The Refugee Experience, Psychological Trauma, and Project Resiliency

Vanessa Cunha and Christine Francis

Lasell College

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Table of Contents

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Introduction

Throughout history to the present, individuals have had to escape their homelands to seek asylum from other countries. Individuals and families are forced to leave their country due to the country's dysfunction that threatens their ability to live safely. Refugees, or asylum seekers, are individuals who are petitioning for protection outside of their home countries because of the threat or fear of persecution based on race, religion, nationality, political opinion or membership in a particular social group (Kalt, Hossain, Kiss, & Zimmerman, 2013). Exposure to whatever situation they faced, the abrupt force to leave, and the stressful journey to a new environment can be a great deal for one to handle. Another difficult aspect is moving to a location that is vastly different culturally.

Given all these elements, it is common to experience some form of trauma. Trauma is severe emotional and mental distress caused by an experience (Sperry, 2016). One might endure shock, denial, unexpected severe emotional outbreaks and even unstoppable flashbacks (Sperry, 2016). Refugees flee their homelands in whatever capacity possible to escape dire circumstances that occur in their country. During this process, refugees experience events that may present various forms of psychological distress. The purpose of this review is to examine the struggles that refugees face and to highlight how their adversities can result in several forms of psychological distress. Furthermore, this review seeks to see how this distress manifests in personal and family dysfunctions and psychological difficulties such as Post Traumatic Stress Disorder, separation anxiety, and various other forms of trauma related responses.

Background

Recent events that are occurring across the globe have created what is commonly known as the refugee crisis. This crisis has captured the attention of the entire world through a host of broadcasting and social media platforms. Presently, according to the United Nations High Commissioner for Refugees (UNHCR), 19.5 million people have been forcibly displaced from their homes (Pejic, Hess, Miller, & Wille, 2016). An important distinction to make throughout this review is between asylum-seekers and refugees. Asylum seekers and refugees differ in the sense that asylum-seekers are in the process of seeking or applying to a place of refuge, whereas refugees are individuals who were successful in undergoing this process ("Migration Watch UK | MW70 : The distinction between asylum seekers and refugees," n.d.). Common issues that occur within several mother countries that produce asylum-seekers and eventually, refugees, stem from issues such as exile, religion, politics, and human rights violations. These aspects of the refugee experiences have been and continue to be deeply delved into by researchers (Thommessen, Corcoran, & Todd, 2015).

As mentioned previously, there are an overwhelming number of asylum seekers awaiting confirmation to be allowed into new countries. It is imperative to be cognizant of which parts of the world asylum seekers are expecting to target. According to Kalt, Hossain, Kiss, and Zimmerman (2013) the countries with higher incomes received 45% of all asylum applications in 2010. South Africa registered 180,600 new claims, with the remainder of five countries receiving the most applications (Kalt et al., 2013). The five top countries include the United States (54,300), France (48,100), and Sweden (31, 800).

These high-income countries that are host countries to this population often implement deterrence strategies which includes extended detention, restricted health and social services, threat of deportation, and denial of work permission (Kalt et al., 2013). Although these countries may offer asylum-seekers protection, these deterrent strategies by wealthier host countries produce further adversities for such individuals.

Common Issues Experienced by Asylum-Seekers and Refugees

Religious persecution has been one of the constant themes throughout history that frequently produces refugees. Every year it seems that cases involving torture, execution, marginalization, and kidnapping, and other atrocities are exercised based on religious beliefs (Rodrigues Araújo, 2014). The effect that religious persecution has on refugees is comparable to individuals who have been persecuted for other reasons besides religious persecution. An example of refugees that have been persecuted for these reasons is seen in the aftermath of the Iraq-Iran war and in the 1990's after the Persian Gulf War (Abdulahad, Graham, Montelpare, & Brownlee, 2014). In these instances, more than 150,000 Christians left the country because of the reigning power. Moreover, prior to the US invasion in Iraq, Iraq had become more focused on Islam and the state of anarchy forced non-Muslim Iraqis to flee the country. About 400,000 Iraqi-Christians have fled Iraq and comprise approximately 20 percent of all Iraqi-Christian refugees (Abdulahad et al., 2014).

Sexuality and gender have raised various questions within refugee cultures. The struggles surrounding the conflicting implications pertaining to sexuality and gender are difficult to comprehend in more conservative countries that are less accepting of these differences (Global Public Health, 2015). Refugees that come from these types of

cultures live by very traditional values and any individual who tests those cultural boundaries are often persecuted. As a result, the refugees of the LGBTQ community often experience various forms of abuse (Alessi, Kahn, Chatterji, 2016). Social and legal protection for people of the LGBTQ community is nonexistent in the majority of these countries. Homosexuality remains illegal in most of the refugee's home countries and there are no signs that these laws will change (Baily, Vasey, Diamond, Breedlove, Vilain, 2016). Religion is one of the many factors these countries maintain conservative values towards (Global Public Health, 2015). Refugees come from places that have beliefs which prohibit premarital sex, overexpose women in a sexual nature, and have a restriction of women in general (Global Public Health, 2015). These beliefs and practices have come from generations of values existing for centuries. In some of these societies, men are seen as people of power whose role is to protect the people of their household (Global Public Health, 2015). The stereotypes associated with men make it difficult for these cultures to accept men in nontraditional roles. These roles may include stay at home men, or dads who make less money than their wives.

Domestic violence in refugees occurs mainly because of the cultural structures of the countries these families come from (Gustafson, & Lluebbey, 2013). By being forced to live in a new country, refugees are expected to follow the new laws immediately, leaving no time for adjustment (Gustafson, & Lluebbey, 2013). When a refugee family is placed in a country with completely different cultural values, it becomes culturally difficult to make sudden changes by conforming to these new values. These refugees consider violence to be a reasonable form of punishment, but to other countries those behaviors are known as domestic violence (Gustafson, & Lluebbey, 2013). Violence is

used legally in most of the refugees' home countries because it is seen by their cultures and legal system as a form of punishment that will scare their people into not making the same mistakes (Gustafson, & Lluebbey, 2013). People from other countries feel that as a married couple they have the right to exercise their differing of opinions through violent related punishments. In most countries, it is also a matter of gender power and men are allowed to use violence as a form of punishment, but it is against the law for women to do so.

Sexual abuse or sexual violence is especially significant to this population. Presently, developed countries around the world, particularly European countries, are experiencing a "refugee crisis" where millions of asylum seekers take drastic measures to reach these countries (Freedman, 2016). Images of men, women, and children taking this dangerous journey have been circulating across the globe through various media platforms. Gruesome pictures of overturned boats and drowned refugees are highlighted, while other forms of violence such as gender-based violence and sexual violence against women are not as apparent (Freedman, 2016). A representative from the UNHCR stated that although most refugees have been males, there are an increasing number of females traveling alone or with children since 2015 (Freedman, 2016). It has been theorized that this was a strategic plan where husbands send their wives with or without children in hopes that the countries they are traveling to will perceive them as vulnerable, offer them protection, and then the husbands may join them later (Freedman, 2016).

