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Trauma and Children: A Refugee Perspective

Jabrulla Shukoor

Clinical and Detention Services Coordinator, Association for Services to Torture and Trauma Survivors, 286 Beaufort Street, Perth, Western Australia 6000

Post-traumatic stress affects both the mental and physical health of individuals, giving rise to various psychological disturbances. The neurological effects of these disturbances are similar across age groups, irrespective of race or culture. However, the perception of psychological disturbances differs from culture to culture depending on issues such as the stigma that attaches to mental illness and the ability or willingness to seek assistance. While much research has been undertaken on the impact of trauma on both adults and children, research to explore the effect of trauma on people in the context of their various cultures, especially people of refugee background, remains at an early stage. Mental health professionals working with refugees encounter various challenges. They range from dealing with resistance by individuals to the notion of counselling itself, to barriers such as the perceived stigma that prevents some individuals from acknowledging mental health problems. Other challenges in providing mental health services in such cases are contributed to by government policies and the limited resources available. All this exacerbates the mental health of traumatised parents and caregivers, and has a ripple effect on their children, who exhibit the effects of trauma in their own ways. This paper aims to highlight and discuss these issues through the presentation of two case studies, suggest a workable recovery model, possible ways to deal with the challenges, and to propose recommendations for working with non-Western children and their families.

■ **Keywords:** trauma, refugee, children, counselling, challenges, stigma

Imagine yourself as a recently registered counsellor about to start a new job in a small counselling agency. You have just completed a Master's degree, and consider yourself fairly knowledgeable about psychological theories and disorders from spending untold hours reading from books and journals. The agency you work for provides clinical mental health services to individuals of all ages and also to a small number of people from refugee backgrounds who have suffered torture and trauma. You have just been allocated a child client and you read intently the referral form written by a general practitioner.

"Seven-year-old male client severely traumatised by events that happened in Iran and during the journey here to Australia. Presented symptoms are nightmares, insomnia, bedwetting, uncontrollable anger, yelling, highly anxious, cries a lot, inability to concentrate, hurting others, threatening to self-harm on several occasions. Father deceased in a drowning accident en route to Australia, client cared for by his mother".

You scan the form for the contact details of the caregiver and find that the client's mother is only contactable after 4 p.m. She does not speak English and needs a Farsi interpreter to communicate. Up until then, you have never dealt with children, let alone a traumatised one. You have limited knowledge of trauma and its effects. You do not have experience in working with individuals whose first language is not English, and you have limited knowledge and experience when it comes to dealing with people from a culture other than your own. You read the symptoms again, and before long you start to worry as thoughts about how you are going to deal with this highly vulnerable child fill your mind. Rather than panic, you take a deep breath and reach for the phone. You hear the familiar voice of your supervisor on the other end of the line.

The above scenario could be somewhat familiar to mental health professionals in private agencies that deal with all sorts of mental health issues, but for a clinician who has been dealing with traumatised individuals from refugee backgrounds, both adults and children, this is standard fare. Referrals like the above are a common occurrence in

ADDRESS FOR CORRESPONDENCE: Jabrulla Shukoor, Registered Psychologist, Clinical and Detention Services Coordinator, Association for Services to Torture and Trauma Survivors, 286 Beaufort Street, Perth, Western Australia 6000.
E-mail: jabrulla.shukoor@asetts.org.au

a trauma counselling agency like the Association for Services to Torture and Trauma Survivors (ASeTTS) based in Western Australia, and in similar agencies around the country and throughout the world at large. Such scenarios are increasing, given the international growth of populations seeking humanitarian refuge.

