit if he or she desperately needs a job to be able to feed the family. Also, the different cultural norms and values of the diverse populations served will naturally place an emphasis on certain components. For some refugees, relationships with the family and community will take priority, while for other refugee groups, a priority may be the spiritual life. However, it is necessary to ultimately address all the components in an effort to enhance a positive state of mind.

1. Physical State

This component primarily relates to the body. This includes meeting basic needs – adequate housing, food, and safety – as well as developing and maintaining physical health. In terms of the body and maintaining a good physical state, the three areas of focus: diet, exercise, and practicing good health habits while avoiding harmful ones.

a. Diet

Eating sensible amounts of nutritious foods provides many rewards, including: helping to prevent a variety of diseases, providing more energy; allowing for better weight control; and more control over cholesterol levels. The Food Guide Pyramid suggest guidelines regarding the number of servings per day from the five basic food groups: 1) bread, cereal, rice, and pasta; 2) vegetables; 3) fruits; 4) dairy (milk, yogurt, and cheese); and 5) meat, poultry, fish, dry beans, eggs, and nuts. The number of servings an individual needs from each of the five groups depends on age, gender, size, and level of activity. Teenagers, young adults, and pregnant or breast-feeding women will need additional servings from the milk, yogurt, and cheese group. For all individuals, fats, oils and sweets should be eaten sparingly.

Naturally, diverse refugee populations have diverse eating habits that may include or exclude particular foods. Some groups may be vegetarian, while others only eat certain types of meat, and still others may want only specific fruits and vegetables, or frequently eat sweets. It will be helpful if individuals can find foods in this country similar to the foods that they ate in their home countries. Resettlement workers should review that their clients' diets to confirm that within their cultural norms, varied food groups are included. In addition, refugee may not have consumed certain foods, as they were too expensive or unavailable in their homeland. Try to introduce foods in the various food groups for individuals to sample.

Often food will be donated through aid organizations which are not aware of special cultural dietary needs of the refugees. Because clients may not want to seem ungrateful or impolite, food may be stored away and not consumed. Sometimes disuse is a simple matter of not knowing what to do with boxed or canned foods labeled in English.

To support refugee clients in eating in a healthy manner, work with them to:

- Make lists of foods that are culturally acceptable and normally eaten
- Note what food groups are missing
- Discuss why the food groups are missing and add them if possible
- Try to find foods that are comparable to foods they know from their homeland
- Go over boxed and canned foods to provide explanations of the labels

Refugee children deserve special attention. If they attend school, they may eat their lunch, and possibly breakfast, there. It is important to review school menus, which are usually available every month, with the child and parent. If children do not recognize the food they get for lunch as food they usually eat, they may eat nothing at all and be hungry all day. This can have a direct effect on their level of concentration and productivity at school. Children may become accustomed to eating American food at school and refuse to eat anything else at home. In this case, it will be important to work with the mother or other primary caregiver and the child to find foods acceptable to both.

b. Exercise

Exercise plays a major role in maintaining good physical and mental health. Exercise provides many benefits, including:

- the heart pumps more efficiently, improving circulation
- lungs becomes better able to process oxygen,
- muscles stay toned
- endurance increases
- digestion and sleep improve
- stress reduces

An effective exercise regimen includes 20-60 minutes of exercise 3-5 times per week. If it is difficult to exercise regularly, at least 30 minutes of moderate activity, such as using stairs, shopping, and walking, should incorporated into the daily routine.

For refugee families, finding time to exercise may seem impossible with all the demands on their time. Furthermore, exercise may or may not have been a part of the daily routine in their homeland. If

not, refugee workers should introduce exercise in an appropriate manner. It is critical to frame exercise as something that will make them feel better in many ways.

For children, the question of exercise will be addressed in school. Helping adults find time to exercise may prove more difficult. Walking remains one of the best and easiest forms of exercise. Suggest that every person get out for a walk each day, whether it is a leisurely stroll or as part of another activity, such as going to work. Walking can also be a social activity that the family does together or with neighbors. In many cultures, soccer is very popular group activity for many cultures is soccer. If a field can be located, adult and children's games can take place on the weekends. Exercise should be a fun activity for the refugee. If refugees experience exercise as work, they will be quickly abandon it.

The most important point about exercise is that it be an activity that the refugees find to be fun. If exercise is seen as work, it will be discontinued.

PRACTICING GOOD HEALTH HABITS AND AVOIDING HARMFUL ONES

Harmful risk behaviors include smoking, overuse of alcohol, substance abuse, and unprotected sexual activity. It will be very important to know and understand the cultural norms of a refugee population before advising them on good and harmful behaviors. In Somalia, men chew *khat*, which is similar to chewing tobacco. While we may consider this a harmful habit, it constitutes an integral part of Somali culture. Refugee workers will need to be creative in addressing sensitive topics such as tobacco and alcohol use and sexuality.

2. Social State

The social state refers to the emotional and material support a person receives from other people. In contrast to social isolation, wherein an individual has little contact and support from others, social support contributes to a person's resilience. Studies show that social support lessens or eliminates the negative effects of stress and may give some protection against disease and premature death. In the refugee community, it is very important to understand the cultural barriers that may prevent one from receiving social support.

Among some ethnic minorities, disclosing needs to outsiders goes against their values and brings shame to the entire community. "It is better to die of hunger alone and not ask for help from strangers," declares one such proverb. Similarly, distrust and suspicion, typical of some cultures or political groups among the refugees, may hinder building links to the larger society. Refugees also may experience difficulty in making contact with the new society because of cultural and/or racial prejudice.

To help refugees understand the benefits of creating a wider network and a circle of social support:

- a) Help individuals to become less critical of the differences between themselves and others.
- b) Help individuals to engage in caring for others Who may need their help?
- c) Teach individuals, within their cultural context, how to ask others for help without feeling "one down."
- d) Provide opportunities for individuals to engage with others in cultural activities.
- e) Help individuals create a network of other people with similar interests and cultural background.

For a refugee, social isolation may negatively affect all the other areas of health and ultimately, may jeopardize efforts to move ahead. One way to help the refugees to move through social isolation is improving their economic condition through employment.

3. Vocational State

Poor economic conditions and related stresses can adversely affect a person's health. The National Wellness Coalition states that “90 percent of all physical and mental illnesses is a reflection of our economic, environmental and social conditions.”¹

Refugees may talk about their economic circumstances in several ways: not being able to find the job they used to do in their home country, working at a job with less status, or not being able to find a job at all. Some types of jobs that refugees frequently have put their physical health at risk. Individuals with high demand jobs, a low level of control, and little social support may be at a high risk for cardiovascular disease when compared to jobs with low demands, a high level of control, and adequate support from co-workers.

In dealing with refugees, one must distinguish between true medical illnesses and symptoms of life stresses, i.e., occupation. For example, in many non-western populations, psychological distress becomes reflected in bodily pain and discomfort. In many cultures, individuals should not complain about hardship related to work. However, it may be culturally acceptable to show symptoms of physical illness and visit the doctor, even when stress caused the illness.

In additions, stresses related to unemployment, underemployment, job dissatisfaction and economic hardship can result in depressive and/or anxiety disorders. The following groups are especially at risk for psychological disorders:

- a. Refugees who are overloaded with work and have very little material reward.
- b. Refugees who have lost their social status and have not been able to find employment compatible with their job in their home country.
- c. Refugees whose employment has been disrupted due to lay off or termination by employers.
- d. Refugees with fewer skills in coping with change and stress.
- e. Refugees with long-term gaps in their employment, which has resulted in an extreme financial imbalance

4. Psychological State

A person's physical and mental health interact to affect a person's functioning. In a study conducted by Keith McInnes of Harvard University, many refugees experienced physical and mental exhaustion, whereas only a small percentage exhibited symptoms of serious mental illness². A pyramid model showed the relatively large numbers of refugees who experience such exhaustion at its base, with decreasing levels of the population experiencing the following functional outcomes: basic income generation/subsistence functioning; social justice/revange; despair/hopelessness; family problems; vocational problem; and finally mental illness. Characteristics at the top of the pyramid involve a small percent of the population, but tend to receive the most attention.

Many refugees experience significant trauma in their home countries and during flight. The stressful events can continue even after being resettled in a foreign country far from the chaos of the homeland. How refugees respond to this trauma depends on a variety of factors, such as:

Psychological disorders commonly found in the refugee population will be discussed in detail in the section entitled “Common Mental Health Issues for Refugees.”

5. Intellectual State

Intellectual state refers to a person's pattern of thinking. For refugees who have suffered loss, life may be perceived as overwhelming and at times, unbearable. Refugees may have trouble breaking out of the patterns of wondering why difficult events happen. A refugee may have been so preoccupied by the events of the situation that it is only after arrival in the United States that there is time to think about why such events took place. Some refugees will not address such issues at all. It may be too painful to reach the conclusion that there is really no just answer as to why loved ones died or why one had to flee a homeland.

While emphasis should be put on the present and future, the past can never be overlooked. Most refugees need time to grieve. Severely traumatized refugees may need to be referred to a mental health professional. Every individual will need the support of family, friends, and resettlement workers. Resettlement workers can help a person slowly take steps towards established goals. Even small accomplishments should be noted and praised, because this can help raise self-esteem. As a person experiences progress through personal action, his or her mindset will reflect will undergo change.

6. Spiritual State

Spirituality has been defined in many ways. One definition states “the transcendent relationship between the person and a Higher Being, a quality that goes beyond a specific religious affiliation”.³ Another definition understands spirituality as “an innate capacity that exists in every human being. Psychologically healthy spirituality is not limited to any one set of doctrines or practices. From a psychological perspective, spirituality is a universal experience, not a universal theology.”⁴

People enrich their spiritual lives in different ways: through organized spiritual groups, or by engaging in activities that bring serenity, relaxation, and happiness. These activities may vary for different people. For example, a refugee from Kurdistan may enjoy nature and gain serenity from being in nature. Other refugees may feel relaxed by simply being silent. Each person's spiritual life reflects individual life experiences.

Spirituality can add have a sense of meaning to life. Spiritual individuals generally view life as purposeful and meaningful. They actively connect with others and their environment. They consider life as worthwhile, despite the problems they may face. For refugees, the stresses of life in exile may endanger such a connection. This may result in losing awareness of feelings and emotions. Even for refugees with strong spiritual life, the experience of being uprooted from their homeland may cause them to lose their sense of self. People with strong spiritual lives view problems as opportunities for learning and growth, but this inner belief may be challenged by exile.

Spirituality affects mental well-being; that is, people who are spiritually healthy often take responsibility for their own wellness. Since wellness does not occur all at once, workers should support the refugee community to reach out to its people to raise awareness about their own role in promoting wellness among themselves.

To help regain a sense of spirituality, encourage refugees to:

- a) Express their feelings and emotions to friends or write them down in their own languages
- b) Help others in their community who need help and care

- c) Get engaged in ritual ceremonies in their organized religious institutions or with a few people close to them
- d) Define the meaning of life and how they may anchor themselves to a higher power
- e) Pray, meditate, and contemplate on a daily basis
- f) Talk about their spiritual experiences
- g) Talk about their religious/spiritual history at the time of assessment to differentiate religious/spiritual problems from psychopathology
- h) Express feelings of guilt that are related to religious duties which were neglected during the process of fleeing their country
- i) Address their preferences for life goals and ways of life
- j) Express their spiritual values (note: be careful not to question these values as they may think you doubt their faith in a higher being)
- k) Take responsibility for their health and illness, even if they use their own healing systems

Spiritual well-being relates to other components of holistic health care, especially the social state. In the lives of refugees, an enriching social component not only facilitates the process of adjustment but also may provide opportunities for economic empowerment.

C. Finding a Path To Building a New Life and Sense of Well-Being

For the busy resettlement worker, the idea of addressing six different components in order to attain successful adjustment might seem overwhelming. Achieving results in all these areas is actually reaching optimal health. It takes time to reach goals; refugees and their caseworkers cannot expect to address all these components within the first few weeks. However, the worker, and eventually the refugee, should reference this framework, as a way to help organize how needs should be met. The following table can help case managers to organize the refugees' needs and the actions necessary to meet them.

The refugee experience can obviously be very stressful. The needs of displaced persons are many. Resettlement workers should take care not to get overwhelmed by these needs. Keep in mind that workers who take good care of themselves will be more grounded and productive in working with refugees and will serve as positive role models. For those refugees who appear to have acute stress or a mental illness, referrals to community health centers should be made immediately. **Not all the needs of refugees will be met by the worker alone.** But a worker can give refugees the gifts of empathy, understanding and patience. These will help a refugee make great strides toward building a new life, developing a positive state of mind, and reclaiming a sense of well-being.

Figure I

Component	Issues/Needs	Intervention	Priority
<i>Physical</i>	No permanent housing	Locate housing	1
	Bad cough	Make appointment at health center	1
<i>Social</i>	Isolated	Learn to take a bus to visit friends	2
<i>Psychological</i>	Many symptoms of stress	Assessment at mental health center	1
<i>Vocational</i>	Job	Do skills assessment Take to job interviews	2
<i>Intellectual</i>	Feels she doesn't accomplish much	Set achievable goals together	2
<i>Spiritual</i>	No mosque in area to attend	Find a community room to use, or, if acceptable, devise system where each person takes a turn having prayers at their home	2

A positive state of mind may seem unattainable for refugees who have endured:

- war
- dictatorship
- religious oppression
- losing loved ones
- rape
- torture
- physical harm
- starvation
- fleeing their homeland
- resettlement in another country

Successful adjustment and health depends on many different factors – some that individuals can control and others that they cannot. Traumatic events such as war, famine, and persecution, which turn

the lives of people upside down and turn their identity into that of a “refugee,” are events over which they have no control. Sometimes the effect of past events proves to be too much to bear.

Excess stress shows up in a variety of symptoms, such as:

- problems sleeping and eating
- headaches, and other somatic complaints
- anxiety
- feelings of sadness
- agitation
- fatigue
- feelings of worthlessness
- feelings of guilt and helplessness
- withdrawal and isolation
- anger and rebellious behaviors

Excess stress may also be seen in the social arena, in areas such as:

- housing
- transportation
- parenting issues
- social isolation or loneliness
- poverty
- lack of job skills or inability to find a job using one's skills
- conflict in cultural values
- change in gender roles
- lack of health care

Many of these factors can be brought under control. Locating a place to live, finding a job, being able to take a bus to visit a friend, are all attainable accomplishments. Each accomplished task provides evidence of progress, which can promote a positive state of mind. The resettlement worker’s primary responsibility lies in helping refugees feel that once again they can have some control over their lives. A good starting point to help individuals regain this control is to help them meet their basic needs –income, housing, employment, and learning English.

Those serving refugees should be mindful of the need to manage their own stress. The section “Self-care for the Caretaker” offers perspectives and strategies useful to the refugee worker to alleviate stress and manage secondary traumatization, as necessary.

¹ New Wellness Coalition

² Kenneth McInnes, Harvard study

³ Peterson, 1987

⁴ Walker, 1991

III. Refugee Adaptation in the Resettlement Process

by
Dennis Hunt, PhD

Dennis J. Hunt, PhD is a Licensed Clinical Psychologist who graduated from the George Washington University in 1988. For over 25 years, he has held numerous faculty positions at various local, national and international universities. From 1982 until 1992, Dr. Hunt directed several large multicultural foster care, adoption and counseling programs for Catholic Charities of Richmond, Virginia. One of those programs, the Center for Multicultural Human Services, separated from Catholic Charities to become the independent non-profit agency of the same name, a founding member of the National Alliance for Multicultural Mental Health, where he has been Executive Director since 1984. Dr. Hunt has published and given numerous presentations on refugees.

Overview

Refugees vary enormously in their ability to adjust to life in the United States. Some refugees move quickly to self-sufficiency, while others become dependent on the human service system for survival. Some refugee adults become entrepreneurs and flourish, while others turn to criminal activity. Some refugee children become valedictorians, while others become gang members.

To begin to understand why some refugees adjust better to their new lives than others, we must first recognize that there is as much diversity among refugees in ability, personality and other individual characteristics as there is among native-born Americans. Second, we must recognize that each individual is unique and that each individual's behavior is the result of many complex factors. This chapter provides information that may be helpful in understanding what factors contribute to the dynamics of refugee adjustment.

Outline

- A. The Phases of Refugee Adjustment
- B. Stressors Affecting Refugee Adjustment
- C. Factors Affecting the Impact of Stress
- D. The Connection Between Stressors, Psychological and Physical Problems, Behaviors, Outcome and Interventions
- E. The Advantages of Focusing Interventions on Underlying Physical and Psychological Problems
- F. Resources Needed for Successful Refugee Adjustment

A. The Phases of Refugee Adjustment

While refugees vary considerably in the time it takes them to adjust to life in the United States, most pass through four major phases: arrival; reality; then either negotiation followed by integration, or alienation followed by marginalization. Initially, most refugees feel elated that they have arrived in a place where they will be safe and have a chance to rebuild their lives. This elation is often accompanied by confusion and bewilderment over the many new cultural challenges they face daily. During this first phase, newly arrived refugees are filled with hope about their future.

During the second phase, refugees come face-to-face with the reality that building a new life in the United States will not be as easy as they may have thought. They realize that they will have to overcome many obstacles before they will have the life they have dreamed of. Frequently in this phase refugees begin to feel more intensely the impact of the traumas and losses they may have experienced. In this second phase refugees are most vulnerable and most in need of intensive and comprehensive support services. The course of resettlement may be determined by how well refugees fare during this critical time.

If support services are adequate, refugees are more likely to cope well and move to the negotiation phase during which they begin taking steps and changing attitudes that will prepare them for full cultural and psychological integration in phase four. When adequate support is not available to refugees in phase two, the stresses of their new lives combine with the consequences of past traumas to paralyze them in their move toward independence. These refugees enter a phase of alienation that is characterized by apathy, isolation, and other dysfunctional attitudes and behaviors that lead to marginalization in phase four. Marginalized refugees are likely to be unemployed, have serious

psychological, family, and legal problems, and have a very limited support network. It is very difficult to help refugees move toward healthy integration if they have drifted into the alienation or marginalization phase because of a lack of support earlier.

When considering the factor of time in country, it is important to be aware of several factors that influence the amount of time spent in each phase of adjustment:

1. the stability of life before becoming a refugee
2. the individual's personality structure
3. the level of trauma experienced
4. skills possessed
5. amount and quality of support and resources available after arrival.

The various phases of adjustment are characterized by the following.

Phase I: Arrival, characterized by:

- Excitement
- Relief
- Bewilderment
- Confusion
- Enthusiasm
- Sense of safety
- Fascination

Phase II: Reality, characterized by:

- Awareness of challenges
- Disappointment / Anger
- Fear / Sense of abandonment
- Feeling overwhelmed
- Preoccupation with losses
- Plagued with memories of traumatic events
- Confusion / Frustration

Individual personality, family stability, physical and psychological health, and degree of support -
- all of these influence which direction the person takes next, either into negotiation or into alienation.

Phase IIIa: Negotiation, characterized by:

- Initiative
- Action to move ahead (ESL, training, job)
- Development of support network
- Beginning to accept losses
- Beginning to heal from trauma
- Determination to succeed
- Defining new roles/identity

which leads to

Phase IVa: Integration, characterized by:

- Good psychological and social adjustment
- Self-sufficiency / Self confidence

- Well-defined roles and identity
- Sense of power and control
- Language competence
- Good social support system
- Well-functioning family/children

Or the refugee may take the other direction to

Phase IIIb: Alienation, characterized by:

- Withdrawal
- Isolation
- Despair/sadness
- Apathy
- Poor physical health
- Mental health problems
- Lamenting loss of old roles

which leads to

Phase IVb: Marginalization, characterized by:

- Dependence
- Unemployment
- Legal difficulties
- Lack of or negative roles
- Minimal social support system
- Family dysfunction/break-up
- Children who act out

B. Stressors Affecting Refugee Adjustment

In order for the worker to understand the refugees with whom they interact, it is helpful to understand the stressors which refugees may have encountered. In the course of their flight from their homeland it is likely that many refugees have experienced a combination of positive and negative experiences, witnessing both the best and the worst of human nature. Many may have observed bravery and heroic acts in efforts to save others, while also seeing examples of brutality and inhumanity. Therefore, it is important to maintain a perspective with each individual refugee that includes both the supportive/strengthening factors affecting that person as well as the stressors that have had an impact on that refugee.

Because stressors can create problems – physical, mental or emotional -- for the refugee, and because these stressors may be different than those familiar to the field worker, following are some possible stressors that refugees may encounter. It is important to remember that during each phase of flight, including post-arrival in the host country, refugees may encounter stressors. However, not every refugee will experience any or all of these stressors.

1. Refugee Stressors between Flight and Arrival in the Resettlement Country

Refugees may experience significant traumatic events in the various phases between their flight from their country and their arrival in this country.

Some of these possible stressors are:

a) Pre-flight

- Imprisonment
- Death or disappearance of family member
- Being forced to inflict pain or kill
- Malnutrition
- Exposure to toxins, chemical weapons, or disease; lack of medical care
- Loss of home and other personal property
- Loss of livelihood
- Repeated relocation
- Physical assault (beating, rape, torture)
- Fear of unexpected arrest; harassment by police or uniformed soldiers
- Living underground with a false identity

b) During flight and in processing

- Illness
- Robbery
- Physical Assault / Rape
- Witnessing others being beaten or killed
- Malnutrition
- Loss of contact with family members – whereabouts unknown
- Long waits in refugee camps
- Anxiety over the future
- Interviews and other pressure from resettlement countries to justify refugee status

c) After arrival in the United States

- Unmet expectations
- Language barriers
- Identity issues
- Role loss/ambiguity/reversal of roles (i.e., husband/wife, child/parent)
- Bad news from home
- Transportation limitations
- Discrimination/racial insults
- Values conflict
- Loss of economic status/joblessness/underemployment
- Loss of social status/social isolation
- Inadequate housing
- Neighborhood violence
- Legal status (uncertainty)
- Secondary migration/ family reunification
- Intergenerational conflicts
- Poor physical and mental health and lack of adequate treatment
- Loss of comforting and familiar sights and smells and sounds, that provided a sense of stability, security, predictability and control

2. Refugee Children

Refugee children may be particularly vulnerable because they lack the power to make many choices for themselves to affect their situations. However, children can also be the most resilient of refugee groups and can adapt to new situations more readily than older family members.

