Healing in a New Home: An Analysis of Psychosocial Interventions for Refugee Women Survivors of Gender-Based Violence in a Resettlement Context

Author: Meredith Hawkins

Abstract

While the current refugee crisis is the result of various factors, sexual and gender-based violence (SGBV) remains a significant issue for refugee women. This particular thesis is an applied perspective on the socioecological approach and feminist constructivist theoretical orientation to mental health and psychosocial service provision for refugee women survivors of sexual and gender-based violence. The findings are an analytical stand based upon four interviews conducted with mental healthcare providers working among Maine's population of recent-arrival refugees from Central/Eastern Africa, as well as a comprehensive literature review on refugee mental health and sexual and gender-based violence theory. It argues that, vis-a-vis these frameworks, care providers can best account for the intersectional identities of the immigrant woman, as well as the collective identity of the culture in which she is situated, both ethnographically via the country of origin, and physically within the resettlement society. The interviews were each individually coded and aggregated into three thematic concentrations spanning a descriptive discussion of cultural differences in perceptions of mental health, a reflection from practitioners regarding the needs for furthering the field, and an inquiry into the macro-level barriers to care. The resulting qualitative evidence from the interviews supports the aforementioned orientations to care and, therefore, illustrates a strong case for culturally-competent applied psychology as a means for both individual and communal healing.

Acknowledgements

I am incredibly fortunate to say that I could write an entire thesis solely on the people that have contributed to my intellectual and personal development over the course of my time at BC and beyond. For those who I have mentioned below, please know that a few sentences will never be enough to truly acknowledge my gratitude for you in supporting me during this process. For those unnamed, our time together has influenced the writing of this thesis in countless ways – thank you for making me who I am.

To the International Studies Department and Professors Owens and Nakazato, thank you for providing me the opportunity to combine my two majors into a year-long project that, hopefully, illuminates the voice of so many who are otherwise silenced.

To my McGillycuddy-Logue Fellows cohort and Professor Wells, I want to be all of you when I grow up.

To my co-interns and supervisors at the BC Center for Human Rights and International Justice, I hope you hear your voice in this – I promise you, it's there.

To my SWSG community, thank you for helping the next generation of women to be Strong. Loud. And Proud. They are lucky to have you by their side.

To my roommates (including Hart), vacationland crew, unaccompanied minors, chachi's, reinas, and Nicola, this simply wouldn't have been possible without you – thank you for the laughs yesterday, today, and tomorrow. I love you all.

To my O'Neill 3 Squad (Yahya, Nick, Nurun) & Reading Room Fanatics, I'm so glad our friendship extends beyond the library at 2 a.m. I love you.

To Alex, thank you for it all. Safe to say you learned coffee was the way to my heart pretty quickly. Hopefully the caffeine paid off here. Xx

To my advisor, Professor Oliveira, thank you for taking this on and for your unwavering support personally and academically. It has been an honor to work alongside you in this.

To my family, this thesis, and my education are possible because of you – I cannot think of a greater gift. 143.

To Ruth and those at Gateway Community Services, thank you for all that you do. These are your words. This is for you.

Table of Contents

Chapter 1
Introduction

Introduction & Topic of Investigation

While the current refugee crisis is the result of various push-pull factors, sexual and gender-based violence (SGBV) remains a significant issue for many recent arrivals, particularly for refugee women. Rape, as well as many other forms of gender-based violence, are frequently used as tools of war with the intention of demoralizing the entire community. However, in addition to the community, the impact of rape and gendered violence on individual survivors fleeing war-torn societies can have serious and long-lasting influence over their mental, emotional, social, and psychological wellbeing in the years to follow. For survivors who have fled to seek protection and refuge in other countries as a result of such violence, the implication and need for systems of support aimed at addressing both the immediate and residual trauma is paramount (Yohani & Hagen, 2010). Therefore, when considering how psychosocial care providers should orient themselves toward culturally-competent accompaniment of refugee women survivors within a resettlement context, it is necessary to adopt a holistic approach centered around the female experience.

This particular thesis is an applied perspective on the socioecological model and feminist constructivist theoretical understanding of mental health and psychosocial service provision for refugee women survivors. It argues that, vis-a-vis these frameworks, care providers can best account for the intersectional identities of the immigrant woman herself, as well as the collective identity of the culture in which she is situated both

ethnographically via the country of origin and physically within the resettlement society. It is through this integrated inclination to care that providers can appreciate the unique undergirding power differentials between men and immigrant women, consider the multifaceted set of circumstances in need of addressing within care provision, and understand the link between SGBV, war, and genocide. Through doing so, psychosocial companions can begin to link the individual with the whole and conceptualize the complexity of the relationship between individual experiences and the bidirectional influence existing between them and the residing social and cultural superstructures. This particular orientation to care concurrently requires a unique understanding of the particular needs of women refugee survivors that can be cultivated through a feminist practice of cultural reflexivity, geopolitical and cultural education surrounding the client's country of origin, and focus on community healing in order to engage in truly culturally-competent service provision.

The findings of this investigation are an analytical stand based upon four interviews conducted with psychosocial care providers of various capacities working among the population of recent-arrival refugees from Central/Eastern Africa in the state of Maine, as well as a comprehensive literature review on the related topic of refugee mental health and sexual and gender-based violence. The interviews were each individually coded and aggregated into three larger thematic concentrations spanning a descriptive discussion of cultural differences in perceptions of mental health, a reflective description of the needs for furthering the field from the perspective of practitioners, as well as an inquiry into the macro level barriers to care. The resulting qualitative evidence

from the interviews supports the aforementioned orientations to care and, therefore, illustrates a strong case for culturally-competent applied psychology as a means for both individual and communal healing.

Maine's Refugee Community

Since the recent summer months, the sanctuary city of Portland, Maine has witnessed the arrival of over 300 African refugees (Elizondo, 2019). A traditionally liberal and progressive area, the city has welcomed the large wave of primarily Angolan and Congolese refugees arriving from San Antonio with especially open arms. Many arriving to Maine have endured long and dangerous journeys following migration pathways stretching from Central/Eastern Africa, to South America, and across Central America to arrive at the U.S./Mexico border. If they were not already victims of violence in their country of origin, the journey itself did not prove any easier for many of Maine's most recent arrivals. The Darién Gap, considered the most dangerous section of swampland and jungle between Colombia and Panama, has been crossed by more than 3,500 African refugees this year alone and is a popular place for smugglers and armed criminals to target migrants. Women and girls are at an increased risk of targeting here as well with many falling victim to rape (Mohamed, M. & Millan, A., 2019).

Being that Portland is a longstanding gateway community for East African refugees, community members have been able to lean on pre-established financial, social, and economic support systems to accommodate the number of new arrivals (Feinberg, 2019). However, an influx of this magnitude is largely unprecedented and has put a strain on emergency supplies and resources. As a result, social service agencies and individual

practitioners in Portland and the surrounding areas have become especially experienced in providing culturally-sensitive psychosocial support. This thesis attempts to highlight the efforts of various service providers, both individual and organizational, throughout the state of Maine for their exemplary and revolutionary work in cross-cultural care coordination.

Chapter 2
Theoretical Understanding of GBV & Sexualized Violence

Given that SGBV is an issue that disproportionately impacts women, it is necessary to center the female voice when discussing the theoretical underpinnings of such a brutal crime. Such a feminist orientation requires a not only a consideration for the intersectional identities of the woman herself but also for the collective identity of the culture in which the woman she is situated, whether that be the host or resettlement society. A socioecological approach to the issue of SGBV and the psychosocial interventions for its survivors is necessary to link the individual with the whole to and understand the complexity of the relationship between individual interactions and the bidirectional influence existing between them and the residing social and cultural superstructures. It is through a feminist orientation that we approach the theory undergirding power differentials for immigrant women, aforementioned socioecological orientations to psychosocial care for this population, and the link between SGBV, war, and genocide. This thesis takes this particular stance in order to account for the various intersections of the individual woman's lived internal and psychological experiences of the political violence faced during the migration process as a result of her many identities. It does this in hopes of providing a narrative of "social empowerment and reconstruction" for a significantly marginalized group of women (Crenshaw, 1991).

The Power and Control Wheel – Adapted for Immigrant Women

A common tool for understanding the many interfaces of domestic violence is the Power and Control Wheel. This wheel, depicted below, has been adapted to reflect the

specific vulnerabilities of immigrant women. The Power and Control Wheel highlights sexual violence's particular relationship with power and dominance through both the perpetrator's actions and the resulting sense of powerlessness and loss of control that can exist in the experience of trauma for survivors. While the general Power and Control Wheel displays the patterns of action an individual may typically use to express dominance or control over their intimate partner, this particular wheel also highlights the ways in which a perpetrator may capitalize on various aspects of an immigrant woman's identity to further assert their power over her.

The adapted wheel highlights various forms of emotional, economic, and sexual abuse, as well as the use of coercion and threats related to law enforcement, citizenship, or employment as specific expressions of power and control over this population. This visual aid is helpful in conceptualizing the dynamics of sexual violence and in facilitating service providers in directing their care towards combatting or working to preemptively avoid risk of these components occurring (Futures Without Violence, n.d.).

