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INTRODUCTION TO REFUGEES
AND IMMIGRANTS*Newcomers to the United States*

Today there are more refugees and forcibly displaced migrants than at any other time in history (United Nations High Commissioner for Refugees [UNHCR], 2018a). Global conflict and instability have led to mass migrations of people fleeing violence and brutality. Climate change threatens to make lands uninhabitable, adding to the global migration crisis. Globally, more than 68.5 million individuals have been forcibly displaced (UNHCR, 2018a); more than half of today's refugees are children under the age of 18 (UNHCR, 2018a). As they cross seas, lands, and ultimately borders seeking refuge, forcibly displaced migrants become stories in our newspapers and statistics in our political debates. But they are, more than anything else, individuals and families seeking a chance to survive and—ultimately—thrive.

Mental health providers may have the opportunity, for a brief period, to walk a part of the journey with refugee and immigrant children and families. That part of the journey may be soon after resettlement, as families struggle to make sense of their new land and challenges, or it may be a generation later, as a family grapples with questions of identity and historical trauma. Against the tapestry of political history, culture, violence, and flight that

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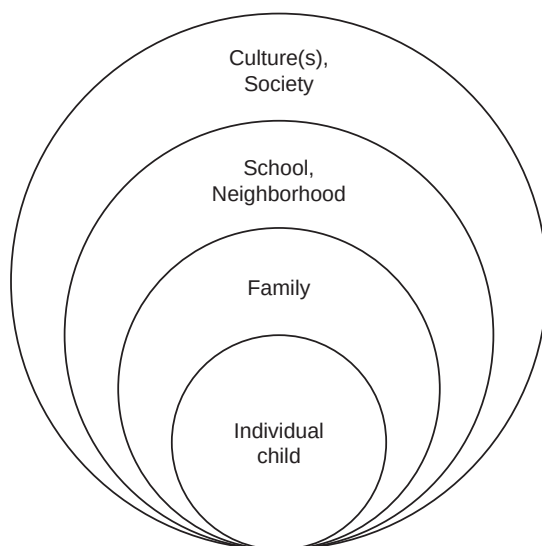
Mental Health Practice With Immigrant and Refugee Youth: A Socioecological Framework,
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weaves together the life experiences of refugees and immigrants, the therapeutic part of the journey may seem small and insignificant. However, it may also hold the potential to help children and families shift their journey toward one of greater hope, recovery, and resilience. This book is for mental health providers who may have this opportunity to work with refugees and immigrants or who would like to work to create this opportunity. Reading the chapters herein will provide frameworks to guide thinking around the needs and challenges of serving this population, as well as concrete steps to providing evidence-based, culturally responsive care. This book is also for providers from other disciplines who want to understand how culture, trauma, and mental health can shape the experiences of refugee and immigrant children. Finally, this book is for fellow citizens who, like us, believe we have a role in making our country a refuge and home to all who live here. Reading this book will provide a window into both the experiences and stories of refugee and immigrant children, as well as how the communities we build shape these stories.

This book explores the refugee or immigrant child's experience using a socioecological model (Bronfenbrenner, 1979; see Figure 1.1). Through this lens, the developing child is seen as being at the heart of a series of concentric

FIGURE 1.1. Socioecological Model Showing How the Individual Child is Nested Within Layers of the Social Ecology



Different levels of the social ecology interact such that disruptions or interventions within one level of the ecology may affect functioning and stability of another level.

circles of the social ecology: He or she lives in a family, attends school, is part of a neighborhood and larger society, and all of this is embedded in a culture—or, for immigrants, both their culture of origin and the culture of their resettlement community. Disruptions in any one layer of this social ecology can have profound consequences for the developing child at its core. So, too, can assets—the gifts of family bonds, a teacher’s warmth, a place on the town’s soccer team. As we examine the evidence related to how trauma and stress impact a refugee child’s development, we will also quickly move to understand how levers of intervention in the layers of the social ecology can reverse this impact and help foster resilience.

In this chapter, we describe what it means to be a refugee or forcibly displaced migrant, common experiences and challenges, and the diversity of outcomes that can be realized by the human spirit despite adversity. Chapter 2 provides an in-depth look at culture and how culture—both ours and those of our clients—is central to the relationship and work. Chapter 3 discusses barriers to engagement and practical strategies for overcoming them. Chapters 4 through 6 directly addresses working with refugee and immigrant children and adolescents, starting first with assessment, followed by office-based and trauma-focused approaches, and then collaborative or integrated approaches to care. Finally, Chapter 7 considers how resilient communities can positively shape the experience of refugees and immigrants, as well as what we need to do to build these communities.

