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Psychotherapy with Refugees: Emerging Paradigm

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Much clinical and trauma work has focused on interventions with individuals experiencing interpersonal violence and past traumas. Refugees' experiences include past and present and chronic intergroup and interpersonal traumas with cumulative linear and nonlinear dynamics. Refugees face unique social and political traumatogenic ecologies that can play at least an equivalent or even more significant role in traumatic stress compared with that of survivors of interpersonal trauma who do not experience atrocities such as exile, political and religious persecution, and torture. Evolving paradigms of intervention need to be developed to integrate individual and ecological models of recovery that focus on the whole person within her or his social and political ecology and on past as well as present traumatogenic experiences; in addition, these paradigms need to mobilize refugees' resilience.

KEYWORDS *refugees, torture, discrimination, ecological model of recovery, intergroup trauma, interpersonal trauma, continuous traumatic stress*

In the past decade, international conflicts, social oppression, and civil wars have generated 16 million refugees worldwide, with approximately 500,000 refugees being resettled in the United States (Office of Refugee Resettlement, 2010; United Nations High Commissioner for Refugees, 2010). Refugees, fleeing oppression, atrocities, discrimination, torture, and/or

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genocide, experience numerous adversities before leaving their own countries, in transit as refugees in other countries, and upon arrival and resettlement in the host country, facing past as well as ongoing intergroup and interpersonal traumas and societal oppression (e.g., discrimination and acculturation stress, economic difficulties, and community violence) (Porter & Haslam, 2005). Epidemiological studies on the effects of migration, both voluntary and forced, show that compared to others, refugees have more psychotic disorders and higher rates of depression, anxiety, and posttraumatic stress disorder (PTSD) (Bhugra, 2004). Along with these adversities, resilience and survival capacities among refugee individuals and communities are unique.

Research, theoretical analysis, and clinical experience suggest that clinicians who have been trained to work with victims of interpersonal trauma and on the usage of past-trauma-focused interventions will need to gain more understanding and competence in interventions with intergroup and continuous traumas to be able to help refugees. Refugees are victims of past intergroup traumas as well as enduring, ongoing interpersonal and intergroup traumas. Understanding their histories and level of distress, the linear and nonlinear dynamics of traumatization and resilience, and their models of coping and resilience are all important in providing effective psychological and psychosocial interventions (Nickerson, Bryant, Silove, & Steel, 2011).

This article aims to enrich clinicians' knowledge of the differences between refugees and non-refugee clients coping with interpersonal trauma, which may enhance their competence in working with this population. We will explain the etiological differences between their symptoms and other presenting issues and those among non-refugee clients, with the goal of raising awareness and knowledge for clinicians working with refugee populations. We utilize a development-based trauma framework (DBTF) that helps to outline the factors contributing to refugees' mental health outcomes, discuss relevant empirical findings, and specify approaches that may be effective in helping refugees. While our discussion of theory and practice is relevant to refugees from a wide array of countries, we derive a great part of our discussion from studies of Iraqi refugees in the United States, who represent one of the most traumatized refugee communities (Gorst-Unsworth & Goldenberg, 1998; International Rescue Committee, 2009). We draw from various emerging models of treatment with specific refugee populations to help frame clinical strategies for working with refugees and provide a case illustration that demonstrates the relevance of a framework that attends to the specific needs of refugees.