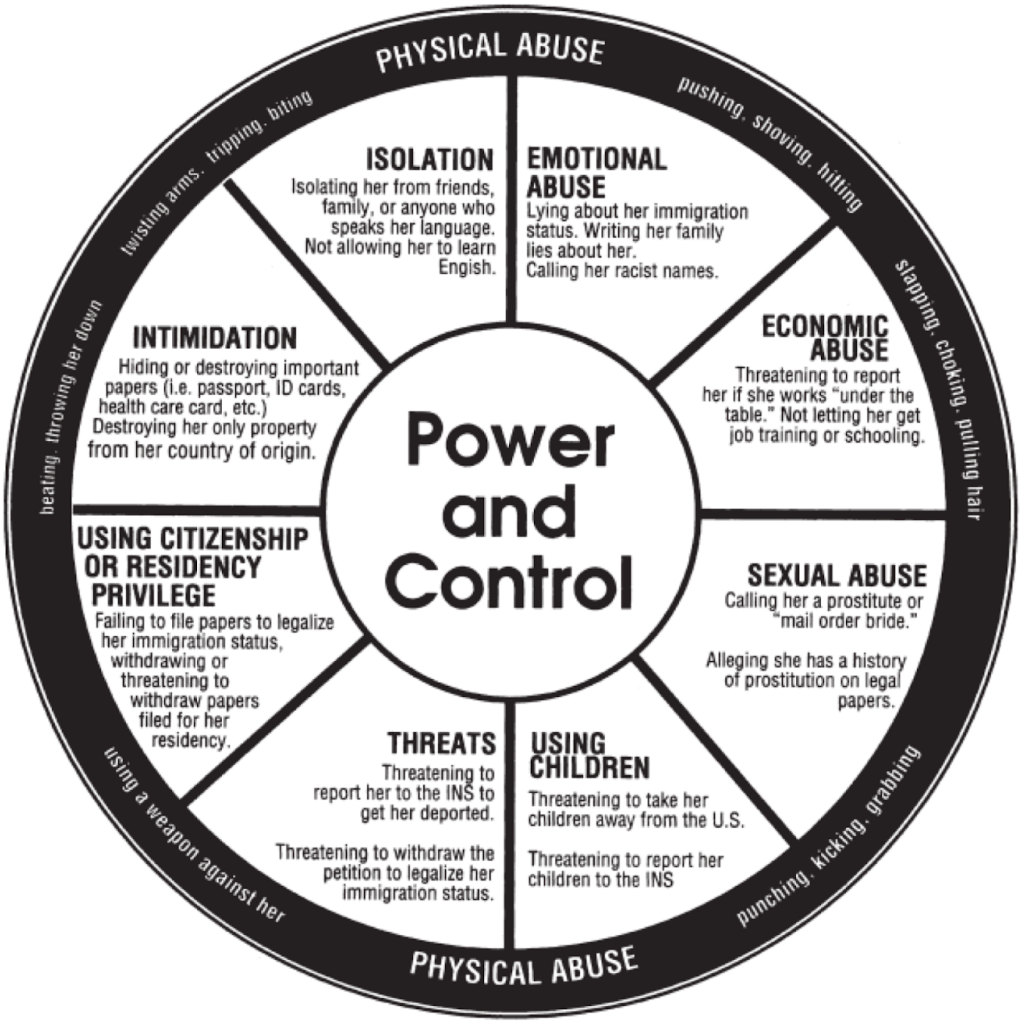

Figure 1: This version of the Power and Control Wheel, adapted with Permission from the Domestic Abuse Intervention Project in Deluth, Minnesota, focuses on some of the ways battered immigrant women can be abused. Image taken from Futures Without Violence, www.futureswithoutviolence.org.

Ecological Model

Many of the proposed approaches for psychosocial intervention for this population point to a feminist constructivist modification of Urie Brofenbrenner's 1979

Ecological Systems Theory of Development as a foundation of practice. Moving to incorporate systemic influence through socioecological models of understanding originally utilized as a means for conceptualizing the complex relations between the individual and various environmental factors, Brofenbrenner's framework seeks to contextualize human development within the ecological environment in which growth occurs. His original model is comprised of five socially organized subsystems for human development that each contain bidirectional influences and indicate the dual directional nature of relationships between the individual and their environment. The subsystems consist of the microsystem, mesosystem, exosystem, macrosystem, and chronosystem – each nesting within the other but moving further and further away from the individual progressively (as cited in Mootz, Stabb, & Mollen, 2017).

The World Health Organization (WHO), Center for Disease Control (CDC), and many practitioners and researchers working among refugee survivors of sexual and gender-based violence have extrapolated the theory behind this model to both conceptualize its implication in service provision for survivors as well attempt to explain gender-based violence as a tool of war. Sexual and gender-based violence comprises many forms of engendered aggression and can, therefore, be more holistically understood beneath a biopsychosocial framework such as Brofenbrenner's. SGBV consists of: sexual violence, emotional-psychological violence, physical violence, harmful cultural practices, and forms of socio-economic violence (Keygnaert, Vettenburg, Temmerman, 2012, p. 511). The WHO and CDC have adopted a four-level model and viewing of SGBV through an individual, relational (microsystem), community (exosystem), and societal

(macrosystem) lens that allows for an integrated approach to treatment and a multifactorial understanding of SGBV especially during times of war. The macro level takes things like socioeconomic policies and various structural mechanisms that maintain underlying social stratification and inequity into account. The meso level considers things like socioeconomic status and social class as entities that impact the individual's purchasing power and access to healthcare and psychosocial resources for support. Lastly, the micro level refers to material and psychosocial factors that influence one's aptitude to seek out such support. Heise (1998) was one of the first to apply a socioecological framework to violence against women and identified variables between perpetrators and survivors across all four levels as identified by Mootz et al. (2017)

Results of multiple studies applying this model in an analysis of wartime SGBV found that individual factors like internalized blame or shame were common among women, and that high levels of alcohol consumption among men correlated strongly to gender-based violence (GBV) in society. At a relational level, isolation/lack of social support, perceived transgression of gender roles for women, and men's inability to provide resources for their families or combat unemployment were associated with increased rates of GBV. Community-level influences were seen in community resistance to addressing GBV either through continued stigmatization or lack of police authority regarding the reported instances. Additionally, a cultural patriarchy or environment of hegemonic masculinity may also exist within a series of oppressive legislation that further perpetuates poverty in different sectors of society and contributes to high instances of GBV.

The social constructivist perspective takes this idea of hegemonic masculinity as the organizing structure through which interactions of authority and dominance manifest in the intermingling of gender and culture. This orientation advocates that individuals are capable of expressing dynamic and diverse forms of masculinity and femininity that are influenced by cultural conditions - including wartime violence. Therefore, according to a social constructivist model, gender expression and armed violence's shared ultimatum of dominance can come together to result in high instances of gender-based violence. This gender-informed understanding reflects a feminist approach to studying SGBV. It adopts a baseline assumption that gender-based violence in armed conflict settings is primarily based upon, and perpetuated by, the patriarchy and heterosexual notions of masculinity that are amplified through militarization and its associated expectations of aggression.

Tool of War

Indirect Pathways Between GBV and Armed Conflict

In utilizing the feminist social constructivist approach, Mootz et al. (2017) was able to produce community-based results that relate the perpetuation of gender-based violence within armed conflict settings via a socioecological model of understanding that accounts for the integration of violence from multiple levels. Mootz and her team were the first to conduct such a community-informed study with survivors in Northeastern Uganda, but their findings are grounded in the work of Alan Kazdin (2011) and his proposition of a concurrent conceptualization of interpersonal violence (IV) as a complex or "wicked" problem. This form of understanding is not suggested as an alternative to models such as the socioecological approach but rather as a means of drawing attention to

other facets of IV that may help in directing various approaches to research, policy, or interventions for care. IV as a wicked problem also lends to a wider formulation of what constitutes IV, what is to be considered a problem , and therefore, creates potential for a broader range of solutions. Kazdin's proposition also emphasizes the globalized aspects of interpersonal violence and their subsequently transferable features that allow interventions in one part of the world to be relevant to others domestically, which has important implications within a resettlement context.

A social constructivist modality of feminist orientation emphasizes hegemonic masculinity as the organizing and maintaining superstructure for power relations that are enacted constructively via individual's expressions of masculinity and femininity - both of which are affected by culture and conflict. This understanding takes the particular stance that, within a socioecological understanding, the prevailing patriarchal macro-system and social structure must be integrated with other structural, community, family, and individual variables when examining GBV. The researchers were able to identify a direct pathway between sexual violence and armed conflict through instances of rape, abduction, and forced/exploited labor. In addition to this direct pathway, they identified a host of indirect pathways between sexual violence and armed conflict. Four of these variables are particularly important in highlighting the multifaceted and socioecological influences on the perpetuation of gender-based violence and the implications for the survivor's further victimization (see Figure 2 below).

The first of these four indirect pathways between gender-based violence and armed conflict is manifested through the looting of resources. Within a socioecological

context, this first variable is at the community level. This particular study, focusing on military raids in Northern/Eastern Uganda, highlighted the looting of finance-generating resources, like cattle and livestock, as further exacerbating the individual or family's experience of poverty through a lack of basic income and higher prevalence of famine. As a result, many women were forced into sex work as a means of providing supplemental financial support - a subsidiary manifestation of hegemonic masculinity through the re-victimization process. When considering SGBV from an ecological standpoint, Wachter et al. (2018) cites the critical macro-level notion that armed conflict erodes any chance of existence for protective social structures and access to economic opportunity for women. The lack of structural support, along with the process of displacement itself, only further exacerbates changes in gender roles and conceptions of identity.

Also at the community level, these authors cited the militarization of the community as another indirect pathway linking gender-based violence and armed conflict. For example, increased police presence further contributed to a power differential among men and women in that the community-based data indicated that police and soldiers are regarded as perpetrators and women and girls as victims. Narratives focusing on power differentials in this study pointed to a greater emphasis on economic power and highlighted the relationship between poverty, economic power, and sexual violence. In this particular community, during situations of economic need, the vulnerable – i.e. children and women of lower economic status – indicated the common

practice of turning to those with financial means for support and being subsequently lured into sexual exploitation as an exchange (Mootz et al., 2017).

In addition to these indirect community-level pathways, Mootz et al. (2017) identified two other indirect pathways relating gender-based violence and armed conflict at the individual level: death of a family member (specifically the father) and sexual violence. This study highlighted a gendered aspect of the violence in that men were unduly targeted for killings while women and girls were disproportionately targeted for sexual and physical violence. The death of a parent, usually a father in this case, often resulted in significant economic loss and pairing with a larger power differential and heightened risk for gender-based violence. For young girls, this often correlated with vulnerability to sex work or early marriage, often to their perpetrator, as a means of supporting herself and her family after the loss of their primary provider. Similarly, wives who were widowed as a result of the armed conflict, were subjected to further patriarchal violence through forced eviction as women had no enforceable rights to their land without a husband.

Sexual violence at the individual level was both an indirect and direct link between gender-based violence and armed conflict. It is direct through physical acts of violence against women like rape, sexual assault, or sexually transmitted disease, and indirect through its influence on a cascade of gender-based violence in the community. For example, if a husband finds out his wife was raped by a soldier or member of the police, he may shame her and/or perpetuate similar violence within their home. Husband-wife dynamics such as this are also indicative of GBV's disruption of family relations

and can be the result of the aforementioned power differential between women and soldiers in instances of economic exploitation.

Kallivayalil (2015) cites rape as a crime of honor rather than a crime of torture, further placing the burden on the woman as someone who has disgraced her family. This often leads to separation from the community, divorce from her spouse, and a pervasive societal stigma discouraging her remarriage. In societies, such as those in Uganda, where women have little to no economic property and are dependent on their husbands for financial support, this kind of societal rejection can also lead to victimization through poverty. Ultimately, sexual violation of women can be seen as a tactic of war with the goal of demeaning men by dehumanizing the women who are seen as their property (Mootz et al., 2017).

