

5-2018

Healing the Mind and Body: Practitioner Perspectives on Integrating Cognitive and Somatic Approaches in Psychotherapy with Refugees, Asylees, and Asylum Seekers

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Recommended Citation

Ament-Lemke, Amanda. (2018). Healing the Mind and Body: Practitioner Perspectives on Integrating Cognitive and Somatic Approaches in Psychotherapy with Refugees, Asylees, and Asylum Seekers. Retrieved from Sophia, the St. Catherine University repository website: https://sophia.stkate.edu/msw_papers/816

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**Healing the Mind and Body: Practitioner Perspectives on Integrating
Cognitive and Somatic Approaches in Psychotherapy
with Refugees, Asylees, and Asylum Seekers**

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the University Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

There is an abundance of studies in the literature highlighting psychotherapy methods for people who have experienced trauma. This is not true for the specialized treatment of refugees, asylees, and asylum seekers. Despite the growing worldwide displacement of people and the trauma they endure, there are only a limited number of studies conducted involving interventions with these populations who have survived prolonged and complex psychological trauma. This research project focuses on refugees, asylees, and asylum seekers who have experienced complex psychological trauma as a result of persecution, war, violence, and migration; specifically, it focuses on the mind-body based psychotherapeutic interventions that best meet refugees, asylees, and asylum seekers' unique set of needs. Traditional psychoanalytic therapy and body-based psychotherapy are two approaches with people who have experienced trauma; the psychoanalytic approach addresses cognitive needs while body-based psychotherapy approaches trauma by beginning with somatic sensations. This study will explore somatic-cognitive therapeutic interventions which combine these two approaches and provide hope for those suffering from trauma, including refugees, asylees, and asylum seekers with complex trauma histories. This qualitative study explores what types of integrative somatic-cognitive therapies are being used with refugees, asylees, and asylum seekers. Psychotherapist practitioners who work with these populations were interviewed to learn about effective interventions for addressing somatic and cognitive needs to heal trauma, best practices, and other related areas where further research would be beneficial.

Keywords: refugees, asylum seekers, asylees, psychotherapy, mind-body psychotherapy, somatic-cognitive psychotherapy, trauma, complex psychological trauma, PTSD, Complex-PTSD, CPTSD

Acknowledgements

I have many different people to thank during the process of writing this paper and conducting my research. Many thanks to my chair, Dr. Courtney Wells, for your guidance during this process and your reminders that data collection and writing is a process. Thank you to my committee members, Eva Solomonson and Bobbi Jo Moujid, for giving of your time, resources, and experience in helping me fine tune this paper. Courtney, Eva, and Bobbi Jo, your encouragement sincerely helped me see this project through. Thank you for being on my committee.

I have been incredibly lucky to be in this MSW program with an amazing cohort of women. Amanda, Bethany, Bridget, Julia, Phyllis, and Tracey: I respect each and every one of you so much. You are each fiercely encouraging, supportive, smart, and kind. Thank you for all the kind words, laughs, meals, and group texts along the way.

To all my friends and family who have helped me get to the library to work on this project by watching my kids, thank you for your generosity and support. You all have been invaluable to me; not having to worry about the care of my kids helped me tremendously to focus on this project.

To the staff and student workers at Access & Success on St. Kate's campus, thank you for all the emotional support, use of the computer lab, and play space for my kids. You really know how to take care of student parents.

To Jake, there isn't enough room here for all the thanks you deserve. You have been my greatest source of encouragement for years. Thank you for stepping up even more than you already do when I needed it the most. Thank you for being the best partner in life for me. I love you and our kids more than I can express in words.

To the participants in this research study, thank you for your generosity to meet with me and share your experiences and expertise. I truly enjoyed learning from each of you and have been encouraged and in awe of the amazing work you do.

To all people experiencing forced displacement: I am humbled by the bravery and resilience you exude despite the traumas you have endured. I see you. I hear you. And I am committed to being the best practitioner and advocate I can be because you deserve to live a life filled with peace, safety, and joy.

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According to the United Nations High Commissioner for Refugees (UNHCR, 2014), there are an estimated 65.6 million forcibly displaced people worldwide. This is approximately the populations of California and Texas combined (UNHCR, 2014). Of this number, 22.5 million are refugees, over half of whom are under the age of 18 (UNHCR, 2014). In 2016 alone, 189,300 refugees were resettled worldwide (UNHCR: Figures at a Glance, 2017). Internally displaced people, refugees, asylum seekers, and asylees present with a unique set of mental health needs compared with the general population.

High rates of post-traumatic stress disorder (PTSD) and comorbid mental health needs are found among refugees who often survive multiple war and persecution traumas (Rohloff, Knipscheer & Kleber, 2014; Shannon et al., 2012). Ter Heide and Smid (2015) discuss some of these traumas inflicted upon refugees, such as rape, sexual abuse, torture, brainwashing, being close to death, witnessing death of a family member, and separation from family as well as, “the stress of forced migration, including involvement in legal procedures and loss of their home country, cultural resources, family and social status” (p. 183). With a growing worldwide crisis of displaced people and unrest, mental health and trauma-focused therapy is of the utmost importance.

There are different types of traumatic events that displaced people can face, but at the core, Rothschild (2000) describes trauma as a “psychophysical experience, even when the traumatic event causes no direct bodily harm” (p. 5). That is to say, traumatic events affect both the mind and body of any individual. Various types of trauma-focused psychotherapy approaches exist among the literature. Trauma-focused treatments include, but are not limited to, mindfulness based approaches, psychodynamic therapies, cognitive behavior therapy, exposure therapy, eye movement desensitization and reprocessing (EMDR), somatic therapies,

hypnotherapy, yoga therapy, mindfulness-based stress reduction (MBSR), and energy psychology. This study will explore the mind-body based trauma therapy interventions that promote healing for this community. What types of mind-body psychotherapies are being used to treat adult refugees, asylum seekers, and asylees from non-Western cultures living in the United States who have experienced complex psychological trauma? What best practices can be learned from the practitioner perspective?

Literature Review

Defining Terminology

Displaced people. There are an estimated 65.6 million forcibly displaced people worldwide (UNHCR, 2014). This number of forcibly displaced people include: internally displaced persons (IDPs), refugees, asylum seekers, and asylees. It is important to clearly note the distinction between these different groups of people to better understand the literature and the unique set of needs for each group.

IDPs are people who have been forced to leave their homes due to armed conflict, violence, natural or human-made disasters, and, as the name suggests, have not crossed an international border (UNHCR, 2014). IDPs are displaced people, but they do not go through any legal processes since they remain in their country of origin, often in an IDP camp setting.

Refugees are people who have been forced to leave their home countries due to war, disease, starvation, torture, or ethnic cleansing (UNHCR, 2004). Refugees are granted an immigration status prior to physically arriving in a host country. Some refugees may reside in a refugee camp in a temporary country until granted refugee permission to enter a permanent resettlement country, such as the United States. In the U.S., a refugee is considered a Legal Permanent Resident and holds what is often referred to as a 'green card.' After five years, a

refugee or Legal Permanent Resident is eligible to apply for citizenship. According to Mollica et al. (1998), many refugees have been exposed to a number of traumatic events over their lifetime such as the threat of death, torture, rape, sexual assault, starvation, injury, death or disappearance of family members, separation from family, difficulties during the migration journey, and having a prior trauma.

According to the United Nations Educational, Scientific, and Cultural Organization (UNESCO, 2016), asylum seekers are people who have fled their country of origin and crossed an international border with the hope of obtaining a legal status. The definition for asylum seeker or asylee differs from country to country, depending on the national immigration laws. In the United States, an asylum seeker must establish a well-founded fear of returning to their home country. In general, an asylum seeker asks for protection after arriving in the final host country and a refugee asks for protection and is granted this protected status before entering a host country and resettling. For this study, those who have been granted asylum will be referred to as asylees and those in the process of seeking asylum will be referred to as asylum seekers, to distinguish between these two groups.

While there are an estimated 65.6 million displaced people worldwide, which includes refugees, asylees, asylum seekers, and IDPs, this research study will focus only on adults, ages 18 years and older, currently residing in the United States with a refugee status, those who are seeking asylum, and those who have been granted asylum.

Traumatization. It is important to define trauma or traumatization as it will be discussed in regards to refugees, asylees, and asylum seekers. Traumatization refers to “extreme, painful experiences which are so difficult to cope with that they are likely to result in psychological dysfunction both in the short and in the long term” (Van der Veer, 1998, p. 4). The environments

and situations that lead these populations to flee their home countries vary, but all involve suffering and the abuse of power.

While traumatization can involve physical abuse, it can also encompass mental and emotional strain for refugees, asylees, and asylum seekers. Van der Veer (1998) discusses different types of abuse, trauma, and torture, including political repression, detention, psychological torture, physical violence, sexual assault, exposure to violence, disappearance of relatives, being separated from family, exposure to extreme temperatures or hunger, and living in exile.

While trauma takes place in the pre-migration stage, post-migration involves issues related to uprooting. According to Van der Veer (1998), uprooting refers to the forced migration a displaced person experiences along with living in unfamiliar environments, such as refugee camps and host countries. These traumas can span decades and occur in the home country, while fleeing, and after resettlement. This compounded trauma is referred to as the Triple Trauma Paradigm, a helpful way of conceptualizing the many traumas of displaced people. The following table lists different traumas associated with each phase of movement for a displaced individual: pre-flight, flight, and post-flight.

Table 1

Triple Trauma Paradigm

Pre-Flight	Flight	Post-Flight
Harassment/intimidation/threats	Fear of being caught or returned	Low social and economic status
Fear of unexpected arrest	Living in hiding/underground	Lack of legal status
Loss of job/livelihood	Detention at checkpoints, borders	Language barriers
Loss of home and possessions	Loss of home, possessions	Transportation, service barriers
Disruption of studies, life dreams	Loss of job/schooling	Loss of identity, roles
Repeated relocation	Illness	Bad news from home
Living in hiding/underground	Robbery	Unmet expectations
Societal chaos/breakdown	Exploitation: bribes, falsification	Unemployment
Prohibition of traditional practices	Physical assault, rape, or injury	Underemployment
Lack of medical care	Witnessing violence	Racial/ethnic discrimination
Separation, isolation of family	Lack of medical care	Inadequate, dangerous housing
Malnutrition	Separation, isolation of family	Repeated relocation/migration
Need for secrecy, silence, distrust	Malnutrition	Social and cultural isolation
Brief arrests	Crowded, unsanitary conditions	Family separation/reunification
Being followed or monitored	Long waits in refugee camps	Unresolved losses/disappearances
Imprisonment	Great uncertainty about future	Conflict: internal, marital, generational, community
Torture		Unrealistic expectations from home
Other forms of violence		Shock of new climate, geography
Witnessing violence		Symptoms often worsen
Disappearances/deaths		

Note. Adapted from The Staff of the National Capacity Building Project at the Center for Victims of Torture. (2005). Chapter 3: Core Competencies in Working with Survivors. In *Healing the Hurt*. Retrieved April 29, 2018, from <http://www.healtorture.org/content/chapter-3-core-competencies-working-survivors>

Complex Psychological Trauma. The *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5; American Psychiatric Association [APA], 2013) defines a trauma as:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: directly experiencing the traumatic event(s); witnessing, in person, the traumatic event(s) as it occurred to others; learning that the traumatic event(s) occurred to a close family member or close friend (in case of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental); or experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (p. 271).

