

A FAITH-DRIVEN PROTOCOL ON GRATITUDE, FORGIVENESS, AND STRESS FOR
CHIN REFUGEES FROM BURMA: AN EXPLORATORY STUDY

by

Sally Goh

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

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ABSTRACT

The influx of immigrants from a diverse cultural and religious tradition into the United States has renewed counselors' and researchers' interest in how collectivistic populations from a refugee background experience pre-settlement and post-settlement stress in this country. Refugees who have experienced trauma before their settlement are more likely to experience increasing psychiatric pressure from daily stressors such as language barriers, employment difficulties, familial and generational conflicts, and dwindling psychosocial support. However, some refugee populations, such as the Chin people from Burma, have a low-uptake of help-seeking for their psychological problems, leading to more insufficient adjustment to the host culture. Since the Christian faith and the exercise of spiritual disciplines play a critical role in the mental and subjective health of the Chin population, this researcher conducted a workshop to teach a faith-driven approach (also known as GRACE). This exploratory study will describe the development, rationale, and implementation of the protocol. In the outcome analysis using paired sample T-test, participants who practiced the protocol experienced a statistically significant reduction in psychological distress and improved levels of gratitude and motivation to forgive. The researcher also reports on the lessons learned from this ethnic minority study, including the limitations of recruitment, randomization, the assessment procedures, and retention of participants.

Keywords: Burma, Chin, grace, refugee, faith-driven, daily stressors

Dedication

This manuscript is dedicated to the memory of my late parents, who left their homeland and made many loving sacrifices for our future.

Acknowledgments

The LORD your God is in your midst, a mighty one who will save. He will rejoice over you with joy. He will calm you in his love. He will rejoice over you with singing. (Zephaniah 3:17).

I want to give all glory and honor to God, who called me into His marvelous light and this abundant life in His Son, my Lord Jesus Christ. First, I am thankful for my best friend and spouse, Yat Por, my three children, and their spouses who loved me and encouraged me throughout the Ph.D. journey. I also want to acknowledge my ever-growing extended family (n=61). To my parents-in-law who loved us sacrificially, and gave us their joyous blessings to go back to school ten thousand miles away from them: To my siblings and my in-laws, my nieces, nephews, and their spouses who loved me: A big thank you to you all.

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TABLE OF CONTENTS

Acknowledgments.....	v
List of Tables	xii
List of Figures.....	xiii
List of Abbreviations	xiv
CHAPTER ONE: INTRODUCTION.....	1
Terms in Refugee Studies	1
The Problem.....	6
Background of the Problem	7
Purpose of the Study	10
Research Questions	11
Limitations/Delimitations	12
Limitations	13
Significance of the Study	14
Theoretical and Conceptual Framework.....	15
Organization of Remaining Chapters.....	17
Summary	18
CHAPTER TWO: REVIEW OF THE LITERATURE	19
Burmese Chin Experience.....	20
Burma (Myanmar)	20

History of Present Conflict	24
Pre-Settlement and Settlement Issues	25
Pre-Flight	26
Pre-Settlement Challenges	27
Resettlement in the United States	29
Mental Health of Refugees	36
Protective Factors.....	37
Psychological Evaluation.....	38
Interventions for Trauma	39
Trauma-Focused Approach.....	42
Psychosocial-Focused Approach	43
Cognitive-Behavioral Therapy (CBT)	43
Narrative Emotion Therapy (NET).....	46
Religious and Spirituality-Oriented Approach	48
Historical Background	49
Positive Psychology	50
Psycho-Spiritual Framework	59
Spirituality-Based Intervention.....	59
Christian Devotional Meditation.....	60
An Overview of GRACE Protocol.....	61

What is GRACE Protocol?	61
Rationale for the Protocol	62
Summary	72
CHAPTER THREE: METHODS	74
Research Design.....	74
Research Questions.....	75
Methodology	77
Selection of Participants	77
Random assignment	78
Psychoeducation Workshop.....	79
Procedure	79
Instrumentation	80
Measure for Post-Settlement Stress	81
Measure for Spiritual Constructs	82
Data Processing and Analysis.....	86
Summary	86
CHAPTER FOUR: RESULTS	88
Analysis.....	88
Sample Demographics	88
Restatement of Purpose.....	91

Research Question One.....	91
Research Question Two	92
Research Question Three	94
Research Question Four.....	95
Research Question Five	98
Further Analysis.....	99
Summary.....	103
Summary.....	104
Lessons Learned.....	105
Conclusions.....	110
Other Limitations	110
Implications for Practice.....	111
Follow-up Visit.....	112
Potential Future Modifications	112
Implications for Future Research.....	113
Discussions	115
REFERENCES	118
APPENDIX A.....	167
APPENDIX B.....	173
APPENDIX C.....	212

APPENDIX D.....	213
APPENDIX E.....	214
APPENDIX F.....	215
APPENDIX G.....	216

List of Tables

Table 1: Components of the GRACE Protocol.....	70
Table 2: Country of Transit.....	89
Table 3: Paired T-test Analysis of RHS-15 Pre- and Post-Intervention	92
Table 4: Paired T-sample analysis of pre- and post-intervention GQ-6 scores	93
Table 5: Paired T-Sample Analysis of Pre- and Post-Intervention TRIM-12 Scores.....	94
Table 6: Paired T-Sample Analysis of Pre- and Post-Intervention SWLS Scores	95
Table 7: Paired T-Sample Analysis of Pre- and Post-Intervention DSES Scores	97
Table 8: Descriptive Analysis.....	99
Table 9: DSES Scores for Male and Female	99
Table 10: Bivariate Pearson Correlation Analysis.....	101
Table 11: Mean RHS-15 Scores of Groups 1, 2 And 3	102
Table 12: Summary of Paired Analysis	105

List of Figures

Figure 1: Mediation by Daily Stressors (adapted from Miller & Rasmussen, 2010, p. 9)	5
Figure 2: Summary of Stress and Cumulative Stress Identified from the Literature	35
Figure 3: The Components of the GRACE Protocol	61
Figure 4: The Biopsychosocial-Spiritual Domains Under Threat	72
Figure 5: Percentage of Participants	89
Figure 6: Flowchart of Study Participants	90
Figure 7: Pre-RHS-15 scores and Post- RHS-15 scores.....	91
Figure 8: Pre- GQ-6 Scores and Post- GQ-6 Scores	93
Figure 9: Pre-TRIM-12 Scores and Post-TRIM-12 Scores	95
Figure 10: Pre- SWLS Scores _(n=15) and Post- SWLS Scores _(n=15)	96
Figure 11: Pre- DSES Scores and Post-DSES Scores	98
Figure 12: RHS-15 _(n=43) Across Groups 1, 2 and 3	102

List of Abbreviations

Altruism Born Of Suffering (ABS)

American Counseling Association (ACA)

Bureau for Population, Refugees, and Migration (BPRM)

Centers for Disease Control and Prevention (CDC)

Christian Devotional Meditation (CDM)

Cognitive-Behavioral Therapy (CBT)

Council for Accreditation of Counseling and Related Educational Programs (CACREP)

Culturally-Adapted CBT (CA-CBT)

Daily Spiritual Experience Scale (DSES)

Eye movement desensitization and reprocessing (EMDR)

Gratitude Questionnaire-Six Item Form (GQ-6)