TYPES OF IMMIGRANTS AND WHY IT MATTERS

Approximately 13.4% (43.2 million) of the U.S. population are immigrants (Pew Research Center, 2018). Depending on the legal determination made related to the circumstances of migration, immigrants may be refugees, asylum seekers, asylees, undocumented immigrants, unaccompanied children, unaccompanied refugee minors, or authorized immigrants. Understanding the legal standing of the child or family with whom a clinician works is important to recognizing what benefits they have access to and the stability of their residency. Some immigrants are voluntary migrants and migrate for reasons such as educational or professional opportunity or for family connection (American Psychological Association [APA] Presidential Task Force on Immigration, 2012). In contrast, some immigrants—including refugees, asylum seekers, and many undocumented immigrants—migrate in search of humanitarian refuge (APA Presidential Task Force on Immigration, 2012). These immigrants, who are forced to leave their home countries because of

violence or political instability, not only share with other immigrants the challenges associated with acculturation but also must contend with stressors associated with the nonvoluntary nature of their migration. Although some of what is discussed in this book will be relevant for all immigrant children and families, the focus of this guide is on the particular needs of forced, or involuntary, migrants who come seeking refuge. Despite the diversity in cultures and journeys, some important common threads unite them all. (See Exhibit 1.1, Table 1.1.)

Globally, there are 25.4 million refugees today, coming from regions around the world (UNHCR, 2018a). In 2017, the most frequent countries of origin included South Sudan, Afghanistan, and Syria, which together accounted for 57% of the world's displaced people (UNHCR, 2018a). They migrate where they can, and some receive formal resettlement opportunities in countries around the world. The term *refugee* is a formal legal status given by the UNHCR to an individual who, “owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country” (UNHCR, 1951). Typically, refugees flee from their homelands out of fear for their safety and find their way across country borders to a refugee camp, where they may wait indefinitely for conditions to allow them to return home or to be accepted for resettlement in another country.

Once resettled in the United States, refugees receive a one-time Reception and Placement Grant (RPG) that they can use to secure initial housing, food, or clothing; and 8 months of cash assistance from the federal Refugee Cash Assistance program (amounts vary by state and household size; Economic Services Administration, n.d.). Beyond this period, refugees may be

EXHIBIT 1.1. Refugee and Immigrant Quick Facts

- In the United States, there are an estimated 43.2 million immigrants, comprising 13.4% of the nation's population (UNHCR, 2018a, 2018b).
- There are 68.5 million forcibly displaced people worldwide (UNHCR, 2018a, 2018b).
- Of these, 25.4 million are refugees, more than half of whom are under the age of 18.
- An estimated 11.3 million immigrants in the United States (approximately one fourth) are undocumented (Zong, Batalova, & Burrows, 2019).
- The largest immigrant ethnic group in the United States is Latinx, with Mexico being the top origin country (Pew Research, 2018). Seventeen percent of Latinx children are undocumented, and approximately 40% of Latinx children have at least one parent who is undocumented (Fry & Passel, 2009).