The term “trauma” is used to describe both/either physical trauma and psychological trauma. It is important to clearly define “complex trauma” often associated with refugees, asylum seekers, and asylees. In order to make a clear distinction, the term “complex psychological trauma” will be used to describe the results from severe stressors that, as defined by Ford and Courtois (2009), “(1) are repetitive or prolonged, (2) involve harm or abandonment by caregivers or other ostensibly responsible adults, and (3) occur at developmentally vulnerable times in the victim’s life, such as early childhood or adolescence” (p. 13). The resulting conditions from complex psychological trauma include changes in the body and mind, and individuals may exhibit dissociation, emotion dysregulation, or somatic distress, resulting in complex traumatic stress disorders, such as post-traumatic stress disorder (PTSD) or complex post-traumatic stress disorder (CPTSD) (Ford & Courtois, 2009).

Mind-Body Connection

In order to understand complex psychological trauma that affects the lives of refugees, asylum seekers, and asylees, one must understand memory and the mind-body connection in every person. Brain science and the technology of brain imaging have had a tremendous impact on the field of complex trauma recovery. Rothchild (2000) discusses the understanding around memory that emerged in the late 1980s regarding explicit or declarative and implicit or

nondeclarative memory. These two systems hold different memories and utilize different information types. Table 1 outlines the fundamental differences between explicit and implicit memory:

Table 2

Explicit Memory vs. Implicit Memory

	Explicit / Declarative Memory	Implicit / Nondeclarative Memory
Process	Conscious	Unconscious
Information types	Cognitive Facts Mind Verbal/Semantic Description of operations Description of procedures	Emotional Conditioning Body Sensory Automatic Skills Automatic Procedures
Mediating limbic structure	Hippocampus	Amygdala
Maturity	Around 3 years	From Birth
Activity during traumatic event and/or flashback	Suppressed	Activated
Language	Constructs Narrative	Speechless

Note. Adapted from *The body remembers: the psychophysiology of trauma and trauma treatment* (p. 29), by B. Rothchild, 2000, New York: Norton.

Implicit memory does not involve speech or language; emotions and body sensations relating to events are stored in the part of the brain with implicit memory, which is activated during a traumatic event. As Rothchild (2000) discusses, “traumatic events are more easily

recorded in implicit memory because the amygdala does not succumb to the stress hormones that suppress the activity of the hippocampus” (p. 31).

Bessel Van der Kolk (2015), a leading psychiatrist in the field of complex psychological trauma, discusses the mind and body connection with trauma in his book, *The Body Keeps the Score*. Van der Kolk (2015) describes the brain in terms of “bottom up,” beginning with the reptilian brain located in the brain stem. This area of the brain is responsible for survival, such as how to eat, sleep, breathe, and feel pain. The brain stem also detects danger and organizes the danger response of fight, flight, or freeze. Bodily sensations and impulses come from the brain stem. The limbic system is home to emotions and feeling tones. Implicit, nondeclarative, and unconscious memory are stored in the limbic system. This part of the brain stores emotional experience. The neo frontal cortex is the part of the brain that controls conscious thought and verbal expression. Intellectual and executive functioning, verbal language, and self-awareness are all controlled and stored in this part of the “thinking brain.”

Securely attached individuals who are not in danger, either actual or perceived, enjoy optimal functioning of all areas of the brain. When danger is alerted by the amygdala, the brain stem is engaged. The frontal cortex area of the brain is shut off while the brain stem dictates the body into fight, flight, or freeze mode. The body experiences physical changes when faced with danger, such as adrenaline pumping through the body, heart rate increasing, eyes dilating, and the senses engaged on high alert for the danger. This survival mode functions to do just that, survive and save the body from harm. It is then that the body stores the memories of the trauma in the limbic system. When triggered, the body, senses, and emotions will be activated. Because the neo frontal cortex was shut off during the trauma, explicit memory will be suppressed.

The organization of the brain and the divide between explicit memory and implicit memory have implications for traumatized people. Individuals who have experienced trauma, will express the trauma through their bodies because of the area of the brain that stores the implicit memory of the event. Bodily expression of trauma symptoms vary from person to person and are influenced by culture. Trauma work in psychotherapy begins in the body, not cognitively, because the trauma is organized in the area of the brain that controls senses, emotions, and impulses, not the area of the brain that controls language and intellectual thinking.

Diagnoses Related to Trauma. As a result of traumatization from the pre-flight, flight, and post-flight phases, some refugees, asylees, and asylum seekers experience adverse responses. There are several trauma- and stressor-related disorders, including acute stress disorder (ASD), post-traumatic stress disorder (PTSD), major depressive disorder (MDD), complex post-traumatic stress disorder (CPTSD), somatic disorders, and dissociative disorders associated with complex psychological trauma. The American Psychiatric Association (APA, 2013) outlines criteria for an individual to meet a PTSD diagnosis as follows: “Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the events(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s)”
(p. 271).

Many refugees, asylees, and asylum seekers meet the criteria for a PTSD diagnosis and experience the hyperarousal, hypervigilance, flashbacks, intrusive dreams, difficulty sleeping and concentrating, irritability, anger, and a sense that the event is still happening in the present moment. If symptoms take place within a month of the event(s), an individual is diagnosed with acute stress disorder (ASD). But if an individual experiences symptoms after a month, a PTSD diagnosis is given. Refugees, asylees, and asylum seekers with ASD or PTSD can experience a wide range of symptoms, depending on certain factors related to temperament, environment, and genetics (APA, 2013). Risk and protective factors vary from person to person (APA, 2013).

Culture-related diagnostic issues are also highlighted in the DSM-5 as important considerations for therapists to make, since individuals from different cultural groups will express symptoms differently and respond differently with idioms of distress, featuring symptoms such as headaches, neck pain, or gastrointestinal pain. This is particularly important for practitioners to recognize with diverse groups of refugees, asylees, and asylum seekers.

CPTSD is not currently recognized in the DSM-5. Herman (1992) argues that CPTSD is marked by prolonged and repeated trauma where “the victim is in a state of captivity, unable to flee, and under the control of the perpetrator” (p. 377). Herman (1992) suggests prisons, concentration camps, and slave labor camps as places where such conditions exist. Many refugees, asylees, and asylum seekers who experience political trauma have traumatic experiences in such captive settings.

There is an overlap in symptomology between PTSD and CPTSD. Those who suffer from PTSD experience a sense of threat, avoidance, and re-experiencing of the trauma. The CPTSD symptoms associated with complex trauma also include a sense of threat, avoidance, and re-experiencing of the trauma in addition to interpersonal disturbance, affect dysregulation, and

interpersonal disturbance (Cloitre et al., 2013). Survivors of prolonged psychological trauma have a complex symptom picture impacting their personality, identity, somatization, dissociation, vulnerability to self-inflicted harm, and revictimization (Herman, 1992).

The DSM-5 does not currently differentiate between PTSD and CPTSD or between a single episode of trauma versus prolonged trauma and the impact this has on symptomatology. Herman (1992) argues that evidence exists to expand “the concept of PTSD to include a spectrum of disorders, ranging from the brief, self-limited stress reaction to a single acute trauma, through simple PTSD, to the complex disorder of extreme stress (DESNOS) that follows upon prolonged exposure to repeated trauma” (p. 388). While the DSM-5 does not officially recognize CPTSD, clinicians and researchers acknowledge its existence in practice with individuals, such as refugees, asylees, and asylum seekers, who experience prolonged or repeated trauma (e.g. Aragona et al., 2010; Courtois, 2008; Herman, 1992).

Table 3

PTSD Symptoms vs. CPTSD Symptoms

	Interpersonal Disturbances
	Negative Self-Concept
	Affect Dysregulation
Sense of Threat	Sense of Threat
Avoidance	Avoidance
Re-experiencing	Re-experiencing
PTSD	Complex PTSD

Note. Adapted from Cloitre, M., Garvert, D. W., Brewin, C. R., Bryant, R. A., & Maercker, A. (2013). Evidence for proposed ICD-11 PTSD and complex PTSD: a latent profile analysis. *European Journal of Psychotraumatology*, 4(0).

Somatization. Somatization is the “expression of one or more physical symptoms which cannot be explained by medical examination” (Rohloff, Knipscheer & Kleber, 2014, p. 1794). Rohloff, Knipscheer, and Kleber (2014) found somatization to be prominent within refugee populations

due to traumatization, torture, and feelings of stigmatization towards psychiatric care, with psychiatric disorders being more common among refugees who express these disorders in the form of somatic symptoms.

Refugees, asylees, and asylum seekers suffering from PTSD or CPTSD due to trauma or torture inflicted to them may be in a constant state of arousal which has somatization implications. The permanent or prolonged state of hyperarousal experienced by these populations can cause muscle contractions that lead to headaches or pain in the back and limbs due to the autonomous nervous system being in an activated mode (Rohlof, Knipscheer & Kleber, 2014). Physical pain, such as headaches, fatigue, dizziness, heart palpitations, and gastrointestinal issues, leads many refugees, asylees, and asylum seekers to primary care clinics where they encounter practitioners who may or may not know about the link between somatic symptoms, traumatic experiences, and stressor related mental health implications (Aragona et al., 2010; Aragona et al., 2011).

The extent to which a particular refugee, asylee, asylum seeker experiences somatic symptoms seems to depend on various circumstances, such as age, pre-migration trauma, post-migration events, language proficiency, and depressive symptoms (Fenta et al., 2010; Westermeyer et al., 1989). While the level of pre-migration trauma and/or torture a refugee experiences has an impact on somatization, psychopathology and somatization tend to increase among this population after resettlement and is strongly associated with post-migration life (Lie, 2002; Schweitzer, Brough, Vromans & Asic-Kobe, 2011). Aragona et al. (2011) attributes distress from post-migration living difficulties (PMLD) to somatization among refugee populations in primary care settings. Early childhood secure attachment can also be a protective factor against PTSD or CPTSD.

Trauma Interventions

Since many refugees, asylum seekers, and asylees suffer from complex psychological trauma, great care must be taken to choose an appropriate method of psychotherapy. The following are explorations of promising psychotherapy methods considered most likely to be effective with refugees, asylum seekers, and asylees: 1) Eye Movement Desensitization and Reprocessing, 2) Somatic Therapies: Somatic Experiencing, Sensorimotor Psychotherapy, Somatic Transformation, 3) Cognitive-Behavioral Therapy, and 4) Mindfulness.

Eye movement desensitization and reprocessing. Eye Movement Desensitization and Reprocessing (EMDR) has been established as an efficacious therapy modality for PTSD among the general population (Figley, 2012). The majority of the general population receiving EMDR therapy have PTSD and/or depression from a single episode of trauma (Söndergaard & Elofsson, 2008). EMDR is often a preferred method of trauma therapy because of the short duration, typically eight EMDR sessions for the general population, in comparison to other types of trauma therapy (Söndergaard & Elofsson, 2008). Developed by Francine Shapiro in 1989, EMDR has been endorsed as an effective treatment for PTSD by many mental health organizations, including the International Society for Traumatic Stress Studies (ISTSS), the U.S. Veterans Administration/Department of Defense, and the American Psychiatric Association (Figley, 2012).

An EMDR-trained therapist leads the client to recall a traumatic memory while they simultaneously make horizontal eye movements by following the therapist's hand or light or by engaging in other bilateral stimulation such as tapping or vibrations (Shapiro, 2001). It is hypothesized that EMDR mimics rapid eye movement (REM), stimulating associated memories and images for the client as part of reprocessing. In EMDR, the client is instructed to recall

painful memories while being mindful of what occurs in their body. Clients are then guided to create new associations with the traumatic memory, including positive self-cognitions. This process is repeated until desensitization or processing is complete.

While EMDR has been primarily endorsed as an effective therapy for PTSD, it has also been reported as effective for people with other diagnoses such as depression, body dysmorphic disorder, chronic pain, phobias, and anxiety (Figley, 2012). The general population receiving EMDR have either a single diagnosis or have experienced a single episode of trauma (Söndergaard & Elofsson, 2008). While EMDR has proven effective for individuals who have experienced a single episode of trauma, emerging literature indicates that it may be an effective therapy modality for refugee populations who have experienced multiple traumatic events, but some research indicates hesitation.