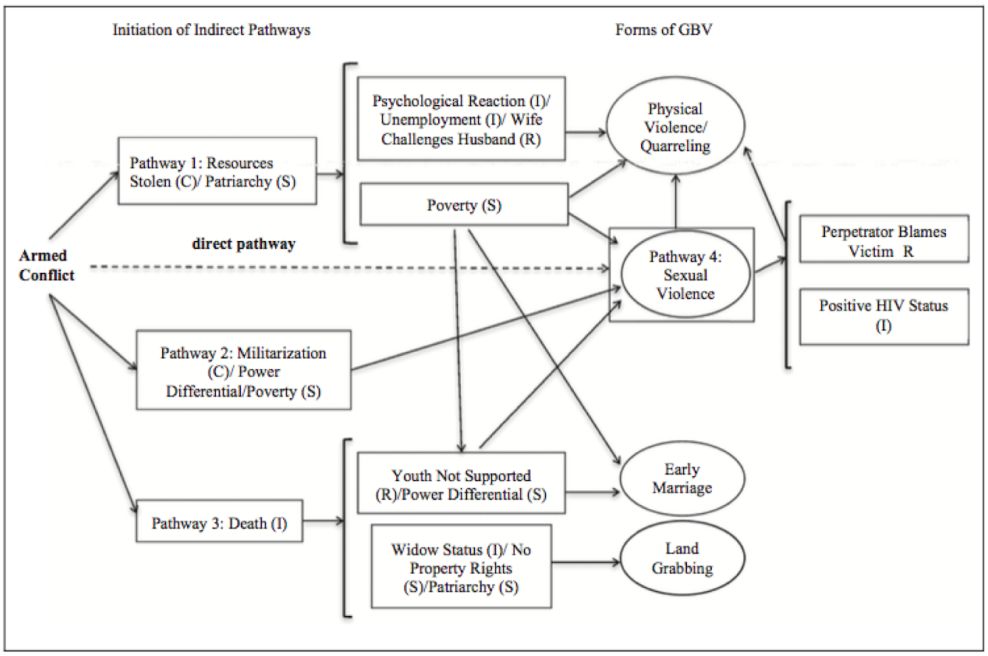

Figure 2: Community-informed conceptual diagram of how armed conflict relates to gender-based violence in Northeastern Uganda. (S) = socetial variable; (C) = community

variable; (I) = individual variable; / = paired with. Squares are contributing variables and circles are forms of gender-based violence (GBV) (taken from Mootz et al., 2017).

Gendered Genocide

While Mootz et al. (2017) highlighted the implications and unduly targeting of male family members during armed conflict, Kaiser and Hagan (2015) challenge the archetypal, battle-aged male victim of genocide in approaching violence from intersecting forms of victimization as a result of targeting certain social identities. They do so through highlighting the socially destructive process of genocidal rape and killings in Darfur through an examination of the gendered causes and collective effects. They argue that there is a misunderstanding or lack of academic acknowledgement surrounding genocide's impact on social destruction that can only be seen through a truly socioecological approach that focuses on the "victims' differential experiences" (p. 79). The tendency, instead, to focus on one kind of victim during armed conflict, often leads women, children, the elderly, and surviving younger men to be forgotten or treated as irrelevant to genocide. This view of genocide leads to an artificial separation of the raped, displaced, and murdered, and furthers an understanding of genocide that fails to account for its socially destructive influence that can exacerbate the experience of gender-based violence. Kaiser and Hagan argue for a conception of genocide that requires a holistic understanding of extermination that accounts for interacting mechanisms that socially destroy group members through shared experience and recognizes victimization as

differently targeted and experienced depending on ones' gender, age, or other social identity.

Taking a feminist approach to the gender-selective targeting of genocide similar to that of Kallivayalil (2015) requires a central emphasis on women. This includes the perception of women as bearers of a given culture and community identity and of men as the "users" of this culture (Seifert, 1994 as cited by Kaiser, 2015, p. 82). With this understanding, Kaiser and Hagan argue that the Darfur genocide operated through multiple forms of gender-selective violence that interacted through victims' shared experience in a given community and, therefore, led to social destruction. In this particular model of understanding, one can see the individual, micro-level forms of gender-selective violence having a macro-level social impact that alters the "shared meanings" of a given collective way of living.

According to the ideas of gendered genocide, sexually-based violence can be constituted as a form of genocide in that it destroys group membership, either through perpetuated rape that results in death, sexually transmitted disease, or through social interpretations of victimization that leads to the aforementioned ostracizing. In extreme cases, successful social destruction can also manifest in displacement or migration. The authors argue that genocide requires an intent to destroy a certain social group and involves both immediate killings of group members, what they deem "extermination," and crimes that cause slower and more subtle destruction known "elimination" (2015, p. 103) (see Figure 3 below). With this goal of destroying a collective entity, both extermination and elimination can elicit community break-up and, therefore, a dissolution

of collective meaning-making that impacts individual conceptions of identity. Moving past a conception of genocide that focuses strictly on mass murder and towards one that incorporates the inherent socially destructive intention is key to understanding the larger link between sexual violence and armed conflict.

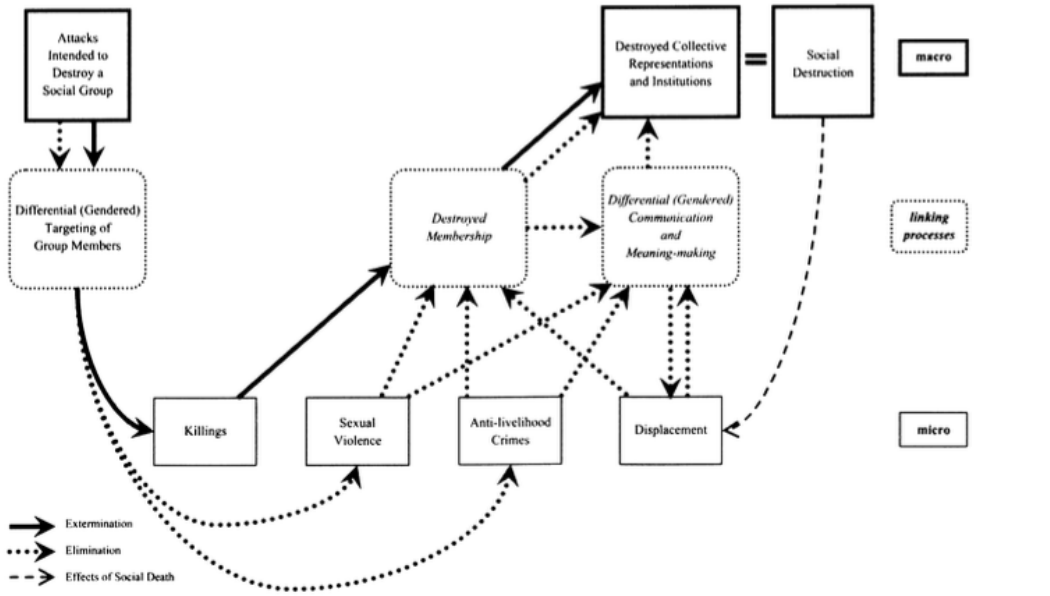

Figure 1. Genocide as Social Destruction, Occurring through Dual, Experiential Processes of Extermination and Elimination

Figure 3: Genocide as social destruction, occurring through dual, experiential processes of extermination and elimination (taken from Kaiser & Hagan 2015).

Chapter 3
Psychosocial Interventions &

Women Refugee Survivors of Trauma

A feminist analysis of SGBV as a tool of war as well as orientation of care for survivors permits practitioners to, not only understand the specific needs facing this subset of the population, but also propels them to act with a sense of cultural reflexivity. While this thesis focuses specifically on the experiences of women and girls within Central and Eastern Africa, it is important to acknowledge the potential in fortifying a perception of subordination when writing about African women in a light that paints them "as a homogenous group who are uniformly powerless, oppressed, culture- bound, and inferior (Beoku-Betts & Njambi, 2005)." This thesis does not intend to project the idea that Western mental health practitioners from the Global North are, instead, liberated saviors responsible for the salvation of women victimized by a violent and backwards culture of hyper masculinity. This chapter, rather, analyzes and promotes literature emphasizing education on the population's specific needs, cultural sensitivity and identity reflection, as well as community healing.

Female Refugees and Psychosocial Interventions

Per the theoretical discussion, it is known that women are disproportionately targeted by acts of politically-motivated violence through their extreme vulnerability to sexually-based aggression beneath the patriarchy. Many female refugees arriving to the United States are survivors of politically-motivated violence: international/intra-state war, political/ethnic/secessionist/religious conflict, human rights violations, and

oppressive state laws or lack of legislation that violates basic rights as members of a certain social group. The effects of gender on pre-flight trauma are apparent in the troubling statistics regarding mass amounts of gender-based violence as a tool of war in countries like the Democratic Republic of Congo. Additionally, without a more robust immigration policy accounting for gender-based violence as a legitimate legal basis from which someone can claim asylum, female survivors must find a way to circumvent the policy in order to be recognized as refugees and avoid further subjugation to systemic violence (Kallivayalil, 2015).

Although many survivors of trauma face interactions with various social, legal, and religious institutions, women refugees and asylees face particular systemic obstacles that impact their access to care. This usually depends on where they are in their asylum or refugee status process and tends to be specific to each case. Oftentimes, women who present for psychiatric care sit in one of two camps: 1) they are in the process of applying for asylum and have to prove legitimacy of their claim to the legal system or 2) they have entered the country without documents and have no intention of applying for asylum for various reasons but are seeking treatment because the severity of their symptoms is impacting their ability to live, work, or parent in the resettlement context. Regardless of the woman's asylum status in either of the situations above, it is likely she is facing serious systemic barriers to optimizing her wellbeing in the host country. This difficulty is compounded with things like a lack of access to basic resources, language barriers, family separation, racial discrimination, and maintaining a vulnerable position within the law enforcement due to lack of legal status (Kallivayalil, 2015).

This apprehension towards authority extends beyond law enforcement as well and can severely impact willingness to seek psychosocial treatment and support from health professionals. Many survivors are hesitant due to fear of past experience of interrogation when describing symptoms, unfamiliarity or cultural difference in perceptions of mental health, or fear of disclosing due to worry that the information could be used against them. Additionally, a woman's previous exposure to patriarchal or familial violence has the potential to lead to significant long-term psychosocial impairment if resurfaced and left untreated within a resettlement context. Clinicians should, thus, be aware of this apprehension towards treatment and of the differences surrounding cultural norms, gender roles, sexual violence, and mental health in general in order to provide the most attuned and preventative care possible.

These dynamics of gender and its intersection with migration have just as salient an impact within the post-migration pathway and lived daily experience upon resettlement as well (Yohani & Hagen 2010). While both men and women are often confronted with new gender role prescriptions in the host society, there are also challenges that are unique to women that can exacerbate the difficulty of the adjustment process such as unwanted pregnancy, restricted access to education and employment, and increased vulnerability to exploitation in the labor market. These difficulties are concurrently marked by barriers to self-sufficiency such as decreased language proficiency and obstacles in achieving access to secondary education - aspects that, when made more available to men, can eventually perpetuate power imbalances between a husband and wife in the same household. As a result of victimization to SGBV, women

and their children (whether born as a result of rape or not) are often shunned or met with serious shame. Therefore, not only is the female identity unduly targeted in the acts and aftermath of political aggression but also simultaneously held responsible by fellow-community members and the larger society for not upholding the virtue of being a woman or mother which is typically a symbol indicative of honor and respect for one's country.

The unique challenges facing refugee women, both prior to and after the migratory process, put them at increased risk for further victimization and must remain at the forefront of service providers' approach within a resettlement context in order to avoid further mental health complications. A truly feminist approach to psychosocial treatment for this population would account for the various intersections of the individual's lived internal and psychological experiences of the political violence, including the repercussions faced upon resettlement. This could include psychotherapeutic, via individual or community healing, or psychopharmacological attention to the emotional/psychological consequences of migration, such as disrupted family dynamics or exposure to extreme trauma, or to the socioeconomic impact on the women's daily/working lives through their disrupted entrance into the labor market.

