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Connecting Cultures: A training model promoting evidence-based psychological services for refugees

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Abstract

Training clinical psychology graduate students in providing effective psychological services to refugees can be extremely complex. The training approach requires a culturally sensitive framework, potential modification of empirically validated techniques, and flexibility on the part of trainees and supervisors. Connecting Cultures is a program that creates a culturally sensitive context from which trainees can learn to effectively work with refugees within a social justice framework and the ecological model of human development. Connecting Cultures graduate students provide both community-based outreach and direct clinical services to meet the mental health needs of refugees in the Northeast region of the United States. The primary aim of this manuscript is to provide an overview of Connecting Cultures' training and supervision model, highlight the importance of working with cultural consultants, interpreters, and community elders, and discuss the impact this work has on clinical psychology graduate students. A secondary aim is to describe our method for evidence-based psychological assessment and to present preliminary outcome data from our graduate students. Strengths of the Connecting Cultures program include its clinical and research efforts with refugees from over 20 countries, and its ability to flexibly incorporate alternative therapeutic frameworks such as Acceptance and Commitment Therapy. Finally, the manuscript concludes by providing the implications of our work in attempting to meet the mental health needs of refugees after resettlement.

Keywords

Refugees; social justice; ecological model; culturally sensitive; clinical science

Since 1990, there has been a dramatic increase in the number of refugees and asylum seekers in the United States (US) with 280,996 residing in the US as of January 2013 (UNHCR, 2013). Although refugees and asylum seekers present with much resilience and strength (Miller & Rasco, 2004), they have often endured severe hardships including torture and other traumatic events (Campbell, 2007; Porter & Haslam, 2005). While refugees and asylum seekers (from here referred to as refugees) face similar struggles in the US, asylum seekers have the unique stress of not being granted legal status (Herrman, Kaplan, & Szwarc, 2008; Tribe, 2002). The mental health concerns of refugees can be far reaching,

affecting their family members and extending into their new communities within which they are attempting to re-build their lives. Failing to adequately address mental health concerns can lead to re-traumatization, poverty, discrimination, and unsuccessful integration (Campbell, 2007; Miller & Rasco, 2004). Providing effective psychological services to this population can be extremely complex and requires a culturally sensitive framework, potential modification of empirically supported treatments, and overall flexibility on the part of clinicians (Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). These and other challenges raise the question: “How can we best teach clinical psychology predoctoral clinicians and interns to work with refugees as part of their clinical training?”

This manuscript first proposes that a social justice framework (Fondacaro & Weinberg, 2002) and the ecological model of human development (Bronfenbrenner, 1994) provide a culturally sensitive context from which predoctoral clinicians and interns (from here referred to as graduate students) can learn to effectively work with refugees. Next, a review of the cultural aspects of working with refugees is provided. Connecting Cultures is then introduced as a program designed to meet the mental health needs of refugees, while providing unique training opportunities for graduate students. The supervision and training model utilized by Connecting Cultures is described, followed by our use of Cultural Adaptations for Refugee Engagement (CARE), and our method for evidence-based psychological assessment.

Social Justice Framework and Ecological Model of Human Development

A social justice framework (Fondacaro & Weinberg, 2002) emphasizes a social ecological epistemology and provides a culturally sensitive context in which graduate students can learn to engage with refugee communities at multiple levels and simultaneously utilize their clinical and scientific training. This framework emphasizes community voice, while acknowledging multi-agency professional expertise, and evidence-based prevention, intervention and evaluation strategies. Given that refugees likely have experienced multiple traumas, loss of power and control, as well as numerous family and community stressors (Campbell, 2007; Porter & Haslam, 2005), the ecological model is particularly useful as it promotes intervention at the micro, meso, exo, and macro levels, and ensures that individuals are viewed within the context of their social environments (e.g., current community, country of origin) (Bronfenbrenner, 1994).

