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1 INTRODUCTION TO REFUGEE MENTAL HEALTH

JAMIE D. ATEN AND JENNY HWANG

No one leaves home unless home is the mouth of a shark.

—Warsan Shire

Kasim, an Iraqi refugee in his late 30s, has been hospitalized after an attempted suicide. You are assigned his case and instructed to follow up with a contingency plan of assessing for further risks and enhancing stability. After Kasim's release from the hospital, his resettlement case manager asks specifically if you can do home visits. The case manager tells you that Kasim has lost a leg from a bomb that destroyed his town. After several years, he fled to Turkey with his family. His injury qualified as a disability, which expedited his resettlement case. However, because he was an adult at the time, only he was given permission for resettlement, meaning he had to leave his family behind. Although it has been more than 8 years since his resettlement, the case manager explains that his case is still open due to his disability and repeated suicide attempts.

When you arrive to Kasim's house, you notice that he has a grave countenance. You look around his apartment and see books, DVDs, and posters in Arabic. He tells you in broken English that "they" stopped giving him Social Security income, his only financial support. He tried to call the Social Security office but struggled to communicate. Without any money, he tells you he does not know how he will survive. He tells you of his recurring nightmares that keep him awake at night. When you ask him if he is part of the local Iraqi community or if he has any social support, he says Iraqis can't be trusted.

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Refugee Mental Health, J. D. Aten and J. Hwang (Editors)

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PURPOSE OF THIS BOOK

Are you a current practitioner or researcher already working with resettled refugees and looking for more resources? Are you a current student interested in working with refugee communities? Or are you simply interested in learning more about the mental health issues of refugee communities? Whatever your reason may be for picking up this book, we hope it can shed some wisdom, add some skill sets, and encourage you to become part of a community that cares for the millions of people who were forced out of their homes and are rebuilding their lives in a foreign land. Overall, advocating and supporting quality mental health care for resettled refugees is an interdisciplinary and collaborative effort. It relies on concerned practitioners and researchers who are willing to truly listen, engage, and be humbled throughout the process.

Over the past couple decades, the rhetoric supporting refugee mental health resources and services have fallen at two ends of the spectrum: the Westernized medical model and the broad ecological framework of understanding refugee communities. We believe both perspectives bring unique strengths and weaknesses to the overall refugee mental health field. Although the Westernized medical model often provides tangible and easily applicable solutions, it often fails to capture the comprehensiveness of the unique cultural and social experiences of refugees and often places the clients out of context from the factors that influence their mental health. On the other hand, the ecological framework addresses the layers of complexities of the refugee experience, emphasizing the importance of individual, community, and societal intersections. However, this perspective tends to fall heavy in theory and is challenging to translate into tangible actions. This book intends to bridge these seemingly polarized perspectives, introducing both practice-oriented and applicable interventions alongside ecological frameworks of understanding refugee communities.

Although we strongly support the need for quality mental health care for all refugees worldwide, this book focuses specifically on the mental health care intervention and literature for resettled refugees in countries with established mental health care infrastructure. By doing so, we are able to home in on the unique needs of resettled refugee communities and address their specific mental health care gaps. Furthermore, this book focuses on resettled refugee communities in efforts to introduce interventions with history of clinical efficacy. Our aim is to encourage and strengthen existing mental health care services to be genuine healing spaces where breaches of

trust and security can be restored holistically with the support of evidence-based interventions.

As the paradigm of mental health rapidly shifts toward alleviating the suffering for the socially vulnerable, we see limitations of traditional mental health care interventions (Miller & Rosaco, 2004; Mollica, 2006; Murray et al., 2010). To understand the way in which social vulnerability intersects with mental health, we must thoroughly examine the factors that create and perpetuate social vulnerability. Without doing so, we find ourselves in danger of overgeneralizing, pathologizing, and neglecting the importance of situational context. Refugees resettle into their new country economically disadvantaged, burdened with exposure to highly traumatic and stressful events, and most often with linguistic and cultural barriers. Life after resettlement may exacerbate existing conditions, subsequently increasing social vulnerabilities. Silove et al. (2017) recommended “Creative solutions are thus necessary, including networking of all agencies to ensure the sharing of responsibility of care for refugees with mental disorder” (p. 132).