A study conducted by Stark, Asghar, and Meyer (2017) aimed to target the connection between interpersonal exposure to violence and the intra-communal prescriptive norms related to the acceptability of such violence. Their ultimate goal was to predict future orientations for populations affected by widespread exposure to violence as well as provide context for practitioners seeking to promote wellbeing for survivors.

Their evidence points to the fact that both violence victimization and acceptance of traditional (binary) gender roles correlated with lower overall wellbeing in adults and attitudinal acceptance of interpersonal violence with increased exposure to violence in adolescents. The study was conducted beneath the guise of the theory of role congruity in which individuals are slated to be rewarded for engaging in behavior that is "in line" with their prescribed gender roles and punished when seen as "violating" such prescriptions. The study took place in the eastern part of the Democratic Republic of the Congo, where the North and South Kivu regions alone house over 68% of the displaced population of individuals fleeing the violence of the country - including the proliferation of armed sexual violence as a weapon of war.

They found that girls in the region, aged 10-14, were particularly vulnerable to this form of violence and expressed significantly lower levels of hope. Given the study's aim in attempting to understand the moderating role of gender norms in the relationship between violence and hope for the future, hope was quantified and measured via surveys assessing the girls' self-perception of their ability to achieve their goals in the face of such violence. This age group's already-low expression of hope was especially common among the young women who reported interpersonal violence as "acceptable." This strong indication of prescription to gender norms highlights adherence to the role congruity theory. Girls who experienced violence and were more apt to accept traditionally gendered ideas about interpersonal violence were more likely to internalize beliefs of inferiority and feel as though they were deserving of violence, further contributing to feelings of low self-worth and diminished hope for the future. The

particular vulnerabilities of young adolescent girls highlighted in this study have important implications for service provision regarding the embedded potential of empowerment and resilience-building workshops. With the known association between poor mental health outcomes and armed conflict, an improved understanding of the factors that ameliorate or worsen the overall wellbeing of women refugee survivors could have serious impacts on their capacity for building emotional resilience in the face of pre and post-migration manifestations of violence.

Review of Methods of Intervention for Refugee Survivors of Trauma

Cultural Competency and Sensitivity

Within a resettlement context, there is a difficulty in classifying mental health disorders that may not fit into a Western paradigm, i.e. those that correspond to the diagnostic criteria largely imposed by the majority of developed nations, or align with Western conceptions of "precursors" or risk factors. Practitioners must not only develop a deep history and social understanding of their client's country of origin but should also become well-versed in their spiritual and religious background in order to maximize sensitivity to the other factors that may be influencing the survivor's conception of mental health. Prior to beginning the given intervention, it is recommended that providers develop a strong working relationship with their client that accounts for the potential for varied adherence to traditional understandings of courses of treatment. In order to best understand the schedule, needs, beliefs, and social-emotional understanding of the individual survivor, the service provider must take time to account for the cultural, linguistic, and stigmatic differences between them and their clients. This knowledge of

specialized psychosocial and cultural considerations should ultimately inform the comprehensive psychiatric assessment and treatment plan to ensure the best course of care (Jaung, Jani, Banu, & Mackey, 2017).

If we are to define acculturation as the process through which immigrants acquire the culture, language, and values of the host society, it is imperative that the psychosocial care practitioners understand that the interaction between mental health professionals and refugees is, in itself, an intercultural exchange. While recent perspectives have posited that the eventual adoption of host society values without abandonment of aspects of the culture of origin are actually quite beneficial in avoiding further exacerbation of refugee mental health complications, practitioners must pay attention to the intergenerational variation in states of psychological adjustment. Parents who could be reeling with the pain of exile may have influence over their host country-born child's mental health upbringing if care is not accurately attuned to these considerations. Practitioners must also acknowledge their own inherent socio-cultural biases in viewing the link between their client's history, reason for seeking asylum, migration process, and culturally-shaped perception of mental distress and attitude towards interventions. This level of acknowledgement requires that providers spend time learning about their own histories, individual identities, and unconscious biases regularly (Hodes, Anagnostopoulos, & Skokauuskas, 2018).

Given that SGBV is encompassing of many forms of violence, refugee and asylum seeker survivors of such violence, as vulnerable new members of a host society, are evidently at particular risk for further victimization. Their identity as such has serious

implications amidst the public health sphere and in terms of their access to culturally-sensitive, accessible, and effective forms of treatment (Keygnaert et. al, 2012, p. 517). Yohani and Hagen (2010) suggest a collaborative practice model that accounts for both the gender (individual level) and cultural (societal) influence in the occurrence and aftermath of sexualized violence and seeks to integrate the two into a multicultural framework for service provision. Their research highlights the importance of the recognition for cultural influences on the propensity towards help-seeking behavior and mental health in general. This method of service provision should also be grounded in the voice and experience of the survivor so as to empower the individual through a collaborative therapeutic relationship and ensure that the potential for culturally-agnostic Western health intervention methods is not dominating the scene. This form of service provision, is, thus, oriented towards the prevention of further victimization, rather than just the remediation of the presenting symptoms of distress.

Working Within the Context of the Community

Other researchers highlight similar claims, suggesting variations of this culturally-sensitive model through community-based empowerment programs. Akinsulure-Smith and Jones (2011) cite the importance of highlighting survivor voices in the development of their grassroots organization Nah We Yone (NWY) for asylee and refugee survivors of trauma. Given that their organization works primarily with individuals from Africa, they have developed a community-based empowerment model centered around the strengths of many African cultures, particularly those surrounding systems of familial and community support. Given that many of the survivors expressed reluctance in seeking out

formal mental health treatment as a result of their traditional reliance on local and cultural religious leaders, healers, and elders, NWY sought to capitalize on the opportunity to develop a culturally-informed therapeutic intervention within he growing African forced-migrant community. They developed five psychosocial programs, all run by and grounded within the belief systems and practices of members within the community: detainee-support groups, various forms and identities of therapeutic groups, an internship program, educational service training, and an advocacy coalition.

While NWY is a specific example of a culturally-informed, community-based and multifaceted psychosocial intervention effort, it speaks to a generalizable theme of the literature. In order to engage in meaningful and truly therapeutic practices with this population, a well-rounded understanding of what it means to work within the larger historical, sociopolitical, economic, and cultural background of the individual – especially if they are not members of the impacted community itself - is imperative. This perspective not only implicates that practitioners orient their intervention style to match this cultural understanding, but that they also utilize this understanding to attend to the factors that could place the individual at risk for further victimization or mental health complication. It is the job of practitioners to target the barriers in the host society that could prevent the individual from successfully integrating into the resettlement context so that the post-conflict recovery process is not characterized by the violence that accompanies a battle with poverty or victimization via other means (Yohani & Hagen, 2015).

Social Determinants Impacting This Population's Psychosocial Health

Such factors linked to political, cultural, environmental, economic, and social conditions that affect the health status of groups or individuals are known as social determinants of health (Solar, 2010). Via a socioecological approach to care, recognition for the impact of these determinants within the resettlement context should inform and guide the practice of mental health professionals working among this population so that they can preemptively or proactively reduce the risk for re-victimization via ulterior forms of violence. First and foremost, they must consider the impact of the migrant trajectory itself and its potential to exacerbate the development of psychosocial stress. The World Health Organization characterizes the migrant trajectory as a journey defined by the imbalance between a multitude of requests placed upon the individual and their simultaneous aptitude, influenced by structural and individual factors, to complete them. In the host country, there is a particular risk for depression, due to isolation as a result of language barriers, and a likelihood of predisposition to PTSD due to exposure to war-time violence among this population (Gewalt et. al, 2018).

In a study conducted by Stark et. al (2016), a group of young female survivors of sexual violence in Uganda identified societal stigma as their primary source of psychosocial distress and largest barrier to recovery and societal reintegration. Due to cultural norms, many of the young women were blamed for their own rape as having a sense of compromised morality, and as a result, were subject to various stigmatizing behaviors such as verbal harassment, gossip, and social exclusion. This societal stigma and victim blaming would lead to feelings of shame and further hinder emotional well-being and willingness to seek out formal care services. As a means of navigating the

stigma, many of the girls cited reassurance from close friends as a powerful way to counteract the negative messages and seek social support.

While recognizing that this study was not conducted within a resettlement context, it is still worthy to note that certain close family members, oftentimes the mother, and friends, also remained helpful in serving as a link between the informal sector and forms of formal and professional services (legal, medical, etc.). This relates back to Brofenbrenner's model with the informal network of family and friends helping to serve as the innermost circle and link to the outer, societal level system of formal services.

The Promise of Direct Service

For women refugee survivors of gender-based violence, there is significant risk for compounding trauma upon arrival to the United States once confronted with the daily stressors of a system that is inherently stacked against them. In other words, the refuge sought from the pre-migration circumstance is met with the potential for further trauma that can result from the host of vulnerabilities that accompany an immigrant, asylee, or refugee status in the United States. In taking a socioecological model of understanding, one can easily see how pre-migration trauma has the potential to be felt at a community level. Whether it be via the disruption of the family unit through the loss of a member, the concurrent isolation, shame, or guilt that results from a rape or sexual assault, falling into poverty through the looting of financial resources, or living amongst fear with an increased militarization of society, entire life systems have the potential to be obstructed (Mootz et al., 2017). Because this is the foundation upon which many refugee women

survivors of gender-based violence are arriving to the United States, special care must be taken among professionals within the resettlement communities to work with women refugees on establishing a routine that yields a level of normalcy and consistency as soon as possible (Shattuck-Heidorn, 2019).

While common thought might suggest a link between mental health complications in a resettlement context and the witnessing of pre-migration trauma, the strong predictor for what actually yields mental distress for this population appears to lie in the daily stressors of the American immigrant life (Shattuck-Heidorn, 2019). With these daily stressors serving as the main mediator between a mental-health response and war-related trauma, direct service provision can play a pivotal role in reducing the risk for re-victimization through poverty or further situations of gender-based violence within the host country. As highlighted in the Power and Control Wheel and within the socioecological understanding, it is important to consider the influence of culture on the refugee woman's perception of her own risk. It may be unlikely that she would see herself entering back into a potential situation of violence given that home culture perceptions of mental health, sexuality, and sexual violence may vary from the prevailing conception in the U.S. As service providers, the most important implication, then, comes in reducing barriers to disclosure so assistance may be provided if necessary (Britton-Anastas, B. & McNamara, P., 2019).

