

Georgia State University

ScholarWorks @ Georgia State University

Anthropology Theses

Department of Anthropology

5-2019

Childhood Trauma in Refugee Children: Caretakers' Perspectives

Ghazal Khaksari

Follow this and additional works at: https://scholarworks.gsu.edu/anthro_theses

Recommended Citation

Khaksari, Ghazal, "Childhood Trauma in Refugee Children: Caretakers' Perspectives." Thesis, Georgia State University, 2019.

https://scholarworks.gsu.edu/anthro_theses/160

This Thesis is brought to you for free and open access by the Department of Anthropology at ScholarWorks @ Georgia State University. It has been accepted for inclusion in Anthropology Theses by an authorized administrator of ScholarWorks @ Georgia State University. For more information, please contact scholarworks@gsu.edu.

CHILDHOOD TRAUMA IN REFUGEE CHILDREN: CARETAKERS' PERSPECTIVES

by

GHAZAL KHAKSARI

Under the Direction of Cassandra White, PhD

ABSTRACT

Many refugees, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred. These traumatic events may occur while the refugees are in their country of origin, during displacement from their own country, or in the resettlement process in the US. This study aims to investigate the mechanisms associated with childhood trauma and adverse childhood experiences among refugee communities living in Clarkston, Georgia. This is accomplished through measuring multiple indicators of psychosocial stress of parents in conjunction with other factors including cultural habits and access to facilities, income and socioeconomic factors, medical support, and social and governmental support.

INDEX WORDS: Trauma, Refugee, Clarkston

CHILDHOOD TRAUMA IN REFUGEE CHILDREN: CARETAKERS' PERSPECTIVES

by

GHAZAL KHAKSARI

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

In the College of Arts and Sciences

Georgia State University

2019

Copyright by
Ghazal Khaksari
2019

CHILDHOOD TRAUMA IN REFUGEE CHILDREN: CARETAKERS' PERSPECTIVES

by

GHAZAL KHAKSARI

Committee Chair: Cassandra White

Committee: Steven Black

Jennifer Patico

Electronic Version Approved:

Office of Graduate Studies

College of Arts and Sciences

Georgia State University

May 2019

DEDICATION

Over the course of this research, I have been fortunate enough to meet an inspiring group in Clarkston. This group is considerate, invested, and very generous in helping me with my work. This work is in honor of this non- profit organization and its very wonderful managers and staff. I feel incredibly privileged and appreciative to have met and experienced a lot of things with this excellent group.

ACKNOWLEDGEMENTS

First and foremost, I would like to acknowledge my advisor Dr. Cassandra White, whose patience and positivity were incredibly helpful in the writing of this document. Also, thanks to my other committee members, Dr. Jennifer Patico and Dr. Steven Black for their support and guidance. I would also like to thank those organizations with whom I worked, including the Family Heritage Foundation (FHF); particular thanks go to Mr. Benneth Ekandom and Ms. Idong Ekandem, the managers of FHF. I greatly appreciate the help I received from other tutors who are working in this great organization.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	V
1 INTRODUCTION	1
1.1 Purpose of the Study	1
2 CHILDHOOD TRAUMA	3
2.1 Incidence and Demographics	4
2.2 Etiology.....	4
2.3 Consequences of Child Abuse and Neglect	5
3 COMPLEX TRAUMA.....	7
3.1 Refugees’ Trauma Experiences.....	7
3.2 Adverse Childhood Experiences among Refugee Children	7
3.3 Refugee Main Stressors	11
3.3.1 Traumatic Stress	12
3.3.2 Relations between Family Structures and Maltreatment of Children	13
3.3.3 Maternal identity in refugee community.....	13
3.3.4 Resettlement Stress, Acculturation Stress and Culture Shock.....	16
3.3.5 Refugees as Survivors of Political Issues.....	17
3.3.6 Depression concept among refugees	20
3.4 Isolation Stress.....	22
3.4.1 Social Suffering.....	22

3.4.2	<i>The role of “Race” or “Ethnicity” in social suffering</i>	22
4	METHODS	24
4.1	Design	24
4.2	Ethical Consideration	24
4.3	Problems in describing Adverse Childhood Experiences Cross-culturally . 25	
4.3.1	<i>Limitations on Research Method</i>	26
4.3.2	<i>Solving the problem in definition of childhood trauma</i>	27
5	CLARKSTON REFUGEE POPULATION	30
5.1	Clarkston	31
5.2	History of Clarkston	31
6	DATA COLLECTION	32
6.1	Participant Observation	33
6.1.1	<i>The Church Building and after -school program</i>	34
6.1.2	<i>The church efforts in healing the trauma</i>	34
6.1.3	<i>Food Pantry</i>	36
6.2	Refugees’ Narratives	36
7	DISCUSSION	45
7.1	Research Significance and Future Directions	45
7.2	Results	46
	REFERENCES	48

APPENDIX: INTERVIEW QUESTIONS 56

Appendix A Questions for Interviews with Parents/Guardians 56

Appendix B Staff interview questions 58

1 INTRODUCTION

Traumatic experiences can have negative, long-lasting effects on the health and mental health of people experiencing them. In public health and psychology, Adverse Childhood Experiences (ACE) is a term which is used to define childhood trauma. ACE can be defined as a “traumatic experience in a person’s life occurring before the age of 18 that the person remembers as an adult” (Minnesota Department of Health 2018). These experiences might include physical, emotional, or sexual abuse, as well as parental divorce or imprisonment. More research are necessary in this field since trauma has several consequences as child progresses to adulthood. An increasing amount of research is needed to examine the frequency of adverse childhood experiences and emphasize their association with negative behavioral and health consequences. These negative consequences may include obesity, alcoholism, and depression.

In this study, I am interested in adult perspectives on trauma that may be experienced by children from refugee families in the Clarkston, Georgia area. I carried out my research through a non-profit organization which is a Christian organization that assists refugee families and at-risk children in Clarkston, Georgia. I have held a volunteer position there since June of 2018.

1.1 Purpose of the Study

This study aims to investigate the mechanisms associated with childhood trauma and adverse childhood experiences among refugee communities living in Clarkston. This was accomplished through observation and ethnographic interviews that considered multiple indicators of psychosocial stress of parents in conjunction with other factors including cultural habits and access to facilities, income and socioeconomic factors, medical support, and social and governmental support.

In this study, I wanted to research how the refugee experience is especially traumatic for children; while different parenting strategies cross-culturally may affect this, I want to look at the wider context of trauma in the experiences of living in refugee camps, migrating (sometimes leaving family and community behind), experiencing food insecurity, linguistic adaptations, death of family members, exposure to warfare, experience of new school environments, etc. In other words, I tried to broaden my research out of the construct of ACEs as “traumatic events”, which are outside of the control of caretakers. This study will attempt to answer the questions about when and where a pattern of trauma is predictable at high occurrences among refugee families because of social and environmental backgrounds in which various elements are found. In this study, I attempted to take a holistic approach to studying immigration and resettlement processes and their possible effects on refugees’ mental health, as well as the factors which may mitigate or exacerbate the effects of trauma on the child’s development. Measuring and characterizing psychosocial stress among refugee families provided insights into the vulnerability of refugees and their children to trauma.

2 CHILDHOOD TRAUMA

Adverse Childhood Experiences have happened throughout history and within different cultures. Efforts have been made using an anthropological cross-cultural approach to describe inappropriate and violent behavior toward children (Kempe *et al.* 1962, 17-24).

Child mistreatment became known to the public when it was recognized in the medical and social work literature in the United States and Europe in the 1960s and 1970s. The definition was mainly based on physical injury “resulting from acts of omission or commission by parents or other caretakers” (Ember and Ember 2004, 301). Over the next 40 years, the definition included broader level to encompass a range of injuries and neglect to children. The four basic types of child maltreatment are: “physical abuse, physical neglect, emotional maltreatment, and child sexual abuse.” Neglect also includes medical neglect or educational neglect meaning that if a parent or caretaker does not meet the child’s needs educationally and medically (Ember and Ember 2004, 301). In one of the earliest publications by pediatrician C. Henry Kempe and his colleagues, they used the term the “battered child syndrome,” and is considered as the beginning of this field (Kempe *et al.* 1962, 17).

Initially, many countries rejected the existence of child maltreatment within their boundaries, but later admitted its existence. This has increased attention in the gathering of data about child maltreatment cross-culturally (Ember and Ember 2004, 301). Anthropology’s cross-cultural perspective was helpful to understandings, explanations, and etiology of child maltreatment as well as many professional studies on culturally competent responses to child maltreatment.

Creating culturally valid definitions of child maltreatment has been difficult. Ember and Ember (2004) categorized three stages for culturally informed definitions of child maltreatment.

They noted that cultural practices are different, and the actions one culture considers abusive may be considered part of normal behavior toward children. Because child maltreatment has not always been categorized as such in other cultures, some anthropological works have studied physical punishment or emotional climate, as maltreatment necessitates behaviors that meet the following three criteria. First, the behavior must be forbidden by the culture in question. Second, it must not be maltreatment that results from wide-ranging conditions beyond parental or caretaker control, such as warfare or famine. Third, it must be potentially avoidable (Ember and Ember 2004, 301- 302). However, legal definitions of abuse in different countries may differ from this attempt to provide a cross-cultural standard definition or set of criteria.

2.1 Incidence and Demographics

There is not much data on the rate and frequency of child maltreatment in different cultures. The available evidence proposes that child maltreatment is happening to some extent in all societies. However, it is difficult to evaluate because of the definitional problems since each society and culture has its own definition about child maltreatment (Ember and Ember 2004, 302).

2.2 Etiology

The etiology of child abuse and neglect is rarely recognized, even among those nations with more history of research and policies that attempt to address the problem. In regard to the etiology and causes, family, community, sociocultural situations are considered to be important factors in increasing the occurrence of childhood trauma (Ember and Ember 2004, 303).