Although asylum seekers and refugees may travel from place to place as groups of families with other people from a common area, or as individuals, it is important to acknowledge the unaccompanied children who are refugees or are seeking refuge. Given

the breadth of information on psychological trauma that asylum seekers or refugees undergo, it is likely that unaccompanied children in these circumstances are especially vulnerable to experiencing extreme distress. A study done on unaccompanied asylum seeking children from Afghanistan by Thommessen, Corcoran, and Todd (2015) highlights this sentiment. The study involved six participants who achieved refugee status in Sweden and participated in interviews to share their unique experiences. Overall findings summarized participants' stories of young boys who had to learn to be independent; they had to travel without the protection of guardians or parents, learn to survive on the six month journey from Afghanistan to Sweden, and finally learn to acclimate to a new life in Sweden (Thommessen et al., 2015). The findings of this study underscore the anxiety and concerns these boys experienced during the initial months in Sweden, regarding the outcomes of their asylum application as well as loneliness (Thommessen et al., 2015). A powerful excerpt from a participant encapsulates this concept in the following quote: "During those first nine months [waiting for the asylum decision] I was under a lot of pressure. I cried a lot because of my family. They [Taliban] said they were going to burn down our house because of our religion. During the first months I had two main problems, or one double problem. The first thing was thinking about Afghanistan and my family and worrying about them, and the second thing was the uncertainty of what was going to happen to me, worrying that I would be deported and that I would land in the hands of the enemy, "(Thommessen et al., 2015 p. 377)." The themes of isolation, loneliness, and fear experienced by these young participants were consistent and had similar quotes. It was evident that in all six individuals, although they found temporary safety in Sweden, their memories from the past, uncertainty of their

asylum applications, and their families left behind, caused a tremendous amount of mental burden (Thommessen et al., 2015).

Trauma

Asylum Seekers and refugees experience many significant challenges. From the time they are forced to leave their country for a myriad of reasons, from the dangerous excursions to different parts of the world, to the suspense of seeing if their refugee status is granted, acclimating to a strange environment and culture can result in severe trauma. Dr. Len Sperry (2016) defines trauma as an event or series of events that creates psychological trauma when it overwhelms the individual's ability to cope and leaves that individual fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, pain, confusion, or loss (Sperry, 2016). Dr. Sperry goes on to further explain that psychological trauma involves experiences that may be extremely threatening both psychologically and physically and those experiences may trigger feelings of terror, horror, or helplessness.

The experience of a traumatic event, particularly for the refugees, has numerous effects. Although traumatic responses vary on an individual basis, those who experience trauma are at risk for many psychological disturbances and disorders (Sperry, 2016). Some of the distress is known to produce symptoms of anxiety, depression, angry outbursts, and increased drug and alcohol use (Sperry, 2016).

On a physiological level, the pervasive effect that psychological trauma has on the body has been uncovered by recent research. Dr. Nadine Burke Harris, a pediatrician, unravels the effects and health outcomes in children who experience trauma in her article

exploring the link between chronic stress, poverty, and how it manifests physiologically (Harris, 2014). Through several studies as well as her own, Dr. Harris talks about the hypothalamic-pituitary-adrenal (HPA) axis that regulates the fight, flight, or freeze responses in the body. The HPA axis releases a surge of stress hormones such as cortisol and adrenaline creating a host of chemical reactions in the body. Trauma also affects the ventral tegmental area (VTA) of the brain's nucleus accumbens, or the reward and pleasure center of the brain…When these systems are constantly activated in response to frequent stressors, they become overtaxed resulting in a surplus of stress hormones. The constant activation of the HPA axis can weaken the immune system and putting the child at increased risk for chronic inflammation which underlies ailments such heart disease and chronic obstructive pulmonary disease. Lastly, the effect of trauma on the VTA has been shown to increase chances of engaging in high risk behaviors such as smoking, substance abuse, and early sexual activity; these behaviors also impact health outcomes in children (Harris, 2014).

In light of recent events, the world knows that a significant population is exposed to severe trauma and loss in the context of persecution and conflict (Nickerson et al., 2014). The most recent refugee crisis that is well known are refugees from Syria. In the conflict seen in Syria, men, women, and children have been victims or witnesses of torture, kidnappings, and massacres (James, Sovcik, Garoff, & Abbasi, 2014). Moreover, rape and other forms of sexual violence have been used as well (James et al., 2014). Syrians have witnessed the decimation of their neighborhoods and homes being destroyed, they have been subjected as targets and have seen people, including their loved ones, brutally murdered by bombs and snipers (James et al., 2014). As seen in Dr.

Sperry and Dr. Harris' explanations on what trauma is and the severity that such experiences have on human beings, it is imperative to understand how these occurrences impact them both psychologically and physiologically.

Differences in mental health disturbances related to trauma across genders in refugees are also evident. Generally, the risk of mental illnesses within this population increases due to pre- and post-migration stress in addition to the asylum-seeking process (Hollander, Bruce, Burström, & Ekblad, 2011). Although this risk increases, some studies show conflicting results that after a significant amount of time lapse (approximately 10 years) between pre-migration to settlement, the more that the stress is reduced (Hollander et al., 2011). There was also a study that explored the specifics of gender-related mental health differences. (Hollander et al., 2011). This study found that refugee women in Sweden purchased more psychotropic drugs compared to non-refugee women. However, Sweden-born men did not have a significant difference in purchasing psychotropic drugs compared to refugee men (Hollander et al., 2011). Furthermore, Hollander et al. mention how other studies from the Netherlands suggested that the immense stress of the asylum-process is certainly a contributing factor for the amount of mental illness individuals among immigrants, especially for women. To strengthen this assertion, findings from the Swedish Red Cross highlight that women in particular, faced stressors and strains that add up to increased levels of mental health disturbances in refugee women from low-income countries (Hollander et al., 2011).

These strains and stressors experienced by refugees, pre and post migration often result in mental health problems due to these traumatic experiences (Tay, Rees, Kareth, & Silove, 2016). The experiences refugees face including war, violence, torture, killing,

imprisonment, and abuse, as well as the subsequent losses suffered increase the potential risk of psychological distress and the development of psychiatric disorders (American Psychiatric Association, 2016). Those mental health problems consist of many disorders including posttraumatic stress disorder (PTSD) and separation anxiety disorder (SAD).