Kira and Tummala-Narra (2015) warn that, “interventions with an interpersonal and single past trauma focus may not be adequate in working with refugee victims of political violence who are multiply traumatized and who suffered and are suffering additionally from intergroup and ongoing traumatic stressors” (p. 462). Specifically, Kira and Tummala-Narra (2015) highlight the effectiveness of narrative exposure therapy, relaxation and direct problem-solving approaches, and trauma-focused cognitive behavioral therapy (TF-CBT) as all models of treatment with evidence for effectiveness with traumatized refugees. However, EMDR Recent-Traumatic Episode Protocol (EMDR R-TEP) focuses on the most recent traumas impacting the person while taking into consideration past traumas and working on desensitization and reprocessing of one trauma at a time (Acarturk et al., 2016). EMDR R-TEP may be more appropriate than standard EMDR for refugees, asylees, and asylum seekers who have experienced multiple or prolonged traumas.

Somatic Therapies. Somatic Experiencing (SE), Sensorimotor Psychotherapy (SP), and Somatic Transformation (ST) are all examples of somatic therapies used for the treatment of trauma.

Emerging somatic therapies vary when compared to each other, but overall hold the notion that trauma dysregulates the body and traps unfinished movements from the traumatic event in the body of the individual (Levine, 1997; Ogden, Minton & Pain, 2006; Shapiro, 2001). Somatic based therapists guide individuals to pay attention to sensations in their bodies to release the trauma through movement. Despite the name, somatic therapies also include aspects of exposure therapy where individuals are guided to remember the trauma as well as mindfulness to be in the safety of the present moment in time (Shapiro, 2001).

SE was developed by Peter Levine, a physiologist and psychologist, while studying animals' response to trauma (Levine, 1997). In his book, *Waking the Tiger*, Levine (1997) describes the physical changes animals often go through from a hypervigilant state to a relaxed state when they, "vibrate, twitch, and lightly tremble" (p. 97). These physical reactions recorded in animals demonstrate a way of regulating the nervous system after experiencing trauma. Levine hypothesizes that when humans endure trauma without discharging energy, the freeze response can become chronic and people can develop PTSD.

SE therapists guide clients between positive orienting and the freeze response. While in the freeze response, clients may experience shaking, which therapists guide clients to stay with while they release this energy. During this process, the client is guided to focus on their body and note any areas where they feel tension. Clients are then encouraged to imagine what they might have done differently during the traumatic experience, such as run away or fight back. This process is continued until all the tension and energy is released and the client is relaxed (Shapiro, 2001).

Research conducted with tsunami survivors in Thailand reveal SE to be a promising mind-body intervention for trauma associated with disaster relief. Since many people become refugees from human-made or nature-made disasters, SE may be an appropriate intervention for this population. Leitch (2007) found SE to relieve PTSD symptoms by re-establishing self-regulation in their small sample size of participants. Shapiro (2001) notes however, that SE is an efficacious therapy for individuals that experience a single incident of trauma, but not necessarily for developmental trauma or complex trauma clients because it does not have the necessary components of attachment needed.

Sensorimotor Psychotherapy (SP) is described as a body-oriented talking therapy (Ogden, Minton & Pain, 2006). Developed by Pat Ogden in the 1980s, this type of therapy integrates traditional talk therapy with body therapy by incorporating somatic interventions into psychotherapy. SP focuses on stabilization and healing physiological symptoms of trauma with an emphasis on attachment (Shapiro, 2001). Physical movement, stillness, and collapse are all used in the healing process during the three-phased approach as described by Shapiro (2001):

- “1. Development of somatic resources for stabilization
2. Trauma processing
3. Integration and success in normal life” (p. 104).

Cognitive-Behavioral Therapy. Cognitive-Behavioral Therapy (CBT) is an evidence-based treatment modality used for the treatment of PTSD. Evans and Coccoma (2014) discuss the techniques used in CBT to “facilitate fear extinction and assist in restructuring maladaptive cognitive distortions related to trauma” (p. 88). At the core, CBT helps clients restructure negative cognitions and perceptions that they hold; trauma survivors are able to change their thoughts which then positively change their behaviors. According to Evans and Coccoma (2014),

CBT has evolved from the focus on cognitive and behavioral changes to include the therapeutic relationship.

In its evolution, CBT has been altered for work with complex traumatic stress disorders (Jackson, Nissenson & Cloitre, 2009). Refugees, asylees, and asylum seekers suffering from complex trauma seek to heal on an interpersonal level, making the importance of the therapeutic relationship crucial during CBT (Jackson, Nissenson & Cloitre, 2009). Elements of CBT encourage the client to recall past traumatic events while being mindful of the present in an attempt to help the client avoid dissociating. The skills a client with a complex trauma history and PTSD diagnosis can obtain from CBT include not only interpersonal work, but also emotional regulation. Clients with somatic symptoms and a need for emotional regulation can benefit from CBT in conjunction with Skills Training in Affective and Interpersonal Regulation plus Modified Prolonged Exposure (STAIR-MPE), because this combination helps clients be mindful and present in their bodies (Jackson, Nissenson & Cloitre, 2009).

Mindfulness. Many of the trauma therapies discussed thus far include elements of mindfulness. The concept of mindfulness is both a theoretical construct and a practice. Meditation and yoga are both examples of mindfulness based practice. Germer, Siegel, and Fulton (2005) gives the definition of mindfulness as a “moment-by-moment awareness” (p. 6). Mindfulness is a belief or practice of awareness, present experience, and acceptance. All these aspects are important in trauma therapy, making mindfulness an important aspect of therapy. Mindfulness practices or meditation are often used in psychotherapy to help clients be in the moment, be attuned to their bodies, and experience emotions. Mindfulness is a tool that can be incorporated into therapy to engage clients and cultivate centering and grounding.

Conclusion

Many refugees, asylum seekers, and asylees suffer from complex psychological trauma, and this impacts the degree to which any method of psychotherapy will be appropriate or effective. Research indicates that many refugees, asylees, and asylum seekers experience complex psychological trauma, during pre-migration, the migration journey, and post-migration, making them prone to PTSD and CPTSD as well as other mental health diagnoses. Considering what is known about the mind-body connection as it relates to trauma and healing from traumatic events, what types of integrative somatic and cognitive psychotherapeutic interventions are being used with refugees, asylum seekers, and asylees? The researcher will conduct a qualitative study and interview psychotherapists that work with refugees, asylum seekers, and asylees to explore what mind-body psychotherapies are being used for these populations with complex psychological trauma and what best practices can be learned from the practitioner perspective.

Conceptual Framework

When discussing trauma and the real effects it has on individuals, families, and communities, it can be easy for the discussion to focus solely on pathology. The various clinical diagnoses that can impact those who have survived complex psychological trauma are very real, but it is only part of the story. As social workers and other clinicians who work with refugees, asylum seekers, and asylees, it is important to be reminded of the resiliency factors held by our clients and in turn, remind our clients of these powerful factors. The conceptual framework from which the researcher operates for this study is grounded in an emphasis and understanding in resilience and trauma.

Family Resilience Model. Resiliency is not merely an attribute. Walsh (2006) describes resilience as, “the capacity to rebound from adversity strengthened and more resourceful” (p. 4).

Resiliency in these terms is active, not passive, where growth in the individual can be seen as a response to a challenging situation. Resilience is more than surviving or getting through a difficult situation; resilience is being better off because of those challenging situations. For refugees, asylees, and asylum seekers who have survived complex psychological trauma, resilience can often be found through the adversity faced pre-flight, during the flight, and post-flight.

The researcher has chosen to focus on family resilience as opposed to individual resilience. The main tenet of family resilience is that supportive relationships nurture resilience. These supportive relationships can be immediate and extended family as well as communities and social networks. While we often think of therapy from an individual perspective, it is important to note the importance of relationships in the process. Hauser (1999) notes that resilience is woven into relationships and experiences. Walsh (2012) writes of family resilience as the systemic view that, “serious crises and persistent adversity have an impact on the whole family, and in turn, key family processes mediate the adaptation of all members and their relationships” (p. 401). The Western concept of individualism can be a foreign concept to many refugees, asylees, and asylum seekers that feel more comfortable in communal settings. Operating from the Family Resilience Model can be beneficial for refugees, asylum seekers, and asylees in order to see how resilience is active from the relationships and experiences of these individuals.

The Family Resilience Model encourages a shift in perspective of the therapist and client from difficulties to challenges, from what has gone wrong to what can be right (Walsh, 2006). Walsh (2012) emphasizes that the family response to crisis is central. “Key processes in resilience enable the family system to rally in troubled times to buffer stress, reduce the risk of

dysfunction, and support optimal adaptation” (p. 401). The key processes in Family Resilience include: making meaning of adversity, having a positive outlook or optimistic bias, and the use of transcendence or spirituality (Walsh, 2006; Walsh 2012). From this perspective, refugees, asylees, and asylum seekers who have experienced the challenges of complex psychological trauma are encouraged to find meaning in the adverse events experienced and to integrate their own culture and/or spirituality into the therapeutic process of healing and the therapist is encouraged to look at the family system and its impact on resilience.

Trauma Resiliency Model. The Trauma Resiliency Model (TRM) is a biologically based model developed by Elaine Miller-Karas (2015), used in countries around the world, including Kenya, Rwanda, China, Haiti, and the United States. Miller-Karas (2015) discusses the interdependence of the mind and body when working with survivors of trauma; TRM approaches therapy from the perspective that the mind and body are interdependent. Therefore, cognitive-focused therapies, such as traditional talk therapy, may be helpful but incomplete for survivors of trauma, such as refugees, asylees, and asylum seekers. Addressing the fear circuitry and stress dysregulation that follows a trauma is important before engaging with the prefrontal cortex (Miller-Karas, 2015). While TRM does explore fear and the body’s natural response when faced with life-threatening situations, this model also highlights resiliency and how clinicians can restore balance to the mind and body in survivors of traumatic experiences (Miller-Karas, 2015).

One of the greatest aspects of TRM is the normalization of symptoms experienced by survivors of trauma. Traumatic stress symptoms, such as hypervigilance and paranoia, are discussed as normal biological responses to traumatic events. This normalization is integral to TRM and takes the focus away from pathology and perceived weakness. Instead, since there is a biological connection between the mind and body, these normalized symptoms are viewed as a

way to reestablish homeostasis within the body and nervous system (Miller-Karas, 2015). The TRM trained clinician provides psychoeducation to the client, normalizes the experience, and focuses on the body and then mind in the therapeutic process.

Social Work Code of Ethics. The National Association of Social Workers (NASW) Code of Ethics consists of core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence for practice (NASW, 2018). In addition to core values, the NASW Code of Ethics (2018) also lists ethical standards social workers should uphold within the profession. Cultural competence and cultural sensitivity are woven throughout the Code of Ethics, which directly correlates to social workers working with displaced people groups, such as refugees, asylees, and asylum seekers. The first standard highlights the importance of understanding a client's culture, which encourages social workers to seek out opportunities to further develop cultural humility and recognizes strengths found among different cultural groups (NASW, 2018).

The sixth standard of the NASW Code of Ethics (2018) discusses the social workers' ethical responsibilities to the broader society. This is directly relevant to social work practice involving communities of displaced people where immigration is of concern. Section 6.04 states,

Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people. (NASW, 2018, p. 30)

Social workers engaged in work with diverse communities, both within the United States and globally, are expected to promote respectful and culturally appropriate interventions and practices at the individual, agency, and macro level.