Following are stressors that can affect refugee children after arriving in the United States:

- Intergenerational value conflict
- Role reversal/ambiguity/child as interpreter for family
- Inadequate educational preparation/cognitive limitations
- Language barriers
- Bad news from home
- Peer pressure
- Residency in low income/high crime area
- Pressure to excel in school
- Exploitation/abuse
- Racial discrimination
- Family conflict/inadequate parental figures
- Family reunification
- Surrogate family issues
- Unpredictability of life events
- Rejection by family or sponsor
- Feelings of physical inadequacy

C. Factors Affecting the Impact of Stress

Research has given the following insights about the impact of stress¹:

1. Stress over a long time (chronic stress) has a more negative impact than a one-time stressful event.
2. Multiple stressors can have a cumulative impact that is greater than the impact of each one considered separately.
3. Characteristics of the individual (intelligence, personality, etc.) can diminish or strengthen the negative impact of a stressor.
4. The level of stability of the individual's family life before the onset of the stressor can diminish or strengthen the negative impact of a stressor.
5. Previous success in coping with a stressor can help an individual deal with a new stressor.
6. The presence of a support system can diminish the negative impact of a stressor.
7. In children, the impact of a stressor may be influenced by their level of cognitive and emotional development.

D. The Connection Between Stressors, Psychological/Physical/Behavioral Problems, and Intervention

Any single stressor or combination of them can result in a variety of consequences – physical, psychological and behavioral. Some people respond to stress by developing new coping skills and

adapting their behavior to difficult situations, in the process becoming better at coping and thus contributing to their adjustment.

Others may have less adaptive responses that result in further problems in their adjustment to life in their new country – problems such as unemployment, homelessness, family conflict, illness, social isolation, legal involvement, dependence on others and difficulty with acculturation. Listed below are some possible consequences of stressors, divided into psychological/physical consequences and behavioral consequences.

Possible psychological/physical consequences of refugee stressors:

- Brain injury and various forms of physical impairment
- Nightmares and other sleep difficulties; tiredness
- Obsessive-compulsive tendencies
- Flashbacks/intrusive thoughts of traumatic scenes
- Startle reaction/hypervigilance
- Panic attacks
- Anxiety over the future/generalized fear and anxiety
- Intense anxiety and fear at sight of police or sound of police sirens
- Fear of rejection or being assaulted
- Dissociation (a transitory disconnection from reality)
- Psychosis (severely impaired thinking)
- Reappearance of symptoms associated with previous traumas
- Frustration, or anger and difficulty controlling it
- Distrust/suspiciousness/paranoia
- Impaired immune system, vulnerability to physical illness
- Overwhelming sense of grief and loss /depression
- Disappointment over shattered expectations
- Emotional numbing (emotional shutdown)
- Emotional lability (emotions swing quickly between extremes)
- Low birth weight/at-risk infant children with developmental delays or disabilities
- Anemia, parasites
- Apathy/hopelessness /learned passivity/dependence/sense of helplessness
- Withdrawal
- Lack of motivation, lower aspirations
- Shattered sense of self/ identity or role confusion
- Role reversal (husband may become dependent on wife's income; parents may become dependent on acculturated children)
- Sense of disconnectedness, not belonging, alienation
- Low self-esteem, lack of self-confidence
- Feeling infantilized, disrespected, humiliated
- Process of identity formation in children interrupted
- Sleep and eating problems
- Incompatibility with new family members (step-parents, siblings, etc.)

Some possible behavioral consequences of refugee stressors include:

- Crying and angry outbursts
- Too tired to work

- Repetitive, non-goal directed behavior
- Difficulty in planning/setting goals/difficulty concentrating
- Resistance to change
- Difficulty parenting
- Self-mutilation and other self-destructive behaviors
- Domestic violence
- Frequent illness preventing participation in training/jobs/school
- Unwillingness to learn new job skills or accept employment below status of previous occupation
- Inability to handle challenges of daily life
- Sexual difficulties
- Lethargy, difficulty sustaining effort in work setting/difficulty sustaining relationships or jobs
- Withdrawal from family
- Difficulty engaging in activities that lead to self-sufficiency
- Difficulty planning and setting goals
- Reluctance to allow children to play outside
- Family conflict as a result of crowding
- Conflict with spouse and children who accept new ways or don't expect traditional power/hierarchy in family
- Reluctance to go out alone at night and to take night jobs
- Distrust of neighbors /self-isolation in own ethnic community
- Unwillingness to access police assistance when needed/repeated victimization by those who know of reluctance to engage police
- Running away or resisting police when stopped for minor violation
- Distrust of anyone connected with the government
- Resistance to new living conditions, dress, food and/or routines
- Hoarding behavior/stealing
- Excessive drinking
- Gambling to regain losses
- Inflexibility and over control to prevent further changes and losses
- Dropping out of ESL/use of children as interpreters
- Reluctance to begin new life until whereabouts of loved ones is known
- Lack of motivation to learn English, receive training, seek jobs, etc.
- Behaviors of children and adolescents:
 - Acting out behavior in school
 - Not paying attention in class
 - Learning and behavioral problems at home and at school
 - Lack of confidence in parent's ability to protect them
 - Withdrawal
 - Regressive behavior
 - Selective mutism
 - Stealing
 - Self-destructive behavior
- Affiliation with people outside family (gangs, boyfriends) in response to inability to reconnect with biological family
- Identification and affiliation with marginal elements in community or school environment for purposes of self-protection or of filling the identity void

For those refugees who experience some of the extreme stressors listed in the previous section, the physical, psychological and behavioral consequences affect how well these refugees adjust to their new lives in the United States. Interventions at the psychological, physical or behavioral level can help in diminishing the impact of refugee stressors and can ease the refugee's adjustment.

E. The Advantages of Focusing Interventions on Underlying Physical and Psychological Problems / Mitigating Factors That Affect a Person's Response to Stress

When trying to assess a person's response to stressors it is important to consider pre-flight factors. A stable family situation and certain personality characteristics may help diminish the impact of stressful events associated with the refugee experience. At the same time, a dysfunctional family and a history of emotional difficulties increases vulnerability to the effects of refugee stressors. A good psychosocial history and a clinical interview should provide information about these factors.

Next the caseworker needs to explore the refugee stressors along with the physical and psychological consequences. Refugee stressors, such as the death of a family member, rape, torture, or illness may have negative physical and psychological consequences, such as depression, distractibility, social withdrawal, poor sleep and appetite, a weak immune system, and frequent illnesses.

Then it is time to plan interventions to assist the refugee. Physical and psychological difficulties diminish with interventions such as psychotherapy, support groups, medication, food, and shelter. When interventions directly address the negative physical and psychological consequences of stress, the result can be positive changes such as improved mood, higher motivation, improved concentration, good health, high energy, and an increase in self-esteem. As a result positive behavioral changes can also occur -- changes such as participation in job training and ESL classes, and increased social involvement. Positive outcomes result in improvement in both physical and psychological status which, in turn, leads to more positive behaviors and outcomes.

There are limitations when an intervention is aimed only at the behavioral level. For example, when a refugee experiences negative physical and psychological consequences of stressors (i.e., depression, distractibility, social withdrawal, weak immune system, frequent illness, and/or poor sleep and appetite), and the intervention is aimed at negative behaviors, there is often little positive change. Examples of such behavioral interventions might include job training, placement and ESL classes that focus exclusively at the behavioral level and ignore underlying physical and psychological problems. Should the refugee fail to succeed in a job, training or ESL class, this could be discouraging and diminish further the refugee's psychological ability to cope with the past and current stressors. Negative outcomes such as unemployment continue when negative behaviors are not affected by interventions and this further undermines the refugee's self-confidence and motivation. Therefore, when seeking positive outcomes it is often helpful to address the underlying physical and psychological consequences of refugee stressors, as well as focusing on the behavioral consequences.

F. Resources Needed for Successful Refugee Adjustment

While most refugees adapt successfully to their new lives in the United States on their own, some may need extra support and services in order to do so effectively. The categories of services necessary for supporting the refugee in his or her attempt to adjust successfully are as follows:

1. Health Care, Nutrition and Hygienic Education to re-establish and maintain good physical health
2. Assistance with Basic Needs such as food, shelter, clothes, furniture, etc.

3. Psychotherapy to cope with past traumas and current stressors
4. Connections with Social/Religious Support Systems
5. Physical and Vocational Rehabilitation of physical impairment
6. Skills Training to achieve self-sufficiency (i.e., ESL, job skills, using public transportation, etc.)

To facilitate refugee adjustment the refugee's needs in multiple areas must be recognized and addressed. Failure to receive assistance in any one area of need can seriously undermine the effectiveness of assistance received in other areas. A comprehensive, integrated approach to working with refugees must be employed in order to help those in need to make a successful transition to their new lives in this country.

Possibly most important to the refugee's successful adjustment is their connection with the refugee community itself, with its traditional support systems, rituals, spiritual leaders and healers. Every effort should be made to assist the refugee with this connection to their group's community as well as to the wider community services necessary for successful adjustment.

¹ Dennis Hunt, 1987

IV. Potential Mental Health Issues for Refugees

by

Rebecca Mueller, PhD and Judy Okawa, PhD

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Outline

- A. Introduction
- B. Psychological Reactions to Loss and Trauma
- C. Factors Affecting the Severity of Symptoms
- D. Special Issues with Refugee Children

A. Introduction

Refugees come to this country from many different countries and as a result of many different situations. The moving process produces unique stressors for the refugee. Moreover, stress do not end after arrival. Refugees arrive with certain expectations about what life will be like here, but they may find things might not meet their expectations. They may not speak English; daily living might be much harder in their new environment, and they may have different values than the people around them.

Refugees may experience stressful events adjusting to life in the United States. At times, they may feel hopeless, nervous, helpless, or worried. They may sometimes have difficulty sleeping, experience nightmares, or feel depressed. Sometimes, these feelings become very serious and last for long periods. When this happens, refugees need professional help, but might not know what help is available, or how or where to find it.

Because people from different cultures respond to trauma in different ways, the manner in which they talk about their feelings also vary. In some cultures, people who feel unwell discuss their aches and pains. In others, they talk about feeling sad or irritable. Some individuals may express their feelings through family conflict or alcohol abuse.

Many refugees may experience stressful events in adjusting to life in the United States. At times, they may feel hopeless, nervous, helpless, or worried. They may sometimes have difficulty sleeping, experience nightmares, or feel depressed. Sometimes, these feelings become very serious and last a long time. When this happens, refugees need professional help, but might not know what help is available, or how or where to access it.

Refugees come to this country from many different countries and as a result of many different situations. People from different cultures respond to trauma in different ways, and the ways in which they talk about how their feeling also vary. In some cultures, people who feel unwell talk about many aches and pains. In others, they talk about feeling sad or irritable. In still others, their bad feelings come out in family conflict or alcohol abuse.

As you work with people from different countries, it will be helpful to learn from that group how their culture talks about unresolved responses to trauma. It is also important to know about the specific circumstances that led the group to leave their country. This will help you understand what to look for and what questions to ask.

B. Psychological Reactions to Loss and Trauma

The very definition of a refugee – one who is forced to flee one’s homeland due to threat of persecution – indicates that the majority of refugees experience loss of home, friends, family, and a familiar way of life. In addition, many refugees experience trauma, unexpected and extreme occurrences that threaten their own lives or those of others. Trauma usually involves a loss or a sudden change, such as having to leave one's country, being uprooted from one's culture, family and friends, the death or

disappearance of a loved one, a sudden change in financial circumstances or social rank, the breakup of a marriage, being in a natural disaster, (such as a hurricane, flood, earthquake or tornado), unemployment, starvation, and/or bodily assault (such as being raped, imprisonment or torture.)

Any one of these events may traumatize a person, and many refugees have experienced more than one of these traumatic events. People react to trauma in different ways. You may see some mild reactions and some severe reactions. Three frequent psychological reactions to trauma are depression, anxiety, and post-traumatic stress disorder (PTSD). In persons experiencing these reactions, you may encounter some or all of the responses described in this section. If the responses are severe, the person may have a mental or emotional disorder. The important thing to remember is that people with these disorders can get better with help.

Following is a brief description of each of the frequently encountered reactions to trauma.

1. Depression can be a problem for refugees.

For example, Hawa, a Somali woman, left her three small children in the refugee camp in the care of a teenage relative and came pregnant to the United States. She feels that she is dying now because her head, back, and shoulders ache, and she has no energy. She has no appetite and wants only to sleep. Hawa feels she can't cope with the needs of her one-year-old baby and admits to getting very angry with him. She thinks often about death, although she insists she would never kill herself because "it is a sin against Allah." Hawa suffers from depression.

Most people feel sadness or anxiety when bad things happen to them; many people say that they are depressed when they feel down, or low, or have a bad day. Real depression is characterized by a very deep sadness that lasts a long time.

The symptoms of depression include:

- Deep sadness
- Feeling hopeless
- Thinking about dying
- No interest in anything
- No energy
- Decreased sex drive
- Sleep problems
- Change in appetite/weight
- Body aches and pains
- Slowed body movements
- Problems concentrating
- Feelings of worthlessness, guilt

Most refugees experience some sadness over the losses of being uprooted. When someone becomes depressed, the person experiences a deep, persistent sense of sadness. The sad feelings last longer, at least two weeks and in some cases, years. Depression can be disabling: People with depression have a hard time working, studying, or enjoying anything. They lose interest in doing things they used to enjoy. If the person has always acted this way, it is not depression. A depressive reaction occurs when a person experiences significant a change in feelings or energy levels that prohibit enjoying the way of living as they had before.

Indicators of depression:

- The person cries easily, feels hopeless or discouraged, or is irritable.

- Some people talk about having many body aches and pains
- Along with the sad and hopeless feelings, people usually, but not always, lose interest in activities that they enjoyed in the past, like work, hobbies, or sex
- A depressed person can get through the day only with great effort

There may be other changes also:

- There may be a change in appetite, usually a decrease. People say they have to force themselves to eat or they eat all the time, even when not hungry. People may have lost or gained a lot of weight quickly.
- The person may have trouble with sleep. Sometimes the person will have trouble getting to sleep. Other times, she or he may fall asleep easily, then wake up and have trouble falling back to sleep. It is very common for people to wake up early and not go back to sleep. Sometimes people say they sleep too much.
- People may say they feel nervous, tense, or worried. They may also show their anxiety physically by pacing, picking or pulling at themselves or their clothing, or moving around in their chairs.
- People may say they feel exhausted or tired even though they do not do anything physical. Or the person's body itself may appear depressed and weighted down. The person may speak very slowly, or pause for long periods of time, or it may take a lot of energy for the person to move. The person may say it takes a long time to do simple tasks, like dressing or clearing the table. They may say small tasks require a lot of effort.
- Depressed people often blame themselves for things they cannot control or they feel they don't matter as people.
- Depressed people find it hard to think or make decisions. They may say they have memory troubles. You may notice the individual drifting or being easily distracted. They may say they can no longer study or do things that take thinking.
- Depressed people often think about death. They say they want to be dead. They say that everyone else would be better off if they were dead. It is important to determine if this is a passing thought, a wish, or a real plan.

Refer to section on Suicide for help in perceiving if someone is suicidal.

2. Many refugees can experience anxiety and related problems.

Refugees may occasionally worry, become nervous, and have concerns about getting used to their new country. They worry about finding housing, work, learning a new language, how they will survive, what will happen to their children. It is common to worry about these things sometimes. However, when someone worries about many things, or nearly always has nervous feelings, he or she may have an anxiety disorder. In an anxious reaction, the worry feeling remains very strong, refers to many things, and seems excessive, especially compared to other refugees. The worries continue even though problems have been solved. For example, the person worries even after he or she has housing, school arranged, language classes, and/or employment.

The symptoms of anxiety include:

- Sleep problems
- Intense worrying that interferes with enjoying life, working, thinking clearly, and sleeping
- Feeling very tired
- Tense muscles; stomach or back problems
- Feeling nervous
- Feeling afraid
- Feeling irritable

Anxiety is experienced in different ways:

- Some people talk about changes in their thinking. They say it is hard to do anything but worry. They feel afraid. They can't concentrate.
- Some people feel anxiety in their bodies. They clench their teeth, have very tight muscles, stomach troubles, or back problems.
- Some people talk about how they feel emotionally. They talk about fears or feeling edgy or nervous.
- Some people have other types of problems related to anxiety. They may experience panic attacks. A panic attack can be very short; it is very intense: The person may feel as if he or she is dying. People say they feel their heart beating fast, they sweat a lot, feel very frightened, and may breathe very quickly.
- Another type of anxiety is a phobia. People with phobias fear one specific thing, place, or situation, such as knives, dogs, small spaces. Somewhat related to this is a special kind of phobia, called agoraphobia, literally, "fear of the marketplace." Persons with agoraphobia fear leaving their homes or being in public places

Indicators of anxiety:

- The person worries a lot, about a lot of different things, most of the time.
- The person can't stop worrying and person can't control the worries.
- The person feels edgy, as if their nerves are on fire, or they can't sit still.
- The person may be very, very tired and/or weary. He or she feels tired even after a good night's sleep or after doing only easy work.
- Anxious people are sometimes crabby, easily angered or irritated.
- Sometimes there is tension in the body, especially in the shoulders, neck, back and face. There can be tenseness anywhere and the person might say their muscles are sore or tight.
- Anxious persons usually experience poor sleep, which may be talked about as trouble getting to sleep, staying asleep, light, or uneasy sleep.
- The worries and uncomfortable feelings get in the way of the person's ability to focus on work, conversations, social events, sleep or other activities.

3. Other refugees suffer post-traumatic stress disorder (PTSD)

Some refugees have seen or experienced life-threatening situations, such as imprisonment, torture, and death-threats. Refugees may have witnessed or heard about traumatic events including kidnappings, explosions, and bombings. Children may have seen bodies in the streets or had relatives disappear. Women may have been raped or heard about rapes. Some refugees may have lived in fear for prolonged periods. People have different reactions to traumatic events: Some may seem to be unable escape their memories of the events and have severe, intense fear which requires professional help.

Many of the signs of this reaction are similar to those of depressive or anxious reactions. There are two important differences in a PTSD reaction:

- a) the person saw, heard, or was in a very frightening and threatening event, perhaps to the extent of believing that they were about to be killed
- b) the person relives that event over and over, even though it may have happened long ago. In this case, the person is often taken over by reliving the event, which may happen while the person is awake or asleep. Sometimes when people have a terrible experience they think about it over and over. PTSD is different: the memories come frequently and not by choice. Sometimes, it is almost as though the people are actually in the event again. They may not know someone else is with them. They might

mistake others around them for their former prison guards or torturers. They might smell the smells of prison or bombs exploding. They might hear the noises they heard when the event occurred.

For example, when soldiers burst into his home in Somalia, 30-year-old Mohammed and his brothers fled through a window, leaving their father behind. Later, a laughing soldier forced a gun in Mohammed's mouth and threatened to kill him. He saw another soldier hack a man to death. Mohammed cannot get these images out of his mind. He cannot forgive himself for leaving his father alone to be murdered. Now sometimes he feels he must be going crazy. At times, he has the taste of blood in his mouth. He gets so explosively angry that he bashes his head against a wall to keep from hurting someone else. He does not care about anything anymore and thinks a lot about dying. He has lost his appetite and his interest in sex; he can't sleep, and he has constant muscle pain and headaches.

As a 16 year-old, Faduma, a 16 year-old was gang-raped by a ten soldiers, some of who were her neighbors. The soldiers repeatedly bashed Faduma's head against a wall. As Faduma had been circumcised, these rapes were excruciatingly painful. The soldiers forced her younger siblings to watch her experience. Now 22 and living in the United States, Faduma has no idea if any of her family members are still alive. She feels completely alone and vulnerable. She has nightmares, sleep problems, and constant headaches. She feels too depressed to speak or to move, has no interest in life, and longs to be with her family. She has almost daily flashbacks, where she feels she is actually experiencing the rapes and feels the physical pain. She is terrified of strange men and of being touched. She "spaces out" and can't concentrate long enough to learn English.

Mohammed and Faduma suffers from post-traumatic stress disorder. People with PTSD have many symptoms of anxiety and depression. With PTSD, the person also experiences memories that are as real as actually re-experiencing the trauma.

Symptoms of post-traumatic stress disorder include three major categories. The person:

- a) Relives the experience over and over or is very, very fearful when reminded of the event (Re-experiencing)
- b) Tries to avoid reminders of the event (i.e., avoids people, places or doing things that remind them of it (Avoidance)
- c) Sometimes can no longer feel or talk about love or other strong feelings (Numbing)

Specific examples of each type of symptom are listed below.

Re-experiencing Symptoms:

- Flashbacks (reliving a terrifying life event over and over as if it were actually happening)
- Nightmares
- Frequent intrusive thoughts about the trauma
- Physical symptoms as a culturally acceptable way to express stress (prominent in many cultures) – examples include: chills, sweats, palpitations, headaches, etc.

Avoidance and Numbing Symptoms:

- Avoiding anything that reminds the person of the event
- Loss of interest in significant activities they used to care about
- Having trouble getting close to people or feeling love
- Emotional numbing
- Sense of foreshortened future
- Difficulty trusting

Arousal Symptoms:

- Being on the alert for danger at all times, extremely watchful
- Feeling anxious
- Sleep disturbances (has trouble getting to sleep or staying asleep)
- Becoming angry easily
- Problems concentrating
- Getting frightened easily

Each of the above reactions to trauma -- depression, anxiety, PTSD -- has one thing that distinguishes it:

- With a depressive reaction, you look for sadness. When people have a depressive reaction, they are extremely sad. It can seem like even their bodies are sad.
- With an anxious reaction, you look for intense worry. When people have an anxious reaction, they are very, very worried, nervous and jumpy. It can seem like their bodies are tense or electrified.
- With a post-traumatic stress reaction, you look for memories that are like reliving the real and very traumatic event. When people have a PTSD reaction they believe they have come close to dying and they relive the event over and over. It can seem either like they are numb and removed or very tense .