PTSD is defined as a disorder that is caused by a person witnessing or experiencing a terrifying event that can cause mental and psychological distress (Drožđek & Kamperman, 2014). Common symptoms of PTSD include nightmares, flashbacks, having many triggers that connect to the event, and hyper arousal (American Psychiatric Association, 2016). PTSD is commonly found in refugees as a result of a number of events that they witnessed or personally experienced leaving them with these forms of distress. Once refugees move to their new home, they have 50% average at developing PTSD due to political, cultural, and religious oppression (Kukaswadia, 2016). Kukaswadia's studies showed that people had difficulties when being forced to live in a country where their cultures and religious values were not accepted (Kukaswadia, 2016). A questionnaire examined the effects cultural oppression had on families from different countries. The results concluded that over 52% of refugees who immigrated to Canada were affected by cultural oppression. An example of cultural oppression is when someone grabs at their purse when a person wearing a headdress walks by them. This tells the refugees that people fear them and may not be accepting of their religious beliefs. Refugees are prone to mistreatment by others including abusive actions that could cause different forms of PTSD. The events witnessed or experienced from their motherlands do not get erased from their memories. According to Tay's research, about 23% of all refuges experience PTSD and an additional combined 55% experience low

symptoms of either PTSD or Separation Anxiety Disorder (SAD), so they will still be faced with PTSD symptoms as a result of those events (Tay et al, 2016). Both Kukaswadia's and Tay's findings show different ways PTSD both before and after asylum seeking can contribute to refugees' psychological distress. The oppression refugees endure in their new country can trigger past memories of trauma from their motherland.

In addition to PTSD, many asylum seekers suffer from separation anxiety disorder or SAD (Tay et al, 2016). Separation Anxiety Disorder is classified as developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached (American Psychiatric Association, 2016). The common symptoms of SAD include, distress when being separated from their family, constant worry, and having trouble sleeping (Ehrenreich, Santucci, & Weiner, 2008). Although SAD is more prominent in children and adolescents, the disorder still exists with adult refugees (Tay et al, 2016). SAD can be developed due to the act of a person or family being removed from their home and forced to move into a completely new environment, which can cause mental distress and anxiety (Ehrenreich, 2008). SAD is also caused by the families being separated from their home countries and having to undergo the process of acculturation (Kukaswadia, 2016). The bonds that people make throughout their lives become a part of their mental being and when that gets taken away it is often replaced in the form of distress or anxiety (Tay et al, 2016).

As a result of the many stressors refugee children face, they have the potential of developing psychological disorders (Tay et al, 2016). As expected, SAD is very common among children and adults who undergo the process of asylum seeking (Tay et al, 2016).

About 22% of all refuges experience SAD and an additional 55% experience a combination of low symptom SAD and PTSD (Tay et al, 2016). The symptoms children may experience are different from adults. These symptoms include, crying when approached by strangers, constant worry of abandonment, nightmares about separation, not wanting to be alone, and refusal to leave a loved one's side (Ehrenreich, 2008). Children and adolescents are still attached to their families and have bonds that are ruptured by the process of asylum seeking (Tay et al, 2016). Children and adolescents are most reliant on caretakers, particularly parents (Milrod, 2007). The force of separation during a period in their life where having that nurture is important can manifest into SAD and can leave them psychologically damaged for a lifetime if untreated (Tay et al, 2016). Separation anxiety can also lead to panic attacks (Tay et al, 2016). Panic attacks are characterized by overwhelming surges of fear and discomfort that can lead to accelerated heart rate, shortness of breath, and shaking (Allan, Oglesby, Short & Schmidt, 2016). The likelihood of a child refugee growing up and having panic anxiety attacks is about 17%. (Tay et al, 2016).

Depression is one of the most common forms of psychological disorders with over 30% of asylum seekers being diagnosed with the mental illness (Feyera, Mihretie, Bedaso, Gedle, & Kumera, 2015). Depression is defined as a mood disorder that can affect a person's thoughts, behavior, feelings and sense of wellbeing (American Psychiatric Association, 2016). Some symptoms of depression can be lack of feeling in completing daily activities such as eating, sleeping, working, and taking care of responsibilities, other symptoms including feeling sad, empty, anxious and hopeless (National Institute of Mental Health, 2016). Refugees who immigrate to a new country

will begin to feel lost or a lack of belonging to their new surrounding which often causes depression (Feyera et al, 2015). Many refugees have depression due to loss of family, lack of shelter, or being exposed to a wide variety of traumatic events. In Melkadida's study, a Harvard Trauma Questionnaire was used to assess depression in Somali refugees. The results showed that over 38% of the refuges met the criteria for depression. The contributing factors as expressed by the refugees were, witnessing a murder of a family member or friend, lack of house or shelter, and being exposed to increased number of cumulative traumatic events. The study also showed the majority of the refugees who suffered from depression were females (Feyera et al, 2015).

Another common disorder that manifests in the refugee population is prolonged grief disorder (PGD). Grief, to the extent where it is considered to be a psychiatric disorder or PGD, is defined as a severe grief reaction that persists more than twelve months after the death of a close friend or relative (Bryant, 2012). The individual ruminates on feelings of intense yearning, emotional pain, or preoccupation with the deaths that may have occurred (Bryant, 2012). These responses may be because the individual has difficulty with acceptance, anger, a diminished sense of identity, feeling that life is empty, and has issues with engaging in relationships or activities (Bryant, 2012). Thus far, it is widely known that in areas of conflict or on the journey of seeking asylum, individuals, children, and families bear witness to murder and assault of loved ones. Perhaps for refugees, seeing such atrocities happen to their loved ones may make them more susceptible to PGD. It is important to acknowledge that it is within reason that grief manifests within this population. Grief is a natural and expected reaction post loss of a loved one (Nickerson, Lidell, Maccallum, Steel, Silove, & Bryant, 2014).

Fortunately, in a study that looked at this disorder within this population, it was found that the majority of the sample that was exposed to trauma and loss recovered naturally over time (Nickerson et al., 2014).

Although the majority of this study reports that they were able to recover overtime, the investigators recognized a profile that encompassed individuals who showed signs of both PTSD and PGD (Nickerson et al., 2014). This was typically found in refugees who experienced high levels of trauma and loss and creates a "dual emotional burden" (Nickerson et al., 2014). This combination found that individuals may display fear related responses (PTSD) and grief reactions (PGD) (Nickerson et al., 2014). In summation, refugees in particular who have experienced a series of traumatic events including loss of loved ones, suffer devastating effects of mental health illnesses (2014).