International Organization for Migration (IOM)

Interpersonal Psychotherapy (IPT)

International Rescue Committee (IRC)

Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ)

Medial Prefrontal Cortex (MPC),

Migration Policy Institute (MPI)

Narrative Therapy (NT)

National Institute for Clinical Excellence (NICE)

National Institute of Mental Health (NIMH)

National League for Democracy (NLD)

Narrative Emotion Therapy (NET)

Office of Refugee Resettlement. (ORR)

People Living with HIV/AIDS (PLWHA)

Political Prisoners (PPs)

Posttraumatic Stress (PTS)

Posttraumatic Stress Disorder (PTSD)

Randomized Control Trial (RCT)

Refugee Health Screener (RHS-15)

Refugee Health Technical Assistance Center (RHTAC)

Satisfaction with Life Scale (SWLS)

Transgression-Related Interpersonal Motivations Measure (TRIM-12)

Trauma-Focused Cognitive Behavioral Therapy (TFCBT)

Transcultural Psychosocial Organization (TPO)

United Nations High Commissioner for Refugees (UNHCR)

United Nations International Children's Emergency Fund (UNICEF)

U.S. Refugee Processing Center (USRPC)

CHAPTER ONE: INTRODUCTION

Refugees frequently epitomize this modern trope of human suffering; silent and anonymous, they signify both universal humanity and the threat of the pre-modern and uncivilized, which they have supposedly barely survived (Hinton, 2002, p. 21-22).

This chapter begins with a discussion of the problem under study, followed by a discourse on the background and the rationale for creating a non-clinical intervention meaningful to the Chin refugee population. The chapter will also delineate the relevance of natural treatment to the scholarship on trauma and faith-driven interventions. It will also provide the study's purpose, the research questions, including several possible study limitations.

The recent media reports and images of thousands upon thousands of refugees desperately fleeing the political and religious war in the Middle East by perilous means to reach safety in other European countries have captured the hearts and minds of citizens around the world (International Rescue Committee [IRC], 2016). These images of human misery and displaced people's death are reminiscent of Hinton's (2002) words cited above.

Terms in Refugee Studies

Refugees.

According to the United Nations High Commissioner for Refugees (UNHCR; 2016) and other refugee literature, refugees are civilians, ordinary people who have experienced forced displacement from homes and land, and other human right violations in their country of origin (Farr, 2005; Kamler, 2009; Lutfy, Cookson, Talley, & Rochat, 2014; Miller & Rasmussen, 2010; Priebe et al., 2010). Although there are 65.3 million displaced people worldwide, only 16.1 million are classified and registered as refugees with the UNHCR.

Chin.

In this study, *Burmese* refers to all majority and minority ethnic groups of Burma (Spoorenberg, 2013). The 2010 U.S. Census recorded a total of 100,200 people who claimed their country of origin or ancestry from Burma. However, Burma has one majority group, the Burmans, which constitutes almost 80% of the total population (Spoorenberg, 2015). The Chin people are one of the several minority ethnic people groups. Within the Chin ethnic groups, there are at least eight other sub-groups, each with their unique language. Hence, a Chin may introduce herself as a Hakha Chin or Tedim Chin. A secondary name such as Burmese Chin or Chin from Burma for the people group will be used in this study to mean the whole ethnic Chin minority people group to avoid confusion of the terminologies.

Pre-flight.

The pre-flight is defined as between the displacement from their homes and their actual departure from their country of origin (Burma). Some literature uses the term pre-migration or pre-displacement, and both terms are also used interchangeably in this project. However, pre-flight also includes the brief internal displacement period experienced by some of the Chin refugees.

Flight.

Subsequent flight from their country of origin describes the journeying by sea or land to a neighboring country that is usually unwelcome. The flight is also known as the period of post-displacement. For the Burmese people, the flight comprises fleeing by foot through the tropical jungles to Burma and Thailand (Rhoden & Rhoden, 2011).

Pre-settlement.

Pre-settlement encompasses pre-flight, flight, and living in a country of exile. Countries of exile are temporary host countries in Asia, such as Bangladesh, India, Malaysia, and Thailand

(Shukla, 2008). The term pre-migration is used occasionally, but it is not an accurate term as it may describe the condition of pre-flight only. Events such as a prolonged stay in an UN-sanctioned institutionalized facility or a government-run refugee camp, the non-resolution of refugee status, and the uncertainty about future settlement prospects can contribute towards refugees' persistent anxiety, depression, feelings of hopelessness, and mental distress (Steel, Frommer, & Silove, 2004; Steel et al., 2011). The Chin participants of this study took to Malaysia through Thailand.

Settlement.

Of the 16.1 million refugees of concern to UNHCR, only a minuscule percentage (approximately 1%) are resettled annually in a Western country (UNHCR, 2016); in other words, a vast majority will languish for years in a transit or third world temporary host country. Unfortunately, refugees' plight or refugeehood represents one of the modern world's bleakest realities, and their resettlement in another country is only a piecemeal solution to a colossal problem.

Transit country.

Most refugees escape to the nearest neighboring country, whose authorities are sometimes hostile to their undocumented presence (Figure 1). The Chin refugees who resettled in the United States., Europe, or Australia come from Malaysia, where they usually reside for between two to ten years while undergoing the process of registering with the UNHCR and applying for resettlement (Alexander, 2008).

Post-settlement.

The term post-settlement or post-migration describes the period living in the new host country, such as the U. S., a European country, Australia, or another signatory nation of the Refugee Convention (1951). These countries receiving the refugees also granted them conditional permanent residency. Subsequently, this residency visa would allow them to legally apply for citizenship, usually after a few years of working and residing without incidents, in the host country.

Daily stressors.

Daily stressors are persistent stress from urban living, unemployment, poverty, overcrowded housing, living in dangerous neighborhoods, language barriers, and difficulties accessing mental health care (Figure 1). Daily stressors can jeopardize longer-term health trajectories (Beiser, 2009; Beiser, Hou, Hyman, & Tousignant, 2002; Boothby, Strang, & Wessells, 2006; Edberg, Cleary, & Vyas, 2010; Fernando, Miller, & Berger, 2010; Lum & Vanderaa, 2010; Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008). In several studies, daily stressors accounted for more variance than the psychological sequelae of exposure to violence during pre-settlement, for women and youths (Fernando et al., 2010; Miller et al., 2008).

Post-traumatic stress (PTS).

PTS (Figure 1) is psychological stress derived from the refugees' exposure to violence experienced before settlement or pre-settlement (Neuner & Elbert, 2007), while adjustment stress is post-traumatic stress compounded by daily stressors during post-settlement (Miller & Rasmussen, 2010; Silove, 1999; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011).

