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Pepperdine University
Graduate School of Education and Psychology

CLINICIAN CONCEPTUALIZATIONS OF POST-MIGRATION REFUGEE YOUTH
PREVIOUSLY EXPOSED TO POLITICAL VIOLENCE

A clinical dissertation submitted in partial satisfaction
of the requirements for the degree of

Doctor of Psychology

by

Sara Michele Mehrabani

September, 2013

Thema Bryant- Davis, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Sara Mehrabani

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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DEDICATION

To my family. My protective shield. I could not have done this without you.

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Finally, I want to acknowledge my family. To my mother, for teaching me grace and compassion. To my father, for his support and love. And to my brother: you are a pal and a confidant.

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ABSTRACT

Researchers have examined the experience of distress with refugee children and adolescents who have been exposed to political violence. Recognition has also been given to migration stress and traumatic grief as additional stressors in the lives of refugee youth. Studies in this area have established the fact that development appears to influence the expression of distress in youth who have experienced adverse experiences such as political violence. Reaction to political violence and the refugee experience also appear mediated by culture as well as other contextual factors such as the nature of the violence. The purpose of this study was to focus on clinician conceptualizations of refugee youth who have been exposed to political violence, as well as the factors that contribute to developing their conceptualizations. A total of 6 clinicians were interviewed and were analyzed using qualitative methods to identify emergent themes. The clinicians addressed 6 major themes associated with conceptualization, including sources of information, formal assessment, conceptualization, cultural factors or cultural influences, and advice to clinicians working with refugee youth. Three subthemes emerged regarding conceptualization, namely trauma- based conceptualization, loss, and resiliency. It is hoped that the results of this study will bridge the gap between clinicians and researchers regarding refugee minors with exposure to refugee youth.

Introduction

The victims of postmodern warfare often include noncombatants (Jackson, 2006). Unfortunately, children in these communities are not immune to violent conflict, and are often specifically targeted as future opponents (Fisher, 2002), and, as a result, may experience more direct exposure to violence and brutality (Aboutanos & Baker, 1997; Goldstein, Wampler, & Wise, 1997; Ladd & Cairns, 1996). War also produces high numbers of refugee women and children (Garbarino, 2001).

The effects of war violence on children has been studied in several different countries including Bosnia (Goldstein et al., 1997; Jones & Kafetsios, 2005; Smith, Perrin, Yule, Hacam, & Stuvland, 2002), Sarajevo (Husain, Allwood, & Bell, 2008), Gaza (Thabet, Tawahina, Sarraj, & Vostanis, 2008), Lebanon (Dubow et al., 2010; Macksoud & Aber, 1996), Rwanda (Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000), and the Sudan (Morgos, Worden, & Gupta, 2008), among many others. Research on the effects of trauma experienced by children exposed to political violence has supported significant prevalence of mental health problems and increases in emotional and behavioral symptoms and disorders including Posttraumatic Stress Disorder (Goldstein et al., 1997; Thabet et al., 2008), anxiety (Smith et al., 2002; Montgomery & Foldspang, 2005), depression (Jones & Kafetsios, 2005), attention problems (Husain et al., 2008), and externalizing problems (Qouta, Punamaki, & Serraj, 2005), among others.

Violent experiences during war may include directly witnessing violent acts, hearing about violence or brutality such as murder, beatings, rape, and torture, or being threatened personally with violence (Barber, 2008; Dubow et al., 2010; Dyregrov, Gupta, Gjestad, & Mukanoheli, 2000; Pynoos & Eth, 1986). Children who experience war violence also often experience non-violent trauma in the form of displacement or changes to community and

environment, as well as grief and loss (Dyregrov et al., 2000; Jones & Kafetsios, 2005; Kohrt et al., 2010; Macksoud & Aber, 1996). The influence of war extends further than exposing children to traumatic events. They also create additional stressors that impede the child's normal functioning including poverty, displacement, loss of social networks, lack of resources, homelessness, starvation, and death of loved ones (Allwood, Bell-Dolan, & Husain, 2002; Fernando, Miller, & Berger, 2010). These types of experiences can create a threat to physical integrity as well as feelings of hopelessness characterized by the definition of a traumatic event (American Psychiatric Association, 2000). However, even when these experiences do not meet the criteria as a traumatic event under the DSM-IV TR (American Psychiatric Association, 2000), they are indicated as significant influences on the manifestation of psychological symptoms among war exposed children (Allwood et al., 2002; Joshi & O'Donnell, 2003; Kohrt et al., 2010). The presentation of symptoms and disorders resulting from war violence vary depending on several factors including the type of exposure or traumatic event, loss of support, migration stressors, cultural differences, as well as developmental stage among others (Barber, 2008; Joshi & O'Donnell, 2003; Thabet et al., 2008). Therefore, to understand the process by which children experience and process traumatic incidents, one must consider the multitude of experiences in war conflict, including exposure, displacement, and traumatic grief, in addition to developmental factors and culture.

The majority of current knowledge on war-affected children is based on research using assessments that focuses on symptoms associated with PTSD (Berman, 2001). The research in this field has been controversial, some arguing for a primarily trauma-focused conceptualization while others argue that a focus on trauma does not adequately acknowledge the other multiple stressors in the lives of refugee children and adolescents that can influence mental health (Fernando et al., 2010; Miller & Rasmussen, 2010). Further, there is criticism in the field of

refugee mental health that a focus on symptom presentation might not be appropriate given contextual and cultural factors because of the reliance on Western-based paradigms (Bracken, Giller, & Summerfield, 1995; Miller & Rasmussen, 2010; Summerfield, 1999).

There is very limited research to date on how clinicians conceptualize the experiences of refugee youth who have experienced war violence and how research or assessment influences these conceptualizations. The purpose of this study is to rectify this paucity in the literature by providing qualitative accounts of clinician's conceptualizations of refugee children and adolescents and the theories guiding these conceptualizations. The study will first review the main variables discussed in the literature on youth who have experienced violence, displacement, and traumatic grief, as well as developmental and cultural factors, and then provide information on major assessments supported by research for use with refugee youth exposed to war violence.

Background

This section provides an overview of the literature for the following topics: (a) exposure, (b) displacement and migration, (c) traumatic grief, (d) developmental influences on trauma, (e) assessment, and (f) culture and context.

Exposure

Experiences of exposure during political violence may include sexual assault, witnessing a shooting or death of another, shelling or mortar fire, witnessing killing by machete, being tortured, and being threatened to be tortured, rape, among many others (Dyregrov et al., 2000; Husain et al., 2008, Klasen et al., 2010). In a study with Palestinian children and their mothers, the majority of the children witnessed shooting, fighting, explosions, a family member being injured or a stranger being killed (Quota et al., 2005). Similar reports of types of exposures have been found in studies with children from Sarajevo (Husain et al., 2008), Rwanda (Dyregrov et

al., 2000), Kenya (Seedat, Nyamai, Njenga, Vythilingum, & Stein, 2004) and Lebanon (Macksoud & Aber, 1996).

Children exposed to political or ethnic violence may be at greater risk for developing mental health problems (Ladd & Cairns, 1996). Specifically, some studies have reported an association between violent traumatic exposure and poor concentration (Husain et al., 2008), hyperactivity (Thabet et al., 2008), somatic complaints (Geltman, Grant-Knight, Ellis, & Landgraf, 2008), aggression (Dubow et al., 2010), and Post Traumatic Stress Disorder (Thabet et al., 2008). A study with Palestinian children found that a youth's exposure to violence is a significant predictor of symptoms of Posttraumatic Stress Disorder (Dubow et al., 2010). Chronic exposure, similar to the experiences of children living in war zones, can alter the normal course of development and is associated with greater levels of distress (Sagi-Schwartz, 2008). A study of children in the Gaza strip found that the greater the incidents of exposure to trauma, the more severe the behavioral and emotional problems (Thabet et al., 2008) as did studies in Bosnia (Allwood et al., 2002; Smith et al., 2002), the Congo (Mels, Derluyn, Boekaert, & Rosseel, 2010), Lebanon (Macksoud & Aber, 1996), Russia, Belgium, and the United States (Vermeiren, Schwab-Stone, Deboutte, Leckman, & Ruchkin, 2003).

However, a study with Bosnian adolescents supported that it is not the quantity of exposure ("the dose effect") that influences the mental health consequences of trauma, but rather the severity and proximity to the exposure (Jones & Kafetsios, 2005). They found that directly witnessing a violent event, such as the death or injury of a family or close friend, or being victim of a violent event, has been strongly associated with anxiety, depression, and PTSD among Bosnian adolescents. Other studies reported that Bosnian children who had witnessed the death, injury, or torture of a family member endorsed greater symptoms of PTSD (Goldstein et al., 1997), and found significant associations between severity of exposure and reported PTSD

symptoms of intrusion, arousal, and anxiety (Smith et al., 2002). A study of children in the United States who had been exposed to a sniper attack found that children who witnessed the sniper attack and were directly exposed to the shooting endorsed more symptoms of PTSD than those who were not exposed, and these symptoms endured longer over time (Nader, Pynoos, Fairbanks, & Frederick, 1990). In the Sudan, direct exposure to violence such as rape, murder, and torture, and invasive or threatening experiences are considered strong predictors of traumatic reactions and symptoms of posttraumatic stress (Grant-Knight et al., 2009; Morgos et al., 2008). The association between the severity of the trauma and PTSD has also been supported with children from the Gaza strip (Thabet et al., 2008).

Montgomery and Foldspang (2005), in a study with children from the Middle East, reported that witnessing war violence appeared to significantly predict anxiety symptoms, including separation anxiety, fear of being alone, and fear of the darkness. Verimeren et al. (2003), in a study with adolescents from Russia, the United States, and Belgium, discovered that in each country, the severity of violence exposure was associated with increased substance abuse, suggesting that despite geographical location and culture, there appears to be a relationship between violent exposure and substance use. Dyregrov et al. (2000) found that children in Rwanda who had been exposed to violent physical threats were more likely to report avoidance symptoms. Further, in a study of child soldiers in Nepal, children were seven times more likely to endorse PTSD if they had experienced torture during war time (Korht et al., 2010). Macksoud and Aber (1996) in a study with Lebanese children and adolescents also found that children who were victims of violence reported the most symptoms of PTSD. Similarly, Seedat et al. (2004) found that among adolescents from Kenya and South Africa, boys and girls who had experienced sexual assault endorsed the highest rate of PTSD, followed by physical assault. The association between the severity of exposure to the magnitude of the reaction may

be the result of perceived or actual threat to life (Smith et al., 2002) which occurs when exposure to violence contributes to a fear of dying through similar means (Goldson, 1993). Morgos et al. (2008) in a study with Sudanese children, found the strongest predictors of trauma symptoms and depression were exposures that were physical and emotional such as rape, abduction, being forced to fight or kill friends and family members, seeing someone burned alive, or hiding due to a perceived life threat. A meta-analysis of risk factors for the development of Posttraumatic Stress Disorder in children and adolescents supported large effect sizes when examining the influence of perceived threat to life on the development of PTSD (Trickey, Siddaway, Meiser-Stedman, Serpell, & Field, 2012). Therefore, severe and brutal violent exposure can be associated with a greater substantial threat to life, which then contributes to greater levels of distress (Carlson & Rosser-Hogan, 1994; Smith et al., 2002). Alternately, a study among Lebanese children found that children who had witnessed violence and who had more active involvement in the war reported more prosocial behaviors than those who had experienced other war traumas (Macksoud & Aber, 1996), which might indicate a relationship between the severity of violent exposure and posttraumatic growth. Sagi-Schwartz (2008) hypothesized that external forms of trauma, like war violence, might be associated with more adaptive coping than when it is individual or familial.

Indirect exposure includes children's experiences of vicarious traumatization, typically through the narratives of family or community and the effects of interruption on caregiving practices (Williams, 2007). Ecosystemic conceptualizations of trauma posit that as a child exists in a nested system including family and community, violence and trauma experienced during wars by family and community would have significant influence on a child in addition to direct exposure (Elbedour, Bensel, & Bastien, 1993; Kohrt et al., 2010). Exposure to direct violence experienced by the parent affects the members in the family system, including the children

(Williams, 2007), and may contribute to transgenerational and emotional trauma (Elbedour et al., 1993). For example, the consequences of the exposure on the parental figures may adversely affect the ability to provide supportive care-giving during times of political conflict (Paardekooper, de Jong, & Hermanns, 1999). War violence may also impede the community's ability to respond to the needs of children, limiting traditional coping and leaving children more vulnerable (Dyregrov et al., 2000). Further, adults who have witnessed violent acts may use emotional withdrawal as a coping strategy which might contribute to their child's vulnerability to vicarious traumatization (Sagi-Schwartz, 2008). Thabet et al. (2008), found that among children and parents in the Gaza strip, children's reports of PTSD and anxiety was significantly related to parent's PTSD and anxiety scores. Another study in the Gaza strip found that poor maternal mental health served as a risk factor for both externalizing and internalizing symptoms among Palestinian children (Quota et al., 2005). Quota et al. (2005) found further indication that boys in high trauma families were more likely to show concentration problems and hyperactivity and girls endorsed greater sleep difficulties. The results of this study also supported that poor maternal mental health might contribute to a greater risk of developing posttraumatic stress as compared to political violence alone. Guttmann-Steinmetz, Shoshani, Farhan, Aliman, and Hirschberger (2012) in a study examining Israeli and Palestinian mothers and children, reported that mothers with increased symptoms of depression and anxiety had children with higher externalizing problems, and that familial factors may strongly mediate the severity of problems in war-exposed children, despite level of exposure. Similarly, research on Bosnian mothers supports that the mother's psychological symptoms during and after periods of conflict are a highly predictive factor of distress in children (Robertson & Duckett, 2007).

Displacement and Migration

Understanding the effects of exposure to war violence on mental health outcomes for children and adolescents may be confounded by several other variables, including context of the political situation, context of the environment, and changing communities, among others (Catani et al., 2009; Jones & Kafetsios, 2005). Refugees are displaced individuals who seek asylum in other countries while internally displaced individuals find refuge within their country's borders (Ladd & Cairns, 1996). Migration stress can be defined as stressors associated with displacement such as adjustment to new environments and loss of peer and social networks, and lack of previously established resources and supports (Birman & Chan, 2008). Children who have been displaced from their homes or communities may experience stressful circumstances including starvation, lack of medical services, separation from family, loss of home, social networks, and culture, as well as threat and uncertainty about the future (Allwood et al., 2002, Eisenbruch, 1991; Joshi & O'Donnell, 2003). Children and adults in resettlement camps often experience many significant daily stressors such as lack of food, water, or medical services (Paardekooper et al., 1999). Refugee and internally displaced children may also experience trauma through the dangerousness of the escape and migration from the conflict (Fantino & Colak, 2001).

The stress of displacement has been associated with vulnerability to the development of mental health problems (Hyman, Vu, & Beiser, 2000). Mediating factors in the development of pathology in children related to war trauma can include loss of community and loss of resources related to displacement (Sagi-Schwartz, 2008). Allwood et al., (2002), discovered that children and adolescents in Bosnia endorsed the highest levels of PTSD when they were exposed to war violence and experienced non-violent events such as displacement. Children in Lebanon who had been displaced from their communities as the result of political violence also reported

significant symptoms of Posttraumatic Stress Disorder (Macksoud & Aber, 1996). Mels et al. (2010), in a study with adolescents from the Congo, found that adolescents who had experienced displacement reported significantly greater levels of PTSD symptoms and internalizing symptoms when compared to their non-displaced peers. In a study of Bosnian displaced children, 90.6% endorsed significant sadness and 95.5% reported high levels of anxiety, both interfering with daily functioning (Goldstein et al., 1997). In the same study, more than half of the children experienced pessimism about the future. Similar mental health problems were found in a study with children from the Middle East seeking refuge in Denmark, with time spent in refugee camps significantly predicting symptoms of anxiety (Montgomery & Foldspang, 2005). Displaced individuals may also report experiencing loneliness, culture shock, lack of belongingness to new environment, and stress associated with trying to adapt to new circumstances and environments (Fantino & Colak, 2001; Keyes & Kane, 2004).

Interpersonal consequences of displacement can include disruption and limited access to traditional support systems including community, school, and the presence of extended family (Grant-Knight, Geltman, & Ellis, 2009). Loss of coping from disruptions to community and educational support systems during displacement may leave children vulnerable to experiencing mental health problems related to the traumatic experiences (Dyregrov et al. 2000; Morgos et al., 2008). In a study with Bosnian adolescents, Jones and Kafetsios (2005) found that missing school impacted well-being, and hypothesized that it may be because there was less contact with peer support and activities to distract from the war. Shaw (2000) also emphasizes the importance of school, specifically the role of peer relationships, in mediating the effects of trauma for war exposed communities.

Some children experience loss during the process of displacement due to separation from one or both parents and family during flight (Pardekooper et al., 1999; Yule, 2002). Children

who are reunited with their families and systems of support after displacement present with better outcomes (Sourander, 1998). However, poor or absent support of refugees can contribute to symptoms associated with trauma and grief (Gorst-Unsworth & Goldenberg, 1998). Children without family or community support are particularly vulnerable to traumatic symptom reactions because the lack of support stunts the ability to cope with the traumatic experiences (Almqvist & Brandell-Forsberg, 1997; Dyregrov et al., 2000; Sourander, 1998).

Children who remain separated from their families under traumatic conditions can experience enduring psychological distress (Derluyn & Broekaert, 2007) with symptoms similar to grief (Boris et al., 2008). Children may also experience grief for the loss of home and community due to displacement to a new and unfamiliar environment (Fantino & Colak, 2001), and in collaborative cultures, the separation and loss of family outside of the immediate family similarly contributes to significant distress (Almqvist & Brandell-Forsberg, 1995).

The true effect of the experiences of displacement on children may be significantly underestimated (Ladd & Cairns, 1996) because of lack of access to those living under these conditions. Further, some research has indicated that adolescents who experience high levels of displacement also report high levels of exposure (Jones & Kafetsios, 2005; Mels et al., 2010) which make it difficult to determine the specific effects of displacement on mental health. Refugee children and adolescents experience unique challenges because of the loss of community and culture in addition to having to adapt to the cultural and language expectations of a new country post-migration (Ajdukovic & Ajdukovic, 1993; Bolea, Grant Jr., Burgess, & Plasa, 2003; Ehntholt & Yule, 2006). A factor in post-migration trauma can also be the distress associated with adjustment and cultural dissonance, which includes the dissonance between the identity pre-migration, and the identity placed upon by the host society towards those who have been displaced (Grant-Knight et al., 2009; Perez-Sales, 2010). Acculturative stress can be

understood as the distress resulting from adapting to new cultural norms and expectations of the host country (Birman & Chan, 2008). Refugees are expected to acculturate (adapt to the dominant culture) upon arrival to the host country by integrating alternate (and sometimes contradictory) beliefs and rules into their own worldview (Berry, 2001). Through this process of acculturation, refugee children and adolescents can experience distress in trying to understand self in a new environment (Fantino & Colak, 2001). These stressors may include culture shock, isolation, and loneliness, and are associated with higher psychological distress among refugee youth (Keyes & Kane, 2004; Lustig et al., 2004). Refugees also may experience racial discrimination and prejudice upon arrival at the host country, which has been associated with significant increased rates of PTSD and depression among adolescents (Ellis, MacDonald, Klunk-Gillis, Lincoln, Strunin, & Cabral, 2010).

Traumatic Grief

It is important to recognize the experiences of distress other than Posttraumatic Stress Disorder and depression as the primary psychological consequences of exposure and displacement because of the overwhelming grief experienced by refugee children due to traumatic circumstances (Laor, Wolmer, Kora, Yucel, Spirman, & Yazgan, 2002). A qualitative study with child soldiers from Sierra Leone, reported that the death of family members was considered the most distressing event that they experienced during the conflict (Denov, 2010).