Psychological trauma, particularly pertaining to the refugee population, often manifests into mental, neurological, and substance abuse (MNS) problems (Kane, Ventevogel, Spiegel, Bass, van-Ommeren, & Tol, 2014). As discussed previously, various epidemiological literature concerning refugees have consistently shown that the adversities faced puts them at risk for a number of psychological disorders such as PTSD or depression (Kane et al., 2014). However, MNS issues may persist in refugee camps or as a result of traumatic experiences (Kane et al., 2014). Kane et al. (2014) examined these issues by collecting MNS data from the health information system (HIS) from 2009-2013 from 90 refugee camps in fifteen participating countries: central Africa and the Great Lakes, East and Horn of Africa, Southern Africa, West Africa, Middle East, South Asia, and South East Asia. From the data extracted, seven categories were formed to include MNS issues: epilepsy seizures, alcohol and substance use disorders, mental retardation

and intellectual disabilities, psychotic disorder, severe emotional disorder, medically unexplained somatic complaint, and other psychological complaints. They found that most MNS issues in their sample were attributed to seizures and epilepsy disorders (40.6%), then the psychotic disorders (22.7%), followed by emotional disorders (12.8%). Higher rates of MNS were found in women and lower rates were found in children perhaps because symptoms manifest differently across genders and ages. The conclusion drawn from this study was that there is a high number of refugees with epilepsy and psychotic episodes that need to be addressed urgently and appropriately in addition to developing interventions to address several psychological issues and prevent psychosomatic issues among this population.

Current Interventions for Refugees

Community Building

One of the most critical needs of refugees and migrants in the United States is mental health services (Goodkind et al., 2014). Thus far, the research on the efficacy of trauma-focused mental health interventions is divided (Goodkind et al., 2014). The loss of valued social roles such as parents, spouses, or children from death or separation and unemployment as well as the inability to utilize former job skills has been noted in several studies (Goodkind et al, 2014). The loss of these roles significantly impact their overall well-being and social support is a powerful tool in enhancing quality of life post-migration (Goodkind et al., 2014). Supporting this sentiment, researchers Gorst-Unsworth and Goldenberg (as cited in Goodkind et al., 2014) found that depression among refugees was more related to poor social support than from exposure to trauma

(Goodkind et al., 2014). This is where community building helps with the healing process.

Community Gardening is a popular method for interweaving refugees with the society they reside in by promoting psychological healing, self-sufficiency, community engagement, and replenishment of human dignity (Gerber et al., 2017). Gerber et al. (2017) studied the process of interweaving Nepali Bhutanese refugees in society. Although their results found no significant group differences in regards to depression, anxiety, somatic complaints, or adjustment to the United States, their qualitative findings supported that participation in community gardening created new supportive networks, learning how to access practical services, and overall engagement with the community (Gerber et al., 2017). As mentioned in this article, this finding is crucial given that much of the literature has found that social isolation heightens negative impacts on mental health and well-being (Gerber et al., 2017).

Pejic, Hess, Miller, and Willie (2016), explored a program for Somali parents seeking asylum designed to increase parental social support and empowerment (Pejic, Hess, Miller, & Wille, 2016). Additionally, this eight week psycho educational program sought to address post settlement challenges by fostering a bicultural understanding of mental health and overall well-being within this population (Pejic et al., 2016). The program was led by a trained group facilitator trained in behavioral health with ties to the Somali refugee community (Pejic et al., 2016). These sessions were two hours long with 4 components: an initial check-in with the parents where Somalian food was served and identified; current feelings with a card featuring different emotions through pictures; a brief psycho educational lesson on a specific topic; an experiential activity that allowed

the parents to express themselves through art, music, and storytelling; and lastly a closing discussion (Pejic et al., 2016). The findings and the feedback from this program seemed positive, as one program participant said: "I never had a chance to have a meeting with or support group with a lot of females and that has given me more knowledge and more power (Pejic et al., 2016)."

Art Therapy

Art therapy is defined by Cathy A. Malchiodi as a creative process of art making facilities reparation and recovery and is a nonverbal communication of thoughts and feelings (Malchiodi, 2012, pg. 1.). Art therapy is a way of allowing different populations of people who suffer from mental distress to recreate a narrative for their nonverbal memories. This allows them to experience their frustrations and anger without having to verbally speak about the trauma itself (Hongo, Aileen, Katz, Valenti, 2015). It also allows the refugees to learn a safe way of improving their coping skills and resilience. Art therapy can allow asylum seekers to improve their emotional pain through expression. Creating different art forms is a communication mechanism for people who cannot communicate verbally due to the pain they have endured (Hongo et al., 2015). Through the art, professionals are able to obtain information as the group members connect their feelings and express them in art form.

Research shows that art therapy has excelled the healing process with refugees who have experienced trauma (Kalmanowitz, Debra, Rainbow, 2016). The refugees have endured many challenges, including trauma experienced both while in the process of immigrating and prior to immigrating from their motherland. As a result of the trauma experienced by these families, most members of the family are left with mental distress

that can lead to a variety of mental disorders (Kalmanowitz et al., 2016). Refugees suffering from trauma typically do not know how they can express their thoughts, feelings, and emotions, thus another reason for experiencing mental distress. Working with this population requires attention to their internal experiences with trauma and external emotions (Kalmanowitz et al., 2016). Some of these memories exhibited are verbally expressed while others are nonverbally stored through senses. Trauma is often ignored and suppressed by refugees in order for them to cope with the negative effects (Hongo et al., 2015). These traumatic events not only require healing through therapy, but also often are suggested to heal through other methods such as allowing the refugees to show their creativity.

A study conducted by Kalmanowitz at the University of Hong Kong focused on how art therapy combined with meditation could impact asylum seekers who faced trauma (Kalmanowitz et al., 2016). They worked with refugees from seven different cultures and different countries at the Inhabited Studio, which is an art therapy and mindfulness studio. Twelve participants took part in this four day experiment where they made art, learned mindfulness meditation, and ended the experiment with a focus group. The purpose of the focus group was for the participants to identify cultural and religious factors that would help them cope with their trauma. The objective was to see how the asylum seekers responded to the art therapy, explore the cultural aspect of art therapy, and to see if the combined methods of treatment helped improve resilience. Nonverbal behavior, semi structured questionnaire, discussion groups, reflective writing, written evaluations, focus groups, and individual interviews were used to collect data. Workshops, discussion groups, individual interviews, and focus groups were audio and/or

video recorded and transcribed. Observations were made of the artwork and the nonverbal behavior of the refugees. The results showed the majority of the male refugees created art that exhibited fear (Kalmanowitz et al., 2016). Many of the refugees recognized that the art helped them in a variety of ways including, keeping them busy and focused on something other than their pain. Many refugees created artwork that reminded them of their life back in their motherland before everything began. Some of the participants were able to envision a new reality for themselves, which resembled hope. What was gathered from the results of this experiment was the ability of this program to help the refugees with their expression of themselves (Kalmanowitz et al., 2016).