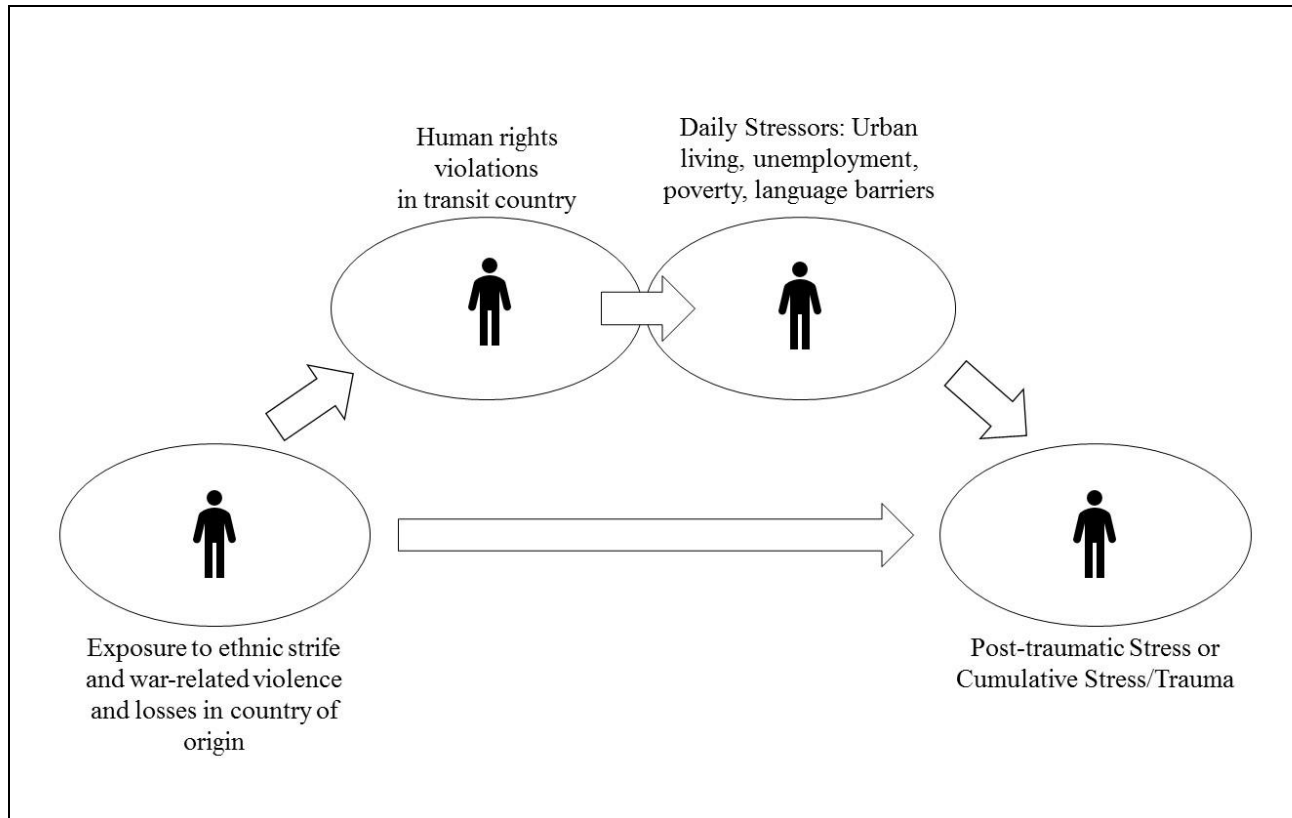


Figure 1: Mediation by Daily Stressors (adapted from Miller & Rasmussen, 2010, p. 9)

Trauma-focused advocates such as Neuner and Elbert (2007) postulate that treating posttraumatic stress (PTS) will improve mental health and the refugee's coping skills in dealing with daily stressors.

Cumulative stress or trauma.

Cumulative stress or trauma (as depicted in Figure 1) often results from acute or chronic situations that are unusual such as the refugee status and daily stressors. Post-traumatic stress disorder (PTSD) is frequently used in refugee studies to exemplify repetitive, cumulative, and increasingly stressful occurrences over their duration. Also, cumulative stress defined for this paper is a combination of PTSD and daily stressors (Norredam, Garcia-Lopez, Keiding, & Krasnik, 2009; Schweitzer et al., 2011). There is additional empirical evidence supporting the dose-effect relationship and the relation between cumulative stress patterns and different patterns

of post-traumatic stress, which is a subject for another research (Norredam et al., 2009; Schweitzer et al., 2011).

The Problem

PTSD is a chronic, unremitting, and psychosocially debilitating disorder that affects 7-8% of the general population (National Institute of Mental Health [NIMH], 2016), and varying between a modest 8% to a high of 40% among the refugee population (Fazel, Wheeler, & Danesh, 2005; Gerritsen et al., 2006; Schweitzer et al., 2011; McColl & Johnson, 2006; Slewa-Younan, Guajardo, Heriseanu, & Hasan, 2015; Steel et al., 2009), with one refugee study reporting a high prevalence rate of 74% for PTSD (Sieberer, Ziegenbein, Eckhardt, Machleidt, & Calliess, 2011).

For some refugees, their unremitting PTSD and other adjustment-related stress symptoms can persist years after their resettlement because of the compounding effect of pre-settlement trauma on daily stressors (Hollifield et al., 2013; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Priebe et al., 2009; Vinson & Chang, 2012). Adults with PTSD and adjustment-related issues often exhibit comorbid problems in several domains of functioning, such as depression (Steel et al., 2004; Steel et al., 2011), anxiety (Schweitzer et al., 2006), and somatic problems (Rohlof, Knipscheer, & Kleber, 2014; Vinson & Chang, 2012).

Research also shows a strong correlation between untreated psychiatric illnesses and a host of psychosocial risks such as substance use (Ullman, Relyea, Peter-Hagene, & Vasquez, 2013), social isolation, homelessness (Deckert et al., 2015; Fazel, Khosla, Doll, & Geddes, 2008; McColl & Johnson, 2006), and suicidal behaviors (Ao et al., 2012; Centers for Disease Control and Prevention [CDC], 2013; Hagaman et al., 2016).

More important, although evidence-based interventions such as trauma-informed cognitive-behavioral therapy (TF-CBT) and eye movement desensitization and reprocessing (EMDR; Shapiro, 1989a/1989b/1991) treatments are known to decrease symptoms of post-traumatic stress disorder (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013); research using these interventions is limited among the ethnic minority refugee populations (Eshun & Gurung, 2009; Spring et al., 2003).

Generally, some refugee populations are likely to underutilize mental health services because of their internalized cultural stigma of mental illness (Chung & Bemak, 2007; Kim et al., 2015) and fear of Western pharmacotherapy or their preference for alternative treatment (Gozdziaik, 2004; Highfield, Lama, Grodin, Kaptchuk, & Crosby, 2012; Longacre, Silver-Highfield, Lama, & Grodin, 2011; Slewa-Younan, Guajardo, Heriseanu, & Hasan, 2015; Van Wyk, & Schweitzer, 2014). Other challenges include time-limited psychosocial support (Murray, Davidson & Schweitzer, 2010) and a decrease in access to the correct healthcare services because of language barriers and their religious beliefs (Bienenfeld & Yager, 2007; Milosevic, Cheng, & Smith, 2012; Moore-Thomas & Day-Vines, 2008; Oleson et al., 2012; Vermette, Shetgiri, Al Zuheiri, & Flores, 2015; Vukovich, 2016). Finally, programs to treat ethnic minority populations are also limited in their outreach (Edberg et al., 2010; Knight, Roosa, & Umaña-Taylor, 2009; Spring et al., 2003), especially after the initial two years of resettlement.