REFUGEE TRAUMA: THEORETICAL FRAMEWORK

The lingering general concern about the relevance of current trauma frameworks and current mental health programs and existing interventions for refugees is not new (Summerfield, 1999). To be more specific, current

stress and trauma paradigms have been accurately criticized as fragmented and having individualistic, past trauma, and single trauma biases (Burstow, 2003; Kira, 2010; Kira, Ashby, et al., 2013; Kira, Lewandowski, Choido, & Ibrahim, 2014). They tend to ignore intergroup systemic and continuous traumatic stress (Straker, 2013), as well as the dynamics of cumulative trauma and poly-victimization that may be central to refugees' experiences. The unique negative effects of cumulative trauma on physical and mental health and on cognitive processing are now well documented (Hodges et al., 2013; Kira, Omidy, & Ashby, 2014; Martin, Cromer, DePrince, & Freyd, 2013). The application of the existing stress and trauma frameworks to the contexts of refugees' past, present, and ongoing traumas and emerging threats and dangers is problematic. The exclusive focus on past traumas tends to obscure the temporal dynamics of ongoing traumas, which may modulate or amplify the effects of past traumas and increase the proliferation of and vulnerability to future traumas. The sole focus on trauma perpetrated by individuals tends to ignore stressors and traumas perpetrated by institutions and social systems and those transmitted through generations, cultures, and history involving a sense of collective identity.

Further, the diagnosis of PTSD is based on identifying a single limited trauma type (as contrasted with cumulative trauma and its linear and non-linear dynamics) as a causative factor, which has been criticized for its limited applicability in refugees who are multiply traumatized (e.g., Burstow, 2003). The mental health effects of such cumulative interpersonal and intergroup traumas can be more serious and chronic, as we will further elaborate (e.g., Kira, Fawzi, & Fawzi, 2012; Kira, Lewandowski, Yoon, et al., 2012). Complex PTSD (Herman, 1997) and continuous traumatic stress syndrome (Straker, 2013) have been suggested as alternative conceptualizations of PTSD. The cumulative trauma disorders (CTD) model is another framework that has been suggested to describe the potential outcomes of the cumulative effects of refugee trauma (Kira, 2001; Kira, Templin, Lewandowski, Ashby, et al., 2012). CTD is a trans-diagnostic cluster that may follow such cumulative trauma and may encompass different profiles of comorbid diagnoses and syndromes, including psychotic symptoms, dissociation, memory and executive function deficits, PTSD, and comorbid depressive, anxiety, and somatization disorders (Kira, 2010; Kira, Templin, Lewandowski, Ashby, et al., 2012). In this model, different profiles of traumas yield different profiles of CTD. Considering the comorbidity of disorders that refugees may be suffering from, trans-diagnostic approaches may be more appropriate for their condition. Trans-diagnostic treatments are interventions aimed to treat multiple disorders at the same time concerning their shared causes, commonalities, course, and symptom maintenance (Chu, Merson, Zandberg, & Areizaga, 2012).

In considering the complex nature of trauma among many refugees, the linear dose-dependent response model is insufficient in explaining the risk for developing symptoms. Nonlinear dynamics are especially relevant. While

the dose-response model (the change in effect caused by differing levels of exposure) describes linear traumatogenic dynamics (Altshuler, 1981), a cumulative trauma model proposes different cumulative nonlinear dynamics inherent in the threshold model (which describes a threshold value at which the behavior varies significantly). For example, an individual who is resilient in the face of trauma can experience a breaking point at which he or she feels deep psychological distress and/or engages in destructive behaviors. Such nonlinear dynamics of cumulative trauma are especially important to multiply traumatized victims of political violence (Kira, Amer, & Wroble, 2014).

Further, the diagnostic category of PTSD has been thought to contribute to the medicalization of suffering resulting from political struggle, which may divert attention from understanding and addressing the broader social and political causes and consequences of refugees' traumatic experiences (e.g., persecution, war, occupation, and genocide) (Giacaman et al., 2011; Summerfield, 2004).

UNIQUE FEATURES OF REFUGEES' TRAUMAS

Refugees experienced uprooting and relocation far away from home, community, culture, and, in some cases, from family. Uprooting and displacement and related exclusion dynamics shape the mental health of refugees and create profound disconnections in relationships. Related to uprootedness is the loss of family ties. Refugees with immediate family in their home country have higher levels of symptoms of PTSD and depression and more mental health problems than those without family in their home country (Nickerson, Bryant, Steel, Silove, & Brooks, 2010).