This book aims to provide a creative and comprehensive compilation of frameworks and interventions that have been adapted and fine-tuned for various refugee communities. It brings together a diverse group of esteemed practitioners and researchers with extensive background in refugee mental health. In each chapter, readers are introduced to new and familiar intervention strategies and challenged to further contextualize them for their own use. Furthermore, readers will repeatedly examine the infrastructural injustices and systematic social vulnerabilities that impact refugee mental health today.

HISTORY OF THIRD COUNTRY RESETTLEMENT

Before diving into the current status and issues of refugee mental health care, we take our readers back to a pivotal point in history leading to the institutionalization of refugee resettlement.

Involving more than 30 countries, World War II, to this day, remains the deadliest of wars in human history (United Nations High Commissioner for Refugees [UNHCR], 2019a). It took nearly 50 million lives and displaced an estimated total of 40 to 60 million, including extirpated Germans (Zampano et al., 2015). When the United Nations formed in 1945, replacing the League of Nations, it established a new body, the International Refugee Organization (IRO) with the mandate of protecting existing refugee groups in Europe. By 1947, the United Nations Relief and Rehabilitation Administration (UNRRA)

was running nearly 800 resettlement camps throughout Europe (Bundy, 2016). Despite the insurmountable devastation, with the efforts of the IRO, UNRRA, and the Allied power, millions of displaced people returned home or emigrated and begin the process of rebuilding their lives. But for tens of thousands (known as “nonrepatriable refugees”), repatriation was not an option due to the possibility of persecution or ongoing political instability in their country of origin. Several of the Allied countries took in quotas of refugees, mainly as designated labor workers. With the passing of the Displaced Persons Act in 1948, the United States authorized entry for more than 200,000 displaced people (Refugee Council USA, 2019). From 1947 to 1951, the IRO resettled well over a million people (UNHCR, 2011).

The atrocities of World War II brought on a collective political will and an awakened sense of humanitarian responsibilities (Bundy, 2016). In 1948, the United Nations proclaimed the Universal Declaration of Human Rights, an agreement on 30 basic rights and fundamental freedoms to which all individuals are entitled with their personhood. Unofficially, it supported demarcating standards for forthcoming political dissensions and warfare. Influenced by the horrors witnessed from previous wars, the declaration outlines freedoms and rights that are most often violated in times of war, intentionally stripping individuals of their sense of security, dignity, and worth. And within these rights specifically addressed was *the right to asylum in other countries from persecution* (Article 14; Amnesty International, 2019).

By the 1950s, all displacement camps closed, along with the dissolution of the UNRRA. In 1951, a multilateral treaty, also known as the 1951 Refugee Convention, led to the formation of the UNHCR replacing the IRO. Much like its predecessor, the purpose of the UNHCR was to provide international protection to refugees and assist governments to find durable solutions for them (UNHCR, 2011). Along with its establishment came the institutionalized definition of a *refugee*: “someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion” (UNHCR, 2020). Any country signing to be a petitionary state of the convention agreed on the parameters of *who* is a refugee and a set of rights that comes with claiming refugee status. Embedded in the convention is a refugee’s right to security, work, education, housing, public relief, freedom of religion, issued identity and travel documents, and access to the legal system (UNHCR, 2019b). At the time of establishment, the institutionalized term and rights for refugees only extended to Europeans displaced by World War II. It was not until 1967 that an amendment was made to the 1951 convention upheaving geographic constriction as a criterion for refugee status. The amendment allowed for any person who has (a) a presence outside their home

country, (b) a well-founded fear of persecution (being at risk of harm is insufficient reason in the absence of discriminatory persecution), and (c) an incapacity to enjoy the protection of one's own state from the feared persecution to be considered a refugee (UNHCR, 2020). This definition remains unchanged and continues to be the universally accepted criterion for claiming refugee status.