Trauma in a refugee/asylum seeker pathway usually follows a three-step pattern. It begins with the cause for forced migration- gender-based/sexualized violence in the case of this review. The ensuing phase, the migration flight process and refugee camp

experience, is typically marked with a lack of access to basic resources and a diminishing or non-existent sense of control. Finally, resettlement is a period of further disruption in cultural and family life. Despite the baked-in potential for trauma across the entire migration journey, many refugees do not arrive with what many Western practitioners would call PTSD or other ongoing mental health problems but rather require services that help them regain a sense of control over their immediate circumstances and family. The Direct Effects Model suggests that the more pre-flight trauma experienced yields a higher risk of mental health problems, and would therefore predict that greater exposure to war events is related to higher incidences of PTSD/mental illness in a resettlement context. However, this model leaves many aspects of the migration process unaccounted for and neglects to consider that other factors mediate the experience of a traumatic event and the development of a mental condition (Shattuck-Heidorn, 2019).

According to Shattuck-Heidorn (2019), what the Direct Effects Model almost entirely neglects to account for is the importance of recovery in the post-conflict environment. Given that the assessment of risk for re-victimization is strongest when a socioecological approach is taken, it is therefore also meaningful to consider taking a more holistic approach to healing rather than a strictly trauma-informed practice. Care providers must consider the specific vulnerabilities facing immigrant women within a resettlement context. The aspects that are most likely to implicate the relationship between war-related exposure and later mental health complications are things like inadequate housing, social isolation, experience poverty/lack of basic needs, and chronic fear of deportation/questions of legal status. For adult migrants, culturally appropriate

provision of care regarding community reconnection, access to basic needs and housing, and ethnic/cultural reconnection are some of the most important factors in promoting healing and growth in a resettlement context. For children, early childhood educational programs providing safe, affirming, and predictable spaces for practicing emotional resilience and routine are the most efficient in reducing risk for further mental health complications. While mental healthcare is a critical component to each of these factors, the larger environmental context, situated within the individual's culture and specific set of needs in the resettlement context, yields attention to the promise of direct service within a psychosocial support regime.

Chapter 4
Presentation of Data

Methodology

In order to understand how psychosocial interventions within the resettlement context reduce the risk of re-victimization for refugees, specifically those who are survivors of sexual violence or trauma, this particular investigation consists of two components. Given that the ultimate aim of the project is not to propose alternative forms of intervention or recommend the direction of global policy change, the objective behind the data collection process was primarily one of applied psychology. In other words, this study represents an analytical stand on the data collected that is grounded within a comprehensive literature review on the aforementioned topics of refugee mental health and sexual and gender-based violence theory. This perspective is substantiated by four interviews conducted with mental healthcare providers working among Maine's population of recent-arrival refugees from Central/Eastern Africa. It is also supplemented by information gathered at a conference centered on calling attention to Western-biased approaches to mental healthcare and expanding practitioner understanding of culturally-competent care to fortify their response to sexual and domestic violence in New-Mainer communities and bridge the gap between direct service providers and mental healthcare.

This specific population and geographic region was chosen for its particular significance to the author as her state of origin. In attempts to maintain an investigation that is as relational and community-based as possible, it is the hope that this thesis can amplify the perspective of practitioners working within and among the recent-arrival

population in Maine to illustrate the diversifying efforts of the sanctuary state and its commitment to accommodating the needs of all its inhabitants through culturally-competent care. Below is a brief description of each of the practitioners interviewed or observed for the completion of this investigation.

Abdullahi Ali - Gateway Community Services

Abdullahi Ali is the CEO and founder of Gateway Community Services, an organization that provides direct and wraparound services for children, youth, adults, and the elderly community. Across its three locations (Lewiston, Portland, and Augusta, Maine), Gateway has served over 2,500 individuals since it started providing services in 2015, 70% of whom are members of the immigrant and refugee community (Abdullahi Ali, November 27, 2019). The majority of Gateway's clientele are reflective of the larger New-Mainer refugee population as many hail from Central/East African nations such as the Democratic Republic of Congo, Somalia, Sudan, and Burundi, as well as the Middle East with a large portion arriving from Syria and Iraq. As a member of the refugee community himself, Ali views his primary role as dedicating himself to addressing the needs and amplifying the voice of Gateway's clients through the supervision of the organization's four department heads, overseeing all programming, and helping to approve and implement new policies that affect this population. He is based in the Portland, Maine office.

Krista Hall - Gateway Community Services

Krista Hall is the Clinical Director at Gateway Community Services where she oversees the counseling team, behavioral health/home care programs, and serves as the case manager and MSW intern supervisor. She is based in the Portland, Maine office.

Kheyro Jama - Gateway Community Services

Kheyro Jama is a case manager and mental healthcare provider within Gateway as well as a member of the Somali immigrant community in Lewiston, Maine. As a case manager with an inter-community understanding, she views her primary role as assisting individuals in realizing their potential to address and accomplish their own needs and goals through coordinating all of their care services and connecting the individual to the wider community. In addition to her advantages in understanding due to her identity as a Somali immigrant, she also indicated a particular strength in working with women and mothers.

Ruth Grady - LCSW

Ruth Grady is an LCSW practicing in Portland, Maine. She provides counseling and therapy to all individuals receiving care at her facility with a large portion based within the immigrant and refugee community.

Building Bridges Conference and Heather Shattuck-Heidorn

The Building Bridges Conference hosted on November 4, 2019 in Lewiston, Maine was a gathering of service providers across the state of Maine working to advance the trust and understanding between practitioners and members of the New-Mainer population. Sponsored by the Immigrant Resource Center of Maine, the conference focused specifically on addressing experiences of rampant sexual and domestic violence

across this population and coordinating professional responses across all fields of service provision. Heather Shattuck-Heidorn, Assistant Professor of Women and Gender Studies at the University of Southern Maine and former Refugee Health Coordinator at the Office of Maine Refugee Services, delivered a session on New-Mainer mental health and the experience and impact of trauma on the journey to wellbeing in a resettlement environment.

Results

The raw data collected for this investigation, in the form of quotations, were each individually coded and aggregated into the three ensuing thematic concentrations: a descriptive discussion of cultural differences in perceptions of mental health, reflections from practitioners regarding the needs for furthering the field, and an inquiry into the macro-level implications for policy and practice. Presenting the data in this manner ultimately serves to aid in constructing an analytical comparison in the following chapter based on the afore-reviewed theory and literature.

Taboo and Stigma: Cultural Differences

Without making a sweeping generalization about the areas from which many of the Central/Eastern African refugees are coming, the consensus among practitioners is one of deep resistance to or cultural fissures with a Western model of mental health among the recent-arrival communities. Every practitioner interviewed highlighted the immense difficulty that exists in attempting to bridge the gap between such varying conceptions of mental health and the current systems of psychosocial support that exist to assist with the resettlement process. Testaments from care providers indicated that many

of the refugees within the greater Portland area come from societies in which mental health is stigmatized or seen as taboo and at odds with a healthcare system constructed around a Western, deficit-focused, conception of mental health. For example, varying cultural understandings of delusional symptoms or hallucinations has, unfortunately, left many clients to "get lumped into this generalization as crazy" (Krista Hall, on December 16, 2019) within their communities. Such a conceptual divide has largely contributed to, alongside other macro-level barriers to care, a significant reduction in the pursuit of treatment among New-Mainer immigrants and refugees - leaving many to navigate a new geographic and cultural space untreated, unaccompanied, and feeling isolated. As a means of encouraging care, Krista Hall cited one of Gateway's largest goals as helping to educate immigrant and refugee community members on their organization's perspective of mental health as a continuum that comprises a great range of feelings and behavior, not as a binary of crazy versus sane, in order to validate the experiences of transition, distress, and trauma that many refugees are facing upon resettlement (December 16, 2019).

These varying understandings have not only led many to misinterpret the anxious or depressive symptoms that are common to periods of transition or healing from trauma as "crazy," but also as something other than the psychological condition itself, such as a heart attack. In the case of survivors of violence, many believe that the circumstances from which they are fleeing cannot compare to the stressors of adjustment to daily life in the resettlement society. Especially if the basic needs are met, it is common among New-Mainers to cast mental distress aside as a non-concern at that moment in time.

Kheyro Jama of Gateway stated that many individuals struggling with mental illness and psychosomatic symptoms are often at a loss of where to turn for support so they turn to substances as a means of coping, subsequently leading to more judgement from non-approving community members and increased difficulty with the adjustment process. Without a common, community-wide understanding of mental illness, those experiencing symptoms can feel, not only a sense of isolation or lack of direction on where to go for resources, but also a deficit of vocabulary for describing their situation:

> severely mentally ill...they don't know what to do next. They go to mosque, they get judged. You know, I smoke weed. If you told Imam, they smoke weed "ohhh he make fun of me, it doesn't help me. I'm not going no mosque. I don't care. I rather go rehabilitation centers because they listen when I cry and my emotions are more reasonable for them." (Kheyro Jama, December 16, 2019)

Gateway's educational efforts center around strengthening community members' understandings of mental health to encompass various psychosomatic symptoms and behavioral indications of discomfort without necessarily making a comparison to where they are coming from or currently live (Abudallhi Ali, November 27, 2019) as will be evident in the ensuing discussion of cross-cultural methods for talking about mental health. While these cultural differences have appeared to have led to a resistance among refugees in "[acknowledging] they have mental health issues" (Abudallhi Ali, November 27, 2019), they are also significantly related to fear of law enforcement/authority and the cultural, societal, and legal norms surrounding the disclosure of sensitive material. Many fear that full revelations of anxieties during the resettlement process or associated with

traumatic pre-migration circumstances will be used against them. Much of this also depends on the level of trust the client has with the service provider, a key component of culturally-competent care, as the biggest reservation lies in not knowing with "whom the service provider is associated" (Abduallahi Ali, November 27, 2019). Most practitioners cited a common fear among clients that information may be relayed to the government that could result in their children being taken away or impact their ability to find employment.

Reflections from the Field

Basic Needs Within the Resettlement Context. Given that the set of needs facing recent-arrival refugee survivors of trauma is so multifaceted, much of the work that service providers for this community end up doing is psychosocial in nature. However, many of the strictly mental health practitioners remarked on the difficulty in straddling their role as a provider of psychological and behavioral support and their perceived role as the client's designated case manager - who, ostensibly, would help them to acquire basic needs upon arrival. As mentioned previously, because there is such a lack of propensity to seek mental health treatment, let alone a lack of a common interpretation of mental health in general, many clinical providers end up being the overall care coordinator in helping to discern what needs are to be met in order to achieve the stated goals of therapy (Kheyro Jama, December 16, 2019). Krista Hall highlighted an important connection when she underscored that, without the mental health consideration, there would be no Section 13 or 17 in the legal infrastructure of Maine designated to providing case management to meet the needs of those experiencing distress. She has

noted that for many communities "having a case manager is considered a status symbol," (December 16, 2019) because they become the "person who's going to help [you] meet those basic needs" and achieve, what many practitioners alluded to as, the American dream of romanticized grandeur and prosperity upon resettlement. Hall also mentioned the commonplace notion of a "let down" upon arrival when confronted with things like racism, language barriers, and general unfamiliarity with the motions of this new society that is deeply tied up with the "several layers of trauma" experienced by refugee survivors (December 16, 2019). However, oftentimes, without the acquisition of the basic needs required for survival, especially during periods of heightened vulnerability to stress, making any legitimate movement in mental health counseling is extremely unlikely (Ruth Grady, December 19, 2019). Grady remarked that it is once basic needs are met, and the parasympathetic nervous system can kick out of fight or flight mode, that the symptoms of trauma typically to set in. She believes it is at this point that refugee survivors are able to, albeit differently from a Western diagnostic description, articulate some level of distress as a result of embodied, residual, or exacerbated trauma.