Further, collective traumatic experience related to political oppression and genocide can contribute to group annihilation anxiety and fear of culture extinction. Empirical findings indicate that trauma and difficulties with acculturation to a new cultural context, along with posttraumatic stress, contribute to a fear of cultural extinction and identity annihilation anxiety in some refugee populations (Kira, Templin, Lewandowski, Ramaswamy, et al., 2012; Nickerson et al., 2010).

Besides uprootedness and fears about cultural extinction, many women and girls experience severe gender inequality in their countries of origin. The World Health Report (World Health Organization, 1988) has documented how sexism is pervasive in many refugee societies. There is empirical evidence for the serious negative mental health effects of gender discrimination (GD), as ongoing continuous trauma, on refugee women after controlling for all other life traumas. Additionally, GD has been found to contribute to trauma spectrum disorders including PTSD in female torture survivors (Kira, Ashby, et al., 2012; Kira, Smith, Lewandowski, & Templin, 2010).

One particular traumatogenic condition that negatively affects many refugees' adjustment and integration in the new society is the racial and

political discrimination and backlash directed against them, especially refugees from the Middle East and Muslims following the terrorist attacks of September 11, 2001. Micro (e.g., interpersonal insults) and macro aggressions (e.g., bullying and hate crimes) have added to ongoing identity threats of annihilation, subjugation or denigration, cultural extinction, and the experience of pervasive vulnerability (Tummala-Narra, 2005).

Discrimination and backlash have been found to cause serious physical and mental health suffering among Iraqi refugee adults and adolescents (Kira, Lewandowski, Choido, & Ibrahim, 2014). Backlash has predicted significant neurological problems, hypertension, and respiratory and digestive health problems. Additionally, bullying victimization, intersecting with discrimination, has been found in a path-analytic study to exact a serious toll on mental health as well as to suppress the IQ of Iraqi refugee adolescents after controlling for all other life traumas (Kira, Lewandowski, Ashby, et al., 2014).

In addition to uprootedness, oppression, torture, GD, discrimination, and bullying, many refugees face stressors related to loss of previously held social and economic status that may precipitate some forms of depression (Wroble, Farrag, & Hymes, 2009). Further, they face acculturative stress (e.g., learning a new language and dealing with a new culture, customs, and laws). Higher levels of acculturative stress were found, in some studies, to be one of the strongest overall predictor of mental health (Nicholson, 1997) and of increased poly-substance abuse (Weaver & Roberts, 2010) among refugees. Another factor complicating the traumatic experience and mental health of refugees is higher internalized stigma of mental illness, which may contribute to disparities in accessing mental health services and negative attitudes toward counseling (Soheilian & Inman, 2009).

Understanding uprootedness and displacement, political oppression, discrimination, bullying, GD, and stigma (some of which happened in the past and some of which is ongoing and may be chronic) is critical in designing clinically meaningful interventions for refugees. Of special importance is to understand and address not only past traumas but also current ongoing stressors and traumas. It is worth noting that studies indicate comparable efficacy of present-focused and past-trauma-focused therapy (Classen et al., 2011).

RESILIENCY AND RESOURCES

Regardless of these different past and present adversities, many refugees are resilient. A collectivistic orientation, connection with their intact and extended family, their striving for just cause, and their seeking a sense of fairness and justice seem to be particularly important protective factors among many refugees. Moreover, survival throughout the oppression and dislocation processes itself is an indicator of resilience. While studies of stigma faced by

clients from different refugee communities (e.g., Arab and Muslim refugees) have found that over 40% resist the mental health stigma imposed on them by labeling and stereotyping (Kira, Ramswamy, & Lewandowski, *in press*), informal sources of support seem to be especially important in the recovery process. Empirical studies with two large samples of Iraqi refugees ($N=501$ and $N=356$) have suggested that although tortured individuals experience severe traumatic stress, they report more posttraumatic growth; seek more social support from family, friends, and community; identify with their religious and political beliefs; and express more tolerance of differences in religion, race, and culture when compared with non-tortured refugees (Kira et al., 2006). It is important to note that factors such as a strong connection to family are often protective for refugees, and yet may be experienced differently across individuals. In particular, the relevance of family connection should be considered in the context of the interactions between an individual and his or her specific ecology (e.g., family relationships, history of trauma within the family, degree of support from family members).