TABLE 1.1. Definitions of Legal Statuses and Clinical Implications

Legal status	Clinical implications
Refugees	Definition: A legal status provided to individuals who are recognized by the 1951 Convention definition as persons who have crossed an international boundary because they are “unable or unwilling to avail themselves of the protection of their former country due to a well-founded fear of persecution based on race; religion; nationality; membership of a particular social group; or political opinion” (UNHCR, 1951). Clinical implications: Knowing the rights and benefits that refugees can claim in their state or country will allow providers to best serve these individuals. Refugees are eligible to work immediately upon arrival, and may apply for a green card one year after arrival.
Asylum seekers	Definition: Individuals who have applied for international protection but whose refugee-status claims have not been verified. Asylum seekers may have similar experiences as refugees but have not been afforded the same legal protections and benefits. Clinical implications: Understanding that these individuals face additional uncertainty around legal status and deportation can help providers address the unique challenges they may face.
Unaccompanied children (UAC)	Definition: Children under the age of 18 “who have been separated from both parents and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so” (UNHCR, 1951). Clinical implications: A UAC’s age and lack of legal status may make them particularly vulnerable to exploitation or victimization during their journey. UACs may also be accustomed to assuming adult responsibilities. A UAC may seek to remain in the country legally through applying for asylum or a Special Immigrant Juvenile Status visa. During the application process, UACs are housed under the auspices of the ORR (Office of Refugee Resettlement) in foster homes, residential centers, detention centers, or other care facilities.
Unaccompanied refugee minor (URM)	Definition: Children who enter the United States legally as refugees through the U.S. refugee admissions program, or children referred from the UAC program who have received Special Immigrant Juvenile Status. URM typically are placed in foster care until age 21, with some benefits extending to age 23. Clinical implications: A URM may be placed with families whose ethnicity and associated customs differ from their own. Older children or adolescents may have functioned independently for many years and may be unaccustomed to being within a family system where they lose independence and autonomy.
Undocumented immigrant	Definition: An undocumented immigrant enters the United States without proper authorization documents or enters legally but then overstays his or her visa. Clinical implications: Undocumented immigrants may not access needed services out of fear that they will be reported and deported. Federal policies restrict access to federal public benefits such as food stamps and Supplemental Social Security Income (SSI), though a small number of states provide access to benefits (Fix & Passel, 2002).

eligible for several time-limited cash, medical, and social benefit programs, such as Temporary Assistance for Needy Families or Social Security, most of which benefits expire after the first five to seven years (U.S. Government Accountability Office, 2010).

The structure of these programs varies by state: Whereas the majority of programs are state-administered cash-assistance programs, a third of states operate private–public partnerships whereby cash-assistance programs are administered through local resettlement, nonprofit, or religious agencies and are integrated with case management and employment services (Office of Refugee Resettlement [ORR], 2014). The public–private partnerships provide refugees with intensive and integrated services in their first months to establish economic self-sufficiency early in resettlement, with the goal of reducing long-term dependency on welfare programs (ORR, 2014).

In contrast to refugees, asylum seekers flee from unsafe conditions in their home country to a country where they then apply for the right to remain. The circumstances that would lead someone to be considered a refugee or an asylee are fundamentally very similar; however, asylum seekers apply for protection within the country to which they have fled. The process of applying for asylum is lengthy and the outcome is uncertain. Both the legal application process and the uncertainty of its outcome can be highly stressful and retraumatizing (Procter, Kenny, Eaton, & Grech, 2018; Schock, Rosner, & Knaevelsrud, 2015). During the period when their application is under review, asylum seekers may remain in the country in which they are applying for legal status and may apply for employment authorization 150 days after filing an asylum application. While their application is pending, asylum seekers are not eligible to receive federal benefits (U.S. Citizenship and Immigration Services, 2019).

Undocumented immigrants may share many of the same experiences as refugees and asylum seekers, but they do not have legal status within the country to which they have migrated and have not applied for asylum. Within the United States, some undocumented immigrants from Central America have fled violent conflict or gang violence (or both) and desperate economic circumstances (Corsetti, 2006). Mexican and Central American immigrants make up just over half of the undocumented population within the United States (Migration Policy Institute, 2014). Undocumented immigrants face particular challenges related to discrimination, restricted access to benefits, fear of deportation, and family separations (Torres, Santiago, Walts, & Richards, 2018). Families with even one member who is not documented, or “mixed-status” families, must contend with the heightened risk and fear associated with being undocumented (Torres et al., 2018). Parental

deportation can be traumatic for children in multiple ways, including by witnessing the forced removal of the parent, the sudden and unexplained absence of a parent, and the ensuing instability in housing or family functioning (Brabeck, Lykes, & Hunter, 2014).