Methodology

Research Design

The researcher conducted a qualitative study by interviewing four psychotherapists trained in mind-body based modalities that work with adult refugees, asylum seekers, and asylees. The interviews were semi-structured with eight questions (see Appendix D). Purposive methodology was used to recruit the participants due to the narrow focus of this research study.

Emails (see Appendix B) and recruitment flyers (see Appendix C) were sent to contacts known by the researcher as well as networks of individuals who work with refugees, asylees, and asylum seekers. After receiving an invitation to participate in the research study, four individuals who met the qualifications to participate were interviewed.

Sampling and Recruitment

The sample for this qualitative study consisted of psychotherapists trained in mind-body based psychotherapy modalities that work with adult refugees, asylum seekers, and asylees who experience complex psychological trauma (see Appendix A). Participants were recruited from the Midwestern region of the United States. All participants are licensed psychotherapists with one or more of the following licenses or degrees: Licensed Independent Clinical Social Worker (LICSW), Licensed Mental Health Counselor (LMHC), Licensed Professional Counselor (LPC), Licensed Clinical Professional Counselor (LCPC), Licensed Psychologist (LP), Licensed Marriage and Family Therapist (LMFT), Doctor of Psychology (PsyD), and Psychiatrist (MD). In addition to being licensed, all participants have experience practicing psychotherapy with adult refugees, asylum seekers, and asylees.

Protection of Human Subjects

This qualitative research study was submitted to the Institutional Review Board (IRB) at the University of St. Thomas for approval. The participants were given a consent form (see Appendix A) and were informed of the risks involved in this study. There were no benefits to participate in this study. The researcher collected audio recordings of the interviews with the Voice Memos Application which will be destroyed after the completion of this project. The recordings and subsequent transcriptions of the interviews are stored on a password-protected device. The participants were given pseudonyms and their identities remain confidential.

Data Collection

The interviews for this qualitative study were audio recorded on a password-protected device. The researcher transcribed the interviews and coded for themes. The interviews took place at the discretion of the interviewee, either in person at a private location, such as an office space, or in a public setting, such as a coffee shop. None of the interviews took place over the phone.

Data Analysis

The researcher utilized grounded theory methodology to code the interviews for themes. Coding was conducted by the researcher in two phases, the initial coding followed by a focused coding (Charmaz, 2006). Following this method, during the initial coding phase, the researcher remained close to the data, focused on words, lines, or segments of the transcription, and created concise terms (Charmaz, 2006). During the second phase of coding, a focused approach was used to compare and synthesize the initial codes with data in the field (Charmaz, 2006). As Charmaz (2006) indicates, “coding shapes an analytic frame from which you build the analysis”

(p. 45). The codes developed in the first and second phases impacted emerging theories and shaped the discussion.

Findings

Eight semi-structured research questions were asked of the four individuals interviewed for this research project (see Appendix D). After coding the four interviews, thirty-one themes were found in the data. The themes found will be organized in the following eight sections: Demographics, Theoretical Orientation, Symptomatology, Interventions, Therapeutic Alliance & Stabilization, Effective Practice, Suggestions for Medical Professionals, and Resiliency Factors.

Demographics

Therapists. Four individuals were interviewed for this research project. All individuals interviewed are licensed psychotherapists in the Midwestern region of the United States who have experience conducting psychotherapy with refugees, asylees, and asylum seekers. Two psychotherapists interviewed are Licensed Independent Clinical Social Workers (LICSW), one psychotherapist is a Licensed Professional Clinical Counselor (LPCC), and one psychotherapist is a Licensed Psychologist (LP). Two interviewees identified as female and two interviewees identified as male. Two interviewees identified as a person of color (POC) and two interviewees identified as Caucasian.

Experience. The interviewees' years of experience working with refugees, asylees, and asylum seekers ranged from 10 years to 26 years of experience. The types of agencies the four interviewees have experience working at with these populations include the following settings: medical clinics, community based organizations, human rights organizations, hospitals, behavioral health clinics, and school based organizations. Several of the interviewees also have experience working with or for these populations in private practice, consultation, licensure

consultation groups, training mental health professionals, on interdisciplinary teams, and in higher education.

Clients. Participants were asked to describe the populations they have worked with in terms of ethnicity, age range, language ability, and any other information they found relevant. Due to the extensive experience in practice with refugees, asylees, and asylum seekers found among the interviewees, people from many parts of the world were discussed during the interviews. Some interviewees named specific cultural groups, while others spoke broadly about work with refugees, asylees, and asylum seekers from all around the world, including Eastern Europeans, Caucasians, Asians, Africans, and Hispanics. The following cultural groups were named explicitly by some participants while discussing communities with whom they have experience in psychotherapy settings: Hmong, Lao, Bhutanese, Karen from Burma, Cambodian, Somali, Ethiopian, Eritrean, and Latino communities.

Some participants expanded upon client demographics, including language ability and education. All participants discussed the use of interpreters during therapy. One participant discussed the diversity found within the refugee, asylee, and asylum seeking clients they work with, stating:

Others may have English as a secondary language and some may have never spoken nor do they speak now any English. And for them we work with interpreters. The population-- I would say some of the demographics include people from extremely rural areas where they may have been farmers or other trades to people who have --who are coming from huge urban centers from around the world.

With regards to education, some are preliterate some have never had any formal education to people who had multiple years of higher education, including doctors, people with PhDs, people who are lawyers, masters degrees, multiple masters degrees.

And also in terms of ethnicity I would say we have worked with Eastern Europeans, Caucasians, Asians, Africans, Hispanics, Latinos, in terms of the ethnic spectrum we have worked with lots of different populations. And then in terms of any disability, we have worked with people who are able bodied as well as people who are-- have some type of disability, psychologically or physical disability.

Theoretical Orientation

When asked what theories influence their practice, the participants answered with an array of theories. The theories or models that were named could be broken down into the following categories: systems focused, trauma/somatic focused, meaning making/cognitive approaches, and solution focused. Three participants named the systems focused theories of family systems theory and looking at the person-in-environment.

Systems theory. Three participants connected the need to utilize the person-in-environment approach with a family systems model with refugees, asylees, and asylum seekers due to the environmental context of forced migration and resettlement. One participant stated,

The person in environment, that's really, really a key piece because refugees especially, they do not come from individualistic cultures, so you need to be thinking about all of the environment that's affecting them, in resettlement as well as the larger community. And the family systems. So there's also this sense of system models.

Trauma/somatic approach. Three participants named theoretical orientations that fall under the category of trauma and somatic focused theories when working with refugees, asylees, and asylum seekers. One participant noted that their trauma focus includes all aspects of a client's trauma, which includes war, resettlement, historical, and community trauma. One participant connected their trauma focused orientation with the relational core of the therapeutic process, stating,

I tend to follow the tri-physic model of trauma work where, trauma recovery model, when looking at safety and stability as one sort of phase of treatment and then remembrance and mourning, which would include trauma processing as one of the second phases of treatment and then reconnection. Reconnection of the self. I think I draw from a relational perspective. I guess one could use this dynamic or framework. Relationship as the core of the therapeutic process and healing.

The concept of viewing resettlement as a traumatic experience came up in multiple interviews. Two participants discussed resettlement and life in exile as trauma. Both emphasized

the weight of exile as significantly impacting their clients. They stressed the need to not only look at interpersonal trauma and war related trauma, but also displacement as an ongoing traumatic event. One participant explained this perspective, stating,

I think life in exile is trauma. I think that needs to be given the -- like the smells are different, the sunsets are different, the natural networks that we would have are different, the cultural values around work-work-work here, and individualism, collectivism, like all of that, there are so many losses that are going on for a client in exile. So it may be not just about symptom reduction of PTSD, and depression but how is this person going to navigate life? For our clients here in exile or refugees, people who have been plopped down here in the US, I think it's as big a part of treatment as the past trauma.

Meaning making. The next most common approach discussed by every participant centered on meaning making through cognitive approaches. Behaviorism, looking at client's behaviors and manifestations of how they feel, theories around Cognitive Behavioral Therapy (CBT), and theories around Narrative Therapy were all named as theoretical approaches to therapy.

Participants emphasized the need to help clients make meaning of their trauma through the use of CBT and narrative approaches. When participants discussed the use of CBT and Narrative Therapy, it was said in terms of utilizing aspects of each therapy, not utilizing the therapy solely.

This concept was explained by one participant, stating,

I would also say that there definitely are aspects of CBT that I integrate in my work because our clients have experienced such catastrophic stress and are living here in exile. Lots of issues around meaning and purpose and more of the existential pieces about how to have a meaningful life and make sense of trauma, suffering. It's really important to me and my clients as well as a narrative approach. And how to think about trauma within the context of a person's life and creating a narrative around that. So I would say narrative therapy as well.

Solution focused. The final type of orientations named were those that were solution focused in nature. Solution focused approaches and reality therapy were named as being used with refugees, asylees, and asylum seekers. Both of these types of orientations are action focused in nature. One participant elaborated on their use of solution focused therapy, stating,

And pieces of solution focused therapy where refugees aren't really big on lots of personal psychoanalysis. There certainly are pieces of insight, but it's not a really, I haven't found that to be particularly as helpful. But saying, here are the problems and struggles you are facing -- What are the solutions? How am I going to become more functional? How am I going to feel better? How are we going to meet the needs?

Symptomatology

Body pain, mood dysregulation & psychological distress. Participants were asked to describe typical symptomatology of their clients. All participants discussed various types of body pain and psychological distress that their clients experience, including: headaches, difficulty sleeping, intrusive thoughts, nightmares, strong startle response, losing interest, losing energy, irritability, difficulty maintaining important relationships, worry, isolation, panic attacks, body pain in areas where an old injury occurred, stomach pain, dizziness, anxiety, depression, and other symptoms commonly associated with PTSD. Distinctions were made between clients who experience PTSD and CPTSD symptoms. One participant discussed the differences they find with these types of trauma clients, stating,

I would say diagnostically people are -- many of our clients are experiencing symptoms consistent with the diagnosis of post-traumatic stress disorder, major depressive disorder, and some type of somatic disorder. Those are probably some of the more common diagnosis that people have. And I would say some clients have more of a complex-PTSD symptom -- complex PTSD spectrum, where they might be experiencing some post-traumatic stress symptoms from torture and more current traumatic events, as well as childhood trauma that might include abuse or neglect or just a long, long trajectory of torture targeting or forced labor, things like that.

Mind-Body-Spirit connection. All participants went beyond describing symptoms as connected between mind and body; each participant explained the mind-body-spirit connection that is a commonly held perspective by their clients. One participant described when they first began working with refugee, asylee, and asylum seeking populations, stating,

And almost always refugees start talking about body pain. My head hurts, my neck hurts, my shoulders hurt, my leg hurts. And at first I thought--well when I was first doing that work, I was thinking that that's not mental health, that's physical health. And then I

learned quickly that the Western world looking at it, that we separate mind, body, and spirit. And most of the rest of the world doesn't separate.

Another participant further described how they incorporate spiritual components into therapy because of the significance to their clients, stating,

I think more so for this population, people actively talk about their faith. So that is a huge part of my work with them. Not in any dogmatic way, but that people don't separate psychological and spiritual....For example, the relaxation response. I know that's more of a secular exercise. But I work with a lot of Muslim clients. So I'll work with them prior to the relaxation response activity trying to draw upon Allah or Jesus or whatever figure might give them comfort. And like-- just knowing how important faith is to them, I try to incorporate the deities that might be important to them, both in terms of building coping strategies and even things like guided imagery exercises as well as relaxation response and things like that.