Other Evidence-Based Therapeutic Interventions

There are several types of evidence-based interventions that clinicians use when they treat refugees, particularly individuals who display symptoms of PTSD (Nakeyar & Frewen, 2016). Foa (2011) asserts that such interventions like prolonged exposure therapy (PE), which involves structured retelling of the trauma to promote extinction of distress associated with the traumatic memory (as cited in Nakeyar and Frewen, 2016). Resick (2001); Resick & Schnicke, (1992) states that cognitive processing therapy (CPT) is effective in that it aims to increase comprehension and reconceptualization of the memories to reduce distress (as cited in Nakeyar and Frewen, 2016). Although these modalities have been shown to reduce PTSD symptoms, they typically address responses from a single event, which may or may not be effective since refugees may experience trauma from multiple events. As stated by Schauer, Neuner, & Elbert (2005, 2011) narrative exposure therapy (NET) is similar to PE, yet differs in the way that NET strives to treat multiple traumatic events across the lifespan in a brief amount of time and is

specifically relevant to refugee and torture populations (as cited in Nakeyar and Frenwen, 2016). Interestingly another aspect of this therapy is that some clinicians may use a string to signify the patient's lifeline, stones to signify traumatic events, and flowers for positive events, hopes, and future aspirations (Nakeyar and Frenwen, 2016) In this aspect, NET may be a more effective treatment option for refugees than PE. Lastly, Trauma-focused cognitive behavioral therapy (TF-CBT) is another framework that seems to be all encompassing and effective in treating this population (Unterhitzenberger et al., 2015). TF-CBT includes eight components that can be remembered with the following PRACTICE acronym; psychoeducation and parenting skills, relaxation, affective modulation, cognitive processing, trauma narrative, in vivo exposure, conjoint child and guardian session, and enhancing safety and future skills (Unterhitzenberger et al., 2015). All of these treatments mentioned above, are shown to be effective and relevant treatment options for refugees who are not receiving these services.

Conclusion

In summary, asylum-seekers who are fortunate to receive refugee status relocate all over the world. Ultimately, although refugees are being placed in safer environments, they will carry emotional, psychological, and physical problems with them. These problems stem from their background which consists of several forms of violence that include witnessing and being a victim of torture, false imprisonment, and forcibly being removed from their country. Another crucial part of the refugee experience involves traveling outside of their country and seeking asylum in different countries, and then having to acclimate to their new environment. As a result of these traumatic experiences, refugees will often have mental distress, which can form a variety of different disorders

including PTSD, SAD, depression, and prolonged grief disorder (Nickerson et al., 2014.; Tay 2016.; Feyera, 2015). This literature review highlighted some of the common adversities refugees confront, despite trying to build a better life for themselves and their families. This research emphasizes that it is imperative that refugees have access to and utilize proper treatment options within the host countries to cope with their trauma. In receiving effective services, these refugees may be empowered to join the new society in meaningful ways.

Proposal: Project Resiliency

Given the extensive amount of literature available on several aspects that influence the mental health of refugees as well as the current events affecting immigrants, we propose a program that would integrate refugees into the community and focus on healing any psychological distress that they may be experiencing. The literature also supports our concerns that refugees and immigrants often feel isolated when they arrive in a new country and in this case we are focusing on the United States. We are planning on inviting 5 families from the Boston Center for Refugee Health and Human Rights and 5 clients from Newton Wellesley Weston Committee for Community Living Inc., to participate in this program. The multilingual staff at Saheli will provide translation services at any given time during this program. The program will be located at the South Boston Community Health Center and will involve art therapy and other activities. To do this, we will 4 culturally competent counselors that specialize in individual and family therapy and 2 art therapists who have worked with culturally diverse populations. Because of the vast amount of literature regarding the mental health of refugees as well as the current events in our country, we wanted to structure a program

around integrating refugees into a community and focusing on healing the psychological anxiety that they may be experiencing.

Program Time and Location

Our program will take place at the South Boston Community Health Center, which is located where the clients are already receiving other services at Boston Center for Refugee Health and Human Rights. Our program will run on Tuesdays and Thursdays for two concurrent months. The program will be conducted over an eight hour session from 9 AM to 5:30 PM. Before the program begins we will conduct a weekend long orientation where the refugees will learn about the program, the goals that we want to accomplish, the therapeutic services being provided and their benefits. Moreover, we will provide the clients more information about transportation, meals, and childcare provided by the interns at Saheli and Webster House. Our goal is to have the refugees leave our orientation with a complete understanding of the services that we will be providing them. As mentioned previously, different methods of therapy will be offered such as family, individual, and art therapy. The therapy sessions will not overlap in time, therefore, the clients will have the ability to attend as many as they can. The clients are given some flexibility and are allowed to come and go, hence if they have to go to work they can come in and leave at their convenience. We want to make sure that this program is free at no cost for the families, therefore, we will allocate a portion of the grant to provide for transportation and food (refer to appendix D). Specifically, participants will be given MBTA Charlie cards, free lunch, and all the art supplies will be provided. Webster house residents will have access to vans provided by their organization and the staff from Saheli are willing to use their personal cars for transportation. Depending on the ethnic

background of the families, our team will ensure that the food choices we provide are culturally appropriate and we will consider dietary restrictions and allergies as well.

Schedule

Project Resiliency will be conducted during a two month trial period from 9AM to 4:30PM on Tuesdays and Thursdays. The 6-hour sessions will include art therapy, family, and individual therapy. The program will begin with a specific scheduled time for each session. The clients can select the options that most interests them. Each session will be followed by a thirty minute break period. The orientation will be conducted on the second weekend of July (Refer to appendix A). The first scheduled session will take place on Tuesday, July 11th and the program will conclude on Thursday, August 31st. The refugees will arrive on both days between 9 and 9:30 AM, have time to ask questions, familiarize themselves with daily announcements, and arrive at the location for their first session. The first session of the day will begin with family therapy from 9:30 AM to 11 AM followed by the other sessions (refer to appendix A). Lunch will be provided between the hours of 11:30 to 12:30PM, individual therapy will be offered at 1pm-2:30pm, finally, the day will be concluded by an art therapy session with the residents from Webster House will continue between 3-4:30pm. We will ask for client feedback on the schedule and modify the sessions with a rotating schedule and depending on the feedback we receive (refer to appendix B and C). The schedule for August will remain the same, however the times of family and individual therapy will be switched. A flexible schedule would allow clients to come in at times that are more convenient for them and allow participation in a specific program of interest. If the program is successful, we will change the times to accommodate to the school schedule.