A cross-cultural viewpoint has the possibility to improve understanding of the risk and protective factors that lead to or prevent the occurrence of child maltreatment. At this time, it is not known whether common or contrary pathways lead to child maltreatment across various

populations. For example, does the interface of poverty and an individual's history of child maltreatment have different consequences in different community contexts? Etiological factors should be explainable "both within and between cultures" (Ember and Ember 2004, 303).

The cross-cultural record defines some groups of children at risk for maltreatment. Even in cultures that highly value children and rarely punish them, some children may get a different standard of care than others. These categories of children may be recognizable by demographic studies that explain disparities as products of factors such as gender or birth order. Identification of classifications of children at risk also requires knowledge of cultural values on specific child behaviors or trait (Korbin 1987, 31-55).

Societal level of child harm is sometimes mistaken for culturally standard behaviors. Societal neglect is the level of harm or deprivation, such as poverty or war, that a greater political setting imposes on its children. Because child maltreatment has not always been categorized as such in other cultures, some anthropological works have studied physical punishment or emotional climate, as maltreatment necessitates behaviors that meet three criteria. First, the behavior must be forbidden by the culture in question. Second, it must be close to the child and caretaker and not be maltreatment that results from wide-ranging conditions beyond parental or caretaker control, such as warfare or famine. Third, it must be potentially avoidable (Ember and Ember 2004, 301- 302).

2.3 Consequences of Child Abuse and Neglect

Child abuse and neglect have been connected to increased risk of adverse results. Not all abused and neglected children suffer instant or long-term consequences as a result of their immediate injuries. However, abused and neglected children are at higher risk for a variety of physical, mental/emotional, and social/behavioral problems. There are many ways that these

adverse effects can manifest. Cross-culturally, children who are treated with rejection rather than with cordiality and acceptance by their parents and caregivers show negative psychological consequences (Ember and Ember 2004, 304). Anthropology has provided more holistic understandings of the topics by making cross-cultural comparisons (Ember and Ember 2004, 302).

3 COMPLEX TRAUMA

Complex trauma refers to children’s experience of multiple traumatic events—often of an aggressive, relational nature—and the extensive, long-lasting effects of this exposure. These events are severe and pervasive, such as abuse or intense neglect. They usually happen early in life and can disturb many features of the child’s development and the establishment of a sense of self. As these events often occur with a caregiver, they affect the child’s ability to form a strong bond. Many aspects of a child’s healthy physical and mental development depend on this major foundation of safety and stability (The National Child Traumatic Stress Network 2018).

3.1 Refugees’ Trauma Experiences

A refugee is a person who fears being harmed or be in danger due to multiple reasons, for instance race, religion, nationality, participation in some social group or having some political ideas. For these reasons, a refugee flees his country of origin and does not want to go back to his country because of safety reasons. A refugee might spend several years in the second country (refugee camps) waiting for the host country to accept their refugee status. An asylum seeker is someone who leaves his/her country and travels to the host country and then applies for refuge. (The National Child Traumatic Stress Network 2018). These processes usually can be stressful for both refugees and asylum seekers.

3.2 Adverse Childhood Experiences among Refugee Children

Many refugee children have some traumatic experiences associated with war or persecution that may disturb their mental and physical health even years after the events have happened. These traumatic instances may occur while the refugees are in their country of origin, during movement from their country of origin, or in the resettlement procedure in the U.S. In

their country of nationality, refugee children may have experienced traumatic events or hardships including: violence (might be witnesses, victims, and/or offenders), war, lack of nutrition, housing, physical harm (infections, illnesses), torture, slavery (forced labor), sexual assault, lack of medical care, death of loved ones, long-term absence from school or lack of access to schooling (The National Child Traumatic Stress Network 2018).

In addition to these types of traumatic experiences in their country of origin, during displacement refugee children usually encounter other types of traumatic experiences such as: living in refugee camps, separation from family and community, insecurity about the future, harassment by local authorities, traveling long distances on foot, incarceration (The National Child Traumatic Stress Network 2018).

It is essential to help and support the people and their children who escaped from their countries unwillingly. In their study, Thommessen and Todd (2018) present results from interviews with adults who came as asylum-seekers as children to two countries, Denmark or England. They have been asked about their memories of that time. They talked about how they decided to be successful in integrating in their new countries through gaining more social support, encouragement and guidance. Qualitative findings showed that the participants' emphasis more on language-barriers and challenges that result in more difficulties. The researchers propose that “seeing, hearing and understanding” children's needs is crucial process in working with asylum seekers and refugees, especially children. The participants' experiences about how they could integrate to the new society can inform researchers, educators and other practitioners working with refugee children and families (Thommessen and Todd 2018, 228).

There were a lot of people and children who came to the Western asylum countries in the past years; it is necessary to speed their integration and facilitate the process of integration into

the new countries. One of the ways to gain this goal is through children's school conditions. Usually refugees encounter several difficult situations even before their migration, during their travel to the asylum-countries, and after their arrival. Some of these problems are asylum claim deferrals, waiting a long time for their approval which causes stressful situation, financial problems, social loneliness, "stigmatization and discrimination" (Thommessen, and Todd 2018, 228).

There are several factors that affect parental awareness in refugee populations which include unwilling migration, distressing experiences and loss. When refugee parents experience stressful situations, it can negatively affect their ability to interact properly with their children. They might be unable to provide a secure foundation for their children to flourish. In these cases, it is necessary to support and help refugees.

By conducting this research, the authors wanted to understand refugee children's different experiences while they integrate and adapt to the asylum-country. These kinds of studies are necessary for facilitating the integration process and increasing refugee children's health and future opportunities. People who study, research, make policies or educate the refugees in Western countries might have different experiences and backgrounds. Their background affects their world view and ideas about different concepts as well as refugee's situations (Thommessen and Todd 2018, 228).

Thommessen and Todd argue that there is a critical requirement to ease the integration of refugee children into Western asylum-countries. Findings based on qualitative interviews suggest some prevention and intervention is necessary. The research shows many different ways that teachers and people from the community can help refugee children who are struggling to integrate into a new society (Thommessen and Todd 2018 228-238). In doing my study I tried to

understand different refugee children's problems through conducting qualitative interviews with several tutors who have a lot of experiences interacting with traumatized refugee children.

In the research, conducted in a center at Hamilton, Ontario, Canada, which was providing settlement as well as integration facilities to new comer youth, the researchers try to emphasize the socio-cultural parameters, in order to gain a deeper understanding of how refugee youth comprehend and explain health and well-being. The research methods used by them were participant observation, focus groups, and in-depth interviews. Their results showed that the youth's understanding of health was vast including: education, income, etc. But they considered some factors such as: "a sense of belonging, positive self-identity, emotional well-being, and sense of agency or self-determination" more important than their educational and economic well-being (Edge et. al. 2014, 34). The researchers named these more important factors as "mediating" factors, which as the refugee youth also stated; these factors help them increase their ability to adjust or cope with hardships related to their new situation in the new country. The participants also mentioned another main category which researchers interpret as "facilitators" that cause mediating features to function positively e.g. informal, non-biomedical settings and programs that increase trust, facilitates communication, and stimulates a sense of community between refugees, mentors, and health professionals (Edge et. al 2014, 34). At the end of their study, the researchers concluded that in making policies for health promotion techniques for refugees, considering and understanding the factors that may influence the effects of different risks/stressors negatively or positively is very crucial (Edge et. al 2014, 34).

Based on qualitative research conducted by interviewing with students and staff at five secondary schools in Norway, the researchers investigated the role of schools in helping and supporting young refugees in important psychosocial transition processes including:

“socialization, integration and rehabilitation upon resettlement” (Lutine 2015, 245). The results suggest that the psychosocial care offered by schools is unsystematic and needs determined and hard work from related professionals. The authors argue that in order to make schools “refugee-competent” there are needs for more broad interaction of refugee students and teachers, developed teamwork in relation to psychosocial support and “school-based interventions” as an essential part of educational policy and practice (Lutine de Wal Pastoor 2015, 245-254).

In their study, Linton and her colleagues note that many pediatricians see refugee children. The authors continue that even though these children may be at risk for health inequalities involving socioeconomic disadvantage and cultural or linguistic challenges, immigrant families have distinctive strengths and are able to weather difficult situations in new countries. Different cultural media can help the process of adjusting to the new society, particularly in regards to health and well-being. The authors argue that pediatricians have a professional responsibility to provide for the medical, mental health, and social needs of immigrant families. They conclude that advocacy and research can further explore the unique needs of this population and evidence-based policies for health advancement (Linton *et. al* 2016 115-130). In one of my interviews with a staff member, they informed me about having a kindergarten student who had health issues and they helped his family to find the appropriate health facilities. Schools and other childcare facilities might also serve this function of identifying refugee children’s healthcare needs.

3.3 Refugee Main Stressors

When they are resettled in the U.S. refugee children may feel a temporary sense of relief. However, the difficulties they face do not stop once they enter the country. As soon as resettled in the U.S. refugees may face many new stressors. The National Child Traumatic Stress Network

suggests four major categories of stress: “Traumatic Stress, Acculturation Stress, Resettlement Stress, and Isolation” (The National Child Traumatic Stress Network 2018).

3.3.1 Traumatic Stress

Traumatic Stress happens when a child experiences a severe event that leads harm to his or her emotional and physical health. Refugee children can experience traumatic stress in these fields: war and harassment, displacement from their home, migration, poverty, family/community violence.

In her study, Luis Zayas argues the conditions of adolescent refugees and citizen-children and how threats of detention and deportation affect them. Zayas discusses that hostile immigration implementation damages the very youngest children. The author discusses that refugee and U.S.-born children of undocumented immigrants experience many childhood adversities, impeding their development and health. Zayas argues that refugee children run away from traumatizing violence in their home countries, encounter demanding migrations, and are hurt further by being detained. The author continues by explaining that citizen-children of undocumented immigrants worry every day that their parent will not come home because they were arrested, imprisoned, or deported. They become hyper aware, anxious, and depressed from endless worry. When parents are deported, citizen-children become orphans or exiles (Zayas 2018, 20-25).