Since its establishment, the UNHCR uses the following three options for permanent solution: voluntary repatriation, local integration, and resettlement. As noted earlier, resettlement was used extensively as a means of resolving the refugee crisis from World War II for those who definitively could not return home or stay in their temporary residence. Since its origin, however, resettlement has been the least preferred of the options because it is the costliest and most cumbersome of solutions. In the decades to follow, however, political agendas and urgent humanitarian needs repeatedly ceased in massive resettlement.¹ Nongovernmental organizations (NGOs) and international organizations played a prominent role in assisting the resettlement process. In efforts to collaborate with other key resettlement organizations, the UNHCR formed the Working Group on Resettlement (WGR), which consisted of resettlement States, UNHCR, and international organizations. WGR meetings became a platform to discuss resettlement policies and efforts to enhance the use of resettlement as a tool of international protection (UNHCR, 2011).

To this day, among the international community, resettlement is still considered the least preferred option, and priority is given to those who are in immediate danger or have serious disabilities. In 2018, there were 70.8 million forcibly displaced people worldwide, of whom 25 million were refugees. Of the 25 million, only 55,680 were resettled (UNHCR, 2019b). Repatriation being the favored solution, refugees wait on average 15 years before they are resettled. Over the years, the process of resettlement has developed into a lengthy and tedious process (Chapters 2 and 5 discuss this more extensively). Once refugees enter their resettlement country, they leave the jurisdiction of international law and protection and become dependent on their resettlement country's infrastructure. Receiving countries, as petitionary states to the refugee protocol, have a responsibility to promote the well-being and dignity of refugees. As historically indicated, refugees needing resettlement are most often the ones in the direst of circumstances, which understandably elicits more complex psychological and emotional concerns.

¹In the 1960s, thousands of Cubans sought refuge to flee the administration of Fidel Castro. In the 1970s, after the Vietnam War, hundreds of thousands of Vietnamese refugees were resettled. The United States also resettled hundreds of thousands of former Soviet Union citizens from the 1970s to the 1990s. In the 1990s, hundreds of thousands of Iraqi refugees fleeing the Gulf War were resettled.

LIFE AFTER RESETTLEMENT

Many resettlement countries use the 1951 convention and the 1967 amendment as principles for their refugee resettlement policies. Along with the further establishment of human rights advocacy groups and the expansion of WGR, quality of care and services for resettled refugees has improved tremendously. Resettlement countries, whether through government established programs or collaborative NGO networks, aid resettled refugees to access their right to security, work, education, housing, public relief, freedom of religion, identity and travel documents, and to the legal system. In receiving access to these rights, resettled refugees are expected to rebuild their lives and integrate into their new country. But establishing normalcy after years of exposure to violence and uncertainty can be challenging, especially across language and cultural barriers and post-resettlement difficulties (further discussed throughout this book). Rebuilding a life that has been tumultuously upheaved by factors outside one's control is inevitably an idiosyncratic process.

For some resettled refugees, mere access to basic rights may suffice to seamlessly acculturate into their new lives. But for many others, years of research and thousands of recorded narratives indicate a need for deeper interventions and more diverse healing opportunities.

MENTAL HEALTH THEMES FOR RESETTLED REFUGEE COMMUNITIES

Early studies conducted among Southeast Asian refugees found that addressing mental health issues of refugees is an important aspect of their assimilation to resettled countries (Ying & Akutsu, 1997). In the following 2 decades, there was a burgeoning of epidemiological studies in the refugee mental health field (Silove et al., 2017). Hundreds of studies have examined patterns of psychiatric symptomatology and the effects of ongoing stressors related to displacement (Miller & Rasco, 2004); these studies collectively indicate post-traumatic stress disorders (PTSD) and depression as the two most prevalent disorders in refugee populations (Steel et al., 2002). Meanwhile, systematic reviews suggest that refugees who have resettled in Western countries (such as the United States or Canada) are as much as 10 times more likely to have developed PTSD compared with the general population (Fazel et al., 2005).