Cohen, Mannarino, Greenberg, Padlo, and Shipley (2002) describes traumatic grief as the death of a loved one due to subjective traumatic circumstances, resulting in traumatic symptoms that interfere with the child's process of grieving. Childhood traumatic grief shares characteristics of Posttraumatic Stress Disorder and Major Depression Disorder (formally, or just depressed mood) (Brown & Goodman, 2005) such as avoidance, re-experiencing the traumatic loss, and traumatic estrangement (Cohen, Mannarino, & Deblinger, 2006). Trickey, Siddaway,

Meiser-Stedman, Serpell, and Field (2012) in a meta-analysis of risk factors for PTSD among children and adolescents, found that bereavement had a medium effect size as a risk factor for the development of PTSD. In a study of children who had experienced the suicide of a peer in the United States, traumatic grief occurred independently of Posttraumatic Stress Disorder and depression, and was more significant and prolonged in the process of healing (Melhem, Day, Shear, Day, Reynolds, & Brent, 2004). In this study, traumatic grief also predicted the development of PTSD as well as depression after 6 months.

Several studies have identified the high prevalence of traumatic grief with adults and children who have experienced direct or indirect loss due to political or ethnic conflict (Craig, Sossou, Schnak, & Essex, 2008; Pfefferbaum, North, Doughty, Pfefferbaum, Dumont, & Pynoos, 2006; Putnam et al., 2009). In studying the effects of war in Angola, (Wessells & Monteiro, 2001) identifies that grief might be complicated during times of war because of the interference with cultural burial rites, which in some cultures is an essential part in creating peace among the living. A study with adult Bosnian refugees found that complicated grief accounted for the majority of mental health problems (31%), whereas PTSD only accounted for 6% (Craig et al., 2008). Grief was found to be associated with posttraumatic stress in a population of children in Nairobi in relation to a bombing at an embassy (Pfefferbaum et al., 2006). Morgos et al. (2008) found that the best predictors of traumatic grief in children from the Sudan were death or loss of a parent and witnessing violence against others. They also found that grief and war experiences were mediated by trauma, suggesting that there is a significant interaction of violent exposure and grief on the development of traumatic responses.

Direct exposure to loss (such as witnessing the death of a parent) may also magnify the experience of grief and trauma (Pynoos, Nader, Frederick, Gonda, & Stuber, 1987). This form of direct exposure is also related to a threat to life in conjunction with the enduring experience of

grief (Momartin, Silove, Manicavasagar, & Steel, 2004; Brown et al., 2008). In a study with Bosnian adolescents, Jones and Kafetsios, (2005) found that 27 out of 40 participants regarded the death or injury of friends and family as the worst experience, and endorsed symptoms of sadness and depression and trauma symptoms, specifically when the death was witnessed by the adolescent.

Developmental Influences on Trauma

Child and adolescent response to trauma may depend on developmental factors (Sagi-Schwartz, 2008). Proponents of the cognitive model of development emphasizes differences in appraising trauma dependent on the child's coding ability, knowledge base, and language capacity (Salmon & Bryant, 2002). Developmental differences in the child's response to a traumatic event may also depend on emotional regulation, memory, and other comorbid responses such as depression and anxiety (Salmon & Bryant, 2002). Fivush (1998) emphasizes the role of language significantly alters the child's response to trauma because the ability of children to verbally remember and recollect organizes the experience. Therefore, symptom presentation can differ depending on the child's cognitive and emotional development, as well as language in addition to other developmental factors (Fivush, 1998; Sagi-Schwartz, 2008; Thabet et al., 2008). Infants and toddlers might experience issues of trust or attachment with caregivers due to an interference with the development of security in the child-caregiver relationship, causing difficulty with being soothed, fearfulness, vigilance, and behaviors such as clinging and poor eating or sleeping (Cook et al., 2005; Osofsky, 1995; Punamaki, 2002; Sagi-Schwartz, 2008). Trauma may also interfere with the infant and toddlers ability to explore and engage in social interaction (Punamaki, 2002). Infants may also be particularly vulnerable because of a reliance on caregivers who might also be experiencing traumatic reactions (Osofsky, 1995). School aged-children might experience separation anxiety and issues with dependency, learning

difficulties, concentration and attention problems resulting from intrusive thoughts, issues with reasoning and empathy, sleep disturbances, worry and fear, or increased aggression or violent tendencies (Osofsky, 1995; Punamaki, 2002; Sagi-Schwartz, 2008). Trauma experienced during adolescence might affect the development of intimate relationships, abstract thinking, and may influence negative appraisals about the future exhibited through behavioral and emotional problems, anxiety, risk-taking and dangerousness, violence and aggression, and avoidance and numbing responses (Punamaki, 2002; Sagi-Schwartz, 2008).

Stressors that occur early in life, including abuse or other traumatic events, may interfere with healthy brain progress, thereby altering the course of the child's biological development (Anda et al., 2006). Some theorists believe that younger children may have greater vulnerability to developing maladaptive coping and experiencing negative mental health outcomes in response to traumatic events due to their limited cognitive capacity, verbal expression, and memory, but alternately, this might serve as a protective factor in the development of symptoms (Fivush, 1998; Punamaki, 2002; Salmon & Bryant, 2002). Similarly, there are mixed results regarding age and the presentation of PTSD (Foy, Madvig, Pynoos, & Camilleri, 1996). In a metaanalysis of risk factors for PTSD in children and adolescents, Trickey et al. (2012) found a small and insignificant effect size supporting younger age as a risk factor.

The presentation of grief may also relate to developmental stages in children, but there is little evidence on the effects of traumatic grief related to age (Cohen et al., 2002). Children appear to experience grief differently because the meaning of loss is variable; preschoolers have difficulty understanding the permanence of death, whereas younger school-aged children might view death or the deceased as something more tangible, such as ghosts and spirits. Older children may have a greater understanding of the irreversibility of death, but still lack cohesive

logical thinking in response to death and adolescents may experience death more existentially while questioning meaning and purpose.

There is little information of children's response to political violence from a developmental perspective (Gilligan, 2009) and results of the effects of age on traumatic responses appear mixed. In a study of children between the ages of 9 and 14 in Bosnia, there was a tendency for younger children to report more anxiety and arousal symptoms (Smith et al., 2002). In another study with Bosnian children between the ages of 6 and 12, older children reported more symptoms of PTSD than younger children (Goldstein et al., 1997). Allwood et al. (2002), found that older children in another sample of Bosnian children 6-16 years of age reported greater exposure to political violence and more death resulting from war violence, but were not more likely to report symptoms of PTSD. Macksoud and Aber (1996) in a study of Lebanese children between 10 and 16 years of age, indicated that adolescents reported more adaptive behaviors than younger children and that age did not appear to moderate the interaction between exposure and traumatic response. Mels et al. (2010), in a study of Eastern Congolese adolescents between the ages of 13 and 21 discovered small significance with younger adolescents reporting more symptoms of PTSD and supported other research hypotheses that reduction in symptoms as age progresses is the result of the development of coping responses. In a study with pre-school aged children from Gaza, Thabet et al. (2008) found that in contrast to older children and adolescents who might present with symptoms consistent with established psychiatric disorders, pre-school aged children appeared to exhibit more disorganized, non-specific symptoms representing underlying anxiety resulting from exposure to war violence. Morgos et al. (2008), in studying Sudanese children between the ages of 6 and 17, reported that older children exhibited higher clinical levels of trauma than younger children, particularly with somatic symptoms, re-experiencing, isolation, and fear of future trauma, while younger children

endorsed more sleep disturbances. Older children in this study also reported more symptoms of grief than younger children. Differences between the results of the interaction of age and trauma might result from cultural differences in regards to the definition of “child” and variability in societal expectations of children and development dependent on region and culture.

Assessment

The majority of research-supported assessments available to clinicians working with war-exposed youths include questionnaires and semi-structured or structured interviews regarding PTSD symptoms (Gilligan, 2009). Some transcultural measures have been constructed for particular populations through locally developed measures (emic) while some have been adapted from assessments originally developed for populations in the United States and the United Kingdom (etic) (deJong & Van Ommeren, 2002). The majority of assessments for war-exposed populations tend to focus on diagnosis (Miller, Kulkarni, & Kushner, 2006). Proponents of quantitative measures reference that it might be easier for populations exposed to war violence to express their experiences in a more neutral format, such as a questionnaire, rather than recount their experiences in person (Birman & Chan, 2008; Mollica, Wyshak, de Marneffe, Khuon, & Lavelle, 1987). Ehntholt and Yule (2006) recommends surveys as a useful tool for screening children affected by war in identifying need for mental health services as well as tracking treatment progress and effectiveness. A few of the major measures used in research with war exposed and refugee youth are described below.

Questionnaires.

The UCLA Posttraumatic Stress Reaction Index was developed to measure children and adolescents for PTSD in accordance with the DSM-IV diagnostic criteria including the occurrence of a traumatic event that elicited a related emotional response, intrusion, avoidance, and arousal (Steinberg, Brymer, Decker, & Pynoos, 2004). It incorporates both a self-report

form and a parent form and is a pencil and paper test. Participants are asked to identify any traumatic events they have experienced and their lifetime prevalence, as well as identify the event that is considered to be the most distressing to the youth. Severity and prevalence of symptoms are measured using a likert scale. The measure has been supported as having good internal reliability and convergent validity (Ellis, Lhewa, Charney, & Cabral, 2006; Roussos et al., 2005; Steinberg et al., 2004). The PTSD Reaction Index has been used with youth from Bosnia (Allwood et al., 2002; Layne et al., 2001), Greece (Roussos et al., 2005), Sarajevo (Husain et al., 2008), Palestine (Dubow et al., 2010; Quota et al., 2005), and Somalia (Ellis et al., 2006).

The Impact of Events Scale (IES; Horowitz, Wilner, & Alvarez, 1979) is a measure designed for adults in the United States who had experienced a stressful life event. The IES is a self-report organized around evaluating symptoms of re-experiencing and avoidance on a likert scale measuring frequency and intensity for stressful life experiences. The test-retest reliability was 0.87 total with 0.89 for intrusion and 0.79 for avoidance sub-scales (Horowitz et al., 1979). The IES has also been supported as sensitive in assessing and discriminating avoidance and re-experiencing symptoms for those who have experienced stressful life events as compared to those who had not. The IES scale has been revised for children (RIES) by shortening the re-experiencing and avoidance scales and adding items assessing for arousal in congruence with the DSM-IV in order to classify children with PTSD (Dyregrov et al., 2000). The IES and the RIES have been used with war-exposed youth in Sarajevo (Husain et al., 2008), Bosnia (Smith et al., 2002), Gaza (Thabet et al., 2008), and Rwanda (Dyregrov et al., 2000).

The Harvard Trauma Questionnaire (HTQ) was a measure developed to evaluate trauma symptoms and trauma experiences using self-report checklist and an open-ended question for refugees from Southeast Asia (specifically Vietnamese, Cambodian, and Laotian adults)

(Mollica, Caspi-Yavin, Bollini, Truong, Tor, & Lavelle, 1992). It is divided into three parts; the first asks about particular traumatic events experienced by the participants, and the proximity to these events (experienced, witnessed, heard about, none). The second part asks participants to share their most difficult experience during their time as a refugee in an open-ended question. The third part evaluates symptoms of PTSD derived from the DSM-III R and adds an additional 14 questions based on the author's knowledge and experience with the presentation of distress among Southeast Asian refugees. The measure was translated from English and then back-translated into English to maintain language consistency. The HTQ is supported as having an interrater reliability of 0.93 for the traumatic events and 0.98 for the traumatic symptoms; test-retest reliability of 0.92 for the traumatic events and 0.98 for the trauma symptoms; and an internal consistency of 0.90 for the trauma events and 0.96 for the trauma symptoms. Sensitivity of the HTQ to correctly diagnose PTSD was 78% and the predictive value was 85%, meaning that 85% of participants were correctly identified as having PTSD by the HTQ. The author's indicated that the sensitivity with diagnosing PTSD increased with the additional 14 items that were added to the third section of the HTQ that were more culturally relevant to the experience of Indochinese refugees. The HTQ has been translated and adapted for use with Bosnian adolescents (Jones & Kafetsios, 2005) and children and adolescent refugees from Kosovo (Mohlen, Parzer, Resch, & Brunner, 2005) and is available in several languages including Vietnamese, Cambodian, Laotian, Japanese, Croatian, Bosnian, and Albanian (Birman & Chan, 2008).

The Depression Self-Rating Scale (DSRS; Birleson, 1981) was developed in the United Kingdom as a measure for youth, to assess for moderate to severe depression. It is a self-report evaluation that measures depressive symptoms on a likert scale (Birleson, 1981). The DSRS has been supported as having a test-retest reliability at 0.80 and internal consistency at 0.86. It has

also been supported as a valid measure in differentiating between depressed and non-depressed children. The DSRS has been adapted for use with children who have experienced natural disasters and war trauma in Bosnia (Smith et al., 2002), Nepal (Kohrt et al., 2010), Somalia (Ellis et al., 2006; Kia-Keating & Ellis, 2007), and Greece (Roussos et al., 2005).

Semi-structured and structured interviews.

The Childhood War Trauma Questionnaire (CWTQ) was developed by Macksoud (1992) as another measure to identify the war experiences of children and adolescents exposed to political violence, particularly with Lebanese youth. The CWTQ is a semi-structured interview with children and adolescents that inquires about the type of events that youth have experienced during war (including exposure to shelling or combat, witnessing violence, personal physical injuries, separation from parents; loss and bereavement, displacement, immigration, personal involvement in violence, and deprivation) and was developed based on research with Lebanese youth as well as interviews by the author. This measure has been supported as having a Cronbach Alpha coefficient of 0.65 (Macksoud, 1992) and has been adapted for use with Bosnian youth (Goldstein et al., 1997; Smith et al., 2002) as well as former Ugandan child soldiers (Klasen et al., 2010). Macksoud and Aber (1996) also developed the Posttraumatic Stress Reaction Checklist (PTSRC) for Lebanese youth as a structured interview based on the Post-Traumatic Stress Reaction Index. The intent of the PTSRC was to measure PTSD symptoms related to one traumatic event related to a war experience. Macksoud and Aber (1996) reported that the Cronbach Alpha for the PTSRC was 0.77 and supported internal consistency.

The Mini-International Neuropsychiatric Interview for Children (M.I.N.I. Kid) is a brief structured interview developed using the DSM-IV and ICD-10 to assess for psychiatric diagnoses in youth including PTSD, anxiety, and depression (Sheehan et al., 1998). It was

originally developed in the United States and Europe, but has been adapted for use with youth from Afghanistan (Catani et al., 2009), and Uganda (Klasen et al., 2010).

Culture and Context

Margolin (2005) discusses three theoretical perspectives regarding children and adolescents exposed to violence including developmental psychopathology perspectives, trauma theories and family systems theory. In developmental theory, the context of the violence interacts with the youth based on developmental stage and has less of a focus on diagnosis and more emphasis on functional well-being. In trauma theory, the violence exposure is theorized to create a threat to life and a stressful environment for the youth, which can then yield symptoms of PTSD as well as other consequences and functional impairment. According to Margolin (2005), family systems theory proposes that violence in the child's family or community creates threat to the youth's sense of security because there is less availability for caretakers to provide safety to the youth. War-affected children not only experience traumatic events in relation to political violence, but also may experience family-related stressors such as domestic violence and substance use as well as community-related stressors such as poverty and child labor (Catani et al., 2009). Miller and Rasmussen (2010) highlights the difference between trauma-focused advocates and psychosocial approaches to understanding communities affected by war violence, specifically is that trauma-focused conceptualizations emphasize the exposure and psychosocial approaches recognize the secondary consequences, displacement, loss, and the primary contribution to distress. The former focuses on symptom relief and the latter on altering environment and alleviating stressful life conditions to improve mental health. Elbedour et al. (1993) supports five ecological dimensions influencing the development of trauma with children exposed to war violence, including developmental characteristics and resources of the child,

influences of family, loss or damage to community structure, cultural influences, and the political and social characteristics of the war violence.

The majority of current knowledge of war-affected children is based on research using assessment that focuses on symptoms associated with PTSD (Berman, 2001; Catani et al., 2009). Examinations of the “dose effect” by researchers elucidate a trauma-focused viewpoint where the exposure is the primary factor in explaining posttraumatic symptomatology (Miller & Rasmussen, 2010). However, Miller and Rasmussen (2010) also support that war exposure typically explains less than one-quarter of the variance (25%) in reports of PTSD. Hollifield et al. (2002) examined instruments used in refugee research and discovered that the primary issues with the available assessments for refugees is a lack of consistent theory directing the construction of instruments specific to refugee populations and the limitations in standards of measurement, contributing to variability of findings between studies. Summerfield (1999) argued that there is no consistent definition of what constitutes “trauma” and that questionnaires do not take into account the subjectivity of the experience and the social context that contributes to the meaning of the event. When studying refugee adolescents from Khmer, Sack, Seeley, and Clarke (1997) supported that PTSD symptoms were prevalent, including avoidance, intrusion, arousal, and numbing among youth, and that assessments into PTSD can be reliable and valid if constructed carefully. Berman (2001) further supports that although questionnaires that focus on PTSD might contribute to some awareness of the consequences of war on children, it does not appear representative of the full magnitude of issues experienced by children living amidst political violence. Berman (2001) emphasizes an approach in conceptualizing children based on their meaning from within a sociocultural frame. Miller, Kulkarni, and Kushner (2006) argues that the overwhelming focus of assessment in the area of war-affected populations has focused on Western diagnoses with roots in a biomedical paradigm using a “trauma-focused psychiatric

epidemiology” which perceives distress related to war violence as universally experienced and expressed. Further, he states that these assessments focus on the exposure to violence, which then guides a trauma-based conceptualization, when other stressors (such as those associated with displacement or daily stressor) might be more relevant and prevalent in causing distress. Fernando et al. (2010) emphasizes that assessments have been targeted to focus on individual symptoms rather than functioning in the greater cultural and social context, which is an essential component in understanding trauma reactions with children from collectivist cultures. Additionally, Fernando et al. (2010) proposes that the majority of assessment into child reactions to traumatic events has occurred without much attention to cultural process, and there is little research in understanding cultural idioms of distress. DeJong and Van Ommeren (2002) indicates that idioms of distress are better understood from within a sociocultural frame. Miller et al. (2006) recommends that organizations serving war-affected populations look towards studying local idioms of distress, culturally specific forms of coping, and cultural perceptions of impairment to functioning and maladaptive psychological factors. Further, they argue for identifying what the population believes are the most problematic issues and incorporating how war- related and non- war- related stressors influence presentation of distress. Bracken et al., (1995) proposes that conceptualizations underlying PTSD be used with caution and applied with recognition of their limitations. Dyregrov, Gupta, Gjestad, and Raundalen (2002) indicates that a denial of trauma can contribute to a lack of services promoting psychological recovery and supports, and that it is important to incorporate trauma into understanding the effects of political violence on war- affected populations.