Background of the Problem

Since the end of World War II, the United States has been a country of refuge to over 20 million refugees and asylum-seekers accepted through the UNHCR (U.S. Refugee Processing Center [USRPC], 2014). And in recent years, the United States has been receiving ethnic minority refugees and asylum-seekers from Burma in increasing numbers (USRPC, 2014). These

refugees were part of the over two million people displaced by the protracted civil conflict in Burma, also known as the century's longest ethnic strife (Shukla, 2008; Thawngmung, 2012; UNHCR, 2015). Along with the suffering from displacement violence trauma in their country of origin, many of these Burmese refugees have also encountered exile-related stress such as poverty, hunger, detention, and the separation and/or loss of loved ones prior to their resettlement in the United States (Alexander, 2008; Steel et al., 2006).

According to the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013), the basis for identifying the context of the experience of illness is first to understand the culturally constructed identity of the individual, from either the group identity or ethnicity. Since culture, race, and ethnicity are central to the operative, diagnostic assessment, treatment planning, case management, and investigation of health disparities are salutogenic resources that mediate adaptation and coping (APA, 2013; Borwick, Schweitzer, Brough, Vromans, & Shakespeare-Finch, 2013; DeJong, 2004; Kohrt et al., 2014).

However, not all arriving refugees are given a full psychological assessment (Hollifield et al., 2002; Hollifield et al., 2013; Savin, Seymour, Nguyen-Littleford, Bettridge, & Giese, 2005; Taylor et al., 2013) using the diagnostic taxonomy for PTSD or depression of the DSM-5 (APA, 2013) because of the long and complicated resettlement process, the cultural gap between the interviewer and the interviewee, the inherent language barrier, the refugees' internalized cultural stigma of mental illness (Chung & Bemak, 2007; Kim et al., 2015), and their want of empowerment to negotiate for care (Courtois, 2008; Laddis, 2011; Rosbrook and Schweitzer, 2010; Schweitzer et al., 2011).

Additionally, many refugee resettlement agencies providing mental health screening often use informal interviewing rather than the standardized clinical measures or protocols

(Hollifield et al., 2013; Shannon et al., 2012; Vukovich, 2016). Conversely, researchers should not arbitrarily apply the concept of PTSD to non-western populations because of the variability of their pre-settlement experiences (Johnson & Thompson, 2008; Miller & Rasmussen, 2010; Vinson & Chang, 2012). Finally, many incoming refugees tend to under-report their health concerns for fear of not qualifying for residency visas or citizenship (Kuile, Rousseau, Munoz, Nadeau, & Ouimet, 2007).

Regardless of the challenges, the concept of “nonmaleficence” within the American Counseling Association [ACA] Code of Ethics requires the counselor to do “no harm” to the clients. Hence, if clients will only accept interventions that are congruent with their perception of the disorder within their cultural and spiritual values, the counselor is ethically bound to engage with them using the ethnomedical model as a possible frame of reference (Ahn et al., 2006; Barimah & Van Teijlingen, 2008; Berthold et al., 2007; Edberg, Cleary, & Vyas, 2010; Gozdzia, 2004; Oleson et al., 2012).

In other words, it is ethical to include the practice of spiritual disciplines if spirituality plays a critical role in the identity of a person from a religious background (Mohr, 2006). According to the literature, 80-90% of the Burmese Chin are professing Christians (Alexander, 2008; Christians, Burma, Ling, & Mang, 2004; Sakhong, 2003); hence, it is reasonable to teach a culturally-adapted and/or faith-driven intervention in their community (Griner & Smith, (2006). This rationale also resonates with previous research that concludes educational interventions are acceptable to the minority population and can be potentially efficacious in increasing mental health awareness as well as in improving the utilization of mental health services (Murray et al., 2010; Teng & Friedman, 2009; Van Wyk & Schweitzer, 2014).

Purpose of the Study

Given the significance and scope of risks associated with untreated post-traumatic stress and adjustment-related symptoms, the development of effective treatments that target multiple functioning domains is a critical public health need. Such limitations motivate a culturally adaptable or sustainable community intervention for the psychological distress that also values their religious background (Griner & Smith, 2006; Patil, Maripuu, Hadley, & Sellen, 2015). The current study contributes to the existing literature by evaluating the efficacy of a faith-driven protocol to improve the biopsychosocial-spiritual domains of participants whose religious faith is salient of their spiritual schemas and collectivistic worldview.

This study has one overarching purpose: to test the GRACE protocol's feasibility as a culturally adapted and community-based treatment that recognizes post-settlement daily stressors and adjustment-related symptoms. And this primary objective can be further broken down into the following sub-objectives:

1. To develop an integrated approach from current literature to address the pre- and post-settlement stress found among a religious-ethnic minority group from a refugee background.
2. To use the theoretical understanding gained in the first objective to guide the development of a workbook for the Christian Chin refugee population (Appendix C).
3. To test the GRACE protocol's feasibility by measuring spiritual health indicators' operationalized constructs such as gratitude, motivation to forgive, and psychiatric distress, pre-and post-intervention.
4. To generate preliminary data for a future randomized control trial (RCT).

5. To determine the acceptability of the intervention to inform the direction of the next phase of research.

The researcher is unaware of published or unpublished empirical studies of a faith-driven and community-based intervention for the Chin refugees from Burma who have experienced trauma. Hence, this study has the potential to be a notable contribution to the literature on faith-driven treatment of refugee trauma. While culturally adapted and trauma-informed cognitive-behavioral therapy (CBT) has demonstrated efficacy for many psychiatric problems, including PTSD among refugees, it has not previously been explicitly adapted to this refugee population's religious faith. Besides, researchers have only tested spirituality informed CBT among the college student population (Good, 2010). In Chapter Two, the investigator will conceptualize the trauma from a biopsychosocial-spiritual framework before developing the intervention based on CBT's theoretical principles and tenets.

Research Questions

This study represents an innovative approach to exploring a critical issue that research has not been adequately addressed in the clinical or empirical literature: using a faith-driven intervention in the safety of the population's community meeting place to ameliorate daily stressors and past trauma. And the following five research questions will guide the investigative study by measuring the change in biopsychosocial-spiritual wellness among the participants who practiced the protocol compared to those who did not.

1. Does the GRACE protocol practice for five weeks resulted in reducing somatic and psychological problems as measured by the Refugee Health Screener-15 (RHS-15; Hollifield et al., 2013) at post-intervention?

2. Will there be an improvement in gratefulness as measured by Gratitude Questionnaire-6 (GQ-6; McCullough, Emmons, & Tsang, 2002) among the participants who practiced the GRACE protocol?
3. Will there be a lowering of avoidance and a tendency to seek revenge (or an improvement in the motivation to forgive) measured by (TRIM-12) at post-intervention?
4. Will there be an increase in the participants' wellbeing as measured by the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen & Griffin, 1985) and their spiritual condition as measured by the Daily Spiritual Experience Scale (DSES; Underwood, 2006/2011; Underwood & Teresi, 2002) among the participants who practiced the GRACE protocol?
5. What lessons are learned from this randomized control trial (RCT) among an ethnic minority refugee population?

Limitations/Delimitations

According to Knight et al. (2009), two factors influence the generalizability of research findings: The sampling context and the research design. In other words, generalizability depends on the accessibility of the target population. Hence, this study has limited generalizability due to the convenience sample selection of an ethnic minority Chin people group who are actively involved with their Christian community in the United States. Since the purpose of this study is to test the feasibility of using the protocol GRACE (taught in a brief four-hour workshop within the Chin community meeting place), the results cannot be generalized to other ethnic minority refugees or group counseling and individual counseling.