THE ROLE OF INTACT FAMILY, RELIGIOSITY, AND SOCIAL SUPPORT

Generally speaking, refugees come from more traditional intact families, and as such family support is an important source of resilience (Dwairy, Achoui, Abouserie, & Farah, 2006). Studies demonstrate that family connection is central to the lives of most refugees (Kira et al., 2011). However, obligations to family members who remain in the home country or in the country of first asylum may be a source of stress because some resettled refugees experience feelings of guilt and continue to feel responsible and want to assist those family members in need back home. Other protective factors include belief systems such as religious/spiritual beliefs and political ideologies. Religiosity has been found to be an important coping strategy in the face of trauma among refugee torture survivors from over 30 countries (Isakson & Jurkovic, 2013). It is important for practitioners to understand culture, religion, family, and racial-religious-ethnic identifications as sources of resilience (Tummala-Narra, 2007). Religious leaders such as Christian pastors, Muslim sheikhs, and imams have an enormous amount of influence among refugee communities and can play an increasingly vital role in mediating family conflicts, facilitating problem solving, and promoting community healing through weekly sermons and public lectures that address community issues. Strengthening community outreach through churches, mosques, and cultural and community centers is critical. Religious leaders have the unique opportunity to help in reshaping conflict transformation, reconciliation, moderation, and social justice between sects who have a history of conflict (e.g., Jews and Arabs, Shiites and Sunnis).

TREATMENT MODELS

In recent years, there have been strong arguments for the need to develop or adopt novel assessment approaches and more effective integrative service and intervention strategies for refugees that integrate individual and ecological models of recovery involving holistic multi-systemic and multimodal interventions that address individual and collective traumas (Kira, 2002, 2010; Tummala-Narra, 2007). Further, there has been increasing attention to the need for continuous and present-trauma-focused treatment, as contrasted with past-trauma-focused interventions (Kira, 2013; Straker, 2013).

INDIVIDUAL AND ECOLOGICAL MODELS OF RECOVERY

Refugees may come from the same country, religion, or culture, but they also come from different sub-cultures, sub-religious affiliations, social classes, levels of education, and political ideologies. Clinicians should adopt a conceptual lens that integrates an understanding of the sociopolitical and cultural context that uniquely shapes their core life experiences. In assessing the concerns of survivors of cumulative trauma, clinicians are confronted with core traumas associated with different comorbidity profiles. Trauma profile analysis, rather than single or triggering trauma, is important to assess in such victims. Cumulative trauma burden, intense adversities, and poly-victimization across the life span have been found, generally, to contribute to significant unique variance in mental health outcomes beyond that accounted for by the combination of all aggregate trauma and victimization types (Richmond et al., 2009). Further, to effectively address the needs of refugees, mental health professionals need to be aware of their own biases, negative transference, and misperceptions regarding refugees' different cultural and religious contexts. They should have an accurate understanding of their history, culture, and sociopolitical dynamics and be able to identify culturally appropriate interventions with refugee clients (Erickson & Al-Timini, 2001).