Goodman and colleagues apply a phenomenological method to analyze refugee experiences of trauma as well as undocumented immigrant experiences of trauma and stress. The authors also examine the ways in which these people cultivate resilience to deal with these experiences. The authors also argue that migration and transfer procedures are often regarded as stressful and traumatic conditions. Immigrants may experience premigration trauma in their

home countries and trauma during their migration journey. Additionally, refugee and undocumented immigrant women traverse distinctive and constant stressors post migration (Goodman *et al.* 2017, 309-321).

3.3.2 Relations between Family Structures and Maltreatment of Children

Researchers of child abuse and neglect in the United States have found that certain structural arrangements of families and caretakers increase the risk that children will be abused. Maltreatment tends to be related to marital instability, separation, and divorce (Gelles 1983, 151).

Felitti found a connection between negative household environments and several risk factors for many leading causes of death in adults (Felitti *et al.* 1998, 245-258). Dr. Shanta Dube *et al.* (2001a) also discusses that although there are still some other factors, the exposure to parental alcohol abuse is strongly related with facing adverse childhood experiences. She (Dube *et al.* 2001b) found out that there is a direct relationship between adverse childhood experiences and risk of attempted suicide throughout the lifetime. Muhtz *et.al* 2016 have discussed the influence of parental post- traumatic stress disorder on children, as well as the intergenerational transmission of psychological trauma. During their survey, the authors studied 50 refugees' children who were rigorously traumatized as children at the end of World War II. From these, 25 of the refugees were suffering from chronic post- traumatic stress disorder, and 25 had no symptoms of post- traumatic stress disorder. (Muhtz *et al.* 2016, 367).

3.3.3 Maternal identity in refugee community

Often the socioeconomic background and living conditions have a strong influence on maternal feelings toward children. Dr. Nancy Scheper-Hughes, in her article, "Culture, Scarcity, and Maternal Thinking: Maternal Detachment and Infant Survival in a Brazilian Shantytown"

discusses the connection between culture, scarcity and maternal thinking. She studies maternal beliefs, attitudes, and practices bearing on child care and child survival between women in Alto do Cruzeiro, a shantytown of recent rural migrants. Dr. Scheper-Hughes refers to this area as “the heart of The Third World in Brazil.” She argues that infant and childhood mortality in the Third World is a problem of political economy, not of medical technology. Dr. Hughes discusses two other factors that may occur during childhood—maternal detachment and indifference toward infants and babies seen as “too weak or too vulnerable to survive” the malicious conditions of shantytown life. In this article she emphasizes the ways in which social and economic contexts shape “the expression of maternal sentiments” and the “cultural meanings of mother love and child death, and determines the experiences of affection, separation, and loss” (Scheper-Hughes 1985, 291- 292). The same situations usually happen to the newly-entered refugees. A lot of them suffer from financial instability, which causes both parents to work, and as a result the mothers can have less intense maternal instincts toward their children.

Another factor influencing maternal behavior is economic situation. Donna M. Goldstein in her book “Laughter out of place: Race, Class, Violence, and sexuality in a Rio Shantytown” chapter four, “No time for childhood” discusses about the role of economic situation in parenthood. Dr. Goldstein gives an example of a typical family in which the mother was working all the time due to a difficult economic situation, and she didn’t have much time to spend with her older boy and he turned to be a criminal in his later life. The mother explains that she was too busy to be able to keep track of her son, and her parenthood with her son was a failure and she lost him to the street, to the gang, and to a life that was lead to end violently (Goldstein 2003, 143-144). The author further argues that in many families in Rio de Janeiro, the women worked in the homes of others, taking care of children of other people, but they had to leave their own

children with older siblings, grandmother, or “the street” (Goldstein 2003, 142). This example shows that background situations (here economic factor) affects parenthood.

In their research, Sangalang et.al (2017) try to document the psychological effects of trauma among refugee adults and children. In their study, they examine the long-term effects of maternal traumatic suffering on Southeast Asian refugee women and their adolescent children. In this study they found that maternal traumatic distress was indirectly related to child mental health effects. Maternal traumatic suffering was also indirectly connected with depressive signs and harmful and criminal behavior. For children, dysfunctional family dynamics were significantly associated with poorer mental health. At the end of their study, the authors suggest interventions that try to solve the parental mental issues. They also suggest that providing care and support for intergenerational relationships may improve mental health within refugee communities for future generations (Sangalang et. al 2017, 178-186).

In the study of refugee women’s experience of struggling to preserve a strong cultural identity from their home country while adjusting to their new situation and country, Pangas et. al argue about “Building maternal identity across cultures,” which details the cultural struggle experienced by refugees accessing maternity services in their host country (Pangas et.al 2019, 31).

Furthermore, they discuss “liminality,” which they describe as a pervasive experience for refugee women in search of maternity care in high income countries. They argue that liminality is often a challenging experience for many women and a time in which they reshape their identity as mothers and citizens. This review found that the experience of liminality could be extended by social factors and inequality of healthcare coverage, where communication and cultural barriers prohibited women getting the kind of care that was equivalent, available, and

significant. Their findings showed both positive and negative experiences with maternity care. Also, culturally proper care and healthcare relationships were important parts in the positive experiences of women (Pangas et.al 2019, 31-45).

In her studies, Dr. Faith Warner examines the vulnerability and distress through studying the relationship between social support systems and traumatic stress in a Q'eqchi' refugee women community in Southern Mexico. Factors such as sociopolitical violence, forced movement, and relocation of Guatemalan Mayan people caused the breakdown and scattering of relatives and community groups. Additionally, these factors caused many Q'eqchi' women to experience destabilized social support communities. After conducting research, including interviews and traumatic anxiety and social support surveys, the author shows that Q'eqchi' refugee women with weaker social support networks showed more feelings of suffering and signs of traumatic stress than women with stronger kinship networks (Warner 2007, 193- 217). While interacting with a lot of parents at the non-profit organization and observing their behavior, I understood that the women who come to pick up their children feel more comfortable while interacting with other mothers from the same country. They also feel more closeness, safety, and supportive interacting with each other.

3.3.4 Resettlement Stress, Acculturation Stress and Culture Shock

Acculturation stress is a kind of stress that refugee children and families experience as they try to adapt to the culture of their new country without losing their own culture. Examples of this might include disagreements between children and parents about new and old cultural opinions, conflicts with peers about cultural misunderstandings, the need to translate for family members who cannot speak English, difficulties fitting in at school, and struggling to shape an identity including features of their new culture and their culture of origin.

Culture Shock

Culture shock is a phenomenon that might be experienced by immigrants and refugees who encounter other culture's aspects. Culture shock might affect their mental health to some extent. It takes time and energy for immigrants to be able to adjust with the new society's culture as well as their other situations such as financial hardships.

Resettlement stresses are stresses that refugee children and families encounter as they try to make a new life for themselves. Some examples of this may include language barriers, financial stressors, problems with finding suitable housing, troubles in finding employment, loss of community support, lack of access to resources, and transportation problems.

3.3.5 *Refugees as Survivors of Political Issues*

Mc Kinney examines the way the "trauma story" is gathered and arranged in the framework of psychotherapy with survivors of political violence. He presents information gathered from two ethnographic case studies. One of them is based on the participant observation data he gathered from events at a rehabilitation program for survivors of refugee trauma in New York (Mc Kinney 2007). The other is based on interviews he conducted with clinicians. Through analysis of the results, Mc Kinney demonstrates that the survivors not only suffer from political violence, but also their bad memories that affect their attitudes toward people in the long term (Mc Kinney 2007, 265-299).

In her studies titled "Refugee Dilemma," Rachel Aviv presents a profile of former child soldier and refugee Nelson Kargbo from Sierra Leone. Kargbo was resettled in Minnesota, but he was imprisoned for domestic assault, and later faced deportation. The author implies that Kargbo is in that situation because of his underlying social issues of trauma and mental illness. The

author tries to show the life of political refugees in search of asylum in the U.S. from countries such as Somalia, Sudan, and Liberia evading civil war and other armed violence. (Aviv 2015, 46-55).

In their research, the scholars argued that war-traumatized refugee youths are a susceptible and under-researched group. During this survey, the authors evaluated two different groups of war-traumatized youth newly resettled in Sweden, and the other group of settled students with childhood war experiences. The authors tried to analyze their war experiences, refugee journey, general trauma experience, posttraumatic stress indications, and dissociative experiences. Both groups were affected by many traumas and a significant proportion reported levels seen in posttraumatic stress. The survey also offers data about the kind of adverse events encountered by refugee adolescents, as well as their own subjective reviews of the worst events. The results of the study imply that the level of trauma exposure and posttraumatic and dissociative “symptomatology” among refugee adolescents are significant even after a period of migration; a result that has educational, clinical, and social insinuations (Gusic *et al.* 2017, 1132-1149).

In the article “Trauma exposure and IPV experienced by Afghan women: Analysis of the baseline of a randomized controlled trial” (Jewkes *et al.* 2018), the authors provide a background about the history of conflict in Afghanistan which has permanently impacted the lives of Afghans, causing them different forms of trauma. The researchers try to investigate a postulate that trauma is a main factor of domestic violence in Afghanistan. Women who were traumatized were more probable to have ever experienced IPV, to have struck their children in the last 4 weeks, and be hit by a family member of their husband or their mother-in-law in the last year. These women retained less patriarchal personal gender outlooks and observed the community to

be more patriarchal. Finally, the authors argue that trauma experience due to conflict will persist until the conflict finishes but the effect on women can be amended. This study suggests interventions to decrease women's exposure to IPV should concentrate on reducing poverty, shifting social standards on gender, providing relationship skills to help reduce conflict and supporting women's mental health (Jewkes et al. 2018, 1-15).