Although it is possible to adapt the faith-driven intervention to another religion, the protocol's operational constructs (grace, forgiveness, gratitude) may not be pertinent to another

faith. The intervention's focus will be the daily practice of the protocol to facilitate daily stress; the study cannot elucidate other components' role and their associated dynamics such as personality, predisposition, previously learned coping skills or personal protective factors that may influence the outcome of the intervention.

Limitations

The boundaries of this quantitative study include potential transcultural measurement error and sampling biases. Measures were explicitly chosen to measure the biopsychosocial-spiritual constructs rather than their past psychometric performance. However, the researcher endeavored to maintain the psychometric value within reasonable limits because of the cross-cultural nuances and the standard translation–back translation methods. Additionally, the researcher, translators, and interpreters' cultural competency were not formally assessed and vetted. Also, the participants were expected to self-select to participate in the study since their pastor requested their full cooperation with the survey researcher. Finally, prior experience in using mindfulness or other relaxation medication to alleviate stress was not assessed and explored for their moderating effects because of inadequate sample size and specific previous experience measures. Finally, the outcome relied entirely on self-report measures that may be more vulnerable to confounding constructs, such as response bias.

Working with interpreters. This study involved three languages: The Burmese (Sanskrit), the Chin (Roman characters) languages, and the English language. A native Chin speaker from Burma (who is also fluent in the spoken and written the Burmese language) and with more than forty years of experience in the religious teaching and the cultural aspect of the refugees, assisted in translating the consent form (Appendix A), measures, workbook, notes, and power-point slides (Appendix C– H). Also, the researcher used two Chin interpreters (college

students) during the workshop. The interpreters' role at the workshop was necessary to clarify the meaning of items in the workbook (Appendix C) and the instructions of the protocol with participants because of the presence of several members who were not literate in the written Chin or Burmese language. Since the researcher has limited knowledge of their heart language, she involved the church's pastor and leaders in the interpretation during the workshop. The researcher is aware that limitations to language nuances' accuracy in instances of interpreting psychological terminologies existed. Hence, the researcher limited her use of such vocabularies when she was teaching the protocol.

Significance of the Study

There is a growing awareness that there is a mental health service disparity among the refugee population (Des Meules et al., 2005). And yet, refugees are at a higher risk of struggling with a mental illness than the general population because of pre- and post-settlement stress (Beiser & Hou, 2001, 2006; Fazel et al., 2005). Sue and Chu (2003) argued that Asian ethnic minorities experience mental distress differently from other ethnic minority populations. Also, studies using intervention to address the refugee population's posttraumatic stress and daily stressors within the context of their cultural values and religious faith are scarce (Patil et al., 2015). Hence, this study seeks to expand the understanding of intervening at the community level using a faith-driven protocol to lessen the effects of daily stressors by improving their levels of gratitude and their propensity to forgive. Additionally, using a faith-driven intervention is consistent with the contention that counselors should be multiculturally competent to treat religious clients with approaches that are well integrated with their belief systems, cultural values, and living experiences (Akinsulure-Smith, Ghiglione, & Wollmershauser, 2008; Alexander, 2008; American Counseling Association Code of Ethics, 2014; Bergin & Jensen,

1990; Bienenfeld & Yager, 2007; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015; Kira, et al., 2012; Loewy, Williams, & Keleta, 2002; Moore-Thomas & Day-Vines, 2008; Papadopoulos, 2007; Sakhong, 2003; Sue & Sue, 1999; Young, Wiggins-Frame, & Cashwell, 2007). Furthermore, Cashwell and Young (2011) suggest that working within the clients' value or belief systems will generate more desirable counseling outcomes.

The outcome of this randomized control trial is anticipated to be meaningful to the Chin population from a refugee background because of their low uptake of mental health services for their post-settlement difficulties. Moreover, there are clear expectations that using a psychoeducational approach to teach a protocol will render the process efficacious for improving their subjective wellness. A protocol taught in a community setting will not single out any groups of people for intervention. This research challenges the view that psychology is universal. The Western pharmacotherapy model based on the paradigms of individualistic worldview is rigorously ubiquitous; it further offers a multimodal educational approach that is multiculturally and religiously sensitive for a population with a low uptake of mental health services.

Theoretical and Conceptual Framework

There are several theoretical and conceptual approaches to understanding trauma among adult survivors. However, any theory or model relevant to trauma treatment must provide a basis for understanding the psychological, interpersonal, and intrapersonal effects of trauma on the refugees' biopsychosocial and spiritual domains. However, despite the robust findings relating to trauma, no model can adequately capture the survivors' traumatic experiences of the Holocaust or Killing field (Power, 2013). Evans (1993) instead postulated that to know people and appreciate their experiences, one must first understand their ways of construing and interpreting

their worldview. Accordingly, refugees who lived through being uprooted and displaced thousands of miles from their families, communities, familiar surroundings, and culture will frequently suffer from post-traumatic stress symptoms because of their exposure and losses.

Silove's (1999) trauma model explains that stress disrupts refugees' dynamic and complex acculturation process to produce distress (also in Burstow, 2003; Kira, Fawzi, & Fawzi, 2012; Sam & Berry, 2006). However, within some refugee populations, the individuals would also experience guilt for leaving loved ones behind in their country of origin because of their strong collectivistic worldview (Schweitzer et al., 2006; Silove, 1999).

In contrast, Kira (2004) said trauma theory has a dualistic terminology depending on the traumatic stress trigger. Type I trauma is developmentally based. Instances of type I trauma are related to attachment issues, abandonment by parents of a child, and personal violations such as rape, sexual or physical abuse (Kira, 2004). In contrast, type II trauma covers the objective characteristics of traumatic events that are pervasive and chronic. It includes cumulative stress trauma experienced by the refugee population, including collective trauma (such as targeted genocide and discrimination). The type I trauma model finds support in another study that postulates the interaction of the persons and their environment in the immediate aftermath (proximal) and the long-term aftermath (distal) to function as triggers that exacerbate posttraumatic symptoms (Pynoos, Steinberg, & Piacentini, 1999). For instance, parent-reported financial hardship correlates with poorer mental health in their children, while perceived discrimination (Type II trauma) produces psychiatric distress (Jasinskaja-Lahti, Liebkind, & Perhoniemi, 2006).

In the refugee population, when the individuals' "personal safety, attachment, and bond maintenance, justice, existential-meaning, and identity/role functioning" (Warfa et al., 2012, p.

2) is violated, any further exposure to stress such as acculturation or discrimination in the form of daily or regular stressors can produce heightened powerlessness, and helplessness (Silove et al., 2007). Some culture expresses such distress as somatic symptoms or feelings of fear, anxiety, and guilt and shame (Kira et al., 2012; Nickerson et al., 2010; Sam & Berry, 2006). According to Budden (2009), shame can be experienced individually and collectively. In Asian culture, shame is an unpleasant feeling of exposure and censure to preserve the family and community's moral integrity and is often experienced collectively. Fessler (2007) posits that shame involves "the recognition of one's inferior social status and associated aversive feelings" as well as the "the painful recognition of the self's failure to conform to social norms and expectations" (as cited in Budden, 2009, p.1034).

