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ORIGINAL PAPER

Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice

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Abstract Each step of the refugee migratory journey has its own unique characteristics and mental health consequences, which require much attention from social work service providers. In an effort to provide quality service delivery for refugees, their premigration, migration and post-migration traumatic experiences need to be examined and understood beyond current narrow formulations. Integrating the concepts derived from refugee trauma and psychological distress literature, the author presents in this paper group-based interventions grounded in cultural competency, spirituality and strengths which will enable social workers to provide efficient service delivery and adopt a leadership role among service providers as advocates for refugees.

Keywords Refugee trauma · Social work practice with refugees · Group-based interventions with refugees · Cultural competence · Spirituality

In order to provide quality service delivery for refugees, social workers must deepen and broaden their comprehension of refugees' traumatic migration experiences beyond narrow formulations. To achieve this, a clear picture of the life journey taken by refugees needs to be captured as they interact with their new environment. It is essential that the voices of refugees be heard so that clinicians can better understand refugee perspectives and needs and thereby provide efficient intervention, particularly as it pertains to trauma. The goal of this paper is to provide social work practitioners with an in-depth understanding of refugees' migration journey in order to make the most appropriate decisions regarding refugee service delivery.

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Migration Traumatic Experiences

A refugee is a person who has been forced from his or her home and has crossed an international border for safety (U. S. Department of State 2009). Since the end of World War II, an estimated 42 million refugees in the world have been forcibly uprooted from their country of origin due to fear of persecution in their native country on account of race, religion, nationality, membership in a particular social group, or political opinion (UNHCR 2011). The effects of refugees' traumatic migration experiences are immeasurable, long lasting, and shattering to both their inner and outer selves (Steel et al. 2006). Three areas of inquiry are germane to the discussion of refugee migration traumatic experiences: pre-migration, migration and post-migration. Knowledge of these areas will provide the necessary understanding for social work practitioners working with refugees.

Analysis of pre-migration literature from different regions of the world revealed one constant thread: colonization. Colonizers brought with them their own social, political and economic values and practices that transformed the colonies into places they could understand. Colonial imperialism replaced the native systems to the point where it became increasingly difficult for natives to survive in their own land. Colonization left countries with social, political, cultural, economic and environmental chaos and oppression, with no organizational structure to intervene in the inter-racial, inter-ethnic and/or

inter-religious conflicts left behind, which were originally created by colonizers as a means of control (Askeland and Payne 2006; Hyndman 2000; George 2009; Mollica 2001; White 2004). Economic inequality combined with demographic pressures and environmental crises have generated ethnic conflict, civil war, terrorist threat and forced migration (Richmond 2002). Refugees are forced to leave home to escape danger with no destination in mind (Collins 1996).

During the migration period, refugees often move between different countries and different refugee camps. By this time, they are typically separated from their families and friends, creating intense anxiety and depression as they realize all they have lost (Mollica 2006). Refugees' lives remain in limbo until their legal challenges are sorted out. During this time, refugees must confront the losses in their life, as well as develop a new sense of hope for the future (Hunt 2004). They are simultaneously required to pass through the asylum-seeking process, which is intensely re-traumatizing (Quiroga 2004).

Until refugees receive their status in the host country, their lives are controlled by the United Nations, governments, refugee boards and non-profit agencies. Only after recognition of their protection needs by the host government are they entitled to refugee status, which carries certain rights and obligations according to the legislation of the receiving country (Crepeau et al. 2007; Steel et al. 2004). According to Steel et al. (2004), many countries such as Australia have instituted mandatory detention for all persons arriving without valid entry documents. Consequently, a significant number of refugees and their children have been held in detention for considerable periods of time (Steel et al. 2004). Many cannot even think about settling into society due to their ongoing legal battles for permanent resident status (Burgess 2004). Refugee claimants who do not have adequate identity documents to prove their claim must face continuous interrogation by immigration and naturalization authorities (Burgess 2004).