Berman (2001) highlights the challenges in understanding trauma according to a universalist approach because children raised in war environments experience “traumatic events” on a regular basis, which conflicts with the conceptualization of trauma as an abnormal event

which causes an abnormal response. Possible issues that also might not be addressed in research are macrosystem factors such as the political, economic, and social implications of war (Rosner, 2003). Bracken et al. (1995) emphasizes that social, political, and cultural context are central in understanding responses and influence the meaning ascribed to violence, the experienced and expressed distress, and the supports and coping available. The NCTSN Core curriculum on Childhood Trauma Task Force (2012) identifies culture as one of the core components in understanding a youth's experience of trauma. The task force indicates that culture mediates the meaning associated with a traumatic event as well as a youth's and family's response to a traumatic event including coping strategies as well as distress. Further, the task force references previous history of trauma experienced multigenerationally or systemically by cultural groups as influential to the individual's traumatic response. Although universalism has been found in studies using questionnaires as their measures, symptoms of PTSD may not carry the same meaning cross-culturally and might not be salient for use among non-western populations (Bracken et al., 1995; Miller et al., 2006). Some have argued that symptoms of PTSD such as re-experiencing and arousal might be universal cross-culturally because they are biological responses, but symptoms of avoidance might be culturally bound (Dyregrov et al., 2002; Marsella, Friedman, Gerrity, & Scurfield, 1996). Elbert and Schauer (2002) support that PTSD is based in neurobiology and the effect of flight or fight responses, and that cultural variations influence the specific expressions of symptoms and coping. Others postulate that intrusion-avoidance symptoms are culturally-bound because responses to violence exposure carry different meaning (Bracken, 2001).

Further, conceptualizations focused around PTSD emphasize the individual and intrapsychic experience interfering with neurological and psychological processes, which might not be applicable in non-Western settings and might isolate individuals by identifying them by

means inconsistent with their cultural and social worldview, or causing delineations within communities, and causing potential disconnect in their societies (Bracken et al., 1995; Eisenbruch, 1991; Kirmayer & Young, 1999; Summerfield, 1999). Resilience is an expression termed by dominant culture of the United States in understanding individual characteristics attributing to success, while resilience among different cultural populations, particularly with collectivist worldviews, might value contribution to community over individual success in response to traumatic circumstances, or may lead to blaming the youth if they are not able to achieve resiliency (Aisenberg & Herrenkohl, 2008). War might cause greater impairment on the collective rather than the individual due to the damage inflicted on social values and identities (Summerfield, 1999). Experiences of distress related to war-conflict might be beyond the classifications designated by western-derived diagnoses, and may incorporate spiritual factors or psychosomatic complaints outside of the psychological paradigm (Miller et al., 2006). Further, PTSD might not be the primary area of distress influencing impairment to functioning, or impairment might be different depending on worldview. For example, Wessells and Monteiro (2001) discuss how belief systems in Angola place emphasis on spiritual and communal domain in relation to traumatic events and the meaning of adverse experiences is attributed to a failure to honor ancestry. Qualitative evaluations with women from Uganda found that although they presented with symptoms of PTSD, these were not the primary concerns, and that somatization was found to be the way in which women in Uganda experience distress (Bracken et al., 1995). In a study of African-American and Latino adolescents in the United States, the most severe event was correlated with higher rates of PTSD, but there was contrast in what adolescents reported was their most severe event and what was their most “bothersome” event (Aisenberg, Ayon, & Orozco-Figueroa, 2008).

The intent of this study is to collect interviews from clinicians who have worked with refugee youth with a history of war exposure in order to understand how the varying and sometimes contradictory research and assessments in the field of political violence, refugee, and youth have influenced clinical therapeutic practice with this population. This exploration also seeks to understand how the clinician's theoretical orientation might influence conceptualization for refugee youth exposed to trauma. Furthermore, there is interest in the process by which clinicians create formulations based on the multitude of potentially distressing life events that refugee youth endure, particularly considering pre-migration, migration, and post-migration experiences. Finally there is interest in the influence of culture and development on conceptualization as well as other systemic factors, such as family, religion, and community because these have been proposed by some researchers as integral components that might go overlooked by assessments and conceptualizations.

Research Strategy

Characteristics of Qualitative Research

Qualitative methods and design focus on meaning and context. They allow for emergent information that focuses on the experiences of the participant (Hatch, 2002). Qualitative methodology is especially useful among diverse ethnic populations because the researcher is expected to reflect on potential biases and prejudice throughout the process so that the participants' experiences are fully represented (Krahn & Eisert, 2000). This form of methodology also grants more control over the process of gathering research by encouraging collaboration and the active role of the participant; as the participant has control over the presentation of their interview; which is later used as data in the analysis (Corbin & Morse, 2003).

The purpose of the interview is to gather an oral history where participants are encouraged to share their experiences and personal reflections (Plummer, 1983). The purpose of the analysis is to recognize themes and meanings in the interviews within the participant's contextual and sociocultural frame and to connect the experiences of the individuals to their greater cultural, social, and political influences (Huber & Whelan, 1999). The present study focused on aspects of the interview that elucidated the conceptualizations of clinicians who have worked with refugee youth exposed to political violence, as well as the types of experience and resources used by these clinicians when developing these conceptualizations.

Participants

Participants consisted of clinicians who have worked with child and adolescent refugees with histories of war exposure. This was defined as a violent event that has either been directly witnessed (i.e. seeing a family member harmed or being personally harmed in the context of war violence) or secondarily witnessed (i.e. hearing about a friend being shot, a family member being harmed, or going to jail as a consequence of political violence). There were 6 clinicians who participated in the study, which is an appropriate number considering the depth of qualitative research in understanding the experiences of the individuals involved (Creswell, 2007). All of the participants in the study were women. Four participants identified as Caucasian, 1 identified as Hispanic, and 1 as African- Creole. They were licensed between 7 and 19 years at the time of the interview and the range of clinical youth they had seen in a clinical capacity ranged from 10-180 clients. Five of the clinicians worked with refugee youth clients in community mental health settings, 2 in hospital- based settings, 2 through non-governmental organizations, and 1 at a non-profit organization.

For the purposes of this study participants needed to meet certain criteria in order to address themes central to the research questions (Creswell, 2007). Participants were required to

be licensed therapists (Masters level or higher) with a history of working with at least three refugee youths (defined as under the age of 18) and at least one that had been exposed to political violence. The participants were also required to have seen the refugee youth with political violence exposure for enough sessions that they felt they completed the intake, and could provide a comprehensive conceptualization of the youth.

The purpose of using this target population is the result of limited research with understanding how clinicians conceptualize the experiences of refugee youth who were exposed to political violence pre-migration. The participants were also required to have been licensed while working with the youth and were expected to uphold confidentiality for the youth they were discussing by not providing any identifying information as outlined by HIPAA. This included de-identifying the youth by not discussing names, all geographic subdivisions smaller than a state, all dates smaller than a year, phone number, fax numbers, e-mail, social security numbers, medical record numbers, health plan beneficiary, any other account numbers, certificate/license numbers, vehicle identifiers, device identification numbers, web url's, internet IP address number's, biometric identifiers, full face photographs or comparable images, and any other unique number, characteristic, or code. Understanding the contextual means in which clinicians conceptualize and make-meaning of the distress of refugee children and adolescents was constructive in understanding the processes by which research and assessment regarding refugee youth has influenced practitioners.

Interview Protocol

The establishment of rapport, the type of questions, and feedback are all significant considerations within the qualitative interview protocol (Clandinin & Connelly, 2004). Patton (2002) emphasizes the importance of establishing rapport with the participant through empathy

and non-judgment. He also stresses feedback that is neutral to minimize the consequences of negative or misperceived reactions.

The structure of the interview protocol was focused around the central research questions and sub-questions and was targeted towards gathering more latent and meaningful content (Creswell, 2007). The semi-structured interview provided some order to the protocol in addressing the research questions with the freedom for the participant to go beyond what was being asked in the interview through the use of open-questions and probes (Berg, 2001). The use of open-ended questions minimizes the implication of a predetermined response and allows the participant to direct their answer in a more contextual and meaningful way with the focus on process rather than purpose (Patton, 2002).

The interview protocol designed for this study focused primarily on the research central and sub questions (see Appendix A). The initial question (Question 1) was designed to give the participant the purpose of the study and inquire about how the participant generally conceptualizes clients according to their clinical theoretical orientation in order to provide a frame of reference for the conceptualization. The protocol was also targeted towards understanding context of the setting where the clinician provided services to the refugee youth and in what capacity (Question 2) as well as what had informed their work when constructing a conceptualization with refugee youths (i.e. assessments, clinical experience, school experience, research experience, personal experience, etc.) (Question 3). Question 5 sought to understand the process by which the youth was assessed (i.e. intake interview, questionnaire, structured interviews etc.). Questions 4 and 6 inquired about the background of the refugee youth client as well as their experiences before migration (including exposure to war trauma, grief, etc.), during migration (the process of the flight, resettlement camps, poor access to recourses, separation), and post-migration (acculturation difficulties, language and cultural dissonance, lack of

resources, integration into school etc.) to provide context to the answers for Question 7, which focused on assessment and conceptualization. Question 7 asked the participant for their perspective on the issues and distress experienced by the youth that necessitated therapy. Question 7a. inquired about how the participant conceptualized the client based on the client's history and presentation of distress. The last two questions sought to understand how assessment was incorporated into the conceptualization of the refugee youth client (Question 7b) and cultural considerations that were factored into conceptualization (Question 7c).

Data Collection Procedures

Recruitment.

Participants were actively recruited upon approval from the Pepperdine University Institutional Review Board. The process of recruitment was through the snowball method, where prominent or involved leaders in the community are relied upon to identify individuals relevant to the purpose of the study (Creswell, 2007). Participants were recruited through leaders in the trauma field with whom the researcher and the dissertation chair have professional relationships. These clinicians were sent a brief description through email describing the study and were asked to forward these on to other clinicians residing in the United States that meet the participant requirement of the study. The author also contacted these potential participants directly if contact information is provided to give brief descriptions of the study and request participation in the study.

Consent procedure.

Participants were over the age of 18 and could therefore provide consent for their own participation in the study. After interested participants were identified, the participants were called and the researcher reviewed criteria with the participant; such as the criteria for participants (clinician must have a history of working with one previous refugee youth that had

experienced direct or indirect exposure to war violence; clinician must have been licensed at the time and must still be licensed and under HIPPA laws to protect patient confidentiality). If the participant met the criteria; interviews were scheduled. These meetings were conducted at the facility most convenient to the participant. The meeting site was in a safe and comfortable environment that was secluded to ensure confidentiality.

During the meeting, the researcher read the consent verbatim. The consent (Appendix B) was developed in accordance with recommendations by Creswell (2007) and Patton (2002). The consent addressed the purpose and intent of the study, outlined the procedure, and indicated issues regarding confidentiality as well as the potential risks and benefits of participating in the study. Additional information included in the consent addressed the use of digital recording, compensation, the ability to stop the interview if the participant is experiencing overwhelming distress, and the limitations to confidentiality. This consent also addressed the difficulty in maintaining complete confidentiality due to the depth and breadth of interviews. The participants were also reminded to uphold confidentiality by not providing any identifying information about the youth, as defined by HIPPA. Once the consent procedure was completed and the participant had agreed to participate, signatures were required on two consent forms; one copy for the researcher and the other copy for the participant. The researcher was also required to sign the consent form as a witness.

Research procedures.

After obtaining consent, the interview commenced with the principal researcher conducting the interview. Interviews were expected to last between 1-3 hours depending on the participant and the content of their story (Seidman, 1998). All of the interviews were between 1-1.5 hours long. They were recorded onto an mp3 recording device. The entire interview protocol occurred over the period of one day. Breaks and refreshments were provided periodically at the

request of the participant when available. During the interview, the researcher used prompts in the form of probing question in order to achieve more clarity or depth and dimension in regards to the story. The end of the interview protocol included closure questions that asked the participant to inform the researcher of anything important or salient that was missed or overlooked during the interview. Further, sociodemographic questions such as age, place of birth, etc were asked initially as a way of establishing rapport. The researcher then expressed appreciation and validation to the participant. The researcher informed the participant that the researcher might contact the participant after the interview to discuss any areas of confusion about the meaning of a particular word or phrase so that the researcher could ensure that the meaning in the coding was true to the participant's intentions. Following each interview, the primary researcher journaled regarding the process and content of the interview as well as feelings, reactions, or insights in addition to potential biases that may have occurred during the interview. This step was very important for assessing potential subjectivity that might interfere with coding the interview during data analysis.

Data Management Procedures

The interview was recorded onto a digital recording device with a USB port and was then saved onto the primary researcher's password protected computer and one cd before being destroyed. The files were hidden and assigned pseudonyms. A de-identified USB drive of each transcript is kept locked in a file cabinet that only the primary researcher can access. A research assistant was hired and used the designated computer only for transcribing the interviews. The research assistant was a student in a MA psychology program at Pepperdine, and completed the HRI training to ensure that they are aware of the laws protecting confidentiality. The files were labeled with pseudonyms before they were given to the research assistant. Any identifying information is kept in a separate locked filing cabinet, and only the primary researcher has access

to this information. One hard copy of the transcripts was made (again under pseudonyms) by the research assistant to distribute to the primary researcher for coding. Further, information stored on the primary researcher's computer was saved onto a USB drive and is being kept in the same cabinet, and all the related digital files on the researcher's computer have been destroyed following transcription. Following the consultation, the hard copy has been retained and is kept in the same file cabinet as the USB drive with the transcript. The locked cabinet is stored in the primary researcher's home office. All other materials with identifying information, including consents, has been secured in a different locked cabinet with the primary researcher's chair. Only the primary researcher has access to these materials.

Data Analysis

The process of analyzing the data was conducted both within-case and between-cases. In this type of analysis, thematic content of the transcripts was reviewed for both the individual, and then for the sample as a whole.

Within-case analysis.

The purpose of the within-case analysis was to understand and give context to the experiences and meanings of the individual participants (Creswell, 2007). This provided information on the ways in which each clinician conceptualized their client given the contextual information of the youth being discussed. The within-case analysis focused on the conceptualization questions answered by the participants rather than the entire interview because the conceptualization question addressed the primary goal of the study. The additional factors, in addition to the conceptualization, were only examined in the between-case analysis. The initial responsibility in the data analysis was reducing the massive amounts of text provided during the interview for each participant into manageable and interpretable data (Mertens, 2005). This was done first through creating margin notes in each of the transcripts, highlighting potentially

meaningful or significant patterns emerging from the data. Through the margin notes, the primary researcher identified key phrases or terms used by the participant in understanding or explaining their story (Patton, 2002). This was an important step in ensuring that the interpretations of the meanings were more context and culturally specific because the results were directed more from the participant than the researcher.

These notes were then assigned into preliminary codes, which involved assigning labels to interrelated text. The researcher relied on consultation and feedback from the researcher's chair in developing these codes to reduce the influences of researcher bias on interpretation (Mertens, 2005). These codes are an organized representation of the interview, and all the meaningful text indicated through the margin notes were reviewed and placed into their appropriate codes.

These codes then underwent thematic analysis, where codes were organized into themes through a process of reduction. These themes represented the deeper underlying constructs indicated by the preliminary codes. This was conducted through identifying emergent themes and patterns recognized during the previous steps that might have indicated systems of meanings associated with the experiences of each separate participant. The process of thematic analysis involved frequent review and revisions until each relevant code was represented in a theme. This also required convergence within themes (codes "hang together") and divergence from other themes (no significant overlap) (Patton, 2002).

The emergent identified themes for the within-case analysis have been presented through individual profiles containing thick descriptions of each participant (particular attention to time, place, cultural, and individual context). This type of data presentation of each individual frames the analysis from within the contextual experience of the participant and enhances the validity in

interpreting the meaning of the participant's conceptualizations (Mertens, 2005; Patton, 2002). The dissertation chair was utilized as the auditor to evaluate the validity of the codes.

Between-case analysis.

The process of the between-case analysis was similar to within-case analysis, except that themes were constructed using information across and between the entire sample of participants (Creswell, 2007). This type of analysis was used as a means of providing a better understanding of the cumulative themes of clinicians in conceptualizing refugee youth. Through this analysis, the researcher first made margin notes on potential patterns and themes emerging from examination of the entire sample. Transcripts were coded again for each participant by looking for meaningful text, but with the intent on interpreting the sample and not the individual. This involved a different set of codes than the individual codes that were specifically designed for capturing themes and context across the sample.

The codes were then distilled and placed into themes that focus on the shared meanings for the clinicians. These patterns or themes elucidated similarities in understanding and expressing the meaning by which clinicians conceptualize refugee youth. The results of the between-case thematic analysis have been presented according to theme and through interrelated text from the participants supporting the presence of the theme.

Results

Within- Case Analysis

The sample consisted of 6 licensed therapists in the United States. Table 1 represents some of the demographic variables of each therapist. Each participant is represented by a number (i.e.A-F).

Participant A: “I see this as trauma- related now, how could I not?”

Participant A is a Masters level therapist who has been licensed for 14 years. She is currently finishing a Psy.D. program in clinical psychology. Participant A opted to focus her conceptualization on a young boy, approximately 8 or 9 years old, from a country in Central America. She reported that she had been licensed for one year prior to seeing the client. The boy had been referred after his mother had “taken a belt to him.” The boy lived in a low income neighborhood with his mother and two siblings (the client was the middle child). Participant A described the boy’s presentation as having “very strong, violent reactions.” Specifically, she described the client as having “externalizing behaviors,” and engaging in “verbal threats,” as well as kicking and punching walls and screaming.

Three central themes emerged from Participant A’s conceptualization of her client’s presentation of distress during therapy. They were (1) loss (2) disruption to family dynamics and (3) exposure to war violence pre-migration.

Loss.

Loss was a significant theme that was prevalent during Participant A’s account of her client’s conceptualization. Loss for this client can be defined as the loss of family members due to war violence pre- migration. The participant indicated that the client’s father and brother disappeared while the soldiers were encamped at his house, and the mother suspected that they were taken to fight as soldiers for the war:

One of the sides took his older brother and they never saw him again. The same thing with the dad, and mom had explained that the older son and the fathers were often recruited and so they had been taken and recruited... And so for the kid, it was a little, it was quite impactful seeing brother and father taken away.

The participant described that particular factors contributed to the client's distress regarding the loss of his brother and father, particularly the suddenness and confusion about the purpose of them leaving:

He didn't understand about the politics and why he couldn't leave, he couldn't understand why his father and brother were no longer in his life and, and now they were non-entities so to speak, in the family because now, that they didn't even really talk about them anymore, it's- they were ghosts in the family, they upped and left one day, not by their choice, but they, you know, this kid felt abandoned and he needed, you know, those male figures in his life.

Disruption to family dynamics.

The second theme that emerged through Participant A's conceptualization of her client was the disruption to family dynamics. This theme describes the client's distress as a result of changes in the family structure which disrupted the family system and interfered with traditional coping due to loss of family support resulting from the war violence, migration, and post-migration struggles: "The issues and distress came from, there were sudden changes for these families, for this family, you know, life as they knew it, and then it suddenly changed."

When the client's father and brother disappeared while the soldiers were encamped at his house, his mother became the sole caregiver of the client and his siblings. According to Participant A, this shift in caregiver responsibilities and traditional roles affected the client's support system. She stated:

It was this woman who was suddenly head of household and not only was she mom but she was also father and provider now to this family in ways that she hadn't been provider, which pulled her out of a less of a nurturing role.

Further, the client's sister adopted a parentified role in the family. This was the result of both the loss of the client's brother and as well as acculturation difficulties, which caused conflict within the family:

The older daughter became very much the translator, and had this parentified role because she helped navigate things for mom, and the older sister, I want to say she was only about 12, so she was still a very young girl, but had assumed this very adult role with mom, and it felt like the two of them forging forward in this new country with the little boys. Which created conflict for my client, because he wasn't that much younger than his older sister, and he resented her being in a role, kind of telling him what to do, so post-, the acculturation issues were enormous initially.