Adapting and Advancing Evidence-Based Treatments with Refugees: Some Lessons from Clinical Practice

WORKING WITH REFUGEES TORTURE SURVIVORS

For torture survivors, talking about the horrible details of torture or torture-rape can produce painful emotions in psychotherapy. Confrontation with and premature exploration of past traumatic events may reactivate traumatic reactions, without first addressing ongoing and current traumatic and chronic stressors. Traditional exposure therapy may not be as effective with refugee victims of political oppression and of cumulative trauma, and can

decrease compliance and increase dropout rates (Ford et al., 2005). Acknowledging and appreciating clients' political struggles and what has befallen survivors who become refugees has both therapeutic and human rights dimensions. It is often the case that one cannot avoid talking about religion and/or politics when working with survivors of torture and political oppression. Empirical studies of the effects of eliminating the oppressive regime in Iraq and accomplishing redress and retributive justice for Iraqi refugees have found that perceived retributive justice helped refugees to cope with depression and anxiety, promoted a feeling of peace with the self and others, and helped them regain self-control, memory capacity, and executive functions. The feeling of regaining control was found to be a significant predictor of depression and anxiety reduction, as well as of post-traumatic growth and an optimistic future orientation (Ford et al., 2005).

WORKING WITH REFUGEE CHILDREN AND WOMEN

It is expected that many refugee children may develop psychosocial problems during the process of resettlement due to secondary traumatization (e.g., exposure to traumatic stress of parents and close relatives). School-based and community-based multi-systemic, multi-component, multi-modal integrated services have been found to be more effective than any single modality of intervention (American Psychological Association, 2010; Murray, Cohen, Ellis, & Mannarino, 2008). For refugee women, concerns about economic survival, safety of the self and family members, and care for children play a prominent role. Assessment of trauma and intervention with refugee women should address GD, which may be high in some refugees' cultures, to re-empower victims and minimize the effects of such potentially ongoing gender-specific trauma. Assessing GD in female clients, their internalized beliefs about gender inferiority and/or subordination, and the interaction of GD with other past and current traumas and discrimination is important when working with female refugee clients. Psychotherapy with women can focus on self-efficacy in their new environments in ways that acknowledge refugee women's gendered experiences of disadvantage and exposure to violence in paternalistic cultures. Therapists must challenge aspects of culture that violate women's human rights while understanding the unique situation of refugee families (Brown, 2010; Kira et al., 2010).

THE CRITICAL IMPORTANCE OF ADDRESSING ONGOING DISCRIMINATION

Discrimination, which may be ongoing and chronic, is often at the core of clients' feelings of anxiety, insecurity, and helplessness. There is often insufficient clinical attention to discrimination-related factors as contributing etiologies to disease and illness. Empirical studies have found that discrimination has been associated with negative mental and physical health

outcomes among several immigrant communities in different age groups (Kira et al., 2014; Tummala-Narra, Alegria, & Chen, 2012). Further, empirical studies have found that discrimination explains a high degree of variance in Iraqi refugees' mental health symptoms (Ellis, MacDonald, Lincoln, & Cabral, 2008; Kira et al., 2008).

Effectively addressing discrimination includes coping with ongoing micro and macro aggressions. Clinicians should validate the reality of oppression and discrimination, working toward restoring collective self-efficacy, collective self-esteem, and perceived control through therapeutic and school- and community-based interventions (American Psychological Association, 2010). Interventions should also involve efforts to facilitate ethnic community rebuilding (Harvey, 1996; Kira, 2002, 2010; Tummala-Narra, 2007).

Adapting and Advancing Evidence-Based Treatments with Refugees: Some Lessons From Theory and Research

Systematic reviews of treatment modalities for posttrauma spectrum disorders in refugee populations indicate that no treatment modality has been firmly supported, but there is growing evidence for the effectiveness of narrative exposure therapy (Robjant & Fazel, 2010; Stenmark, Catani, Neuner, Elbert, & Holen, 2013). Additionally, relaxation and direct problem-solving approaches have been found to be effective when coupled with verbal exploration of traumatic experiences (Bemak, Chung, & Pederen, 2003). There is empirical evidence for the effectiveness of trauma-focused cognitive-behavioral therapy with some refugee populations (Nickerson et al., 2011).