Culturally-Competent Care. To provide an effective level of mental health care, however, every practitioner expressed the need for extensive education and understanding in what it means to engage in culturally-competent care. Based on the interviews, this form of care appears to consist of an accounting for the unique bicultural identity straddled by many of Maine's refugees, particularly second generation immigrant children, an understanding and employment of cross-cultural methods for articulating

questions of mental health, significant and ongoing training in the latest approaches to culturally-competent care and the practice of practitioner cultural reflexivity, as well as a substantial amount of practitioner-client trust. Many practitioners highlighted the importance of accounting for the differences in understanding and cultural orientations within multigenerational households and the implications this has in approaching conversations of mental health.

Biculture. Ali cites that, while many parents arriving here as adults attempt to retain their home culture as much as possible, immigrant children, often those who are born in the United States, find themselves having to reconcile this bicultural identity - a struggle that often exacerbates conflict at home (Abduallhi Ali, November 27, 2019). Similarly, Kheyro Jama noted that many second-generation adolescents, because of this bicultural background, tend to be much more comfortable speaking about mental health, and speaking about it with American providers (December 16, 2019). On the flipside, however, this requires a level of agility on behalf of the practitioner to be able to communicate with the adolescent in a relatable and approachable manner while also garnering the respect and support of the parent who may not have the same understanding or appreciation for mental health. Not only do certain topics of conversation, such as sex, sexual orientation, and challenges related to drugs or alcohol, remain taboo within certain cultural traditions, creating yet another barrier for the practitioner to cross when discussing the child's care to the parents, but this bicultural divide between parents, adolescents, and their provider can also serve to aggravate true mental illness if an individual is presenting with distressing symptoms.

Cross-Cultural Methods of Understanding Mental Health. Given this barrier in understanding of mental health among first-generation parents and their children, as well as among various cultural and ethnographic backgrounds, many of the practitioners interviewed cited the importance of practicing cross-cultural methods of identifying mental distress. With a healthcare system and societal understanding structured around the Westernized, deficit-focused classification of mental illness, practitioners working within the resettled immigrant and refugee community have had to find a relatable vocabulary in order to bridge the gap in communicating experiences of mental distress. Unfortunately, if symptoms are left unattended, many individuals end up receiving treatment retroactively after their distress and/or trauma has resulted in some sort of criminal activity or interaction with law enforcement. Therefore, in order to normalize treatment and promote a more proactive approach to seeking psychosocial support, the mental healthcare providers and case managers interviewed described their attempts to strip the current mental health paradigm down to a measurement of basic functioning in the new host society. By relating emotional feeling and general affect to prosocial behaviors, basic functioning, or somatic sensations, such as those associated with anxiety like stomachaches, headaches, etc., practitioners are best able to veer away from the neocolonial terminology of Westernized mental health conceptions and understand the meaning of any situation from the perspective of the individual regardless of their culture (Ruth Grady, December 19, 2019).

Grady made the important qualification that, engaging in truly trauma-informed care, involves, not only the means to communicate issues of mental health cross-

culturally, but also the ability to differentiate between maladaptive behavior and the behavior an individual may perceive as necessary for survival. It is when such actions become distressing, socially disruptive, or potentially dangerous for the individual and larger community, that they become maladaptive and require the care of a culturally-competent professional (December 19, 2019). Grady also described how, if practitioners must conform to the current classificatory system of mental health, they can go about doing so via identifying the hallmark symptomology of certain disorders:

> ...So if you take depression, is there a sort of hopelessness? Is everything too much work to do? Are you eating OK? What's going on in terms of what is indicative of depression and the same with anxiety. Are you looking at how much they're engaged in the world around them versus stuck in their head perseverating and ruminating on thoughts. (December 19, 2019)

Krista Hall described a similar efficacy in approaching individuals and survivors of trauma via a non-pathological conversation about their general feelings and how they may identify and/or verbalize such feelings through providing them with "examples of symptomatology…to pick from" (December 16, 2019). In being cognizant of the fact that many recent arrivals are coming from cultures that do not adhere to the Western concept of mental health, describing a relatable range of psychosomatic symptoms allows them to articulate how they feel without necessarily having a similar vernacular to do so. This process helps to simultaneously normalize the concept of mental health as well; providing clients with various opportunities and methods of conversing about the topic helps to paint mental health as a wide-reaching continuum and less of the aggressive binary of

sane versus crazy. Normalizing the conversation also helps to decrease feelings of social isolation that often accompany trauma and the perception of singularity when it comes to experiencing symptoms.

Trust. The normalization of such symptoms resulting from the experience of pre-migration trauma, resettlement stressors, or the general acculturation processes was a common method cited in helping individuals to feel more comfortable opening up and describing how they feel more openly. Achieving such a level of comfort, many of the practitioners interviewed noted, is a product of intentional time spent working on building rapport and trust with the client. Without an established understanding of the relationship between the practitioner and the client and an explicit statement of the role and purpose of psychosocial care providers, many clients do not feel comfortable discussing mental health and often emit key pieces of information that would help clinicians develop a comprehensive assessment, only further inhibiting their chance at being eligible for certain services. As previously mentioned, trust plays a huge role in mitigating the apprehension towards authority figures as well. Until a client can be sure that the practitioner is working with them, rather than against them, there will be omissions in their level of disclosure (Abudallhi Ali, November 27, 2019). One thing Gateway does to establish their role as accompanier and to assert client confidentiality is administer the Rights of Recipients of People Receiving Mental Health Services in Maine, a Mainecare-generated document that Gateway has designated as a mandated portion of their intake. The use of this document as an informant to adults receiving services can help to provide a formal declaration of privacy and further outline the

relationship of the practitioner to the client as someone there to facilitate their transition into the resettlement context (Krista Hall, December 19, 2019).

There is a certain level of necessary effort on behalf of the practitioner as well to practice patience and constant reflection on their service provision as these relationships, built on an established level of rapport and trust, can take multiple sessions to achieve. This involves continued participation in trainings aimed at aiding the practitioners in their understanding of any existing power imbalances, diversity, equity, and inclusion in cross-cultural and culturally-competent mental health service provision. Many of the practitioners interviewed claimed that small gestures, such as presenting as inquisitive (yet without ulterior motives), kind, genuine, and forgiving, can help to "give [the client] the courage and push [they] need to come forward" (Kheyro Jama, December 16, 2019). Another tenant in culturally-competent care is understanding the potential for gaps in understanding that accompany language barriers. Therefore, conducting care in the native language of the client will help to bring everyone on the same page as best as possible. However, even attempting to learn the language or speak to the client in their native tongue can serve as a huge expression of genuine care and desire to meet them where they're at (Krista Hall, December 19, 2019). In order to establish a deeply rooted relationship of trust, and to avoid the potential discrepancies that accompany linguistic differences earlier on, two of the Gateway employees discussed the importance of intercommunity practitioners. Intercommunity psychosocial care providers have an unparalleled understanding of the normative standards surrounding certain subject matter, such as drugs, sex, or alcohol use, as well as the customary manner to go about

discussing such topics. This allows them to, not only facilitate bicultural dynamics in conversations between second generation children and their parents, but also provide an insightful ear to those who are less acculturative to a highly sexualized Western society (Kheyro Jama, December 16, 2019). This level of intercommunity empathy not only advances the capacity for trust and eliminates language barriers but also levels the cultural understanding and capacitates the provider to accompany the client in a manner that is consistent with structural demands of Westernized mental healthcare yet is still in line with the individual's set of values, experiences, and ethnic way of being.

Training. For practitioners not native to the cultures or geographic regions of the new-arrivals, it is extremely imperative for them to remain up to date on what it means to provide culturally-competent care. When practitioners do not have this level of intercommunity advantage they have to be careful not to exacerbate the already-stressful cultural exchange that is Western therapy in general. Certain questions or assessments, if not asked in a culturally-sensitive manner, have the ability to confuse the client and, potentially, the practitioner themselves if they are naive to the normative functions of their client's particular community and culture (Kheyro Jama, December 16, 2019). Avoiding the tendency to associate a group of individuals from a specific geographic with certain stereotypes regarding various cultural practices or norms via continued geopolitical and ethno-cultural education is imperative in challenging the inherent ethnocentric bias in Westernized mental health. A constant practice of cultural humility, the acknowledgement and respect for cultural difference, as well as the avoidance of superimposing one culture above another, is necessary in honoring and accommodating

the desired way of life for the individual in this new host society (Ruth Grady, December 19, 2019).

Implications for Macro Level Policy and Practice

Much of the data collected also points to the need for attention on some of the larger scale, systemic, structural, and normative aspects of psychosocial care for refugees and immigrants. While these superstructure elements are harder to tackle through direct service or via mental healthcare they are, nonetheless, important for reporting and organizing purposes as grievances to keep in mind when advocating for equal rights on behalf of this community.

Gendered Power Dynamics and Trauma. One of the major cultural differences cited by the interviewed practitioners had to do with varying perceptions in what was accepted as culturally-appropriate displays of male/female dynamics within a household. Of particular note was the victimization of many women to, what many mental health professionals in the United States would refer to as, domestic violence and its contribution to the compounding trauma that is characteristic of the resettlement process. Krista Hall stated that one of Gateway's interpreters had been noticing a trend in which refugee women arriving from countries such as a Rwanda or the Congo, where rampant state-sponsored violence promotes and thrives off of patriarchal dominance, are experiencing a major shock when confronted with such a profound level of support and education surrounding domestic violence survivorship (Krista Hall, December 16, 2019). While domestic violence may not be the vocabulary used in many Central/East African countries to describe the varying forms of violence inflicted upon women, Ruth Grady

stated that “regardless of culture or geographic area...I have never once met a woman who appreciated being hit, cut, [or] any of those things” (Ruth Grady, December 19, 2019). Shattuck-Heidorn reported that 55% of women refugees interviewed in the Greater Portland Area cited experiencing domestic violence after arrival, of which 99% indicated feeling as though they didn’t have the means to flee the violent situation (November 4, 2019). Numbers such as these highlight the gender-specific barriers to self-sufficiency faced by refugee women as many are less likely to speak English or have a secondary education. There is a specific labor market role reversal as well for women in that their specific skill set upon arrival lends them to be desired employment for sectors wherein there is always a need and vacancy -such as housekeeping or nannying. In various households this has resulted in men staying home with the children, resulting in a shift in traditional notions of the domesticated sphere. This gender role reversal has proven difficult for many of the men arriving from the aforementioned, hyper masculinized cultures and is reflected in the statistic that refugee men are 50% less likely to seek mental health support within a resettlement context (Shattuck-Heidorn, November 4, 2019).