Introduction

The United Nations High Commissioner for Refugees (UNHCR) reports that in 2013, there was a 28% increase in asylum applications registered in the 44 industrialised countries. The report advises that the given statistic is derived from the initial claim for asylum, and does not include applications for appeal or review, nor information on the outcome of asylum procedures. For Australia, the increase is 54% from 15,800 claims made in 2012 to 24,300 claims made in 2013 (UNHCR, 2014). As of the 31st of March 2014, there were 4484 people in detention centre facilities with 27% originating from the Islamic Republic of Iran, 15% from Vietnam, 13% from Sri Lanka, 5% from Afghanistan and 11% registered as Stateless. The rest come from countries such as Iraq, Pakistan, China and Somalia. There were 895 children under the age of 18 living in detention centres, 1560 children living in the community as detainees awaiting outcome of their asylum applications and 1821 children on some sort of visa arrangement (Department of Immigration and Border Protection, 2014). While asylum seekers await their migration outcomes, the anxiety they live with and the fear of being sent back to their countries of origin grow. Research has found that torture and trauma survivors with insecure residency status and ongoing traumatic events occurring in their country of origin become highly vulnerable to a range of mental health problems such as anxiety, mood and dissociative disorders (Ford & Courtois, 2013; McFarlane & Kaplan, 2012). Some of these individuals are referred to services like those provided by ASeTTS when they come into contact with mainstream service providers such as medical practitioners, charitable organisations and educational institutions. Some, however, tend to fall through the cracks for various reasons, which will be discussed later, and do not receive psychological services or treatment.

The effects of trauma are deeply damaging, and how survivors react and respond can be very different. This paper identifies challenges involved in working with traumatised individuals from refugee backgrounds, and addresses the practical issues encountered in a counselling setting when working with adults and children whose reactions and behaviour are largely influenced by cultural and religious beliefs and norms and the workings of family systems. The paper proceeds to explore the stigma that prevents individuals from acknowledging the presence of mental health problems, and the difficulties and challenges in accessing mental health services, generally. The paper then considers the impact of current Australian government policies involving refugees, the limited resources available and how this shortage of resources exacerbates the mental health of already traumatised adults, and the effect it has on their children. Case studies of two children I have worked with in my clinical practice are presented to illustrate some of the difficulties encountered. All names and specific identifying data have been deidentified in order to maintain the confidentiality of the parents and children. Parental consent was obtained (as required by Australian Psychological Society Code of Conduct) to use the case materials which appear below. The paper suggests a workable recovery model, possible ways to deal with challenges and to propose recommendations when working with clients from refugee backgrounds.

Prevalence of PTSD

The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5; American Psychiatric Association, 2013) has reclassified Post-Traumatic Stress Disorder (PTSD) as part of a cluster of trauma and stressor-related disorders. It provides two diagnostic criteria: one for adults, adolescents and for children above the age of six; and the other, a new classification, for children below the age of six. The new subtype takes into consideration the importance of child development, recognising that children below the age of six exhibit a different set of symptoms from adults while keeping the precipitation of the disorder the same – that is, the exposure to, or witnessing of, a traumatic event. Among the symptoms which may be experienced are negative alterations in cognitions and mood, avoidance, intrusive memories and alterations in arousal and reactivity. Gillies, Taylor, Gray, O'Brien and D'Abrew (2012) explain that the types of events that cause this disorder can be either naturally occurring disasters, or intentional or unintentional human causes such as war, rape, physical and psychological assault, sexual abuse, exposure to acts of violence to self or witnessing acts of violence to others. One of the most vulnerable groups is that of refugees who are displaced from war-torn countries, and who frequently suffer from PTSD as well as from other psychological disorders (Mehraby, 1999; Tyrer & Fazel, 2014). The challenges involved in living in refugee camps or detention centres for prolonged, uncertain periods of time while waiting to be resettled, or fleeing to another country, add significantly to their distress.

Stages of Trauma

Fazel and Stein (2002) posit that for refugees, there are three stages of traumatic experience: (i) while in their country of origin, refugees are exposed to a high number of traumatic events leading to various degrees of loss such as family, friends and relatives while being forced to flee to safety. Lives of children are disrupted, and the witnessing by them of parental and environmental distress occurs which gives rise to general insecurity; (ii) during their flight to safety, where stress increases for refugees as they endure exposure to dangers, and where possible separation from family

members may occur. Children and young adults may be inadvertently, or sometimes deliberately, separated to increase their chance of survival in a country where migration might be more readily granted to minors; and lastly (iii) having arrived in a country of refuge, asylum seekers undergo the arduous ordeal of processing and proving claims for asylum status which, if successful, is followed by the ongoing process of integration into a new society, while at the same time dealing with the ongoing effects of trauma, loss and grief.