A study of psychological distress and migration trauma among South Asian refugee claimants in Indian refugee camps and in Canada (George 2009; 2012) found that those refugee claimants in Canada, had higher scores for psychological distress and trauma, likely due to the greater degree of interrogation by immigration officials. Moreover, this study revealed that refugee claimants experienced re-traumatization each time they were exposed to interrogation by immigration boards in the host country. Fong and Mokuau (1994) claim that the terms used with respect to forced migrants—such as *refugee claimants*, *asylum seekers*, and *displaced persons*—exemplify the complexity of the immigration systems' ascribing of status and conditions of treatment. Furthermore, these statuses reflect the variety of migration experiences and affect the ways in which refugees settle into their new country.

Crepeau et al. (2007) and Steel et al. (2004) examined the lack of tolerance in many of the refugee policies in host countries. Numerous refugees are subjected to additional traumatic experiences by policies which involve third party agreement; for example, Canada will not grant refugee status to persons who have been denied acceptance by a country with which Canada has an agreement. Traumatic experiences are also heightened by the burden of proof policy whereby during the process of determining eligibility, the onus is on the claimant to provide a medical certificate to prove their claims of having been physically, mentally or sexually abused. Often refugee review board members' lack of knowledge of international refugee law, ambivalence toward traumatization, ignorance regarding trauma and lack of understanding of refugees' historical, social, cultural and political backgrounds adversely affect the decision-making process (Crepeau et al. 2007). Many host country policies are highly Eurocentric and not applicable to the diverse social, cultural and political nature of individuals. These policies need to be expanded and negotiated in order to provide meaning to human experiences. Only after all these legal struggles are status-awarded refugees eligible to receive settlement services, which include language training, housing and securing identity documents (Valtonen 2004).

Refugee-host relationships can create an atmosphere that either aids or hinders the post-migration experiences of refugees (George 2003). Refugees who have already survived pre-migration traumatic experiences in their country of origin often experience particular difficulties, including feelings of not being safe, during the resettlement period. After the difficult experience of migration, refugees approach the new land with mixed feelings (Cummings et al. 2011; Finklestein and Solomon 2009).

During the initial post-migration period, refugees are confronted by the loss of their culture—their identity, their habits and their place. Every action that used to be routine will require careful examination and consideration (White 2004). Culture shock will particularly affect those refugees who did not think about, intend, or prepare for exodus, and who were caught up in panic, hysteria or even adventure (Mollica 2006; Mollica 2000). When refugees learn the difficult realities about settlement services, their anxiety and feelings of exclusion from their host country greatly increases (George 2003). Nostalgia, isolation, depression, anxiety, guilt, anger and frustration are so severe that many refugees may want to go back to their country of origin even though they fear the violent consequences (Mollica 2000). These factors tend to increase psychological problems (Ehntholt and Yule 2006; Mollica 2006; White 2004).

Most host countries' refugee service agencies are funded by the government and managed by non-profit and/or faith-based organizations. Lack of coordination among refugee settlement support systems often increases the difficulty refugees face during the settlement process (Keung 2006). An example from the Canadian system is the lack of communication between the Immigration and Refugee Board, which is under the federal government of Canada, and the Ontario Health Insurance Program, which is under the provincial government. To make things worse, refugees are often not sure what help-seeking behavior is appropriate in the host country (Collins 1996). It is a general observation that whatever behavior they put forward will be assumed to be due to cultural difference. The tension between culture as a basis of universal human experience and culture as the primary basis of difference has important social and political implications for social work practice (Hyndman 2000).

A phenomenon of particular importance with respect to refugee behavior during resettlement is many refugees' strong belief that they are owed something by someone (Hyndman 2000). People from developing nations and/or formerly colonized nations may have the impression that Western governments provide social and economic services to their citizens without any obligation (Reese 2004; White 2004; Hyndman 2000). Since their persecutors are unavailable, many refugees shift their demands to the host government and the helping agencies. They may continually complain of not receiving enough (Hyndman 2000). This discontent can create a feeling among refugees of being controlled by agencies (Crosby 2006), causing them to become aggressive and demanding of more and more resources. At the same time, refugees are often stigmatized by their own refugee cultural communities, as well as by society in general, for utilizing social welfare services. Compounding these issues, refugees may find themselves isolated from the mainstream community due the intersection of racism, classism and sexism (White 2004; Fung and Wong 2007; Levine et al. 2007). The toll of the stressors refugees must face during the pre-migration, migration, an post-migration periods on their physical and mental wellbeing can be quite devastating.