Miller and Rasco (2004) specifically apply this model for refugee mental health and emphasize the ecological principles of community intervention, prevention, empowerment, local values and beliefs, and priorities of the community. Based on these principles, a graduate student might meet with an individual, a family, school personnel, cultural consultants, or attend a community-based function such as a celebration, wedding or funeral. Graduate students are also encouraged to understand the socio-political impact of their work and possibly engage with policymakers via scientific research findings (macro level). A primary strength of the Connecting Cultures program is that it requires graduate students to learn evidence-based practices along with gaining skills in continuing to modify treatments based on their work with community members and multiple stakeholders. Re-visiting the framework and model that form the basis of the Connecting Cultures program throughout

training is essential. While this has sound theoretical basis, the authors acknowledge the complexities involved in the actual practice.

Unique Cultural Aspects of Working with Refugees

Refugees represent a unique cultural group as they have often experienced multiple past traumas including terror associated with war conflict, loss of loved ones, and physical and psychological torture (Campbell, 2007; Wojcik & Bhugra, 2008). Moreover, they struggle with re-settlement stressors, and post migration challenges such as language barriers, employment and housing difficulties, and racial discrimination (Carswell, Blackburn, & Barker, 2011; Chung, 2001; Herrman et al., 2008). An important unique aspect of working with this population is the relative unfamiliarity they have with the mental health system as defined by Western society (Gong-Guy, Cravens, & Patterson, 1991). Similar to findings in the literature, we have found that refugees usually do not seek treatment at mental health clinics by their own initiative. Therefore, it is imperative that exo and macro-level interventions are integrated with services (Miller & Rasco, 2004). For example, focus groups, informal discussions with elders, interpreters, and other refugee community members (e.g., Somalia, Bhutan, Burundi, and Iraq) are critical steps to building relationships, safety and eventual trust of professionals associated with mental health training clinics. Refugee focus group members describe mental health problems most commonly as meaning “crazy” and emphasize psychotic features of severe mental illness possibly underlying some of the reluctance to seek mental health services (Gong-Guy, et al., 1991). Graduate students learn to break down some of these barriers by intervening at the community (exo) level in a respectful dialogue.

Connecting Cultures: Psychological Services

Connecting Cultures is a specialty service within a non-profit training clinic for graduate students working toward their doctoral degrees in clinical psychology. Connecting Cultures was established in 2007 and designed to promote wellbeing through the provision of mental health services for refugees with four unique components providing an integrated culturally sensitive approach to mental health services including: 1) community-based outreach services; 2) direct clinical services; 3) mental health research and evaluation; and 4) professional training.

Community-Based Outreach Services

Working with community elders is a first step in the outreach component of Connecting Cultures. In fact, outreach is the cornerstone of our program and we believe Connecting Cultures would not exist if we did not spend over two full years listening and talking with elders, interpreters, and community members from varying refugee populations in their environments (e.g., Somali Bantu Community Association and Bhutanese Association). After establishing trusting relationships, we began identifying ourselves as “talking doctors or talking doctors in training,” a term readily accepted by various communities. As trust was further developed, community members started to request psychological services at our clinic. We were initially concerned by the fact that our students and staff did not originate from refugee communities. Fortunately, this has not presented an insurmountable challenge.

While this issue is complex, most refugees are accompanied by trusted interpreters, and have been referred by elders in their community. When clients express initial fear of the clinic we provide services in their homes. Typically families present at the clinic after relatively short periods of home visits (~3 months) and this process has allowed us to reach clients who otherwise would not have received services.

Graduate students learn to establish rapport with individuals from different refugee groups by stepping into environments that are not their own such as local community agencies. They have the opportunity to lead community events such as breakfast discussions about parenting in the US as compared to other countries in which they learn early on that food can be a universal way of connecting and sharing (Savin & Martinez, 2006). Graduate students have been invited by refugee groups to attend refugee cultural events such as Somalia Independence Day, Bhutanese Puja (a Hindu ritual honoring the gods), and Tazaungdaing (a Burmese Festival of Lights occurring every year of the eighth month of the Burmese Buddhist calendar on the full moon day). Less experienced graduate students are paired with experienced clinicians when engaging in these activities. These events typically represent the first *in vivo* exposure graduate students have to refugee populations.