In recent years, some countries have engaged in the practice of holding unauthorized immigrants in detention indefinitely or while asylum applications are adjudicated (Wood, 2018). Research resoundingly documents that detention has a negative impact on the mental health of asylum seekers, and in particular can be damaging to the psychological well-being of children (Fazel, Karunakara, & Newnham, 2014; Silove, Austin, & Steel, 2007). In a study of 70 detained asylum seekers, detentions were associated with significant psychological distress that worsened over the course of detention (Physicians for Human Rights & Bellevue/NYU Program for Survivors of Torture, 2003). Detention can negatively impact parents' mental health, threatening their capacity to care for their children both during and after the period of detention (Mares, 2016; Mares, Newman, Dudley, & Gale, 2002; Steel et al., 2004). Children are particularly vulnerable to the detrimental effects of detention; young children held in detention can suffer from developmental delays that impact their development long after they have left the detention center (Mares & Jureidini, 2004). In a study of 10 children ages 6 through 17 who had been referred to mental health services following a period in a detention center, 100% met criteria for both posttraumatic stress disorder and major depressive disorder with suicidal ideation (Mares & Jureidini, 2004). Detained children have also been found to have higher levels of mental health symptoms than nondetained peers (Reijneveld, de Boer, Bean, & Korfer, 2005; von Werthern et al., 2018). In Australia, where the issue of child detention has been widely debated, two inquiries found that "immigration detention has harmful health, mental health and developmental consequences for children and negative impacts on parenting" (Mares, 2016, p. 11). This conclusion is supported by research in other nations where child-detention policies have been put in place, including England (Lorek et al., 2009), Canada (Kronick, Rousseau, & Cleveland, 2011), and the Netherlands (Reijneveld et al., 2005).

In the United States, a "zero-tolerance" policy related to immigration was put in place in 2018, leading to the detention and federal prosecution of all immigrants crossing the U.S.–Mexico border without legal documentation. At the same time, a policy of family separation was implemented as, by law, children were not allowed to remain with parents who were in detention (Wood, 2018). Outcry regarding the damaging effects of family separation on child health and development eventually led to a change in the

separation policy, but the practice of holding families in detention continues (Wood, 2018). Professional societies such as the American Psychological Association, the American Academy of Pediatrics, the American Medical Association, and the National Association of Social Work have strongly opposed both family separation and detention of immigrant families, declaring these practices unethical (Kraft, 2018; Madara, 2018; Mills, 2018; National Association of Social Workers, 2018).

Over the past 5 years, instability and violence in the Northern Triangle region of Central America have led to a significant increase in the migration of unaccompanied children (UAC)—that is, minors who are sent, or flee, to the United States without an adult guardian (Torres et al., 2018). According to the UNHCR, more than half of unaccompanied immigrant children are eligible for international protection (UNHCR, 2014). These children present with particular needs, both because of the lack of guardianship and because many have had to assume adult responsibilities at a young age, making it more difficult to transition into the roles expected of children within the U.S. cultural context (L. Collier, 2015). In a study comparing immigrant students who had and had not been separated from parents for extended periods, Suárez-Orozco, Bang, and Kim (2011) found that those who had been separated were more likely to report symptoms of anxiety and depression in the early years of migration. Similarly, in a study of refugee adolescents in Belgium, those who migrated without parents were more likely to have been exposed to more traumatic events and also demonstrated higher levels of mental health problems (Derluyn, Mels, & Broekaert, 2009). Thus, the stress and danger of migration in the absence of a parental figure may be particularly detrimental to the health and well-being of immigrant youth.

Common across refugees, asylum seekers, and some undocumented immigrants are the immense challenges of forced migration, the likely exposure to trauma and loss along the way, and the enormous task of acculturating to a new land and a new way of life. Despite these commonalities, however, the different legal statuses have important practical implications. Those without formal legal status may experience significant anxiety about their long-term resettlement prospects and the threat of deportation (Torres et al., 2018). Asylum seekers must go through an often arduous legal process involving detailed interviews about past trauma in order to document their necessitated departure from their country of origin. Undocumented immigrants may be afraid to seek services or turn to authorities for help and protection because of their legal status (Hacker et al., 2011). Children in mixed-status or undocumented households may be exposed to constant fear of discovery and deportation, or of separation from primary caregivers.

Additionally, neither undocumented immigrants nor asylum seekers have access to the benefits and resettlement assistance afforded to refugees. Thus, practically and clinically, legal distinctions among immigrant children and families are important to understand.

Within this book, we largely use the terms *refugee* and *immigrant* to refer to immigrants or their children who have come to the United States fleeing violence and instability in their homelands. Where particular legal statuses play a role, we more specifically reference implications for someone with refugee status, or who is an undocumented immigrant, unaccompanied child, unaccompanied refugee minor, or asylum seeker. We hope our book will be helpful for clinicians and other providers working with any child or adolescent and his or her family who is contending with acculturation and a history of trauma and loss.