Participant A also described that the disruptions to family dynamics as not only structural, but also related to the stressors that they had experienced pre-, during, and post-migration. According to Participant A, there was interference to the traditional styles of coping within the family resulting from the myriad of adverse events they experienced during the conflict that were inhibiting the client's ability to recover:

They came in for this issue of physical abuse, and I could see that these kids, initially on, you know, the surface, these kids are out of control. I can see this mom just has no hold over her kids, and really no influence, and I could see her getting frustrated and taking a belt, and she was a passive woman. So then, I started asking the questions in terms of how they had gotten here and heard this harrowing journey through the desert and the coyotes and the threats, of how the coyotes would threaten them, which led to another question, which led to what has happened in country of origin. So this theme emerged of violence and exploitation, and so that really how I started to conceptualize the case, as looking at what the overall theme that this family had experienced, and, although this

child, this boy, had come in as my client, it really felt like a family issue and a family that was hurting and needed help making sense of their shared experience and how to come together as a family to support each other.

Exposure to political violence pre-migration.

Another theme that Participant A endorsed during her interview supported that the exposure to political violence pre-migration created an environment of violence for the client, which in turn contributed to the client's own violent and aggressive behaviors. Participant A explained her understanding of the client's symptoms as the result of his exposure to threats and violence during his pre-migration and migration period:

We had, at the agency, always wondered what kind of head trauma this kid may have experienced, and we, we had had some suspicions of kind of this impulsive anger that he had. He would just go into these rages and I, I think in hindsight, that it had everything to do with the things he witnessed.

Participant A described the traumatic exposure pre-migration that her client witnessed as the result of soldiers encamped at his house with massive amounts of weaponry including tanks and big machinery. According to Participant A, his mother was "not treated very nicely by the soldiers" and was forced to feed and care for both factions of the war: "The soldiers had somewhat taken over the house with them there, and mom was required to feed them."

Participant A described the client's witnessing the guns and weaponry that accompanied the soldiers as a type of modeling of violence and violent behaviors, which the client continued to present with post-migration:

He described what sounded like a tank coming down the road, like big, some sort of big machinery, when the soldiers had come through and he was, just 'cause he was so fascinated with their equipment and found them so impressive.

Participant A went on to describe the glorification of war violence for the client as contributing to his tendency towards aggressive behaviors:

This kid was always getting in trouble at school and couldn't understand why he was acting out so much. Well, of course we understand so much related to trauma now and he was always getting in trouble and fighting, and for him it was fun.

According to Participant A, the client's perception of violence had been perpetuated by his exposure to war violence pre-migration as well as the fact that while staying at his house, the soldiers were "encouraging his violence." She also suspected that post-migration, her client was "getting triggered right and left," which also contributed to his violent behaviors. Participant A described this learned behavior as particularly salient given the violence he continued to experience post- migration:

They moved into an area with a lot of heavy gang influence as well, which of course seemed exciting for this kid, because it was, he had this kind of, he was, felt the violence was somewhat glorified and was very drawn to that.

According to these emergent themes, the participant's integration of loss, exposure to violence, and disruption to family dynamics appears to address several variables contributing to the client's behavioral problems, that have implications not only related to the political violence, but also post- migration struggles as well.

Participant B: "When you encounter that kind of courage, how do you speak?"

Participant B is a clinical psychologist with a Ph.D. who has been licensed approximately 16 years. Participant B focused on a 17-year-old African female who she worked with after having been licensed for 4 years. The client was the oldest daughter in a two- parent household with one younger sibling. According to Participant B, the client was the "victim of politically

motivated kidnapping, imprisonment, rape, and torture.” She also described the client as “very frightened” and that the reason for the referral was “trauma.”

Two major themes emerged through Participant B’s conceptualization of the presentation of her client. These were (1) trauma- based conceptualization and (2) resiliency.

Trauma- based conceptualization.

Participant B endorsed conceptualizing the client using a trauma- based conceptualization, which is a consistent theme throughout her interview. The trauma- based conceptualization can be understood as a means of understanding the client’s distress as trauma reactions to adverse life experiences: “The conceptualization was a trauma- based conceptualization that took into account the kinds of things that torture victims, victims of politically motivated violence experience. I think that’s what it was at the core.” The formulation around Participant B’s theme of trauma- based conceptualization appears to relate to the client experiencing symptoms consistent with Posttraumatic Stress Disorder including “restricted range of affect, numbness, avoidance. Incredible avoidance, incredible hyperarousal.”

Although Participant B referenced the client’s stressors related to migration as central to contributing to her client’s distress, she placed emphasis on the traumatic experiences she endured:

So she showed up, and finally found this person and it was such relief that all of this had somehow worked, combined with, “oh my, ok, now that it worked, now I finally have to pause and reckon with all- this thing that’s happened to me.” It was the trauma combined with the refugee experience. The refugee experience was probably the least of it, and it was a lot, but now she had to just sit with all of it.

Participant B particularly referenced her client's avoidance resulting from fear of revictimization towards her and her family stemming from the exposure to violence that she had experienced as the result of political discord in her home country:

She was so, so, so frightened... to the point that she wouldn't; she would never go to places where people from that country, there are communities in LA where she might have found some connection, and she avoided all of them because she was just so afraid that either she or her family would not be safe.

During her conceptualization, Participant B also referenced trying to discern between cultural normativity and avoidance symptoms resulting from the exposure from within the context of the client's history. She explained her client's symptom presentation related to her trauma as complex and nested from within her client's experiences, both trauma and cultural, particularly in her client's relationship with men:

She had not been allowed to have any contact with men, not even a conversation, not a touch, nothing, for however long it had been, and I honestly don't remember. It wasn't more than two years, but it might have even been up to about two years, or at least it was several months, and then suddenly to have to get on a bus and come, and maybe a guy is going to hand you your ticket, and you have to reach up and get your change from a guy. That felt really different and weird to her, and because some of that culturally sanctioned behavior actually protected her avoidance, she kind of liked it, and so that had to be understood. It wasn't just regular avoidance, it's no; she hadn't been doing these things for the last couple of years.

Resiliency.

The theme of resiliency during Participant B's interview can be defined as the ability for her client to adapt and recover related to stressful life circumstances, and how that mediated her

response to the adverse experiences she endured pre-, during, and post- migration. Participant B focused largely on the client's strengths in describing her overall presentation of the client:

“There was a lot of positive psychology that one couldn't help but conceptualize, because when you encounter that kind of courage, it's...how do you speak? It's so touching.” Participant B described her resilience in the context of her client's “trauma” experiences:

It was quite beautiful, I think, to show her who she was, to have the privilege of holding up a mirror, while helping to ease some of what she was afraid of, in the ways that we know how to do, at the same time really bearing witness to, not only the tragedy, but to the raw strength and courage, was quite a privilege, and I think she came to see it in ways that are quite good for her to.

The Participant B also described the client's value system as a protective factor in promoting her recovery from the trauma experienced during her imprisonment, and her ability to maintain her values during this time may have mediated the effects of her exposure:

She described how every third or fourth day, she was brought in, and new people were arrested, and she was required to say whether she knew these people or not, and she always, every single time said, “No, we've never met.” Even when she knew that they had said that they knew each other, or when it was obvious that they knew each other, or when there was evidence that they knew each other, and she knew there was evidence. She knew she was going to get beaten and raped, and never the less, she said, every single time, “Nope, we've never met.” Because worse than being raped and beaten, was to feel, for her, responsible for someone else's.

She additionally described her client's strengths and resilience in the context of her seeking treatment to continue with her recovery. That her motivation to seek therapy and evolve

beyond her adverse life experiences was both a reflection of her resilience, and a factor that continued to engender greater resilience:

That, in spite of all this, she was going to get herself on a bus, where she was scared to death to be because men were there, and come from this really far; if I could tell you where it was, you'd say 'No way! There's no way somebody could go to Santa Monica from there, twice a week...Just, and then a couple times when she missed a bus and then it turned into like a four hour each way, just that she could do that from the very first meeting, and then once I knew what had happened to her, and what she had made happen, you know, on the positive side, she was such a mixed, exquisite picture of somebody who was so victimized and so powerful simultaneously. But all of that was obvious, so first we had to work to alleviate some of the trauma symptoms, but I knew from the start that anybody who was going to actually do this is- this is going to be quite a lovely piece of work she's going to get to do.

The strengths and challenges that were identified by Participant B appear to reflect a holistic representation of the client that occurred throughout the entirety of her refugee experience, which directed her treatment approach to address trauma symptoms while encouraging strengths.

Participant C: "He definitely was very focused in the now."

Participant C is a Masters level therapist who has been licensed approximately 7 years. Participant C decided to focus her interview on a 15- year- old male from the Middle East that she had worked with after being licensed for 2 years. This client was "self-referred" due to problems in school, such as difficulty concentrating, as well as for being "scared all the time" and "not sleeping." According to Participant C, the client experienced both direct and indirect exposure to shootings and bombings in his country of origin, as well as death threats towards his father and himself, threats of sexual assault towards his sister, and his father was taken captive

for a short while due to his political views. The client spent some time in a refugee camp after leaving his home country, but Participant C reported that: “That was not a part that they focused on. With other people that I’ve worked with, that’s a big focus, and then actually coming here is itself really traumatic. For this particular person, it wasn’t.”

Two major themes appeared to emerge from Participant C’s conceptualization of her client’s overall clinical presentation. These major themes were (1) Post-migration struggles, and (2) Trauma- based conceptualization.

Post-migration struggles.

One of the major themes prevalent throughout Participant C’s conceptualization of her client is post- migration struggles. This theme can be defined by the client’s experiences post-migration, including acculturation issues, exposure to violence, and living situation, that contributed to the client’s presentation of distress. Participant C describes the client as being very “focused on the now” and so much of his distress was related to current stressful situations post- migration. One of the major issues that Participant C emphasized as distressing to the client was the living situation the client experienced upon arriving in America, and the violence he continued to witness in his neighborhood.

I would say probably his biggest one initially; he was resettled into a very poor African-American neighborhood, and for him that was really difficult. He didn’t feel like it was safe, there was still routinely regular kind of gunshots that were happening, so he felt very, very unsafe in his neighbor. They stayed in the house almost all the time; he wasn’t let out of the house for the most part. His father was working really long hours, so mostly it was him and his mother in a very small, kind of cramped space, and they didn’t go out, and that was probably for him the most stressful. School, initially he had a really hard time. He actually didn’t think the school was very safe, he was really surprised by

some of the drug and gang activity in the school, and was actually really scared and his nightmares increased after that.

Participant C also referenced acculturation and lack of community as another issue that was creating distress with the client that was related to his post- migration experience. In discussing the client's clinical presentation and difficulty with adapting to the United States, Participant C stated:

He had a huge language barrier. There wasn't anyone in that school that was even from their region. No one else spoke the language. They were one of the first families that came, so there wasn't even like a community in the area where they resettled. So I would say actually that's probably the hardest.

Participant C went on later to indicate that the client presented as being reserved upon their first meeting, and she attributed much of that to language, but that his guarded manner went beyond just language difficulties:

Yeah, I think he was even more so than most. I feel like you kind of assume that if you're going to talk to somebody who's just come, and there's language issue in the beginning between the two of you, that that's part of it, but I think he was even more so than that.

She attributed his particular reserved manner to "all the change that happened so quickly for him, and once he kind of was able to feel like he was ok and safe, he actually wasn't reserved at all."

Also related to the client's stressors upon arrival in the United States, Participant C indicated that post-migration, the client experienced additional distress resulting from his feeling isolated and discriminated against by his host country:

Social isolation was a big part of it. There's a lot of kind of discrimination and like perception that he received of what people thought, and what his country of origin was like, and he had a really hard time with that.

Participant C went on to say that: "once he had a support group, then he felt more accepted, and once he felt more accepted, actually some of the symptoms went down." This again supports that the client's symptom presentation, according to Participant C, was related to his feeling marginalized and isolated from his surrounding community post- migration.

Trauma- based conceptualization.

Another major theme endorsed by Participant C when describing her clinical formulation of her client, was a trauma- based conceptualization. This theme can be defined as the client's expression of distress resulting from the exposure to political violence he experienced pre- migration. According to Participant C, the client experienced a myriad of stressful and violent experiences pre-migration during the political conflict, which interfered significantly with his normal coping strategies. Participant C also supported that the client adapted new coping strategies following his pre- migration war experiences:

I think, for him- for me it was more of a trauma specific thing, 'cause he had a lot of coping strategies that he had utilized before the trauma kind of intervened in that and had major consequences in his life, but also in his functioning. So from talking with him and talking with his parents, he didn't really utilize denial and internalization and avoidance prior to the trauma, but did very much so after the trauma.

Participant C described the major strategies that the client utilized to cope with the violence exposure to political conflict pre- migration as avoidance and "denial." Although avoidance is considered one of the major symptoms associated with PTSD, Participant C

suggested that his avoidance had some adaptive qualities because it allowed him to focus on improving his current circumstances.

I think his primary coping mechanism was like, ‘if I can do well in school now, I’ll be ok, and I don’t really want to spend a ton of time thinking about, talking about what’s happened,’ and he kind of shut it off, which, I think later worked out in a different way, but initially he really wanted to focus on the here and so initially I followed that.

Participant C reported that the client expressed symptoms consistent with Posttraumatic Stress Disorder, in addition to his avoidance, that were the direct result of the violence experiences he endured as the result of war- violence that the client was unable to mediate through his avoidance: “Yeah. He would have nightmares of things being bombed, his sister being raped, his mother being raped, his father being tortured. He had very visceral PTSD symptoms. I just think initially he didn’t want to talk about those.” This supports the client’s exposure to political violence as a significant factor in Participant C’s trauma- based conceptualization of the client.

Participant D: “it was not particularly useful to think of this of this boy as the patient, but rather to think of the family as having experienced something together.”

Participant D is a clinical psychologist with a Ph.D. who has been licensed for about 13 years. Participant D chose to focus her conceptualization on a 10- year- old male from southeastern Europe whom she worked with after having been licensed one year. According to Participant D, this client was referred to therapy for “acting out in school... acting up on the bus, getting very aggressive.” Participant D described the client’s pre-migration exposure to political violence as persecution, which included the assault of his father, the “refugee flight” of his eldest brother, and an incident at his home where a soldier poured a pot of boiling oil on his head after demanding money from his mother. Following this incident, the family was forced to flee on foot to a refugee camp, where they witnessed very violent events en route as well.

Two themes appeared predominant throughout Participant D's conceptualization of her client and the contributing factors to his presenting problem. These two themes were (1) direct exposure to violence (2) indirect exposure to trauma.

Direct exposure to violence.

The first theme that Participant D identified as a major contributing factor to the client's distress was the direct exposure to violence that he experienced pre- and during migration. In this circumstance, the direct exposure to violence includes experiencing the act of having hot oil poured on his head by a soldier, in addition to violence and threats that he witnessed in flight on the way to the refugee camp. Although Participant D worked with the entire family, she recognized that the boy was "sort of symptomatic in the most severe degree due to his exposure, the victim of the burning, and to the fact that he was young and a boy."

There were particular meanings that the participant uncovered due to the client's gender and the unique roles ascribed to being a male in his culture that will be explored below. Participant D related the client's presentation of distress as posttraumatic symptoms that were manifesting as aggression in school and on the bus resulting from his direct exposure to violence, and particularly the threat to life that he experienced during the incident with the soldiers.

What I felt was happening with the boy was that I felt that in the new school, he was manifesting sort of posttraumatic symptoms of arousal and fear, coming out with him, then aggressing against others, and it was a way, I believed, for him to try to protect himself from ongoing threats and things coming at him that were quite frightening, given what he'd been through. I meant, if you think the world is going to harm you, one of the best things we do is put a shell on, and get ready to fight, like I'm going to protect myself, and I can even- I'm going to come at you if I have to.

Participant D emphasized contextual factors, particularly his gender, in her conceptualization of the direct effects of his exposure, including cultural factors and the political situation, and how those contributed to the client's presentation of distress:

In terms of his presentation, it's hard to separate out from the fact that he was the kid who was traumatized too, because he was so severely assaulted, but I think as a boy, there was a particular set of meanings associated to being tough and fighting back, that were now really brewing in him, from having been so helpless and so powerless when he got victimized, and I thought that those were really playing a part in his aggressive presentation. It was not just posttraumatic stress, which it was, it was also the meanings this boy had not attributed to being a boy. What does it mean to be a boy in this culture? Well now, it means you're going to be attacked, soldiers are trying to kill you, how does he, and this is a 9-year-old, so how does he internalize that, then, into his presentation as he lands in a U.S. school? Well guess what? He was coming off as a real tough guy.

Indirect exposure.

Another theme supported by Participant D's conceptualization of her client is the effects of indirect exposure. Indirect exposure can be defined as the client's experience of vicarious traumatization from the adverse events experienced by his family, as well as the interruption to traditional caregiving practices. Although the client was identified as experiencing the most significant distress in the family, Participant D recognized the importance of formulating the client's issues from within the context of his family.

So it was mom and a dad and six children, and one of the children ended up being sort of the identified patient according to the school and according to the family, but I began, pretty quickly, to believe that the entire family had been really traumatized, and that it

was not particularly useful to this of this boy as the patient, but rather to think of the family as having experienced something together.

According to Participant D, the stressors that the client's family endured were not just limited to the assaults and threats, but also the stress associated with the migration and post- migration adaptation:

The family had to, on foot, walk to a refugee camp. Imagine the amount of stress this family was under, losing their home, all of their belongings, but of course, first having gone through this terrible experience with the boy, so by the time I came into the scene, they had already been flown over to the US, put into these apartments, they spoke no English, and they were just very, very stressed people who had more disruption and adverse events that you could imagine, right?

Participant D described her meeting with the client's mother, and how the loss of her eldest son had contributed to a depressed presentation, and how that interfered with her caregiving towards her other children:

Well, so when I went to see these kids and the mother, the mother was incredibly distraught and tearful throughout much of my evaluation of her. She had a hard time focusing on the kids at all. She was very, very tearful, she was very focused on her eldest son, who had been displaced, I think, if you remember, to Germany, but had missed all this. But she was very focused on missing him and him being separate from the family, and she was really struggling with that, and I felt pretty quickly that she was depressed, from, given what the family had endured, not the least of which was this severe trauma of the youngest boy being burned.

Therefore, the context of the stressors experienced by the family and the breakdown of traditional caregiving practices contributed to the client's distress because of a lack of safety at home or a protective shield to mediate the effects of the direct exposure to violence:

So coming into a new environment that was supposedly safe, that was not an environment in which he could sort of which he could sort of relax and begin to adapt, because he was carrying with him all of this fear, and all these memories of what happened, and he was returning home to a very disrupted family, with the mom being depressed, and so there was really no safe haven for this kid anywhere. School certainly wasn't, and back home was just a real, I think, powder keg of everybody being overwhelmed, exhausted, depressed, and frightened, so there was no safety for him, and I felt that really was the context of what his aggression was, was posttraumatic reaction based in fear and disruption.

Although both of the major themes in the participant's conceptualization appear to be trauma-themed, the participant recognizes the family system as a large contributing factor as the result of these various traumas. As a result, the participant directed her treatment to address both the trauma individually and with the family to decrease the client's distress and promote recovery.

Participant E: "I would not be surprised if 10-15 years from now I see him back in his country running for president or something."

Participant E is a clinical psychologist with a Ph.D. who has been licensed approximately 15 years. The client that Participant E elected to focus on was approximately a 14-16 year old male from West Africa who she had been seeing after having been licensed for 8 years. According to Participant E, her client was an unaccompanied minor who had "been through a lot of traumatic circumstances. These included witnessing people killed, destruction, and loss of

family members. Her client was then forced to flee his community to go to a resettlement camp where he experienced stressors such as “trying to find food, sustenance, trying to find shelter, trying to find people who he could trust who would direct him in the right way.” Upon arriving in the United States, her client went to stay with an uncle. When the client was referred for services with Participant E, he reported symptoms of depression and PTSD as well as difficulty concentrating in school.