Employment

The goal of our program is to provide the best treatment possible for our clients. In order to accomplish this, we want to hire professionals who will give our clients the best chance at treatment options. We care about our clients and want to see them overcome the obstacles that they have had to overcome throughout the years. We would like to hire a diverse group of professionals to represent the different cultural backgrounds and gender equality. It will be a requirement for the staff to be educated and knowledgeable according to the position they will be responsible for at Project Resiliency. The therapists we intend to hire will require a Masters in therapy counseling, clinical psychology, or social-work and be licensed. Our staff is also required to have completed coursework that reflects their understanding of cultural diversity. Furthermore, we will look for potential candidates with experience working with refugees or people of diverse backgrounds. The art therapist will be required to have a Masters in art therapy. Our translators from Saheli will be instructed to accommodate each family based on their native language. We will also hire a director to lead the program. We also plan to invite various interns from the organizations we are partnering with to join our staff and to provide childcare while the parents or guardians are attending their desired sessions. We are confident that our program will not only help our clients and their children, but also provide knowledge and experience for people interested in the social sciences field. We expect our therapists and translators to have compassion for the populations that they will be serving. We will look for characteristics such as patience, empathy, and understanding in those individuals we want to hire to be part of our program.

Participants

Residents from Webster house

There will be five residents from Newton Wellesley Weston Committee for Community Living Inc., who will take part in the art therapy portion of Project Resiliency. These individuals who live together in community-based housing are senior citizens with physical, intellectual, and mental disabilities. Four of the residents have been living together for ten years and the fifth resident moved into the house in May, 2016. The Newton Wellesley Weston Committee for Community Living Inc. cares about providing their residents with opportunities to interact with the Newton community. The center offers such programs as music, art, and sports. These programs have allowed the residents to further excel in their daily activities through learning different social skills. Research shows, people who suffer from a mental disorder can learn a variety of skills by having interactions and collaborating with one another (Hongo et al., 2015). By integrating these two populations, it gives both groups a chance to be surrounded by different people. The refugees will learn how art therapy can positively impact others by watching and interacting with the residents from Webster house. This opportunity also benefits the residents at Webster house because they can engage in social activity through art with a new population.

Refugees from The Boston Center for Refugee Health and Human Rights

In 2015, the Boston Center for Refugee Health and Human Rights served 384 clients in total; females (58%) and males (42%), with an immigration status of asylum seekers (68%), asylee (10%), refugee (2%), permanent resident (7%), U.S citizen (11%), temporary protected status (0.5%), undocumented (0%), visa (-), derivative asylee (1%) (BCRHHR, 2014). The religious backgrounds include Christians (60%), Muslims (31%),

and other (8%) (BCRHHR, 2014). The clients that are served come from all over the globe including but not limited to Uganda, Cameroon, Somalia, Democratic Republic of the Congo, Bosnia and Herzegovina, Ethiopia, Iraq, Sudan, Syrian Arab Republic, and China (BCRHHR, 2014). They are often referred by resettlement or assistance organizations (12%), communities or places of worship (3%), attorneys or judges (39%), self, family, or friends (21%), healthcare clinics or provider (19%), and others (6%) (BCRHHR, 2014).

The Boston Center for Refugee Health and Human Rights stemmed from the International Mental Health Program established in 1995 by Dr. Piwowarczyk (Boston Center for Refugee Health & Human Rights (BCRHHR), 2014). The program is an interdisciplinary collaboration that was founded in 1998 by several mental health, medical, and legal professionals. This organization provides vital services such as case management, career development, refugee patient navigation, medical and mental health services, legal services, and health literacy education (BCRHHR, 2014). We recognize clients may already be receiving mental health services from this organization, therefore, we want to recruit the clients that are not using the mental health services at BCRHHR. Furthermore, we offer community building and integration activities within the program and the therapy options can be something that the clients can choose to do if they want.

Description of Program Offerings

During our orientation weekend, we will provide a tour of the venue, to introduce the staff and clinicians. This will be followed by an information session about the programs. We will hire 3 people from Saheli to provide Arabic translation for 2 families from Syria, 1 family from Iraq, and 2 families from Somalia if needed. The clients will

learn about each clinician's specialization and they will be taught the benefits of those services. After lunch is served, the clients can choose a clinician and receive whatever treatment they feel necessary: individual or family therapy. We want to reiterate that we are only recruiting families from BCRHHR who are using services besides counseling to introduce them to therapy. Changes can occur at any point during the 2 months or in future weeks if a client feels that a specific therapy is not working for them. We want this experience to be beneficial for the clients. Therefore, if they need to change clinicians or the type of therapy they are receiving we can help them do so.

Next, the clients will meet with the residents from the Newton Wellesley Weston Committee for Community Living Inc. for the art therapy sessions. Hereafter, parents may be introduced to the interns of our partnering organizations who will be providing childcare. The children of the participants and the interns will strongly be encouraged to join in the art therapy classes with the residents as well. These art therapy classes will allow both populations to communicate and begin feeling comfortable with one another. After the first day, it is up to the clients to schedule times to meet with their preferred clinicians. For example, if a family member feels that they need individual therapy and art therapy, they may come in on Tuesday at 1PM and stay at the center until 4:30 PM (Please refer to appendix A). If they want to try other sessions, they would have to notify either one of the clinicians in charge of the particular therapy or the director of the program. We believe this will be a successful and empowering program that will bring communities, organizations, and generations together to benefit from one another.

Budget Logistics

We are asking for a grant in order for us to create Project Resiliency and provide refugees with a therapeutic way of healing from the trauma they have experienced in their motherland. This money will be used to create 3 different types of treatment methods for our clients including family, individual, and art therapy. The majority of the funds will be allocated for the rental of the South Boston Community Health Center and to allow service payment for the professional clinicians and translators. The remainder of the funds will go towards the supplies used for the art therapy classes, food that will be provided for our clients, and other miscellaneous expenses. We strongly believe in this program and are confident in its goals to invest in this grant. The money received from this grant will assist a group of people to obtain the services that they need in order to begin building a new life in our country (refer to appendix D).

Evaluation of Project Resiliency

An evaluation is an important aspect in determining the success of our program. We will create a survey for the clients to complete and elicit the feedback on our program via miscellaneous questions. We will work with our translators from Saheli to construct surveys in every language and dialects in order to reach every member. We will begin with a standard survey and make adjustments to the questions as we go along. For some families, certain specific questions may be difficult or trigger an event, hence we will modify the survey accordingly. Another way to evaluate our program is by having the clinicians take notes following their sessions with the clients. They can use the notes and answer an evaluation survey that will give the program feedback on the client services. If these evaluations show that our clients are making good progress, it will confirm that we have reached the goals we set out to accomplish. Different programs

tend to have their own assessment tools to help determine how their clients are progressing. The staff would be advised to have a meeting with the program director on a weekly basis to share the progress of their clients as long as the information shared remains confidential.