Stigma. While talking about symptoms, all participants described the stigma many clients feel around mental health. To counteract the stigma, participants described the adjustment in the language they use around mental health and the associated terminology. Two participants discussed regularly using the term behavior as opposed to mental health. One participant elaborated on their decision to approach mental health from a behavioral perspective:

I struggled for a long time about what to write on my business card. I didn't want to have mental health or mental anything. Because when they see that they think of crazy and don't want to have anything to do with that. So I came up with consultation and director of immigrant and refugee behavioral health. Behavioral health seemed to be -- cultures understood behavior. And we were talking with kids, so parents were often concerned with behavior.

Language adjustment. Similarly, another participant spoke about adjusting their language from mental health to emotional health. This participant discussed being asked to speak to new refugees in their organization who just arrived in the United States about mental health, stating,

And I would use a scale. Ok physical health, it's not a matter of being healthy or dead. Right? There's this gradation. And I would say the same is true, I usually called it, talked about emotional health, because mental health means "crazy." And it's not you're sane or you're crazy. And as I would kind of work my way into that topic, I would ask them, you know, it's really hard coming here. And you know, they nod at me and I say, so there's a lot of things that happen in terms of how you feel. And I would ask them, like

what have your experiences been? And you know they named every symptom. Every depression and anxiety symptom. And trauma symptoms that exist. So they experienced all these things even though they were afraid of being called crazy.

Interventions

The diversity in interventions implemented by the participants reflects the wide range of work settings each practitioner comes from. The different interventions described can be divided into the following categories: “Bottom-up” trauma approaches, mindfulness/meditation, cognitive approaches, and physical activity. No single type of intervention was named as the sole intervention used with refugees, asylees, and asylum seekers who have experienced trauma.

“Bottom-up” trauma approaches. All participants described using different “bottom-up” trauma approaches and techniques, including, Somatic Experiencing (SE), Somatic Psychotherapy (SP), hypnosis, penjulation, body scans, and autogenics. Two participants referenced EMDR, but did not utilize that type of intervention. All participants referenced utilizing various trauma interventions in order to help clients build resources or skills during therapy. When asked about the types of interventions used, one participant stated,

I would say whatever works...I've gotten some training in somatic psychotherapy so some of those interventions related to building resources and helping, and using the body first in sort of a bottom-up approach to working with trauma. Because you're saying maybe not talk therapy but let's-- wherever the physical sensations and experience, like use that as the entry point, whatever type of work with a client, whether that's staying with the body or being able to find safety or neutral space or neutral sensations in the body I'll do that.

Another participant discussed utilizing SE because of the nature of how trauma manifests itself in the body. This participant also described the range of symptoms and affect a client may experience and how SE works, stating,

In SE you're really looking at how the emotion, the trauma, the whatever experience is happening, is showing up in the body. So SE really tries to get past the frontal cortex, cognitive processing. Because in trauma, that part of your brain shuts down. So you can

only do so much with that level of memory and cognition. Then you have to get back to the limbic system. The amygdala and midbrain.

You're working with people to regulate some of that hyperarousal. That high anxiety that comes. That's often where you get the panic attacks and lack of sleeping and the anxieties and ruminations and stomach aches and the tense muscles and the body pain. Or on the opposite end, when that gets to be too much, they shut down, so the levels of depression where there's no activation, right? There's no ability to do things, to get up, to interact with others, to care about things. So depending on where the person is, if they're in the more shut down state or the more hyper aroused state, either way, I'm trying, I'm looking, I'm assessing.

Mindfulness. Mindfulness and meditative practices were also discussed as successful interventions with these populations, including incorporating visual imagery. One participant discussed how meditative practices come naturally to some Muslim clients who incorporate prayer into their daily lives. This participant discussed speaking with clients about how their meditative practices can be therapeutic, stating,

What I find helpful is that, in order to simplify some of these interventions I try to say things that they can relate to their practices that already exist in their culture. So for example, if we are talking about relaxation techniques or maybe being mindful, what is it in that culture that provides that kind of process? For example when you are praying, you are supposed to be mindful about what you are reading and the rituals that you are doing. A lot of time what happens, because people have been praying for a long time, it becomes habitual or automatic. And sometimes they are not aware of how many times...you get up and put your forehead to the floor and then get up. It needs to be at least four. Sometimes you will talk to people who will say I can't remember if I did 3 or 4. Because they weren't present, their mind was thinking of something else. So I will say, ok let's practice being mindful about that. Make sure that every time your mind wanders, that you bring it back and be right in the moment.

They like that for one, they know that in order for their prayer to be accepted, they need to pray the right way, it's something internal that they feel they have to do. But I also tell them, I can help them do it better by helping them learn to be mindful and in the moment...That's good in the sense that, if I just explain to them about regular mindfulness, it might sound weird to them. Like why do I have to pay attention to my breathing? But if I say, if you are praying, maybe you should pay attention to what you are saying and what you are doing. And they will be happy to do it because that's what they are supposed to do to begin with.

Another participant discussed personally and professionally incorporating meditation and mindfulness into their practice, along with various techniques, including the Loving-Kindness Meditation, stating,

I am personally and professionally interested in mindfulness and using mindfulness approaches. So I would and -- different approaches from the Center for Mind-Body Medicine. I guess specifically that would include visual imagery, autogenics, body scans, resourcing through some hypnotic work, hypnosis, I've used the loving kindness meditation quite a bit.

Cognitive interventions. Narrative therapy and CBT were named as cognitive interventions used in psychotherapy during discussions around theoretical orientations. These types of interventions were spoken about as being used with other interventions. One participant discussed these cognitive interventions, stating,

I would say also that pieces of cognitive therapy are helpful, in terms of especially the whole idea of reframing and seeing if you can help someone see something a little differently. And the pieces about working with kind of really negative thoughts that aren't necessarily based in truth. So helping people in some of the cognitive theories to help challenge those thoughts.

And I would say narrative therapy. Pieces of narrative therapy. Again working with not denying the narrative that's there, but also pulling out pieces of the narrative that maybe people have forgotten or not focused on that are more positive in helping shift that narrative.

Body movement. Interventions related to physical activity were also named, including yoga, exercise, and drumming. The physical activities used in therapy were discussed in both individual and group settings. One participant described a group setting where members began tapping, which led to the use of drumming as a therapeutic intervention:

But then there were sometimes when I think it started spontaneously. I remember some of the staff would come in and get together and they would have Tupperware and they would just start tapping and they would all start doing that. And it ended up being sort of like drumming. And then they started seeing that people really liked it. So the leaders said let's do it again next time.

Therapeutic Alliance & Stabilization

Relationship building. In order to gain a deeper understanding of how practitioners integrate mind and body based approaches in psychotherapy with refugees, asylees, and asylum seekers, participants were asked how they approach the therapeutic alliance and stabilization with these populations. Five themes pertaining to approaches towards the therapeutic alliance and stabilization with clients were identified. The most common theme identified by all the participants was regarding relationship building and establishing trust early on during therapy. One participant discussed building trust, safety, and legitimacy early on in therapy in a collaborative manner while also incorporating psychoeducation as necessary:

I try to be as transparent as possible about what my hopes are and I guess for me, having worked in this for so long, can talk about having seen probably hundreds of torture survivors from their country and from other countries, to try and build some trust and build some legitimacy in their eyes. I will-- I think that in some ways I will not assume that they know much about psychotherapy. And or-- I ask and I think that a lot of it is sort of questioning back and forth and really collaborative. What questions might you have? And can you let me know what you're hearing me say? Just to sort of see are we on the same page or not.

Repetition. Three out of four participants discussed the importance of slowing down and being repetitive in the process of building a relationship. The reasons given by participants were twofold: the need to be repetitive due to the language barrier in an attempt to make sure what they are saying is understood as well as memory-related issues with clients who have experienced trauma. One participant explained their process of establishing a relationship and their approach to informed consent:

It's really healthy and it's really good to keep boundaries and I-- nothing bad is going to happen. I'll go over, like if they have to sign consent forms or things like that, knowing that people have been forced to sign things to be able to get out of prison.

I'll both name that I understand like some of these experiences might be really triggering, even like an assessment where I'm asking a thousand questions about their lives and their families and their histories. I explain why I'm doing it. Probably more so

than I would with a different population, about you know, I write a report, that this is all private, and confidential, and in American health systems we keep a record of all the visits, it's not everything that you say.

So I'll talk about privacy and confidentiality a lot and reinforce that over and over again, knowing that what a person might be able to retain in a first session in a different language where they're already sort of activated may not always linger, so going back to like sort of rules or guidelines for our work together, like share what you want to share, keep private what you want to keep private, protected health information, HIPAA, I think when we have interpreters, we review rules around privacy for interpreters, especially if they are from their communities. A lot more I think I reinforce, I'm repeating things a lot more with this population.

Psychoeducation & extended assessment. One participant discussed being repetitive during therapy and incorporating psychoeducation with these populations. This participant further discussed their use of multiple sessions for assessment in order to slow down the process while forming a therapeutic alliance:

I ask about who they are, their family, whatever I can do to connect a little bit and usually they are pretty willing. Well why do you think your doctor sent you? How have you been feeling? And they are pretty quick. And I always explain I'm writing some things down, because I'll never remember. And I want to remember what you've told me. Is that ok? So that they don't wonder why is she writing? Why is she asking me all these questions and so on. And so I always because of the need for the slowing down and the taking time, and building the trust, and talking about what therapy is and so on and so forth, it would be very rare that I would not do an extended assessment with a refugee or an immigrant. Plus the amount of time the translation takes when working with an interpreter.

Another participant discusses the need for psychoeducation early on with refugees, stating

So with the refugees, it's a little bit unique. I mean most of the refugees I work with. It's a little bit difficult to help them understand the concept of therapy, and how it works, and how it's going to help them. And if they don't see the value in what you're doing, it's sometimes difficult for them to keep showing up, with all the other demands that they have. So I do psychoeducation to explain what I'm doing and how it's going to help them.

Action oriented. While discussing their approach to the therapeutic alliance and stabilization, two participants emphasized the need to be action oriented and useful to their clients. Both

participants indicated the crucial nature of being useful, even in a small way, to their client early on in therapy. One participant stated,

So basically the way we, I talk about it, we talk about it among some of us practitioners who work with refugees and immigrants, we're trying to be useful to them as quickly as possible. So that we have time to develop that therapeutic relationship you know in a way that there's relational connection, that then allows us to do deeper work. Because if we aren't useful in some way, we're not going to ever get the subsequent visits. A lot of refugees will start and end therapy within a session or two. Especially because the first part is usually the assessment, and who is this person asking all these questions. Why should I talk to them? And there's no sense of connection. So even in the very first assessment part, I try to develop some sense of relationship.

Worldview. The concept of understanding a client's worldview and culturally held beliefs was another theme that emerged while discussing the therapeutic alliance and relationship building. One participant provided several examples of differing worldviews between their individualistic perspective and the commonly held collectivist culture of many of their clients. This participant further explained the importance of acknowledging and understanding worldviews that are different from your own and how a client's worldview impacts therapy, stating,

I think about the therapeutic alliance because I always assumed that we were coming -- that we were looking at the world from very different perspectives. So one of the things I talk about in class is worldview. People's worldview. It's important for us to have some understanding that people have different worldviews and what certain culture worldviews are...So the therapeutic alliance has to bridge all those differences in seeing the world and come to a common understanding of what the problem is, why you're here, and then the next step is what can be done about it. And some people don't even believe or don't understand that what they are feeling is something that can be done about. Some people believe that this is just the way it is. So like, you know that there's this big mental health system and we know that if we have problems there are at least some chance of resources out there that can help us change that. But a lot of people in the world don't know that there is -- that what they are experiencing is something that can change at all.