Direct Clinical Services

In addition to outreach services, graduate students are also trained to provide direct clinical services. Connecting Cultures has provided direct psychological services to refugees from over 20 countries of origin from all over the world including Sub-Saharan Africa, Europe, Middle-East, Asia, South East Asia, and South America. Specific countries include: Bhutan, Somalia, Bosnia, Burma, Congo, Sudan, Iraq, Democratic Republic of Congo, Burundi, Nepal, Angola, Iran, Dominican Republic, Honduras, India, Kenya, Mexico, Moldova, Morocco, Rwanda, South Sudan, Thailand, Vietnam, and Zimbabwe.

Individual Treatment Services

Given the trusting relationships established with refugees over the years, many individuals and families have reached out to the clinic for psychological services. Services in the clinic focus on concerns raised by refugees, including symptoms related to posttraumatic stress, depression, and anxiety. Additional concerns include acculturation, dealing with torture, grieving the loss of loved ones, and poverty, amongst many others (Wojcik & Bhugra, 2008). We are committed to providing best practice evidence-based treatment while listening to client needs and modifying our services to ensure client-centered and culturally sensitive treatment. This integration was initially challenging as our therapeutic frameworks first included those focused primarily on symptom reduction, such as Cognitive Processing Therapy (CPT) (Resick & Schnicke, 1992) and Narrative Exposure Therapy (NET) (Schauer, Neuner, & Elbert, 2011), designed specifically for individuals in refugee camps with post-traumatic stress.

Currently, we integrate a guiding clinical framework known as Acceptance and Commitment Therapy (ACT) (Harris, 2009; Hayes & Strosahl, 2012). ACT has been extremely useful as it is value-driven, strength-based, and allows a respectful collaboration between clinician and client. Moreover, ACT uses mindfulness techniques, metaphors and

additional strategies that easily transcend cultural bounds. This clinical framework helps us to emphasize non-judgment by the clinicians and focus on values or “what is important to the client” and not only on symptom reduction. It does not focus on psychopathology but rather on the struggles of humanity. Graduate students emphasize the resilience of refugees, personal strengths, safety, coping skills, sleep hygiene, grounding, and social support.

Group Treatment Services

Graduate students receive specific training for survivors of torture groups lasting 12–16 weeks and designed to aid survivors of torture in learning about and dealing with the impact of torture. These groups for posttraumatic stress and post migrations stressors experienced by survivors of torture include NET and ACT with an emphasis on safety (Herman, 1997). A treatment manual is currently being prepared.

Connecting Cultures: Supervision and Training Model

Connecting Cultures provides integrated training and supervision. Supervision includes individual and vertical team components, formal case presentations, and attending to vicarious trauma, vicarious resilience, and self-care. The training model includes working with interpreters, cultural liaisons, and learning about cultural perspectives on mental health.

Students in the clinical psychology program or internship are self-selected for this supervision model in that they express interest in working with refugees. Interestingly, graduate students seem to know intuitively if they want to be involved. Sixty-five percent of all graduate students in our clinic expressed interest in Connecting Cultures this year even with the knowledge that the required emotional and physical time is well beyond that of the rest of our specialty services.

Supervision: Individual and Vertical Team

Licensed-doctoral level clinical psychology faculty with expertise in trauma, and working with refugees provide weekly individual supervision. Weekly vertical team (i.e. group) supervision involves case supervision by the director of Connecting Cultures. Graduate students at each level of training (1st through 5th year) and internship year are typically represented on the vertical team with sequentially greater expectations of the more senior students. First year students observe individual and group treatment while second year students work with at least two individual clients on their own. Third through fifth year students (including interns) may provide services for up to 10 clients along with group treatment. Since it is emotionally draining to conduct exposure techniques with survivors of torture, clinical intensity is titrated by the number of clients and the clinical severity (e.g., suicidality, torture experiences) with interns having the greatest responsibilities of caseload and peer supervision of junior colleagues.

Supervision: Formal Clinical Presentations

Formal clinical presentations by graduate students are conducted using a consistent format in order to enhance retention of country conflicts and cultural adaptations. The presentation outline includes: 1) Visual map of the country; 2) Brief history of the country and war

conflict; 3) Presenting problem (as stated by client and traditional “western diagnoses”); 4) Pre-assessment results; 5) Treatment plan via traditional empirically validated treatment; 6) Cultural Adaptations for Refugee Engagement; and 7) Post assessment results after intervention.