It is important to note, however, that the studies do not suggest that all refugees have or will develop PTSD or depression. In a population-based study in 2002 of Vietnamese refugees residing in Australia, researchers found that the majority were free from overt mental illness and existing trauma-related

mental illness seemed to reduce over time. Nevertheless, the study also noted that a subgroup of people with a high degree of exposure to trauma had long-term psychiatric morbidity such as depression, anxiety, and PTSD (Steel et al., 2002). These findings resonate with the majority of the existing research that link the degree of the traumatic experiences to the severity of trauma symptoms (Mollica et al., 1993; Norris, 1992). By referencing these studies, it is important to acknowledge their limitations even ones claiming positive cross-validity and reliability tests. According to ecological frameworks on refugee mental health, individual PTSD symptomatology is only one layer to which traumatic experiences can manifest in refugee communities. In their book *The Mental Health of Refugees: Ecological Approaches to Healing and Adaptation*, Miller and Rasco (2004) stated that

acknowledging the presence of trauma within individuals in no ways contradicts the idea that trauma may also occur as a psychosocial phenomenon that affects entire communities and their underlying fabric of social relationships. (p. 8)

In particular, traumatic exposure to political violence, which many refugees experience, can elicit the development of complex trauma (Herman, 1997). As more research elucidates the impact of post-resettlement issues on the mental health of resettled refugees, we see a shift in the research agenda toward understanding post-resettlement social and economic conditions (Chapter 6 discusses this in more detail). Kim (2016) noted that a lack of reserved resources and community support at the beginning of the resettlement period reflects economic challenges for refugees even decades after they have resettled.

At this point, we reiterate why bridging the medical model perspective and the ecological frameworks can provide both a comprehensive and applicable understanding of refugee mental health needs. By taking an ecological framework to initially grasp the context to which mental health needs exist and cultivate in diverse refugee communities, existing mental health resources and treatment modalities can be appropriately adapted and implemented. In this process, practitioners and service providers can also recognize limitations in services and strategically advocate for better suited treatments. In efforts to leverage both the medical model and the ecological perspective to refugee mental health, this book examines the following:

- research and case studies on the efficacy of Western therapeutic interventions,
- best practices in providing culturally appropriate services,
- examples of ways to culturally adapt existing mental health care services, and
- ecological frameworks for providing holistic care.

CHALLENGES FOR REFUGEE MENTAL HEALTH INTERVENTIONS

We acknowledge that practice-based evidence in the area of refugee-related interventions is still in its emerging stages despite the availability of a small number of meta-analytic studies examining prevalence of mental health disorders (Fazel et al., 2005; Porter & Haslam, 2005). The demographics of resettled refugees fluctuate each year, making interventions and research catered for a particular ethnic group potentially inapplicable or ineffective (Birman et al., 2008). Birman et al. (2008) stated that “with the unpredictable and under resourced circumstances that confront service providers daily, make it extremely difficult to develop manualized procedures, define a homogeneous sample, and conduct controlled trials” (p. 122). Despite these challenges, we believe practitioners and researchers share a responsibility to continue efforts to enhance services and foster thriving conditions for resettled refugee communities.