Three themes emerged from the interview with Participant E and her conceptualization of her client. These three themes are: (1) resiliency, (2) loss, (3) trauma reactions.

Resiliency.

One of the major themes supported by Participant E as a contributing factor to her client’s presentation was resiliency. Resiliency in this context could be defined as the ability for the client to adapt and recover as the result of internal and external factors. Participant E described the client’s resilience as a contributing factor to his survival pre- and mid- migration: “He was in a camp, struggling, scavenging. He was then and is now amazingly, amazingly, resilient and resourceful, but somehow was able to get to various points to get himself there.”

While describing her client’s resilience, Participant E attributed his ability to recover and adapt as the result of internal factors including motivation and hope.

And this is a young man, a young person who’s very, let me see, he had a lot of optimism and it wasn’t a case of ‘I’ve had all these losses, I might as well just crawl into a hole and stay there.’ He had a lot of aspirations, a lot of dreams that were not unrealistic. He wanted to go back to school, he wanted to learn, he wanted to do certain things with his future.

Participant E also reported that his internal factors contributed to his ability to receive social support, which then facilitated his recovery and adaptation post- migration: “He’s a very likable

person, so he wound up, people responded to him in positive ways, and wanted to help him, wanted to support him.” Participant E stated that his social support system and stable safe home environment with his uncle also served as factors facilitating his grown from adversity:

When he found his uncle, unlike other people, he had stable housing, so that was not such a big issue, too, as it could have been, but at least having somewhere safe, somewhere to lay his head, somewhere where he could get food, was a really important part of a shoring up of his strengths... it was a very important part of shoring up his own strengths to move on.

Participant E also conceptualized external factors contributing to the client’s resiliency as the result of his life before his flights as well as strengths related to his upbringing:

I think, when you look at some of these things I think it is something to be said for premorbid functioning, and where he was raised, and you know, when he’s talked about his family in the past, the little bit that he has talked about, it seemed like he came from a very supporting, intact family, so there were strengths over there. I think that, even though he was relatively young when he had to flee and he lost everyone, but there were some good, solid foundation building blocks were already there, before he had this experience, and so somehow, I think, even though he had these horrible things happen, he was able to tap into some of those strengths, and then I think having supportive adult figures along the way, like his uncle, the adults from our program, he had good teachers who clearly saw his potential, and worked, wanted to give him that extra edge, that extra help in many, many ways.

Loss.

Another theme that emerged from Participant E’s conceptualization of the client’s expression of distress was that of loss. For Participant E, loss appeared defined as the loss of

family through death or displacement, loss of community and tradition, as well as loss of personal identity:

Well the loss of his family is a big, big one. When you talk about war and refugee trauma, it's not like, you're living here, somebody, God forbid, somebody you love dies, everything else remains stable around you. You know, there is that loss, but you have your support systems, you have your schools, your family, your friends, your home is still there. Well in his case everything was gone, so it was not knowing where family is, not knowing where siblings were, homes were burnt down, the community that you were raised and grew up in is gone, you're constantly moving, there are questions about, are you who are, do you come from where you say you come from?

Participant E conceptualized the client's symptoms and impairment to functioning as partially resulting from his experience of loss:

He wanted to go back to school, but wasn't sure how he would do that, how he would be able to concentrate and focus, because he was often being really distracted by memories and thoughts and just a lot of missing, when you've had so many losses.

According to Participant E, the client's loss of his immediate family contributed to his symptoms of depression and his sociability:

And that was also factor of his levels of depression, irritability, whether he could stand people or not, what he felt when he saw other people with their families, versus when he was [annoyed] that he was without his immediate family, and how that affected him.

Beyond just the loss of family and community, Participant E also found that the client's experience of loss extended to a loss of identity and tradition resulting from his migration to the United States and cultural expectations to adapt by his host country:

I didn't talk about that in terms of acculturation, but what does it mean to be a young person in the U.S.? What does it mean to be a black African within the U.S. culture as opposed to being African-American? How did his peers at school view him and interact with him, also was part of making sense, and that sense of adjustment and loss, if I were in my country, would I have to deal with this kind of thing. It's great that I'm in the U.S., but look at all the other challenges. So, to say that, the trauma piece was a piece of the refugee stuff that we dealt with, but there were also, as you said, the acculturation things like who am I within this new context, within the new society, in terms of language, food, dress, weather, relationships, how does that work?

Although loss may be typically attributed to the loss of a person, Participant E explains that the loss of identity and community appeared to be just as difficult for this client, particularly considering the demands to leave behind his traditional practices to adapt to those in his host country.

Trauma- based reaction.

The final theme that was supported in Participant E's clinical formulation of her client's distress was a trauma- based reaction. This can be defined as the client's presentation of distress resulting from adverse experiences during his pre- migration and migration period. Although this theme was not mentioned as frequently as the themes of resiliency and loss in the interview, Participant E emphasized the client's "traumatic experience" as an area that contributed to the conceptualization. Participant E described the client's trauma reactions as "some depressive symptoms, some, again, some of the classic PTSD symptoms in terms of the nightmares, he was having some startle responses."

Participant E also referenced the client's avoidance as a means of coping with the exposure he had witnessed during the political conflict, and the struggle he experienced as a result:

Of course, having witnessed and seen, those memories, the [country deleted] war was brutal, and I was talking about all this strength and this resilience, but that's not to say he didn't still struggle with those aspects of his life. They were definitely there, and I think one of the ways he coped really well was, at times really shoving those deep down inside, and maybe even splitting some of those feelings and affect off.

Participant F: “Despite the fact that she had been violated repeatedly by numerous people, she still was an individual who was able to have compassion and empathy for others.”

Participant F is a therapist with her Ph.D. in social work who has been licensed 19 years. Participant F chose to focus on a 17- year old female from Africa who arrived in the United States as an unaccompanied minor. According to Participant F, she had been licensed about 12 years before seeing the client. The client's pre-migration exposure to political violence included “her parent being killed in her arms, and witnessing the other parent being raped before they disappeared.” Participant F also described that the client was “held sex captive, being gang raped repeatedly over the course of a year.” The client escaped and was “smuggled by a stranger” and was in a United States airport for several days before she was taken home by another stranger, who then held her as a slave where she was “forced to do slave labor.” The interview with Participant F revealed three major themes related to formulating an understanding of the client's clinical presentation, including (1) cumulative traumas, (2) grief, and (3) resiliency factors/coping strategies.

Cumulative trauma.

The first major theme that emerged from Participant F's interview regarding the conceptualization of her client was cumulative trauma which can be understood as the client's presentation of distress as the result of adverse political violence, which was physical, sexual, and psychological as well as post-migration traumatic experiences of exploitation which caused an emotional response. These experience included trafficking in her country of origin as well as modern day slavery after migrating to the United States. Considering the many adverse experiences that Participant F's client endured pre-, mid, and post- migration, Participant F indicated that her trauma presentation was more complex:

And so actually there were aspects of her traumas that came out much later in the course of ongoing therapeutic work, that she way more than met the criteria then for PTSD, which of course there's problems with that as well, because it's pegged to one trauma, whereas that's very hard to do in the context of an individual such as this person who has experienced a plethora of traumas.

Participant F goes on to describe the particular trauma reactions that her client exhibited and their relation to her pre- migration "traumas:"

I think I indicated that there were a number of contributing factors, you know, not just one. So the multiple traumas that she had gone through, that violated her own personal integrity, such as the numerous gang rapes that she experienced, where she was unable to- I did not mention that she did dissociate, developed a, if you want to think of it as a defense mechanism, a way of doing what she could, within her capacity, to protect herself and not feel that it was happening to her as much during the gang rapes. The multiple times where her own life was in danger, such as when the militia threatened to kill her in front of her family and rape her first, and then the one parent intervened. The

content of these things and the other traumas that I mentioned were frequent visitors in her waking intrusive, traumatic memories and in her nightmares, and also figured into the aspects of some of her surroundings that would trigger the memories.

Further, the client continued to experience adversity upon her arrival to the United States, and according to Participant F, also facilitated a “retraumatization” related to her earlier trauma experiences:

Yeah, [she was] enslaved in the U.S., she was assaulted, she received death threats in the U.S., she had to go through a very retraumatizing asylum process, her court-appointed interpreter leaked information about her to the people who were oppressing her in the U.S.

Grief.

Another major theme supported by Participant F’s conceptualization of her client was grief. This theme appeared to relate primarily to the loss of loved ones, either through death or displacement, as well as the distress associated with the interference of traditional burial practices. As Participant F indicated: “I also understood that the complex process that she was going through in terms of grieving the loss of her loved ones was a huge contributing factor, several of them actually.”

Participant F describes her client’s grief related to the witnessed death of a family member as having traumatic features that interfered with her ability to grieve, consistent with a traumatic grief presentation:

She was still working through her grief and loss, which is, understandably, was completely compromised by the fact, one, that one of her parents was assassinated in her arms as they were trying to save her from being raped and killed.

Participant F also related the client's distress to issues involving grief as the grief over losing family members through displacement and the political discord, and not knowing their fate. As a result, she was not able to engage in traditional grief practices and rituals:

Despite numerous efforts, she was unable to ascertain whether the other folks were dead or alive. So she didn't even know- there's certain prescribed rituals that, I had mentioned that she had a very strong faith, and spiritual, religious life, that it was hard to even know how to proceed.

Resiliency factors/coping strategies.

Resiliency factors/coping strategies was the final theme that emerged from Participant F's understanding of her client's presentation in therapy. Participant F indicated: "long before she was an adult, that she had decided no matter what life threw at her she was going to persevere." Resiliency factors/coping strategies in this context can be defined as the ability to recover from adverse life events and adapt to difficult situations due to internal and external factors. This theme was evident when Participant F discussed her client's ability to draw on her adaptive resources when in both "oppressive" and "healthier" environments:

When I learned she was actually in an enslaved situation, she had been using her vast coping strategies to deal with that. So she was not- so she was functioning well in some areas, although the adaptation of course was to an oppressive or persecutory environment, but then she was later able to use her internal and external resources to function in a [more] normal, healthier environment.

Participant F referenced the client's religious affiliation as a strong factor in promoting her recovery and facilitating her adjustment to difficult circumstances, and contributing to her "persevering with life:"

Very strong faith background, which is something that was extremely valuable in helping her to survive, even when she was held captive for over a year, as well as during her migration to this country, or escape, one might call it, and her adjustment, and the ongoing stresses that she experienced here such as being held captive here in this country, having to also go through an asylum process, etc.

Participant F also referenced the client's values as being a significant contribution to the client's resiliency in the face of adversity, which was instilled by her family:

But that was another thing that her parents, particularly her father, would read to her and would encourage that, and so she carried those values, the values of education, of her faith, of the way her parents raised her to treat others, with her, and so despite the fact that she had been violated repeatedly by numerous people, she still was an individual who was able to have compassion and empathy for others.

Finally, Participant F referred to the client's humor as another factor that was encouraged by her family, which was utilized as a resource to cope as well as shape the meaning of her adverse circumstances:

She also, I learned a lot about her and her incredible sense of humor which is something that she had as a young kid and was also part of her family life, but another really source of [strength] in helping her, she utilized it also to help gain perspective when she faced new traumas in her life.

It is interesting to note that each of the participants in the study referenced a type of trauma- based conceptualization as a major theme. However, the other major themes, such as post- migration difficulties, family struggles, loss, resiliency, and others, differed based on the needs and situation of each client. This elucidates that the participants incorporated factors other

than trauma when formulating their conceptualization, and that these factors were contextualized to fit the unique presentation of each individual client.

Between- Case Analysis

During the interviews with the participants, several major themes emerged across participants that elucidated the means through which clinicians gather information about clients and how they apply that knowledge toward a formulation about the client's presentation. These major themes that were addressed in each of the interviews by all the 6 participants were (1) sources of clinical information, (2) assessment, (3) conceptualization, (4) cultural factors incorporated in conceptualization, (5) advice to future clinicians.

Sources of clinical information.

One theme that was present in the interviews was sources of clinical information. This major theme can be defined as the basis of knowledge obtained that guided clinicians towards formulating a conceptualization with refugee youth. This major theme had three subthemes emphasized by the participants in their interviews which identified the particular factors that contributed to their understanding of refugee children and adolescents. These subthemes were (1) Consultation, (2) Research, and (3) client context.

Consultation.

The first subtheme that was endorsed by 4 out of the 6 participants in the study as a factor informing their clinical work with refugee minors was consultation. Consultation can be interpreted as the seeking out of advice or expertise from professionals or members of the community to help provide a greater understanding of the issues experienced by refugee youth. Participant A, who had been licensed one year before seeing her client, indicated that supervision was the most important contributing factor in informing her clinical work with refugee youth,

particularly because she was new to therapy as well as inexperienced within this particular population:

At that time I had an amazing supervisor slash mentor, who had quite a bit of experience and was instrumental in helping guide me on these cases. I was fair- I felt fairly green to doing this work and, um, felt the, uh, weight of the responsibility of helping these families and these, particularly these kids make sense of what had happened, so supervision I really used quite a bit.

Participant C reported that she used consultation with professionals as well as from members of her client's own culture or similar backgrounds, which she calls "cultural brokers" to inform her clinical work with her refugee clients.

I'd say the coworkers that I had at the time, it was a staff of about 35 to 50 people, very, very diverse, many of whom were refugees themselves, and we worked a lot with the refugee communities that had already been resettled when people were coming in, so I would say they informed a lot of my theory and work. Part of the time I worked a lot with [name and identifying information removed] and I'd say her work influenced me quite a bit. Working with her influenced me quite a bit. But I would say primarily they influenced me, and people that I knew from that background who I went to as kind of culture brokers and resources.

Participant F referred to a history of seeking the opinions and advice of various types of professionals in the field: "The mentoring I've received, by experience, supervision, but I've received ongoing continuing education, clinical consultation throughout my career." The various forms of consultation supported by the participants highlight the potential benefits towards utilizing the expertise of professionals or members of the community to guide clinicians towards a better understanding of their refugee clients.

Research.

Another subtheme supported by 3 out of the 6 participants was the use of research as a contributing factor to advising clinical work with refugee youths. The subtheme of research can be defined as the use of systematic investigations or exploration of phenomena to provide knowledge about refugee youth. Participant D explains her work with refugee minors as guided by evidence supported by research regarding trauma and the refugee experience:

You know evidence-based practice, which is out of great research, by the way. So evidence-based practice often has informed my work, especially in terms of certain trauma treatments... And then the other thing is definitely the research that's been done in the field.

Participant B described her own research into the client's country of origin to inform her clinical work with her clients to provide an awareness of traditional cultural practices:

Almost always if I am invited to be in a country about which I know nothing, I would read books about the country and try to educate myself about etiquette and ways families live, or philosophies and religions, and that kind of thing.

Participant A also emphasized using literature about the political conflict in addition to other forms of research so that she would best be able to understand and confront the issues brought to her by refugee clients:

And through supervision, uh, my supervisor gave me some leads for me to research and so I found myself looking a lot of the things up and doing a lot of reading. Particularly also to inform myself of the political situation that had been going on in, in (the) country of origin for these clients, so that I could understand a little bit more of the issues that they were describing in treatment.

Client's perspective of context.

The final subtheme that 3 of the 6 participants used to provide information to guide their conceptualization of refugee youth was the client context. The subtheme of client context can be understood as the participants emphasizing the context of the client's story and information gathered from the client about their worldview to inform their work with refugee youth.

Participant B explained her use of openness when working with a refugee youth and appreciating their experience from within their own culture in addition to using more standard psychological practices:

Openness, I think, to- really appreciating that cultures have different ways of being, different cultures perceive so many things differently that a lot of the assumptions that we take to be true, a lot of the foundations of our nosology, and Western approaches to medicine, sometimes really don't apply... I think what informs the treatment is to just stay as open as possible, to letting go of almost everything I thought I knew, or we think we know, and starting again from what the culture knows about itself, and then trying to blend, in any way that makes sense, what we think we know about pathology, and healing, and what the culture already believes.

Participant D reported that in regards to factors that inform her work with refugee youth, she relied on information provided by the client about their perception of distress and their experience in addition to clinical knowledge:

I believe with people who've been through war and refugee trauma and who are always from other countries and cultures from you, you need to also have a tremendous kind of recognition of their ability to tell you who they are and what they need and what they've been through. So I guess it's sort of leveling the playing field a little bit, of course you're still in some way an authority, and you're still a doctor, or whoever, who's going to feel

in some ways that you have control, but for with refugee patients I often hope that I can create at least in effect just a sense that they have equal control, that their conceptions of what they need are as important as what my perception of what they might need is.

Participant E also relied on the client as the expert to inform her clinical therapeutic work with her refugee clients:

I've learned a lot from the youths themselves, about how they conceptualize their experiences... how they conceptualize their experiences, what was helpful to them, what was not helpful to them, the impact it's had on them, as well as learning from them

The various forms of information that clinicians integrate in guiding their formulations of refugee youth include various resources. These resources help guide clinicians towards building conceptualizations that are based on both the experience of the client as well as the knowledge in the field, by professionals, "cultural brokers," and research.

Formal assessment.

Another major theme discussed among the 6 participants in the study in regards to clinical work with refugee youth is in the area of assessment. This theme of assessment involves the means of gathering clinical information about the client to guide clinicians to formulating a conceptualization of the client. The subthemes that support the major theme of formal assessment includes (1) family based assessment, (2) interviews, and (3) self- report measures.

Family based assessment.

The first subtheme associated with assessment is the use of family-based assessment, which was emphasized by 3 out of the 6 clinicians. This can be defined as the use of collateral interviews, as well as family observation, to gain a better understanding of the client. Participant A explained the need for family- based assessment with her refugee client initially because the client had a poor "tolerance to be in the room with me." However, Participant A gathered

important data regarding family dynamics influencing the client's presentation when using family observation as a means of assessment:

So it was really about trying to just get family composition, what they like to do, um, even getting them- even that they wanted to be together, it was hard for them to play a game 'cause I remember thinking they'd want to be together and I brought a game in to try to get them to engage together to see how they interacted with each other and that was a difficult process for them to even sit down to play an organized game together.

Participant C reported that she engaged in family observation and collateral interviews to provide a more comprehensive picture of the client's history and presentation:

Our program was set up that in some, you'll often have informal contact before formal contact, so I'd say that was part of my assessment. I saw him with his family, interacting with his family... Mostly talking to him, but I also had access to his parents, so I talked to his parents together and separately, which I feel like doesn't always happen.

Participant D, who also identified a primary component of her theoretical orientation as family systems, indicated that her assessment was a "family assessment," which was a process of interviewing the family members separately and individually before establishing a conceptualization of the client:

So I assessed them on the resettlement site, and I did what I would call a family assessment. I interviewed all the members of the family, I interviewed some of them together, the kids, the siblings I interviewed together, I interviewed the mother and father separately, I did an assessment of how everyone was doing. I mean, I don't have some formal way how to answer that, except I did what I would call an in-depth clinical assessment of the family's functioning.

One of the significant commonalities between these 3 participants was that each of their clients migrated to the United States with their families, so they had access to family members to gather additional information guiding a clinical conceptualization. The other 3 participants who did not indicate that they used family- based assessments with their clients all had client who were unaccompanied minors.

Clinical interviews.