More importantly, because most of the Chin population embrace the Judeo-Christian faith and come from traditional intact families and collectivistic societies, the researcher will use the type II trauma classification as the framework to explain their psychological distress face of daily stressors. The researcher proposed that when the Chin refugees apply grace or compassion to themselves (through the daily practice of the protocol), they become more able to forgive themselves and others and accept their past and current stressors as part of their reality in the new host country. Underscoring this rationale is the proposal that the protocol's practice will also improve their gratefulness and satisfaction with life, as their biopsychosocial issues are reduced.

Organization of Remaining Chapters

In Chapter Two, the researcher reviews the literature relating to the Burmese Chin refugee experience, and their mental health at post-settlement in high-income countries, within the context of their pre-settlement experiences. It will also draw on evidence-based treatments conducted for the refugee population here in the United States and overseas. Following that, the

focus shifts to the discourse of spirituality-oriented and faith-driven interventions in past research. The chapter will conclude with the theoretical framework for the systematic development of the protocol. Chapter Three, on the other hand, describes the research design that the researcher employed for the exploratory study, in addition to describing the community-placed location, selection criteria of participants, the psychoeducation workshop, instruments used, and how the data will be analyzed. In Chapter Four, a discourse dedicated to the data analysis and generation of the meaning of the results. Finally, Chapter Five discusses the literature outcomes on refugee studies and the limitations, implications of the findings, and suggestions for future research.

Summary

Mental health practitioners in North America, Europe, and Australia have attended to the new arrivals' mental health needs using a Western psychiatry model and the diagnostic criteria for PTSD (Bird, 2013). Given the salience of their exposure to violence trauma, most studies with arriving refugees assume that all their psychological distresses were the direct and indirect results of their pre-settlement experiences. However, in recent years, there is a change in underlying assumptions of clinical and research work from just pathologizing refugees' post-traumatic stress experiences to using models that include post-settlement daily stressors in the conceptualization. Additionally, mental health practitioners are compelled by their ethics code to use an intervention that honors the refugees' cultural values and religious faith. Hence, there is increased interest in clinical practitioners employing culturally appropriate interventions in communities of underserved ethnic minorities and populations from a refugee background.

CHAPTER TWO: REVIEW OF THE LITERATURE

It is important to remember the obvious fact that becoming a refugee is not a psychological phenomenon per se; instead, it is exclusively a sociopolitical one, with psychological implications (Papadopoulos, 2007, p. 301).

A review of the literature on the lived experiences and health service disparity of the refugee populations revealed a plethora of quantitative and qualitative research focusing on the prevalence and treatment of post-traumatic stress disorder (PTSD) and its allied co-morbidities such as depression and anxiety (Birman & Tran, 2008; Carlsson et al., 2005; Fazel et al., 2005; Palmieri, Marshall, & Schell, 2007; Rasmussen, Smith, & Keller, 2007; Steel et al., 2004; Steel et al., 2011; Tran, Manalo, & Nguyen, 2007); however, there is a research gap in studies specific to the Burmese community. However, this review will focus on the conceptualization and measurement of mental distress relevant to the Southeast Asian or Burmese refugee population (Lee & Lim, 2008; Poston & Hanson, 2010).

Besides, the focus will be on studies that encapsulate the pre-and post-settlement experiences of the Burmese resettled in developed countries. Additionally, it will also examine burgeoning research that uses cognitive-behavioral therapy (CBT), culturally adapted CBT (CA-CBT), and variations of CBT psychotherapy to treat adjustment-related distress (Bisson et al., 2013; Hinton & Lewis-Fernández, 2011; Hinton, Pich, Hofmann, & Otto, 2013). More important, it will distill existing information on the complexity of cumulative trauma by focusing on interventions that honor the participants' culture and religious faith. Finally, the researcher will present the GRACE protocol as an iteration of a cultural adaptation of the CBT framework and spiritual disciplines.

Burmese Chin Experience

Burma (Myanmar)

The name Myanmar is new to the often known country, Burma. The majority of a people group, the Burman, who also form the ruling regime of the last fifty years, implemented the name change in May of 1989 (Dittmer, 2010). However, ethnic people groups such as the Karen and Chin resisted the new name (Barron et al., 2007) because they viewed the change and the enforcement of a single language and cultural identity as the government's concerted effort to eradicate the minority's national identity (Barron et al., 2007; Dittmer, 2010). Out of respect for the ethnic minority people groups, the United States continues to recognize the nation by its old name, Burma; hence, for this study, and consistency sake in literature, this manuscript retains the use of "Burma." While the phrase Burmese Chin is commonly used, many Chin people prefer, "the Chin people from Burma"; this study has attempted to comply with the request.

Chin. The Chins from Burma were tribal people from Chin Hills in Chinland or Chinram (Myint-u, 2001). Within the Chin clan, there are many different ethnic groups, who speak 40 to 45 dialects or languages that are categorized into four main language groups (Hakha, Falam, Tedim, and Mindat Cho) based on linguistic similarity while other linguistic experts list it as seven main languages (Alexander, 2008; Myint-u, 2001; Sakhong, 2003). The Chin people do not have a first, middle, or family name common in Western countries; they have one name compound, usually with three short words (Alexander, 2008). Naming a child is very important to the family tradition because each name is unique and chosen to reflect the success or accomplishment or project the grandparents' future wishes for the child (Barron et al., 2007).

As a people group, they are also known as Zomi, and they claimed self-rule before the nation was conquered and annexed by the British Empire. The advent of the colonial rule

resulted in the country's parceling into three regions for administrative purposes: The west of Chinram went to India and Bangladesh, and the east became part of the Union of Burma. Ann and Arthur Carsons were the first missionaries appointed by the American Baptist Mission to work among the Chins in the late 1800s. The Carsons were tasked earlier in their mission work to have a Romanized written language for the various Chin dialects and a hymn book (Sakhong, 2003). Converts to the Christian faith grew slowly before World War II. When World War II broke out, Chin preachers and teachers trained in schools built by the American missionaries carried on their work when the latter could not return (Sakhong, 2003).

Religious beliefs. Buddhism is the official religion of Burma, and 83% of her citizens embrace it as their way of life, giving rise to the name “Lands of the Pagodas.” As the national religion, Buddhism exerts tremendous influence not only on the religious life but also on the development of Burmese lifestyle, culture, and perceptions of a disordered person as possessed by supernatural spirits called “Nats” (Tint Way, 1996). In other words, intervention for mental illness can involve alchemy, traditional healers, and the process of overcoming spiritual forces.

Christianity. Adoniram Judson was the first Protestant missionary from North America to introduce Christianity to Burmese people in the 1700s. However, the significant increase in Christian converts only occurred after World War II when a new cohort of missionaries from America returned to share a more culturally contextualized form of the Christian faith. These missionaries encouraged the different minority clans and tribes to gather to celebrate a local religious festival together. Hence, by the sharing and the partaking of food in the spirit of hospitality, which was very much their tradition of welcoming friends and strangers, the Chin people took the participation seriously as one would with the Holy Communion of their new faith. Consequently, this form of sharing a meal became not just a formative moment of

hospitality and fellowship but a confirmation of love for another from a different tribe (Myint-u, 2001; Sakhong, 2003).