One final note on terminology: Children of refugees and immigrants who are born in the United States have full citizenship but often still contend with the challenges of navigating the distinct cultures inside and outside the home, and they may also feel the effects of intergenerational trauma. Thus, much of what is described in this book will be relevant to children raised in families of refugee or immigrant origin, even if they themselves are second-generation Americans.

REFUGEE AND IMMIGRANT JOURNEYS: PREMIGRATION, MIGRATION, AND RESETTLEMENT

The journey of many refugees and immigrants can be described in several discrete phases: premigration, migration (including time spent in refugee camps or detention centers), and resettlement. Although every journey is unique, here we describe experiences typical of each phase and how this may influence working with a child or adolescent refugee or immigrant.

Premigration

Premigration refers to the period of time prior to leaving one's home country. In some countries that generate large numbers of refugees, times of relative stability are quite recent, and the premigration period may have consisted largely of peace and stability until the onset of violence. For example, prior to the outbreak of civil war in 2011, children growing up in Syria might have easily presumed they were on a path to receive a full elementary and secondary education, continue to college, and establish a

career (Pearlman, 2017). Children from countries that only more recently experienced significant political and economic disruption may have strong educational backgrounds, and their parents may have obtained high levels of education (e.g., advanced degrees in medicine, law, and engineering) that may directly and indirectly aid them in navigating the resettlement process. Despite these educational and economic advantages, the relative loss of status for families who previously occupied a higher socioeconomic status—for example, one with a parent who worked as a physician and now works as a night-shift custodian—can be a major stressor and traumatic loss that can deeply affect families (Alemi, James, & Montgomery, 2016; Gans, 2009).

Some countries, in contrast, have experienced decades of upheaval and social instability. Children growing up in these contexts have never had the basic scaffolding foundational to healthy child development, such as functioning schools, clean water, safe neighborhoods, and an intact government. Refugee or immigrant children from settings of prolonged disruption may have had little or no formal education prior to resettlement, may have cognitive or health complications related to poor nutrition and sanitation, and may have lived in a state of chronic stress and adversity. Although these experiences may contribute to increased vulnerabilities that add to the challenges of resettlement, for some children and families resettlement may also offer opportunities that would never have been possible in their homelands. Girls from patriarchal cultures may see opportunities for leadership and equity (Abdi, 2014), and across families the opportunities for advancement and education may offer additional hope and motivation (Hauck, Lo, Maxwell, & Reynolds, 2014).

Clinicians will want to understand the nature of the premigration context. One key question to consider related to the premigration phase is, to what degree did the child know a life of stability and normalcy? Has the child grown up with an understanding of what a safe world looks like and, thus, can cognitively place the time of war and flight as a period of temporary disruption? Or has the child never known what it is like to be protected by laws and to be assured of food and shelter? Did early experience foster healthy development or was it beset by adversity? Understanding how a child fares in resettlement requires understanding what resources he or she had going into migration, as well as the challenges he or she currently faces (see Exhibit 1.2).

Migration

The decision to flee one's home country marks the beginning of the *migration* phase of the journey. For some this happens precipitously: an imminent

EXHIBIT 1.2. Key Questions About Premigration

- To what degree did the child know a life of stability and normalcy before migration?
- To what degree did the child have access to education, health care, good sanitation, security, and nutrition prior to migration?
- How long was the child exposed to adversity/instability prior to migration?
- Does the family view resettlement as holding new opportunities for themselves and their child?
- Did the caregiver experience a loss of professional status/opportunity?

threat of danger may lead to an unexpected departure with no chance to plan and gather belongings. Families may be separated. The period of flight is often exceedingly dangerous and may be marked by exhausting journeys, deprivation, chronic danger, and immense uncertainty (Lustig et al., 2004). For children who undertake this journey without their parents, whether because they flee alone as unaccompanied children or because of the separation and loss that is intrinsic to the brutality of war, their experience of migration may be one of even greater vulnerability (Derluyn et al., 2009). Remarkably, some parents are able to shield their children from the terrifying nature of the journey (Apfel & Simon, 1996). Regardless, the migration journey through which parents bring their children to safety is a testament to their strength and courage.