RECOMMENDATIONS FOR USE OF INTERVENTIONS

The guidelines in providing mental health services for refugees have also been a challenge. The diversity and the idiosyncrasy of the refugee experience along with the fluctuating circumstances that force people into refugee status concocts difficulty for standardization of best practice guidelines. Existing resources on refugee mental health recommends a need to take a holistic approach on refugee mental health, bringing the persons in context and fostering the innate wisdom and strengths existing with refugee communities (Murray et al., 2010). So how do mental health professionals bring culturally diverse clients in context? How can we foster innate wisdom and strengths existing within the refugee communities? And how do we take our Western interventions and put them in appropriate context? Birman et al. (2008) stated that because of the challenges of catering to broad and dynamic populations, refugee mental health programs are recommended in the development of generalized principles of “multicultural competence,” or an approach that attends to specific cultural perspectives, needs, and circumstances but can be used across diverse cultural groups. Thus, we recommend to readers the following principles outlined by the 2017 American Psychological Association (APA) Multicultural Guidelines to maximize the efficacy of this book:

- Seek to recognize and understand that identity and self-definition are fluid and complex and that the interaction between the two is dynamic.

- Psychologists [mental health professionals] aspire to recognize and understand that as cultural beings, they hold attitudes and beliefs that can influence their perceptions of and interactions with others as well as their clinical and empirical conceptualizations. As such, psychologists strive to move beyond conceptualizations rooted in categorical assumptions, biases, or formulations based on limited knowledge about individuals and communities.
- Psychologists [mental health professionals] strive to recognize and understand the role of language and communication through engagement that is sensitive to the lived experience of the individual, couple, family, group, community, or organizations with whom they interact. Psychologists also seek to understand how they bring their own language and communication to these interactions.
- Psychologists [mental health professionals] endeavor to be aware of the role of the social and physical environment in the lives of clients, students, research participants, and/or consultees.
- Psychologists [mental health professionals] aspire to recognize and understand historical and contemporary experiences with power, privilege, and oppression; as such, they seek to address institutional barriers and related inequities, disproportionalities, and disparities of law enforcement, administration of criminal justice, educational, mental health, and other systems as they seek to promote justice, human rights, and access to quality and equitable mental and behavioral health services.
- Psychologists [mental health professionals] seek to promote culturally adaptive interventions and advocacy within and across systems, including prevention, early intervention, and recovery.
- Psychologists [mental health professionals] endeavor to examine the profession's assumptions and practices within an international context, whether domestically or internationally based, and consider how this globalization has an impact on psychologist's [mental health professionals] self-definition, purpose, role, and function. For example, Western-educated mental health professionals learn to understand positive and maladaptive human behavior and psychological processes in the context of Western society. In countries like the United States, self-reliance, self-efficacy, self-actualization, and self-care are emphasized as positive deterrents for functioning. In many cultures, however, the concept of self-psychology is interpreted differently. So as society becomes increasingly more globalized, it is imperative that mental health professionals are

aware that their understanding of human behavior is simply part of a bigger narrative.

- Psychologists [mental health professionals] seek awareness and understanding of how developmental stages and life transitions intersect with the larger biosociocultural context, how identity evolves as a function of such intersections, and how these different socialization and maturation experiences influence worldview and identity.
- Psychologists [mental health professionals] strive to conduct culturally appropriate and informed research, teaching supervision, consultation, assessment, interpretation, diagnosis, dissemination, and evaluation of efficacy.
- Psychologists [mental health professionals] actively strive to take a strength-based approach when working with individuals, families, groups, communities, and organizations that seeks to build resilience and decrease trauma within the sociocultural context. (American Psychological Association, 2017)

OVERVIEW OF THE CHAPTERS

Like any therapeutic work, the process is not linear but involves many detours, impediments, and adaptations. As you read through the chapters of this volume, you will hear from an array of practitioners and researchers who have dedicated their profession to the cause of refugee mental health. Each chapter is based on the authors' clinical experience and supported by existing research and literature. Each chapter is meant to be comprehensive with the acknowledgment that supporting mental health of refugees means work within the walls of the clinic and in the community, whether that means working alongside cultural navigators, conducting home visits, or even doing advocacy work. The chapters are intentionally curated to bridge the medical and ecological approach to refugee mental health by addressing important topics within both disciplines. Each chapter begins with a brief introduction on the scope of the refugee crisis as it relates to the contents of the chapter.