At every stage, refugee children feel the distress of their parents while trying to deal with their own traumatic experiences. For instance, during the resettlement stage, their risk of psychological disturbance increases as they endeavour to deal with a new home and school environment, seek friends for themselves, and are sometimes required to assume the role of an adult, as they become the language bridge between their families and the outside world. Even in a relatively safe environment, living is difficult for them as they attempt to adapt to their new living conditions, try to comprehend the adopted country's educational and school cultural systems and endure disruption to accommodation arrangements which, in turn, results in further change to school arrangements and impacts on school attendance (Tyrer & Fazel, 2014).

Symptom Presentation

The psychological disturbances in refugee children tend to result from emotional and behavioural issues with high rates of PTSD, anxiety with high prevalence of sleep disorders, depression, affect and impulse dysregulation, cognitive and interpersonal difficulties (D'Andrea, Ford, Stolbach, Spinazzola, & Van Der Kolk, 2012; Fazel & Stein, 2002). To amplify these symptoms and what has been discussed so far, two case studies are presented in the following section. Clinical manifestation of symptoms in children is variable, but the clinical diagnosis was derived using the definition contained in DSM-5 (American Psychiatric Association, 2013). In the two cases studies, the children were considered to meet the diagnostic criteria of PTSD according to the DSM-5 criteria, from clinical interviews and from clinical assessment.

Case Study 1

Ten-year-old Rohan was referred for counselling by a mainstream refugee clinic. The recorded symptoms were that he had been exposed to war when he was four years old, and suffered ongoing night terrors and enuresis. An interview was conducted with his parents to obtain background information about Rohan and his family. Rohan was born in Iraq and was the second child of four.

The family lived in Iraq until 2007 before fleeing to Syria and then relocating to Turkey. They next travelled to Cyprus before finally heading to Australia. The family arrived by boat in Australia in 2012 seeking asylum. They were living in community detention awaiting the outcome of their asylum application at the time of referral.

Rohan witnessed many things while in Iraq which a young child should never experience. When he was four, he was exposed to traumatic events such as the sighting of dead bodies lying on the road being savaged by dogs. The circumstances in which he happened to witness these scenes were when he was accompanying his father, who was working in a bakery and delivering goods to shops.

On one occasion while Rohan and his father were out on a delivery, two teenagers approached Rohan's father and asked to see his ID. The moment they saw the father's name, which identified his religious sect, they began to taunt and intimidate him. Before long, they pulled out a gun and pointed it at the father's head and were debating whether to kill him when two American soldiers came along. The teenagers left the scene abruptly, and the father was spared.

Subsequently, the father developed high blood pressure and diabetes. As for Rohan, he became anxious whenever he was on his own, feared sleeping alone, bedwet as a daily occurrence, and suffered night terrors. As a result, he became withdrawn, isolated, angry towards his family and others, stubborn, defiant, aggressive, tough-acting around peers and refused to talk about events that occurred in the past.

Preliminary clinical assessment indicated that Rohan met the criteria for PTSD co-morbid with anxiety as set out in DSM-5 (American Psychiatric Association, 2013) based on the symptoms reported by his parents. However, these symptoms were not apparent in the first meeting with him. He spoke English fluently, was rather shy, but had a big smile on his face when spoken to. He was quite reluctant to talk in the early sessions, but after many rapport building exercises, he engaged well through various forms of art therapy such as drawing, painting and sand-tray therapies. As the therapeutic relationship progressed, he became more comfortable in subsequent sessions, confiding bit by bit the existence of his nightmares, flashbacks and the recurrent memories he was experiencing of the traumatic events he had witnessed prior to arrival in Australia.