From 1999 to present, 80 to 955 of the Chin population consider themselves Christians (Myint-u, 2001; Sakhong, 2003). The conversion from the worship of lesser gods, Khua-hrum, to the Supreme Being or Jehovah God, Khua-zing, within the same conceptual pattern of belief system was a significant milestone for the Burmese Chin community (Sakhong, 2003). More importantly, they now see themselves on par with the Burman Buddhists, the Bengali Muslims, and the Indian Hindus, regarding worldview and value system. Sakhong (2003) argues that de-tribalization and the community's adoption of the Christian faith became a process of strengthening the Chin people's national identity (Sakhong, 2003). Interestingly, many Chin people have continued in the Christian faith tradition for the last four generations (Alexander, 2008). However, although the Chin people's spiritual beliefs are grounded in the Judeo-Christian faith for some time, their views about mental illness are still influenced by their traditions (Oleson et al., 2012; Vukovich, 2016).

Family systems. As a rule, Chins seldom practice arranged marriages, although parental approval is highly valued (Sakhong, 2003). Whenever a family celebrates a wedding, it is common for them to invite the entire village and everyone in the community. Chin people tend to marry young and are encouraged to have large families because children are considered one's heritage. Within each household, the oldest male is the head of the family, and it is common for many families to live together or near each other. The head of the family is also the sole provider and makes the major decisions in the household. All women should learn to cook and take care of the children and home. Women will carry their babies in a cloth sling up to the age of three or four. It is common among families resettled in the United States to have both parents working or

one parent working two jobs to help pay for bills and living costs. Around the world, Burmese Chin people are known for their diligence and loyalty (Alexander, 2008). It is common for Burmese Chin to work 12 hours daily and six and a half days a week with very few days of vacation, even in the United States.

Politics. The Chin people are often described as a peaceful, humble, gentle, and highly religious people group. Most of them were involved in agriculture and education in their homeland. Like the Karen minority group, the Chins were involved in the civil uprising in 1988 that started soon after Burma was granted independence from Britain. Their leaders were promised secession after ten years (Alexander, 2008; Fink, 2009/2013). Unfortunately, the ruling government did not grant the Chin population the right to secede. Till today, the state remains undeveloped with few roads and essential infrastructures. The over half a million people in the Chin state live in abject poverty and are mostly ignored by the federal government (Alexander, 2008).

The 2015 election that saw Aung San Suu Kyi's National League for Democracy (NLD) party winning almost all the contested seats in parliament may translate into better times for the Burmese people in general, and for the remaining Chin and Karen who are still living there (Bird, 2013). However, Burmese people in the United States are adopting the “wait and see” attitude because, in 1990, the NLD led by Suu Kyi won 80% of the parliamentary seats too. Still, the government annulled the poll results and instead placed Aung San Suu Kyi and her leaders under house arrest. It has been a year plus since Aung San Su Kyi, and her party ruled Burma's country, and changes have been slow.

Diaspora of the Chin. Soon after the civil unrest of 1987-1988, a steady stream of Burmese Chin managed to find their way into Malaysia – since they were almost the last people

group forced to leave Burma, they chose Malaysia over the overcrowded refugee camps at the border of Thailand and the scarcity of work in India or Bangladesh. Although Burma has undergone some socio-political changes in the last ten years, the future for the ethnic minority people groups remains uncertain. Thousands still live in limbo in Malaysia, India, Bangladesh, and Thailand as undocumented residents and exploit by the locals with low wages and long work hours. Although the authorities largely ignored them, some were detained and eventually deported. Zo, a Burmese Chin in his late 30s, said he was fortunate not to be caught because those that were deported had to raise or borrow additional funds to return at a later date. Research indicates that the longer the detention, the more severe the mental distress during settlement (Steel et al., 2006).

History of Present Conflict

Since 1948, the country has been in a protracted civil conflict that has displaced between two and three and a half million people of Burmese minority ethnic groups, internally and externally (Shukla, 2008; UNHCR, 2014). The political events of 1987 and 1988 exploded and perpetuated ethnic and sectarian violence that affected the ethnic minority people groups of Chins, Karen, Karenni, Shan, and Rohingyas (Alexander, 2008; Bird, 2013; Sakhong, 2003; Thawngmung, 2012). As recent as 2014, clashes between the national army with non-state and severely ill-equipped military groups in Kachin and the northern Shan States have been reported.

Although several of the ethnic minority groups in Burma have been engaged in armed conflict with the military regime for an extended period, in the early years, the bulk of the resettled Burmese refugees are of Karen and Karenni ethnicity (Bird, 2013). Both people groups had lived in refugee camps in Thailand for more than two decades before their resettlement in the United States (Fink, 2009; Rhoden & Rhoden, 2011; Thawngmung, 2012; UNHCR, 2014).

This first wave is mostly made up of ordinary people caught in the military conflict, such as farmers who fled because their lands were confiscated for infrastructure development, or young men who feared being forced by the military government to become laborers and porters on the front lines of the conflicts with their own or other minority ethnic groups (Fink, 2009; Rhoden & Rhoden, 2011). The remnant of the first wave was political prisoners tortured and starved in prison (Fink, 2009). Apart from the Karen, the Burmese Chins, and some smaller minority people groups such as Mon, Shan and Karenni comprise the second wave of people to flee Burma out of fear for their children's future (Bird, 2013; Fazel, Doll, & Stein, 2009; Fink, 2009; Rhoden & Rhoden, 2011; Sakhong, 2003). The most recent arrivals in the United States are Burmese Chin, who has transited through Malaysia after escaping from Burma (Alexander, 2008).

Pre-Settlement and Settlement Issues

Research on resettlement stress seems to imply that the convergence of previous experiences of violent trauma and post-settlement stress is more likely to precipitate moribund mental health than just post-traumatic stress alone. According to Johnson and Thompson (2008), resettlement is an interaction framework that includes genetic predisposition, pre-migration exposures and experience, post-migration stressors, and individual and social. The researchers disagree that post-traumatic stress should only involve exposure to physical harm to oneself. Instead, they propose that any event perceived by the refugees to be incongruent with their worldview and ability to cope can be interpreted as trauma (Johnson & Thompson, 2008). Likewise, reviewers (e.g., Carlsson et al., 2005) found that only a small percentage of Southeast Asians from a refugee background developed Western-defined clinical PTSD after settlement; the same is found among refugees from African countries (Vinson & Chang, 2012). Besides,

they located the development of mental illness was in large part due to the absence of the same ethnic communities and family support systems. Therefore, using the Western model of mental health diagnoses to depict the sequelae of refugees' traumatic events may be incomplete in telling the whole story of the refugee experience (Bracken, 2002; Murray et al., 2010).

Pre-Flight

Zo, a Burmese Chin, was in his early twenties and recently married when he was persuaded to seek employment in Malaysia because of the threat of starvation in his homeland. He said he was earning about 500 Kyat (or 37 cents in U.S. currency) per day whenever he could find work, but the prices of food and sundries were ten to twenty times more, and inflation was skyrocketing daily. The high unemployment rate of as high as 70% and other food security-related events are frequently reported in the Chin state (Sollom et al., 2011). According to Sollom et al.'s (2011) population-based study, their assessment showed statistically significant links between hunger and several human rights violations, such as being forced to contribute food out of fear, or having their household crops or food stores and livestock stolen, destroyed, or killed if they should resist.