Immigrants crossing the border from Mexico and Central America sometimes face the double threat of both dangerous journeys and being financially beholden to violent criminal smugglers. For instance, travel by cargo train colloquially referred to as “La Bestia” is a common path for those seeking to cross into the United States via Mexico; interpersonal violence and injuries or deaths associated with falling from the train are common (Torres et al., 2018). Others suffer or die from dehydration and exposure to the elements (Fulginiti, 2008). Once in the United States, some “coyotes” (smugglers) seek to extort additional funds from families and have been known to murder people if they do not pay (Fulginiti, 2008). As noted above, others may be held in detention centers at the border, a process that may involve human-rights violations, separation from family, and uncertainty regarding deportation and family reunification (Brabeck et al., 2014). For some refugees the migration phase includes a stay in refugee camps. Refugees may live in camps for years or even decades while awaiting resettlement. Typically run by UNHCR, governments, or nongovernmental organizations (NGOs), refugee camps seek to offer shelter and food. Camps often are overcrowded, unsanitary, and dangerous (de Bruijn, 2009). Some refugee children will have spent much of their childhood in a refugee camp. Some camps offer

education for children; others do not, although camp residents may informally arrange classes for children (UNHCR, 2017).

Clinicians will want to understand the nature of the migration journey. What types of trauma did the child experience on his or her journey? Was the child separated from his or her primary caregivers during this period? Was the child deprived of food, water, and other basic necessities? If yes, for how long? Was the child held in a detention facility? Is the child feeling safe and settled in his or her current social environment? Or is the child still psychologically in the migration phase, or feeling as if he or she cannot set down roots because of uncertainties in his or her current legal status? Understanding this context will help the provider address not only the child's current symptoms, but also some of the underlying drivers that might be missed without understanding the migration experience and its ongoing impact on the child. (See Exhibit 1.3.)

Resettlement

The third phase of the refugee journey is *resettlement*. Although the word *refugee* contains within it the root *refuge*, the process of resettlement can itself be fraught with stress, disappointment, and—at times—trauma. Refugees do not get to choose where they resettle and are often resettled in low-resource communities (Rawlings, Capps, Gentsch, & Fortuny, 2007; UNHCR, 2018b). As is the case in many low-resource communities, exposure to crime and neighborhood violence is not uncommon (Hecker, Fetz, Ainamani, & Elbert, 2015). Furthermore, stress and mental illness—such as posttraumatic stress disorder (PTSD), depression, and anxiety—may inhibit some refugee or immigrant parents' capacities to parent effectively (Sangalang, Jager, & Harachi, 2017). The stress of acculturation itself may tear at families and introduce conflict and loss within the home. Although initial stressors of resettlement diminish over time, the experience of acculturating to a new home and culture is an enduring experience that may lead to different

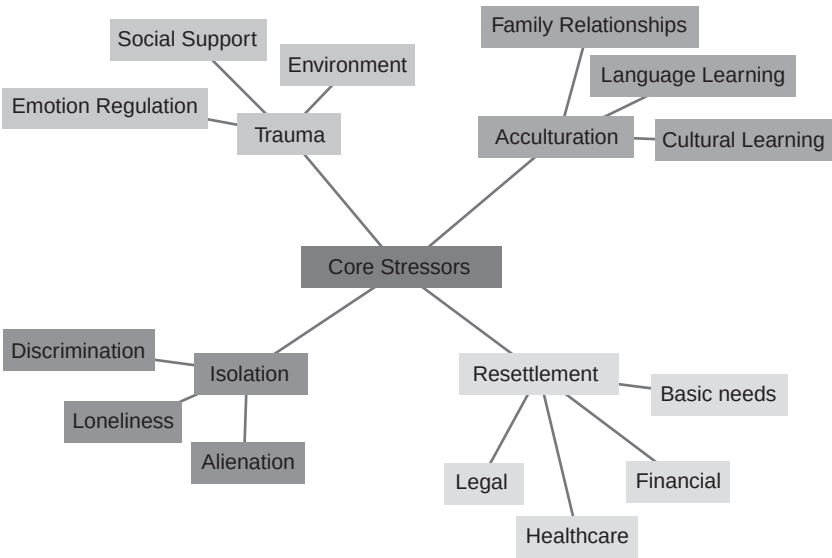
EXHIBIT 1.3. Key Questions About Migration

- How long was the journey (days, months, years, a generation)?
- Did the family stay in a refugee camp? If so, what camp, and what conditions?
- Did the child have access to any formal or informal education during this time?
- What kind of trauma and/or loss occurred along the way?
- Was the family separated during this time?
- Does the family have any financial obligations/demands that contribute to stress or risk?
- Is resettlement in this country legal or is the family at risk for deportation?

questions, stressors, or assets at different times in a youth’s development (Collie, Kindon, Liu, & Podsiadlowski, 2010).