In Chapter 2, Hilado, Reznicek, and Allweiss provide a broad context for understanding the current refugee crisis. The authors examine the current political climate and the global trend in displacement and its impact on refugee resettlement. Furthermore, the authors highlight the political instability of three specific countries—the Democratic Republic of Congo, Myanmar, and Syria—to explain the staggering number of refugees fleeing from these

countries. The chapter chronicles the tedious third country resettlement process, which begins from the protracted time in refugee camps and ends with the final resettlement in a new country. As clinicians and researchers based in the United States, the authors focus specifically on the U.S. resettlement procedure. The authors outline several common mental health challenges resettled refugees face during the resettlement process. The chapter ends with a case vignette based on the authors' clinical experience.

In Chapter 3, the authors introduce the vital role humility plays when working with refugee clients and communities. Humility—more specifically cultural humility—has been shown to be critical in working with diverse clients. The authors explore the ways in which mental health professionals can become more self-aware by examining power differences, privilege, and the influence of Western notions of helping. Captari et al. discuss why humility is important to work with cultural differences while providing concrete recommendations for cultivating mental health professional humility. The chapter discusses navigating possible cultural differences, challenges (e.g., mental health stigma), and even mistakes in therapy. A case vignette and a self-awareness exercise are provided. Readers will be challenged to see themselves, refugee clients, mental health issues, and treatment from the perspective of refugees.

In Chapter 4, Singer, DeBoard-Lucas, and Pujeh discuss common ethical issues and dilemmas faced in providing mental health services to refugees. The authors introduce the inevitable gray areas when working with refugee populations and offer ethical guidelines that can help navigate these specific waters. Singer et al. present the applicability of the American Psychological Association Ethical Principles of Psychologists and Code of Conduct when working with refugees and also provide a translation of the World Health Action Plan Guidelines into the domestic context. The authors also discuss culturally sensitive ways to respond ethically to presenting problems that the average mental health professional likely has not encountered. Lastly, they help readers to be mindful of therapist's role and presence and how those in itself may raise ethical dilemmas.

In Chapter 5, Bemak and Chung expand on Chapter 2 to discuss the broad trends in displacement. The authors delve specifically into the modern-day challenges refugees face and how those unique challenges impact their overall mental health and life after resettlement. Bemak and Chung discuss the factors influencing refugee mental health interventions such as cultural beliefs on mental health and employing translators and interpreters. The authors also cover the challenges of facilitating Westernized mental health interventions to individuals and communities who are rooted in more collectivist and holistic cultures. Lastly, they present a comprehensive framework

called the multiphase model (MPM) of psychotherapy, social justice, and human rights that encapsulates the complexities of the refugee experience into treatment. The chapter ends with case study examples of using the MPM model.

In Chapter 6, Mollica, Augusterfer, and Campanile begin with a review on the magnitude of the mental health problem for traumatized refugee populations. The authors then introduce examples of emerging evidence-based and culturally adapted therapeutic interventions such as cognitive behavioral therapy, eye movement desensitization and reprocessing, and narrative exposure therapy. This chapter explores the concept of healing and the ways in which alleviating human suffering, especially suffering experienced by refugee communities, involves employing a vast range of psychology, social, cultural, and economic practices. This chapter discusses a new healing model called healing environment and restorative therapy (HEART) where readers build on a universally used basic model of humanitarian relief.

In Chapter 7, Tay and Silove begin with an overview of the modern refugee mental health research. They proceed to discuss the way in which research on refugee mental health shapes and guides the current methods of screening and assessing refugee mental health. The authors introduce the strengths and limitations of various assessment tools and models. Furthermore, Tay and Silove provide evidence-based research on complex refugee mental health needs such as complicated bereavement and explosive anger. They present common refugee mental health needs that service providers should be mindful of when facilitating assessments. Last, Tay and Silove outline how mental health professionals can move toward an evidence-based multilevel approach to refugee mental assessment.