The second subtheme that was present for 4 of the 6 participants under the major theme of assessment was the use of clinical interviews with the client in establishing a clinical conceptualization. This subtheme includes interviews completed directly with the client that examined history, present functioning, and areas of strength and distress. Participants B and C reported that the majority of their assessment was conducted through interviews directly with clients. Participant B stated that “most of the interview was collected via interview” and Participant C stated “I got a lot of information from him. We do have like a formal intake assessment, so I did that” and that the assessment included “mostly talking to him.”

Participant E indicated that her assessment was an interview designed towards understanding the various aspects contributing to her client’s distress, even though he had completed a “formal intake process” prior to her seeing him as a client. According to Participant E, this additional level of assessment contributed to a greater understanding of the client beyond what the formal assessment provided:

I wanted to get a sense of not only what I’d of course read about from paper, but what his daily interactions were like, what his resources were like, how he was coping, what his network was like, his day to day, that kind of thing. So I did some assessing and getting a sense of that, and also how he was functioning. I wanted to get a better sense of kind of depressive symptoms as well, because, like I said he was kind of really withdrawn.

Participant F also reported that she engaged in interviews targeted towards gathering information to establish a conceptualization. She indicated that her assessment process and information gathering extended past the initial interview and throughout treatment and that there was trauma which “came out much later in the course of ongoing therapeutic work.”

A series of clinical interviews that spanned a number of sessions, as well as, actually now I am remember her, normally we would do a joint trauma history interview with the physician and the psychotherapist, a person such as myself, to minimize the amount of time and the number of times the individual would need to go over talking about these traumatic experiences... The way I approach assessment is as an ongoing process throughout the time that I am working with a person. So even after formal assessment period, initial assessment I might call it, is over, it’s an ongoing process.

Self- report measures.

Another subtheme that contributed to the major theme of assessment that emerged in 3 of the 6 participants was the use of self- report measures. The use of self- report measures can be understood as the participants administering formal measures, such as questionnaires, to the clients to gain a better understanding of their clinical presentation.

Participant C mentioned that she administered measures designed around trauma: “He did like the UCLA, Briere, that’s two assessments.” She later described some hesitation with relying solely on the standard instruments to provide an accurate picture of the client due to the potential limitation of the measures related to the cultural identification of her refugee youth client.

I don’t think that a standard assessment always gives you a full picture of the person. I think some people are more likely, especially if they have any kind of perception of what they think you expect them to write, so sometimes people will underscore or overscore, depending on their background, religiously, culturally, educationally, socioeconomic, I

think that can change, and I think the interpretation of the form into different languages, if it's interpreted by someone from a different region than they're from, the wording can be slightly off. So I think that factors into how people answer the questions, so I think it's helpful because it gives you some good information, but I don't think it's an end all, be all.

Participant F indicated she used screeners that were designed to measure symptoms of trauma as well as aspects of the refugee experience:

I did use a couple of screening instruments, Hopkins Symptom Checklist, the PCLC, just that were, well the PCLC is based on the DSM IV criteria for PTSD and the Hopkins Symptom was originally developed through the DSM III-R. I did an internship with [name removed for anonymity], who developed that with Southeast Asian refugees.

Participant F also mentioned in regards to assessment that she refrained from using some formal assessments because they had “not been normed for someone from my client's background, particularly with extremely limited English, very low education.”

Conceptualization.

Another major theme that was emphasized in the interviews with each of the participants was conceptualization. Conceptualization can be understood as the way in which the participants formulated an understanding of the factors contributing to the client's clinical presentation in therapy. Although there were several significant subthemes expressed individually by the participants and represented in the within- analysis, the subthemes that occurred most frequently across participants were (1)Trauma- based conceptualization (2) Resiliency and (3) Loss.

Trauma- based conceptualization.

The first subtheme that emerged from the interviews with participants when conceptualizing their refugee youth clients was a trauma- based conceptualization. A trauma-

based conceptualization can be defined as the participants considering their client's presentation of distress as derived from adverse life experiences. Each of the 6 participants included a theme of trauma in their conceptualizations of their clients. One example of this subtheme used during the interviews was with Participant C, who interpreted her client's distress as evident through the alterations in his coping before and following the adverse circumstances he endured:

I think, for him- for me it was more of a trauma specific thing, 'cause he had a lot of coping strategies that he had utilized before the trauma kind of intervened in that and had major consequences in his life, but also in his functioning. So from talking with him and talking with his parents, he didn't really utilize denial and internalization and avoidance prior to the trauma, but did very much so after the trauma.

Participant D also conceptualized her client's clinical presentation as the result of life-threatening circumstances associated with intense fear, which created symptoms as a defense against continued fear of harm:

What I felt was happening with the boy was that I felt that in the new school, he was manifesting sort of posttraumatic symptoms of arousal and fear, coming out with him, then aggressing against others, and it was a way, I believed, for him to try to protect himself from ongoing threats and things coming at him that were quite frightening, given what he'd been through. I meant, if you think the world is going to harm you, one of the best things we do is put a shell on, and get ready to fight, like I'm going to protect myself, and I can even- I'm going to come at you if I have to.

Participant F also described her client's symptoms (including dissociation, "intrusive traumatic memories," and nightmares) as the result of multiple traumas that she endured as the result of political violence that created dangerous situations, a violation of "personal integrity" and the need to protect herself using defenses:

I think I indicated that there were a number of contributing factors, you know, not just one. So the multiple traumas that she had gone through, that violated her own personal integrity, such as the numerous gang rapes that she experienced, where she was unable to- I did not mention that she did dissociate, developed a, if you want to think of it as a defense mechanism, a way of doing what she could, within her capacity, to protect herself and not feel that it was happening to her as much during the gang rapes. The multiple times where her own life was in danger, such as when the militia threatened to kill her in front of her family and rape her first, and then the one parent intervened. The content of these things and the other traumas that I mentioned were frequent visitors in her waking intrusive, traumatic memories and in her nightmares, and also figured into the aspects of some of her surroundings that would trigger the memories.

Resiliency factors/coping styles.

The other subtheme that was present during 3 interviews out of 6 when describing the conceptualization of their clients was resiliency. The definition of resiliency can be considered the ability for the client to recover and adapt in relation to adverse circumstances resulting from of intrinsic and extrinsic factors. Participant B discussed her client's strengths as the result of intrinsic factors of "strength" and "courage." These strengths contributed to the client's ability to engage in therapy and work towards recovery from the adverse events she experienced pre- and mid- migration:

That, in spite of all this, she was going to get herself on a bus, where she was scared to death to be because men were there, and come from this really far; if I could tell you where it was, you'd say 'No way! There's no way somebody could go to Santa Monica from there, twice a week...Just, and then a couple times when she missed a bus and then it turned into like a four hour each way, just that she could do that from the very first

meeting, and then once I knew what had happened to her, and what she had made happen, you know, on the positive side, she was such a mixed, exquisite picture of somebody who was so victimized and so powerful simultaneously. But all of that was obvious, so first we had to work to alleviate some of the trauma symptoms, but I knew from the start that anybody who was going to actually do this is- this is going to be quite a lovely piece of work she's going to get to do.

The resiliency that Participant E portrayed in her depiction of her client's clinical presentation was the result of both intrinsic and extrinsic factors. One example was the stable living situation the client experienced upon arriving in the United States as an unaccompanied minor, and how that provided him with the ability to recover from past experiences and adapt to his present situation:

When he found his uncle, unlike other people, he had stable housing, so that was not such a big issue, too, as it could have been, but at least having somewhere safe, somewhere to lay his head, somewhere where he could get food, was a really important part of a shoring up of his strengths... it was a very important part of shoring up his own strengths to move on.

Participant F focused on several aspects of her client's history that contributed to her resiliency in regards to recovery from her "traumatic past," including religious identification and belief system, as well as "pre-morbid" family support. The participant also discussed the client's humor as an adaptive coping strategy facilitated by her family prior to the "primary trauma" that aided her in recovery as well as adaptation to future negative experiences:

She also, I learned a lot about her and her incredible sense of humor which is something that she had as a young kid and was also part of her family life, but another really source

of [strength] in helping her, she utilized it also to help gain perspective when she faced new traumas in her life.

One interesting similarity that was noticed among the participants who emphasized resiliency as a major theme was that their client's were all unaccompanied minors upon their arrival to the United States. There could be several interpretations to this occurrence, but one could potentially be that the ability to flee political violence and migrate to a country alone would assume significant strengths in the ability to adapt to unfavorable situations.

Loss.

The last subtheme that emerged from the interviews of 3 of the 6 participant's conceptualization was loss. The definition of loss included loss of family, community, and identity as the result of war violence, migration, and post- migration experiences. Participant A described her client as experiencing emotional distress related to the loss of his brother and father, which she indicates was magnified by additional factors such as the suddenness of the loss and lack of information about their disappearance:

He didn't understand about the politics and why he couldn't leave, he couldn't understand why his father and brother were no longer in his life and, and now they were non- entites so to speak, in the family because now, that they didn't even really talk about them anymore, it's- they were ghosts in the family, they upped and left one day, not by their choice, but they, you know, this kid felt abandoned and he needed, you know, those male figures in his life.

Participant E also referenced the client's loss as complex because of the additional losses he experienced on more systemic levels including family, school, and community due to the political conflict:

Well the loss of his family is a big, big one. When you talk about war and refugee trauma, it's not like, you're living here, somebody, God forbid, somebody you love dies, everything else remains stable around you. You know, there is that loss, but you have your support systems, you have your schools, your family, your friends, your home is still there. Well in his case everything was gone, so it was not knowing where family is, not knowing where siblings were, homes were burnt down, the community that you were raised and grew up in is gone, you're constantly moving, there are questions about, are you who are, do you come from where you say you come from?

Participant F also further referenced loss as a central part of her client's presentation, and that her normal process of grieving was interrupted and constricted due to the traumatic nature of her loss.

She was still working through her grief and loss, which is, understandably, was completely compromised by the fact, one, that one of her parents was assassinated in her arms as they were trying to save her from being raped and killed.

Cultural factors or cultural influences.

Another major theme prevalent in the interviews with all of the participants regarding their refugee clients was culture. Cultural factors or cultural influences can be defined by the discussion of various cultural factors involved in the assessment and conceptualization of refugee youth. These factors include but are not limited to: gender, country of origin, religion, age, area of political conflict, and language. Two subthemes emerged from discussions regarding culture; these themes included (1) open dialogue about culture, and (2) influence of cultural factors in conceptualization.

Open dialogue.

The subtheme of open dialogue about culture appeared as significant in 4 out of 6 of the participants' interviews. The open dialogue about culture subtheme can be characterized as the attempt of the participants to create an atmosphere of openness, engaging the client in an open exchange through dialogue. One example of this subtheme occurred during Participant F's interview where she discussed her approach to working with refugee youth as creating an open dialogue to invite the client to educate the clinician on their cultural worldview: "I invite them to help me to understand what this means to them on many different dimensions, and also how they conceive of the work that we're entering into together."

Participant B described creating an open space for discussions regarding culture by addressing it directly, which she reported provided a positive therapeutic connection between herself and her client:

I didn't know much at all about that part of Africa, and we had to work together. So we just named it and I do remember having some nice bonding sessions in the beginning, where she was trying to teach me the correct pronunciation of some names of several cities that were relevant in her future story, and I was a disaster at pronouncing them correctly, and it was really important to her, I think, and it became the source of some fun between us. It was important to me to say them correctly and to know about them and so I think I realized that I knew nothing about this culture and had eaten some of its food, but I knew nothing beyond that, and I think there was a time when I realized I had to know more to understand even a little bit of what her world was, and I think in spite of that, probably there were all kinds of things that I didn't know, that if I had known, would have been even more useful.

Participant A also described the method of opening a dialogue between herself, the client, and the client's family about culture as a way to exhibit interest in their process and to facilitate an atmosphere of connectedness. She described the creation of an open dialogue following an incident where she used the incorrect terminology for a word in Spanish:

That actually opened a door to have open dialogue with them about differences and so, it was, it- it, you know, I, and I'm still mortified when I think about it, but it was a nice doorway to being able to have those exchanges with them and I remember we even had a kind of nice moment culturally talking about, um, things like food and similarities and differences and, um, things that are, you know, they would do in, in [country removed for anonymity], and things that, you know, my family did and so it was kind of a nice exchange and I think that also helped to engage a little bit, um, and um- they also saw me as a little bit more connected, also, culturally with them.

Therefore, the process of opening a dialogue for these participants was a means of connecting to the client's contextual experience, as opposed to the therapist imposing their biases on the conceptualization of the client, as well as increasing the therapeutic relationship between the participant and their client.

Influence of cultural factors in conceptualization.

Another subtheme in all 6 of the participants contributing to the major theme of culture is the influence of cultural factors in conceptualization. The influence of cultural factors in conceptualization can be considered the participants endorsement of incorporating factors unique to the client's cultural experience and worldview when considering a conceptualization.

Participant B reported several times where understanding factors related to the client's culture and values were important in conceptualization. One example was gender differences, particularly considering the client had a background with a culture who valued rigid gender

roles. The participant also discussed the client sharing important nuances in regards to her adverse experiences that influenced her understanding of the client's history, such as the cause for the client aborting her baby after being raped repeatedly while in prison:

She had to explain to me-there were several times she had to explain to me, for example, that giving birth would have identified her as one of those escapees, and people would have taken her back because they would have known that any girl escaping, giving birth, or any girl who showed up in a new city, or a new town, or a new village, whatever they were, pregnant, of course was one of those escapees from prison.

Participant C discussed how she discovered more about her client's "reality" by understanding the importance of values related to family and ascribed roles with her client:

Family was really significant. Elders were really significant for him. So, he kind of would talk about some of- they expected him to do well, he was the oldest, he was the man, so he talked a lot about what was expected, he was expected to kind of care for his mother, and be responsible for her. He had a lot of- he took a lot of responsibility for things.

The emphasis that Participant D placed on her consideration of cultural factors in her client's presentation was related to issues of gender and gender values in the culture, and how she had to recognize the interactions of gender and culture related to his family's worldview to understand her observations of his family dynamics:

One issue culturally was trying to learn a bit about their ethnicity, their faith as Muslims in a fairly conservative culture in terms of gender beliefs. I mean the girls in the family were much more expected to sort of behave and toe the line, and I felt like there was a little bit of primacy over how boys were talked about by the mom, particularly, and I really felt I had to try to understand that, in a way, as something inherent in the culture,

rather than something that I might have my own feelings about, judgmental feelings. So some of it, for me, was working in some of the gender understandings, cultural understandings of gender, and why boys are important in that culture, and why one might put primacy over boys. First of all, they're going to be, possibly, more vulnerable in a war situation, so maybe you do put your resources towards them, but also that the sort of economic ways that boys are expected that they're going to come up and support their own families someday, so I had to work a bit to understand that.

Further, Participant E identified particular idioms of distress, or culturally bound ways in which distress manifests, with her client that provided a fuller understanding of his symptoms:

I would say initially, maybe, not so much with him, but initially there were a few more somatic complaints, headaches, stomachaches. The thing to also, I think, with this particular population, with West Africans, with Sierra Leoneans, in a sense, too, [country removed for anonymity], we don't always talk about feelings. It's not about the feeling, the emotion, it's about where it is physically. So that was definitely a piece of, ok, so you're feeling this way today, can you tell me about where it is in your body, what's going on? So definitely that was something that I was aware of and I tried to stay on top of and in tune with, that just because something was described as being physical, doesn't necessarily mean that it was physical, that it was another way of getting at some of those emotional things.

Through Participant E's understanding of her client's cultural expression that differs from western perceptions of emotional distress, she was able to provide a more relevant conceptualization to guide a more effective treatment plan.

Advice to clinicians working with refugee youth.

The final major theme that was prevalent among the participants when explaining their work with refugee youth was advice to clinicians working with refugee youth who have been exposed to political violence. This major theme can be considered the recommendations to therapists who are serving refugee minors in a clinical capacity by clinicians who have some expertise in working with refugee youth. There were two major subthemes that emerged from this major theme; (1) Maintaining trauma- informed knowledge and skills; (2) Maintaining Cultural Humility.

Maintaining trauma-informed knowledge and skills.

The first subtheme that supports the major theme regarding advice to clinicians working with refugee youth, is maintaining clinical knowledge, which was emphasized by 3 of the 6 participants. The maintaining clinical knowledge subtheme can be defined as the recommendations of the participants to sustain and utilize their clinical knowledge when working with refugee youth. Participant A described this subtheme in the context of trauma. Specifically, she recommended that clinicians be “trauma- informed” when working clinically with refugee youth, which she related to the client she conceptualized earlier in the interview:

Being very trauma informed and, you know, I'd said earlier, you know, what I would do differently, this case would be so different today and I would have conceptualized it probably a little differently 'cause I would have really been looking at trauma informed work that, I thought I was providing at the time, but we've come so far since then, and, you know, even, even working in terms of how we talked about their experiences

Participant D also supported the subtheme to maintain clinical knowledge when working with refugee youth exposed to war violence, which she refers to as a “tool kit” and “skill set” that clinicians can refer to when serving this population:

I would say recognize the knowledge and skill set that you bring as a clinician, that has been part of your training, meaning all that training you received in everything from proper assessment, diagnosis, mental status evaluations, formulating a treatment plan, evidence-based treatments that we know work, all that stuff you bring, that's your tool kit, hold on to it, remember you have it, that's your grounding, right?

Finally, similarly to Participant A, Participant F also emphasized the importance in having experience and knowledge in trauma-based work as the basis of clinical knowledge when working with refugee minors:

Because being a refugee is inherently traumatic, in one way or another, even if a person has not gone through the kinds of traumas that we've been talking about today, and that you're focusing on. And so I really feel it's imperative for mental health professionals and others who work, the other interdisciplinary professionals who we collaborate with to [seek] and know a lot about trauma and to have that guide element- it would really help to drive the approach to assessment and also treatment.

Adopting cultural humility.

Another subtheme that was present in the interviews of 4 out of the 6 participants when giving advice to clinicians was the importance of adopting cultural humility. This subtheme can be characterized as the recommendation to recognize the client's own cultural worldview as foundational to conceptualization, and how that might differ from the clinician's perspective.

Participant F also provided her definition of cultural humility in her interview as:

My work is very much informed by an approach to my clients shaped by cultural humility. I prefer that concept over cultural competence, in the sense that, for me what it means is that I'm engaged in an ongoing, actually lifelong process of trying to be as aware as possible of my own biases, my own assumptions, etc. that I bring to this work,

and to my work with a given client; to not make assumptions that just because they come from a particular cultural background, or country, or faith tradition, or gender, you can name off the different factors that might be part of shaping “culture” but [it might be really] different for that individual.

She went on to state that when providing guidance to clinicians in their work with refugee youth who have been exposed to war violence, they utilize cultural humility in order to gain a greater understanding of the context of individuals in this population:

Well, one of the things I’ve tried to instill in people who I’ve supervised, or trained, because I’ve done a lot of trainings over the years is a couple of key principles: cultural humility; don’t assume that everyone from a given life experience or culture is the same, right? To really, really look beyond the experiences that led them to be a refugee, or the war, or whatever, and to assess across their lifespan, and more broadly.

Participant D, after indicating the importance of maintaining clinical knowledge when working with refugee youth, then emphasized the necessity in understanding the client’s perspective from within their cultural identification in order to meaningfully apply clinical knowledge:

Remember that you are dealing with somebody from a context that you may really have a difficult time understanding, and your job is to begin to try to really understand that context from the perspective of this patient in front of you, so that when you bring that tool kit back in, you’re not pulling out things that make absolutely no sense to this person. So in other words, understanding the person’s cultural meanings about gender, religion, faith, ethnic identity, what does it mean to them that they are Tutsi coming from Rwanda? What does it mean that they are a male who came from Sierra Leone and who... had his hand chopped off during that war? What does it mean to be a man during

that wartime in Sierra Leone? What does it mean to be a young woman from Kosovo who was raped?