Potential Risks

During the process of creating a new program, there are going to be risks involved. One of the biggest risks for Project Resiliency is the miscommunication that could occur between the clients and the staff. We are determined to make sure the clients are comfortable and feel accepted at our program. To avoid this potential risk from happening, we will obtain as much information about the clinicians that we hire including: background checks, screenings, and confirmation of licensure. We make sure their required license is up to date and that they have provided evidence of all their coursework that is needed for our clinical positions. During this workshop, they will learn ways to work with our clients and receive information necessary to ensure the success of our program. Clinicians will be taught how to speak with people from different cultures. They will practice what they have learned and evaluate their therapy techniques and the language they use. A risk that may arise in this program would be the acculturation process of adjusting to the services that are being provided. We understand that our clients may not have received counseling services or may feel stigmatized for seeking and openly receiving help. This risk is something that we are imparting on our clinicians and staff to be aware of. During the interviewing process, we will ensure that the clinicians we hire are cognizant of this challenge and they will find ways to individualize the treatment for every client.

Summary

As discussed above, community building and the hiring of a diverse, culturally competent and trauma informed staff have been shown to have a positive impact on mental health in refugees. We envision this program as an opportunity to empower the five families to develop relationships with knowledgeable clinicians in order to treat symptoms and offer guidance throughout the adjustment process. Furthermore, we strive to extend the healing process not only between refugees and clinicians, but also between the residents from Newton Wellesley Weston Committee for Community Living, Inc. through art therapy. As mentioned previously, the multilingual staff at Saheli will provide translation services needed to prevent any confusion in addition to connecting with the clients as well. In this sense, the refugees receive treatment for psychological distress on the individual, group, and family levels in addition to engaging in art therapy to meet members from a different community.

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Vanessa Cunha

1844 Commonwealth Avenue,
Auburndale, Massachusetts, 02466
(860)-817-4621
vcunha@lasell.edu

Summary
Highly skilled and ambitious psychology student with work experience that includes communicating with the public and assisting customers. Holds organizational, communication skills and knowledge in psychological testing, counseling, child development and adolescent studies. Skilled in Microsoft Word, Excel, PowerPoint

Education
Lasell College, Newton, MA
Bachelors of Arts, Psychology
Minorin Youth and Crime September 2013- May 2017
GPA: 3.460/4.0
Dean's List: Spring 2014

Coerce Work
Child Development, Adolescents Psychology, Dynamics of a Small Group, Assessments of Individual Difference, Experimental Design, Social Psychology, Psych of Diversity, Sexual Violence Advocacy.

Literature Review/Grant Proposal In Progress

Work Experience
Banana Republic West Hartford, CT
Sales
November 2014 – Present

- Assisted customers with clothing selection.
- Managing the fitting rooms.
- Provided feedback to customers when asked for an opinion.
- Organized store, folded clothes, returned garments to proper location.
- Acknowledged customers as they entered and left the store.

Internships
John M. Berry Boys & Girls Club of Newton MA September 2015-December 2016

- Interact and play with kids
- Help kids complete their homework
- Communicate with the kids and staff about their needs
- Lead and Participate in activities

Newton Wellesley Weston
Committee for Community Living, Inc. Newton MA September 2016-Present

- Work with residents who have physical, mental and intellectual disabilities

- Work with residents on their goals assigned by the supervisor
- Communicate with the residents about their needs
- Helped with the residents daily activities and tasks around the house

Activities

Second Step Organization at Lasell College

- Mentor in the Second Step organization, which provides assistance to parents, and children who have been affected by domestic violence.
  March 2014-Present

Volunteer Work

Pediatric Clinic at Saint Francis Hospital and Medical Center, Hartford Connecticut,

- Filed and organized paperwork, answered telephones and assisted staff.
  Summer 2013

Vanessa Cunha was born on December 27th, 1994 in Hartford, CT. She is currently attending Lasell College with the intent to graduate in May 2017 with a Bachelor of Science Degree in Psychology and a minor in Youth & Crime. After graduation, Vanessa plans on talking a year off in order to work in the Psychology field before presuming her Masters Degree in Child Psychology or Clinical Psychology. Vanessa's ambitions include working with children and adolescents in a therapy setting. Vanessa's biggest passion outside of Psychology is traveling, so she plans on traveling the world before settling down with marriage and kids.

Christine Francis

5 Brooks Road| Wayland, MA 01778| Phone: 508-479-0250| Email: cfrancis@lasell.edu

Summary

Highly motivated psychology student with a solid work ethic and eagerness to continuously learn and grow professionally and personally. Passionate about helping others with a genuine concern for their well being, with proven skills in communication, organization, mentoring and problem solving. Indefatigably strives for quality work in both school and occupation.

Education

Bachelor of Science, Psychology, *Lasell College*, Newton, MA May 2017 (Anticipated)

Minor, Diversity and Inclusion **GPA 3.8/4.0**

Dean's List Fall, Psi Chi International Honors Society

Related Experience

Advocacy Internship, *Saheli,* Burlington, MA September 2016 – Present

- Performed administrative duties
- Assisted advocates on providing plans for clients
- Co-facilitated informational group for South Asian girls at Watertown High School about college

Crisis Intervention Internship, *Call2Talk,* Framingham, MA September 2015 – Present

- Completed training and learned appropriate responses in order to provide empathy and active listening to callers in crisis
- Fulfilled 150+ hours of internship requirement and spoke with people seeking emotional support
- Utilized therapeutic techniques and risk assessment for each caller
- Compiled call taker data for each shift and provided support to other call takers in the office

Research Assistant, *Psychology Department,* Lasell College April 2015 – May 2016

- Assisted recruiting participants for body-ownership study
- Co-conducted experiment paradigm and collected data; presented findings at the APS conference in Chicago
- Collaborated with professor and partner with abstract

Clinical Internship*, Holy Cross Hospital,* Kollam, Kerala July 2015

· Observed and participated in client counseling sessions and exposed to international counseling techniques
· Visited inpatient clients completing rehabilitation and substance abuse programs
· Convened with various doctors in the Psychology department gathering information pertaining to nuances of psychology

Volunteer, *Abbot Gregory English Medium School*, Karichal, Kerala July 2015
· Actively participated in several classrooms from kindergarten to tenth grade
· Presented with language barrier and overcame struggles through classroom observation and playing with children
· Aided English teacher with classwork and provided instruction for basic math
· Created and facilitated hygiene lecture to tenth grade students using both English and Malayalam to effectively convey information

Additional Experience
Tutor | Mentor, *Center for Community Based Learning, Lasell College*
September 2015 – Present
· Visit local underserved schools to mentor young children and act as a role model
· Facilitate educational activities for children in addition to providing homework help
Child Care Provider, Natick, MA October 2013 – Present
· Care for twin siblings, age ten, by driving to after school activities
· Assist with homework and provide engaging activities both indoors and outdoors

Senior Camp Counselor, *Camp Brunenbrook, Newton Parks and Recreation*, Newton, MA June – August 2014
· Supervised 10 to 20 children, varying weekly, ranging in ages eight to twelve
· Ushered children to various activities each day and planned age appropriate activities when camp specialists were absent

Activities
Mentor at The Second Step
October 2014 – December 2015
Diversity and Inclusion Committee
September 2014 – Present
Rasarang School of Performing Arts
September 2011 – Present

Language
· English, Malayalam: Conversational

Christine Francis was born on June 7th, 1995 in Newton, MA. Christine is a second semester senior at Lasell College and anticipates graduating in May 2017 with a bachelor of Science degree in Psychology. After graduation, she plans on working for a year as a legal assistant or a paralegal to see if she wants to attend law school. Dedicated to social change and advocacy, she has been engaged in various activism projects raising awareness on social justice issues on campus, interned at a domestic violence organization for South Asian women at Saheli, and volunteers at a crisis hotline. In her spare time, she enjoys spending time with her family and friends, staying active outdoors, and has been learning bharatanatyam, a classical, ancient South Indian dance form since she was 13 years old.