In a research conducted at a primary care clinic in Kabul, Afghanistan, with the subject of studying "the relationship between war trauma and distress and the potential moderating role of emotion and social, avoidant, and religious coping," participants who were seeking medical services were interviewed. Results showed the direct relationship between war and stress. Qualitative answers also represented different coping strategies and ways in which participants dealt with trauma. Qualitative data proposed that religious and spiritual activities, working and being busy, and seeking help from others were the most often stated coping strategies. It is essential to continue to explore and recognize these factors and others that may help to alleviate the impact of traumatic events (Wildt et. al 2017, 81).

In his studies on refugee children's mental health who were affected by war violence, Entholt argues that there is a need for effective intervention strategies and supportive aids. After reviewing the scholar works who studied the war traumatized refugee children, he emphasizes the need for those strategies which were designed to lessen war-related post-traumatic stress disorder (PTSD) symptoms. He argues that young refugees are often exposed to several traumatic occasions and severe losses, and also their stresses might continue within the host country. He argues that though the young refugees are usually resistant, still they may experience mental health problems, including "PTSD, depression, anxiety and grief" (Entholt 2006, 1197).

The author also calls for an intervention that is designed with the complete understanding of both the risk and beneficial factors (Entholt 2006, 1197).

3.3.6 Depression concept among refugees

It is important to consider how refugees conceptualize and experience depression and how this concept differs between genders and ethno-linguistic groups. Alemi et al. (2017) conducted a study among Afghans residing in San Diego County, California by analyzing their beliefs about depression using a cultural consensus survey. Then, by applying the mixed-method approach, as well as results from in-depth interviews, they developed a “culturally meaningful questionnaire about depression.” The responses to the questionnaire items showed that the refugees see depression as being caused by traumatic experiences and being in the new country. This study is helpful for understanding Afghan refugee responses to depression. (Alemi et al. 2017, 177-197).

Becker examined the narratives of Cambodian refugees' experiences of the Khmer Rouge regime against the setting of an ethnographic study of older Cambodians' lives in an inner-city area. The stories from this study show the “association between bodily distress and memory, and between personal history and collective experience” (Becker et al. 2000, 320). Kohrt (2012) argues that figuring out the kind of mental health needs of Nepali Bhutanese refugees moved from Nepal is a new issue for mental health clinicians in the receiving countries. A lack of current services causes the shortage of data about cultural understandings of mental health. In this study the authors focus on solving the problem by using “ethno psychology”, which is “the study of emotions, suffering, the self, and social relationships from a cultural perspective.” The authors argue that Nepali ethnopsychology can be helpful for improving and adjusting “mental health interventions for refugees” (Kohrt et al. 2012, 88). They argue about applying

ethnopsychology to offer safe and useful mental healthcare for Bhutanese refugees, for example cultural adaptation of cognitive behavior therapy, interpersonal therapy, and dialectical behavior therapy. The high rate of suicide among Bhutanese refugees calls for psychological interventions. In this study, the contribution of ethno psychology to applied anthropology and the developing field of neuro anthropology is also discussed (Kohrt et al. 2012, 88- 112).

Maxwell examines the impact of the introduction of Lao refugees on previously segregated (black/white) ethnic relations in a working-class evangelical congregation in St. Louis. Church members maintain idealized concepts of Lao economic success, youth, gender roles, and academic performance, which they contrast to concepts of blacks whom they perceive to fail where the Lao succeed. Minimizing differences between the Lao and white church members creates a sense of unity which facilitates restructuring the ethnic order into a black/non-black dichotomy that perpetuates racism and sexism, and appears to "prove" the theory that the poor are responsible for their troubles (Maxwell 1989, 153).

In the article "Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review" by Bustmante and his colleagues the authors analyzed the growing evidence supporting the relation between migration and posttraumatic stress disorder (PTSD). The authors argue that because of the increasing number of immigrants and the carefulness of providing delicate culturally based mental health care for these people, health workers should be aware of the latest information about this issue. The authors argue that the migration process causes stress associated with acculturation and migration experience. These might affect mental health. The authors continue by arguing that the frequency of post-traumatic stress disorder among immigrants is very high, especially among refugees, who experience it at about twice the rate of normal migrants. So, the authors argue that mental health specialists must be educated to

diagnose and offer appropriate care for posttraumatic or stress-related illnesses among migrants (Busmante et al. 2018, 220-225).

3.4 Isolation Stress

These kinds of stresses are the ones that refugee children and families experience as minorities in a new country. Some examples of isolation stress are feelings of loneliness and lack of social support network, discrimination, experiences of harassment from peers, adults, or authorities, experiences with people who do not trust the refugee child and family, feelings of not adapting, loss of social status (The National Child Traumatic Stress Network 2018).

3.4.1 Social Suffering

Dr. Kleinman, in his book *Social Suffering*, describes the term “Suffering” by presenting two broad meanings used in everyday discourse. First: suffering is related to bodily pain and the moments of consciousness that come with this pain. This kind of pain just affects an organism’s nervous system which has evolved to the level where we can say that it is conscious of its pain. The second kind of suffering comprises mental conditions that are defined as psychological, existential, or religious and that are identified by such words as “despairing” and “desolated” (Kleinman et. al 1997, 245). This second kind of suffering has a social or moral aspect, in the sense that it is understood locally, by identifiable groups and communities, in the context of ideas about “redemption, merit, responsibility, justice, innocence, expiation,” etc. (Kleinman et. al 1997, 245). The second kind of suffering is based on societal paradigms (which include moral and religious codes).

3.4.2 The role of “Race” or “Ethnicity” in social suffering

Dr. Kleinman argues that the idea of race, which is considered to be a biologically irrelevant term, has vast social currency. Racial groupings have been used to take away basic

rights from certain groups, and consequently play an important role in considerations of human suffering. For South African Blacks, the main cause of increased rates of disease and death is lack of access to resources; poverty remains the main cause of the frequency of many diseases and rampant hunger and starvation among Black South Africans. Social inequality is also seen in the higher percentage of Black African poverty compared to white people. (Kleinman et. al 1997, 275-276). Refugees also have the same experience, since they might experience poverty as a result of society's racist beliefs.

4 METHODS

In this study, I explore adult perspectives on ACES that may be experienced by children from refugee families in the Clarkston, Georgia area. I conducted my research through a non-profit organization, which is a Christian organization that assists refugee families and at-risk children in Clarkston, Georgia. I have held a volunteer position there since June of 2018.

4.1 Design

My goal is to gain more information about the experiences of refugee children from the perspective of their caretakers, including parents, relatives, and staff, at a nonprofit organization. In order to research the adverse childhood experiences among refugee children, I interviewed a maximum of seven refugee parents/guardians and staff to see how the process of immigration affects refugee behavior toward their children. Only participants with conversational English skills were included in the study. I went over the consent form with participants before each interview.

4.2 Ethical Consideration

In discussing the procedures and the details of the consent form, I talked to participants about my obligations for reporting mentions of physical abuse or other crimes; this is particularly challenging in a study that focuses on ACES. However, I designed the questions (particularly for parents/guardians) to avoid the types of questions that could encourage participants to share incidents that might implicate them. The interviews did not take more than 2 hours each. Participation in this research was voluntary and participants' identities and information were

protected. I recruited participants by asking them in person if they would like to participate in an interview, and agreed on a time and private space for the interview.

As inspired by Thommessen and Todd's work, in my study I used open ended questions to encourage refugees to speak more freely and not be bound by my questions. I tried to avoid presumptions and biases. Since participants with a refugee background may have faced circumstances where their ideas and opinions were unheeded or not respected, I tried to design the questions in a way to avoid causing more harm (Thommessen and Todd 2018).

Interviews were audio-recorded if participants agreed. If not, I took notes. Digital files were kept on my password-protected laptop. After transcription, digital audio files will be deleted (within 6 months after the interview takes place). As per protocol with ethnographic data, the transcriptions are kept indefinitely on a password-protected computer and used for grounded theory analysis for both this MA project and future research. Participants were assigned pseudonyms, and their digital files and transcriptions are labeled with pseudonyms only. Consent forms with signatures and a code sheet that links names with pseudonyms are kept in a locked filing cabinet in the office at Georgia State.

4.3 Problems in describing Adverse Childhood Experiences Cross-culturally

There are major differences in beliefs and principles from society to society, and these values and norms vary during the time and history, which further blurs the lines between abuse and normal parenting. For example, in the United States it would not be uncommon to find a social worker disputing a family situation where a mother has shared a bed with her three young children; this would be a proof of a neglectful environment. Among parents in the United States, the normal and accepted sleeping arrangement for children is that they have their own beds and in most cases their own bedrooms. Yet, among the Kung, it would be unbelievable and even

assumed abusive if a parent were to put an infant into a separate bed and put the child to sleep in a dark room alone. Even infanticide, considered by some abusive act, is not certainly or equally categorized as abuse across cultures and situations (Lancaster and Gelles 1987, 20). Evidently, the main problem in evolving valid cross-cultural and historical classifications of child maltreatment are variable values and norms across and among different cultures. There are other issues that also impact the finding useful and identical scientific characterizations of abuse and neglect (Lancaster and Gelles 1987, 20).

4.3.1 Limitations on Research Method

The main problem that I faced several times during this research was the unwillingness of families and parents to disclose information to me. They were willing to interview with me at the time that I asked for their participation, but during the interview, they did not talk about any of their problems, and they wanted to emphasize that their immigration process was successful and went smoothly. They said that they relocated in new neighborhoods and had positive experiences living and raising the children in the new homes. I designed my questions in order to make them feel comfortable and not fear expressing negative experiences about anything, but they were not willing to talk about any difficulties, financial, cultural, etc. I could only gain information about their reason for coming to the U.S. Their reasons were mainly religious or political conflicts.

The majority of information about refugee childhood trauma that I could gain was from tutors and managers of the organization. Unfortunately, I could not gain any information from my interviews with parents. I can only guess that their reluctance is because of fear of being stigmatized or because of their pride; maybe in their cultures, difficulties are not expressed to an outsider. Fear of legal repercussions that result in them losing their children or being deported could also have been a factor.