While adapting evidence-based treatments with refugee populations is in progress, clinicians and researchers acknowledge that working with such complex traumas needs a new framework (Courtois, Ford, Herman, & van der Kolk, 2009). Current evidence-based therapies, regardless of theoretical orientation, need to be adapted to address uprootedness, intergroup traumas, and the interplay between cumulative intergroup and interpersonal trauma and between past and current traumatogenic dynamics and mental health outcomes. Traumatized refugees often become victims of persecution, torture, and backlash because of belonging to a certain group. When people are persecuted because of their group membership, a therapeutic approach that targets group self-esteem and efficacy among its goals has strong therapeutic potential. Additionally, uprootedness destroys the sustaining bond between the individual and the community and displaces him or her from its fabric. Barriers to establishing or reestablishing relationships in new communities and cultures limit potential connections and contribute to the experience of ongoing loss and grief. It is within societal and ethnic reorganization and current pathways of engagement where connections offer a renewed sense of belonging and well-being.

To summarize, cumulative trauma, intergroup collective identity trauma, and uprootedness among refugees are unique in that they not only challenge

individuals' personal agency but also collective and social identity as political actors in their social and/or political groups. As such, complex intergroup and cumulative trauma-informed treatments are promising trends. Judith Herman (1997) proposed three stages through which patients usually move as they heal. Herman suggested that recovery is predicated upon the client's progression: from a feeling of unpredictable danger to one of reliable safety and security, from a sense of dissociated trauma to acknowledged memories, and from feeling isolated and stigmatized to restoring meaningful social connections. The negotiation of safety and reconnecting are especially complicated in the case of uprooted refugees. Realistic threats of ongoing discrimination and deportation and fears of cultural extinction can compromise their recovery. Additionally, refugees negotiate their adaptation to new cultures while coping with these ongoing fears. Of special importance for uprooted refugees is the third stage of establishing new social connections.

One treatment approach that considers this complex interplay of interpersonal and intergroup trauma is multi-systemic therapy (MST) (Bronfenbrenner, 1986; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). This model suggests that behavior problems are multi-determined and maintained by past and current transactions within and across multiple systems of the client's personal and social ecology and across generations. Curtis, Ronan, and Borduin's meta-analysis (2004) of seven primary and four secondary outcome studies using MST found that youth and families treated with MST were functioning better than 70% of those who were treated using alternative approaches. Follow-up data suggested that the effects were sustained for up to 4 years. Multi-systemic, multimodal, multi-component, multi-stage therapies typically include individual, family, and community-based interventions. The development of such ecological sequential treatment approaches that consider temporal dynamics (current and past traumas and expected future dangers) and combine flexibility and adaptability to different contingencies, cultures, types of trauma, ranges of severity of trauma, and developmental stages is promising as mental health professionals respond to the urgent needs of refugees.

Examples of ecological model adaptations are evolving and include the wraparound approach for psychosocial rehabilitation with torture survivors, day treatment and after-school programs with refugee children (Kira, 2010), ecological group therapy models focused on community healing and forming ethnic and cultural organization and community connections (Kira, Ahmed et al., 2012), and trauma systems therapy (Saxe, Ellis, & Kaplow, 2007). While these models have ecological validity, there is emerging empirical evidence for the effectiveness of some of their variants (Abramson et al., 2010). For example, there is some empirical evidence of the effectiveness of multi-component, multi-systemic wraparound torture rehabilitation approaches (McColl et al., 2010; Raghavan, Rasmussen, Rosenfeld, & Keller, 2013). Community-based interventions that go beyond home-based family sessions have shown evidence of enhancing the generalizability and durability

of treatment benefits (Kazdin & Weisz, 1998). The gateway providers model views community cultural, social, educational, and religious organizations as gateways to healing for refugees and their children (Ellis et al., 2010). This model focuses on victims' identified survival strategies and strengths and utilizes reframing and empowerment techniques.