Case Study 2

Syed was born in Iran and arrived in Australia by boat when he was seven years old. He came with his mother and his aunt. They spent about 20 days on Christmas Island (north of Western Australia), followed by 40 days at a Darwin detention centre before arriving in Perth. They had been in community detention awaiting the outcome of their asylum application for about five months at the time Syed was referred to ASeTTS.

Life was difficult for Syed's parents when they were in Iran. His father was wanted by the revolutionary guards, and thus had to go into hiding to escape capture and imprisonment. As a result, Syed and his mother regularly moved from

place to place to avoid constant harassment by the guards, who were trying to find out the whereabouts of the father.

Syed could not comprehend what was happening with his parents. He could not understand why his father was not living with them, and why he and his mother were moving constantly. One day, the guards caught up with them and imprisoned both Syed and his mother. They were held for some weeks before being released. Arrangements were then made quickly for them to flee the country together with the father and Syed's aunt. The family took a typical route, which is to fly to Malaysia, and from there to Indonesia. They had no choice but to arrive on Australian shores by boat. Syed's father somehow became separated from his family on the day they were all meant to board the boat to Australia. He recalls waiting for them at the wharf before deciding he had no choice but to leave without them. It was a further two months before they were reunited.

However, the journey here for Syed, his mother and her sister was a very traumatic experience. Halfway through the journey, the boat they were travelling on started taking water. Syed, his mother and other passengers had to get into the water while the boat was repaired. Both nearly drowned as they did not know how to swim. For Syed, the fear of being attacked by sharks overwhelmed him. A fellow passenger offered to hold Syed on his shoulders while the boat was repaired.

Syed was referred for counselling by his general practitioner. He displayed the following symptoms: "agitation, anger, aggression – family finds it draining to cope. Talks to himself at times, as if there is an imaginary person present. Scared of the devil". Apart from the above, Syed also presented as being very fearful, becoming nervous easily, disobedient, losing his temper quickly, complaining incessantly and manifesting anxiety symptoms associated with the fear of the drowning incident that took place.

Syed presented at the sessions as a very curious little boy, who wasn't shy, was eager to please, and was very engaging during counselling sessions. He showed maturity in his manner and style of speech, remarkable for his age. He was forthcoming with information about himself although he struggled to speak English, and had to rely heavily on the interpreter. He was very concerned about, and focused on, the family's migration status — notwithstanding he was only seven years old. He spoke continually about his worries such as his fear of being sent back to Iran in the same manner they came here to Australia. He spoke about the devil, who taunted him by telling him that he and his family would be going back to Iran. This upset him and made him angry. In addition, he spoke about what he had witnessed in Iran and what he went through during the journey to Australia. On a clinical diagnostic level, the existence of PTSD was apparent together with anxiety, cognitive and behavioural issues. He responded well to various therapeutic interventions and made progress, but there remained challenges aggravated by ongoing external stressors in his life; particularly as his parents also presented as suffering the effects of PTSD. That in itself posed a problem in helping Syed. It was recommended to the parents that they undertake counselling themselves. Syed's mother took up the offer, but his father declined.

Refugee children like Rohan and Syed are among many who endure psychological scars as a result of war, violence, persecution and other traumatic events they have had to live through. The psychological impact caused by such exposure contributes to significant mental health disturbances which can be immediate and often stretching to the long term. The areas in which impairment occurs, according to D'Andrea et al. (2012) are: (i) behavioural, where symptoms include but are not limited to withdrawal, self-harm, aggression and impulsive behaviours; (ii) cognitive, where ability to concentrate is compromised, poor memory and disruption in executive functions such as inability to plan and problem solve; (iii) emotional, such as expressions of anger, irritability, agitation, numbed or flat affect and inappropriate affect; and (iv) interpersonal, where attachment styles becomes disrupted or strained, general distrust, poor social skills and interactions and the expectation of harm from people other than family members. From an overarching perspective, the above domains raise comorbidity issues because children who are found to have a traumatic history tend to meet at least one other psychiatric diagnosis such as mood, anxiety, conduct and disruptive behaviour disorders. These often go hand in hand with ongoing exposure to traumatic stressors.