Supervision: Attending to Vicarious Trauma, Resilience, and Self-Care

Throughout supervision graduate students are encouraged to attend to vicarious traumatization, vicarious resilience, and to prioritize self-care. Vicarious traumatization is the transformation in the clinician or trauma specialist that results from empathic engagement with traumatized clients and their reports of traumatic experiences (McCann & Pearlman, 1990). Vicarious traumatization represents the negative impact on the provider when working with a traumatized population. This phenomenon, referred to as secondary traumatic stress or compassion fatigue (Figley, 1995), is experienced in our program, as most of our clinicians report being negatively impacted by our work. For example, each of our providers has reported nightmares, fear, and intrusive images associated with working with this often severely traumatized population. The emotional intensity of the clinical material can sometimes be traumatizing for clients, interpreters, and therapists, especially when exposure techniques are being used, or when an individual is reporting a torture story. For example, a senior clinician experienced intrusive images of her own child’s decapitated head in her arms after hearing a story from a torture survivor describing the witnessing of systematic be-heading of civilians in which a mother was forced to hold her child’s head before being killed herself. Repeating the story to the team and experiencing the emotions associated with this horrible scene was helpful in reducing the images over time.

In addition to vicarious trauma, graduate students and supervisors have all reported experiencing vicarious resilience (Hernandez, Gangsei, & Engstrom, 2007). Vicarious resilience represents the empowerment experienced by providers when hearing stories of resilience expressed by their clients. The elements include the therapist’s subsequent reflection on human beings’ capacity to heal and the significance of the therapists’ own problems. For example, when one of our therapists was diagnosed with cancer, she did experience the expected emotions such as fear and sadness. However, she also felt quite hopeful in her shifted perspective as she thought of the many refugees with whom she had worked and their sustained resilience in the face of horrific circumstances. The fact that many of our refugee clients have survived severe trauma and torture sometimes displays our own hardships in a relatively easier light. At Connecting Cultures, we believe that discussing vicarious resilience also helps in our ability to cope with vicarious trauma. Our graduate students have reported experiencing vicarious resilience and we are learning how to utilize this process in promoting positive mental health and support of our clinicians. As we eagerly wait for more literature on this topic, we continue to focus on self-care.

Self-care is an integral component of clinical competence and supervision (Wise, 2008). It became evident that the team engaged primarily in discussions of trauma and torture and did not initially spend other time together. The Connecting Cultures self-care committee has brought team members together for cooking dinners, yoga, a ping-pong tournament, and other joyful and relaxing events.

Training: Working with Interpreters

An important yet challenging clinical skill for graduate students at Connecting Cultures is utilizing interpreters. Graduate students are trained in important interpretation issues such as multiple roles, therapeutic alliance, the therapy triad, and vicarious trauma (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005). Useful guidelines exist for working with interpreters (Tribe, 1999, 2002; Tribe & Lane, 2009) and the literature is replete with challenges associated with medical and mental health interpreting (Kravitz, Helms, Azari, Antonius, & Melnikow, 2000). While our experiences with interpretation have been quite challenging, they have also been rewarding. One challenge is our limited access to professional interpreters extensively trained in mental health services. Rather, our pool of interpreters primarily includes community members who speak the language of our clients and are identified as community or “ad hoc” interpreters (Brisset, Leanza, & Laforest, 2013). Some challenges have included the interpreter attempting to take the role of therapist, and the interpreter missing scheduled appointments. These problematic situations have been addressed quickly, professionally and involved direct communication with our interpreters. If a client were to express concern about possible breaches of confidentiality we would no longer utilize that interpreter. These concerns are actually quite rare but have been raised. Our experiences to date suggest that problematic behaviors have decreased over time with increased communication with interpreters. Indeed, a recent meta-ethnographic review by Brisset and colleagues (2013) has revealed the value of ad-hoc interpreters as having emotional proximity, and being appreciated and viewed as allies by clients. In agreement with these authors, we believe an important step is to recognize community interpretation as a profession.