C. Factors Affecting the Severity of Symptoms

The severity of these symptoms may not be the same in all refugees, because mitigating factors cause differences. Some of these factors include:

1. The significance of the event and its interpretation

For example, caseworkers with Kurdish refugees have found that more traditional Kurds may see tragic events as “God’s trial” and thus submit and withdraw emotionally, while other Kurds may view traumas as social injustice and something that must be confronted.

2. The meaning attached to the specific event

For some refugees, the massacre of civilians and the psychological impact on the survivors may mean more fuel for their struggle against tyranny. To others, such a traumatic event may signify destiny and punishment from God.

3. The availability of a support system

Often refugees come to the U.S. with their extended family members for support. However, for a single person who has lost his or her entire family and is left only with temporary public assistance, the traumatic events of the past and their psychological impact can be far more disabling.

4. Coping style and coping skills

Many refugees have experienced insecurity and instability in their own countries prior to their escape. Their coping skills were helpful in their own environment but not necessarily so in a different culture. Again, those who have their families with them are better able to cope.

5. Number and intensity of previous traumas

Some refugees have experienced multiple traumas prior to their escape (i.e., lack of a homeland, abuse in the countries where they lived, loss of family members, etc.). The stress from multiple traumas can be cumulative and can affect a person's ability to cope over time.

6. Religious practice

Faith, for many people, gives some meaning to suffering and hardship. For example, many Muslim refugees gain comfort from the teachings of Islam, particularly in a time of crisis.

Other factors affect the expression of symptoms as well as their severity. For example, in Kurdish culture there are cultural expectations that may affect the manifestation of symptoms:

- "Saving face/ public face" - requires acting with self-control in public (especially true for men)
- Expression of pain - a brave man never complains about pain
- Controlled temper - one does not lose one's temper in front of others
- Courage - one does not exhibit fear unless a situation is exceptional
- Dignity - sensitivity to maintaining dignity in relationships is a significant value
- Patience - impatience is a sign of immaturity
- "God's punishment, God's trial" - destiny: sometimes life events, including tragedies, may be interpreted as predetermined or commanded by God, in which case some Kurds may submit to the situation instead of trying to change it.

Service providers need to be aware that any of the above characteristics may prevent the refugee from being assertive about their health and wellness, showing their symptoms, or seeking help. In many cultures the expression of pain is not encouraged and the appearance of strength is preferred over weakness. Caseworkers need to be alert to symptoms that a refugee exhibits and to try to interpret these symptoms in the refugee's cultural context. This can be done best through the help of the refugees themselves, their families and community members.

D. Special Issues with Refugee Children

Refugee children are of particular concern because of their vulnerability. Many have been uprooted from the familiarity and relative security of their homes and may have experienced deprivation and/or life-threatening events. Most Somali refugee children endured considerable stress and deprivation and witnessed sights such as the death or rape of family members or friends.

Now these refugee children face new stresses in the U.S. including:

- Poverty
- Lack of knowledge of English
- Being placed in the grade that matches their age, regardless of their educational background. For example, many have been in refugee camps for several years and have had no formal education.
- Not having anyone to help with their homework
- Conflict with their parents, who do not want them to acquire American ways
- Experiencing prejudice from other racial groups
- Peer pressure

For example, Abdulahi was 8 months old when a bullet hit him while he was in his cradle in his home in Somalia. His mother carried him while walking for days to another country, but at one point she got so exhausted that she abandoned him for hours by the roadside. Now 7, Abdulahi fights with children at school. His attachment to his mother is disturbed; he screams at her and kicks her. He wants the toys

and nice homes his American classmates have. He has trouble making friends, and his teachers can't handle his anger.

Eleven-year-old Sahra was separated from her family when everyone in her village fled Somalia in a rush. Another woman let Sahra walk with her family to the next country. They nearly starved on the way. She was later reunited with her mother and several siblings and learned that her father and two brothers had been killed. In the refugee camp Sahra saw a wounded man on the ground begging for water. She watched a laughing soldier urinate in the man's mouth, shoot him in the head, then mutilate the man's genitalia. Now 16, Sahra has trouble getting close to people. She cannot concentrate in school, has many stomachaches, and doesn't trust authority figures. She suddenly becomes so angry that she can't control herself, and she strikes out at others. Sahra often doesn't remember what she did during these spells of anger. The teachers think she is a "bad kid" and probably hyperactive.

Many Somali children have problems similar to Abdulahi and Sahra. Not only have they suffered extreme events for the past several years of their lives, but they also live with parents and family members who are now reacting to the stresses of trying to survive in a strange new country. Day-to-day stresses -- such as having little money or facility in English, inadequate housing, or being unemployed -- can make psychological problems from the war much worse for all family members.

The symptoms of depression and post-traumatic stress reactions in children are generally similar to those of adults. However, there are some differences. Younger children may not have flashbacks, or the sense of reliving the trauma. But they may re-enact a traumatic experience in play (for example, a child may smash dolls together repeatedly). Other indicators of depression and post-traumatic stress in children include:

- Body pains, like headaches and stomachaches
- Restless, agitated behavior
- Decrease in play
- Frightening dreams
- Intense fear
- Avoidance of things that remind them of the terrifying event
- Get angry easily/act out
- Sleep problems, sleepwalking
- Sadness
- Problems concentrating
- "Spacey" behavior/withdrawn
- Problems trusting people
- Loss of bladder or bowel control
- Lack of confidence that their parents can protect them
- Loss of speech

These common mental health issues for refugees are important to keep in mind as caseworkers seek effective approaches for assisting refugees in their adjustment to life in a new homeland.

V. Working Effectively with Refugees

by

Shaila Menon, MS, Rebecca Mueller, PhD, Judy Okawa, PhD, and Sarah Shaoee, PhD

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Judy B. Okawa, PhD earned her PhD in Psychology from George Washington University in 1996, and is a licensed clinical psychologist who has worked extensively with adult and adolescent survivors of traumatic experiences. Dr. Okawa has been invited to present various papers, workshops and trainings on refugee, immigrant, and multi-cultural mental health. Currently, she is the Director of the Program for Survivors of Torture and Severe Trauma at CMHS and also the Director of Psychological Services. She coordinates a project for Vietnamese former political prisoners and their families; conducts trainings around the country and has appeared in the international media. Dr. Okawa also serves as a consultant to the Immigration and Naturalization Service, state and community agencies and school systems, and refugee resettlement workers throughout the US.

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Outline

- A. Establishing a Working Relationship
- B. General Guidelines for Identifying Mental Health Needs
- C. Assessing the Needs of Refugee Communities
- D. Referring Refugees for Mental Health Services
- E. Working with an Interpreter
- F. Outreach Strategies

Proud and private people who may have experienced major loss and change over a period of years will not necessarily trust outsiders with their fears, grief, and emotional needs. Depending upon the refugees' culture and political system, talking about such issues outside the family may seem inappropriate or even dangerous to them. So how do you reach out to people who have different world views? How do you help those who have experienced so much difficulty and change in their lives? How do you learn about the needs of a particular refugee community? How do you earn their trust?

As described in Chapter One, *The Refugee Experience*, the resettlement system provides initial assistance to refugees through local affiliates of voluntary agencies. If you are a staff member or volunteer directly involved with resettlement, then you are no doubt quite familiar with the basic services that are provided to refugees in the first 30 to 90 days following their arrival. These services include meeting the refugees at the airport, providing housing, basic furniture, initial food, orientation to the agency and local community, health screenings, enrollment of children in school, and referral to English classes and employment services. In addition, resettlement staff provide a case management function, monitoring refugees' adjustment and making referrals for special needs, including mental health services. Many resettlement agencies also provide a broad range of social services and other programs and—in some cases—may provide mental health services to refugees. Most staff, however, will be assessing refugee needs and referring them on to another agency, as necessary, for additional services.

You may also work for an agency that provides more specialized services to refugees, such as the Center for Multicultural Human Services (CMHS) in Falls Church, Virginia. CMHS is a community-based multi-cultural agency, focusing on providing a broad range of mental health services—from prevention to treatment—to refugees and immigrants. In this article, several CMHS staff members draw from their own experience to address the questions asked at the beginning of this section.

A. Establishing a Working Relationship

Attending to a refugee's immediate and concrete needs gives you the opportunity to begin to build trust. The following list provides some basic guidelines for prioritizing needs and increasing effectiveness when working with refugees, and should help you to develop a good working relationship:

1. Be sure to treat the refugees with warmth and courtesy, and especially remember to respect their dignity.
2. Find out the appropriate means of greeting men, women, and children in the refugee's culture.
3. Find out where the refugee can obtain food that is appropriate for his or her culture.
4. Arrange for an interpreter to accompany you.
5. Remember that many of the refugees may have been in the upper class in their country. It is likely that most lost everything but one another, their dignity, and their faith.
6. Locate a religious community appropriate to the refugee's faith. Alert them about the new arrivals. Ask for assistance and volunteers to help the refugees adjust. (If your community does not have an

appropriate religious community, you may need to search for groups meeting in one another's homes.)

7. Find inexpensive clothing or obtain donations from volunteers, churches, and other public service agencies. But don't be surprised or offended if the refugees are uncomfortable wearing used clothing. Remember that they have lost very much, that they may not have the custom of wearing other peoples clothing, and that it is a reminder of their poverty to have to do so in the U.S.
8. Explain how the local transportation system functions. It is best to demonstrate this in person (i.e., teach them how to take a bus).
9. Make a simple map of the main sites important to them.
10. Most important, connect the new arrivals with other members of their ethnic community.

You will spend time with the refugee family, helping them get settled, escorting them to appointments, and showing them around. This process will help you to get to know them and develop a sense of rapport with them. As months go by, they will begin to trust you and then they may begin to come to your office and ask what to do about their children, who, in their opinion, may be learning the new culture too quickly. They may mention having headaches, stomachaches, backaches, tension, and feelings of disempowerment, anger, and despair that overwhelm them. LISTEN. These are normal ways that stress is expressed in many cultures. It is most important to focus on the refugee's interpretation of these symptoms and to find out what the person thinks they need to do to relieve the symptoms. However, if the symptoms continue or worsen, then you should consider referral for additional assistance, either from an appropriate counselor, medical doctor or traditional healer.

In the process of listening to the refugees a trusting relationship will be deepened and the caseworker will gain a clearer idea of how best to assist the refugees in meeting their needs. For example, a Kurdish woman, a client of CMHS, was not using her food stamps even though the family needed food. She shared with the caseworker that it was humiliating for her to depend on food stamps and government assistance to feed her family. Kurds often feel ashamed to accept this assistance especially since many previously led a comfortable life, had secure and well-paying jobs, and had been well respected in their communities. Knowing that this is a very common feeling among refugees, the caseworker could share this information in order to normalize and support the woman's feelings while at the same time helping her to focus on alternative ways to solve the problem of getting food or to think about the aid. Unless the worker had listened to the refugee's perspective, the problem would most likely not have been addressed.

B. General Guidelines for Identifying Mental Health Needs

If you are concerned that the refugees you are working with are having serious adjustment difficulties, and may need more support than you can provide, then the following guidelines may help you. These suggestions are from the World Health Organization's, 1996 publication, *The Mental Health of Refugees* (pp.39-41):

1. Learn the names the culture uses for emotional distress and mental illness. Many cultures understand mental illness in a spiritual or religious context. Religious or traditional healers use certain terms for such conditions. You can learn these terms by asking people what they call their conditions. You can also ask religious or traditional healers or physicians from the cultural group.
2. List the common ways people talk about emotions. Keep a list of the different ways refugees make known that they are suffering. Have the list available so that you can add to it and refer to it as you talk with different people. Keep it with a copy of the questions this manual suggests.
3. Try to make a home visit in which you can see how the person lives and interacts with family members. Often the family knows about changes in the person's behavior or eating and sleeping patterns.

Family members can help you understand if the person has changed in important ways. They may also tell you things the person has left out or forgotten.

4. Use simple, straightforward terms that are easy to understand when asking refugees about a possible mental illness, for example, ask, "Are you hearing voices that other people cannot hear?"

5. At the beginning of your first meeting with someone you are concerned about, be sure to tell them that you will not tell anyone else anything they say to you; you also won't say anything about them without their permission. All aspects of the interview will be kept private. There is one exception to this. If you learn they plan to hurt themselves or others, you must take protective steps, even if that means breaking a confidence.

C. Assessing the Needs of Refugee Communities

When you are dealing with a new refugee population, it is especially important to learn as much as possible about them. Two effective ways to learn specific concerns of the refugee community are needs assessments and focus groups.

1. **Needs assessments** may involve speaking with leaders in the refugee community, as well as various professionals who offer services to these refugees, and often includes asking them to fill out a survey instrument. Through this assessment, participants give important information about the dominant needs of the particular refugee group and the barriers to obtaining services.
2. **Focus groups** are ideally formed of 10-15 people, usually community members, with the purpose of discussing and identifying their specific needs and concerns. For example, the Center for Multicultural Human Services (CMHS) conducted focus groups during an open house event, including food and drinks, for about 80 Kurdish people from the area. The main objective of the open house was to introduce the agency and its services and in turn to learn and assess the critical needs of the Kurdish community. During the meeting CMHS staff met with Kurdish men, women, and children separately in focus groups to identify specific needs and concerns for each group. These Kurds were very receptive to participating in these groups and expressed their concerns openly, appreciative of a place to air them. The meeting yielded valuable information about the challenges they faced and helped CMHS develop a customized program based on the concerns expressed by the community.

Some practical suggestions when assessing needs:

- Find out what is considered polite to serve at gatherings in the culture of that particular refugee group (e.g., in Somali culture it is polite to serve coffee or tea and food). This results in a positive, welcoming atmosphere and puts people at ease.
- Listen carefully. The refugees may not be listened to anywhere else. They are revealing critical information about their lives that will give you insight into how to work effectively with them.
- Consider inviting a mental health professional to join the group to describe the normal emotions experienced during the cultural adjustment period, as well as normal reactions to loss and trauma. This professional can also provide information to the group concerning extreme reactions that may require additional support, and sources in the community for this type of support.

CMHS learned the following about gaining access to a refugee community:

- To work successfully with any refugee community, it is important to have on staff someone who can act as a liaison with that community. This individual must speak the refugees' language and be sensitive to the needs of that particular group. If such a person is not available, develop a working relationship with a leader in the refugee community who can accompany you to meetings and introduce you to the community.
- Take the time to develop rapport and trust with the community
- Visit the homes of refugees often. Lack of transportation may limit their mobility and visibility in the community. Making home visits and assessing the families' needs where they live is important to understanding their situation, as well as for developing trust.

D. Referring Refugees for Mental Health Services

1. Referrals

Refugees with extreme depression, anxiety, and post-traumatic stress reactions may be successfully treated by mental health professionals. Complementary sources are alternative health practitioners and traditional healers from the refugee community. Consider referring a refugee for help:

- When the person admits to thinking a lot about dying
- When the person appears so severely depressed that he cannot function well at home, school, or work
- When the person's worry is so intense that she has trouble functioning day to day
- When the person shows signs of reliving terrifying experiences or suffers from nightmares

2. In order to make an effective referral the worker needs to be aware of several cultural barriers that may affect successful referral to mental health services:

- a) **Stigma** – Stigma concerning mental health is even greater in most other cultures than it is in the United States. An example from Kurdish culture is that Kurdish men are expected to be strong and brave. Going to see a mental health professional is likely to be interpreted as a sign of being “crazy” or weak and cause for great shame.
- b) **Distrust of agencies** – Many cultures do not easily trust members of other cultures (e.g., Kurds do not easily trust non-Kurds, and often see the world as being split between the "Kurds and their friends" and "the enemy"). In order to help a person it is very important that they trust the caseworker first as a person and not as the representative of an agency. Often refugees learn quickly that in this country they need help that can only be provided through non-family establishments.
- c) **Distrust of the mental health profession** – Because mental health providers are not familiar to many cultures they are often portrayed as people who are themselves "crazy." In addition, in some countries, mental health professionals were part of the system used to control and oppress political dissidents. Depending on the culture, male therapists may be viewed with more suspicion than female therapists or female therapists may not have the power in that culture to be effective. It is important to understand the cultural factors that may affect this aspect of the referral.

- d) **Fear of breaching confidentiality** - This aspect is common among most ethnic refugee groups and is one reason that some people do not seek help from the professionals in their own community.

3. To keep in mind

Keep in mind that it may be more effective to refer the refugee to a medical doctor for a psychological or emotional problem than to a therapist. For example, Kurds respect medical doctors and will respond better if their visit to a professional is for a "check up" rather than, for example, for "psychiatric evaluation."

4. Special cases

A special note for cases in which one has to give difficult medical news: the patient is not necessarily the first or best person with whom to speak. In another example from Kurdish culture, it is often the oldest male (i.e., an uncle, grandfather, or even an old friend) who may be the spokesperson for the family and the one with whom to discuss a poor medical diagnosis. In some traditional cultures, the patient may not know that he or she is dying because it is believed that the patient may lose hope for recovery and hasten death. In the case of a health crisis or critical illness, it is better to give the bad news gradually and indirectly to the family's spokesperson and let that person decide the appropriate action.

E. Working with an Interpreter

No doubt one of the most important factors in your ability to work effectively with refugees will be your interpreter. Since working through an interpreter can be very challenging; the following suggestions may be helpful:

1. Choose an interpreter who translates as accurately as possible what both parties are saying.
2. Train your interpreter. Explain that you want a detailed translation of what the refugee is saying, not just a one-sentence summary. This author once had an interpreter who did not want to offend and thus did not translate a refugee's angry complaints.
3. Educate your interpreter about confidentiality. Somalis, for example, have a strong oral tradition and they like to gossip (just like most people). It is critical that they understand that the interpreter will keep their comments private. It helps to tell the refugee that the interpreter will lose her or his job if she or he breaks confidentiality.
4. Be aware that the age and gender of the interpreter may influence what the refugee is willing to tell you. For example, a woman who has been raped may have difficulty talking about her feelings or symptoms through a male interpreter. Because she was sexually assaulted, she may be afraid others will consider her to be unclean.
5. Ask your interpreter for cultural insight into what the refugee is saying or showing by body language. Be alert to the possibility that some refugees will be sensitive to the fact that your interpreter comes from a different clan. If the refugee cannot trust the interpreter, it may affect her or his ability to trust you, as well. An interpreter who is compassionate and highly respectful of the refugee's dignity is ideal.
6. Pay attention to how the interpreter interacts with the refugee so that you can be aware of potential issues or problems.

F. Outreach Strategies

Once you have assessed the primary concerns of the community, outreach strategies such as support groups and classes can be effective for addressing refugee needs:

1. Life Skills Group

This is an educational group that focuses on teaching skills necessary to function in American society. Some suggested topics include:

- How to use public transportation
- How to go to the drug store and buy over-the-counter medication
- How to look for a job (e.g., look for Help Wanted signs)
- How to write a résumé
- How to shop smart (e.g., look for sales and specials, buy store brands rather than brand names)
- How to apply for benefits
- How to enroll in ESL classes
- How to trace family members still in refugee camps
- How to understand the school system and the roles of teachers (e.g., Somalis have a difficult time understanding why teachers ask them to be more involved in school or ask their opinion on such subjects as which program they prefer for their child. In Somali culture, it is the teacher's responsibility to make all decisions, and parents never go to the schools).

2. Nutrition Class

Classes can cover how to cook nutritious and inexpensive meals for families. The goal is to encourage a nutritious diet to address a range of issues, from choosing foods wisely in this new country to addressing problems that may have resulted from the years of inadequate nutrition in refugee camps. At the same time, the women will get to know each other and can develop an informal support group.

3. Stress Management

Classes or groups can be organized around how to manage day-to-day stress by applying a holistic model. For example, at CMHS the refugee women learn to manage stress through Tai Chi, deep breathing, and relaxation exercises.

4. Women's Support Group

This support group can provide the following benefits:

- Allows women time for themselves outside the crowded atmosphere of their homes.
- Allows opportunities for sharing problems and processing experiences.
- Allows opportunities for sharing information, such as how to deal with social and community services and schools and practical knowledge, such as how to get a bus pass.
- Offers help reading and understanding letters received from social services or immigration.
- Offers educational information, such as how to get a GED, enter a local community college, access various community programs, and write a résumé.
- Offers opportunities to share problems they are having with children, who are rapidly acquiring American ways.
- Offers opportunities to learn how to discipline children in ways acceptable to the American culture. (For example, Somalis use physical discipline in rearing their children. It is critical to warn them that hitting a child is not acceptable in the U.S. and can get them in legal trouble.) Be

sure to offer alternative ideas for disciplining so that parents do not feel that their hands are tied and that they are not allowed to discipline their children at all.

5. Men's Support Group

This group can serve the same function as the women's group. Many refugee men are in need of a place to process their traumatic experiences and receive support to help them cope with current problems. Practical information such as how to write a résumé and how to handle job interviews can be very valuable.

6. English as a Second Language (ESL) Class

These classes serve the primary purpose of helping to prepare the refugee to function effectively in American society and the secondary purpose of providing an additional support group for the members. For instance, at CMHS, the Kurdish women are currently attending ESL classes conducted by a volunteer who had lived in Kurdistan. The classes have offered a great support system and a strong source of empowerment for the women. We have observed a dramatic change in the communication and interaction skills among them as a result.

7. Community Outreach Projects

Network with other community service providers who reach out to refugee families. Find out if there are issues that need attention and try to develop collaborative programs. Several examples of networking and collaboration are:

- a) The staff of CMHS conducted a seminar for local school personnel on Kurdish refugee culture and effective interventions when working with children.
- b) The State Representative from the Office of the State Refugee Coordinator conducted a seminar for refugees on immigration issues and current welfare reform efforts.
- c) Several refugees completed the basic computer classes offered at CMHS.
- d) The CMHS community outreach worker gathered donations for eye surgery for one of the refugee clients.
- e) A Conflict Resolution Project was developed by CMHS in a local middle school to address racial tension between Somali and Hispanic youths. The adolescents decided to plan a party and a basketball game, with mixed teams constituted of Hispanics and Somalis. Relationships between the two groups are reportedly much improved.