Interpreters. Three out of four participants discussed the use of interpreters. One participant discussed sharing the culture and language of their clients and therefore did not need to use interpreters during therapy. Of the participants who did use interpreters, discussions around interpreters helping or hindering the therapeutic alliance emerged. Discussions around in-house

interpreters and contracted interpreters took place. One participant indicated that the organization they work for has trained in-house interpreters and the longevity of their relationship is helpful to the therapeutic alliance with the client:

We have interpreters trained for our organization. So they are considered staff in our organization. So we work with the same interpreter. Like I will, for some clients I've worked with the same interpreter for 2 or 3 years.

Another participant also discussed the use of interpreters, including difficulties with contracted interpreters. This participant discussed an instance with a contract interpreter feeling uncomfortable in a psychotherapy session:

And we could build trust and kind of a way of working together. It was much more difficult my last year when that was not able to happen and we had contract interpreters. And some were good, and some they knew from other places, and some were really not. There were a number of contract interpreters who were not comfortable with mental health. And --

[Researcher asks for clarification]: With terminology?

Well there's that issue. No, they just didn't want to work with "crazy" people. That's basically how it was. They [the interpreters] were uncomfortable with this whole concept of mental health.

Effective Practice

Participants named a number of interventions and approaches to the therapeutic alliance and stabilization that work when engaging with refugees, asylees, and asylum seekers in psychotherapy. Throughout the interview process, two other themes emerged relating to effective practice while working with these populations. Flexibility and having a support person from the same cultural group as the client were named as effective practice aspects in therapy with these populations.

Flexibility. Flexibility was spoken about in terms of therapeutic interventions, personal disclosure, agency level, and boundaries when working with refugees, asylees, and asylum

seekers. All participants discussed incorporating aspects of different therapeutic approaches and not being rigid to one particular intervention, such as the psychoanalytic approach. All participants also discussed flexibility in the area of personal disclosure, meaning they were more likely to share personal information with their clients in an appropriate manner because it was culturally expected. One participant discussed flexibility in terms of personal disclosure, stating,

I had to redefine with self-disclosure. I don't know what the common thinking now is about social workers self-disclosing, but when I was training, it was pretty much you don't do it. If they ask you, say you don't talk about that, say it's about you and not me. But now, when working with refugees, mostly they ask you questions about your family. They want to know who you are. Do you have a family? Where are you from? So I just tell them.

One participant discussed flexibility around boundaries, stating,

I think we have to be sort of nuanced, we have to be sort of flexible about that. So if a client like would go in for a hug and that's just how this woman might greet everybody, it feels injurious and disrespectful to not. I suppose if it feels comfortable for the clinician, I mean if it doesn't that's another thing. But if it does and it doesn't feel like it's sort of unboundaried or sexualized or inappropriate, then we should be accepting that this is like-- in their culture how they might greet people.

Agency level flexibility was discussed around missed appointments and home visits in order to meet the client's needs:

And the other thing I do is if somebody doesn't show up, you know, we call, we make an appointment and they don't show up again, unlike a lot of agencies where you know, then you're just cut off since you're not getting paid-- I just say, can I come to your home? Or even if in the initial session, they are saying, I just can't get there. I say, can I come visit you? So I had the freedom to do home visits. And I -- another therapist I knew did too, and that made a big difference as well. You can see them in their homes, which gives you a whole different perspective. But you can also maybe get higher responsiveness to therapy and you know, you have a better chance of getting that therapeutic relationship going. Because you are going to them. And so it's less effort initially on their part...

It doesn't work to expect constant consistency. So missed appointments, you've got to be flexible with that kind of stuff. The agency has to be flexible. I think one of the areas that I didn't do as much of as I wish I had, I'm just more and more aware of the importance of the family system, again because they're communal. Again, depending on the family. But saying, what are ways we could have engaged more intentionally with the whole family? Or with the community in some way? We tend to view therapy very individually.

Cultural support. One participant discussed the importance for a client to feel validated by having additional support from a person of the same cultural group as themselves if the therapist's culture does not match the client's culture.

And so I think one of the things that works is the process of connecting with the client in a relationship way, also then the connection about what the problem is and agreeing, and have somebody like you or I and our Somali or Hmong colleague or interpreter being kind and understanding and accepting of them even though they have these problems.

Suggestions for Medical Professionals

Due to the nature of trauma and the somatization many refugees, asylees, and asylum seekers experience, these populations find themselves in primary care clinics seeking help for physical pain that is being caused by psychological distress. Because these populations seek medical doctors for somatic issues, participants were asked what they wish medical professionals knew about these populations, trauma, and mental health. Participants responded from their experience working in collaboration with medical professionals both on interdisciplinary teams and across agencies advocating for their clients. Emerging themes for suggestions to medical professionals came to light around: education about forced displacement, understanding a client's triggers, for medical providers to ask about problems because clients may not necessarily tell if they are not directly asked, and mobilizing clients.

Education about forced displacement. All participants discussed the desire for medical professionals to educate themselves about what forced displacement means and how that impacts their patients. On a very basic level, participants relayed the desire for medical professionals to understand why refugees, asylees, and asylum seekers are in the United States; that they have been forced from their home. One participant emphasized a desire for medical professionals to take a vested interest to educate themselves about the patients they work with, stating,

I wish doctors would know what that means, to be a refugee. It means that you are coming from an unsafe situation and that there is a very high level of PTSD in refugee communities. So when you look through a trauma informed lens, then you sort of recognize that people can be triggered in different ways. Education and like down regulation can be really helpful, just to be able to do the medical stuff that you need to do. What does it mean? How many torture survivors are around? Like really what does it mean to be a refugee?

Another discussed positive interactions they had with medical professionals who made it a point to educate themselves about refugee, asylee, and asylum seeking clients, stating,

I was fortunate that several of the doctors at [name of clinic] really committed to working with the refugee population. And so they would come, they came to some of the same mental health for refugee trainings that I was at, there were three doctors in particular. So a lot of my referrals came from them. And I had one particular doctor, Dr. [name of doctor] that I worked especially close with. So that was perhaps unusual. They made it their business to know. I did work with some other doctors where that was less the case. So I want doctors to be aware certainly of the level of trauma and I think they probably are on some level of the war trauma. But also of the resettlement trauma and the ongoing stressors that come.

Another participant discussed a case involving family intervention. This participant expressed the desire for medical professionals to understand depression, stating,

Here is a case I had a while ago. There is a woman that I work with who when you see it on her face, she was just a classic case of depression. Flat affect, no expression, her voice was very soft, she could hardly speak, no energy, nothing. And even psychomotor, you know, she was moving very slowly and all of that. When she came, the family took her to me because they knew what I do for a living. And they took her to almost every doctor. And on that particular day, she received a letter from her doctor, what they were saying, you know we did all kinds of testing and everything is negative. So you don't have anything, so just stay in your home. So here you have somebody who is really struggling and her family is really wanting an answer. And [name of hospital] was telling her, we did all sorts of testing, everything is negative, please stay in your home and don't show up for your next appointment because we have nothing. Because everything is fine. And I just thought, can that doctor just look at her face and see that this woman is severely depressed? She needs somebody to help her with depression.

This participant continued by explaining how psychosomatic issues could have interfered with the medical professional missing the depression:

I could also see why they missed that. Because when she came and I sat down with her, all she talked about was psychosomatic, my legs are heavy, I cannot move, there is an air

in my head coming out. Some weird psychosomatic stuff. That, you know, a medical doctor will just run with it. And say, what's happening here is this, this, and that. They would ask her is there a pain right here and she would say yes. So I wish, for one, know what depression looks like, physically, for people who cannot express symptoms. Secondly, I wish they would probably do some questionnaires that they can ask for people who complain a lot about psychosomatic stuff. And then internally, just learn more about refugees, and their life, and their background, and trauma. And stuff they have been through...So that's why it's very unique to understand the whole process of being a refugee. Just because they are here in a safe place doesn't mean they are stable.

Education about memory & triggers. Discussion around the need for medical professionals to understand trauma related triggers and stressors as they relate to clients and how their memory can be impacted due to trauma and being highly aroused. Three participants emphasized that refugees, asylees, and asylum seekers tend to seek treatment, both with psychotherapists and medical professionals, when they are in great distress or crisis. One participant stated,

They have been on the verge of death, they have seen people die around them. There's a lot of fear in going to a doctor. Usually people go to doctors only when they're extremely, extremely sick. So to try and allay some of the catastrophic fears would be nice for doctors to like offer some comfort, let them know they will be ok. This is happening because of this. Often I've asked clients, so you went to the ER, what did they say? "Well I don't remember." What medicine did they give you? "I don't remember." I think because they are so hyper aroused.

Because these populations may be interacting with medical professionals when they are in a highly aroused state, it is important for medical professionals to understand triggers. This participant continued by speaking specifically about medical related triggers that medical professionals should be aware of, stating,

I think also when people are having a psychiatric crisis and they're really activated and they might be having some type of flashback, they can be triggered very easily with people in uniform. And that might be doctors who have been perpetrators of torture. That might be security guards who are in hospitals. I've definitely seen it both on this end, in the clinic where I work, as well as hospitals where I've worked. It's just been a nightmare. There might be an EMT coming up to the house, for like a reason to try to help a patient, and they see the uniform and they flip out. And then by the time they're in the hospital they're in four point restraints and they're actually not getting the help they need because they're so triggered by all of the stuff going on.

Medical professionals need to ask. Participants discussed clients not telling medical providers about psychological or physical problems because they were not directly asked. One participant discussed how this may be a cultural implication for medical providers to understand, stating,

Just culturally, our clients if they aren't asked they won't tell. So I think for clients who have heavy accents or who need interpreters I sometimes wonder if their histories, be it physical histories or psychological histories, are being explored as much as they could be to really understand etiology of symptoms.

Another participant discussed the conundrum they found themselves in where their clients would speak to them about physical problems. This participant discovered that they were not telling medical professionals during their appointments about their physical ailments. This participant states,

So in my ideal world, I'd like doctors to say, how can we work together? How can we communicate? One of the things that happened especially with Dr. [name of doctor], who I had a strong working relationship with. I have an hour with my clients. So they tell Dr. [name of doctor] about their psychological distress. And they come to me and tell me all their physical symptoms.

And I'd be like ok, it should be the other way around, but ok. But I have an hour to ask them questions. And say, well did you tell the doctor about this? And they say no, the doctor didn't ask. That was a learning moment for me. So I tried to educate my clients that the doctor is not going to ask. They don't know. You need to tell them. So I think that's important for doctors to know, that in some cultures they expect you to ask.

Mobilize patients. Issues around memory and trauma were discussed as it pertains to clients in medical settings. One participant offered a solution that medical professionals can use to alleviate this issue by mobilizing their patients. The importance for medical professionals to be repetitive and help their patients connect with resources in order for them to access care and be successful was discussed:

I think things like repeating themselves a bunch of times, trying to mobilize, like are you working with other people in the community who could help you with some follow up? Because you should see a doctor in two weeks. That would be really helpful. Asking clients or patients like here's your discharge paperwork. This is how you might go and get a prescription. Have you ever gotten a prescription before? Oh you haven't. That means you go to a store, and they have medicines there. Like really basic things of how

people should access care I think is sometimes lost on medical professionals. Because we assume in our country and culture, like we go to Walgreens, you could go somewhere and everyone knows what a pharmacy is and how to get medicine. Some of those things I think would be really helpful for medical professionals to know.

Resiliency Factors

Participants were asked what resiliency factors they see in their clients that make them more likely to successfully heal from trauma. Every participant named resiliency factors which can be organized into the following themes: cultural uniqueness, community, family reunification, and having a belief system.