The most rewarding component of working with interpreters involves our engagement with interpreters from so many different cultures at the community level (meso system). We engage with our interpreters through focus group discussions, mental health trainings and trainings in the specific evidence-based strategies utilized by our clinicians. We respect our interpreters and consider them to be an extremely important part of the mental health treatment. Graduate students value working with interpreters, and recently developed a Health Information Portability and Accountability Act training designed specifically for Connecting Cultures interpreters. Role-plays regarding confidentiality are an important component of these trainings, and trust and respect is gained by all parties. Given the complexities of recognizing vicarious traumatization of interpreters, especially as they have often endured similar traumatic experiences, we are initiating the development of support groups involving interpreters.

Training: Cultural Adaptations for Refugee Engagement (CARE)

Most evidence-based treatment manuals used in psychology graduate training do not attend to important elements or adaptations associated with providing mental health services to refugees. Few core psychological treatments including CPT, NET, and culturally adapted cognitive behavior therapy (CA-CBT) (Hinton et al., 2012) provide a consistent framework from which to implement these techniques in a culturally sensitive way. Hinton and Colleagues (2012) describe important cultural adaptations to Cognitive Behavioral Treatment CA-CBT. However, there are no clear guidelines to effectively implement and

replicate modifications across evidence based treatments. The most salient Connecting Cultures adaptations are described below and categorized as 1) Clinical Process Adaptations and 2) Clinical Content Adaptations. These modifications represent lessons we have learned over the years and hopefully serve as helpful guidelines for other training clinics to implement culturally sensitive services. Indeed, we believe that training clinics are an ideal venue for developing these services as they typically involve low cost services, ongoing supervision, evaluative research, and training. The following are clinical process adaptations.

Safety and Emotional Regulation—Given the past traumatic experiences of refugees it is critical to attend to issues of safety and trust (Herman, 1997; Najavits, 2003; Savin & Martinez, 2006) not only at the beginning but throughout the therapeutic process, reviewing confidentiality, and continuing to validate fears of being betrayed or hurt by authorities. Conflicts in countries of origin are often ongoing and individuals sometimes deal with fears of or actual murders of loved ones by authorities while receiving mental health services. As such, a focus on emotional regulation and mindfulness strategies throughout treatment and especially prior to any exposure techniques is critical. Hinton and colleagues (2012) describe this as a “phase” approach.

Non-Diagnostic Approach—Rather than viewing refugees through a diagnostic or pathological lens, intervention begins with a focus on the values of an individual, family or community (Harris, 2009; Hayes & Strosahl, 2012). For example, when working with groups of refugees who have experienced torture, their post-traumatic stress symptoms are normalized and not discussed as disordered. They are asked how they can live a value rich life even though they have experienced such horrific events rather than being labeled with depression, anxiety, or other common responses to traumatic events. Clients express gratitude for this approach and have told us at the end of treatment that they appreciated our listening and will never forget the treatment experience.

Psychological Flexibility—As previously stated, we have most recently begun to integrate the guiding principles of ACT (Harris, 2009; Hayes & Strosahl, 2012) to help add an additional level of cultural sensitivity and guidance for modifications. The six components of ACT (values, acceptance, mindfulness, cognitive defusion, committed action, and self as context) are used to guide our evidence-based treatments. Promoting psychological flexibility, including mindfulness and acceptance is an important component of refugee intervention (Hinton, Pich, Hofmann, & Otto, 2013) rather than solely focusing on symptom reduction.

Timing and Control—Given that refugee trauma and torture experiences can be so severe (e.g., beheadings, brutal murders) the way in which exposure interventions are approached is critical. Studies question whether repeated exposures are ideal for refugee populations as exposures may be difficult to tolerate and dropout rates can be high in these groups (Hinton et al., 2012). Hinton and colleagues (2012) argue for alternative approaches to traditional exposure and emphasize a reduction in somatic symptoms.

A critical treatment process adaptation we encourage is to give “control” to the client regarding her/his story and to have clients set the “timing” of their own narrations. Clients choose if, when, and how much of their stories they want to share. A benefit of this strategy is enhanced trust between clients, therapists and interpreters. Torture and trauma experiences usually represent a time in refugees’ lives in which they were purposefully stripped of control and coerced into certain behaviors. For example, Bhutanese torture survivors report that they were forced to smile for photographs after being physically and emotionally tortured. While relinquishing their citizenship and possessions, they were forced to sign agreements stating that they were engaging in these actions by their own choices. Bhutanese torture survivors have described being forced to smile for pictures, while in their hearts they were “crying.” In traditional exposure techniques, the therapist guides the telling of the story. We believe it is imperative that clients now have control over their own stories.