One of the main limitation and problem is the ethical standards that restrict doing research within and cross-culturally. In the United States, students of maltreatment must obey to state reporting laws that necessitate cases of alleged abuse to be reported to chosen official agencies. Accordingly, a survey or field researcher who finds a suspected case of abuse would be obligated to report that case. For that reason, researchers are usually required to notify all research subjects of this probability before data assembly starts. As a result of the need to obtain informed consent, researchers may have to compromise some sample representativeness or legitimacy of the study. Cross-cultural researchers do not usually have to worry about the problem of mandatory reporting. They should only deal with the ethical problem of applying their own definitions of apposite child-parenting techniques to other cultures. Researchers may find themselves cataloguing child-rearing activities in another society as abuse or neglect, though the parenting practices in question are actually considered suitable and correct in that society (Lancaster and Gelles 1987, 22-23).

4.3.2 Solving the problem in definition of childhood trauma

A number of researchers have tried to resolve the main problems of definition and strategy. The first technique has been to constrict the issue of maltreatment to a much more exact and objective concept. Straus, Gelles, and Steinmetz (1980) focus less on the broad range of acts that may be considered maltreatment and more on specific acts of interpersonal violence. Violence is described as “an act carried out with the intention, or perceived intention, of causing physical pain or damage to another person” (Straus *et al.* 1980, 20). Abusive violence are those acts that have the high likelihood of causing damage (Lancaster and Gelles 1987, 21-22).

Levinson has used this classification to evaluate violence toward women and children cross-culturally. The benefit of concentrating only on acts of physical violence is that the description is objective and less subjective to differing cultural values than other, more comprehensive definitions of maltreatment. However, this still presents a negative effect; focusing only on physical violence leaves out acts of omission and nonviolent acts of commission that still damage the health of children (Lancaster and Gelles 1987, 23).

A second solution is Korbin's argument that those who try to develop a cross-cultural definition of abuse face the problem of choosing between a culturally relative standard by which any given behavior can be abusive or nonabusive, based on the cultural context or an idiosyncratic standard by which abusive acts are considered behaviors that are at variance with the normal cultural standards for child-rearing. Korbin and others have been inclined to use the second standard as they progress and do cross-cultural research (Korbin 1981, 31-49).

The most advanced solution to the definitional limitation is Rohner's use of the concept of parental acceptance/rejection. Rather than limit himself to a smaller number of harmful acts, Rohner sought a more universal concept to test his theories. Rohner states that abuse is often a specific type of rejection. Rohner explains rejection as the absence or major withdrawal of warmth and affection by parents toward children. Rejection can take the form either of anger and violence or indifference and neglect. Acceptance is defined as warmth, affection, and love (Rohner 1984). The crucial factor to correctly conduct cross-cultural and historical research on child maltreatment is to accept specific, replicable definitions of maltreatment, as well as using the replicable models and processes. Levinson used coded data based on ethnographic reports (Lancaster and Gelles 1987, 24-25).

Another method is Edfelt's replication of Straus and his colleague's analysis of family violence in the United States. Edfelt used the Conflict Tactics Scales for parent-to-child violence and studied a representative sample of families with children in Sweden (Lancaster and Gelles 1987, 24). The last two decades of study on the child abuse and neglect are consistent in one key point—there are many factors related with abuse and neglect. The basic explanations of abuse and neglect that focused on the psychological traits of the abuser have been replaced with models that consider socio-psychological, family structure, and social-cultural variables instead of intra-individual factors. The last three levels of analysis are the most responsive to cross-cultural analysis, and many of the relationships found in the United States should be examined by assessing families in other societies (Lancaster and Gelles 1987, 25).

5 CLARKSTON REFUGEE POPULATION

“Refugee” is defined as people who have run away or been expelled from their own country because of natural catastrophe, war or military invasion, or fear of religious, racial, or political discrimination (Funk and Wagnalls 2018, 1). U.S. immigration law describes a refugee as someone who is “unable or unwilling to return to” his or her country of origin “because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.” An alien must be located outside the U.S. when applying for admission as a refugee; aliens who are residing in the U.S. or who have reached a U.S. port of entry, and who would otherwise meet the criteria for refugee status, may apply as asylum seekers, or asylees (Funk and Wagnalls 2018,1).

War, political persecution, and human rights abuses all cause people to leave their homes. Some individuals can be eligible as refugees, often after living years in camps and other transient places before attaining asylum. The United Nations established World Refugee Day to bring attention to the problems refugees face (Hickerson 2016, 424-438).

Social workers, government, and non-governmental organizations in the United States are not well prepared to deal with the trauma faced by refugees fleeing persecution. In addition to their original trauma experiences, refugees often go through more traumatic migration experiences and issues after relocation in a new country that can have long-lasting effects on their physical and mental health. Micro and macro social work practitioners must recognize the effect of these experiences in order to advance policies, social work training, and clinical practice that improves the well-being of refugees and society. Social workers are in a crucial position to

provide multi-facet, structurally proficient care and support for diverse refugee populations (Ostrander *et. al* 2017, 66- 79).

5.1 Clarkston

Clarkston, Georgia, is a suburb of Atlanta and has the highest proportion of refugees to other residents in the area. In the late 1980s and early 90s, refugee resettlement organizations chose Clarkston as a home for newly arrived refugees from around the world. Several factors make Clarkston an ideal place for refugee placements: Metropolitan Atlanta's highway system, inexpensive housing prices, and key industries of Atlanta offer the prospect of jobs for the newly arrived (Art paper Magazine 2016, 62-64).

5.2 History of Clarkston

In the late- 1800s, white railroad workers and farmers established Clarkston. Clarkston remained rural until the 1970s, when the developers began to build apartment complexes for middle-class workers who came to Atlanta after the opening of the international airport. During the next decade, many of those laborers started to move to newer suburbs. Opportunities increased, and home prices decreased. Global diversity arose began to increase in Clarkston. In the 1990s, service organizations, which had contracts with the federal government to relocate refugees acknowledged Clarkston as the “perfect place for these vulnerable newcomers.” As refugees have adjusted to life in Metropolitan Atlanta, they have frequently left Clarkston for other cities such as Norcross, Tucker, and Duluth. With populations coming from more than 50 countries, Clarkston is one of the most diverse communities in the United States (Art paper Magazine 2016, 62).

6 DATA COLLECTION

Before beginning my formal research, I had a chance to observe children and their relationships with their parents while I worked as an intern at Family Heritage Foundation. I observed the children throughout the Summer Camp program during summer without interacting with them. Then, I wrote down everything I could. I observed different parts of the children's behavior. I looked for patterns in the observations and came up with some interview questions. After receiving IRB approval, I interviewed with some parents to learn more about how they feel about certain situations after they entered the U.S. I made notes and transcriptions of the interviews for later analysis. During the analysis, I searched for themes throughout the interviews. I also have interviewed with staff members with a different set of interview question.

This project was conducted in refugee communities in Clarkston, a city which houses a majority of the refugees when they arrive in the U.S. While doing my internship at Family Heritage Foundation (FHF), I communicated with many refugee kids and their parents. Through this I have learned about their various cultural background and the ways their cultures affect their behavior towards their children. The other important factor that I considered as I conducted my research is how much parents' stress levels affect their behavior toward their children.

I particularly planned to study the obstacles and stresses that they encounter while migrating to the U.S. and for their first five years of residency. These obstacles vary among refugee families depending on their background and their social status in their home country. Still, a certain level of stress and anxiety accompanies all refugee families migrating to the U.S. In many of the life stories of refugee families, both parents have to work long hours to earn enough money, leaving their children with older children or someone else. This leads one to ask

the question: How does this along with other factors affect children's mental health and wellbeing?

6.1 Participant Observation

I started my volunteer work with this non-profit organization at Clarkston in June 2018. I became familiar with them and started my work as coordinator and I prepared facilities for the start of summer camp. As an office assistant I was able to be in touch with both parents and their children who came for a summer camp program.

I also volunteered with this non-profit organization as a tutor, which gave me the chance to build relationships with the children and learn more about the problems they face. This was a great experience and opportunity to know more about refugee families as a whole. As I continued working with FHF, I decided to do my research on childhood trauma in refugee families as my M.A. thesis.

In the meantime, I spoke with one of the managers who has worked at FHF Program for several years. During her time there, she has gained a lot of knowledge about refugee families and their problems. She explained that one of the major problems they face is the language barrier. They cannot improve their English skills because they work full time, and if they cannot improve their skills, they cannot get better jobs or improve their social status. They are forced to work lower-paying jobs in the U.S. in order to make money to sustain their daily lives, which can cause depression and other mental problems over time. Another common problem is that they do not have much time to spend with their children. These are considerable problems refugees face, which can directly affect their behavior toward their children.

6.1.1 *The Church Building and after -school program*

The non-profit organization is basically located within a big church building, and many other activities and events are going on in the Church building. This non-profit organization is a Christian Ministry organization founded with the aim of providing accommodations for refugee families and their children in Clarkston, Georgia. This organization helps and supports families who are in an unstable life situation by orientating them into a new community, as well as other services. The most important help that this organization offers relates to the refugee children. By offering programs and summer camp developmental programs, the organization offers great opportunities for refugee children to learn and succeed in their schoolwork.

A quality education is an important factor in a child's future success. As refugee children, they encounter and struggle with some challenges academically. Additionally, many children have gaps in their education because of the violence and dislocation from their homes. This is a barrier for them and causes them to fall behind their peers in school. FHF provides the support needed to improve children's academic performance. The children who come to this program are from different countries, but there are many from Ethiopia, Somalia, Iraq, Thailand, Democratic Republic of Congo, and Myanmar, among others.