Cultural uniqueness. One participant spoke about resiliency factors in terms of the diversity of resiliency factors found among different cultural groups. Different examples of what types of resiliency factors may be visible among different groups of people were discussed. There was an underlying emphasis on cultural uniqueness for each refugee, asylee, or asylum seeker. When asked to discuss resiliency factors and how to implement them in psychotherapy, one participant stated,

I think it was not so much a conscious thing. Like ok this person has optimism, community. It's more like understanding this person from their culture or world view and offering help in a way that makes cultural sense to them.

Community. Participants expressed having a sense of community or social connection as a resilience factor. One participant discussed community as an essential piece to healing, stating, *"I would say social connection. I think it's such a big thing. I would say rarely have I seen a client have really extremely successful healing if they didn't have some type of social connection to somebody."*

Another participant spoke about community and connectedness in terms of a client being able to reach out to another person for help and the ability to see themselves as a member of a community with something to offer:

Those refugees that are able to reach out for help, whether it be to family, friends, therapists, doctors, whomever. Religious leaders. Those who can reach out, I think have a better chance of healing. Those that still have some sense of personal agency, those that were the most resilient or that became more resilient over time, you know, instead of seeing themselves as only as sick. So for some, there was a sick identity and you know, this is how I get taken care of and I can't take care of myself. So those that began to see successes or who already had. They may have already had mental health symptoms but had a sense of agency. Those that could say, but I have capacities. I can take care of some things. Or I help other people too. So I have my own struggles but I help others as well. Or have some sense of community or connectedness. Reach out for help, but also know how to give help. Or feel like they had some agency to take care of themselves or their kids. They tended to do better and to heal more.

Family reunification. Related to community was the concept of family reunification. All

participants discussed stressors refugees, asylees, and asylum seekers face, including being away from family. One participant discussed how a lack of family reunification can be a stressor, but a resilience factor once families are united:

Because you know, we have definitely a lot of clients who need the work of trauma and torture processing, but they are so activated because their families are in danger. So they might be here, but their families are abroad and are being tortured. Or they're imprisoned. Or the country conditions are just so unsafe. So I think when we have families who can all be reunited here, I think that can help a lot.

Belief system. All participants discussed how holding a belief system was a resource or resilience factor for their clients. Belief systems include religion, spirituality, as well as culturally held beliefs from literature. One participant discussed utilizing culturally pertinent literature as a resource for their clients:

A project I'm working on on my own is looking at indigenous culture and how that expresses in psychology. So I've been mainly working with proverbs. So I use those in therapy. And mainly I use it to gain insight. And even sometimes help them learn more about solutions. So an example would be, earlier I was mentioning early childhood and how that affects your current situation. There is a Somali proverb that says, a snake bite received at age 6 kills you at 60. And the idea is that if you receive a traumatic experience at age 6, let's say sexual abuse, you don't just heal the thing right away. But the impact lingers until maybe the end of your life. And we see that all the time with people who are sexually abused develop, you know, PTSD, or depression, or bipolar, or borderline. And start getting into addiction to self-medicate about all this pain. At the end of the day, the addiction and mental illness, they end up killing themselves or maybe

dying of other things. So then that proverb kind of explains. So then I will say, what do you think about that? And they will just look at it because they know these proverbs, they have been using it all their lives. I don't have to explain why we are talking about early childhood.

[Researcher asking for clarification]: Are these proverbs from Somali culture? Or are they found in the Quran?

No no no, they are in the culture. From Somali literature, like poems. As you probably know, we are more oral tradition than writing. Just like Native Americans and other indigenous cultures. We tend to communicate through oral than writing.

Discussion

This research project began from a place of curiosity and the desire to juxtapose the field of mind-body psychotherapy with refugees, asylees, and asylum seekers, many of whom experience complex psychological trauma and CPTSD. The emerging field of mind-body psychotherapy is increasingly relevant as research about trauma, neuroscience, and body-based approaches grow in acceptance. The worldwide crisis of displaced people brings refugees, asylees, and asylum seekers to the forefront of news coverage with pressing urgency for social workers to effectively work with these populations. Social workers who are psychotherapists must ask what are best practices to work with these populations in therapy?

This research project sought out participants who utilize mind-body psychotherapies with adult refugees, asylum seekers, and asylees from non-Western cultures living in the United States who have experienced complex psychological trauma, in order to learn 1) what mind-body approaches are being used and 2) what are best practices when working with these populations? The four practitioners interviewed for this project answered these questions with a wealth of knowledge and practice based evidence. Practitioners discussed best practices in implementing specific mind-body approaches as well as general effective practices used specifically with these populations.

Summary

The practitioners interviewed for this research study discussed seven main areas in their work of psychotherapy with refugees, asylees, and asylum seekers. The seven areas included: interventions, being action oriented, offering flexibility, using culture as a tool to connect and heal, understanding the triple trauma paradigm, understanding stigma and adjusting language accordingly, and effectively working with interpreters. The following is a summary of each of

the seven areas discussed by participants in order to further understand the practitioner perspective on mind-body psychotherapy approaches with refugees, asylees, and asylum seekers.

Interventions. An array of interventions used in psychotherapy were named by the participants. The “bottom up” approaches or techniques to trauma work named included: SE, SP, hypnosis, penjulation, body scans, autogenics, mindfulness, and EMDR. The cognitive approaches named included CBT and Narrative Therapy. Therapy involving body movement included yoga, physical exercise, and drumming. While each participant spent time discussing their intervention repertoire, there was no single type of intervention that was discussed as the sole intervention to use with these populations. Integrating multiple types of interventions, depending on where the client was at with trauma work, was often discussed.

Mind-body and trauma based approaches were discussed as effective interventions because of the common presenting conditions of body pain, mood dysregulation, and psychological distress. Once a therapeutic alliance was established, psychoeducation given, and trauma processed with clients, integrating a trauma narrative with CBT or Narrative Therapy was an effective method with these populations who have experienced complex psychological trauma.

Action oriented. More important than the type of intervention or approach to therapy was being action oriented and helpful to the client, especially early on in therapy. Several participants discussed the need to have tangible success early in therapy because the concept is often foreign to refugees, asylees, and asylum seekers. Like one participant noted, these populations will not continue in therapy if they do not understand the value of it. Being action oriented or helpful in a tangible way could involve the psychotherapist connecting the client with a case manager to help

meet needs such as food insecurity, housing, and employment. Making these strides early in therapy aids the therapeutic alliance which ultimately allow for further trauma work.

Offering flexibility. One of the most telling areas of this research study was participants' discussion around offering flexibility to their clients. Flexibility was discussed in terms of therapeutic interventions, at the agency level, personal disclosure, and boundaries when working with refugees, asylees, and asylum seekers. There was a consensus of a need for a lack of rigidity in terms of therapeutic interventions, often incorporating more than one type of intervention or method. Agency level flexibility included offering to meet in the client's home for therapy and adjusting rules about missed appointments with these populations. This type of agency level flexibility was influenced by an understanding of the connection between trauma and memory, as well as cultural differences with time. Practitioners who work at agencies who make adjustments accordingly with these populations have the best chance of engaging with them in psychotherapy.

Another area of nuanced flexibility reported was around personal disclosure and boundary setting. Participants reported that they were more likely to disclose personal information to their refugee, asylee, and asylum seeking clients because it was culturally expected to share. It could be viewed as offensive to not share some level of personal information, since these clients are typically trying to connect. Connecting in this way can also help develop and strengthen the therapeutic alliance. Along the same lines, personal boundaries around physical touch were also discussed. One participant discussed clients who hug and how not returning the hug could be very offensive in some cultures. Another participant discussed a client who shook their hand and kissed it, a cultural expression of respect and gratitude.

Culture connects & heals. Throughout the interviews, ideas around using culture to connect and heal clients became apparent. Participants discussed the importance of understanding a client's worldview as well as the culture from which they belong. Taking the time to understand collectivist communities and check one's own individualistic perspective were discussed by three out of four participants. One participant used literature from the culture of their clients as a way to connect, engage, and promote insight. Connecting with cultural values and traditions has multiple benefits: it shows the client you are engaged, is meaningful to the client, and can strengthen the therapeutic relationship. Connecting with culture can also mean openly discussing a client's spirituality or religion. All participants discussed how they incorporate a client's religious beliefs and practices into psychotherapy. Acknowledgment of the mind-body-spirit connection as a source for healing was prominent, since faith is often an important part of refugees, asylees, and asylum seekers' lives.

Triple Trauma Paradigm. All participants discussed trauma extensively and the impact it has on their clients. Complex trauma specifically was discussed because all participants held an understanding of the Triple Trauma Paradigm. All participants had an understanding that the level of trauma experienced by many refugees, asylees, and asylum seekers is profound and can span years and even decades. There was specific references during the interviews that life in exile is trauma and needs to be viewed accordingly and attended to in psychotherapy. War related traumas are significant, but it is just as important to acknowledge and work through traumas that exist during the resettlement phase of life for these populations. The Triple Trauma Paradigm encompasses three areas of trauma experienced by these populations during pre-flight, flight, and post-flight, such as harassment, torture, witnessing violence, loss of home, illness, separation of family, language barrier, unemployment, and shock of a new culture.

Stigma & language adjustment. All participants discussed stigma that exists around the topic of mental health with many refugees, asylees, and asylum seekers. Many individuals from these populations either are not familiar with the concept of therapy and how it can help or hold a negative belief of mental health in general. A commonly held belief discussed by the participants was that people are viewed as either crazy or sane. In order to work in the field of mental health with communities that view it with such stigma, participants discussed adjusting their language. Instead of using the term mental health, some participants discussed using behavioral health or emotional health. All participants discussed speaking in terms of symptoms as opposed to diagnoses and referencing idioms of distress in a way most understandable to the client.

Use of interpreters. Three out of four participants discussed the use of interpreters. The only participant to not discuss interpreters shared the language and culture of their clients and therefore did not need to use an interpreter. Types of interpreters were discussed as either contracted interpreters for a one-time use or in-house staff interpreters that work with therapists and clients on an ongoing basis. Staff interpreters were the preferred type of interpreter because they were trained by the organization, could develop rapport and familiarity with clients, could have an ongoing working relationship with the therapist, as well as offer pre-session and post-session cultural insight and consultation.

The use of interpreters during psychotherapy with refugees, asylees, and asylum seekers also brought to light the notion of slowing down the therapy session due to the language barrier. The slowing down of the session allows practitioners to have more time to think as well as watch what is happening in their client's bodies. This is important for trauma work and when working from a bottom-up approach. Slowing down sessions also allows for time to make sure the therapist's ideas and concepts are clearly interpreted and understood by the client. Due to the

language barrier as well as issues surrounding memory impairment due to trauma, participants reported the need to be repetitive while working with these populations. Repetition was a technique used by the participants both during sessions and from session to session.

Strengths & Limitations

Strengths of this research project include the qualitative nature of this study. The use of semi-structured research questions in the interview process gave room for practitioners to share their perspectives on populations that are underrepresented in the literature. There is a gap in the literature regarding interventions for refugees, asylees, and asylum seekers and their unique set of needs, especially pertaining to trauma. This research project filled a gap in the literature while being relevant considering the worldwide displacement of people and the need for appropriate interventions for individuals suffering from complex psychological trauma.

A limitation of this qualitative research project was in the coding process. The researcher was the only person transcribing the interviews and coding for themes. Typically, the coding process involves more than one person to ensure accuracy and consistency. Due to the nature of this clinical research project, the researcher was the only person coding for themes.

Only four individuals were interviewed for this research project. While this is a small sample size and can be viewed as a limitation, it accurately reflects the smaller community of psychotherapists who work exclusively with refugees, asylees, and asylum seekers. Even though only four individuals were interviewed for this study, the breadth and depth of their experience was evident. While it was not a stipulation to participate in this study, each practitioner interviewed has made it their career to work with these populations.