This socioecological framework suggests that a stronger social web that incorporates elements of security, resumption of social roles and social practices, and reengagement with social institutions, as well as addressing current and ongoing and expected dangers, could provide a therapeutic effect. Interventions, in this model, focus not only on past intergroup traumas but also on present stresses and current acculturation and resettlement challenges. Ongoing acculturation-related stressors, some of which can be traumatic, may take priority over past torture experiences in the therapeutic process.

Kira and his associates introduced a present and continuous trauma-focused intervention model (Kira, Ashby, et al., 2013; Kira, 2013) that focuses on past adversities as part of a packaged sequential open system approach that includes both present and past trauma-focused interventions. The intervention model provides the therapist the flexibility to address sequentially the client's unique current, continuous, and emerging traumas as well as secondary and past traumas and their cumulative effects according to the client's priorities and timeline of urgencies. Continuous trauma-focused cognitive-behavioral interventions, in this model, include seven components: (a) prioritizing safety, (b) addressing current and ongoing threats and dangers (distinguishing real danger from challenges), (c) practicing basic skills training to deal with real threats and dangers (e.g., problem solving, assertiveness training, mindfulness training, anger management, emotion regulation, and enhancing participation and engagement), (d) psychoeducation regarding continuous traumatic stress and cumulative stress generation dynamics, (e) identity work and identity development that may include redefinition of identities (e.g., gender, sexual, racial, religious, and national, in addition to personal and collective self-esteem and self-efficacy), (f) stimulating a "will to survive" and related meaningful effective coping strategies, and (g) inoculation against stress proliferation and accumulation dynamics and training to identify and disrupt such existing dynamics. A sequential treatment plan that prioritizes goals in a comprehensive way and addresses the current, past, and temporal dynamics of stress proliferation and its linear and nonlinear accumulation forces is recommended.

CASE EXAMPLE: MONICA

The following clinical case vignette illustrates some of the potential episodic responses to cumulative trauma among refugees that are usually not considered in the current intervention models and explains treatment implications using the model discussed in this article.

Monica is a 55-year-old Iraqi refugee and a divorced woman. She has lived in the midwestern part of the U.S. 6 six years. She has nine living children, four boys and five girls, ranging in age from 10 to 25 years. In Iraq, under Saddam Hussein's police state, she lost two brothers and two older sons who had been killed by Hussein's regime. She remembers each one was brought into the house soaked in blood. Each had to be buried without a funeral. Moreover, the family had to pay for the bullets that executed them. After the failure of the uprising against the regime in 1991 that followed the first Gulf war, she had to flee, walking in the desert for days with her immediate family to Saudi Arabia. She spent 4 years in a refugee camp in the desert. She recalled the suicides in the camp and the violent killings of those who rose up against the repressive authorities who ran the camp. She remembers the isolation and tornado-like sand storms in the desert. When she arrived with her family in the United States, she coped with multiple traumatic experiences; among them were discrimination, harassment, and bullying of her children in school (because they were refugees from the Middle East), as well as two of her children's mental health issues, which were stigmatizing, and her husband's infidelity and physical abuse. Subsequent to her migration to the U.S., because of her husband's behavior, she divorced him. In the face of deep loss, Monica asked her brothers and uncles to come back together to revive the tribal connections and culture to counter the uprootedness and fears of cultural extinction they were suffering from.

When the counselor first came to know of her, her 7-year-old son (now an adolescent) reported hearing trauma congruent and noncongruent voices, nightmares, and other CTD chronic symptoms that resulted from the severe traumas he and the family endured. He was one of her two troubled sons. All of her family members described her as the heroine of the family, whose personal resiliency helped her and them survive these traumatic experiences. Her functioning remained intact and she presented no symptoms at that time. Several years later, she was a passenger in a car her older daughter (a medical student) was driving. They were involved in a moderate accident that resulted in some bruises for her and for her daughter. After this car accident, Monica developed intense symptoms of fear, panic attacks, auditory and visual hallucinations (e.g., seeing blood everywhere in the house), and nightmares related to the terror she had experienced previously but unrelated to the car accident. Further, Monica called her ex-husband to apologize and beg for forgiveness, for divorcing him, and for violating his rights as man over women.