Non-judgment—Non-judgment is a critical clinical skill (Hayes & Lillis, 2012) especially when working with individuals from other cultures. Our clinical judgments have been challenged during the course of this work and we have learned to take a stance of curiosity and respect rather than judgment. For example, one clinician was confronted with the idea that “polygamy was more honest” than the Western way of lying about marital affairs. Moreover, arranged marriages, marriages between cousins, and healing through prayer are common beliefs in some cultures.

Spirituality—Being open to the spiritual beliefs of an individual, family, or group is essential when working with different cultures, especially as many war conflicts have emerged from differences in religious beliefs and practices. Judgmental responses can result when clinicians are not open and sensitive to varying spiritual beliefs, especially as they relate to mental health. One elder described the importance of placing a chicken on the stoop to spiritually heal a sick child.

Clinical Boundaries—Clinical boundaries can sometimes differ from what is (or is not) presented in our conventional graduate training treatment manuals. We have learned that it is important to use a case-by-case and graded risk model for boundary crossing as described by Savin and Martinez (2006). Flexibility with boundaries based on culture is important for gaining trust and providing good clinical care. For example, it is not uncommon for refugee clients to offer food during treatment. Understanding the significance of food to a given culture is essential. Gift giving is another issue faced by graduate students, though we have found that gifts are usually given at termination of services and do not typically disrupt treatment (Savin & Martinez, 2006). Similarly, wanting to take pictures with therapists is common and we discuss the situation and potential clinical risks prior to engaging in traditional boundary crossings.

Knowledge of Mental Health Practices

Graduate students need to be aware of the practices commonly used in a given culture to “cure” or deal with mental illness. For example, in the Nepalese-Bhutanese culture, an individual known as a jumping doctor performs holistic healing rituals for mental and

physical health concerns. Being respectful and non-judgmental of these practices is important to gaining a trusting relationship. The following are clinical content adaptations.

Learning the Language—Obviously it is not possible to learn the entire language of each of our communities, however attempting to learn key phrases associated with greetings and learning new words over the course of intervention is important to clients. Clients smile, laugh at our pronunciations, and express appreciation for our efforts.

Subjective Units of Distress (SUD)—Given the extreme distress levels of our clients, we consistently use SUDs as a measurement of distress during the therapeutic process. It is helpful to learn the numbers from one to ten in the language within which we are working. We typically learn the child's song counting from one to ten in a given language and the clients truly appreciate this gesture.

Using Direct Communication—We have found that using any strategies that encourage direct communication can be beneficial. A thumbs up usually means yes, whereas thumbs down usually means no. We have found that clients value our attempts at direct communication.

Use of Arts and Crafts and Pictures from the Internet—Clients have expressed the importance of discussing their cultures of origin through pictures and drawings. This has shown to be powerful in both individual and group settings. When clients see visual images of aspects associated with their home countries they often experience strong reactions of joy and sadness.

Home Visits—At times it is important that home visits are scheduled due to initial discomfort with attending the clinic, which may be seen as a representation of authority, or an abusive government. These shifts from traditional practice require providers and clinicians in training to be aware, flexible, and sensitive to cultural experiences and differences.

Training Outcomes

Measuring anonymous feedback is critical to our goal for continual improvement of our program. We collect assessments of satisfaction and knowledge gained from graduate students twice a year. From 57 anonymous responses over the past three years, 93% (range 90% – 100%) reported they were “satisfied with the training [they] received from Connecting Cultures,” and 96% (range 91% – 100%) reported their “involvement in Connecting Cultures trainings has increased [their] knowledge related to working with refugees.” In a recent survey of current and past graduate students, we asked, “Did your training experience in Connecting Cultures impact your work and efficacy as a culturally competent clinician?” Response categories were Yes, Definitely, Yes, Somewhat, and No. With a 95% response rate (19 out of 20), 100% said Yes, Definitely. Several themes emerged from an open-ended question asking graduate students, “If yes, how [has] your training experience in Connecting Cultures impacted your work and efficacy as a culturally competent clinician.” Eighteen out of 19 respondents provided further details on “how.” The

most highly endorsed themes included, learning how to implement culturally competent treatment including modifications to evidence-based techniques, recognizing their own sociocultural biases and learning to manage them during assessment and treatment, the importance of knowing the history of conflict and cultural norms for every refugee population they work with, embracing the notion of meeting the clients where they were at rather than forcing Westernized views of therapy as the right answer in all cases, and how their training at Connecting Cultures has led to a career working with diverse and underserved populations.