Psychological Distress

Being a refugee is clearly a category of risk for physical and psychological distress, because, surrounded within this state is often-unspeakable violence (Keller et al. 2006). Therefore, refugee health care issues can be complex and wide-ranging. Many refugees have experienced torture in their home land, which inflicts severe long-term physical and psychological pain. The first interaction a new arrival encounters with the host country health care system is a refugee medical assessment conducted by health departments (Garrett 2006). Most often this medical evaluation is the only health assessment completed after a refugee's exposure to torture (Miller 2004). The reason for this assessment is to screen for health-related issues before granting refugee status. Refugees typically inform health care providers about their severe headaches, abdominal pain and anxiety. In-depth investigations result in a detailed report on their physical and psychological challenges. Injuries to the skin and muscular-skeletal system from blunt trauma, burns and electrical shock, severe internal bleeding due to rupture of the liver and spleen, head trauma due to brain haemorrhage, and contraction of the HIV virus are widespread physical conditions among refugees (Quiroga 2004). Refugee women are especially at risk for sexually transmitted diseases (STD's) because of the sexual violence that may have occurred during their flight (LaFraniere 2005).

Torture survivors have significantly higher rates of trauma symptomatology than other groups of traumatized individuals (Mollica 2006; Porter and Haslam 2005). Many volumes of research have been completed on refugee trauma (Mollica et al. 1993, 2007; Mollica 2006; George 2009; Porter and Haslam 2005; Steel et al. 2004, 2006; Schweitzer et al. 2011; White 2004). A systematic review by Fazel et al. (2005) of 7,000 refugees showed that those resettling in Western countries could be approximately ten times more likely to have Post-Traumatic Stress Disorder (PTSD) than age-matched general populations in those countries. PTSD can result from undergoing or witnessing torture, combat or violent personal assault as well as structural barriers (Schweitzer et al. 2011; Westoby and Ingamells 2010). Unique psychosocial problems such as loss of social role and social networks, loss of property, acculturation stress, anger, language problems and socio-political factors can complicate the diagnosis of PTSD (Mollica 2000).

In examining refugee mental health, one can clearly see a difference of opinion among researchers and clinicians regarding the effects of trauma. Some researchers state unequivocally that there are traits in refugees that produce specific symptoms in addition to migration stress, and that these individuals are likely candidates to experience mental health problems (Mollica 2006). Others believe that the almost universal similarity of problems in refugees indicates that severe trauma in and of itself is the cause of the symptoms (Stein 1998). The controversy boils down to situational response tendencies based on Refugee Theory. Only a few studies have examined the considerable interaction between Refugee Theory and psychological distress.

A 2009 study provides an alternative perspective on refugees' pre-migration experiences and host country

settlement distress (George 2009). Using a refugee theoretical perspective as proposed by Kunz and Paludan, the study on Sri Lankan Tamil refugees examined the interaction between typology of refugee (acute versus anticipatory), typology of refugee settlement (new versus traditional) and psychological distress. Acute refugees who left their home country within a few days or hours of disaster had a higher levels of psychological distress than anticipatory refugees (George 2009). Silove et al.'s quantitative study (2007) showed that 85 % of refugees fleeing from war-torn Vietnam during the 1970s made the decision to leave their homeland 2 days to 2 hours before their departure. Acute refugees may not have any resources or any support from anyone, and must seek help more frequently. However, due to their direct experience with trauma, they may avoid contact with strangers out of fear of re-traumatization, despite their need for immediate help (Mollica 2006). Keller (1975) strongly argues that the trauma of flight produces residual psychological states in refugees that will affect their health for years to come. Refugees who are late to flee usually endure the greatest hardship and loss, and are therefore likely to come out of the experience with residual characteristics of guilt, vulnerability and aggressiveness. There may be a perception of loss of direction, role or purpose, leading to feelings of pointlessness. These feelings lower a person's self-esteem, which, when coupled with social isolation or a feeling of "uniqueness," can create a sense of alienation, existential distress and severe demoralization (Briggs 2011). Anticipatory refugees, on the other hand, are those who leave their home country prior to the disaster, most often with their families and personal resources intact. They tend to seek less help than acute refugees (George 2009).