Many of the professionals interviewed cited having to learn how to navigate power dynamics between husbands and wives, specifically when it came to providing mental health counselling for the wife alone, especially if she expressed experiencing domestic violence or abuse. Grady noted that some husbands in her practice have gone as far as offering to interpret for their wife, placing the woman at risk of her therapy session being co-opted by the husband as a means of further subversion via omission of key

information or transmission of false information (December 19, 2019). Trust remains a key element here again as many practitioners stated it was imperative for the husband to learn that therapy is a space meant to bolster the individual's capacity for growth and success, not create further conflict. By emphasizing the goal of service provision as a key tenement in improving the experience of the family unit during the resettlement process, providers are often able to create a level of space for the woman to feel both empowered and liberated from her husband to speak openly and vulnerably about her particular needs (Abduallahi Ali, November 27, 2019).

Given that violence against women was emerging as a more or less "normalized" phenomena for many clients of the interviewed professionals, Ali describes a common need for Domestic Violence education as it is understood in the United States both culturally and legally (November 27, 2019). This is especially important as many recent arrival refugees to this area are survivors of some other sort of pre-migration trauma that runs the risk of being exacerbated by the experience of a similar form of physical or mental/emotional abuse. Kheyro Jama describes how the pre-migration experience of gendered aggression manifests itself post-traumatically in the life of a resettled woman:

> I used to have individuals who had been burned physically. Someone would grab fire. They can do that while she was getting raped. And she said, "I forget the event, but one thing that I don't forget is the insanity they have, those guys. To rape me wasn't enough...for them to physically even hurt me." She said "anytime I want to be intimate [with] my husband, I feel those rage in," she said "I can't

separate the Somali guy who was at the refugee camp versus the one I have as a husband." (December 16, 2019)

Psychoeducation becomes a crucial part of the psychosocial accompaniment process within the resettlement context as a streamlined understanding of things like Western conceptions of mental health and domestic violence can have critical consequences for the individual and their family if not properly addressed or mitigated to avoid re-traumatization. Grady describes the entire migration process, encompassing the pre-migration push/pull factors, migratory journey, and post-migration resettlement experience, as one of extreme loss: "loss of your visions of the future, your status in your community, family members, [and the] people that you had to leave behind" (December 19, 2019). As a result, it is echoed across the practitioners interviewed that the main goal of their version of psychosocial support is to assist the individual in living and transitioning with the most ease, which includes accounting for the many gendered aspects and risks within the resettlement process.

Access to Care. Unfortunately, all of the practitioners interviewed indicated that there is a great conceptual divide between the "ideology that the Mainecare system relies on" and what clients are perceiving as the ultimate end goal of most forms of psychosocial service provision (Krista Hall, December 19, 2019). In other words, it has been noted that, without this streamlined understanding of mental health, or in this case, mental distress, among both clients as well as the Mainecare institution financing their care (excluding, at the time of this investigation's writing, asylum seekers), most clients to do not walk away from counseling appointments with the understanding that their

conveying of mental distress is actually beneficial to their receipt of benefits. Hall pointed to a particular difficulty among Gateway's practitioners in learning to balance the demands of the Mainecare system with their organization's philosophy that aims to view clients from a socioecological and strengths-based vantage point. Mainecare, in this case, is interested in adhering to a deficit-based conception of mental health in order to assess the individual and their family's particular level of need (December 19, 2019).

Almost all of the practitioners interviewed also indicated a significant desire and perceived need for the expansion of healthcare. As previously noted, at this moment in time, state-sponsored healthcare is only applicable to individuals and families arriving to the United States with a refugee visa, therefore excluding a large part of the immigrant community, especially within the Greater Portland area, who have arrived here as asylum seekers. Gateway has attempted to address this particular need by providing clinical training and supervision to Master of Social Work students at the University of Southern Maine who can provide, albeit limited and time-restricted, pro-bono direct service to asylum seekers (Abduallhi Ali, November 27, 2019). Refugees who require mental health services, despite being eligible for Mainecare upon arrival, are still required to present a physician's assessment to demonstrate true fulfillment of eligibility criteria. In order for a clinician to conduct an assessment that is thoroughly considerate of all risks faced by the individual, let alone linguistically accessible for both parties, requires a significant amount of time and access to resources to receive an appointment in the first place- time which many recent-arrivals do not have.

Therefore, not only does immigration status present a huge barrier to receiving healthcare but so do the whole host of disparities that accompany an undocumented recent-arrival with compounding mental health difficulties, such as a language barriers and the inability to access resources in native tongue, age gaps and restrictions, as well as various cultural restrictions that are at odd with an ethnocentric, Westernized approach to service provision. Add to this list, historically-rooted racialized power dynamics and the particular risk this poses for recent-arrival immigrants of color as well as the preexisting generalized anxiety towards law enforcement. While racism cannot be solved in one therapy session, continued attention to the interplay of these issues with the specific needs and risks facing this population can only help to fortify the field of psychosocial service provision and culturally-competent care that aims to address these systemic inequities.

Chapter 5
Analysis

Socioecological Approach & Psychosocial Care

Given the multifaceted and systemic nature of the unique needs and vulnerabilities facing recent-arrival refugees within a resettlement context, specifically female survivors of gender-based violence, the existing literature and presented data echo various recommendations and orientations toward treatment that are in line with a socioecological framework. While it stands that large scale institutional changes such as the ultimate reformation of the immigration system could alleviate much of the distress prior to and during migration, goals such as this are beyond the scope of psychosocial service provision. The literature and data within this analysis seems to point, however, to the importance of culturally-sensitive, community-based, direct service provision in order to establish a level of normalcy in the lives of this population within the host society. By focusing on the immediate establishment of basic needs, through a culturally-informed lens, service providers can begin to tackle some of the larger systemic issues facing refugee survivors. This particular investigation argues that attempts at relieving multiple acute instances of mental, emotional, and physical suffering, within a culturally-contextualized and feminist socioecological understanding of the migration context could have significant potential for holistic harm reduction within this population.

It is clear from the data presented that situating the individual or their family within a larger socioecological context illuminates the intersectional considerations practitioners must take into account when offering psychosocial support. A feminist

orientation specifically allows for a special accounting of the unique and added layer of the needs accompanying female refugees and female refugee survivors of trauma or violence. This can include attention to male/female dynamics in therapy sessions, extra efforts in promoting education surrounding domestic violence in the United States and resources for survivors, educational, linguistic, or employment support, sexual and reproductive healthcare considerations, as well as cultural and familial resources. As demonstrated by the literature on gendered genocide and sexual violence as a tool for war, trauma, especially sexual violence, is often felt at a community level. This is manifested in the data as well when post-traumatic stress experiences are shown to severely impact the day-to-day functioning of an individual in resettlement society or in their resistance to treatment due to cultural stigmatization or differences in images of mental health. Therefore, the potential for collateral victimization among family or community members, as well as further victimization of the individual themselves, can be mitigated via direct service provision - i.e. securing safe and reliable housing, equitable employment, education (especially for children), food, water, and other basic needs that prevent the entrance to poverty.

Such an intersectional approach to care provision also accounts for aspects such as a fear of authority and law enforcement or apprehension towards professional service providers. Not only does this fear stem from the manifestations of deeply rooted racism and a disproportionate rate of police violence against people of color, but it may also be exacerbated by the news and stories of maltreatment by ICE and CBP officials towards individuals arriving to the U.S./Mexico border. The recent public outcry among

professional and academic psychological institutions regarding the exploitation of confidential information by ICE agents in deportation hearings (APA, 2020) has likely contributed to recent arrival's generalized apprehension towards revealing personal information or ties to gang or militant-related trauma in the country of origin during counseling sessions. It could also be presumed that, since many of the refugees arriving to Maine are following a migration route with the first point of entry at the Southern border (Elizondo, 2019), they have been introduced to the harsh reality of the United States immigration system and its enforcing bodies while experiencing the unfolding of the humanitarian crisis at the border. News of Migrant Protection Protocols, family separation, and maltreatment by ICE officials further paint a picture of government employees and immigration enforcement that is anything but welcoming or non-persecutory.

In taking a feminist socioecological approach to the psychosocial care of refugee survivors, one can see that socioenvironmental, intertwined with meso and micro-level factors, such as poverty, social isolation, homelessness, food insecurity, and more, are all responsible for intensifying any experience of trauma. Interventions, therefore, should surpass more than just a trauma-informed qualification alone. In reference to Brofenbrenner's Ecological Systems Theory (as cited in Mootz, Stabb, & Mollen, 2017), interventions should focus on addressing all levels of suffering within an individual's sub-systemic environment that prevent the them from, not just functioning in a resettlement society, but thriving in their new and diverse community. In order for direct service provision to aid in the individual or family's resettlement experience, rather than

just serving as a veil for mental distress via an allusion of "successful integration" into the host society, there must be a shift in the orientation to care that accounts for these stabilizing factors and their ability to improve a turbulent transition. The ensuing section will discuss the benefits of a streamlined conception of mental health that is focused, not on mental deficits, but on the obstacles to optimal operation in society, and its potential in mitigating care coordination, improving access to systems of support, and combatting Westernized, individualistic ideologies in service provision.

Streamlining Conceptions of Mental Health

Given that the events and meaning of one's resettlement experience may differ from one individual's national or cultural background to another, and that the meaning attributed to their symptoms may vary as well given their specific culture's understanding of mental health, this not only poses a structural barrier in the propensity to seek care but also an interpersonal barrier via stigmatization and isolation. The current inequities in healthcare coverage are only further exacerbated when it comes to immigration status and the associated eligibility criteria for certain services depending on one's legal standing. This, along with the specific needs facing the immigrant and refugee survivor community only further promotes a distortion in how clients view their psychosocial care providers, drawing an even greater distinction between direct-service-providing case managers and designated mental health professionals. In many cases, licensed mental health providers end up doing direct service work, or case managers find themselves in counselling positions, something that is often not reflected in either party's salary. This fragmented approach to psychosocial support, often due to a lack of coordinated care responses

across all facets of the resettlement process, only contributes to a deeper fragmentation in the fight towards holistic and culturally-oriented care provision for this population.

Per the data, normalizing efforts that present mental health as a continuum (Krista Hall, December 16, 2019) related to the ability to function and thrive in one's current environment could contribute to reducing the potential for harm caused by the isolating effects of stigmatization and varying conceptions of mental wellbeing that reduce mental health to a binary of sane versus crazy. Not only is this effective in addressing concerns of cultural competency, through its attempt to find a common ground in language for talking about mental health as it relates to symptomatology, but it also helps to bolster the individual's sense of involvement and belonging in the wider community. For many New-Mainers, this sociocultural aspect is extremely vital as many are arriving from cultures that stress the collective wellbeing over the advancement of the self, or are survivors of human rights violations that were aimed at destabilizing the entire community - such as sexual or gender-based violence and rape. As the data suggests, any effort towards reconnecting the individual or family to their cultural roots within the resettlement society can play a vital role in easing the period of adjustment and optimizing one's functioning in an unfamiliar environment. While large-scale, systemic, or cultural norm shifts are beyond the scope of this analysis' proposition, a normalization of mental health discourse along with a movement away from what is an otherwise rather exclusionary, binary, and clinical conception of mental "disorder," is certainly attainable within a culturally-sensitive, feminist, and socioecological orientation to psychosocial care.