A final example of this subtheme was during Participant C's interview where she related the importance of attending to the client's culture with "sensitivity" and "humility" and then adapting conceptualization and treatment to fit the client's context:

I think probably the best advice I would give is you don't know them or their experience, and so probably the most helpful thing for me is to approach it with a large amount of cultural sensitivity or cultural awareness, and even kind of cultural humility, of like, I don't really know, and to try and convey that as much as possible to them, that you want to be supportive but you don't necessarily know how the best way that's going to look, and it may not look like what you think traditional counseling or therapy looks like, and you have to kind of be ok to let go of that.

Therefore it appears that the participants advised clinicians to utilize clinical knowledge as well as recognize the potential limitations of this knowledge by attending to cultural variables when working with refugee youth.

Discussion

The purpose of this research project was to examine the conceptualizations of refugee minors who have experienced political violence, as well as factors that are used to formulate an understanding of these youth. This project chose to rely on the expertise of clinicians who have experience working with this population. 6 clinicians participated in interviews with the researcher, which underwent a qualitative data analysis to discover emergent themes both within the individual participants and shared across the entire participant sample.

The themes that emerged during the study that were shared by all of the participants were (1) sources of clinical information, (2) formal assessment, (3) conceptualization, (4) cultural

factors incorporated in conceptualization, (5) advice to future clinicians. A discussion of the themes follows, as well as a focus on the potential contributions of the present study, direction of future research, clinical implications, and limitations to the present study.

Overall, clinicians provided complex and integrated conceptualizations of their refugee clients that drew from many different areas supported in research about refugee youth and political violence. All of the participants incorporated various aspects of the refugee experience, including pre, mid-, and/or post- migration factors which contributed to indicators of strength and distress. Through their conceptualizations, they were able to provide a multidimensional picture of their client's presentation and recognize the client's cultural and contextual features embedded into current and past life events.

Sources of Clinical Information

Although there have been many studies and papers that seek to provide awareness to clinicians of the experiences of refugee youth (Allwood et al., 2002; Almqvist & Brandell-Forsberg, 1995; American Psychological Association, 2010; Geltman et al., 2008; Kia-Keating & Ellis, 2007), there has been no research to date that examines the information clinicians utilize when working with refugee youth in a clinical capacity. The participants each referenced sources of clinical information that contribute to their work with refugee youth who have experienced political violence. These are resources that the therapist rely on to inform their work with refugee youth, which include utilizing supervision and consultation, literature from the research community, or the client as the expert (client's perspective of context).

During the study, the participants referenced consultation as being a significant resource that was utilized when providing services to refugee youth. This included consultation with both professional and members of cultural groups familiar with the culture of the youth. The importance of seeking the expertise of outside resources through consultation appears consistent

with recommendations for competent practice in the literature. Research and literature has long supported the need for therapists to engage in supervision and consultation with professionals as best practice (Falender & Shafransky, 2004). Literature has also encouraged clinicians to seek out consultation regarding cultural factors when working with refugees from a different cultural background than the therapist, such as from paraprofessionals or “cultural brokers” who can provide awareness of the client’s cultural worldview and cultural factors that might influence conceptualization or treatment (APA, 2010; Gong-Guy, Cravens & Patterson, 1991). Utilizing consultation with individuals who can provide guidance about cultural factors can make treatment more meaningful and applicable to the client as well as give the clinician a more applicable perspective in regard to treatment goals. This is especially important given concerns in the literature that western- based treatment and conceptualization does not accurately reflect the experiences and needs of clients who do not share the same worldview (Summerfield, 1999).

The participants also referred to research as a resource of information contributing to their work with refugee minors exposed to political violence. The research that was endorsed varied from research about trauma and evidenced- based practice to research about cultural traditions of the client’s country of origin to research about the history of the political violence the client was exposed to. This is consistent with the recommendations of Ehntholt and Yule (2006) who suggests that practitioners working with refugee children and adolescents have a basic understanding of the client’s country of origin and cultural practices prior to assessment. Barber (2008) studied the difference between youth residing in countries with political violence, and emphasized that the nature of the war conflict can influence effects and identity development in youths based on factors in addition to exposure, such as sociopolitical and cultural factors. The use of evidence based practice has also been established as a means of bridging the gap between the research community and clinical practice (Kazdin, 2008), which can direct clinicians

towards using practices and principles that have been supported through systematic research. However, in spite of the significant amount of research focused on youth, trauma, and political violence (Gilligan, 2009), it appears that this resource may be underutilized by clinicians because this type of research was only indicated by one of the participants. It also may reflect the argument of Summerfield (1999), that research in the field of refugee youth mental health is primarily based on western paradigms that do not accurately reflect the experiences of refugee minors.

Three of the participants emphasized the importance of relying on the client's perspective in informing their work with their refugee minor clients, and relying on the client as the expert into their own experiences rather than consultants or research. The importance of recognizing the client's context and allowing the client's context to inform treatment has been widely supported in literature about working with refugee youth, particularly because of the varied experiences of refugee youth with histories of war violence as well as cultural and systemic factors that might influence clinical presentation (APA, 2010; Lustig et al., 2004).

Formal Assessment

The use of assessment in working with refugee youth mental health has also been somewhat controversial, with some literature advocating that standardized assessments are helpful in measuring the presence of symptoms and monitoring progress (Ehnholt & Yule, 2006), while others argue that these measures may not accurately represent the population (Berman, 2001; Miller et al., 2006). This argument was reflected in the results for this study. Three of the participants endorsed using standardized assessments, like questionnaires and screeners, to evaluate their refugee youth clients. However, 2 of these participants recognized the limitations in using these assessments due to differences in cultural normativity. Therefore, it may be concluded that although standardized assessments appear to be a significant tool for

assessment, clinicians are aware of the limitations and may interpret the results accordingly. All of the questionnaires or screeners that the participants did report using appeared to be primarily trauma- focused. This reflects arguments in the literature that assessment in the field of refugee mental health has been primarily trauma- focused and designed around symptoms of PTSD (Berman, 2001). Although these measures might be effective in understanding some of the adverse effects of war violence and migration, they do not necessarily encompass other aspects of the refugee experience including issues of acculturation or other post- migration stressors. It can be hypothesized that data gathered using trauma- focused questionnaires may influence the content of conceptualization to focus on trauma, and may not address other pertinent and relevant issues experienced by refugee youth.

The use of family based assessments was also utilized by all of the participants who had clients that migrated to the United States with their family members (3 out of 6). Pine and Cohen (2002) reported that gathering information from at least two sources is standard among investigators in child trauma, and that family reports can be invaluable to understanding the client's symptom presentation. The use of family in assessment also appears to be an important step in facilitating a conceptualization because of the significance that research has placed on the role of family in mediating the effects of war violence and displacement (Ehnholt & Yule, 2006; Sagi-Schwartz, 2008; Shaw, 2000). Individual interviews were also prevalent among the participants (4 out of 6). More of the participants may have used individual interviews, but they were not mentioned. These participants engaged in both structured and unstructured interviews that focused on present functioning, trauma history, and/or cultural traditions among others. Ehnholt and Yule (2006) in their clinical work with refugee youth, advocate for the use of interviews with the client to establish rapport and build trust between the client and the therapist, and recommend that several dimensions be included in the interview. These dimensions, which

are related to the refugee experience, include history of trauma, language, family structure, cultural identification, language, country of origin, and legal status. The APA (2010) taskforce for refugee children also emphasizes the importance of gathering information during an interview that reflects current functioning and additional stressors that might occur post-migration in providing a more holistic representation of the client's needs.

Conceptualization

All of the participants were able to share a conceptualization they utilized with their refugee minor clients to guide their treatment planning. The use of conceptualization has been supported by experts as an essential step in formulating an effective and comprehensive treatment (Berman, 2010). A trauma- focused conceptualization was shared by each of the clinicians. The type of trauma experienced differed based on the exposure of the client. All the participants discussed pre- migration experiences as the trauma that contributed to their client's distress (rape, torture, witnessing violence, etc), and some also identified migration or post-migration experiences as traumatic. Each of the participants attributed some, but not all, of their client's emotional distress to their adverse experiences as refugee youth. This form of conceptualization supports the plethora of research that has indicated that trauma is a significant factor in the development of clinical symptoms with youth who have experienced war violence (Kohrt, 2010; Montgomery & Foldspang, 2005; Morgos et al., 2008). The use of a trauma-based conceptualization has been contested by some researchers as too narrow because it does not incorporate the variety of associated stressors related to being a refugee (Miller & Rasmussen, 2010). However, it is interesting to note that each of the participants had at least two dominant themes in their conceptualizations, and that none focused on the trauma as the only variable predicting the client's clinical presentation.

The other subtheme that was discussed in the conceptualizations presented by 3 out of the 6 participants was resiliency. Within this theme, the participants identified several protective factors that promoted their client's ability to adapt and recover through their adverse circumstances. The prevalence of protective factors that mediate the presentation of distress for youth exposed to war violence has been supported in the literature (Betancourt & Kahn, 2008; Ehnholt & Yule, 2006; APA, 2010). These protective factors include both internal factors (humor, temperament, etc.) as well as external factors (family support, religious/faith community, etc.), which is consistent with the factors identified by the participants. However, the majority of research regarding the effects of political violence has focused more on risk factors and symptoms rather than protective factors and resiliency (Betancourt & Kahn, 2008). This study reflects that despite the lack of research support, clinicians are nonetheless considering resiliency and protective factors when establishing a conceptualization.

Finally, loss was supported as a focus of conceptualization by 3 out of the 6 participants. The participants described loss as the client's loss of family, friends, and community, as well as loss of tradition and identity due to political violence and migration which influenced well-being. The focus on loss during conceptualization appears consistent with the literature on refugee youth, which identifies that loss and grief are key challenges experienced by refugee youth (Morgos et al., 2008; Denov, 2010). This includes the loss experienced as the result of death or separation from family as well as the loss experienced as the result of political violence and displacement due to war conflict (Boris et al., 2008; Laor et al., 2002; Sagi-Schwartz, 2008).

Cultural Factors or Cultural Influences

The influence of culture on refugee minors was a core issue in the study and emerged as major theme by each of the participants. Researchers involved in the field of refugee mental

health have called for a greater emphasis placed on culture in understanding individuals who have been exposed to political violence (Bracken, 2001; Miller, 2006; Summerfield, 1999).

Culture was predominantly mentioned by the participants in reference to their client's ethnic identity or practices and traditions in their country of origin. Gender was also referenced more often by the participants regarding the differences in clinical presentation based on gender issues. Religion, socioeconomic status, and the culture of a "warzone" were also discussed, albeit sporadically. Only one participant referenced the client's age as a contributing factor to their conceptualization of their client. Each of the participants referenced culture as a contributing factor to formulating a conceptualization of their clients. This was exhibited through the participant's recognition of the unique cultural influences that had shaped the presentation of each client, such as the influences of gender roles, idioms of distress, meanings ascribed to events, and values.

Although the influence of culture in conceptualization was a major theme in the between-case analysis, there appeared to be a lack of integration of culture into the conceptualizations. Culture did not emerge as a major theme in any of the within- case analysis, which focused primarily on the conceptualizations of the youth, and were rarely spontaneously mentioned by the participants as a significant factor contributing to their understanding of the refugee youth. The major theme of culture in conceptualization only appeared as the result of the question posed by the researcher asking the participant how culture influenced the process of their conceptualization. Further, even when addressing the issue of culture, there appeared to be a lack of in- depth discussion about the unique ways in which culture influenced the presentation of the client. For example acculturation distress, culture shock, and loneliness as the result of displacement did not appear as a major theme or subtheme for any of the participants, although this is a major issue that refugee youth experience in their host country that can complicate the

healing process (Fantino & Colak, 2001; Keyes & Kayne, 2004; Lustig et al., 2004). Further, issues of oppression or discrimination is a common occurrence experienced by refugees in their host country and contribute to increased rates of mental health distress (Ellis et al., 2010). However, this issue was only briefly mentioned by one of the participants. The importance of recognizing and attending to cultural factors during treatment with youth in general has been strongly supported as a fundamental principle in the literature (Schwab-Stone, Ruchkin, Vermeiren, & Leckman, 2001), and this is especially true for refugee youth (APA, 2010).

Although all of the participants supported trauma-focused aspects in their conceptualization, there was limited discussion about how the meaning of the trauma manifested differently dependent on the youth's sociocultural worldview. Literature has supported that the meaning ascribed to adverse experience may differ dependent on cultural factors as well as the nature of the political conflict (Bracken et al., 1995; NCTSN Core Curriculum on Childhood Trauma Task Force, 2012). Considering that the majority of the participants personally identified with cultures dissimilar to their clients, and that their client's came from countries with cultures that are incongruent with a western universalist framework, it appears that this should have been a significant area to address during conceptualization. This seems to suggest that the participants might have adopted a more universal understanding with regards to their trauma-based conceptualization, which literature has supported may not fully encompass the distress presented among refugees with histories of political violence (Miller et al., 2006; Summerfield, 1999).

The subtheme emphasizing the use of open dialogue to address culture in therapy appeared related to the earlier theme of client context proposed by the participants. The similarities are that the participants endorsed creating a space in the therapeutic relationship to allow for the client to provide expertise on their own experiences when constructing a

conceptualization. This is an important practice supported in the literature by Anderson and Goolishian (1992), who emphasize the importance of the therapist engaging in dialogue with the client from a place of not-knowing, and where acknowledgment and interpretation occurs openly in dialogue between the therapist and the client. It is interesting to note that the creation of the open dialogue for 2 of the therapists was related to language errors on behalf of the therapist. This may suggest that providing the client with space to correct the therapist might aid in facilitating the open dialogue.

Advice to Clinicians Working with Refugee Youth

The recommendations proposed by the clinicians included the use of trauma-informed knowledge and skills and cultural humility in working with refugee minors. Regarding trauma-informed knowledge and skills, the clinicians appeared to focus primarily on the importance of being trauma-informed in order to understand and effectively evaluate refugee youth who have experienced adverse circumstances. This recommendation assumes some universalist understanding of psychology, particularly of trauma, that can be integrated and utilized into therapy with refugee youth. Dyregrov et al. (2002), speaks of denial of trauma as a phenomenon that has afflicted the field of psychology, and that recognition of trauma legitimizes and aides in the recovery of youth who have been exposed to political violence. However, literature in the field of children and war has also challenged clinical knowledge in the field of trauma as biased towards western values and suggest that these concepts be used carefully (Bracken et al., 1995).

The participants also appeared to recognize the limitations in solely relying on clinical knowledge when working with refugee youth, because 4 of them advised clinicians to adopt cultural humility during assessment and therapy with this population. Cultural humility in the literature is considered a life-long pursuit by clinicians towards recognizing personal biases through self-reflection as well as the awareness and acceptance of the client's worldview

(Tervalon & Murray Garcia, 1998). Additionally, even though not all of the clinicians explicitly mentioned cultural humility as a recommendation, each of the participants recognized the importance of contextual factors in understanding and attending to the needs of their refugee clients by incorporating it into their conceptualizations.

Methodological Limitations to the Present Study

One of the possible limitations to the present study is the potential subjectivity of the coding and data characterization influenced by the researcher's own experience and worldview. It was the decision of the researcher to allow for emergent themes rather than use coding based on the literature. The researcher attempted to limit this bias through reflective journaling and utilizing an auditor.

Additionally, the snowball method that the researcher used when recruiting participants involved using identified leaders in the community some of whom the researcher had a professional relationship. The researcher has worked in this area and therefore had access to experts in the field of refugee mental health and child trauma. However, again the researcher utilized journaling and the assistance of an auditor to increase the objectivity of the codes. The participants also might have shaped their responses knowing that their interviews might be identifiable to others who were also intimately involved in the case.

Another possible limitation is that the interview structure prompted the participant to share pre-, during, and post-migration experiences of their identified client before the researcher asked them to conceptualize the youth. Therefore, this may have unconsciously contributed to the participant referencing more contextual factors in sharing their formulation of the youth, than they would have had the interview not prompted to consider these factors earlier in the interview. Future researchers may consider varying the order of the interview protocol.

Potential Contributions of the Present Study

The present study was developed to contribute to the literature regarding refugee youth and clinical practice. This study was also aimed towards bridging the gap between clinicians providing services for refugee minors and research about youth exposed to political violence. The hope is that this study will serve as a guide for therapists who are working with refugee youth to develop relevant and informed conceptualizations prior to establishing treatment plans. Further, this study may provide researchers with some insight into the conceptualization process for this population and illuminate areas that have been overlooked in the literature. Finally, the results of this study will hopefully emphasize the importance of qualitative methodology in research, particularly to inform culturally- sensitive practice with individuals who might not be best understood through western psychological paradigms.

Suggestions for Future Research

The purpose of this study was to contribute to the field of refugee and political violence research and remedy a significant paucity in the literature by bridging the expertise of clinicians with information provided by the research. Consistent with the recommendation of the APA (2010), it is advised that future research continue to bridge the gap between research and clinical practice in order to provide more effective and relevant services for refugee youth. This study focused primarily on the factors that contributed to establishing a treatment plan, such as assessment and conceptualization. Future research should examine how conceptualization is implemented into treatment for clinicians working with refugee youth. This study should examine both the process of treatment and how the conceptualization is linked to treatment factors.

Considering the amount of cultural and contextual themes and subthemes that emerged from the interview, it would be important for future research to continue studying how clinicians

understand culture and how they incorporate client context into therapy with refugee youth. Further studies that examine cultural factors among refugee youth are also suggested to provide guidance to future clinicians working with this population, with particular attention to the way culture influences the presentation of distress. It is also recommended that future research incorporate family issues in examining refugee minors, considering that the focus of the conceptualization for most of the refugee youth who arrived with their families pertained to family issues.

One major subtheme that was prevalent in the study but appears to be lacking in the literature is the role of resilience in mediating adverse life experiences with refugee youth. It is strongly recommended that future research incorporate factors of resilience and strengths into understanding the effects of political violence on youth as well as the refugee experience. Aisenberg and Herrenkohl (2008) argue that resilience as it is defined in western culture, as having more individual characteristics, might not be applicable to collaborative cultures where success and recovery is defined in terms of the community. This study also relied on the definition where resilience is considered to be the individual's ability to adapt and recover from adverse experience. Therefore, it is also recommended that in the future, the definition of resilience be examined through a cultural lens when applying this term to individuals, and be studied from within the cultural value system.

Another potential area that has not been explored in previous research with refugee youth are impact of clinician variables on treatment. These variables may include theoretical orientation, gender, years of experience, cultural identity, religious affiliation, among others. Further, there appears to be a significant lack of research into the role of consultation for clinicians who are working with refugee minors, including supervision as well as clinical and cultural consultation. Considering that this was a subtheme that the participants endorsed during

their interviews, this is strongly recommended as an area that requires attention by the research community.

Clinical Implications

The present study provides insight into the ways in which clinicians gather and synthesize the experiences of refugee youth with exposure to war violence. The present study recognized several important factors for therapists working with refugee youth in a clinical capacity. These factors were gathered based on the collective and individual expertise of the participants in the study and can be utilized by clinicians requiring additional guidance working with this population.

Factors informing clinical practice with refugee youth commonly reported among the participants were consultation, research, and client context. Therefore, clinicians with little experience working with this population may benefit from seeking the expertise of supervisors, colleagues, and individuals from the community with similar cultural backgrounds to the client. Research also appears to be an important factor in guiding clinical practice with refugee minors, particularly research into the political conflict and cultural factors of the client's country of origin. Further, it appears that using the client as an expert in informing the conceptualization and treatment is fundamental, and should be utilized by clinicians in regular practice with refugee minors.