Another factor in the refugee experience that deserves more attention from researchers is the typology of refugee settlement—new and traditional. The key differences between new and traditional refugees are that new refugees are culturally, racially and ethnically vastly different from their hosts, and are likely to lack kin or potential support groups in their country of resettlement, whereas traditional refugees are culturally and ethnically similar to their host, and are likely to be welcomed and assisted by family and friends who speak their language and can cushion their adjustment (George 2009). It can be argued that new country settlement will increase the psychological distress of refugees, and therefore, an acute refugee in a new settlement will experience an even higher level of psychological distress because of the pressure to adapt to a new culture, new language and new social practices while also dealing with their direct traumatic migration experiences (George 2009). These specific circumstances should be taken into account during practice interventions with refugees. In all situations, the challenge for the health care professional is to approach refugee distress in a scientifically sound and systematic manner, providing the basis for incorporating each refugee's unique background into the assessment, as well as in the interventions.

An important concept that is often missed or underestimated in refugee mental health research is *resiliency*. A refugee's life is most often marked by pain and oppression. Martin et al. (2000) postulate that refugee mental health challenges may be better understood within the context of refugee resilience and coping capacity. Refugee resiliency serves to counter the social construction of forced migrants as victims without agency, and enables refugees, despite their traumatic experiences, to succeed in the new society. After the initial period of struggle, many refugees display an impressive drive to rebuild their lives (Pipher 2001). The key factor for refugee resiliency is the refugee experience itself, which may make them more aggressive and innovative (Stein 1998; Gronseth 2006). The strength gained from their traumatic migration journey enables them to learn the new language and culture, and to achieve a certain level of stability (George and Tsang 2000; Stein 1998; Weaver 2005; White 2004). A considerable degree of integration occurs simply because life must go on. The recovery of lost status continues, even though the pace may be slow. Interventions should include a resiliency perspective that lends meaning to refugee suffering and places a focus on their strengths and experiences. There may be other factors that impact refugee psychological distress that have yet to be uncovered. More research is needed in order to better understand this issue and provide the most effective treatments and services for the refugee population.

Implications for Social Work Practice

The social work profession has been changing continuously to adapt to international influences. Social workers play a central role on the team of professionals (medical, legal, judicial) that collaboratively respond to refugee needs. Social workers often initiate all other types of support received by refugees. Analysis of the literature on this topic leads to the conclusion that refugee interventions need more coordination and consolidated attention from social work practitioners. The best way to accomplish this is by incorporating various interventions models. This researcher proposes a group practice model of integrated understanding of refugee trauma to enable service providers to respond productively to refugees' needs. This represents a departure from the fully medical model that has guided most trauma research and interventions with refugees that emphasizes provision of services such as psychotherapy and psychiatric medication by highly trained professionals

(Mollica 2006). Group-based interventions grounded in cultural competency and spirituality could more effectively provide support to refugees.

Cultural competence is necessary for the provision of care to clients with diverse values and beliefs, and of varied race and ethnicity, as well for tailoring service delivery to meet clients' social, cultural and linguistic needs (Betancourt et al. 2002). The relevance of understanding race, ethnicity and culture in therapeutic interventions cannot be underestimated. Gaining awareness of differences in cultural identity is hindered by viewing individuals as singular and unitary. Recognition and awareness of one's own culture, gender, race, class and ethnicity in relation to that of refugee clients is crucial for the effective treatment of this client population (Campinha-Bacote 1999). Social workers' knowledge on their own biases, prejudices and subjective interpretations of others that are borne from different life experiences helps to prevent any transference or counter-transference. The degree to which the social worker can have a multicultural perspective will affect the degree to which he or she can understand refugee clients' points of view, barriers, and strengths and incorporate effective interventions.