Clinical Science Research Integrated with Practice

Our clinical science research program has been an integral part of the Connecting Cultures direct services and training of graduate students. We implement a standard assessment packet. There is much debate over the applicability of Western psychological assessments to non-western populations (Kirmayer, 1991; Kleinman, 1988). There is no one assessment or treatment modality that is most appropriate for all refugees, so we follow the recommendation to collect data and conduct continuous evaluations of our program outcomes (Jaranson & Quiroga, 2011). We base our selection of assessment measures on those that have some evidence in the literature of good psychometric properties across diverse societies including those from developing countries, not just refugees, and not restricted to the societies with whom we engage in services.

Our adult psychological assessment includes four mental health assessments. The Harvard Trauma Questionnaire measures the psychological impact of traumatic events as they relate to symptoms of posttraumatic stress and was developed for use specifically among refugees (Mollica et al., 1992). The 25 item Hopkins Symptom Checklist (Murphy, 1981; Parloff, Kelman, & Frank, 1954), is a screener for Anxiety and Depression. The Adult Self-Report is part of the Achenbach System of Empirically Based Assessments (Achenbach & Rescorla, 2003). Our fourth assessment is the National Institute on Alcohol Abuse and Alcoholism's Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993).

Translations of all assessments into the numerous different languages spoken by our refugees has not been achieved, yet we have gone through a rigorous forward translation, back translation, and consensus process for several of our common languages. It has been our experience that refugee clients do not refuse to complete assessments. We incorporate our assessments into the therapeutic process from the beginning; clinicians build rapport with the refugee client and discuss the clinical assessment during the first sessions, openly addressing concerns of confidentiality. Despite these efforts, clinicians have reported two instances in which clients said at the end of group treatment that they did not provide truthful responses on their baseline assessment. We continue to address this issue in our training of graduate students. We also note that clients consistently report treatment gains through qualitative discussions and testimonials describing reduced use of medications, tolerating emotions, and genuine appreciation for the services.

Another pressing issue in completing the assessments is time. Although translations have relieved some burden of time during assessment with interpreters and have added a critical level of validity to our work, our two most common languages (Nepali and Maay Maay) are still a struggle. Many of local Bhutanese interpreters are young and do not read Nepali script, so the translations are useless, and the Somali Bantu Maay Maay language is not written, so translations are posing difficult for us to create. Our next step is to create a voice recording of the translated assessments for these two languages on a hand held device as we continue to strive to improve our assessment process.

Summary and Implications

Based on the work of Connecting Cultures since its inception in 2007, we have shown that graduate students in clinical psychology can learn to work effectively with refugees. Through a social justice framework and the ecological model of human development, Connecting Cultures provides a culturally sensitive context from which these services are conducted. In our program, graduate students learn unique cultural information and participate in all aspects of the program through supervised experiences, including community-based outreach, direct clinical services, research, and training. The supervision and training model utilized by Connecting Cultures is comprehensive with an emphasis on evidence-based principles and practice while allowing room for integration of newer approaches such as ACT. Finally, clinical psychology graduate students will continue to utilize qualitative and quantitative methods with a strong value placed on outreach, engagement, and respect for the voices of the refugee communities.

Our work has several implications for helping to advance the training and supervision of graduate students. At Connecting Cultures, our experience has shown that evidence-based treatments are effective in helping refugees from many different societies and treatment may be enhanced by additional clinical frameworks that easily transcend cultural bounds. Our training model focuses on the importance of continual cultural education, making connections with the refugee community stakeholders, and using outcomes from our clinical science program to inform practice. Finally, looking to the future, we will continue to utilize ACT approaches, strive towards community-based participatory research (Minkler & Wallerstein, 2008), and further develop our understanding and use of vicarious resilience in training graduate students.

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