6.1.2 *The church efforts in healing the trauma*

During my participant observation, I found out that the church pastors also want to participate healing the refugees' trauma by inviting them to the Christianity. There held several meetings which I attend, and they were discussing about having different related workshops at different places for more cooperation of church in this subject. During their meetings they referred to the book *Healing the Wounds of Trauma, how the Church can help* which describes that in the today's world people might suffer from war, ethnic conflicts, abuse, crimes, or even

foods. Many people might have injured mentally from these dilemmas. The church should help its members who traumatized. For this aim, this book is written to help church leaders be familiar with ways they can help people after difficult situations. Each lesson in this book presents how the Bible and mental health teach about healing from trauma. The authors of this book believed that God can help the sufferers, as they saw people suffering from war in the late 1990s. In 2001, a group of people gathered together to write the lessons. The group included “mental health professionals, Bible translators, Scripture engagement consultants, and African church leaders who had experienced war” (Hill et al. 2016, 7). The lessons were applied and tested in war regions and were first published in 2004 by Paulines Publications in Nairobi (Hill et al. 2016, 5-6).

A lot of people tried to learn the trauma healing methods. Because of this, the church realized that trauma healing calls more attention than they could give. Also at the same time American Bible Society wanted to cooperate in trauma healing. American Bible Society also set up a Trauma Advisory Council of mental health professionals in order to make sure that the best mental health principles were applied. In 2012, American Bible Society presented the first Community of Practice to gather organizations that were interested working in trauma healing.

In 2012, the American Bible Society established the Trauma Healing Institute. This Institute was designed to help the program to improve. It works with Bible Societies and other associates all over the world to train and certify helpers to care of traumatized (Hill et al. 2016, 6-7)

6.1.3 Food Pantry

While cooperating with this non-profit organization, I found out about other activities they are doing to provide more help to refugee families. They have a community food pantry mission that directly serves the residents of an apartment complex whose residents are mostly refugees. Their food pantry is located at one of the biggest refugee apartment complexes in Clarkston. They reserve the food and clothes that they gather from the food bank or from their supporters at their Food pantry, and have distribution days two days per month. I sometimes help them manage and organize the foods in the food pantry for the next upcoming day of distribution.

6.2 Refugees' Narratives

Here I provide a summary of some of my interviews that I narrate here. I interviewed three staff members who were working in this non-profit organization for several years and who therefore have a lot of experiences with traumatized refugee children.

Peter

Peter is an African-American who is about 60 years old, and he started working in this non-profit organization about eight years ago. He knows American Sign Language (ASL). He explained that he was contacted by the managers of the non-profit because they had a little refugee boy from the Democratic Republic of Congo who was deaf, and after school program tutors could not help him. Peter explained that different countries have their own sign languages, and that he only knew American Sign Language (ASL). He explained that he had a difficult time understanding this boy's sign language. It was challenging because the boy became frustrated and Peter and started to feel helplessness. He explained that he could not help this boy and that

he had such a bubbly personality and desire to learn. He really could not help the boy, so he decided to push the book aside and tried to learn more about what he was. He started asking him some personal questions about his family, until the boy started to tell him about his homework and what he supposed to do. It took Peter a couple of months to get close to him. Peter went to the boy's teacher for help but she refused to talk because she did not have the parents' permission. Peter wanted the parents' permission but they did not know English; however, the boy's sisters could speak English, and he went through a lot of challenges communicating with parents and finally got their permission. Then, the teacher started to make notes on what the boy was supposed to do and finally Peter started to help him. He dedicated all of his teaching time to helping just this boy.

Peter defined childhood trauma as experiences that cause children to be injured mentally or physically. They withdraw from interacting with others because they hurt. They feel devalued, have low self-esteem, and feel responsible for their misfortune. They do not want to communicate, and therefore, they reject interactions with others. It is clear that they have trouble and that they are unwilling to try to open up because they feel burdened. They have been traumatized.

The deaf boy was traumatized because of the communication barrier. He was taken out of his home environment and placed in a new environment, causing him to change, learn, and adjust simultaneously. He had to learn this new American sign language, adjust the ways in which he did his homework, and maintain the same standards as everybody else. He got limited consideration from his teachers because he needed more one-on-one attention and time to convey his questions, concerns, struggles, and challenges. He needed time and attention to do all of

these. His parents spoke Swahili therefore could not help him do his work. He depended completely on the teacher's help.

Peter explained the difference between other children (who had not experienced trauma and who were not hearing impaired) and this traumatized boy. He explained that he was withdrawn and frustrated at first. As he got more comfortable he started to open up about his likes and dislikes.

In trying to solve the problems of traumatized children, Peter explained that he usually discusses similar patterns with other tutors and the ways to deal with them. He explained that the tutors have to have patience because they do not know the emotions, background, and what caused trauma in these children. They are not willing to talk about it. Peter and his colleagues encouraged each other to exercise patience to let the child get a sense of tutors' consideration about how they could help them. Additionally, Peter and his colleagues try to get the children to relax and give them the time they need to talk to tell their tutors about their situation by listening calmly to what these children want to say about their traumas. Peter tries not to be judgmental and gets the child's trust without jumping to conclusions.

Ms. Candice

I also interviewed with another person who co-founded this non-profit organization with her husband in 2001. She has a Bachelor's degree in Finance. She explained that before working at this non-profit organization, she worked in the field of administration and finance for 20 years. But for this job, they have been educated by DFCS and other agencies about how to work with traumatized children. Each year, they complete 20 hours of training with Families First and the GA Center for Resources and Support on trauma care as it relates to children. She described childhood trauma as "the effect of a negative brain-altering experience that happens to a person

under the age of 18.” She continued that a normal child is one whose brain is developing normally due to having his/her basic needs met in a safe environment. While it is hard to define what a “normal” child is, there is a difference in brain development between children who experience different types of trauma vs. little to no trauma. A traumatized child is one who has suffered from a memorable adverse experience that causes negative reactions to a normal or positive situation.

She described that since this non-profit organization started to operate in 2001, they have worked with children who: Were raised as child soldiers, saw family members harmed or killed, were hurt by rebels, displaced by war or persecution, were separated from their family while fleeing from danger, walked for hundreds of miles in search of refuge, have been exposed to domestic violence, are victims of secondary trauma – have either witnessed or heard first-hand accounts of a loved one’s traumatic experience.

She explained that they had been working with traumatized children long before they realized it. They thought the negative behaviors displayed by many of the children were simply attention-seeking. But after they enrolled a first grader from Iraq in their after-school program, they understood that this kind of behavior originated from trauma. She spoke about how this student had emotional outbursts for “no reason.” He would avoid activities that all the other children enjoyed. His parents clarified that he had been hit on the head with the stock of a gun when he was only two years old. As a result, he was diagnosed with a traumatic brain injury (TBI). After that, Ms. Candice immediately went to work and began researching how to work with children with TBI. She explained that this traumatized student needed lots of visual

indications and reminders. She mentioned that they also recognized his triggers and learned to avoid them to prevent an emotional outburst.

Ms. Candice continued her talk by mentioning that many refugee families are unable to navigate the complicated healthcare system to find the right type of help for their children. One of the services that this non-profit organization provides is to help them find a healthcare professional willing to help them for free, or one who accepted their insurance. She told another success story about a Burmese kindergarten student who was unable to remain calm for more than ten seconds. He would throw furniture and supplies and cry endlessly. He had an IEP (Individualized Education Plan) at school but had been suspended and finally expelled from two schools. Ms. Candice explained that they paired him with a wellness chiropractor who successfully helped him and put him on a diet that helped with self-control. One of the supporters of the non-profit organization paid his bills. The student is now in second grade and has improved a lot and is now doing much better in school.

Concerning the relationship with parents, she said that their team try to build relationships with the parents and caretakers. She also mentioned the importance of gaining parents' trust before providing them with feedback about their living conditions. She added that they provide feedback privately, and if possible, in the families' homes. In the case of needing translation, the team seeks out a trusted neighbor, relative or friend of the parent/caretaker.

Ms. Candice described the techniques that she found to be effective in developing trusting relationships with children's' parents. She described how these techniques include showing genuine concern for their wellbeing, accepting them for who they are, visiting them at home, showing an interest in learning about their cultures, and being transparent with them about

their lives, experiences and beliefs. She explained that these factors are important because the parents want to know that the non-profit organization has no hidden agenda.

She added that they are a Christian organization. When parents know that about them, some of them tend to be cautious, thinking that the organization's agenda is to convert them to Christianity. She explained that "we do not hide our Christian beliefs, and we let them know that we are available to share more about our faith with them if they ever have questions or express an interest. However, our calling as Christians is to help those in need, regardless of their faith or belief. We make this clear in our words and actions."

Ms. Candice continued that during the first year FHF was in operation, in 2001, the children in their program came to the U.S. as refugees. Now the program has more children who were born of refugee parents. These cases were a little different. The program had children who were raised as child soldiers, who actually killed their own relatives. They underwent rehabilitation, which was suitable for them, but they still had some traumatic problems. They were mostly from Liberia, Congo, and Sudan. A lot of the girls had been molested. The Congo children went through the war, and when they fled to the refugee camps in Tanzania, where many were raped. They already had experienced trauma from the crisis in their home country, and then later in the refugee camps which were supposed to be safe but were not. When they came to the program they had so many traumatic problems. Most of the children were in a state of denial where they did not feel emotions anymore because they been hurt so many times that they shut down and closed themselves off from feeling anything. Many of the children did not have emotional responses to their daily life events and circumstances. Then, the program started to help them by including Bible studies in their program because the tutors wanted to be able to

pray with the refugees and help them understand that “God loves them even though they went through so many difficult situations, and he has a plan for them, and it does not matter if they are Christian or Muslim or whatever religion they choose, but they just need to know that God is God, and he has a plan for them,” as one of the managers said.