Overall, the process of resettlement is marked by what we call the *four core stressors*: *trauma* (and the enduring emotional consequences of the adversity experienced preresettlement), *resettlement stress*, *acculturative stress*, and *isolation*. These stressors can create significant challenges to adaptation and development, but at times can also catalyze important growth or empowerment. For instance, experiences of discrimination have been tied to higher levels of civic engagement among some immigrants (Jensen, 2010; Stepick & Stepick, 2002), and trauma can lead to positive growth (Sleijpen, Haagen, Mooren, & Kleber, 2016). Thus, although it is important to consider sources of stress and ways of mitigating them, it is equally important to recognize the strengths being brought to bear in managing such stress. Next, we briefly describe the meaning of these terms and the research that points to their importance; throughout the book the four core stressors provide a framework for understanding, assessing and treating refugee children (see Figure 1.2).

FIGURE 1.2. Refugee and Immigrant Youth Core Stressors



From “Refugee Services Toolkit: Model of the Four Core Stressors That Contribute to Refugee Risk and Resilience,” by Refugee Trauma and Resilience Center, 2018 (http://www.childrenshospital.org/centers-and-services/programs/o_-z/refugee-trauma-and-resilience-center-program/training-and-resource-development). Copyright 2018 by Refugee Trauma and Resilience Center. Adapted with permission.

TRAUMA, MENTAL HEALTH, AND THE RESILIENCE OF REFUGEE CHILDREN

Fundamentally, being a refugee or forcibly displaced immigrant is a socio-political phenomenon, not a personal or psychological condition. As Papadopoulos (2007) noted, “There is a tendency by mental health professionals to approach the state of being a refugee as if it were a psychological, or indeed a psychopathological, state” (p. 302). Although experiences of trauma frequently pervade multiple phases of the refugee and immigrant journey, and refugee youth do present with clinically higher prevalence rates of stress-related psychological disorders than their nonrefugee peers (Fazel & Stein, 2003), being a refugee or forcibly displaced immigrant is not synonymous with being traumatized. As is true for other populations of traumatized children (Copeland, Keeler, Angold, & Costello, 2007), even for those refugee and immigrant children who have experienced significant traumatic events, these cannot be automatically assumed to be traumatizing experiences with associated mental health problems. It is important to recognize that refugee and immigrant children—like other children who have experienced trauma—frequently show tremendous resilience despite histories of severe adversity (Keles, Friborg, Idsøe, Sirin, & Oppedal, 2018; Masten & Narayan, 2012). For instance, in a study of 918 unaccompanied refugee adolescents in Norway, the majority were determined to be either “healthy” (41.9% showed low levels of depressive symptoms at multiple time points) or “resilient” (16.4% showed decreasing levels of depressive symptoms across time; Keller, Joscelyne, Granski, & Rosenfeld, 2017). Even among refugees who do experience significant mental health symptoms, it is not unusual to see high levels of functioning as well (Kinzie, Sack, Angell, Clarke, & Ben, 1989). This broader understanding of refugee and immigrant children as diverse beings with diverse experiences and, frequently, tremendous assets, is critical to bear in mind.

Recognizing that trauma does not define the refugee experience, it is nonetheless of central importance to the treatment and recovery of some youth. Some refugee and immigrant children have experienced the worst of what humanity can be and do and must face the challenges of resettlement while also struggling with the consequences of severe trauma and related mental health problems. Rates of trauma exposure for refugee youth vary greatly depending on their country of origin and individual experiences (Benjet et al., 2016; Keller et al., 2017). Rates of mental illness similarly range widely (Dimitry, 2012; Ellis, Lincoln, et al., 2010). So although it is important to meet each new child and family with an openness to what is most

important to them, for those who do experience mental illness in response to the stress and trauma of the migration experience, acknowledging and addressing past trauma may be critical to allowing them to move beyond it.