VI. Suicidality

by

Rebecca Mueller, PhD

Outline

- A. Factors Surrounding the Suicide Decision
- B. The Influence of Cultural Beliefs about Death and Suicide
- C. Indicators of Suicidality
- D. Identifying Someone Who is Suicidal
- E. What To Do If You Think Someone is Suicidal
- F. Questions to Ask If You Think Someone is Suicidal
- G. Resources

A. Factors Surrounding the Suicide Decision

Refugees have many emotional responses to the stresses and losses of leaving their countries. Their responses range from mild concern and upset to nervousness and deep sadness. In the previous articles, you learned what to look for if you think someone has a very serious emotional response to their situation. Sometimes, when people feel very depressed or nervous, they may think their only option is suicide.

In the United States, some 25,000 persons commit suicide each year, excluding deaths that look like accidents, but may be suicides. Individuals who wish to die may seek fights with others or drive their car into a bridge or tree. We do not know how many refugees commit suicide each year, but we do know that many aspects of being a refugee can contribute to suicidal thoughts.

1. Often, people who succeed in killing themselves:

- Have made previous suicide attempts
- Know family or friends who killed themselves
- Have practiced for suicide
- Are single
- Are very sad or very stressed
- Have a mental illness, such as depression
- Feel badly about themselves
- Feel very hopeless

2. Some types of people are more likely to commit suicide:

- a) people who need to control everything around them and who lose control (for example, those who lose their businesses, or countries, or families).
- b) people who are very dependent upon one particular person who dies or disappears (for example, a woman who depended on her husband for everything and then he dies).

3. There are also some factors that can prevent people from committing suicide.

One example is the person who thinks there is something they must live for (for example, for children, a spouse, or the hope that things will get better).

4. Not everyone who expresses suicidal sentiments really does want to die.

Though people say they wish they were dead, not everyone means it. Sometimes suicidal statements indicates an unwillingness to deal with problems. Sometimes though, the individuals do really mean it. Not everyone who is suicidal talks about it. Sometimes people do not say they wish they were dead, but rather act like they are thinking about dying. They give away possessions to loved ones. They tell people who they want to get their things after they are gone. They arrange for someone to look after their spouse, children, or property.

B. The Influence of Cultural Beliefs about Death and Suicide

Cultural beliefs about death can effect the suicide decision. Beliefs about death and suicide vary considerably from culture to culture. In some cultures, suicide is considered terrible, or an insult to God, while others view it as an honorable action. It is important to find out what the individual thinks about suicide and how her or his culture values life and death. The factors talked about in the previous section that may contribute to suicide may not be relevant for the people with whom you work. However, knowing the cultural background may help you if you think someone might want to take her or his life.

C. Indicators of Suicidality

Suicidality = Thoughts + Intention + Plan + Means

Usually, when people feel they want to kill themselves, the feeling does not last long. It can come and go or be present for awhile, then fade. Usually, the feeling of hopelessness that makes people feel like giving up ends, and later people may feel glad they did not act upon the suicidal feeling. Because most people do not really want to committ suicide, to get them help, so that they do not make a permanent mistake. When people say or act like they wish they were dead, or you suspect they do, you must evaluate the seriousness of their desire. This section explains the clues to look for to discern if someone is seriously thinking about suicide. In section VII of this chapter, there are suggestions about questions to ask to further assess the risk of suicide. Asking someone about suicide does not put the idea in their heads.

For people to take any action, they must first have the thought or idea to do it. People have many ideas that they do not want to act on. It is important to know if the person really wants to act on his or her idea. We call the desire to act, intention. If they have an idea and the desire to act on it, then they need to have a plan of what they will do.

A plan includes:

- when they will take action
- what they will do
- how they will do it
- what they will use

They also need to have the things they need to commit suicide, for example a gun, rope, pills, or car.

If you worry that someone you are working with may be suicidal, you want to find out what they are thinking about, if they really want to do it, if they have a plan and if they have the items needed to carry out the plan. You also want to find out if there is anything about the person's life or personality that

make him or her more likely to kill themselves. Sometimes someone who thinks about suicide but doesn't want to do it, will commit suicide because of other factors. Below are two stories that demonstrate why it is important to find out about other factors that might be involved.

For example, a man says that he wishes he was dead and knows how he would do it. He would drive his car into a tree. But he also says that he doesn't really want to do it. This man drinks heavily from time to time. One night after drinking a lot he drives his car into a tree and dies. When he was drinking, he had become depressed from the alcohol and the alcohol also made him more likely to act without thinking. He wasn't thinking as he normally did. He acted differently than he did when he was sober.

As another example, a woman who has children and is depressed says that sometimes she wishes she were dead, but that she doesn't really want to kill herself. She is Catholic and believes that it would be a mortal sin. She also worries about what would happen to her children if she died. Later she reveals that she sometimes hears a voice that says it is an angel of God and the voice tells her she must die, that there is a devil in her and if she dies the devil will be destroyed too. You learn from her sister that she recently asked the sister to look after her children if anything happens to her. You also learn that she gave her engagement ring to her oldest daughter.

These examples show that it is not enough to know if someone has the idea, intention and plan to kill themselves. In the first story, the man's use of alcohol contributed to his suicide, even though he said he didn't want to die. In the second story, the woman wanted to die, but said she would not do it, because it was a sin. But she also had a mental illness in which a voice was encouraging her to die and she was doing things that one does to prepare for death. If other things are involved, people can be more likely to kill themselves, even when they say they don't want to. That is why it is important to know if people have the idea, the desire and the plan to kill themselves AND to know if there are other factors involved.

D. Identifying Someone Who is Suicidal

If you believe someone may be thinking about taking his or her own life, there are things to look for and to ask. There are two main areas that you want to find out more about:

1. Does the person think about suicide, and does the person want to act on his or her thoughts about suicide?
2. Are there things about the person's life that make her or him more likely to act?

To discover the degree of an individual's risk of committing suicide, you need to find out how the person is thinking about it. Remember, for people to be suicidal, they must have thoughts or ideas about suicide, plus the desire or intention to commit suicide, plus a plan and the things needed to complete the plan.

You can find out about these things by talking to the person, talking to family members, and by observing the person's living conditions and living area. For example, you may see that the person has guns or pills or razor blades. If you suspect someone is suicidal, you will want to ask him or her questions to find out. You should also ask close family members questions, if that is possible. You want to find out if the family notices anything unusual about how the person is acting. They might notice things that the person will not tell you.

You also need to find out if there are things about the person that make him or her more likely to commit suicide, even if they do not seem actively to want to do it. You need to ask them questions about their lives and health. You want to find out if they have a mental illness, if they have a drinking or drug

problem, or if family members have killed themselves. You can also ask family members or friends about these things.

E. What To Do If You Think Someone is Suicidal

It is hard to be completely sure if someone is suicidal, unless they really want you to know. Some people do want you to know. They know they need help to stop themselves. Other people will try hard to keep it a secret, because they are very serious about killing themselves. You need to do the best job you can to find out, but if someone really does not want you to know, they can keep you from knowing.

In each of the following situations, you will take somewhat different action. Even people who are born in this country do not want to go to hospitals or ask for help. It is even more difficult for refugees. You may find that the person resists your suggestions. You try to get them the help they need until they feel better. Be sure that you or a family member go with the refugee to the referral agency or hospital. It would probably be best if you called the agency to make sure they can get in.

Remember: Once they are feeling better, most people are very glad they did not take their lives. You should take action if any of the following are present:

1. The person has the idea and the intention to commit suicide.

- a) Refer the individual to a community mental health center for professional help
- b) Ask family members to be with the individual at all times until a referral is completed. Family members sometimes do not believe the risk is real. It is important to educate them, so that they really monitor and spend time with the individual.
- c) If this resource does not exist, work with the family to develop a plan for ongoing support: frequent opportunities to talk about their feelings; plans to help solve the problems leading to the feelings of hopelessness; people to call when the person feels taken over by problems.

2. The person has the idea, the intention and a plan.

- a) Take the person to a local hospital emergency room.
- b) Stay with the person until she or he is admitted to the hospital or released.
- c) If the person is released, remove access to means of committing suicide. Go through the person's residence to remove dangerous implements, pills, etc.
- d) Make arrangements for someone to stay with the person at home.
- e) Help them connect with the community mental health agency for outpatient treatment.

3. The person has the idea and you believe other factors (for example, recent serious loss, mental illness, acting without thinking, or alcoholism) are present.

- a) You are just not sure, and are quite concerned. Suicide is serious. If you think someone is suicidal, but you aren't sure, it is better to do something about it than not.
- b) Follow the same procedures as outlined for #2.

F. Questions to Ask If You Think Someone is Suicidal

1. Thoughts, ideas, or intentions about suicide

- a) Do you ever wish you were dead? Do you think about killing yourself? How often? How intense are your thoughts? Do you plan to do it or do you only think about it?

- b) Are you thinking about suicide a lot lately?
- c) If you killed yourself, what do you think would happen? To your family? What about to you? What do you think happens after death?
- d) Are you the kind of person who acts quickly? Impulsively? Or, do you make plans?
- e) What would have to happen to make you go ahead and kill yourself? Is that likely? When would that happen?

2. Plans and means to commit suicide.

- a) Do you have an idea about how you would do it, if you kill yourself? (If the person says yes, ask more questions) What would you do? When would you do it?
- b) Ask the person if the means are available to them. For example, do you have a gun, or pills, or a car? Do you have a way of getting a gun or pills or razor blades?
- c) Do you think that a gun or pills or hanging would kill you?
- d) Sometimes, when people think about dying, they make plans for their belongings or make a will. Have you done any of those things?
- e) What do you think about death? Does it seem like a safe, comforting thing? Does death seem bad or scary?
- f) What does your religion believe about suicide? Do you agree?

3. Statistical Factors

The following statistical factors may indicate an increased likelihood of suicide. Refugee workers should look for these factors in someone suspected of being likely to kill him or herself.

Notice those things that fit the person you are worried about.

- a) Elderly people are more likely to kill themselves.
- b) Men are more likely to follow through successfully on a desire to die.
- c) Divorced and widowed people have a higher risk than married or single people.
- d) Women with responsibility for children have a lower risk of suicide.
- e) Find out what the person's cultural group thinks about suicide and if that makes the person more or less likely to kill himself or herself.

4. Personal Factors and History

Some people have personalities and life histories that make them more likely to kill themselves. For example, they have had a recent and painful personal or professional loss, or feelings of failure or embarrassment. Other factors include past suicide attempts, and/or family members who killed themselves, a history of mental illness or family history of mental illness, or mental illness combined with alcohol abuse.

To find out if someone has such a history, ask questions such as:

- a) Have you recently lost anyone or anything important to you? (You may already know that the person lost family members or a spouse or all possessions and homeland. If not, be sure to inquire.)
- b) Have you felt like a failure lately? Has anything happened that hurt your pride?
- c) Are you the kind of person who has to do everything right? When you don't do everything right, do you feel very bad about yourself? How are things going for you now?
- d) Have you known anyone who killed himself or herself? Anyone who tried to? What do you think about his/her death?

- e) Have you ever tried to kill yourself? Have you ever pretended to? Held a gun to your head or put a rope around your neck or thought about driving your car off the road into a tree?
- f) Before you came to this country, did you ever see a doctor or go to the hospital because you were very sad? Heard or saw things others did not hear or see? Sometimes had too much energy? Did you ever feel like that--sad, or too energetic, or hearing or seeing things--without seeing a doctor?
- g) Do you ever hear voices that tell you to do things? Do they ever tell you to hurt yourself? Kill yourself?
- h) Has anyone in your family had those problems or seen a doctor for them?
- i) When people drink, they often do things they wouldn't otherwise do. Observe or find out how much the person drinks. Ask: When you feel very upset or sad what do you do to feel better? Sometimes, when people are very sad or nervous, they drink to feel better? Do you ever do that? How often? Do you ever drink so much you can't remember what you did when you drank?
- j) Are you the kind of person who makes friends easily?

5. Feeling depressed and hopeless.

- a) Do you ever feel that you have no reason to live?
- b) Do you believe things will get better for you?
- c) Do you feel you can take care of things? Make things better?
- d) Do you think things will be better in the future?
- e) What do you think your life will be like a year from now? Five years from now?
- f) Do you feel good about yourself these days?

It is most important to remember that there are resources available to help people who are feeling suicidal – hospital emergency rooms, mental health centers, and other professionals. If you feel concerned about someone it is best to refer them for further evaluation and assistance. See the article on “Working Effectively with Refugees” for more ideas about the referral process.

VII. Healing the Community After Torture and Repression

by

Cheryl Robertson

Cheryl Robertson, MPH, RN comes from diverse training background, including nursing, public health, anthropology and international study. Her MPH thesis in 1988 was “An Evaluation of a Primary Health Care Worker Program in Kasangati, Uganda” and currently her doctoral dissertation in nursing is exploring “Patterns of Survival for Rural Mothers During the Bosnian War and the Post-War Period”. Recipient of several academic honors and human rights awards, Dr. Robertson has attended numerous conferences, seminars and trainings related to health and refugees. She was project director at the Center for Victims of Torture for several years, helping to launch the National Alliance for Multicultural Mental Health before leaving to complete her doctorate at the University of Minnesota in Minneapolis.

Overview

In the past fifteen years, the information available on the consequences of torture and repression on individuals and families has grown significantly. Increasingly, clinicians and researchers are understanding torture and repression as public health problems that profoundly affect the health of communities. Communities suffer symptoms related to the trauma of torture and repression similar to those suffered by individuals and families. Often, the legacy of repression continues in a community in resettlement. Refugee communities in resettlement may be permeated with the same fear, discordance, identity loss, and fragmented organization that survivors had hoped to leave at their home borders.

Outline

- A. The Strategic Purposes of Torture and Repression
- B. How Torture and Repression Affect the Health of Communities in the Home Country
- C. The Continuing Effects of Torture and Repression on the Health of Resettled Refugee Communities
- D. How Resettled Refugee Communities Begin Recovery
- E. Summary
- F. Resources

A. The Strategic Purposes of Torture and Repression

Torture and repression aim to destroy community. Johnson and Dross identify the strategic purposes of torture and repression:¹

- To eliminate particular leaders, usually from the grassroots--to prevent them from exercising their influence in the community;
- To create a climate of fear in those communities, to discourage political opposition and activism;
- To produce a culture of apathy in which small groups of powerful people and interests can wield enormous influence on the shape of society for generations to come.

Torture and repression destroy communities by breaking the bonds of solidarity between people and by filling that broken space with terror and distrust. These broken bonds are made visible to care providers who serve the refugee community. Part of healing individual survivors lies in rebuilding the injured community.

B. Torture and Repression and the Health of Communities in the Home Country

Interestingly, the more that is learned about the impact of torture and repression on the individual, the more torture and repression can be seen as intentional culture-transforming events. Clinical research indicates that not only do many survivors of political violence remain affected their entire lives, but also that their children and even grandchildren are often affected. When repression and atrocity are not addressed, they leave a legacy of fear that is highly manipulated by repressive forces that generate spirals of violence and repression in the future.²

Individuals are closely interrelated with their communities, from which they draw identity and a sense of belonging and meaning.³ Therefore, the imprisonment and torture of selected individuals can begin threatening community solidarity quickly, as control is established and helplessness engendered. If

the terror continues, discordance within the community takes hold, resulting in cultural change, social structures erosion,⁴ and stunted leadership and development capacity.⁵ Such repression can produce a damaged community that is disjointed, untrusting, non-supportive, withdrawn, isolated, and unproductive—essentially the same symptoms that can occur on the individual level.

Communities respond differently to repression, but most communities experience some similar broad effects.⁶ outline the general and fairly universal effects of repression in Guatemala:

Repression creates a climate of fear.

The purpose of repression and torture is to create a global fear of death—the overwhelming fear of individual, family and community alienation. Individuals are targeted for torture precisely because of the terrifying effect it has on the rest of the community. Sometimes communities respond with organized resistance, but more often, people feel they must leave to survive—either as displaced persons in a distant region of their country or as refugees.

Repression brings discordance to communities.

Fear gives rise to divisions and confrontation within families and ethnic groups, leading to mass displacement, loss of land, and increasing isolation for families and communities.

Repression leads to cultural changes.

Displacement of families and even entire communities leads to loss of cultural identity and sometimes efforts to hide identity. People adapt to the dominant culture in order to survive.

Repression limits organizational and development capacity.

The effect of repression and torture on community capacity to organize and develop is profound. By torturing and destroying the individual and by frightening the community, repressive elements seek to create a culture of apathy. The community is transformed into one in which citizens are afraid to become engaged in even the most basic of civic activities.⁷ Local leadership is stunted, only to be replaced by apathy, wherein people distrust their own capacities and see the situation as inevitable. Damaged communities offer limited hospitality to strangers; individuals seek anonymity, fearing being followed, persecuted, and losing their jobs. As individuals and families become more insular in their thinking, the possibilities of organization are increasingly limited. Few initiatives for community development emerge in this context.

C. Effects of Torture and Repression on the Health of Resettled Refugee Communities

To understand the effects of torture on resettlement communities, it helps to consider the ripple effect of torture and repression. The legacy of fear, discordance, loss of cultural identity, stolen leadership, and fragmented development follows refugees into resettlement—often recreated wherever new communities are developed. Resettled communities often honor a tacit silence. The perception is that to maintain the integrity of the community, the collective horror of the past must be ignored; to do otherwise, it seems, is to risk community disintegration. A silent pact is made to disregard the new community's history.

Consequently, resettled communities are often filled with repressed, but intense fear, anger, and guilt, resulting in continuing ethnic and religious factions. Since refugees usually have family and colleagues still in their home countries, they may have reason to feel fearful of word of their whereabouts traveling home. Sometimes the fears are exaggerated and sometimes they are not. An elderly refugee man, for example, may find himself living in a high-rise, next door to a man from the clan that tortured

him and murdered his family. Though the men never met in their home country, and though both are desperately lonely and isolated, their history and fears preclude a friendship.

Sometimes it appears that ethnic or religious divisions become even more pronounced among resettled refugees. The small size and isolation of new communities often cannot tolerate anonymity or neutrality; those who historically avoided political affiliation may now feel forced into making public choices. Receiving services at the neighborhood mutual assistance association, or even selecting a restaurant, may be tantamount to announcing party affiliation. The potential for emerging leadership, organization, and development continues to be thwarted by distrust and division.

D. How Resettled Refugee Communities Begin Recovery

Since trauma threatens the adaptability and general capacity of individuals, it makes sense that it also threatens the community's ability to foster resiliency and healing among survivors.⁸ Many communities--in the home country and resettled--disintegrate under and after repression, but many communities demonstrate amazing resiliency even without outside assistance. Much still needs to be learned about the factors that enhance such resiliency.

As with individuals, communities can develop strong mutual support, meaningful community structures, and the capacity to encourage recovery. The continuum of recovery potential depends on several factors, including prevailing attitudes and values about race and gender, the political and economic climate, and the accessibility of relevant care for survivors.⁹

Sometimes factors that support recovery have long been present; the community may have suffered other periods of repression, and remained relatively intact. People may have learned that they will not be abandoned and isolated during repression, but that they will be listened to and believed.

Communities are naturally resilient, but many communities need assistance to develop support systems, new meaning, and recovery. In resettlement communities, community-based education and assistance interventions need to target the entire refugee community as well as the larger society. Though most people using this manual will not be responsible for implementing such community-based strategies, they may have a key role in encouraging community participation in supportive programs.

1. Interventions for Recovery in the Refugee Community

Both new communities and the larger society have responsibility to create demand for treatment services for survivors. The presence of treatment can be a powerful symbol to the refugee community--symbolizing the power of healing, the community's commitment to the recovery of survivors, and the community's commitment to health in the larger society.¹⁰

Services for survivors should aim at recovering the lives, and therefore the leadership, of people targeted for repression. By restoring community leadership, some of the community's fear about the lasting effects of torture can be relieved. However, most recovery from repression generally happens outside of institutions, so it is important to consider mechanisms for community healing as well. Many aspects of community recovery happen naturally, without any specific planning. Nevertheless, if the community has been highly affected it is appropriate to consider planned interventions.¹¹

An open community discussion of emotional reactions to the trauma of repression is the first step toward attacking the tacit silence. People are often frightened by the symptoms related to trauma-- the

sleeplessness, anxiety, and overwhelming sadness. The distrust and fear in their community also frighten them. A public discussion can be a first step toward normalizing the personal and community-wide response to the trauma.

It is important for people to assign responsibility to the perpetrators of torture (e.g., death squads, governments, army, and secret services.) Assigning responsibility does not heal in itself, but it places the anger with the perpetrators, and diffuses the distrust among neighbors. It also helps to counter any prevailing attitudes that the past should simply be forgotten as people build new lives.

Community discussions need to acknowledge the grief, rage and shame present in the newly created community. Community leaders deserve education to understand the consequences of torture and repression and to assist people to get help. When leaders have information, they can participate in public information and education campaigns.

Cultural identity can be recreated and reconfirmed by bringing forth new cultural symbols or reinvigorating old ones. This might include demonstrations, rituals, memorials, and celebrations. New communities find themselves searching for new meanings and creating new values.¹²

2. Interventions in the Larger Community

Many in the larger community have no idea that individuals who have survived torture and repression live in their midst. Educators, employers and care providers need information about the effects of torture on family dynamics, work relationships, and school performance of children. They need to understand the deep isolation and loneliness of survivors, as well as the power and potential for recovery through basic social interventions that assist survivors to integrate into the fabric of their new community. Some examples of social intervention include: providing access to language learning; job training or retraining; basic income-generating projects; women's mutual support groups; and parenting groups, to name only a few.