FHF managers and staff tried through praying and sitting with them to discuss things with them. They had a few counselors who came and worked with the girls. They also had a teacher who did art therapy and a music teacher who did music therapy with them. They got help from different angles: spiritual help, mental help, and emotional help. Then the refugees started to change and feel better. Ms. Candice described that these kinds of therapies affected their schoolwork. She explained that the refugees came to the program with Fs and Ds on their report cards, in spite of knowing the materials. Many knew the math, but the reality was that they did not care about themselves, and it affected how they performed in their courses or at home.

Once the program addressed their problems and made them talk about their issues and seek help they started to open up. The manager explained that the only help they were getting was through this program because the parents were not open to counseling. Ms. Candice added that this was another cultural barrier. Every time they tried to talk with the parents to suggest counseling, the parents said there was nothing wrong with their child and that she/he was just being stubborn. The parents also did not know better because they also came from a culture where trauma was a stigma, and if a set of parents said their daughter was raped, it would affect how others viewed them and would even bring shame. Families could not tell anybody if their daughter was raped or if their son had been killed someone because then other people would treat them like an outcast. The parents tried to keep these things inside, but the kids were speaking up.

Children were sharing with the program's tutors that they killed somebody, they were raped or molested, they watched their father beat their mom, or they watched their uncle kill their dad. When these children came to FHF with these stories, the managers of FHF took responsibility and partnered with different agencies that could help these children. The program decided to help them indirectly by not telling the students that they would get therapy because the children would shut down if they knew they were going to therapy. Therefore, the program set specific art and music days, so that the children could learn to draw or play music and have fun creating while getting help. They also had counselors who came and talked with the girls by sitting around the table, drinking tea, and eating snacks, to make them open up to the counselors. They saw these girls move from having lower scores on their report cards to higher scores.

Ms. Candice also talked about one girl from Congo who could not graduate because she was not able to meet the graduation requirements. She came to the U.S. when she was seventeen years old, but she could not read. It was pointless to put her at the high school level. FHF managers informed her parents about a school in Stone Mountain, which is a school for students who are older than eighteen but have not graduated high school. The girl went to that school and eventually graduated. She struggled a lot and had low self-esteem because she had been raped multiple times. She always said, "I am not good for anything. I cannot do anything good. I am just going to have a baby who loves me." She barely made it through school, but in the end, she succeeded. FHF managers kept in touch with her and encouraged her to pursue a career and keep succeeding.

Finally, Ms. Candice explained that serving traumatized children and their families requires a great deal of resources and long-term commitment. Sometimes, they have to make

hard decisions and personal sacrifices to continue to provide services for families in need. About the difficulties in their work, she explained that they encounter work difficulties every day, from finding enough funding to sustain the program to being able to meet the growing needs of families. She said that “It is hard to say “sorry, we are full” to a child who is struggling in school because we don’t have enough funding or volunteers. We try to find other help for these families or raise more money to add one more child to the program.”

She also added that for the last 17 years, they have refused to charge after-school tuition because they know that many traumatized families are struggling to pay rent and feed themselves. She said “one way we have resolved the funding problem is by encouraging parents to make a donation, only when they can. Not only do these donations help us, but they also give the parents a sense of dignity and ownership in the program.”

7 DISCUSSION

In this study I interviewed both the parents whose children attend the after-school program and the staff of the non-profit organization where I was an intern. The purpose of the present study was to examine the effects of different kinds of stress on refugee children's mental and general health who had a hard time migrating to the U.S, based on participant observation and interviews with caretakers and tutors. This research has shown that refugee children may be at risk for mental health problems.

Based on the studies and results of interviews, I found out that there was a relationship between the traumatic stress of children and their mental health problems, and as a result, their behaviors. The parents' stress levels were also found to be one of main causes of the children's stress. Researchers should further analyze the connections between refugee children's low grades at school and their mental health. Tutors who are in contact with refugee children should be concerned with mental health problems as well as physical problems of children. Tutors and teachers should be mindful of all the circumstances that affect children's development and should be supporters of their basic human rights.

7.1 Research Significance and Future Directions

Potentially traumatic experiences are common among refugee families. They are exposed to a lot of hardship, primarily in the first five years of immigration. The findings of this research will have important implications for refugee families' health and well-being, including early detection and treatment of children affected by their parents' immigration trauma and stresses. This research will also help identify the negative conditions in families and communities that contribute to adverse development.

Preventing adverse childhood experiences and identifying people who have experienced them could have a significant impact on a range of critical health problems. Improving the mental and physical health of refugee families is essential to ensuring their kids will grow up in a healthy environment. This research could potentially help lawmakers to see the negative effects the immigration process on refugees. This could prompt them to change the process and make the resettlement process simpler for incoming refugees. Looking at research on refugee living conditions during resettlement might also prompt them to improve support that is given to refugees.

Clarkston, Georgia is one of the best places for housing the refugees in the Atlanta area because of the low cost of housing and its easy access to Metropolitan Atlanta Rapid Transit Authority (MARTA). There are a lot of organizations that formed in Clarkston to help the refugees and provide them easier access to needed services and resources. During my time as a graduate students at Georgia State, I became familiar with some organizations in Clarkston, such as WellRefugee center, Friends of Refugees, and Family Heritage Foundation (FHF).

7.2 Results

Educators should recognize the children with problems, create prevention strategies, educate the parents about their children's situation, and guide them to the best solutions. The educational professions should also advocate for immigrant children's rights in the policies for them. They should consider that these children might have special needs and they should improve their abilities to recognize that these children may have mental health problems due to the immigration process. The teachers also should intervene with immigrant children's mental and physical health problems. Future research should be conducted based on longitudinal group studies that look at ways to improve the immigrant children's situations and facilitate them

solving some of their mental and physical problems. The ways to facilitate for these communities to easily access to health care resources.

REFERENCES

Qais Alemi Susan C. Weller Susanne Montgomery Sigrid James

2017 “Afghan Refugee Explanatory Models of Depression: Exploring Core Cultural Beliefs and Gender Variations.” *Medical Anthropology Quarterly*; 31 (2): 177-197.

Aviv, Rachel

2015 “The Refugee Dilemma.” *Conde Nast Publications*.91(39):46-55.

Becker Gay., Yewoubdar Beyene., Pauline Ken.

2000 “Memory, Trauma, and Embodied Distress: The Management of Disruption in the Stories of Cambodians in Exile.” *American Anthropological Association. Ethos.* 28(3):320-345.

Bustamante, Lineth H. U. Cerqueira, Raphael O. Leclerc, Emilie Brietzke, Elisa.

2018 “Stress, trauma, and posttraumatic stress disorder in migrants: a comprehensive review.” *Revista Brasileira de Psiquiatria.* 40(2): 220-225.

Carol R.Ember and Melvin Ember.

2004 *Encyclopedia of Medical Anthropology: Health and illness in the World’s Cultures.*

Kluwer Academic/Plenum Publishers, New York.

Cicchetti, D., Lynch, M.

1993 “Toward an ecological/ transactional model of community violence and child maltreatment: Consequences for children’s development.” In R. Ember and M. Ember *Encyclopedia of Medical Anthropology: Health and illness in the World’s Cultures.* Kluwer Academic/Plenum Publishers, 303.

Cicchetti, D., and Lynch, M.

1993 "Toward an ecological/ transactional model of community violence and child maltreatment: Consequences for children's development." *Psychiatry*, 56, 96-118.

Daly Martin Wilson Margo.

1987 "Children as homicide victims." In R. Gellens and J. Lancaster (Eds.), *Child abuse and neglect: Biosocial dimensions* pp. 201- 229.

Dube Shanta Anda, Robert F, Felitti, Vincent J, Croft, Janet B, Edwards, Valerie J, Giles, Wayne.

2001a "Growing up with parental alcohol abuse. exposure to childhood abuse, neglect, and household dysfunction." In *Child Abuse & Neglect* 25(12):1627-1640.

Dube, Shanta R. Anda, Robert F. Felitti, Vincent J. Chapman, Daniel P. Williamson, David F. Giles, Wayne H.

Edge Sara, K. Bruce Newbold, Marie McKeary.

2014 "Exploring socio-cultural factors that mediate, facilitate, & constrain the health and empowerment of refugee youth." *Social Science & Medicine* 117: 34-41

2001b *Childhood Abuse, Household Dysfunction, and the Risk of Attempted Suicide Throughout the Life Span*. *JAMA: Journal of the American Medical Association*.

Egeland Byron. Jacobvitz Deborah. Papatola Kathleen

1987 "Intergenerational continuity of abuse." In R. Gellens and J. Lancaster (Eds.), *Child abuse and neglect: Biosocial dimensions*. 255- 275.

Ember, R, and Melvin Ember.

2004 *Encyclopedia of Medical Anthropology: Health and illness in the World's Cultures*. Kluwer Academic/Plenum Publishers, New York. 301-305.

Ehnholt, Kimberly A. Yule, William.

2006 "Practitioner Review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma." *Journal of Child Psychology & Psychiatry*. 47 (12):1197-1210.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., & Koss.

1998 "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study." *American journal of Preventive Medicine*. 14(4):245-258.

Funk, Wagnalls.

2017 *New World Encyclopedia*. World Book. Chicago.

Galdston, R.

1975 "Observations of children who have been physically abused by their parents." *American Journal of Psychiatry*. 122(4): 580-590.

Garbarino, James.

1987. "The consequences of child maltreatment: biosocial and ecological issues." In R. Gellens and J. Lancaster (Eds.), *Child abuse and neglect: Biosocial dimensions*. 299-312.

Goldstein, Donna M.

2003 *Laughter out of place: Race, Class, Violence, and sexuality in a Rio Shantytown*. University of California Press. 136- 147.

Goodman, Rachael D. Vesely, Colleen K. Letiecq, Bethany Cleaveland, Carol L.

2017 "Trauma and Resilience Among Refugee and Undocumented Immigrant Women." *Journal of Counseling & Development*. 95(3):309-321.

Gelles, R. J.

1983 "An exchange/social control theory. In D. Finkelhor, R. Gelles, M. Straus, and G. Hotaling, Eds., *The dark side of the family: Current family violence research*. Beverly Hills, CA. 151-165.