In this clinical vignette, the client survived a series of severe interpersonal and intergroup adversities that have cumulative effects, and the last, which probably may have been one of the least severe, became the tipping point or "the straw that broke the camel's back." In addition to the linear dose response, the nonlinear threshold traumatogenic dynamics were potentially more problematic. Further, her resistance to gender discrimination collapsed in the face of cumulative posttraumatic stress.

TREATMENT STRATEGIES WITH MONICA

This case was an eye-opener, as Monica suffered multiple forms of traumatic stress and challenged trajectories typically delineated in traditional trauma treatment. The case highlights the importance of preventive interventions for those multiply traumatized who do not present symptoms for some time and emphasizes the relevance of systemic clinical care for the whole family when working with children and families. Assessing, planning, and conducting a comprehensive family intervention strategy from the DBTF wider lens that considers both the linear and nonlinear dynamics of traumatization should help in coping with the unique traumatic stress faced by refugees. Designing a sequential treatment plan that addresses successively present and past traumas, as well as those continuous traumas that will presumably not end in the foreseeable future, may be more helpful than approaches supported in most existing trauma-focused manuals.

The interdisciplinary bilingual team of therapist, social worker, case manager, and psychiatrist applied the ecological multi-systemic, multimodal, multi-component interventions and utilized Herman's three-stage model of recovery, as well as Kira's model of continuous trauma-focused interventions, with Monica. Interventions included antipsychotic medication (biophysiological level), home visits to work directly with her in her natural environment (to enhance her feelings of safety and trust) and with the family system, connecting her with women's support groups in the community, and encouraging her participation in Iraqi cultural center activities and in her children's school associations (to reestablish meaningful connections and facilitate healthy acculturation to address uprootedness and reinforce her cultural identity and new emerging identities). Using home visits helped to reframe and form an intervention in a flexible way that addressed past and ongoing traumas. Individual treatment focused on psychoeducation regarding continuous traumatic stress, the cumulative dynamics of past and ongoing traumas (meaning making), identity work and bicultural identity development, and current and ongoing threats and dangers. These therapeutic goals were achieved through skills training (assertiveness, problem solving, social skills, and mindfulness skills), stimulating a will to survive and coping by empowering her as a survivor who maintained her family in a time of extreme adversity and continued resistance of gender-based and other types of discrimination, and supporting her engagement in advocacy efforts for her community (Kira et al., 2013).

The interventions helped to move the client toward restoration of her sense of agency; develop new insights and positive meanings of her experience, stronger distress tolerance, and better emotional regulation and mindfulness skills; and focus more on the present and, as the head of the household, the future of her family. The availability and utilization of a

bilingual team was important in facilitating effective culturally competent, trusted interventions that minimized negative transference and countertransference. The progress was slow in the beginning. These intensive interventions took over 6 months before the client responded and restored relatively healthy functioning. She regained the ability to recognize her previous strengths when she rejected the second-class gender status and divorced her husband. She was proud of herself, her large family, and her culture and tribe and started learning to drive a car. All of the psychotic features (hearing and seeing things) ended, and her medication dosage was gradually reduced upon her request. She maintained the progress at a 2-year follow-up.

CONCLUSION

Current evidence-based manualized interventions with an interpersonal and single past trauma focus may not be adequate in working with refugee victims of political violence who are multiply traumatized and who suffered and are suffering additionally from intergroup and ongoing traumatic stressors. We recommend a new, comprehensive approach to assessment and intervention based on the DBTF framework that assesses and addresses interpersonal and intergroup past, present, and continuous stressors using a sequential treatment strategy that is determined according to the client's priorities and needs within an ecological approach.

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