Providing information to health care providers and future providers (students) about issues surrounding survivors of torture dramatically increases the number of professionals in the community who recognize the needs of survivors and who can provide appropriate care. Health care professionals are already seeing survivors of torture and repression in their daily practice, but they often do not know it. For example, it is common for survivors to visit one hospital after another to seek relief from symptoms related to trauma--anxiety, depression, and exhaustion. Emergency room staff is likely to have no experience in identifying survivors of torture, and therefore fail to address root causes.

The following is a common scenario: The patient comes in to the emergency room with vague symptoms of chronic pain, headaches, a history of sleeplessness, and a rapid pulse. The physician sees the patient, conducts the medical work-up, is unable to make a diagnosis, and sends the patient home with medication to calm him. The patient is mystified by what is happening to his body, so he visits another hospital with the same results, not knowing that he is having fairly universal symptoms related to trauma. The health care team is mystified as well; they may have seen several such refugee clients without knowing what they are seeing. The first step in healing comes when a care provider knows to ask the patient some basic questions about his experience back home.

The need to educate providers about caring for survivors of political violence invites comparison. For example, not long ago, women suffering from domestic abuse had few options in the health care system, because care providers were frightened by domestic violence and did not know how to address it. Today, however, many providers have been educated to ask the right questions and assist women to seek help and rebuild their lives. Similarly, persons who deal with refugee victims of violence, as well as other

professionals in the larger community--health care and social service providers, employers, educators, and religious leaders--need support and education to assist survivors of torture and repression to become productive and fully integrated community members.

E. Summary

Torture and repression are grave public mental health problems that profoundly affect the health of communities. Torture and repression aim to destroy community, leaving a legacy of fear, discord, cultural change, and stunted leadership and development capacity--a legacy that continues in resettled communities. However, the leadership stolen through repression can be restored. The recovery of individuals and communities is tightly interrelated; as the community develops the capacity to support survivors, individuals become strengthened; as individuals are strengthened, the community slowly heals. Both new communities and the larger society must come to support, expect, and even demand that strategies for healing individuals and communities be implemented.

¹ Johnson, D.& Dross, P. (1997) Toward a New Paradigm in Human Rights Thinking and Democracy –building Activities. Unpublished concept paper written for the Center for Victims of Torture, Minneapolis, MN

² Ibid

³ Harvey, M. (1996) An Ecological View of the Psychological Trauma and trauma Recovery. *Journal of traumatic Stress*. 9(1),3-23

⁴ Beristan, C. Valdeseda, M. &Paez, D. (1996) Coping with Fear and Loss at an Individual and Collective Level. In Perrren-Klingler, G. (Ed.) *Trauma: From Individual Helplessness to Group Resources*(p.43-68). Vienna:Paul Haupt Publishers.

⁵ Beristan, C. Valdeseda, M. &Paez, D. (1996) and Johnson, D.& Dross, P. (1997)

⁶ Level. In Perrren-Klingler, G. (Ed.) *Trauma: From Individual Helplessness to Group Resources*(p.43-68). Vienna:Paul Haupt Publishers.

⁷ Johnson, D.& Dross, P. (1997)

⁸ Harvey, M. (1996) An Ecological View of the Psychological Trauma and trauma Recovery. *Journal of traumatic Stress*. 9(1),3-23

⁹ Harvey, M. (1996)

¹⁰ Johnson, D.& Dross, P. (1997)

¹¹ Teter, H. (1996) “Mass Violence and Community Treatment” In Perren-Klinger, G. (Ed) *Trauma: From Individual Helplessness to Group Resources* (p.72-86). Vienna: Paul Haupt Publishers.

¹² Teter, H. (1996)

VII. Three Cultures: History, Culture and Refugee Experience

Whether you are a teacher, a law enforcement official, a hospital worker, a food stamp eligibility worker, a landlord, a clerk at a small grocery store, a bus driver, or a concerned neighbor, you may have daily contact with refugees. You may be engaged in resettling or serving refugees in your community, as a volunteer or as an employee of a voluntary agency or other organization. You are busy and you may have little spare time to keep up on current events unless they affect you directly. You may find that you are meeting refugees about whom you know very little.

In order to assist a given group you must seriously consider the cultural context of that group. The more you understand the traditions, values, and beliefs of a community, the better able you will be to establish a trusting, working relationship with that community and to help facilitate their move toward greater self-sufficiency.

Following are descriptions of three cultures of refugees that have arrived to the United States. Each section provides some history, culture, and descriptions of experiences that refugees from that geographical area may have in common. It is important to remember, however, that each refugee is an individual and may share these experiences and characteristics to a greater or lesser degree. Therefore, in addition to becoming familiar with the following information, we should remember to ask each refugee about their traditions and experiences, and to listen with care.

A. Somalia

by

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Filsan A. Darman, BS, originally from Somalia, graduated from Peking University in the Peoples Republic of China in February 1978. For six years she actively worked with the UNHCR in Mogadishu, Somalia, as a Program Assistant coordinating various education projects. Ms. Darman worked with Independent Consultancy Services as a consultant to increase awareness of the American public regarding the plight of the Somali Nation. In 1987 she founded and is the executive director of AADAMIGA, an NGO, which assists low-income women and their families through various development programs with the goal to mobilize women to become independent, self-sufficient and self-skilled. She currently works with Somali and other refugees at the Center for Multicultural Human Services (CMHS) in Falls Church, VA, providing extensive case management and therapeutic services. In addition to offering training and presentations on refugee issues, she also provides interpretation and translation services in French, Somali, Italian, and Chinese for human and social service agencies.

Eleni Getachew, MA, received her Masters of Arts in Counseling Psychology from Bowie State University, Bowie, MD. As an undergraduate in Psychology, Ms. Getachew was a volunteer companion at both the Mental Health Association and Saint Elizabeth's Hospital. Later, while completing her Masters, she presented an awareness workshop on sexual transmitted diseases for youths. Ms. Getachew continued her community involvement working as a health educator at Planned Parenthood of Metropolitan Washington. She currently is a bilingual interpreter (fluent in Amharic and French) and is completing her doctoral in psychology at the American School of Professional Psychology.

Judy B. Okawa, PhD earned her PhD in Psychology from George Washington University in 1996, and is a licensed clinical psychologist who has worked extensively with adult and adolescent survivors of traumatic experiences. Dr. Okawa has been invited to present various papers, workshops and trainings on refugee, immigrant, and multi-cultural mental health. Currently, she is the Director of the Program for Survivors of Torture and Severe Trauma at CMHS and also the Director of Psychological Services. She coordinates a project for Vietnamese former political prisoners and their families; conducts trainings around the country and has appeared in the international media. Dr. Okawa also serves as a consultant to the Immigration and Naturalization Service, state and community agencies and school systems, and refugee resettlement workers throughout the US.

Sailaja Menon, MS, has extensive experience in Program Development and coordination, teaching, cross-cultural training and psychotherapeutic services with the immigrant and refugee population. She has direct work experience in the community and in the field with new refugee and immigrant groups nationally and internationally. Before receiving a Post Masters Degree from Johns Hopkins University in Multicultural Counseling in 1995, Ms. Menon consulted with government officials in the Department of Health on Mental Health programs in Malaysia and provided psychotherapy to in-patient clients and conducted a support group for an alcohol detoxification unit in Egypt. With the Organization for Eelam Refugees Rehabilitation (OFFERR) she worked with Tamil refugees in camps in Chennai, India conducting a children's group and an adult's group in the camp. She is currently the Refugee Mental Health Program Coordinator at the Center for Multicultural Human Services (CMHS) in Falls Church, VA.

Azalech Teklemariam, MSW. Ms. Teklemariam has twenty years of experience in initiating, managing, organizing, consulting, planning and evaluating community based integrated human development projects and cross-cultural negotiation skills with public, private and community organizations nationally and internationally. After receiving her Master in Social Work from the University of Michigan, Ms. Teklemariam worked in Ethiopia as a Counseling Officer for Refugees with the United Nations High Commission for Refugees. She served as Project Manager for several social, cultural, environmental and developmental programs. She is currently a counselor at Center for Multicultural Human Services (CMHS) in Falls Church, VA, and is responsible for developing programs devoted to enhancing refugee family adjustment.

1. Map and Introduction

Since civil war broke out in Somalia in 1991, more than 450,000 Somalis have been forced to leave their homeland and many of those have suffered severely traumatizing experiences. Thousands of these Somali refugees have come to the United States, where they find that their difficulties are far from over. This section describes the Somali refugee population, its culture, experiences, strengths and needs. Our goal is to help refugee resettlement workers, teachers, school counselors, primary health care workers, mental health professionals, and social services providers work more effectively with the Somali people and guide them towards healthy self-sufficiency.

2. Brief History of Somalia

Somalia is situated in Eastern Africa where it forms the cap of the Horn of Africa. It is bordered by Kenya on the south, Ethiopia on the west, Djibouti on the northwest, the Gulf of Aden on the north, and the Indian Ocean on the east. Somalia, slightly smaller than Texas (638,000 square kilometers), has the longest coastline in Africa (3,300 kms) and has been an important route for trade between the Middle East and Africa. The population of Somalia is mostly rural. Nearly 80% of the people are farmers or raise camels, cattle, sheep and goats. Farmers grow corn, millet, rice, sugarcane, sorghum, beans, and citrus fruit, the staples of the Somali diet. Bananas are grown for export. Typically Somalia experiences two rainy seasons and two dry seasons per year, both hot.

In 1988 an armed revolt broke out against the regime of Somali President Siad Barre. People began departing Somalia as early as 1989. Clans became polarized and waged war against one another. By late 1991, Siad Barre was forced into exile; houses were being blasted by artillery; and neighbor fought against neighbor, friend against friend.

Before the civil war, the population was estimated to be around 7.7 million. It is believed that about 400,000 people died of famine or disease or were killed in the civil war and nearly 45% of the population was displaced inside Somalia or neighboring countries. The first Somali refugees who came to the U.S. tended to be wealthy and well-educated, used to living comfortable lives; they left behind fine houses, cars, and servants. Many of the Somalis who came later to the U.S. are from much more modest backgrounds.

3. An Overview of Somali Culture and Traditions

Language

Somalis speak the Somali language. However, since the north of Somalia was colonized by the British (until 1960) and the south was colonized by the Italians, some Somalis speak English and/or Italian, and some speak Arabic. A minority speak the Digil/Raxanweyn dialect. Prior to 1972, the Somali language had no written version; English and Italian served as the official languages in the government and in education. The Somali script is based on the Roman alphabet.

Religion

Somalis are Sunni Muslims. Islam is the principal faith and is vitally important to Somalis' sense of national identity. The holy book of Islam is the Koran, and Somalis are committed to following the word of Allah as revealed in the Koran. The importance of the Koran is seen in areas such as Somali dress (women are required to cover their bodies and their heads) and choice of foods (Muslims do not eat pork, which is strictly forbidden by the Koran). Many Somalis pray five times a day.

Social Structure

Somalis come from a complex and sophisticated culture. They belong to clans and subclans that in Somalia provide their members protection, political power, and help to gain critical access to water and good land. The two major clan divisions are the Samaale and the Sab. The majority of Somalis are Samaale, which includes four main clan families; Dir, Isaaq, Hawiye, and Darood. Each of these is further divided into subclans. The Samaale are primarily of nomadic origin. The Sab has two subclan families, the Digil and Raxanweyn, who are mostly farmers and herders. There is much intermarriage among clans; in such cases, children from the marriage are considered members of the father's clan.

Disputes between clans have traditionally been resolved through negotiation, following an ancient system. Each clan has elders, or chiefs, who meet when a dispute erupts. They sit together and discuss both sides of the dispute before agreeing on a solution considered just and respected by the clans involved. The solution is determined by a consideration of what is right according to the Koran, rather than by a constitutional or civil code. With the onset of civil war, this system of settling disputes has radically broken down in the past two decades. A power struggle among clan families has continued since 1991, with devastating effects. Although clan allegiances still hold importance for Somalis in the U.S., many acknowledge that they all need each other in this new country, and there are many examples of cooperation in this country. For example, in Minneapolis, Minnesota, one Somali organization strategically elected their board of directors to represent all clans and subclans in the area. This group has met with great success in working together for the benefit of all Somalis in the area.

Gender Roles and Families

In Somali families, men are the authority figures and the decision-makers. Women are responsible for the home and for raising the children, but it is also quite common for Somali women to work outside the home. Rural Somali women may be involved in agricultural work -- raising produce and livestock such as goats and camels—or in making milk, ghee, ropes and baskets for trading. Urban women may work in factories, trade at markets, and have small businesses. Many Somali women, especially the older generation, have had no formal education, as it was not considered proper for a good Muslim girl to go to school with boys.

The Somali family is the source of security and identity. The importance of family is reflected in the common Somali question, "Tol maa tahay?" (What is your lineage?). When Somalis meet, they ask, "Whom are you from?" rather than "Where are you from?" Genealogy is to Somalis what a birthplace is to Americans.

Elders are respected, women as well as men, among the Somalis. Children are highly respectful of their elders. The oldest man in the family makes the decisions: a grandfather, for example, may make decisions for his middle-aged son.

Somali families tend to be very large, with 5-10 children. The oldest son occupies an important place in the family. Female children are brought up to obey their older brothers. Especially in families where the father has been killed, the oldest remaining son is considered the head of the family and all cater to him.

Education

Children go to Koranic school at the age of five for religious education. After several years of study, depending on their parents and the area in which they live, they enter regular school. Technical schools offer a variety of training in different fields. English, Italian, and Arabic were the languages of education in the schools before 1973, when then-president Siad Barre changed it to Somali. However, the majority of universities in Mogadishu continue to use Italian and English.

Values

Somalis deeply value family. They believe in independence, democracy, and individualism. They also greatly value and respect strength, honor, loyalty, dignity, and pride. Somalis do not express their appreciation verbally, which sometimes leads Westerners to feel that their efforts are not appreciated.

Food

The typical Somali diet is low in calories but high in protein. Meat, beans, rice, bread, legumes, cereals, and spaghetti (baasto) are typical. All meat must be slaughtered in a particular way so that it is halaal (clean and pure). The diet of the rural Somalis consists primarily of milk, mutton, and rice with ghee, the oil from butter. City-dwelling Somalis are fond of spaghetti, a preference that developed in the early 20th century when Italy colonized southern Somalia.

Clothing

Clothing is quite diverse in Somalia. Most Somali women wear the traditional full-length dress called the guntiino. Men wear either Western clothing or the traditional hoosgunti (a cloth wrapped around the waist), a shirt, a shawl and a Somali cap (benadiri koofiya). Since it is considered shameful for women to show their hair, most girls cover their heads with a scarf at a young age and women usually wear head scarves rather than veils.

Festivities

Festivities in Somalia are associated with religious, social, or seasonal events. During Ramadan, a month devoted to God as a time of reconnecting spiritually with oneself and with Allah, Muslims fast for the 29-30 days of the month. At the end of Ramadan, they celebrate Id-al-fiter for three days. During this time people dress in new clothes and exchange gifts. Another religious festival is the Id-al-Adha, which comes three months after Ramadan and coincides with the Haj, or pilgrimage to Mecca on which all Muslims, if able, must go once in their lifetime. July 1st, the Independence Day of Somalia, is celebrated as a national holiday. There are a number of other festivities to mark events such as marriage, the fortieth day after the birth of a child, and special dances.

Somali Names

Somalis have three names--the first name, followed by the father's name, and then the grandfather's. Many names are similar and are derived from one pool of names, unlike American names, which are derived from separate pools for first and last names. Most Somali men and women are identified by descriptive nicknames, such as Gaal (foreigner), Madoobe (very black), and Dheere (tall).

Attitudes Toward Mental Health

Somalis have a unique way of expressing psychological problems, just as each culture differs from other cultural groups. Somalis tend to approach family members and speak to them when they experience problems such as severe sadness, loneliness, marital conflicts and concerns relating to children. It is important to remember that what we consider a mental health problem might not be perceived as such in the Somali culture. Psychotherapy does not exist in Somalia and psychological problems are not acknowledged openly. In Somali culture, a family member with serious mental illness is kept protected in the home. This can keep Somalis from getting help when they are suffering.

Somalis tend to say that everything is fine even when things are bad. A Somali may describe a problem and then deny how much it bothers him, saying, "But no problem!" Somalis, like other refugee groups, are more likely to talk about body pains (like headaches, stomach problems, muscle aches, heart palpitations, and tiredness) than mental pain. They may not admit to wishing they could die because suicide is a serious sin in the Islamic religion; they believe that a person who commits suicide will go to hell. Many Somalis believe that whatever happens to them is Allah's will, which they should not

question. However, if you ask questions tactfully and with empathy, Somali people will often tell you more about their problems. In spite of all they have been through, Somalis are basically a trusting, open, caring people.

4. The Somali Refugee Experience

During Somalia's civil war citizens turned against each other. People who opened their front door to a knock might be shot as their family members watched. Families fled in terror, becoming separated in flight, often permanently. Children witnessed sights such as a father or uncle being killed and their mother or sister being raped. Teenage girls were gang-raped and held captive for several years to be abused by soldiers.

Following are vignettes that portray the trauma experienced by some in this community:

One woman in Virginia tells of being at breakfast with her eight children in their beautiful Mogadishu beach house when, out of the blue, it was blown up. She regained consciousness in an enemy clan's hospital. She was able to escape from the hospital with three of her children by pretending to be a member of that clan. At one point soldiers dragged her behind a store and threatened to rape and murder her unless she gave them all her money. She described an arduous walk from Somalia to a refugee camp in Kenya, where she and the children remained for six years. She wept as she explained that she did not know what happened to her husband or her other five children

A young man in Virginia tells of his horror when his father opened the door and had his head blown off. This man and two brothers escaped out of windows. Several times he saw soldiers kill a man by pounding a nail through the top of his head. Once he saw a man walking towards him with half his face blown away and his skull exposed. He cannot get these images out of his mind. In weekly support groups run by a clinical psychologist at the Center for Multicultural Human Services in Falls Church, Virginia, he has learned the symptoms of clinical depression and post traumatic stress disorder (PTSD). As a result he has become aware that headaches, backaches, and stomachaches can represent the body's protest against too much shame, grief, rage, and loss.

A beautiful young Somali woman with downcast eyes described being at home with her family when gunmen stormed into her house, murdered her father and brother in front of her, and then gang-raped her and her mother. The soldiers kept her captive for four years, treating her as a slave, making her sleep on the kitchen floor, humiliating her, and raping her repeatedly. The trauma of this experience was overwhelming, especially because she had been circumcised, as is the Somali custom, to preserve her purity until marriage. The experience was excruciating physically and devastating in terms of her religion and culture. Now she is considered unclean, she explained, and no one will want her as a wife. Her tragic experiences are ever-present in her mind and she has constant nightmares of the rapes. She "spaces out" frequently, and relives her experiences while awake. Recently she screamed wildly for some minutes when a man touched her shoulder while she was shopping at a mall. His unanticipated voice and touch had served as a triggering incident for her; throwing her back into experiencing the gang-rape as if it were happening there and then.

Terrified by these and other experiences, many Somalis fled their country, later describing this flight as "a second hell." They walked for weeks to get to refugee camps in Ethiopia and Kenya, carrying babies and small children and suffering much physical hardship along the way. Many children starved to death, and parents were devastated by their own helplessness and inability to provide for them. Families were fragmented. Mothers had some of their children with them but had left others behind because they couldn't reach them during the confusion of the fighting.

The camps in Kenya were often referred to as “hell on earth” because of the torturous experiences refugees endured. Refugee camp life was very stressful and characterized by:

- Shortage of food, water and firewood
- Foods were often provided with no consideration of cultural or religious traditions (for example, pork which is forbidden according to Islamic religion)
- Frequent fires consumed everything they had and sometimes killed children, the elderly, and the handicapped
- Medical supplies and provisions to meet hygienic needs were in short supply
- Women and girls were often sexually and physically assaulted when they went in search of necessities such as food, water, and firewood
- Police were not trustworthy, and often misused their power (e.g., they raped women and robbed and killed people).
- Some refugees developed small trades or businesses to get cash by selling food items given to them by UNHCR and other relief agencies
- Children had no access to school during the years in the camps and many never learned to read or write

5. Problems Faced by the Somalis in the United States

The Somalis are one of the largest groups of new refugees to arrive in the United States in the last few years. Most Somali refugees currently arriving here come by way of refugee camps in Kenya and Ethiopia, after a time of being interned in in-country refugee camps. Large numbers of refugees also are being processed into the U.S. by the coordinated work of VOLAGS, the U.S. Government, and the United Nations High Commissioner for Refugees (UNHCR). The U.S. is one of several countries accepting large numbers of Somalis

After the terrors of war and the hardships of the refugee camps, the Somalis thought their lives would be returned to some degree of normalcy when they reached the United States. However, they often continue to face severe stressors, such as:

- Lack of knowledge of the English language
- Need for adequate and affordable housing (as many as ten people might live in a one-bedroom, roach- and rat-infested apartment)
- Problems with transportation
- Social isolation
- Lack of honor or status
- Worry about missing relatives
- Fear about children having problems in school
- Confusion over how to discipline children according to the American system
- Difficulty finding employment because of language barriers and lack of appropriate job skills
- Cultural insensitivity and discrimination due to their appearance, traditional clothing, and in some cases, religion
- Lack of health care coverage

An example shared by one Somali woman with a caseworker was that dodging bullets and bombs in Somalia seemed less stressful and more predictable than contending with harassing letters from social services, the schools, crowded conditions, trying to learn English, and the fear of being evicted.

B. The Kurdish People

by

Sara Brewer, Shaila Menon, Dr. Sarah Shoaee, and Chiman Zebari

Sara Brewer, MA, Ms. Brewer's dedication to human rights issues was expanded with the completion of her Master's of Arts in Social Sciences at Stockholm University in Sweden, where her attention turned to refugee and asylum issues. As an intern at UNHCR regional office in Stockholm, Sweden, she wrote the annual internal protection report on asylum issues in Sweden. At the US Committee for Refugees in Washington, DC she has written European country reports for the organization's annual publication *World Refugee Survey*. Ms. Brewer worked with refugees as a Caseworker/Teamleader at Ft. Dix, NJ. There she assisted in the start-up of Operation "Provide Refugee", the Joint Voluntary Agency refugee processing operation for Kosovars. She continued her work with IRSA as a Refugee Mental Health Program Assistant, responsible for the daily management of the Refugee Mental Health Program during the Senior Program Officer's leave of absence.