BEYOND THE TRAUMA LENS: RESETTLEMENT, ACCULTURATION, AND ISOLATION

Although trauma, both past and present, can be a significant factor in a refugee or immigrant child's adjustment, these experiences need to be understood in the context of other stressors that fundamentally shape the resettlement experience: resettlement, acculturation, and isolation. Children's social environments (e.g., family context, school, neighborhood, broader community) can be a source of strength and positivity for youth who are coping with psychological distress (Torres et al., 2018); however, these social ecosystems can also generate stress that impedes recovery (Porter & Haslam, 2005). It is essential, therefore, to assess the social environment and, if indicated, directly address environmental stressors as one component of treatment.

Resettlement stress refers to the challenges associated with accessing basic resources and services that families need, such as financial stability and health care. Although stress related to meeting these needs is not unique to refugees, accessing critical resources can be especially difficult for refugee families in a new and unfamiliar system. In particular, immigrant and refugee families may struggle to attain proper health care, legal assistance, financial stability, and basic resources such as clothing, housing, and food. Resettlement stress is associated with higher symptoms of posttraumatic stress disorder in refugees (Perera et al., 2013). For newly arrived families, immediate distress related to basic needs like food and shelter can often and understandably overshadow concerns about mental health. Providers can build trust and increase engagement with refugee and immigrant families by acknowledging and assisting with resettlement stressors. Subsequent chapters in this volume provide guidance on assessing (Chapter 4) and managing (Chapter 5) resettlement stressors in treatment.

Acculturative stress refers to the challenges inherent to adjusting to a new culture and language. These challenges include language fluency and the benefits associated with being fluent in a country's dominant language; comfort and fluency in the local language often unlock multiple pathways to economic and social opportunities in a new country. Even a decade after resettlement, higher language fluency is associated with greater odds of

employment and lower symptoms of psychological distress (Beiser & Hou, 2001). The acculturation process unfolds differently for newcomers based on a multitude of factors including age, socioeconomic status (SES), and country of origin. Members of the same family may adjust at different rates, with children learning the new language more quickly and more readily adopting cultural norms (Chudek, Cheung, & Heine, 2015). This can cause strain within families if children are perceived as too “Americanized” by the older generation or lose a common language with their family.

Families may also experience the fourth core stressor, *isolation stress*, as a result of discrimination, alienation, and loneliness. Social support and feelings of belonging can greatly bolster mental health, even in the face of extreme adversity, whereas isolation is recognized as a primary risk factor for psychological distress and early mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Reestablishing supportive social networks and fostering broader community narratives of belonging and acceptance can help children and families feel as though they belong in their new home.

Visible minority refugees and immigrants in the United States (e.g., people of color, Muslim youth who wear a hijab) may be especially vulnerable to experiences of discrimination and, consequently, poor mental health outcomes (Ellis, MacDonald, et al., 2010; Hadley & Patil, 2009). Many refugee youths occupy multiple historically marginalized social and cultural identities, and it is the dynamic interaction of these and other identities that form what these youths experience and how they are treated in their new home (e.g., Ellis, Lincoln, et al., 2018; Roxas & Roy, 2012). In Chapter 2, we examine how *intersectionality* (i.e., the interconnected nature of social-identity categorization) may be an especially effective framework when working with refugee youth.

Throughout this book, we use the framework of the four core stressors to understand common refugee and immigrant experiences and to inform effective clinical practice and intervention. This includes recognizing gaps of service and support in the social environment that can be directly addressed in treatment, as well as building on the individual and community strengths that refugee and immigrant youth and families demonstrate. Chapter 4 guides the reader through the process of assessing the family’s strengths and needs according to the four core stressors and integrating your findings into treatment planning. Chapters 5 and 6 suggest strategies and interventions to address these stressors in the social environment.

In summary, we introduced several organizing frameworks for conceptualizing the experiences and needs of refugees and immigrants. Formal legal categories divide immigrants into multiple categories including refugees, asylum seekers, unaccompanied children and undocumented

immigrants—each associated with different levels of vulnerability and assistance in resettlement settings. We explored some of the common challenges and risks refugees and immigrants face across the three phases of refugee migration journeys: premigration, migration, and resettlement. Finally, we pointed to the four core stressors of trauma, resettlement, acculturation, and isolation that can exacerbate psychological distress upon resettlement. Each of these frameworks helps to guide a clinician’s understanding of how the political and social environment shapes a refugee or immigrant child’s present functioning, and how intervention can best support a youth’s positive adaptation.