Being culturally competent also requires that the social worker recognize the power dynamic between himself/herself and the refugee client. The quality of attitude and engagement a social worker brings to clinician-client interactions is as important as cross-cultural knowledge in facilitating culturally sensitive and culturally comprehensive care (Wheat 2005). In today's post-colonial society, some social workers use information and resource control, expertise or perception of expertise, and/or structural legitimacy as a way to exert power within the helping profession. When working with refugees, social workers should use appropriate relationship strategies for intervention negotiation, rather than using persuasion, exchange, reinforcement, consultatioin, pressure, or coalition. Until recently, the explicit objective of intervention techniques has been the imposing of the cultural norms of the dominant society on minority clients (Sodowsky et al. 1997). By using intervention negotiation instead, social workers can combine mainstream and cultural interventions. In addition, intervention negotiation also fosters empowerment, an artificial factor in intervention with historically oppressed refugees. In this way, the social worker can work together with the client and become more culturally competent.

Social workers should also be able to address discrepancies in the physical appearance of refugees and understand the importance of providing interventions at an early stage. Refugees may physically appear to be healthy, yet there may be unobservable daily stressors. Service models should be developed to not only deal with refugee trauma and refugee settlement needs, but also to emphasize the major contextual issues affecting the daily stressors of refugees. Due to refugees' diverse backgrounds and experiences, they may be either hesitant to seek help or not be given the opportunity to express their concerns. As mentioned earlier, refugees often demand resources based on their belief that they are owed support by the host country. In addition, refugees may also be confused about how to go about seeking help in the new country. As a result, social workers need to consider refugees' contextual information—including whether they are acute/anticipatory (Kunz 1981), traditional/new (Paludan 1981), and their host country status—when analyzing their help seeking behaviors.

Service models should include non-Western intervention methods consistent with the values and traditions of refugee communities (Lacroix and Sabbah 2011). Understanding refugees requires an iterative process involving dialogue between social work practitioner and refugee clients. Social workers need to address the oppression faced by refugees, which is caused by society norms and invisible pressures. One way of implementing direct social work practice is through group interventions. Loewy et al. (2002) contend that traditional one-on-one counseling conducted from a Western perspective view is not sufficient for working with refugees. When working with refugees in group intervention, an appreciation for traditional ceremonies within the cultural context of the group, along with an understanding of main stream societal interventions, can enhance the therapeutic process and build rapport. The ability to understand the way the world works from the clients' point of view enables the group leader to develop trust and connect with group members (Loewy et al. 2002). Asner-Seif and Feyissa (2002) state that the benefit of using group counseling is that it can alleviate the sense of isolation many refugee clients feel during the acculturation process, and offer a support network within the group. This creates a safe place for refugees to explore experiences, creates universality amongst them, and gives them a sense that they are not alone. In addition, social workers using group counseling with refugees should incorporate rituals that come from the refugees' culture, use a combination of intervention techniques that are culturally appropriate, and educate the refugees about their experiences by discussing issues such as trauma, women and trauma, and psychological distress (Asner-Seif and Feyissa 2002; Loewy et al. 2002; Norsworthy and Khuankaew 2004; Stepakoff et al. 2006; Weine et al. 2008).

In addressing the needs of refugee clients, social workers may be unsure about the right clinical intervention for addressing differences in values, beliefs, race, culture and expectations. Regardless of the approach ultimately

pursued, it is often accompanied by doubt that it may lead to miscommunication, and thus they struggle to find the language that will most effectively speak to issues of oppression and stigma faced by mentally ill refugees. In this situation, the incorporation of spirituality and strengths perspectives may lend insight into the refugee client-social worker interaction and help overcome the differences between clinicians and clients.