Sailaja Menon, MS, has extensive experience in Program Development and coordination, teaching, cross-cultural training and psychotherapeutic services with the immigrant and refugee population. She has direct work experience in the community and in the field with new refugee and immigrant groups nationally and internationally. Before receiving a Post Masters Degree from Johns Hopkins University in Multicultural Counseling in 1995, Ms. Menon consulted with government officials in the Department of Health on Mental Health programs in Malaysia and provided psychotherapy to in-patient clients and conducted a support group for an alcohol detoxification unit in Egypt. With the Organization for Eelam Refugees Rehabilitation (OFFERR) she worked with Tamil refugees in camps in Chennai, India conducting a children's group and an adult's group in the camp. She is currently the Refugee Mental Health Program Coordinator at the Center for Multicultural Human Services (CMHS) in Falls Church, VA.

R. Sarah Shoaee, PhD has a Ph.D in Public Policy and Educational Institutions from the University of Wisconsin-Madison. As the Research Director/Social Services Policy Analyst at the Youth Policy Institute, Dr. Shoaee researched, wrote, monitored legislation and published four magazines on issues related to children, youth and families. She has conducted numerous research studies concerning children and Iranians in Iran and the US. Dr. Shoaee has vast teaching and planning experience including coordinating a community-based health care project in Falls Church, VA with funding from W.K. Kellogg. She has published several scholarly works on minority women, children and stress. . Dr. Shoaee is fluent in Farsi and Dari and is currently a child and family counselor at CMHS in Falls Church, VA.

Chiman Zebari, BS earned her BS in Psychology in 1999 and has a strong computer and primary medical background. Fluent in Kurdish (Sorani and Kurmanji), Persian/Farsi and some Arabic, Ms. Zebari provides interpreting and translation services for refugees at the Center for Multicultural Human Services (CMHS) in Falls Church, VA. As a social worker and outreach counselor, she has also developed programs and conducted workshops.

1. Map and Introduction

Although the Kurds represent a distinct ethnic group, the region where they live, referred to as Kurdistan, has never been recognized as an independent state. Kurdistan encompasses land in Iraq, Iran, Syria, Turkey, and the former Soviet republics of Azerbaijan and Armenia. The majority of Kurds live in the mountainous region where the borders of Turkey, Iran, and Iraq converge.¹ As McDowall writes, Kurdistan lies along "...the geopolitical fault line between the three power centres of the Middle East (referring to Turkey, Iran and Iraq)."²

Today, there are an estimated 24 million to 27 million Kurds. Turkey has the largest Kurdish population with an estimated 13 million. Approximately 4.2 million Kurds live in Iraq, while about 5.7 million in Iran. Some 1 million live in Syria, while about 400,000 live in the former Soviet republics of Azerbaijan and Armenia.³ Several hundred thousand also live in Europe. The Kurds constitute the fourth largest ethnic group in the Middle East after the Arabs, Persians, and Turks.⁴

2. Brief History of the Kurds

World War I brought about the final end of Ottoman Empire which had encompassed Kurdistan for centuries. The territory of Kurdistan became divided among Turkey, Syria, Iraq, and Iran.

As a minority population in these countries, Kurds have often experienced forced assimilation programs, marginalization, discrimination, and persecution. In Turkey, Kurds were renamed "Mountain Turks," and were denied education in the Kurdish language. The Turkish authorities have forced mass evacuations of Kurds in an effort to disperse Kurdish populations. Kurds living in Iran suffered severe oppression during the Shah's regime, and many welcomed the 1979 Islamic revolution. While the new regime failed to address Kurdish political aspirations for autonomy, it has permitted a measure of cultural expression and publication.

Most Kurds resettling in the United States have arrived from Iraq, following the 1991 Gulf War. Under Saddam Hussein's leadership, Iraq has savagely oppressed the Kurds. To combat Kurdish rebels and thwart Iranian influence in Iraq, Hussein's regime began a campaign of mass deportations and executions during the 1980s. The authorities launched a series of brutal chemical attacks on Kurdish villages, killing thousands.

In August 1990, the Iraq invaded Kuwait. Once the allied coalition had decisively defeated the Iraqi army, Kurdish and Iraqi resistance forces rose up in revolt. Despite some initial success, the Kurdish forces were unable to withstand the Iraqi military. Some 1.5 million Kurds fled their homes, attempting to reach safety in Iran or Turkey. During the 1990's the United States began to resettle large numbers of Iraqi Kurds

3. Overview of Kurdish Culture

Language

The native language of most Kurds is Kurdish. The Kurdish language varies from region to region; there are two main dialects: Kurmanji (spoken by most Northern Kurds) and Sorani (spoken by most Southern Kurds).⁵ Most Kurds speak more than one language; generally, Kurds speak the predominant or official language of the larger culture (Turkish, Arabic etc.) as well as Kurdish.

The alphabet used to write Kurdish varies across Kurdistan. Kurds from Iraq and Iran use the Arabic alphabets, Kurds in Syria and Turkey use the Roman alphabet, and Kurds who live in the former Soviet Union use the Cyrillic alphabet.

Religion

The majority of Kurds, some 75%, are Muslim; however, some Kurds are Christian, Jewish, or Zoroastrian. While most Muslim Kurds are Sunni Muslims, a small percentage follow the Shiite branch of the religion.

Muslims worship in a mosque and they follow the teachings of the Koran. Observant Muslims pray five times a day, and on Fridays many attend services at a mosque. Muslims observe holidays such as Ramadan, Id Al-Fitir, and Id Al-Haj. The Islamic calendar runs 11 days shorter than the Western calendar and as a result, Islamic holidays vary year to year. During Ramadan, Muslims fast for a month, refraining from food, water, smoking, and sexual activity from sunrise to sunset.

Kurdish Society and Families

Kurds tend to have a tribal social structure. Because some Kurds are in conflict with the central governments of the countries in which they live, the tribe often serves as the principal source of authority in which Kurds place their trust and loyalty.⁶ The size and form of the tribe unit varies significantly across Kurdistan. Tribes usually share a common mythology of the past; McDowall explains “most Kurdish tribal groups have their own real or imaginary ancestry...”⁷ In addition, tribes may share a sense of territorial identity or belonging to a specific region. It is important to note that some Kurds, particularly those from urban areas, may not have a strong tribal connection.

Family relationships are very important in Kurdish culture. The Kurdish family structure is patriarchal, extended, and occasionally polygamous. Women marry young, and families tend to be large with several children.

Gender Roles

In traditional Kurdish households, the males generally make most decisions and have primary responsibility as provider for the family. Kurdish women are expected to be the caregivers of the household, taking care of the children and home. However, women also take part in the decision-making process of the family.

More traditional Kurdish women may wear head coverings in public. Urban Kurdish women are more likely to have pursued an education and/or career prior to marriage and often marry later than Kurdish women from rural areas.⁸

Education

Kurds value education and parents strongly encourage their children to go to school. Urban Kurds usually have had greater opportunities for higher education; many Kurds enjoyed professional careers prior to leaving their homes. Kurds who lived in rural areas generally have been less able to pursue education because of a lack of schools and finances.

Traditional Foods

Kurds primarily eat rice, wheat, vegetables, bread, yogurt, and cheese. Kurds eat meat if available, but devout Muslims prefer to eat meat butchered according to the Islamic law, called *Halal meat*. Muslim Kurds do not eat pork, nor do they drink alcohol or gamble, because the Islam forbids such activities. Kurds drink a lot of tea, and yogurt drinks such as *mast ave* and *dough*. They can generally find typical vegetables at the local grocery stores, but can only buy *Halal meat* at an Islamic butchery. Middle Eastern markets often stock common Kurdish spices, so resettled refugees should be able to find traditional spices.

Clothing

Kurds wear traditional clothes of bright colors around the house, and to parties and weddings. Kurdish women's clothes consist of a loose dress and pantaloon-style pants with either a long coat called

a *kurtak*, *kawe*, or *festan*, or a vest, called a *healak*, or a short jacket called a *qutik* or *salta*. Kurdish clothes and the styles in the urban areas are not as conservative as in the rural areas; urban women generally do not have to cover their bodies as much. Kurdish women in rural areas tend to dress like the Muslim Arab women, wearing the *ababa*, a black veil to cover the face.

Names

In naming a child, the father's name generally becomes the middle name while the grandfather's name becomes the last name. In certain instances, the tribal name becomes the last name. Kurdish women generally retain their maiden names after marriage.

Attitudes Toward Medical Treatment

Kurds are receptive to medical treatment, however, men and particularly, women may be uncomfortable undressing in front of doctors. A Kurdish woman usually prefers to be examined by a female physician while the Kurdish man will prefer to be examined by a male physician.

4. The Kurdish Refugee Experience

Many Kurdish refugees have faced traumatic experiences. In particular, Iraqi Kurds suffered government attacks on the villages and towns in Kurdistan. During some raids, men, women, and children were brutally massacred, some in their own homes. Many of these refugees experienced traumatic events which left them feeling powerlessness. Some examples include:

- Having to watch as family members were killed
- Witnessing other killings, beatings, or life-threatening events
- Being raped, beaten, humiliated and/or threatened with death
- Being victimized by military and law enforcement officers
- Being without food, drinking water and shelter
- Being ill with no access to a medical facility

Many Kurdish refugees experience some symptoms of stress, or even the more severe reactions of anxiety, depression, and trauma-related syndromes. For example, Jalal, a 34-year-old Kurdish civil engineer resettled in the U.S., has been unemployed for some time, and shows classic symptoms of depression. The only job he has been able to find was in sales at the local Kmart. One day at work, Jalal hurt his back and could no longer work. In a home visit by a caseworker, Jalal complained of pain in his back, neck, and shoulders. He also mentioned low energy especially in the mornings, being irritable with his children, and boredom with life. He expressed anger and helplessness over the job market, saying that he was not good for any job. "Death is better than living like this," he said. His wife reports that, in contrast to the past, he is no longer visits friends, and tends to isolate himself. Jalal's depression is manifested in psychosomatic pains, low energy, and the loss of self-worth.

Abdul, a 15-year-old Kurdish boy, represents a typical refugee child who suffer from severe anxiety. While performing reasonably well at home, at school he is extremely anxious, and at times experiences panic attacks. Teachers have referred him for counseling because of disruptive behavior in the classroom. He cannot concentrate, does not pay attention to class lessons, and talks incessantly. When the teacher gives instruction about class work, he gets up, and asks her to repeat the same instructions. Sometimes he reports a difficulty in breathing. He also visits the school clinic very often, complaining of headaches and stomachaches.

Kurdish children like Abdul may experience the following symptoms:

- Intense fear
- Anxiety

- Lack of attention
- Nightmares
- Distrust of the world
- Avoidance of anything that reminds them of the traumatic events of the past
- Sleep disorder or sleepwalking

Often the worst feeling for these children is the fear that their parents cannot protect them.

Attitudes Toward Mental Health

Persons from the Middle East tend to use the body as a metaphor to express their emotional pain and discomfort. Some feel that there is a stigma attached to mental health problems. Individuals may not receive the necessary care because family and friends may minimize or deny any problems.

Najva represents a typical Kurdish refugee. Najva lost many family members during the shooting, bombing, and massacre of the Kurds. Only 32, she looks much older. Najva complains about stomachaches, severe headaches, gynecological problems, and joint pain. A medical exam has failed to reveal any physical problems. Her physical pain might be a manifestation of any psychological distress. It should be noted, however, that not every pain is related to a person's emotions. It is very important that the client be referred for a complete medical exam to assure that there are no organic reasons for pain and discomfort.

Many Kurds have experienced fear and helplessness because of the traumas they faced in Kurdistan such as witnessing the injury or death of others, including loved ones. The feelings of shame and guilt for surviving and leaving their people back home may also intensify their symptoms of trauma, which include:

- Behavioral - hypervigilance
- Cognitive - shame, guilt, self-blame
- Psychological - anger, anxiety, depression, grief

See article on Common Mental Health Issues with Refugees for more detail.

¹ David McDowall's *A Modern History of the Kurds*, 1996: St. Martin's Press, pp.5

² Ibid p.7

³ These figures are taken from David McDowall's *A Modern History of the Kurds*, 1996: St. Martin's Press, pp.3-4

⁴ Kurdish Profile and Resettlement Issues prepared by the Institute for Cultural Partnerships

⁵ David McDowall pg. 9-10

⁶ "Kurdish Profile and Resettlement issues prepared by the Institute for Cultural Partnerships in collaboration with the Kurdish Human Rights Watch 1996

⁷ David McDowall's *A Modern History of the Kurds*, 1996: St. Martin's Press, p.13

⁸ Kurdish Profile and Resettlement Issues prepared by the Institute for Cultural Partnerships

C. Bosnia – Herzegovina

By

Mary Fabri, Psy.D. and Esad Boskailo, M.D.

Esad Boskailo, MD was a general practitioner in Bosnia-Herzegovina for over 10 years. After receiving his medical degree from the University of Sarajevo in Bosnia, he worked in general medicine and the emergency room of a local hospital. After the invasion of his country by the Serbian army in 1992 and the Croatian army in 1993, he was captured while working with a small team of medical professionals. After surviving the concentration camps he provided medical and mental health services with “Doctors without Borders” in a refugee camp for Bosnians in Croatia. He arrived in Chicago in 1994 as a refugee and a year later he began work as a mental health interpreter and counselor for Chicago Health Outreach, an affiliated partner of the Heartland Alliance for Human Needs & Human Rights. He provided psychological treatment and counseling to refugees from Bosnia who continue to flee from strife in their country. Currently, he is completing his psychiatry residency in Phoenix, AZ.

Mary Fabri, Psy.D., graduated from the Illinois School of Professional Psychology in Chicago, Illinois as a Clinical Psychologist trained in adult, adolescent, and child divisions of psychiatry. As a clinical psychology fellow in adolescent health psychology, she assessed and treated adolescents in school, community and hospital health clinics. In 1986 she entered private practice for three years treating individual adults. While working in the Child Psychiatry Division of Cook County Hospital, she developed a consultation-liaison service for the pediatric hematology-oncology division and provided long-term and brief therapy in Child Psychiatry Clinic. Dr. Fabri is currently Director of Refugee Mental Health Training at Heartland Alliance, a founding member of the National Alliance for Multicultural Mental Health. She is also a volunteer therapist for the Marjorie Kovler Center for Survivors of Torture.

1. Map and Introduction

Bosnia–Herzegovina is a country with a rich and complex history. It is a region that is a corridor between Western and Eastern Europe. Bosnians view themselves as Europeans and since World War II prospered with economic development that was shared by all people, even while under a communist regime. Centrally located within the former Yugoslavia, Bosnia is a multinational Republic where Bosnian Muslims (Islamized Slavs), Croat Catholics, and Serbian Orthodox have lived side by side as neighbors. In more recent history, intermarriages became commonplace, particularly in modern urban areas. Following are some descriptions of the complexities and richness of Bosnia.

2. A Brief History of Bosnia

Bosnia-Herzegovina was created in the 12th century and by the 14th century was a strong and independent South Slav state. It had its own Bosnian church that was part of a movement known as the Bosnian Heretics. The Ottoman rule began during the 15th century resulting in the conversion of many Bosnian Slavs to Islam. Although the Ottoman Empire tolerated different religions, religion was linked to social status. Communities formed their own leadership through their church hierarchies. The various communities lived side by side and shared neighborliness, *komsiluk*, developing rituals such as neighbors drinking coffee together and attending each other's celebrations.

Bosnia came under Austro-Hungarian rule during the 19th century at the same time that ethnic and national identities intensified for Bosnian Serbs (Orthodox), Bosnian Croats (Catholics), and Bosnian Muslims. However, Bosnians felt an attachment to their ethnically diverse regions and strong ties with their neighbors.

Modernization had a great impact on Bosnia-Herzegovina as it did in many countries. With modernization, migrations occurred; urbanization created new neighborhoods; and religion became less influential. The process of mixing resulted in shifts within social groups and upward mobility for some, but not all. Changes were seen most dramatically in the cities while many rural traditions and social structures remained intact in the countryside.

With the collapse of the Austro-Hungarian and Ottoman empires, power shifted at the end of World War I and the idea of a Yugoslav union surfaced. Some envisioned uniting three different parts as one single nation; others had the creation of a union of separate ethnic states as a goal. In 1918 the kingdom of Serbs, Croats, and Slovenes was born. In 1929 this kingdom was named Yugoslavia and was transformed into a Serb royal dictatorship. Many internal political crises occurred during this time. Peasant uprisings broke out in the countryside and workers' strikes took place in urban centers. National, regional and social problems weakened the internal structures of Yugoslavia and the country fell apart in 1941 with the invasion of the Axis armies in World War II.

During 1941-1945 the war in Yugoslavia, although a world war, was fraught with civil conflicts that resulted in interethnic massacres. More than one million deaths occurred within the Yugoslav population of approximately 16 million.

In 1945, a second Yugoslavia emerged after World War II under the single-party rule of Josip Tito who employed a combination of repression and concession. The Communist leaders formed a multiethnic leadership. A single Yugoslav citizenship was developed, but was distinguished from the different nationalities that existed. A strong centralized government dominated the country with all officials appointed from above. The Communist leaders turned their attention to the country's underdevelopment, people's basic needs and regional inequalities. Any social, political, or national

movements were viewed as subversive and repressed by centralized forces. Dealings with the world market in efforts to strengthen the Yugoslav economy resulted in a mixture of centralism and local control. This created a degree of openness to the outside that did not exist in other countries under Communist rule. This generated tensions as well as reforms. The first three decades under Tito's regime were generally a prosperous time with rising living standards for all peoples.

Along with the economic growth of Yugoslavia came the development of national debt that highlighted the inefficiency in the government systems. The prosperity continued during the 1970's but not without internal crises within the Communist party. In response, there was an increase in nationalism among the people that resulted in repression being intensified. With Tito's death in 1980, a huge national debt that existed was suddenly made public. Worker's strikes began to occur and the central government's policies were in direct conflict with the growing power of national republics that were determined by historic lines. The 1980's became a decade of crises with an attempt to recentralize the government. Economic decline, however, resulted in more developed regions being less willing to participate in a centralized government. By 1990, most regions were positioned for referendums and elections. The first elections occurred in Slovenia and Croatia, and just months later elections took place in Macedonia, Bosnia, Serbia, and Montenegro.

Bosnia as a part of Yugoslavia was a region of three peoples: Muslims, Serbs, and Croats. They had been living under Tito's Yugoslavia as three equal peoples. Bosnia as a republic envisioned itself as a multinational state. In March 1991, Franjo Tudjman, the elected president of Croatia, and Slobodan Milosevic, the elected president of Serbia, met to plan the partitioning of Bosnia between their two countries. Armed conflicts broke out in Croatia at this time resulting in deaths. By October of 1991 the conflict was spreading in Croatia. The majority of Bosnian people voted for sovereignty and in the spring of 1992 declared themselves as independent. The European Community and the United States recognized Bosnia as an independent country. The siege on Sarajevo began in April 1992. The war in Bosnia was about landed power and was fueled by incited nationalism. The victims of the war were the people of Bosnia. Today Bosnia is an independent nation that hosts a number of U.N. Peacekeepers to assist in protection from neighboring states and in establishing order during the transition to nationhood.

3. An Overview of Bosnian Culture and Traditions

Bosnia is a country with diverse regional differences. There are the flat farmlands of the north, the mountains of central Bosnia, and the rich riverbed lands of the south. By locating the six major urban areas of Bosnia, the different regions can easily be understood.

In the northeast of Bosnia is Tuzla and in the northwest is Bihac. Southeast of Bihac, but still in the western region is Banja Luka. Centrally located are two major cities, Zenica and Sarajevo. In the southern region is the city of Mostar.

Each of these cities has universities and urban centers for the surrounding areas. Major industries are also regionally located: Tuzla has chemicals and pharmaceuticals; Bihac has meat packing; Banja Luka has electronics; Zenica has the steel industry; Sarajevo has lumber mills and automobile plants; and Mostar has the aircraft industry. Many regions are also rich in precious metals and ores. In the central and western part of the country there are copper, aluminum, silver and gold mines.

Bosnians living in the cities and surrounding areas are employed in many different kinds of jobs. Most have completed high school and many have attended universities. There are professionals from business, legal, educational, and medical settings as well as managers and laborers. Both men and women are employed outside of the home. Life before the war was very busy and very satisfying for most Bosnians.

Moving beyond the urban and surrounding areas, there are smaller agrarian communities. Climate and terrain determine the crops that are grown. In northern Bosnia there are flatlands where corn and wheat are the primary crops. In the valleys of the central mountain range, potatoes are grown. In the southern part of Bosnia, in Herzegovina, fruit orchards are plentiful and a variety of vegetables are grown. Cows, sheep, and goats are herded in the rural areas of Bosnia providing a source of important milk products such as cheese, yogurt, and kefir. Many people from the rural areas may stop attending school after the 8th grade to help with the work on family run farms. Others may go on to high school and learn a trade to enhance the income of the farm. This is in contrast to the older generation of Bosnians who were school aged at the end of World War II and did not have the opportunity to attend school at all. These older Bosnians from the rural areas may be illiterate as a result of the post World War II conditions. The increase in educational levels from older Bosnians to the younger generation is a good example of the economic growth of the country, especially during the 1970's and 1980's.

Certain aspects of a socialist government remained after Tito's death. Bosnians continued to have access to employment, housing, education, and health care. Holidays to the Adriatic Sea coast and the central mountain region were commonly enjoyed. Both rural and urban Bosnians describe their quality of life before the war as good.