To recover from psychological disturbances, children need protective factors, the main one being a supportive family milieu (Fazel & Stein, 2002). Unfortunately, not all children receive this. For instance, although Syed had supportive parents, he was all too aware of the ongoing concerns about the family's asylum application since his parents were openly and constantly speculating about possible outcomes. This created a high level of distress for Syed. Further, the existing anxiety, depression and possibly PTSD symptoms of his parents, along with poor parenting responses and functioning, all had a negative impact on Syed. This finding is consistent with a recent review on refugee health by Fazel, Pather-Brick, Reed and Stein (2012), who found the level of adverse events and ongoing stressors experienced by parents or caregivers has a strong association with their children's mental health. However, before seeking professional psychological help for themselves or their children, parents or caregivers have to overcome ingrained barriers. Cultural norms, belief systems and perceptions about mental illnesses are some examples identified by researchers as the types of barriers which lead to reluctance on the part of refugees to seek professional psychological help.

Barriers to Seeking Mental Health Services

Generally, the concept of mental illness is perceived negatively among refugees. Those who are of ethnic groups such as Asian Pacific, Arab and Middle Eastern are especially sensitive to suggestions of mental issues (Chang, 2003;

Nasser-McMillan, 2003). Even depression is stigmatised as a mental health condition, which thus can prevent individuals from seeking help. Their fear of being labelled as "crazy" by people around them, including family members and relatives who hold negative attitudes towards mental illness, can often be deeply entrenched to the extent of rendering them unwilling to seek or engage with mental health service providers (Johnson & Sandhu, 2010; Nadeem et al., 2007; Vandiver & Duncan, 2010). Needless to say, depression co-exists with major psychological disturbances such as PTSD, anxiety, phobias, substance-related disorders and various behavioural disorders in children (American Psychiatric Association, 2013). Other co-existent barriers or challenges facing refugees include, but are not limited to:

(i) a language barrier, which is one of the most common obstacles refugees face as they are unable to speak the language of the host country. As a result, they feel alienated giving rise to helplessness, isolation, anxiety and other psychological issues (Vandiver & Duncan, 2010);

(ii) limited financial resources, because refugees who are not permitted to work and are not recipients of welfare payments are dependent on charity organisations for monetary allowances to get by with day-to-day expenses such as food, rent and transport while awaiting their asylum applications to be processed. Even those receiving some sort of government assistance, have to manage by tight budgeting which means accessing ordinary mental health services becomes nigh on impossible (Vandiver & Duncan, 2010);

(iii) degree of acculturation, where refugees are expected to integrate with a new cultural system other than their own. They are expected to assimilate quickly and with minimal problems to new values, attitudes, beliefs, lifestyles and the cultural identity of the host country (Paniagua, 2010). For many refugees, it becomes a difficult phase where they either learn to integrate or they don't. The less acculturated ones tend to fall through the cracks, and to be at risk of isolation, which exacerbates existing mental health issues (Johnson & Sandhu, 2010);

(iv) lack of trust of mainstream services, due to refugees becoming fearful, suspicious and uncomfortable with regard to mental health services. This mentality can be accompanied by elements of self-loathing because refugees blame lack of willpower, shame, guilt, weakness and possibly spiritual failings in themselves for their problems (Chang, 2003; Tyrer & Fazel, 2014);

(v) accessibility issues, because mental health services are out of reach for refugees as many tend to be located away from urban areas where most service providers are based. This raises issues of transport costs and affordability (Walker, 2005);

(vi) from the perspective of refugee children, low socioeconomic status, poor housing conditions and presence of caregivers' stress impact directly and indirectly upon a child's cognitive and physical development. Other factors include poverty, overcrowding due to being part of a large family, and inadequate housing facilities due to a lack of material wherewithal. Due to limited means, caregivers often will not be able to undertake activities that would stimulate the cognitive and physical development of their children (Fazel et al., 2012; Vandiver & Duncan, 2010); and

(vii) caregiver stress is another important factor which affects the quality of care giving in child development and education, according to Antshel and Joseph (2006). The authors claim that when parents, especially mothers, report high levels of stress, they appear to be more controlling, critical and punitive as opposed to mothers who report lower levels of stress. In addition, the modality of stress experienced by such parents is attributed to negative affect, mood and general distress. General distress here is characterised by: the age of the child such that the older the child, the more stressful for the parents; by the maternal profile, such that the older the parent, the more stress they tend to experience and by education level, such that the less educated the parents, the more stress they experience.