A *strengths perspective* on mental illness serves to counter social constructions and advances the success of individuals with mental illness in society. It is closely tied to the concept of resiliency. The lives of mentally ill individuals are often filled with pain and suffering, yet one of their major strengths is their resiliency (George 2009). Refugees gain durability from the experiences they undergo before resettling (Gronseth 2006). As Harter (1996) suggests, overestimating one's abilities (within reason) is associated with positive mental health. However, recognizing refugees' internal strengths should not lead to underestimating the difficulties they continue to face in their new country. Nevertheless, it is important for social workers to realize the necessity of maximizing the resiliency power of each refugee. Research by Finklestein and Solomon (2009) with Ethiopian refugees found that the challenge is to identify factors and mechanisms that support resiliency and prevent vulnerability. These factors could inform the development of intervention programs and promote successful absorption, as well as increase the well-being of refugees (Finklestein and Solomon 2009). Most traditional intervention strategies focus on problem identification rather than simultaneously recognizing the strengths of these individuals in overcoming their pre-migration traumatic events. Instead of only addressing acculturation issues, poverty, unemployment, racism and mental illness, it is equally important that interventions deal with pre-migration traumatic experiences and the strength gained from these experiences to deal with hardships and successfully settle in the new host country (Gronseth 2006; George 2009).

The courage and strength of refugee clients to seek help for their mental illness and to integrate into society, despite the stigma they may experience from their own community, needs to be recognized. Rapp (1998) views the community as an oasis of resources. For refugees with distress, community resources include family and friends from their country of origin, the collective insight and independence gained during their migration journeys, and the different meanings and inspirations brought with them. Family involvement is common in many refugee communities, and often proves valuable to social workers in times of crisis. Some view it as over-protection, while others see it as continuing care and support by families. During social work intervention with refugees and their families, it is crucial that service models emphasize the importance of social, historical, cultural and political awareness. Furthermore, a strengths-based approach must focus on the complex interplay of risks and strengths among individual family members, the family as a unit, and the broader neighborhood and environment. This will empower clients to take ownership of their treatment, interactions with family members, and connections to social supports.

It would be misleading to restrict *spirituality* to a precise definition. Rather, it may best be described through a cluster of related themes. Spirituality is the soul of the total process of human life. It is the wholeness of being human. Spirituality helps social workers realize there are many different experiences that shape one's life, and the greater this awareness, the more tolerant they will become of differences and diversity (Langer and Moldoveanu 2000). Spirituality relates to a person's search for a sense of meaning and fulfilling moral relationships between self, others and the universe. This critical self-reflection enables social workers to listen more carefully to clients' distress, recognize their own errors, refine their technical approach, arrive at evidence-based decisions and clarify their values, and enhance their practice with compassion, competence, presence and insight (Epstein 1999). Spirituality-based social work practice promotes interconnectedness with clients. Refugee clients who feel the presence of the social worker during clinical interactions are more likely to feel connected and thus perhaps more willing to disclose symptoms or interpretations not obviously evident (Wheat 2005). Inherent within each client are diverse experiences. In the case of refugee clients, they include pre-migration, migration and post-migration struggles, including unemployment, acculturation, adjustment and culture shock. These experiences, however, will affect each client differently. Spirituality aids social workers in accepting and looking beyond the differences between self and client by focusing on how and why each feels as they do, their underlying needs and their desired outcome, thereby enhancing the client's feeling that the social worker is totally present for them. Broadening the clinical scope to incorporate spirituality may help social workers realize the diversity of refugees, the complexities of their individual experiences, and the influence of varied issues on their mental health (Dominelli, 1988). By focusing attention on the present moment of client interaction and reserving judgment on clients' diverse culture, race, experiences, practices, beliefs and values, clinicians can cultivate a longer lasting interconnection with their immigrant clientele.

Addressing spirituality in group counseling can help the refugee client not only relate to the social worker, but also to other refugees. Incorporating spirituality into group counseling can help clients "connect with the other group members at a deeper and more satisfying level" (Cornish and Wade 2010). In groups with refugees from various

places, cultures, and experiences, discussing spirituality may give some clients a safe way to explore how religion and/or spirituality affected the conflict that forced them to leave their homes, the migration process, and acculturation in their host country. At the same time, exploring spirituality in group counseling can also help to identify and highlight the ways that spirituality is a source of strength and resilience for some clients. By addressing spirituality, therapists might help clients to access the beneficial elements afforded by their spiritual beliefs, and practices. Furthermore, it might help clients to apply these strengths to their present concerns in a way that facilitates healing and growth (Cornish and Wade 2010).