Society and Families

Family and Social Life

Across the regions of Bosnia from the urban centers to the remote rural areas, family is the most important social structure. It is very common for adult children to live with their parents, for multiple generations to live in the same house, or to live very near to each other.

In addition to a focus on family, Bosnians are from a strong social tradition of neighborliness (*komsiluk*). The drinking of a strong Turkish influenced coffee with family, friends, and neighbors is an important aspect of social life. Sugar cubes, or a homemade sugar mixture, are commonly used to sweeten the coffee. Some may place the sugar cube in their mouths and then sip the coffee. Conversation is, of course, an essential accompaniment with the coffee. Bosnians tend to enjoy sharing a good story or a joke that commonly pokes fun at themselves.

A visit to a Bosnian home will often find a cluster of shoes just outside or just inside the door. Custom requires street shoes to be removed and left by the door. Once inside, there is often a positioning of furniture to create a u-shaped seating arrangement around a large low table. This is a modification of a traditional cushioned bench called "secija." This is an important social space where families and friends sit to have coffee and talk. It is common for many Bosnians, especially women, to sit on the floor while sipping the strong Bosnian style coffee from a small cup called a "findzan."

Bosnia has a rich tradition of folk music called "sevdah" that has a strong eastern influence. Instruments include the accordion and a stringed instrument called a "saz." Traditional folk dances are an important part of cultural celebrations, as are ballads that are based in a more continental European tradition. Contemporary music is influenced by the rock and roll sound with many bands having a loud and hard driving beat. Cities are full of music and dance clubs that are popular socializing spots. Cafes are also an important location for socializing, again meeting over coffee.

Traditional Foods

Sharing and enjoying food is another aspect of Bosnian social life that crosses the urban and rural sectors. Two commonly served foods are: "cevapcici" (small sausages made from ground meat and spices, then cooked over an open fire), pita, and phyllo pastry filled with meat or vegetables. "Dolmas" or "japrak" are grape leaves filled with a mixture of rice, meat, and spices. Cabbage leaves or hollowed

whole peppers can also be filled with the same mixture and cooked. Sour cabbage, salad made with only tomatoes and onions, and plain yogurt are some familiar side dishes found at a meal.

Clothing

Bosnian dress ranges from the traditional, ethnic clothes to a fashionable European style. Traditional dress for men include pants, shirt, cummerbund, vest, and a fez. Women wear a baggy trouser called a “dimije” with a blouse and a head scarf. Bosnian Muslim women rarely, if ever, wear the traditional covering from head to toe, the “chador,” seen on Muslim women from other countries. Blue jeans and black leather jackets are a common look for casual dress. Basically, fashion in Bosnia is an eclectic mix.

Religion

Bosnia for centuries has been a ground for sharing and mixing many influences from the East and the West. Although racially homogeneous, Bosnia has prided its traditions as multi-ethnic and multi-cultural. The four major monotheistic religions (Catholicism, Orthodoxy, Islam, and Judaism) exist within the country’s boundaries. Although Yugoslav governmental positions discouraged and at times did not allow strong religious practices, they did influence cultural traditions. Religious holidays came to be celebrated more socially. Modern Bosnia evolved into a country tolerant of different religious practices without the development of religious fundamentalism that exists in other countries. By the time the war started in April of 1992, about 40% of the registered marriages in the urban centers were between ethnically (and therefore religiously) mixed individuals. The influence of the incited nationalism created by the war has resulted in many tragic schisms within families, communities, and regions.

THE BOSNIAN REFUGEE EXPERIENCE

There is no single experience of the refugees from Bosnia. One may have left shortly after the war began, but lost everything – family and home in one day. Someone else may have remained in the country for the entire war, surviving the many horrifying events occurring around them, and finally leaving with their family intact. There is no way to quantify the pain or the trauma an individual may have suffered.

Refugees have arrived in the United States coming from concentration camps or refugee camps, directly from Bosnia, or after living in temporary asylum in another country. In many rural areas, regions were ethnically cleansed. This means their homes and villages were destroyed and they were forced to leave. Some may have been taken to concentration camps, while others made their way to refugee camps. Many families were separated and some Bosnians witnessed the murders of loved ones. Many felt dehumanized by the conditions they endured. In the urban centers, states of siege were common, as the siege of Sarajevo which was viewed internationally on television. Many aspects of formerly normal lives were paralyzed as cities were partitioned, curfews imposed, essential supplies (i.e. food and fuel) cut off, home invasions and sniper shootings occurred frequently, and strategic and random bombings targeted civilians.

It is important not to generalize the Bosnian refugee experience. Refugee workers should not to assume what someone has survived. Just as Bosnia has been a regionally diverse country historically, the war generated a vastly diverse set of experiences.

One important aspect of the war in Bosnia was that it incited nationalism that turned neighbor against neighbor, broke trusted relationships, and destroyed the long standing tradition of *komsiluk*, or sharing. Atrocities were often committed, not by strangers, but by long time friends. Women were

targeted in particular and the phenomenon of rape camps developed. Women were systematically and strategically raped as a form of violent aggression and ethnic cleansing. The concentration camps that were set up recreated many of the horrors that were perpetrated in World War II. Individuals, families, and communities have all been profoundly affected by the war.

Refugees seek safe haven in the country of exile. Many make new lives for themselves and their families quite adeptly, while others cannot get the images of what they have survived out of their minds. Some may feel that learning a new language and considering employment are impossible tasks. Many factors enter into how well and how quickly a Bosnian refugee can make adjustments. Sometimes symptoms related to traumatic war and refugee experiences interfere. Many Bosnian refugees have problems with sleep, appetite, mood, anxiety, concentration, and memory.

Understanding the responses to trauma and knowing social, historical, and cultural experiences of different refugee groups is an important part of helping. Being respectful of cultural traditions and being able to talk about what expectations exist in resettlement are an important part of educating refugees about life in their host country. Some refugees may need to receive information several times. It may be difficult for some to remember or to fully understand what they are being told because of symptoms related to trauma or because of cultural differences. Patience and compassion are an essential part of refugee resettlement work. It is important to remember that there is no single response to the resettlement process, just as there is no single experience of a refugee from Bosnia.

VIII. Self-Care for the Care Taker

Working with refugees can be among the most rewarding and energizing of experiences. It can also at times leave a worker feeling drained, hopeless and lacking energy. This section offers various tools and perspectives with which to evaluate one's own work situation so that coping resources as well as problem areas can be identified and addressed by the worker.

This section begins by offering the opportunity for reflection on a series of questions that highlight the factors that contribute to job-related satisfaction or stress, developed by Judy Okawa, PhD of the Center for Multicultural Human Services. These factors include the nature of the work with refugees, the nature of the clientele, the amount of organizational support, a self-assessment of one's personal characteristics, and the social/cultural context in which one lives and works.

Following the two questionnaires are lists of the symptoms of burnout and of strategies for coping that should be useful to those providing direct services to refugees. The final chapter then addresses secondary traumatization for those who work with the most severely traumatized refugees, written by Dr. Andrea Northwood of the Center for Victims of Torture.

A. Factors Contributing To Vicarious Traumatization

Adapted from Transforming the Pain: A Workshop on Vicarious Traumatization,
Saakvitine, Pearlman, & Staff of TSI/CAAP (Norton, 1996)

The Nature of the Work

- How much choice and control do you have over your work?
- Is your work short-term , crisis, or long-tern?
- Are you doing the kind of work
 - a. You like?
 - b. For which you are well-suited?
 - c. At which you feel competent and talented?
- Does this work match your values and beliefs?

The Nature of the Clientele

- With which populations do you work?
- How many clients do you see?
 - Each day?
 - Each week?
- Is there balance and variety in your caseload and work
- Are ther certain clients with whom you especially enjoy working? Why?
- With which clients do you struggle the most? Why?

The Nature of the Workplace (See the Questionnaire on Organizational Support)

- Do you have enough organizational support?
- Do you have collegial support (within your organization, within your profession)?
- Do you get enough helpful supervision?

The Nature of the Helper : Self Assessment

- Is your training appropriate for you work?
- What are your current life stressors and supports?
- What is your relevant life history? (See [TSI Life Questionnaire](#))
- What are your familiar coping strategies?
- What are you emotional style and vulnerabilities?
- How is the fit between you and your work?
- Do you enjoy your work?
- Other personal factors?

The Nature of the Social /Cultural Context

- How are you impacted by social obstacles to the work (e.g., funding cuts to mental health, managed care)?
- How does the community respond to the type of work you (and your organization) are doing?
- How does the community view the population you serve?

B. Organizational Protection Against Vicarious Traumatization

THE QUESTIONNAIRE ON ORGANIZATIONAL SUPPORT

Judy B. Okawa, Ph.D.

1. Does your organization acknowledge the stresses inherent in you job? YES NO

2. Does the management in your organization understand the potential for vicarious trauma survivors and address it? YES NO

3. Do you have anyone to talk to in your workplace about the impact of job stressors, such as hearing about the traumatic experiences of refugees? YES NO
Colleagues YES NO
Supervisors YES NO
Other Management Personnel YES NO

4. Do you feel safe talking to others about your emotional and physical reactions to your work? YES NO

5. Do you feel you will be listened to without fear of being criticized, judged, diagnosed, minimized, shamed, or blamed? YES NO

6. Does your institution ensure that you have adequate supervision with a qualified supervisor where issues of job stress and vicarious traumatizations are addressed and you can process your experience in a safe environment?
Weekly Individual Supervision YES NO
Group Case Consultations YES NO
Peer Process Groups YES NO

7. Do you have adequate working conditions (e.g., quiet workspace, adequate supplies, access to computer when needed)? YES NO

8. Do you have some degree of control over your workload? YES NO

9. Do you have some flexibility in your work schedule? YES NO

10. Do you have opportunities for professional development to continuing education (e.g., funding and time off for work related conferences)? YES NO

11. Is personal psychotherapy valued and supported by management (e.g., good health benefits, acknowledgement of the importance of personal therapy)? YES NO

12. Do you feel adequately paid for your work? YES NO

13. Do you have adequate vacation time? YES NO

14. Is your hard work recognized ? YES NO

15. Do you feel valued at work by management, your colleagues, and /or your clients?
YES NO

Note: Items were based on information in Neumann,D. & Gamble, S (1995, Issues in the Professional Development of Psychotherapists: Countertransference and Vicarious Traumatization in the New Trama Therapist, Psychotherapy (32:2), pp. 341-347) and Saakvitne, K. & Pearlman, L. (1996, Transforming the pain: A workbook on vicarious traumatization, New York: W.W. Norton). Although the writers were addressing the needs of psychotherapists, the information is also applicable to others who work with traumatized populations.

BURNOUT

A STATE OF PHYSICAL, EMOTIONAL, AND MENTAL EXHAUSTION CUSED BY LONG TERM INVOLVEMENT IN EMOTIONALLY DEMANDING SITUATIONS.

Pines and Arnson (1988)

C. Symptoms Of Burnout

- 1. Emotional symptoms**
 - a. Depression
 - b. Hopelessness
 - c. Anxiety
 - d. Guilt
 - e. Sense of helplessness
 - f. "I feel emotionally drained from my work"
 - g. Reduced emotional responsiveness "I worry that my job is hardening me emotionally">"

- 2. Physical symptoms**
 - a. Fatigue and physical depletion
 - b. Rundown; exhausted
 - c. Sleep difficulties
 - d. Somatic problems
 - e. Headaches
 - f. Gastro-intestinal disturbances
 - g. Colds, Flu

- 3. Behavioral symptoms**
 - a. Aggression
 - b. Callousness
 - c. Pessimism
 - d. Defensiveness
 - e. Cynicism
 - f. Substance Abuse
 - g. Resentment towards people

- 4. Work-related symptoms**
 - a. Tardiness
 - b. Absenteeism
 - c. Misuse of work breaks
 - d. Poor work performance
 - e. Quitting the job

- 5. Interpersonal symptoms**

- a. Perfunctory communication with clients/co-workers
 - b. Inability to focus/concentrate on clients/co-workers
 - c. Withdrawal from clients/co-workers
 - d. Tendency to DEHUMANIZE/intellectualize clients
- B. BURNOUT begins gradually and progressively becomes worse.
- C. Burnout includes
1. Gradual exposure to JOB STRAIN
 2. EROSION of IDEALISM
 3. A VOID OF ACHIEVEMENT
 4. Accumulation of INTENSIVE CONTACT with clients

Charles Figley (1995). "Compassion Fatigue: Toward a New Understanding of the Costs of Caring," in B. Hudnall Stamm (ed.) Secondary Traumatic Stress, Sidran Press.

D. Tips For Managing Stress

by Andrea Link, MSW and Sarah Shoae, PhD

1. Get enough sleep -- you can't do much if you have no energy.
 2. Work out anger -- don't let it get the best of you.
 3. Talk out your worries -- sometimes getting another perspective can make all the difference to feeling better.
 4. Be realistic -- set practical goals that are attainable.
 5. Manage your time wisely -- don't get overwhelmed trying to do everything in one day.
 6. Limit changes -- don't make more than one major change in your life at one time, you need time to adjust.
 7. Improve your environment -- rearranging things or making little changes at home or at the office can make you feel in control and give you a lift.
 8. Take a break -- when you feel overwhelmed, take a "time out" to breath deeply and relax.
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IX. Secondary Traumatization

by

Andrea Northwood, PhD

Andrea Northwood, PhD holds a doctorate in child development and clinical psychology from the University of Minnesota. Her clinical and research background is in cross-cultural assessment and intervention with survivors of political trauma. She has provided training on working with torture survivors to diverse audiences, including mental health professionals, the Immigration and Naturalization Service, refugee caseworkers and paraprofessionals, and the general public. She is currently the Director of Training for Psychological Services at the Center for Victims of Torture.

Outline

- A. Why Self-Care Is Important
- B. Factors That Contribute to Job-related Stress and Secondary Traumatization
- C. Stress Management for People Who Work with Trauma Survivors
- D. Resources
- E. Why Self-Care Is Important

A. Prevalence of stress in refugee work

Any job carries with it some amount of stress. However, working closely with refugees, many of whom have experienced difficult losses and trauma, can result in significant stress for the worker. Sometimes this stress can be at the extreme end of the continuum (from mild to severe stress), especially when the worker is exposed to stories of severe trauma. Trauma may be defined as any experience that involves either serious threat of harm to oneself or others, or overwhelming negative emotions, such as fear, helplessness, grief, or rage. Trauma may be experienced at any phase of the refugee experience, including during the resettlement process (see article on “Common Mental Health Issues for Refugees” for further discussion of refugee trauma).

Secondary traumatization refers to the effects of working with people who have experienced trauma and of being exposed to the difficult stories they share. It is called “secondary” traumatization because it is experienced indirectly, through the process of being a witness to another person’s trauma. Secondary traumatization is a normal, inevitable part of working with individuals and groups of people who have suffered major losses or experienced terrible events. Although it cannot be avoided or eliminated, its effects can be modified or reduced.

Since many refugees have experienced major losses or life-shattering events, it follows that many people who work with refugees—be they advocates, case workers, counselors, lawyers, nurses, immigration workers, judges, volunteers, teachers, doctors, or others—are subject to job-related stress or to secondary traumatization and its effects. Stress, as well as secondary traumatization, is often a slow, cumulative process that occurs over the course of hearing many personal stories of tragedy, loss, and pain. This makes its effects difficult to detect. Often, helping professionals do not realize that they are suffering from job-related stress until it is too late and they are already burned out. The effects of secondary traumatization, like the effects of trauma itself, can be quite serious. At a minimum, it interferes with one’s ability to do one’s job effectively. Therefore, it is very important to learn how to recognize, monitor, and minimize the impact of stress and secondary traumatization on one’s life.

Secondary traumatization is one of several terms that have been used in recent years to describe the effects of working with traumatized individuals and communities. Other terms include “compassion fatigue” (Figley, 1995), “vicarious traumatization” (Pearlman & Saakvitne, 1995), “soul sadness” (Chessick, 1978), and “secondary traumatic stress” (Stamm, 1995). While these terms sometimes differ in their focus, they share in common a recognition of the stress experienced by workers who encounter human suffering on a regular basis. This stress takes a toll. It is simply very difficult to hear story after story of tragic losses, needless suffering, gross injustices, and human brutalities. One way not to be affected by these traumas is to become numb and block off our senses, but this is no solution because it renders us ineffective as helpers and can lead to depression and other problems.

We are changed by the unique stresses of our jobs, often in ways we do not anticipate or like. For example, a caseworker who once prided himself on his optimism and desire to help others may find himself becoming increasingly cynical and discouraged. An ESL teacher who previously viewed her

patience as one of her best assets may be alarmed to find herself irritable and impatient with students.

Stress can take many different forms, depending on the individual and the work environment. Because people respond to stress differently, there is no single sign or set of problems that provides definitive evidence of stress or the extreme of secondary traumatization. Likewise, no exhaustive list of signs and symptoms can be provided. However, many of the effects of secondary traumatization are similar to the effects of trauma itself (listed in the article on “Common Mental Health Issues for Refugees”).

Signs and Symptoms of Stress and Secondary Traumatization

- Fatigue, loss of energy, taking greater amounts of time to complete the same amount of work, loss of efficiency
- Sadness, depression, withdrawal from others or from activities
- Apathy, indifference, emotional numbness, inability to have strong feelings, “tuning out” while listening to traumatic stories
- Forgetfulness, confusion, difficulty making decisions, difficulty concentrating
- Cynicism, discouragement, loss of compassion, loss of faith/trust in humanity, use of negative stereotypes to form quick judgments
- Demoralization, disillusionment, grief, despair, loss of faith in beliefs that previously gave meaning to life (e.g., religious beliefs)
- Difficulty containing one’s emotions, loss of emotional control, strong emotional reactions to minor events
- Loss of creativity, loss of problem-solving skills
- Loss of sense of humor or playfulness, loss of capacity to feel joy
- Feelings of helplessness, hopelessness, lack of control over one’s life and future
- Feeling alone, isolated, alienated; feeling like others cannot understand you
- Irritability, intolerance, anger, and rage
- Disbelief and denial of others’ experiences, especially extreme traumas
- Guilt for having survived trauma or having an “easier” life than others, holding unrealistically high expectations of oneself, denying or downplaying one’s own pain and/or difficulties
- Preoccupation with safety of self and loved ones, increased sensitivity to violence
- Nightmares related to refugee trauma, intrusion of violent images into your daily thoughts or activities (can’t “get it out of your head”)
- Sleep disturbances, exaggerated startle response, difficulty relaxing
- Physical complaints: headaches, abdominal discomfort, diarrhea, joint pain, muscle aches or tension, frequent illness

Like other forms of stress, the effects of secondary traumatization can be cumulative. On a day-to-day basis, we may hardly notice that we are experiencing any stress. However, as the stress accumulates over time, it gradually begins to interfere with our work performance and our personal lives. Little by little, extreme stress can wear us down. Eventually, if it is not addressed, it can leave us exhausted. Once exhausted, we are unable to listen well, to make sound judgments, to think clearly, or to help others. In addition, qualities such as cynicism, disillusionment, and despair can become a prominent part of our identities. These are serious consequences. Fortunately, such consequences can be avoided by taking an active role in reducing stress, especially trauma-related stress. Accepting the potential for secondary traumatization and taking it seriously is the first step toward addressing its effects. It is also important to understand what contributes to secondary traumatization.

B. Factors That Contribute to Secondary Traumatization

The factors that contribute to secondary traumatization come from three main sources: the work itself, the work environment, and the worker.

1. The Work Itself

First, characteristics of the work itself contribute to stress and trauma-related stress by affecting the severity and degree of exposure. For example, working with refugees who have suffered multiple atrocities of human design can be more stressful than working with refugees with less severe trauma histories. Some types of trauma, such as torture, are often deliberately designed to be so cruel and bizarre that the victim's story will not be believed. Working with refugees who may have been perpetrators of violence as well as trauma survivors can cause conflicted, mixed feelings that increase stress.

It is also very stressful to work closely with people who are suffering ongoing, current trauma (for example, separation from children, disappeared or missing loved ones, family members who remain in danger, or news of further atrocities from their homeland). Communication difficulties due to cultural and language differences can cause additional stress. Finally, some jobs require more intimate contact with trauma, such as jobs that involve counseling. Greater exposure to graphic or detailed stories increases the impact of secondary traumatization.

2. The Work Environment

Factors in the work environment also contribute to stress and secondary traumatization. Broadly speaking, the work environment includes not only our job setting but also the society in which we live. Social and political forces such as racism, anti-immigrant prejudice, blaming the victim, increased tolerance of violence, ignorance, and denial of refugee trauma all work to increase stress and secondary traumatization. These broad, powerful forces can make workers feel hopeless about their ability to address the root causes of violence and persecution. Examples of factors that contribute to stress and secondary traumatization in the specific job setting include:

- inadequate job training
- inadequate resources and equipment
- work overload
- inadequate job supervision
- lack of choice or control on the job
- inadequate vacation and health benefits
- isolation from other co-workers
- lack of administrative support for employees' needs to address job stress
- lack of places to refer refugees who have additional or special needs

3. The Worker

Finally, characteristics of the worker and his or her current life situation can contribute to stress and secondary traumatization. As noted earlier, the effects of stress are cumulative. Stress in our personal lives can increase the impact of work-related stress, especially when it deprives us of the activities, outlets, or supports we ordinarily use to relieve work-related stress. A personal or community history of trauma may increase vulnerability to stress and secondary traumatization, or it may intensify its effects. Workers who have been refugees themselves may find it difficult to be reminded of their own

experiences or to work with certain groups of refugees. Our individual and cultural coping styles, beliefs, values, histories, and personality characteristics all affect how we respond to trauma and stress.

C. Stress Management for People Who Work with Refugees

Awareness, Balance and Connection have been identified as the “ABC’s of Addressing Vicarious (Secondary) Traumatization” (Saakvitne and Pearlman, 1996). These three concepts provide an easy way to remember how to manage stress.

1. To reduce stress and secondary traumatization, you must first be able to identify its signs and symptoms in yourself. This requires Awareness.