Appendix A

Saturday July 8th Orientation

Times	Activities
9:00 a.m. - 10:00 a.m.	Tour of the facility
10:15 a.m. - 12:30 a.m.	Info Session (about program):
12:45 p.m. - 1:45 p.m.	Lunch
2:00 p.m. - 3:30 p.m,	Match up with Clinicians
3:45 p.m. - 4:30 p.m.	Meeting the residents from webster house

7/8-7/27

Times	Activities
9:00 a.m. - 9:30 a.m.	Arrival
9:30 a.m. - 11 a.m.	Family Therapy
11:30 a.m. - 12:30 p.m.	Lunch
1:00 p.m. -2:30 p.m.	Individual Therapy
3:00 p.m. - 4:30 p.m.	Art therapy

8/1-8/31

Times	Activities
9:00 a.m. - 9:30 a.m.	Arrival
9:30 a.m. - 11 a.m.	Individual Therapy
11:30 a.m. - 12:30 p.m.	Lunch
1:00 p.m. -2:30 p.m.	Family Therapy

3:00 p.m. - 4:30 p.m.	Art Therapy

Appendix B

Client Program Evaluation

Did you and/or your family members feel safe, welcome, and included?

Were you able to find a counselor that you felt connected with?

Do you feel that your counselor understands and sensitive to the needs of you and/or your family?

Do you think the counseling and or art therapy sessions were helpful?

Does the time and location work well for you and/or your family?

Is the food provided appropriate? Is there a particular type of food that you would like us to provide?

What other feedback/improvements would you like to see for next week?

Appendix C

Clinician Program Evaluation

Did the time and location work well for your clients?

Did the time and location work well for you?

In your opinion, did you feel that rapport was established between you and your clients?

Were you able to see improvement in the symptoms of your clients?

What other feedback can you offer to improve for the following week?

Appendix D

Personnel:

Item	Quantity	Cost	Total Cost
Program Director	1	$49/7hrs/16 days	$5,488
Art Therapist	2	$24/7hrs/16 days	$2,688
Individual Therapist	1	$40/7hrs/16 days	4,480
Family Therapist	1	$38/7hrs/16 days	$4,256
Translators	3	$20/7hrs/16 days	$$2,240

$19,152.00

Utilities:

Item	Quantity	Cost	Total Cost
South Boston Community	1	$3000	$3000.00
Internet Bill	1	$50/2 months	$100.00
Phone Bill	1	$288	$288.00
Electricity Bill	1	$750	$750.00

$4,138

Travel Expenses: (MBTA Passes)

Item	Quantity	Cost	Total Cost
Families of 4	2	$2.75/2x Week/16 days	$352.00
Families of 5	2	$2.75/2x Week/16 days	$440.00
Families of 6	1	$2.75/2x Week/16 days	$528.00

$1,320

Office Supplies:

Item	Quantity	Cost	Total Cost
Dell Computer	1	$224.47	$224.00
Printer/Fax/Scanner	1	$259.00	$259.00
Ink Cartridges	2	$34.75	$69.50
Paper (500 sheets)	1	$6.74	$6.74
Mechanical Pencils	2 dozen	$12.12	$12.12
Pens (10pack)	2	$3.14	$6.28
Manilla File Folders (100)	1	$7.98	$7.98
Scotch Tape (4pack)	1	$6.97	$6.97
Paper Clips (1,000)	1	$5.97	$5.97

$598.56

Art Therapy Supplies:

Item	Quantity	Cost	Total Cost

Paper (500 sheets)	2	$6.74	$13.48
Markers (broad lined)	4	$2.38	$9.52
Markers (thin lined/12 count)	4	$4.68	$18.72
Crayons (twistables)	4	$6.97	$27.88
Colored Pencils (150 pencils)	2	$59.99	$119.98
Scissors	25	$2.97	$74.25
Pencils (75 pencils)	2	$13.99	$27.98
Watercolor Paint (pack of 3)	12	$6.97	$83.64
Acrylic Paint (24 colors)	2	$17.99	$35.98
Cups to hold Paint (set of 10)	6	$8.39	$50.34
Paint Brushes (16 pcs)	4	$9.96	$39.84
Modeling Clay (10 Colors)	8	$14.99	$119.92

$621.51

Food/Drinks:

Item	**Quantity**	**Cost**	**Total Cost**
Water Bottles (24 bottles)	6	$8.94	$53.64
Coke (2 Liters)	12	$1.79	$21.48
Diet Coke (2 Liters)	8	$1.79	$21.48
Sprite (2 Liters)	8	$1.79	$21.48
Orange Soda (2 Liters)	4	$1.79	$7.16
Apple Juice (10 boxes)	10	$3.16	$31.06
Lemonade (10 boxes)	10	$3.16	$31.06
Pizza	16 large	$12.00/ 4 days	$768.00
Syrian Cuisine	$7.00 /10 people/12 dys	$7.00	$840.00
Iranian Cuisine	$8.00 /5 people/12 dys	$8.00	$480.00
Somalian Cuisine	$7.50/ 9 people/12 dys	$7.50	$810.00
Dessert Cookies	8 boxes	$5.00	$40.00
Edible Arrangements	2 (1 assortment a week)	$95.00	$190.00
Coffee	2	$8.47	$16.94
Coffee Maker	1	$99.95	$99.95
Coffee Filters	8	$3.28	$26.24
Coffee Creamer	4	$3.50	$14.00
Lipton Tea	4	$3.28	$13.12
Sugar Packets (100 packs)	2	$2.12	$4.24
Electric Tea Kettle	1	$19.94	$19.94
Styrofoam Cups (100 count)	2	$28.89	$57.78
Dixie Plastic Cups (66 count)	4	$10.98	$43.92
Plates (50 count)	8	$4.48	$35.84
Utensils (120 count)	8	$6.84	$54.72
Paper Towels (800)	4	$6.02	$24.08

$3,726.13

GRAND TOTAL: $29,556.20