Cornish and Wade (2010) assert that "the use of ritual or ceremony could be a particularly powerful spiritual tool when working with counseling groups composed of a specific cultural group. Practitioners leading such groups could survey members to identify common spiritual rituals or ceremonies that could be incorporated in the group process. Being able to engage in a shared practice could serve to strengthen the bond among members." Loewy et al. (2002) used an African coffee ceremony during group counseling with Ethiopian and Eritrean female refugees, calling it the "Kafa Intervention". This coffee ceremony is an indigenous form of spiritual and psychological healing that has been part of East African culture for over 3,000 years (Loewy et al. 2002). The Kafa Intervention uses this ceremony to help the women practice altruism, serving and helping each other by listening and offering support. This process helps to clarify, paraphrase, summarize, and reflect back to the members of the group both their personal stories and the common themes emerging in the group. Group counseling incorporating cultural ceremonies allows the group members to feel heard and understood. In general, a culturally grounded group counseling process will help group members to express themselves and to disclose intimate details about their lives.

A study by Weine et al. (2008) used a similar Coffee and Family Education and Support (CAFES) intervention to "analyze the effect of a multiple-family group on increasing access to mental health services for refugees with PTSD. In order to further bridge cultural gaps, they utilized facilitators who were all Bosnian refugees themselves, were fluent in Bosnian and English, were members of the Chicago Bosnian community, and had experiences doing group work (e.g., as teacher, nurse, organizer). In this study, subjects were encouraged to invite any family members over 17 years old to participate in the intervention, empowering clients to interact with family members and foster their support system. This family support approach gives families a place and space to discuss and explore issues pertaining to being a refugee, which can be especially helpful in addressing intergenerational migration stress.

The Weine et al. (2008) study also emphasized the importance of working with families, and specifically children. In some instances, social workers should work with adults and children separately. The social worker may choose to meet with the family as a whole for one or two sessions to build rapport and to assess the family as unit. However, separating the children from the adults may help the social worker to address multigenerational transmission issues that affect the family as a whole, but particularly the children. The definition of child can be different for each refugee community. Thus, it is important that the social worker be culturally competent to know what constitutes childhood in a particular family's culture. The National Technical Assistance and Evaluation Center for Systems of Care (NTAECSC) believes that it is critical to incorporate a strengths perspective in order to increase the safety, permanency, and well-being of children and their families (2008). This approach acknowledges each child's and family's unique set of strengths and challenges, and engages the family as a partner in developing and implementing the service plan (NTAECSC 2008). Instead of focusing on what is wrong with refugee children, a strengths perspective emphasizes each child's strengths—for example, the ability to act as a cultural interpreter between family members and institutions.

One way in which social workers can work effectively with refugee children is through art-based therapy. An example of this would be the Hope Project, a qualitative study incorporating an after-school program in Canada to provide a strengths-based program for refugee children between ages 6 and 18 deemed to be in high-risk, multiple-barrier communities (Yohani 2008). The refugee children participated once a week for 10 weeks in a variety of psychosocial activities with the goal of creating a safe and comforting environment in order to support healing, growth and adjustment to Canada (Yohani 2008). The project utilized photography as a form of expression, allowing the children to step away from the parameters of traditional interventions and explore hope in the various contexts of their lives. The children's photographs depicted how they see hope in themselves, other people, and the environment. The pictures told the stories of the children's lives. Projects combining strengths- and art-based therapy are very useful in addressing refugee issues, and particularly those of children; in doing so, they help bring to the surface the resiliency these children have developed through their refugee experiences.

Conclusion

This paper lays the foundation for informing social workers on complex refugee migration experiences, and possible

group-based intervention strategies. Developing group-based interventions grounded in cultural competency, spirituality and strengths-based practice encourages social workers to seek to understand, accept, and respect different cultures and values, and to recognize how they relate to their clients' needs. Successful service delivery depends on social workers' ability to continuously learn about different human experiences from their refugee clients, as well as from themselves. As we move towards an increasingly pluralistic and multicultural society, social workers are among those best equipped to deliver the needed care and to empower people from all backgrounds to lead connected, healthy lives.

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