Implications for Social Work Practice

This research project and the subsequent interviews shed light on implications for social workers to consider. What are the policy, research, and practice implications to work with refugees, asylees, and asylum seekers?

Policy. Based on the findings from this research study there are policy implications for social workers to consider. Policy issues around immigration greatly impact individuals, families, and communities. The current political landscape has brought immigration related issues to the forefront. The number of refugees allowed in the United States has been dramatically lowered, causing families already resettled in the United States to feel the uncertainty of being reunited with their families.

The findings in this study shed light on the importance and positive impact family reunification has on the mental health of individuals. Uniting families through family reunification removes a significant stressor many refugees, asylees, and asylum seekers experience and ultimately fosters better mental health outcomes for individuals and families. Many refugees, asylees, and asylum seekers come from collectivist cultures, where family and community plays an extremely important role. Social workers should advocate for policies that reunite families, especially refugees, asylees, and asylum seekers who already have a plethora of stressors and ongoing resettlement related trauma.

The asylum process in the United States is an extremely long legal process to navigate. Some asylum seekers spend years, waiting to learn whether they will be granted asylum and be given legal status to stay in the United States. Trauma impacts memory, which makes testifying in immigration court an arduous task for asylees as well as significantly triggering to discuss trauma stories and recall details regarding their flight from danger. Advocating for asylum

seeking clients who face tremendous stress and a long legal process of proving a well-founded fear of persecution is essential. Policy level change should include advocating for shorter asylum processes and trauma informed legal counsel.

The benefits these populations are able to access is another area of policy social workers should advocate for. Asylum seekers are not allowed to legally work in the United States. This makes life extremely difficult for these individuals as well as makes them extremely vulnerable. Refugees receive a limited amount of benefits and after 90 days of resettling in the United States are expected to have secured housing and employment. This is often unattainable and meeting basic needs can become a struggle and another stressor in the lives of individuals and families. Social workers should consider policy that helps support basic needs for refugees, asylees, and asylum seekers regarding housing, food, employment, and education support.

The findings in this study found that interpreters can both help and hinder the therapeutic relationship with refugees, asylees and asylum seekers. Good interpreters can have a positive impact in therapy. But some interpreters are unfamiliar or uncomfortable in mental health settings. Adequate training and ethical standards should be upheld by interpreters, especially those who interpret in psychotherapy, because clients are often in a vulnerable state. Social workers should advocate for standardization among the interpreting profession to ensure training and education, so that every refugee, asylee, and asylum seeking client can have an ethical and competent interpreter.

Research. There is a gap in the literature around work with diverse communities, especially refugees, asylees, and asylum seekers. These are vulnerable populations that need more research, both abroad and after resettlement. Voices of diverse communities need to be heard, including these populations in order to learn what needs exist and how to best work with these populations.

Continued research around mind-body approaches with refugees, asylees, and asylum seekers is needed, as the number of worldwide displacement of people increases. There are a limited number of studies that exist bringing these two areas together in research. Additional qualitative studies should be conducted to gain further insight into practitioner perspectives on approaches with these populations to further learn about what works and does not work in therapy and other settings. Qualitative studies of practitioners of color who work with refugees, asylees, and asylum seeking clients should also be conducted because more diverse voices need to be heard in the literature.

While each refugee, asylee, and asylum seeking group of people share similar trauma stories, each are unique in expression of culture and language. Further research on specific ethnic groups within the categories of refugee, asylee, and asylum seekers should be explored. Interventions or approaches that work with one ethnic group may or may not work for another. Resilience factors and mental health needs may vary between ethnic groups, making this an area of importance for further research.

Practice. The findings of this research study have significant implications for social work practice. Working from a Family Resilience Model is a key component when working with refugees, asylees, and asylum seekers. These communities often come from communal cultures and do not hold individualistic perspectives. Psychotherapy is often conducted from an individualistic mindset, but social workers should work on ways to incorporate family and community support while working with their client. Additionally, social workers should broaden their perspective on who is considered family. For many individuals from collectivist cultures, the nuclear family can look different when compared with the Western perspective. Resiliency

can often be found in being connected to one's community and social workers should consider the cultural components that make their clients unique.

The research showed that best practices with working with refugees, asylees, and asylum seekers include many levels of flexibility. Weighing their own comfort level, social workers should consider flexibility around physical touch and personal disclosure. Refugees, asylees, and asylum seekers often want to engage with their therapist and learn a little more about them personally, since the concept of therapy and speaking with a stranger about their personal problems is often an unfamiliar concept. Social workers should consider cultural norms and expectations and make appropriate adaptations in therapy.

Agency level flexibility is another area social workers can influence their practice. Best practices indicate that agencies allow flexibility around location of therapy and implement policies and practices that reflect an understanding that culturally, it may be difficult for these populations to keep appointments or be on time. Social workers should think outside the box and come up with agency level solutions to partner with these communities. If that is not possible on an agency level, social workers should be prepared to refer refugee, asylee, and asylum seeking clients to agencies that have the capacity to offer these types of flexibility.

Many refugees, asylees, and asylum seekers who have experienced trauma may end up seeking medical help for psychosomatic issues. The findings related to what practitioners wish medical professionals knew about these populations shed light on what medical social workers can implement in practice. Educating medical staff on basic information about who refugees, asylees, and asylum seeking clients are is pivotal. Many professionals, including medical professionals, are not familiar with these groups of people and their unique set of needs, stressors, and the level of trauma they have encountered and continue to encounter in the United

States. Mobilizing patients by helping them navigate medical systems, offering case management, or connecting them with existing community resources gives support and encourages that medical and mental health needs are met. Medical social workers should also consider offering trauma and cultural sensitivity trainings to multi-disciplinary teams that work in medical settings, who may not be attuned to this information and its benefits for working with diverse populations.

Significance

The findings from this research study give social workers, psychotherapists, and other professionals many areas to consider when working with adult refugees, asylees, and asylum seekers who have experienced complex psychological trauma. There is a significant lack in the literature of studies conducted with these vulnerable populations. Even fewer studies exist regarding the use of mind-body based therapy interventions with refugees, asylees, and asylum seekers. This research study worked towards filling the gap, but more is needed. The practitioner perspectives from this study gave direction and ideas for other practitioners to consider and implement in their own practices, whether they work regularly with these populations or only occasionally.

The number of displaced people worldwide is a humanitarian crisis that cannot and should not be overlooked. The stressors and traumas these populations have endured are complex, as are the answers for healing the minds and bodies of these populations. Striving towards healing for these communities is the goal, which can only be achieved by advancement and further research for these underrepresented populations. Despite prolonged psychological trauma, the resilience of refugees, asylees, and asylum seekers is powerful, and in that, there is hope.

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Appendix A: Consent Form

CONSENT FORM
UNIVERSITY OF ST. THOMAS
GRSW 682 RESEARCH PROJECT

Healing the Mind and Body: Practitioner Perspectives on Integrating Cognitive and Somatic Approaches in Psychotherapy with Refugees, Asylees, and Asylum Seekers

I am conducting a qualitative study about the integration of mind-body therapies to work with somatic and cognitive mental health needs of refugees, asylees, and asylum seekers. I invite you to participate in this research. You were selected as a possible participant because you currently or have in the past conducted psychotherapy with these populations. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by: Amanda Ament-Lemke, a graduate student at the School of Social Work, St. Catherine University/University of St. Thomas and supervised by Dr. Courtney Wells, PhD, MSW, MPH, LGSW.

Background Information:

The purpose of this study is to explore what types of mind-body psychotherapeutic approaches are being used by psychotherapists to treat with refugees, asylees, and asylum seekers suffering from complex psychological trauma. The effectiveness of these mind-body therapies will be examined and implications for practice with this population will be explored.

Procedures:

If you agree to be in this study, I will ask you to do the following things: Be interviewed for 45 minutes to 1 hour and answer questions related to this research topic. The conversation will be audio recorded and transcribed. Data collected will be incorporated into a clinical research paper and oral presentation. All identifying information will be removed.

Risks and Benefits of Being in the Study:

The study has no risks. Identifiable information will be removed. Audio recording will be stored on a locked recording device and destroyed after use. The study has no direct benefits.

Confidentiality:

The records of this study will be kept confidential. Research records will be kept in a locked file in my home office. I will also keep the electronic copy of the transcript in a password protected file on my computer. The audio recording will be destroyed by August 1, 2018. As mandated by federal law, consent forms will be kept by the researcher for three years and destroyed on May 14, 2021. Transcripts will be de-identified and saved by the researcher.

Voluntary Nature of the Study:

Your participation in this study is entirely voluntary. You may skip any questions you do not wish to answer and may stop the interview at any time. Your decision whether or not to participate will not affect your current or future relations with St. Catherine University, the

University of St. Thomas, or the School of Social Work. If you decide to participate, you are free to withdraw at any time without penalty. Should you decide to withdraw, data collected about you will not be used.

Contacts and Questions

My name is Amanda Ament-Lemke. You may ask any questions you have now. If you have questions later, you may contact me at [phone number] or [email address]. My research chair is Dr. Courtney Wells and she can be contacted at [email address]. You may also contact the University of St. Thomas Institutional Review Board at 651-962-5341 with any questions or concerns.

You will be given a copy of this form to keep for your records.

Statement of Consent:

I have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study and to be audio recorded.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B: Recruitment Email

SUBJECT LINE: Research Invitation

Dear _____,

I am reaching out to you because you are a mental health professional that conducts psychotherapy with refugees, asylum seekers, and asylees. My name is Amanda Ament-Lemke and I am a graduate student in the Masters of Social Work program at St. Catherine University and the University of St. Thomas. I am currently working on my clinical research project where I am conducting a qualitative study to examine cognitive and somatic approaches to psychotherapy with refugees, asylum seekers, and asylees with complex psychological trauma.

I would like to invite you to be a part of my study since your area of expertise is in practice with this population. My study is exploring what types of psychotherapy approaches are being used with refugees, asylum seekers, and asylees by interviewing practitioners, such as yourself. If you are interested in participating in this research or have any questions, feel free to contact me at [phone number] or [email address].

Best,

Amanda Ament-Lemke

MSW Student | SCU & UST

[phone number]

[email address]

Appendix C: Recruitment Flyer

Are you a psychotherapist who works with refugees, asylees, or asylum seekers?

Do you integrate mind and body approaches in therapy?

Interested in being interviewed for research?



I am conducting a qualitative study about the integration of mind-body therapies with refugees, asylees, and asylum seekers. I am interested in interviewing psychotherapists who work with these populations to learn about the types of integrative cognitive and somatic approaches currently used to treat complex psychological trauma.

If you are interested in being interviewed or have any questions, contact:

Amanda Ament-Lemke

Masters of Social Work Graduate Student
St. Catherine University | University of St. Thomas
[email address]
[phone number]

Appendix D: Interview Questions

Semi-Structured Research Questions

1. Tell me about your agency. (*Private practice, community-based, etc.*)
2. Please tell me a little about yourself, including your title and credentials.
3. What theories influence your practice?
4. Which population(s) of people do you work with? Please note immigration status, ethnicity, age range, language(s), and any other information you find relevant.
5. Describe typical symptomatology of refugees you encounter in psychotherapy.
6. What are cognitive and somatic interventions you integrate into psychotherapy with refugees (*for example: EMDR*)?
 - a. How do you approach stabilization and the therapeutic alliance with refugees?
 - b. Which interventions have proven most effective with refugees, asylees, and asylum seekers?
 - c. Which interventions do not work with refugees? Why?
7. Since many refugees seek medical doctors for somatic issues, what do you wish medical professionals knew about refugees, trauma, and mental health?
8. What resiliency factors make certain refugees/asylees/asylum seekers more likely to successfully heal from trauma?
 - a. How do you incorporate these resiliency factors in psychotherapy?