Common assessments that were used with clinicians working with refugee minors may be individual interviews, screeners and standard measures, and family- based assessments. The family- based assessments appear to be standard with any child who has arrived in the host country accompanied by family members. Individual interviews appear to be an important means of gathering historical as well as current stressors influencing the presentation of distress. Screeners and standard measures may be effective with refugee youth in understanding their

clinical presentation, but should be used with caution because they may not adequately reflect the experiences or distress of the client due to cultural factors and the process of normalization.

The clinicians in our study all relied on a form of trauma- informed treatment to guide their conceptualization. Therefore, it is recommended that clinicians recognize the client's history and trauma as a significant factor in understanding current functioning and formulating a conceptualization to guide treatment planning with refugee minors who have been exposed to political conflict. Further, it seems very important to recognize the strengths and resiliency in order to provide a more comprehensive and holistic representation of these youths. An awareness of the client's strengths may also be effective in understanding the client's adaptive coping responses and expanding upon them in therapy.

It is essential that clinicians incorporate cultural factors in the conceptualization of refugee minors, particularly considering the potential differences in cultural worldview between the client and the therapist as well as the client and a western psychological paradigm.

According to the analysis of the interviews, these factors can include language barriers, cultural worldview, value systems, role expectations, and religious or belief systems. Creating an open dialogue between the client and the therapist may allow clinicians the opportunity to gather information regarding cultural factors that might influence conceptualization and treatment, as well as create an environment of acceptance and understanding in the therapeutic relationship.

The participants made several recommendations to future clinicians which fell under two themes. Adopting cultural humility was strongly advised as a means of recognizing the limitations of the therapist and the field of psychology in fully understanding the cultural context of the client, and engaging in exploration of these influences with the client serving as an expert. It also means recognizing and accepting that the meanings ascribed to different experiences may differ based on cultural or individual factors, and that it is the responsibility of the therapist to

understand those meanings rather than impose them upon the client. The other recommendation was for clinicians to maintain their clinical knowledge when working with refugee youth. The participants tended to focus on clinical knowledge that was trauma- informed given the history and experiences of refugee minors exposed to war violence. Therefore, it appears important that clinicians who are working with this population balance their work with refugee minors on both clinical and contextual knowledge gathered from training and experience as well as the client.

It is also highly recommended that clinicians and clinics who are working with refugee youth emphasize the importance of establishing a working conceptualization in order to guide the course of treatment. Without a substantial and integrated conceptualization, treatment with refugee minors who have experienced war violence may be misdirected or biased towards focusing on issues which are not appropriate given the client's context. The results of this study support that there are many factors which influence the clinical presentation of refugee youth including grief and loss, culture, exposure, displacement, and development, and that in order to establish a relevant treatment, each of these variables should be incorporated and addressed.

Conclusion

The experiences of refugee children and adolescents who have been exposed to political violence have been examined in the literature, particularly with regards to exposure, displacement, and issues of grief. Responses to these experiences appear to vary depending on the developmental age of the youth as well as cultural factors. Assessment with refugee minors, including questionnaires, semi- structured, and structured interviews have primarily focused on symptoms, particularly symptoms consistent with Posttraumatic Stress Disorder, as well as exposure to violence.

Very little research has been conducted with clinicians who have worked with this population. To date, there has been no previous research designed to understand the

conceptualizations of refugee minors formulated by clinicians. This study was designed to fill the dearth of literature in this area by interviewing clinicians with experience working with refugee youth, to evaluate their conceptualization as well as factors associated with establishing a conceptualization. 6 clinicians participated in the study and addressed major themes including sources of clinical information, assessment, conceptualization, culture, and advice to clinicians working with refugee youth. The themes that were prevalent under the major theme of conceptualization were trauma, loss, and resiliency. It is hoped that this study will contribute to the field of refugee youth mental health by serving as a guide to clinicians working with this population as well as a motivating factor for researchers to investigate this area further and finally as a bridge to address the gap between refugee research and practice.

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TABLE 1
Participant Demographics

Participant	Years Licensed as a Therapist	Cultural Identification	Gender	Theoretical Orientation (Primary)	Estimated Number of Youth Refugees	Refugee work in what context
A	14	Hispanic (German and Spanish)	F	Cognitive Behavioral and Object Relations	10	Community Clinic
B	16	Caucasian (dominant) and Native American	F	Attachment and Cognitive Behavioral	180	Community mental health, Non-governmental organizations
C	7	Caucasian	F	Strengths-based	30	Community mental health, Non-Profit
D	13	Caucasian	F	Psychodynamic, Family Systems, and Cognitive Behavioral	30	Hospital-based clinic
E	15	Creole Sierra Leonean	F	Psychodynamic	11	Hospital-based clinic, Community mental health
F	19	Caucasian	F	Self-trauma model (integrated)	50	Non-governmental organizations, Community mental health

APPENDIX A

Interview Protocol

I. Consent and Introduction

- A. The researcher will introduce herself to the participant and will outline the process before continuing onto consent

“Thank you for meeting with me Dr./Mr./Ms. (name of participant). I have provided refreshments for you that you may have at your convenience. As you read in the email, I am here to interview you about your experiences in working with refugee youth who have been exposed to war violence pre- migration. The purpose of the study is to understand how clinicians conceptualize refugee youth and their experiences prior to establishing a treatment plan as well as what informs their conceptualization. I will first go through the consent with you verbatim, which will include information on confidentiality, risks and benefits to the study, limits to confidentiality, and contact information. If you agree to the terms of the consent, I will ask you to sign the consent, will give you a copy, and will retain a copy for my records. Afterwards, we will begin the interview, which will consist of open- ended question with some prompting. It should last about 1-3 hours. I would like you to let me know at any time if you need a break or would like some refreshments. With your permission, I will begin with the consent”

- B. Consent will be reviewed with the participant by the researcher prior to the interview on the same day (See informed consent form).
- C. After consent has been signed, the researcher will commence with the interview

II. Interview

- A. Demographic Questions: “I am incredibly grateful to you for agreeing to participate in this study. One part of this study is to focus on the conceptualization of a refugee youth, but I would also like to get to know about you as a clinician as well.”

- (a) How many years have you been licensed, and in what state?
- (b) How many years were you licensed in this state before seeing the youth you will be discussing?
- (c) What is your religious affiliation?
- (d) What is your cultural identification?

- B. Grand tour questions

1. Would you mind sharing your clinical theoretical orientation?

2. I would also like to hear about your clinical experiences working with refugee youth. In what context did you work with refugee children and adolescents clinically?
 - (a) How many refugee youth have you worked with and from what countries?
3. What has informed your clinical work with refugee children and adolescents?
4. I would like you to focus on one refugee youth in particular that you worked with who experienced a history of war violence pre- migration. I would like you to try to remember the first time you saw the youth in the waiting room, and reflect on those first initial sessions where you were gathering information for the intake. Please tell me some of the background information about that youth.
5. Through which process did you assess the youth?
6. What were some of the experiences that this youth endured during pre- migration? (i.e. violence exposure, grief)
 - (a) What were some of the experiences that this youth endured during migration? (Resettlement camps, dangerousness of flight, lack of resources)
 - (b) What were some of the experiences that this youth endured post- migration? (i.e. acculturation, adoption, school integration, language barriers)
7. Do you remember the nature and the reason for the referral of this youth?
 - (a) How did you conceptualize the issues and distress presented by this youth in establishing a treatment plan?
 - (b) How did your assessment of the youth contribute to your conceptualization?
 - (c) What cultural considerations influenced your conceptualization?

C. Probing questions [*Ask as needed*]

- (a) Can you tell me more about that?
- (b) Can you give me an example of that?
- (c) What led you to think that?
- (d) You seem to be saying _____, is that what you mean?

III. Ending Interview

A. Closure questions

1. What advice would you give to clinicians working with refugee youth who have been exposed to war violence?
2. Has your conceptualization of this youth changed since working with them?
 - (a) If yes, what changed?
 - i. What facilitated the change?
3. Is there anything that I did not ask that you wish to include in the interview?

B. Concluding the interview

If you think of any questions after I leave, don't hesitate to contact me. My contact information is on the consent form.

Just as a reminder, I will likely be contacting you by phone after I have had a chance to transcribe the interview so that we can clarify any areas that may be unclear. I want to make sure that I have correctly understood what you have told me.

Again, thank you very much for your time and support of my research project.

APPENDIX B

Informed Consent Form

I give permission to Sara Mehrabani, a doctoral student in clinical psychology at Pepperdine University, Graduate School of Education and Psychology, to include me in the research project entitled “Refugee youth from war: Clinician conceptualizations of refugee youth previously exposed to political violence.” The project is under the supervision of Thema Bryant-Davis, Ph.D., Associate Professor of Psychology.

I understand that my participation in this study is completely voluntary and that I have the right to refuse to participate in the study or to stop participating in the study at any time. I also have the right to refuse to answer any questions that I do not choose to answer.

I have been asked to participate in this study because I am a licensed therapist; Masters level or higher. I am over the age of 18. I have worked with at least three refugee youths, and at least one refugee youth with a history of war exposure for enough sessions to formulate a conceptualization of this youth, and was licensed at the time in the United States to practice therapy. The purpose of this research study in which I have been invited to participate is to share my conceptualization of at least one refugee youth who had been exposed to war violence pre-migration.

With my permission, the interview will be conducted in a private area to ensure confidentiality and convenience. The interview will be conducted following this consent in a face-to-face meeting. I understand that the interview will be conducted by Sara. Sara may call me after the interview if there are any questions about what I shared that need further clarification. I also understand that I can ask Sara to delete or not include any information from my story that I wish to keep private.

I understand that the interview will be digitally recorded and will take about 1-3 hours to complete during one visit. These recorded conversations will be written out verbatim after the interview is over. I understand that a research assistant will be involved in the research to assist with transcribing the interview, but they will not have access to my identifying information and is also expected to maintain confidentiality. I will be asked to discuss experiences of youth that I have worked with in a clinical capacity. Specifically, I will be asked to talk about some of their experiences and how I conceptualize those experiences. I understand that as a licensed therapist, I will not provide any identifying information about these youth during my interview. During this interview, I agree to abide by HIPPA laws to ensure confidentiality of the youth I will be discussing and will not provide information on confidential information designated by HIPPA laws. This includes de-identifying the youth by not discussing names, all geographic subdivisions smaller than a state, all dates smaller than a year, phone number, fax numbers, e-mail, social security numbers, medical record numbers, health plan beneficiary, any other account numbers, certificate/license numbers, vehicle identifiers, device identification numbers, web url's, internet IP address number's, biometric identifiers, full face photographs or comparable images, and any other unique number, characteristic, or code.

I understand that participating in this study involves minimal risks similar risks experienced during psychological testing or during daily activities. Those risks may include fatigue or inconvenience due to the amount of time required, or mild discomfort in discussing the stressful experience of former clients. If I become uncomfortable during the interview, I should not hesitate to stop and discuss my discomfort with Sara. I am in complete control about what and how much I share. My participation is entirely voluntary, and I am encouraged to tell Sara if I need to stop the interview at any time. I also understand that I have

the right to withdraw from the study at any time, and there will be no consequences for choosing to do so.

If I need a break to get up and stretch or need something to drink, I should let the Sara know so that the interview can be more comfortable for me.

If I experience psychological distress following the interview related to the content of the information discussed during the interview, I understand that I can contact Sara, who will arrange affordable counseling for me in my community.

Although I may not directly benefit from participating in this study, the hope is that professionals in various fields such as medicine, psychology, and education better understand the conceptualizations of refugee adolescents. This information can be used to guide to clinicians working with refugee adolescents as well as future research into the experiences of refugee youth in clinical practice.

I understand that select parts of my interview will be made available to others to read so that they can learn about my experiences. My name and other personally identifying information will not be included in the story, but it is still possible that others who know me and with whom I have shared my case information will know whose experiences they are reading about.

The transcript (entire written copy of my interview) and the digital recording will not be released to others without my permission in order to maintain confidentiality. However, there are limits to confidentiality under California law, which is where the primary research study is taking place. Confidentiality does not apply if there is a suspected abuse of a child, abuse of an elder or dependent adult, or if I communicate a desire to inflict serious harm to myself, another person, or to another's person's property. In these cases, the research assistant or Sara will be required to make a report to the proper authorities.

The recordings of our conversation as well as the written version will be kept in a locked file cabinet that only Sara or the research assistant will be able to access. Only Sara will have access to files that contain my identifying information, and this will be kept in a locked cabinet. When the study has been completed, the audio recordings will be destroyed after being stored in the locked cabinet for three years, and I can ask to have them destroyed in front of me if I choose.

I understand that if there are any questions or concerns that I have before, during, or after the interview, I can contact Sara Mehrabani at [REDACTED] or her advisor, Dr. Thema Bryant- Davis at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045, 818-501-1632. If I have particular questions about my rights as a participant in this research study, I can contact Doug Leigh, Ph.D., Chairperson of the Graduate and Professional Schools Institutional Review Board, Pepperdine University, Graduate School of Education and Psychology; 6100 Center Drive, Los Angeles, CA 90045, (310) 568-2389, doug.leigh@pepperdine.edu.

Name of Participant (please print)

Participant's Signature

Date

I have explained and defined in detail the research procedures in which the participant has consented to participate. Having explained this and answered questions, I am co-signing this form and accepting this person's consent.

Investigator's Signature

Date

APPENDIX C

Initial Email to Participants

Dear _____,

My name is Sara Mehrabani and I am a student at Pepperdine University completing my dissertation in the field of refugee youth and political violence. I was encouraged to contact you by _____, who indicated that you might be a great fit as a participant in my dissertation research. The project is under the supervision of Thema Bryant-Davis, Ph.D., Associate Professor of Psychology.

The purpose of my dissertation is to understand the ways in which clinicians conceptualize refugee youth who have been exposed to political violence. We are looking for 6- 8 licensed clinicians in the United States to participate in our study who have a history of providing therapy to refugee youth (youth is considered a client under the age of 18 at the time of treatment). The inclusion criteria include:

1. Licensed as a therapist in the United States
2. History of providing therapy to at least three refugee youths clients under the age of 18)
3. Worked with at least one refugee youth (under the age of 18) who had a history of exposure to political violence (direct or indirect)
 - a. Therapy was long enough to gather an initial assessment and develop a clinical formulation and conceptualization of the youth.

This is a qualitative study and will require 1-3 hour face- to- face interviews with the clinicians that will be taped and later analyzed according to individual and collective themes. If you consent to participate in the study, you will be asked to provide background history and a conceptualization of the former refugee youth with exposure to political violence. I will make every attempt to conduct the interviews in a place that is convenient for you. If you do not have access to a suitable private or professional place for the interview, you may suggest an appropriate location, or the interview may be conducted at a Pepperdine graduate campus or Pepperdine training facility. There are no more than minimal risks involved with participating with the study. There are also no direct benefits to the participants for participating in the study. However, indirect benefits may include providing insight to the research community about how refugee youth and political violence are conceptualized in the clinical community.

I sincerely hope that you will be able to participate in this study because your involvement would be invaluable. Please let me know by email (_____) or by phone (_____) if you meet the criteria and are willing to be involved in this research, and if you know anyone else who might be appropriate for the study.

Thank you so much for your time and consideration.

Sincerely yours,

Sara Mehrabani

APPENDIX D

Script for Follow- up Phone Calls with Participants

Thank you so much responding to my email. I would like to first review the purpose of the study and review the inclusion criteria before setting up a time and place for the interview. Would this be alright with you?

(If response is no): Thank you for your time. Goodbye

(If yes): Thank you. My name is Sara Mehrabani and I am a student at Pepperdine University completing my dissertation in the field of refugee youth and political violence. The purpose of my dissertation is to understand the ways in which clinicians conceptualize refugee youth who have been exposed to political violence. I would like to make sure that you meet the inclusion criteria before we proceed. Are you currently a licensed therapist in the United States with a Masters level degree or higher?

(If yes): Do you have experience providing therapy to at least 3 refugee youth under the age of 18?

(If yes): Have you worked with at least one refugee youth under the age of 18 with exposure to political violence long enough to gather an intake and form a clinical conceptualization?

(If yes): Thank you, you seem to be an excellent fit for this study. I would like to set up a time and a place that is convenient to you. The interviews should last 1-3 hours long and will be face-to-face meetings. We will first review and signed the informed consent, where I will be outlining the process of the interview and data collection and receiving your consent before proceeding with the interview. Do you have a private or professional location that is convenient to you where we can conduct the interviews?

(If yes, then schedule time for interview)

(If no): Then I can try to arrange a meeting at a Pepperdine location most convenient to you. (Provide possible locations then schedule time for interview).

APPENDIX E

Email to Referral Source for Participants

Dear _____,

My name is Sara Mehrabani and I am a student at Pepperdine University completing my dissertation in the field of refugee youth and political violence. I was encouraged to contact you by _____, who indicated that, as a leader in the field of _____, you might be able to assist in identifying potential participants for my dissertation. The project is under the supervision of Thema Bryant-Davis, Ph.D., Associate Professor of Psychology.

The purpose of my dissertation is to understand the ways in which clinicians conceptualize refugee youth who have been exposed to political violence. We are looking for 6- 8 licensed clinicians in the United States to participate in our study who have a history of providing therapy to refugee youth (youth is considered a client under the age of 18 at the time of treatment). The inclusion criteria include:

1. Licensed as a therapist in the United States
2. History of providing therapy to at least three refugee youths (client's under the age of 18)
3. Worked with at least one refugee youth (under the age of 18) who had a history of exposure to political violence (direct or indirect)
 - a. Therapy was long enough to gather an initial assessment and develop a clinical formulation and conceptualization of the youth.

This is a qualitative study and will require 1-3 hour face- to- face interviews with the clinicians that will be taped and later analyzed according to individual and collective themes. The clinicians will be asked to provide background history and a conceptualization of the former refugee youth with exposure to political violence. I will make every attempt to conduct the interviews in a place that is convenient for the participant. If the participant does not have access to a suitable private or professional place for the interview, the participant may suggest an appropriate location, or the interview may be conducted at a Pepperdine graduate campus or Pepperdine training facility. There are no more than minimal risks involved with participating with the study. There are also no direct benefits to the participants for participating in the study. However, indirect benefits may include providing insight to the research community about how refugee youth and political violence are conceptualized in the clinical community.

I sincerely hope that you will be able identify potential participants for this study that meet the inclusion criteria. Please let me know by email _____ or by phone _____ if you know of anyone who would meet the criteria and are willing to be involved in this research, or please forward them this email so that they might contact me if they are interested.

Thank you so much for your time and consideration.

Sincerely yours,

Sara Mehrabani

APPENDIX F

Institutional Review Board Exemption Notice

PEPPERDINE UNIVERSITY

Graduate & Professional Schools Institutional Review Board

June 13, 2013

Sara Mehrabani

Protocol #: P0313D01-AM1

Project Title: Clinician conceptualizations of post-migration refugee youth previously exposed to political violence

Dear Ms. Mehrabani,

Thank you for submitting Amendment 1 of your approved IRB application, *Clinician conceptualizations of post-migration refugee youth previously exposed to political violence*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor, Dr. Bryant-Davis, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - <http://www.nihtraining.com/bhsa/site/guidelines/45cfr46.htm>) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

Category (2) of 45 CFR 46.101, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at <http://www.pepperdine.edu/irb/graduate/>).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Veronica Jimenez, GPS IRB

Manager at gpsirb@pepperdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,



Doug Leigh, Ph.D.
Chair, Graduate and Professional Schools IRB

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives
Ms. Alexandra Roosa, Director Research and Sponsored Programs
Dr. Bryant-Davis, Graduate School of Education and Psychology