Like other job skills, stress management skills require training and practice. It takes practice to become aware of how you respond to stress and trauma-related stress and what works best for you to reduce this stress. Awareness is not something that can be achieved in a single exercise or event and then crossed off your list of things to do. Instead, it is a continuous process of paying attention to oneself. In particular, it involves paying attention to any changes in yourself, including changes in your feelings, attitudes, beliefs, physical health, and daily activities.

There are many exercises that have been designed to help people develop self-awareness. A list of books that provide these exercises and other stress management techniques is provided in the Resources section at the end of this book.

One simple way to begin developing awareness is to review the list of common signs and symptoms of stress and secondary traumatization given earlier in this article. Have you noticed any changes in yourself in any of these areas? Has anyone else noticed any of these changes in you? Do you experience any of these difficulties? If so, which ones? While this may be a useful checklist to review on occasion, it is also important to remember that you may have your own unique ways of responding to stress, not listed here.

Employers and organizations where people work with refugees also need to develop awareness of stress and secondary traumatization, and its effects on employees. Workers need support from their employers in managing job-related stress. Many of the contributing factors in the work setting are caused by lack of awareness and support within organizations, as well as economic pressures and lack of resources. It may be necessary to organize staff meetings, have staff attend training workshops, or seek outside consultation to find ways your organization can help workers reduce job stress and secondary traumatization.

2. Seek Balance among different types of activities, including work, personal and family life, rest and leisure.

Living a balanced life is a central theme of most training materials on stress management. To many people, the word “balance” sets up unrealistic expectations about achieving perfect harmony among all the different areas of their busy lives. It can be discouraging and even more stressful to have unrealistic goals about stress management. Therefore, it is important to clarify that balance, as it is used here, does not mean a perfect state of equality or harmony among all your life activities. As a stress management technique, seeking balance simply means making sure you do activities that provide you with rest and renewal. It means having a life outside your work, so that you can take care of your health

and your own needs for rest, fun and relaxation, and a meaningful personal life.

There are many ways to build balance into your work and personal life. At work, it may be helpful to rotate or alternate between different tasks, to the extent that your schedule and work setting permit it. For example, scheduling paperwork time and staff meetings in between contact with trauma survivors can provide you with natural breaks from intense work. Working with different refugee groups or changing the variety of tasks you take on at work can help build diversity and balance into your workload. If your job requires continuous, back-to-back work with trauma survivors, it can be helpful to take short breaks in between your contacts (for example, in between appointments, classes, home visits, interviews, or whatever form of contact your job involves).

Taking a minute to stretch, walk, do a breathing or relaxation exercise, listen to music in the car, or do any other relaxing activity, can help clear your mind and reduce stress. There are many short, easy relaxation and meditation exercises you can learn from the books listed at the end of this article. Longer work breaks during the day, such as coffee breaks and lunch breaks, as well as vacations from work, are also important sources of rest and renewal. Setting reasonable limits on the hours you work, the amount of help you are able to offer, and your exposure to trauma stories are other ways to maintain balance on the job. While work with refugees may require some exposure to trauma, it is important to avoid obtaining, sharing, or listening to details of other people's traumatic experiences that are unnecessary for your work. Keep the focus on your work and minimize extraneous intrusions.

In your personal life, keeping your balance involves making decisions that protect and promote your physical, mental, and spiritual health. Because stress wears down the body's immune system and makes it more vulnerable to illness and disease, it is very important to maintain your physical strength by getting enough sleep, good nutrition, regular physical exercise, and good medical care. Beyond meeting these basic needs, the list of ways to find rest and renewal in your personal life is endless, limited only by the imagination! The important thing is to make time for activities you find relaxing, enjoyable, stimulating, or personally meaningful. A simple way to begin is to identify three such activities for yourself. Take a minute to try this right now. For one person, these activities might include playing with his children, taking a nap, and going to a mosque. For another, gardening, reading, and karate might be listed. Everyone has his or her own ways to relieve stress. Once you have identified three ways for yourself, make a plan to do at least one of them in the near future.

3. Build Connection and supportive relationships with your co-workers, friends, family and community.

Maintaining connections with people who support and love us is especially critical in addressing the feelings of isolation, loneliness, hopelessness, grief, and despair that may accompany secondary traumatization.

At work, supportive connections between you and your colleagues can be established by having structured, planned opportunities to talk about stress and secondary traumatization. If these opportunities are not already in place at your work setting, you can create a support group to serve this purpose. To set up a support group, it may be helpful to get advice from someone who has experience with group approaches to dealing with trauma and stress. Following are some basic suggestions for starting a group.

A support group can include people from within and outside your organization who work with refugees. Ideally, support groups should be organized so that group members who have evaluative authority over other members are not in the same group (for example, separate groups for supervisors and supervisees). However, this is not always possible or necessary, and it is a decision that can be made by group members. Before or at the first meeting, group members should also discuss and decide the following:

- Time, place and frequency of meetings (weekly or bimonthly meetings for 1-2 hours are common). Any limitations on how long the group will last or interruptions in its ability to meet (e.g., during summer vacations).
- Group size (6-8 people is common) and procedure for accepting new members once the group has started.
- Format for group meetings (e.g., who, if anyone, will lead meetings, whether outside speakers or consultants will be used, how meetings will be organized, and possible group activities to relieve stress).
- Expectations of group members. These should include confidentiality (what is said in the group does not leave the group), regular attendance, and respect for other members' reactions to trauma.
- Goals of the group (e.g., to provide opportunities to talk about the effects of working with refugees and trauma survivors, to share and work through feelings and other reactions to trauma that may be painful or difficult, to learn from each other about effective ways of managing job stress, to learn how to support each other at work, etc.).

It is important to remember that support groups can offer support only if group members treat each other with respect and acceptance. This means being careful not to criticize, judge, diagnose, blame, dismiss, ridicule, or minimize other people's experiences. An atmosphere of nonjudgmental acceptance is needed for group members to feel safe and comfortable in sharing their reactions to stress and trauma. They will also need to trust that other group members will respect their privacy by not talking outside group meetings about what they said or did in the group meeting.

Sometimes people have very strong reactions to stress and trauma that require professional intervention. If you believe a co-worker is having a serious reaction to trauma that needs more help than a support group can provide, you should encourage him or her to get professional help. Of course, you should also seek such assistance for yourself if you need or want it. It is common and normal for people who work with those refugees who are trauma survivors to get professional counseling or other mental health services at some point during their careers.

The World Health Organization's manual, *Mental Health of Refugees* (1996), has additional suggestions for support groups for refugee workers who have survived refugee trauma, torture, or other forms of violence. (See pages 112-116 of the manual for further information on this topic).

Another way for staff to build connections and support each other is to develop a procedure for debriefing after facing a crisis, critical incident, or difficult situation at work. Debriefing can take place in a large group, such as a staff meeting, or in a meeting as small as a one-to-one discussion with a co-worker or supervisor. Debriefings usually include discussion of the following questions:

- What happened?
- What still needs to happen? What is the plan for making it happen?
- What was learned from the experience? For example, what worked or went well? What didn't work? What could be done differently next time?

- What was the experience like for the staff involved in it?
- What can staff do to take care of themselves and recover from the experience? How can the organization and other staff members support them in these efforts?

Debriefings are best handled in the same respectful, confidential manner described above in the section on support groups. Successful debriefings allow feelings to be openly acknowledged and resolved so that the stress of the incident is not carried forward into new work.

Finally, outside of work, having supportive relationships with friends, family, and a community provides a very powerful remedy for stress and secondary traumatization. As social creatures, human beings are healed, renewed, and restored through positive relationships. Whether these relationships take the form of a marriage or intimate relationship, family, friendship, pet, political party or cause, social action group, ethnic or cultural community, religious community, sports team, club, chat group on the Internet, or any other form of relating to others.

Connecting to something or someone beyond ourselves brings meaning to our lives and reminds us that we are not alone, though we may feel alone in our experiences at times. Trauma-related stress, whether it is experienced directly or secondarily, has the capacity to silence and isolate individuals. This is especially characteristic of violent images and thoughts that can invade our consciousness and sleep long after the trauma is over or long after we have heard about it. Spending time with persons or doing activities that strengthen your sense of connection to something larger than yourself can help break this silence and isolation. By breaking the silence and isolation of trauma, we make it possible to heal ourselves and to hope for a better future.

X. The National Alliance for Multicultural Mental Health

IRSA's National Collaborative Effort

In 1996, with support from the Office of Refugee Resettlement, **IRSA** developed a collaborative effort together with **The Heartland Alliance for Human Needs and Human Rights**, the **Center for Multicultural Human Services**, and the **Center for Victims of Torture**. This collaboration became the *National Alliance for Multicultural Mental Health (NAMMH)*, with the overall purpose of enhancing the responsiveness of resettlement and mainstream service providers to refugee mental health needs. The Alliance has provided a coordinated response to the mental health needs of recently arrived refugees in the United States— needs that are often misunderstood or overlooked. By addressing the concerns of both the client and the worker, the *NAMMH* has sought to improve the quality and effectiveness of service provider response to the mental health needs of refugees. For the past three years, the *NAMMH* has provided on-site trainings and consultations to mainstream and resettlement agencies throughout the United States, produced five regional mental health training conferences, and developed methods of direct service delivery to specific refugee communities, including Bosnians, Somalis, and Kurds.

In October 1999, IRSA was awarded funding from ORR for an expanded national collaborative effort. In addition to the founding partner agencies, the International Institute of Boston, International Institute of New Jersey, and Victim's Services *Solace* Project in New York City joined the Alliance. This new project will continue to provide national conferences and on-site trainings throughout the United States. The Alliance will also produce a twice-yearly electronic information service to disseminate best practices and other information pertinent to the refugee mental health field. The project is guided by an Advisory Committee comprised of experts and representatives from the major target groups: refugee leadership, resettlement agencies, mainstream psychological and psychiatric associations, and graduate schools of social work.

*For more information on the NAMMH, Contact: Lyn Morland, Senior Program Officer, IRSA
Tel: 202-797-2105; Fax: 202-347-2576, Email: lmorland@irsa-uscr.org*

National Alliance for Multicultural Mental Health Member Agencies

Heartland Alliance for Human Needs and Human Rights, Chicago provides the following refugee mental health initiatives:

- **Marjorie Kovler Center for the Treatment of Survivors of Torture:** The Kovler Center is a community-based organization established to treat survivors of torture. Staff coordinate the volunteer services of psychologists, psychiatrists, physicians, dentists, physical therapists, and other clinical professionals. The Center also serves as a training facility for doctoral-level clinical psychologists from local universities. Treatment focuses on helping survivors restore personal autonomy, normal human relationships, and a sense of security. To this end, the Center offers clinical services for psychiatric and physical care, case management to assist reintegration into community life, legal services for asylum seekers, and public advocacy towards ending torture.
- **Bosnian Mental Health Program:** This program specifically addresses the psychological needs of Bosnian refugees through a bicultural, multidisciplinary treatment team approach. Bosnians of all ages and backgrounds are served through a range of creative, culturally sensitive counseling and support services that address the needs of clients in a holistic manner. Bicultural/ bilingual counselors develop treatment plans that may include counseling, as well as art therapy or massage therapy, and work with other services to ensure that the full range of client needs are addressed.
- **Refugee Mental Health Program:** Recognizing the unique experiences of each refugee and the rich heritage of refugee communities, bilingual/bicultural staff trained in providing mental health services serve Kosovars, Bosnians, Romanians, Russians, Vietnamese, Ethiopians, Eritreans, Somalis, Nigerians, Congolese, Liberians, Sierra Leoneans, Sudanese, Iraqis and Iranians. The program also works with other smaller refugee groups, upon request, with the assistance of interpreters. Services provided include comprehensive mental health assessments; psychological and psychiatric assessments; individualized treatment planning; individual, group and family counseling and therapy; crisis intervention and case management; psychiatric treatment; education and training; and networking with other agencies.
- **Refugee Child and Adolescent Mental Health Program:** This project is designed specifically to work with children and adolescents who have experienced the traumatic effects of war or other forms of political violence and who have a language or cultural barrier to treatment. The program is designed to work cross culturally in facilitating a process of healing and adaptation. Aware of the importance of the family and with respect to each culture's definition of family roles, staff work with refugee children and their families in providing comprehensive mental health assessments; psychiatric assessments; individualized treatment planning; individual, group and family counseling and therapy; crisis intervention and case management; psychiatric treatment; education and training; and networking with other agencies

- **Center for Multicultural and Multilingual Mental Health Services:** This Center is a program designed to improve the delivery of culturally sensitive mental health treatment to refugees and immigrants in the state of Illinois. It was created to assist mental health workers in meeting the needs of refugees and immigrants who have a culture or language barrier to treatment. The Center is dedicated to bridging the gap between diverse client populations and mainstream mental health provider organizations through providing a Web site (www.mcmmlmhs.com); Multicultural Resource Library; telephone and on-site consultation; a Resource Manual for culturally/ linguistically appropriate services; referrals; training and an annual conference; and access to interpreter services. In 1998 the Center received a grant to provide similar services to refugee resettlement workers, ESL teachers, mutual aid associations and refugee themselves thus improving the overall system of services for refugee immigrants.

For more information, contact: Mary Fabri, Director of Refugee Mental Health Training, or Mary Lynn Everson, Tel: (773) 271-1073; Fax: (773) 271-0601; email: mleverson@aol.com

Center for Multicultural Human Services, Falls Church VA:

The Center for Multicultural Human Services (CMHS) is staffed by multi-ethnic, multilingual social workers, psychologists, psychiatrists, counselors, education specialists, art therapists and graduate interns from local universities. CMHS offers a broad range of mental health, social, educational, health and language services geared to the unique values and characteristics of individuals and families from diverse cultures. Services are provided in 27 different languages.

CMHS offers culturally sensitive therapy for children and adults experiencing cultural adjustment problems, family conflict, anxiety, depression, early attachment difficulties, physical or sexual abuse and other traumas or psychological problems. Individual, family and group counseling are available. Individualized treatment programs for children often include family, art and/or play therapy in the child's dominant language. CMHS multilingual staff is also available to respond to mental health crises. Psychological evaluations, provided in the client's dominant language, address a wide range of referral questions including evaluation of post-traumatic stress disorder, capacity for violence, ability to parent appropriately, and current cognitive and personality functioning. CMHS provides psychiatric evaluations and medication monitoring with interpreting services as needed. Other mental health services provided by CMHS include intensive family services, anger management programs and parenting groups, and alcohol and drug education and counseling.

For more information, contact: Dennis Hunt, Executive Director, or Shaila Menon, Refugee Mental Health Program Coordinator, Center for Multicultural Human Services; Tel: (703) 533-3302; Fax: (703) 237-2083; Email: CMHS2000@aol.com

Center for Victims of Torture, Minneapolis, MN:

The mission of the Center for Victims of Torture is to heal the wounds of government-inflicted torture on individuals, their families and their communities. This mission is carried out by providing direct and comprehensive care to survivors of government-sponsored torture and members of their families; conducting ongoing research on the long term effects of torture and effective care and rehabilitation

models; providing training to care providers and others who may encounter torture survivors (including refugee resettlement workers, immigration attorneys, I.N.S. officials, ESL instructors, public school employees, teachers and social service providers); contributing to the prevention and ultimate elimination of torture through public education campaigns, public policy initiatives and cooperative efforts with national and international human rights, religious, labor, business and civic organizations.

The Center has pioneered a unique, multi-disciplinary model of care that enables torture survivors to recover from their physical, emotional and spiritual wounds. Strategies are tailored to meet the needs of individual clients and their families and communities, and involve the professions of medicine, psychiatry, psychology, social work and nursing.

In addition to clinical services, CVT initiatives include:

Minnesota Mainstream Project: intended to engage existing networks of health care and human service providers in the task of healing survivors of torture and war trauma.

Minnesota Schools Project: intended to help teachers and other school officials understand that learning and behavioral problems among refugee students are often a direct result of human rights atrocities they witnessed and/or endured during the refugee process – and what they can do to help these traumatized young people.

Refugee Mental Health Project: intended to strengthen refugee communities through leadership development activities, development of resources or tools, and mental health training and interventions.

Through these projects the Center reaches out to diverse communities and groups throughout Minnesota. The projects utilize consistent tools and marketing materials, including a first contact/needs assessment form, standardized training materials, and evaluation tools and instruments. Through these projects the Center has developed a community-based approach to working with refugee populations that has been particularly effective within refugee communities – in large part because the approach has been developed in conjunction with, and with the participation of, the leadership of refugee communities.

For more information, contact: Evelyn Lennon, Refugee Mental Health Project Coordinator, Center for Victims of Torture, Tel: 612-627-42721; Fax: 612-627-4144; Email: elennon@cvt.org

Victim Service's Solace Project:

Solace is a comprehensive, community-based counseling and outreach project for survivors of torture and refugee trauma. It is located in the Jackson Heights Community Office of Victim Services in Queens, New York. The project began in March, 1997 and is funded by the Office of Refugee Resettlement (ORR) of the U.S. Department of Health and Human Services (HHS) and the United Nations Voluntary Fund for Victims of Torture. Since that time, the project has provided direct services to over 90 survivors of state-sponsored torture and refugee trauma throughout the five boroughs of New York City, Eastern Long Island and New Jersey. Services include social adjustment counseling and referral for qualified medical and psychological follow-up, clinical evaluation and assessment, individual, group and family psychotherapy on an as-needed basis, care management and referral for social needs, training for service providers and mental health professionals, and outreach and education to new refugee groups. The majority of participants in the program are Bosnian, Ethiopian and Liberian refugees, though the project has also served people from South Asia, Latin America, the former Soviet Union and the Near East. The

project initiated contact with the Albanian community in New York City in 1998 by holding a community meeting along with our sister agency, the Church Avenue Merchants Block Association (CAMBA). The contact with the community is still in effect, and the project has already worked with a small number of Kosovar Albanians.

Solace is currently implementing a city-wide program, which focuses on orientation and education for refugees, resettlement workers, social service providers, and mental health/health professionals. Refugees will be oriented to mental health concepts and access to mental health services, while respecting the traditional and culture-specific perspectives of refugees and incorporating them into the process. In conjunction with the Center for International Trauma Studies (CITS) and Doctors of the World, USA (DOW/USA), *Solace* is developing curricula for refugee resettlement workers and community-based social service providers on the development of basic therapeutic skills, symptom recognition and understanding of the refugee experience. Curricula dedicated to developing cultural competency and sensitivity, as well as increasing the knowledge-base for working with refugees, is also being developed for mental health and medical professionals throughout New York City. Each year over the next three years two one-day intensive conferences focusing on some aspect of psychosocial work with refugees will be offered and will be open to the public. Direct service provision by *Solace* counselors is augmented significantly by the development of an independent core of clinicians and through formal linkages with Elmhurst Hospital in Queens, NY and the Catholic Archdiocese of Brooklyn and Queens, which has over 75 clinicians in community clinics throughout those boroughs. The goal of the three-year grant from ORR is to develop capacity throughout the city to work with refugees on issues of adjustment and mental health within their extant communities.

For more information, contact: Ernest Duff, Solace Program Director, Victim Services, Tel: (718) 899-1233 ext. 101; Fax: 718-457-6071; Email: eduff@victimservices.org

The International Institute of Boston:

The Navigator project ((Northern Alliance of Volags for Interpretation, Guidance, Assessment, Therapy and Outreach to Refugees) is a tri-state (Massachusetts, Vermont, and New Hampshire) initiative of the International Institute of Boston, focused on meeting the unique mental health needs of at-risk newcomers in the northern New England refugee communities.

The target population is newcomer refugees from the former Yugoslavia for all states and specialized groups for each state according to their needs. Since the needs of this population are unique to mainstream mental health services, a specialized diagnostic tool has been developed, which sensitively engages the individual to discuss their experience of trauma and organizes the information for diagnostic purposes to be of use for mainstream clinicians. Quarterly meetings among the three agencies provide opportunities for ongoing training and discussion regarding the critical issues confronting these communities, as well as safe bicultural worker support. Some of the specific issues addressed are: school-age children, particularly teenagers, crimes against women, torture victims, secondary trauma victims, and integration of resettlement and mental health services.

Training, consultation and outreach to mainstream service providers has been an essential role of the Navigator Project in each site. In addition to enhanced services to individuals across agencies, specialized programs have been established, such as school counseling programs, art therapy classes, employment consultation, and special community gatherings for community building.

Future goals are:

- To develop programs to assist refugees in stress management and to develop a "risk factor checklist" for use in resettlement in order to identify individuals and families who are in need of specialized support.
- To provide education programs to assist newcomers in understanding the laws and regulations regarding child care, domestic violence, substance abuse and other social issues which can be an additional source of family stress during the resettlement process.
- To create a working alliance with local centers specializing in treatment of trauma in order to broaden our service base for victims of torture.

For more information, contact: Sarah Alexander, Director of Social Services, International Institute of Boston, Tel: (617) 695-9990; Fax: (617) 695-9191; Email: salexand@iiboston.org

Cross-Cultural Counseling Center, International Institute of New Jersey:

The Cross-Cultural Counseling Center (CCCC) is a joint project of the International Institute of New Jersey and the Counseling and Resource Center of Christ Hospital. The Center's staff of licensed bilingual clinicians, including psychologists, psychiatrists, social workers, and counselors serve a clientele composed of refugees and immigrants. CCCC provides confidential mental health services to the Haitian, African, Russian, Vietnamese, Chinese, and other Asian communities, and to several African groups. These services include: individual, group, and family counseling; psychological assessment and evaluation, including services and testimony for asylum applicants; psychiatric consultation; and medication monitoring and treatment. The Center also provides extensive training on refugee mental health and cross-cultural issues in diagnosis and treatment to refugee resettlement agencies, mainstream mental health services, schools, and social services, including child protective service agencies.

For more information, contact: Sara Kahn, Cross-Cultural Counseling Center Director, International Institute of New Jersey, Tel: (201) 653-3888, ext.12; Fax: (201) 963-0252; Email: Proalien@aol.com

The NAMMH works closely together with the Office of Refugee Resettlement national technical advisors on refugee mental health:

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