Gušić, Sabina Cardena, Etzel Bengtsson, Hans Søndergaard, Hans Peter.

2017." Dissociative Experiences and Trauma Exposure Among Newly Arrived and Settled Young War Refugees." *Journal of Aggression, Maltreatment & Trauma*.26(10):1132-1149.

Hickerson, Andrea Dunsmore, Kate.

2016 "Locating refugees." *Journalism Practice*. 10(3): 424-438.

Hill, Harriet., Margaret Hill, Richard Bagge, Pat Miersma.

2016 *Healing the Wounds of Trauma How the Church Can Help*. American Bible Society. Philadelphia. 5-7.

Jason Ostrander, Alysse Melville, S. Megan, erthold.

2017 "Working with Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches, *Advances in Social Work*." Indiana University School of Social Work. 18 (1): 66-79.

Jewkes, Rachel Corboz, Julienne Gibbs, Andrew

2018 "Trauma exposure and IPV experienced by Afghan women: Analysis of the baseline of a randomised controlled trial" *Plos One*.13(10):1-15.

Jewkes, Rachel. Corboz, Julienne. Gibbs, Andrew

2018 "Trauma exposure and IPV experienced by Afghan women: Analysis of the baseline of a randomised controlled trial." *Plos One*.13(10):1-15.

Johnston, T. D.

1982 "Selective costs and benefits in the evolution of learning." *Advances in the Study of Behavior*, 12: 65-106.

Kempe, C. H., Silverman, F. N., Droegmoeller, W., Silver, H. K.

1962 "The battered child syndrome." *Journal of the American Medical Association*, 181, 17-24.

Kempe, C. H., Silverman, F. N., Droegmoeller, W., Silver, H. K.

1962 "The battered child syndrome." *Journal of the American Medical Association*, 181, 17-24.

Kleinman. Arthur, Veena Das, Margaret Lock.

1997 *Social Suffering*. The Regents of University of California Press. 245, 275,276.

Kohrt. Brandon A. Sujen M. Maharjan Damber Timsina James L. Griffith.

2012 "Applying Nepali Ethno psychology to Psychotherapy for the Treatment of Mental Illness and Prevention of Suicide among Bhutanese Refugees." *Annals of Anthropological Practice*. 36: 88-112.

Korbin, J.

1987 "Child maltreatment in cross- cultural perspective: Vulnerable children and circumstances." In R. Gellens and J. Lancaster (Eds.), *Child abuse and neglect: Biosocial dimensions* pp. 31- 55.

Korbin, J.

1987 "Child maltreatment in cross- cultural perspective: Volunerable children and circumstances." In R. Gellens and J. Lancaster (Eds.), *Child abuse and neglect: Biosocial dimensions* pp. 31- 55.

Lancaster, J. B., Gelles R. J.

1987 *Child Abuse and Neglect: Biosocial Dimensions*. Aldine de Gruyter. NY. 4-30.

Glossary: Clarkston. Art paper Magazine 2016, 62-64.

Lancaster, J. B., and Lancaster, C. S.

1987 "The Watershed: Change in parental investment and family-formation strategies in the course of human evolution." In J. B. Lancaster, J. Altman, A.S. Rossi, and L.R. Sherrod, Parenting across the life span: Biosocial dimensions. NY: Aldine, 1987.

Linton, Julie M. Choi, Ricky. Mendoza, Fernando.

2016 "Caring for Children in Immigrant Families. Vulnerabilities, Resilience, and Opportunities." In Our Shrinking Globe: Implications for Child Safety, The Pediatric Clinics of North America. 63(1):115-130.

Lutine de Wal Pastoor.

2015 "The mediational role of schools in supporting psychosocial transitions among unaccompanied young refugees upon resettlement in Norway." International Journal of Educational Development. 41:245–254.

Maxwell Carol J. C.

1989 "White Like Them: Asian Refugees in a White Christian Congregation." City & Society.3(2): 153-164.

Muhtz, Christoph Wittekind, Charlotte Godemann, Kathrin Von Alm, Christine Jelinek, Lena Yassouridis, Alexander Kellner, Michael.

2016 "Mental Health in Offspring of Traumatized Refugees with and without Post-Traumatic Stress Disorder." Stress & Health: Journal of the International Society for the Investigation of Stress. 32 (4):367.

McKinney, Kelly.

2007 "Breaking the Conspiracy of Silence": Testimony, Traumatic Memory, and Psychotherapy with Survivors of Political Violence." American Anthropological Association, *Ethos*. 35(3):265-299.

Nancy Scheper-Hughes.

1985 "Culture, Scarcity, and Maternal Thinking: Maternal Detachment and Infant Survival in a Brazilian Shantytown." *Ethos*, 13 (4): 291-317.

Pangas, Jacqueline. Ogunsiji, Olayide Elmir, Rakime. Raman, Shanti. Liamputtong, Pranee. Burns, Elaine. Dahlen, Hannah G. Schmied, Virginia.

2019 "Refugee women's experiences negotiating motherhood and maternity care in a new country: A meta-ethnographic review 2017." In *International Journal of Nursing Studies* 90:31-45.

Rohner, R.

1984 "Foundations of parental acceptance-rejection theory." Mimeographed.

Sangalas Cindy C. Jager, Justin. Harachi, Tracy W.

2017 "Effects of maternal traumatic distress on family functioning and child mental health: An examination of Southeast Asian refugee families in the U.S." In *Social Science & Medicine* 184:178-186.

Smith. S. Hansen. P., and Noble, S.

1973 "Parents of battered babies: A controlled study." *British Medical Journal*, 5(5889): 388-391.

Straus, M.

1980 "A sociological perspective on the causes of family violence." In M. R. Green, Ed., *Violence and the family*. Boulder, CO: Westview. 7-31.

Thommessen, Sara Amalie O'Toole, and Brenda K. Todd

2018 How do refugee children experience their new situation in England and Denmark? Implications for educational policy and practice. *Children and Youth Services Review* 85: 228-238.

Warner, FR.

2007" Social Support and Distress among Q'eqchi' Refugee Women in Maya Tecún, Mexico." *Medical Anthropology Quarterly*. 21 (2), pp. 193-217.

Wildt, Hillary., Umanos, Jerry. Khanzada, Nargis Karim. Saleh, Masooda. Rahman, Habib Ul. Zakowski, Sandra G.

2017 "War trauma, psychological distress, and coping among Afghan civilians seeking primary health care." *International Perspectives in Psychology: Research, Practice, Consultation*, 6(2): 81-100

Zayas, Luis H.

2018 "Immigration Enforcement Practices Harm Refugee Children and Citizen-Children." *Zero to three*.38 (3):20-25.

Minnesota Department of Health

2018 Definition: What is an ACE? Online:

<http://www.health.state.mn.us/divs/cfh/program/ace/definition.cfm>, Accessed October 1, 2018.

The National Child Traumatic Stress Network

2018 Complex Trauma <http://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma>, Accessed October 21, 2018.

What is child trauma? trauma types, refugee trauma Online: <https://www.nctsn.org/what-is-child-trauma/trauma-types/refugee-trauma/about-refugees> Accessed October 21, 2018.

APPENDIX: INTERVIEW QUESTIONS

Appendix A Questions for Interviews with Parents/Guardians

- 1- Can you tell me a little bit about yourself? Where are you from? When did you move to the United States? Did you live in another country or refugee camp before the United States?
- 2- Tell me about your experience with living situation and facilities for raising children in your home country.
- 3- Tell me about your first experience with living situation and facilities for raising children in the United States.
- 4- How many people live in your household?
- 5- How many children do you have?
- 6- How do you feel about raising children in U.S?
- 7- Do your children have separate beds and bedrooms?
- 8- Did your children ever expose to warfare or conflict?
- 9- Did your children ever expose to the death of a very close family or friend?
- 10- Is there any violence in your neighborhood or apartment complex?
- 11- How do you feel about living in U.S. and your neighborhood?
- 12- How do you think about differences in living in U.S and your country? How do you feel being here?

- 13- Do you think your feelings and stresses at that time or even now might effect on your behavior toward your children? if so, how?
- 14- On your first entrance to U.S., what was your first impression? How did you feel?
- 15- Do you live with your partner/ and is he/she is the biological parent of your children?
- 16- If no, how do you feel about that? Do you think it affects your relationship with your children? how? What is your general impression about this situation?
- 17- How much you feel support from your partner/husband/wife raising children?
- 18- Do you usually argue with your partner in front of your children?
- 19- Did you experience any financial stressful situation since you came to U.S.?
- 20- In those situations, do you think it's been difficult for your children?
- 21- Are your children in school?
- 22- What are some of the things that you think are most difficult for your children in adjusting to life in the United States?
- 23- In your opinion, what is the most positive experience you had in relation to raising children since you came to U.S.?
- 24- What is the most negative experience you had in relation to since you came to U.S.?

Appendix B Staff interview questions

- 1- Please tell me that how you became familiar with Family Heritage Foundation and explain about your education and your other experiences before starting your work at FHF.
- 2- As a staff, how long have you been working at FHF?
- 3- How do you define childhood trauma?
- 4- What is your understanding of differences between normal child and traumatized child?
- 5- Tell me about a time you worked with a child who was exposed to trauma. How did you react and deal with those children?
- 6- What might you do in your job to support traumatized children? Tell us about a “success story”—a children and their family that you have had an important role in making a difference in their treatment. What were the problems, and what did you do to make a positive impact?
- 7- Please describe how you will provide feedback to some parents or other caretakers who have been exposed to stressful living conditions which affects their interactions with their children?
- 8- Describe your experience working with children with histories of high levels of aggression, trauma, or violence.
- 9- What techniques have you found to be effective in developing trusting relationships with children’s’ parents?
- 10- Give me some examples of how you engaged a distrustful or distant family in the past.
- 11- What was the most difficult work problem you ever encountered? How did you resolve the problem?