Recommendations

It is challenging to work with individuals from refugee backgrounds. For service providers such as counsellors, psychiatrists, psychologists, social workers and other health care practitioners, it is especially challenging to continue to engage with, and provide mental health services to refugees and asylum seekers. The following are some workable recommendations as suggested by Vandiver and Duncan (2010) when working with ethnic minority groups:

(i) provides pre-counselling orientation to introduce the notion of counselling, taking the time to explain what is involved in order to reduce distrust and fear. Invite the client to provide thoughts, feedback and comments about the process. This enhances control from the client's perspective;

(ii) be culturally competent and aware of a client's cultural norms, belief system, values, customs and practices. This includes being aware of mental health practitioners' own cultural values, practices, biases and stereotypes which enhance reflective practice. Added to these is the need for consideration and increasing awareness of compatibility issues where the provision of mental health services is seen as a Western practice, and is not recognised, if indeed it exists, in many cultures;

(iii) establish trust and rapport with clients to increase interpersonal relationships and the likelihood of return as opposed to premature termination; and

(iv) aim for community outreach, through which increased participation with individuals, their families and relatives enhances community cohesion, trust and reduction of misperceptions of potential clients in respect of counselling and similar services.

Mental health service providers such as ASeTTS who work with refugees, asylum seekers and their children as their main clientele are increasingly adopting a holistic approach when providing treatment and services to torture and trauma survivors. The framework of recovery model by Kaplan and Victorian Foundation for Survivors of Torture (1998) is a working hypothesis which engages individuals, their families, including children and young adults, relatives and friends at a collective, as well as at an individual level when providing services. To address and manage the symptomology at both levels, the model attempts to restore safety and control, attachment and connections, meaning and purpose to life and increasing dignity and value through one to one services such as trauma counselling, psychiatric services, family therapy and various activities which cater for both adults and children.

The main aim of the above services is to help provide stability to clients and their children. Unfortunately, the challenge is increasing when it comes to dealing with asylum seekers' mental health due to current Australian Government policies involving refugees. At one time, there were a number of service providers carrying out general case work, legal support and advocacy services to asylum seekers. However, the number of such service providers is slowly diminishing. As a result, it is leaving asylum seekers more vulnerable and with less access to much needed services; the major policy change being the outcome of asylum applications. Rohan's family members were found to be genuine refugees and given permanent protection visas during the last few months of the Labour government in 2013. Syed's family members were also found to be genuine refugees around the same time and were awaiting the final completion of paperwork. Unfortunately, when the new government took office, policy changed and Syed's family was given temporary visas rather than permanent ones. This has had a considerably negative effect on Syed's family, and has set back work that has been done to date.

Conclusion

The effects of trauma can have a deep impact on individuals and has the potential to impact upon others around them. Children often become the silent victims as they tend to exhibit a different set of symptoms from adults. It can be difficult to detect these symptoms when ingrained cultural norms and beliefs influence the way caregivers function. While it can be challenging and stressful to work with refugee children suffering from PTSD, it can also be rewarding to witness the resilience and the progress made by them. The earlier the intervention, the better the chance in assisting them to become stable, balanced, functioning individuals. These children can have real hope of growing up to be happy, successful, well-adjusted, acculturated adults as opposed to their parents who may not have been given that opportunity in their lifetime. The Federal Government's current policy of keeping some children in detention centres threatens that hope, exacerbates problems already experienced by these children, and risks creating new ones. It needs to come to an end as soon as possible.

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