Chapter 6
Conclusion

If America is to pride itself on being a melting pot of nationality and cultural identities, service providers must work to create a mental and psychosocial healthcare system that is increasingly sensitive to the ever-diversifying population, their varying cultural understandings of mental wellbeing, and the risk this poses for further victimization of recent-arrivals, particularly those who are survivors. This level of cultural sensitivity requires a deep and thoughtful reflection on one's own culture and the avoidance of the tendency to impose a rigid and ethnocentric definition of mental health on the individuals, families, and communities that practitioners are encountering within the resettlement context. This thesis proposes that providers can begin this process by adopting a feminist socioecological approach to care, as well as a streamlined understanding of mental health that moves away from the current deficit-focused, individualized orientation and towards one that is rooted in a common language of psychosomatic symptomology and universal human emotion, and is focused on community healing and optimal functioning within one's environment.

Limitations

First and foremost, the author wishes to acknowledge that, while the data presented and discussed focuses largely on refugee survivors of trauma of all genders, its aim is to bring awareness to the specific set of needs facing women refugees. Ideally the discussion would have been inclusive of a wider-scope of gender identities, but there is a significant lack of literature surrounding the resettlement experience of refugees

identifying with gender minorities or as members of the LGBTQ+ community. While sexuality and gender identification is something practitioners are encountering in counselling sessions, particularly among recent-arrival adolescents, and although it remains a significant part of the discussion on culturally-sensitive care provision, this is a particular area of the investigation in need of further elaboration and research. This limitation is specific to this thesis but can also serve as a call to the wider academic community as a growing frontier in feminist scholarship.

Additionally, this thesis is grounded in theory and data that focuses on the concept of "intervention" as it relates to a Western model of mental health. Given that many of these theories and modes of intervention are conceptualized in the "Global North" *for* the "Global South," this creates the potential for a form of academic neocolonialism that the author would like to highlight. Attempts to break away from neocolonial scholarship are made by offering a more fluid conception of mental health and a more holistic orientation to care that is grounded and led by the experience of the refugee individual or family. However, there is potential for blind ethnocentrism in the author as a non-immigrant. Concurrently, this raises the question of whether or not one can ever truly be culturally-competent in their care provision if they can't speak the native language of the person or community with whom they are working. While interpreters were seen as vital in opening access to treatment within the resettlement context for non-English speakers, there is potential for messages or their sentiment to quite literally get lost in translation due to the normative, emotional, and cultural associations of language. It could be assumed, as well, that not speaking or taking the time to learn the language contributes to the

aforementioned notion of perpetuated neocolonialism in the form of the imposition of culturally-blind psychosocial interventions.

Lastly, it is important to note that the scope of this investigation is limited in its ability to generalize any sort of recommendation for intervention due to its small number of interviews conducted. This limitation largely stems from the fact that most of the data is representative of the larger immigrant and refugee community of Maine as a whole rather than of refugee women survivors specifically. While the research question of this investigation is concerned specifically with the experience of refugee women survivors, the data fails to be entirely illustrative of the proposed theoretical trajectory of this particular portion of the population.

Looking Forward

In addition to expanding feminist and psychosocial scholarship to include the resettlement experience of gender minority and LGBTQ+ refugees, an important consideration for Western practitioners lies in assessing methods of scaling approaches to trauma treatment that match the circumstances faced by refugees living in refugee camps along their migration journey or within the resettlement context. In other words, in efforts to push one step further than culturally-competent care, how can professional care providers in a resettlement environment create models of emotional resilience for refugee survivors so deeply entrenched in the trauma of their past? How can they create modes of intervention that don't just do the bare minimum of acknowledging cultural differences, but instead, resonate so strongly with the experience of trauma and psychosomatic memory that the method of support transcends all borders and language barriers? Perhaps

literature focusing on the physical embodiment of trauma is the next frontier for treating individuals of all language backgrounds or perhaps it is something entirely inconceivable at this moment in time.

Finally, it is necessary to note the timing of this thesis' production and the challenges that the current circumstances will present in relation to this particular research question moving forward. While the data was conducted before the outbreak of the 2019 Coronavirus Pandemic reached the United States, the implications for further study are absolutely apparent in the virus' highlighting of the pre-existing disparities within the healthcare system. The current situation begs the question of how to make culturally-competent and holistic care accessible in times of crisis, social isolation, and limited resourcing? Practitioners and advocates alike must ask themselves how unprecedented and unforeseen circumstances such as COVID-19 can exacerbate the risks facing the population in question and propose a novel set of considerations for those dedicated to their care provision.

References

A. Ali, personal communication, November 27, 2019.

Akinsulure-Smith, A., & Jones, W. L. (2011). Nah we yone -- a grassroots community-based organization in new york city: Successes, challenges, and lessons learned. *International Journal of Migration, Health and Social Care, 7*(1), 44-57. doi:http://dx.doi.org.proxy.bc.edu/10.1108/17479891111176296

American Psychological Association (APA) Calls for Immediate Halt to Sharing Immigrant Youths' Confidential Psychotherapy Notes with ICE. (2020, February 17). Retrieved from https://www.apa.org/news/press/releases/2020/02/sharing-therapy-notes on March 1, 2020.

Beoku-Betts, J., & Njambi, W. N. (2005). African feminist scholars in women's studies: Negotiating spaces of dislocation and trans- formation in the study of women. Meridians: Feminism, Race, Transnationalism, 6, 113–132. doi:10.2979/MER.2005.6.1.113

Britton-Anastas, B. & McNamara, P. (2019, November). Immigration and Sexual Violence. Presentation by Boston Area Rape Crisis Center and Boston College Globe Med. Talk presented at Boston College, Chestnut Hill, MA.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43(6),* pp. 1241-1300.

Elizondo, G. (2019, June 23). Central african refugees welcomed in maine. Retrieved from https://www.aljazeera.com/news/2019/06/central-african-refugees-welcomed-maine-190623185327515.html

Feinberg, R. (2019, June 19). The Recent Influx Of African Asylum-Seekers Is Taxing Social Services In Maine. Retrieved from

https://www.npr.org/2019/06/19/734165446/the-recent-influx-of-african-asylum-seekers-is-taxing-social-services-in-maine

Gewalt, S. C., Berger, S., Ziegler, S., Szecsenyi, J., & Bozorgmehr, K. (2018). Psychosocial health of asylum seeking women living in state-provided accommodation in Germany during pregnancy and early motherhood: A case study exploring the role of social determinants of health. *PloS one*, *13*(12), e0208007. doi:10.1371/journal.pone.0208007

Heise, L. (1998). Violence against women: An integrated, ecological framework. Violence Against Women, 4. (pp. 262–290). doi:10.1177/1077801298004003002

Hodes, M., Anagnostopoulos, D., & Skokauskas, N. (2018). Challenges and opportunities in refugee mental health: Clinical, service, and research considerations. *European Child & Adolescent Psychiatry, 27*(4), 385-388. doi:http://dx.doi.org.proxy.bc.edu/10.1007/s00787-018-1115-2

Immigrant Power and Control Wheel adapted by Futures Without Violence from the Power and Control Wheel developed by Domestic Violence Intervention Programs, Duluth, MN. Retrieved from: www.futureswithoutviolence.org.

Jaung, M., Jani, S., Banu, S., & Mackey, J. M. (2017). International emergency psychiatry challenges: Disaster medicine, war, human trafficking, displaced persons. *Psychiatric Clinics of North America, 40*(3), 565-574. doi:http://dx.doi.org.proxy.bc.edu/10.1016/j.psc.2017.05.015

K. Hall, personal communication, December 16, 2019.

K. Jama, personal communication, December 16, 2019.

Kaiser, J., & Hagan, J. (2015). Gendered genocide: The socially destructive process of genocidal rape, killing, and displacement in darfur. *Law & Society Review, 49*(1), 69-107. doi:http://dx.doi.org.proxy.bc.edu/10.1111/lasr.12122

Kallivayalil, D. (2015). Women, political violence and migration: Feminist and clinical issues in the asylum process. In O. M. Espín, & A. L. Dottolo (Eds.), *Gendered journeys: Women, migration and feminist psychology*. (pp. 150-166). New York, NY: Palgrave Macmillan.

Kazdin, A. (2011). Conceptualizing the challenge of reducing inter- personal violence. Psychology of Violence, 1, 166–187. doi:10. 1037/a0022990

Keygnaert, I., Vettenburg, N., Temmerman, M. (2012). Hidden violence is silent rape: Sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. Culture Health & Sexuality, 14, 505–520. doi:10.1080/13691058.2012.671961

Mohamed, M., & Millan, A. (2019, September 11). The Africans risking death in jungle trying to reach U.S. Retrieved from https://www.bbc.com/news/av/world-latin-america-49667999/the-africans-risking-death-in-jungle-trying-to-reach-us

Mootz, J. J., Stabb, S. D., & Mollen, D. (2017). Gender-Based Violence and Armed Conflict. *Psychology of Women Quarterly*, *41*(3), 368–388. doi: 10.1177/0361684317705086

R. Grady, personal communication, December 19, 2019.

Shattuck-Heidorn, H. (2019, November). Mental Health and New Arrivals. Talk presented at the Building Bridges Conference: Advancing Trust and Understanding in Our Communities. Lewiston, ME.

Solar O, Irwin A. A conceptual framework for action on the social determinants of health Social Determinants of Health Discussion Paper 2 (Policy and Practice). Geneva, Switzerland: World Health Organization, 2010.

Stark, L., Asghar, K., Meyer, S., Yu, G., Bakemore, T., Poulton, C., & Falb, K. (2017). The effect of gender norms on the association between violence and hope among girls in the Democratic Republic of the Congo. *Global*

Mental Health, 4, 10. doi:http://dx.doi.org.proxy.bc.edu/10.1017/gmh.2016.31

Stark, L., Landis, D., Thomson, B., & Potts, A. (2016). Navigating support, resilience, and care: Exploring the impact of informal social networks on the rehabilitation and care of young female survivors of sexual violence in Northern Uganda. Peace and Conflict: *Journal of Peace Psychology, 22*(3), 217-225. doi:http://dx.doi.org.proxy.bc.edu/10.1037/pac0000162

Wachter, K., Horn, R., Friis, E., Falb, K., Ward, L., Apio, C., . . . Puffer, E. (2018). Drivers of intimate partner violence against women in three refugee camps. *Violence Against Women, 24*(3), 286-306. doi:http://dx.doi.org.proxy.bc.edu/10.1177/1077801216689163

Yohani, S. C., & Hagen, K. T. (2010). Refugee women survivors of war related sexualised violence: a multicultural framework for service provision in resettlement countries. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict, 8*(3), 207-222. Retrieved from: https://www.interventionjournal.com/content/refugee-women-survivors-war-related-sexualised-violence-multicultural-framework-service