In Chapter 8, Fazel draws from her years of clinical and research experience in working with refugee children. She discusses the ways in which schools can play an integral part in administering mental health care services for refugee children. The author provides both clinical and research support for school-based interventions as well as their limitations. With growing evidence in favor of expressive therapies for trauma-exposed children, Fazel discuss the ways in which different types of expressive therapies (e.g., theatre, music, art, sandplay, narrative exposure) can benefit refugee children, citing empirical evaluations for these interventions. The chapter concludes with the recommendation and need for more empirical evidence to support more expressive therapy programs and school-based interventions for refugee children.

In Chapter 9, Hilado, Chu, and Magrisso encourage readers to diversify treatment settings by working with family units and fostering healthy familial

bonds. They discuss how the refugee experience and post-resettlement issues can shift family dynamics and cohesion and consequently cause psychological distress and tension. With research supporting the moderating factors early childhood interventions can have in mental illness prevention, the authors emphasize treatments specifically for families with young children. Readers are introduced to a brief historical background on the treatment models then to their applicability for refugee families. To help readers with contextualization, Hilado et al. draw from their clinical experiences to provide case vignettes for each treatment model. The authors conclude with the benefits and limitations of working with refugee families.

In Chapter 10, Allweiss and Connelly discuss the value of community-based and peer group interventions in fostering sustainable and empowering mental health wellness among refugee populations. Barriers to services are discussed, along with the suggestion of facilitating group psychoeducation classes to lessen those barriers. The authors draw from their direct clinical experience working with RefugeeOne, a refugee resettlement agency in Illinois, to provide examples, benefits, and challenges of administering peer, group, and community-based interventions. They describe successful interventions and their applicability throughout the chapter.

In Chapter 11, Marshall explores the way in which indigenous methods of healing can be integrated into Western therapeutic interventions. The author examines how availability and accessibility of mental health services are not the only impasse for refugee populations in receiving mental health care and how critical the role of cultural understanding of healing plays in working cross-cultural settings. Ecological studies indicate that integrating indigenous methods of healing, such as cultural and religious rituals and cultural practices and beliefs, into existing services could enhance receptivity and provides more effective outcomes (Herman et al., 2005). Marshall provides a variety of ways therapists can blend indigenous or traditional ways and knowledge into existing mental health therapy, demonstrating a multifaceted, hybrid approach. Throughout the chapter, the author provides case studies exemplifying an integrated approach in promoting well-being in refugee populations.

In Chapter 12, Aten, Hwang, and Annan conclude the book by reflecting on the themes and trends from the previous chapters. We discuss the current gaps in refugee mental health services and the research that supports evidence-based interventions specifically for refugee populations. Limitations in the clinical and research settings are discussed, along with suggestions for improving clinical skills and training needed to enhance practice competencies. We offer recommendations for existing refugee mental health programs and provide resources for practicing mental health professionals as well as those in

training. Lastly, we highlight the importance of advocacy and its challenges in promoting refugee mental health wellness.

Throughout this volume, all case studies discussed are either fictional or composites, or the client identities and names have been altered to preserve their confidentiality.

CONCLUSION

In compiling *Refugee Mental Health*, our hope is for readers to become aware of the complex intersection that defines the well-being of millions of refugees. As in the case of Kasim at the beginning of this chapter, understanding the refugee experience means exploring the indiscernibly connected past, present, and future. Our aim is to present readers with mental health interventions and strategies that have been adapted and derived to encompass the multiplicity that underlines refugee well-being. This book is not intended to be a definitive methodology for refugee mental health but rather a collection of best practices to help guide practitioners to provide quality and appropriate services.

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