Additionally, it was common for soldiers to round up non-disabled men and children to act as their porters for heavy loads and weapons, and build roads and bridges without pay (Sollom et al. 2011). Shan was 55 years old and had recently retired as a schoolmaster when he was "recruited" to work 12 hours from dusk to dawn as a security guard. He said he had no choice but to work without pay if he wanted the soldiers to leave his family, including several grandchildren alone. A year later, he borrowed money from relatives to pay an agent USD 500 to take him to Malaysia to find work. At the border of Burma and Thailand, Shan was handed to another agent who took him and others on a night trek of four to five hours through thick jungle

to avoid the Thai border guards' detection. At one point, another agent smuggled him and twenty other men, women, and children under layers and layers of rubber sheets in a van. The smell was unbearable and stifling, and some of the people that traveled with him did not survive the trip.

Pre-Settlement Challenges

In Malaysia, Shan was not particular about the kind of work available; he related that he worked as a laborer at a construction site for several months until the company closed its door for lack of workers, and later at a lumberyard during the day, and as a watchman (security guard) during the night. With the money saved, he sent for his children, their spouses, and his grandchildren. After five years, Shan managed to bring his family of 25 persons to Malaysia. They all had to pay agents to smuggle them in like what he did. It was a miracle that all 25 survived the trip, including two grandchildren below five.

In Porter and Haslam's (2005) analysis of 56 reports of comparative studies involving sixty-seven thousand two hundred and ninety-four participants (22, 221 refugees and 45, 073 non-refugees) found that post-displacement conditions tend to moderate mental health outcomes. Additionally, refugees living in institutional accommodations such as refugee camps or those women who are younger and less educated tend to display worse mental health outcomes (Breslau, 2009). Likewise, Fazel et al.'s (2005) review involving some 7,000 refugees supports the view that resettled refugees in high-income countries were ten times more likely to have PTSD than the general populations when matching age, the impact of power, control, class, gender, and their traumatic experiences.

Human trafficking. Farr (2005) found that women and young girls are especially vulnerable to be kidnapped by human traffickers and tricked into the sex trade because of their vulnerability transitioning from their war-torn civil country to a third world country while

waiting for their visa application be processed by the UNHCR and the receiving host country. They are especially vulnerable because their undocumented status in these transit countries afforded them no legal rights and protection. Some fall victim to the human traffickers' clutches because they lack the connection to their ethnic community in the transit countries. Trauma from sexual violence often results in feelings of shame and guilt (Breslau, 2009). This is congruent with Johnson and Thompson's (2008) review that indicated refugees of the female gender and those older are more likely to develop PTSD. Their study also provides a concept of the dose-response relationship between cumulative war trauma and torture and the development and maintenance of PTSD. According to Caruth (1996), the repression of the "impossible" memory is the most harmful aspect of the trauma because it triggers physiological symptoms that affect the victim's psychosocial functioning (p. 6). Conversely, Habermas (1975) describes it as a collective crisis if the personal situation is also manifested in the community.

Detention. Shan, his wife, and three unmarried sons were detained and confined at the holding center for illegally entering and working in Malaysia. Fortunately, before the week was out, he had received his visa to resettle in the United States. His second daughter and her family were not as fortunate; they languished in the detention for almost a year. Studies show that confinement is deleterious to health and mental health (Mollica et al., 1993; Steel et al., 2006).

Cung, a teenager, was about nine years old when he fled Burma. He said he prefers not to answer any questions about what he calls a "frightening trip" from Burma to Malaysia. He came to Malaysia with his two older brothers on foot after crossing Burma and Thailand's border. Since they were undocumented residents, he did not attend a school like the other neighborhood kids. When his father's application for resettlement in the United States was approved, Cung was hopeful about his future. According to a United Nations International Children's Emergency

Fund (UNICEF) report released end of 2016, more than 50% of refugees worldwide are children.

Resettlement in the United States

In 2014 alone, 80% of the 130,000 refugees and asylum-seekers approved for settlement in the United States were Burmese (UNHCR, 2014). The current population of 121,100 Burmese refugees in the United States represents one of the largest groups of refugees recently being resettled in the United States in the twenty-first century; their psychological profile is vital from the perspective of healthcare service providers as well (Kim & Kim, 2014; Office of Refugee Resettlement, 2012; USRPC, 2014).

Generally, refugees are resettled based on the location of the sponsoring agency; in the case of Burmese refugees, they have been resettled either to metropolitan areas such as the Bronx in New York or to smaller towns such as Roanoke or Charlottesville in Virginia (U.S. Department of State, 2010). During the first eight months of the settlement, refugees are given free access to temporary housing, health care, and food stamps to enable them to be self-sufficient (California Department of Social Services, 2010; Massachusetts Refugee Resettlement Program, 2013). However, during this transition period, it was expected that they acquire employment swiftly to support themselves. However, once they are employed, they must pay rent, car installments and repay the resettlement agency for their airfare (for example, from Kuala Lumpur, Malaysia to Roanoke, Virginia).

Researchers into social issues of refugees argue that these resettled Burmese refugees faced tremendous economic hardship when the authorities discontinued these initial benefits and healthcare services (Garrett, 2006; Miller & Rasmussen, 2010; Portes & Rumbaut, 2006; Schweitzer et al., 2011); and this hardship, together with their inadequate communication and employable skills, contribute to their daily stressors. Portes and Rumbaut (2006) support the

proposal to extend access to health care and social services to help these refugees acculturate to the new environment and adapt to their changing family roles.

Every receiving or host country has its policy and strategy in processing applicants for resettlement. The state department's Bureau for Population, Refugees, and Migration (BPRM) of the United States is responsible for contracting nongovernmental agencies to manage the resettlement process, from the processing of the application for admission, determining the applicants' eligibility for resettlement, and to assisting approved applicants in preparing for documentation and interviews with the U.S. Citizenship and Immigration Services (USCIS), a Department of Homeland Security (DHS) agency (Migration policy institute; MPI, 2012). USCIS, on the other hand, conducts the interviews with refugee resettlement applicants (usually in a temporary host country), runs background checks under the evidence before granting the applicants conditional approval for resettlement. The resettlement agencies' staff also guide approved applicants through the pre-settlement process, including medical examinations, cultural orientation, and sponsorship assurances.

The final stage includes a referral to the International Organization for Migration (IOM) for transportation. The resettlement agencies expect refugees to reimburse their flight tickets. Burmese refugees, much like all other refugees admitted to the United States for resettlement, are eligible for lawful employment and resettlement services. The non-governmental agencies will assess each individual or household's needs and qualify to receive medical, housing, educational, and vocational support services, post-settlement.

Usually, after a year of continuous residency in the United States, a refugee can apply to the USCIS to adjust their immigration status to become a lawful permanent resident or, the more popularly known term, the green cardholder. Within two years of admission, refugees can apply

for follow-to-join benefits for their spouse or unmarried children below age 21. Finally, refugees who are lawful permanent residents are eligible to apply for U.S. citizenship after passing the citizenship test and, after five years, post-settlement (MPI, 2012).

Daily Stressors. Miller and Rasmussen (2010) submit several reasons why daily stressors impact the psychological health of refugees. First, daily stressors tend to be immediate and constant. Refugees often must struggle with poverty and isolation during the first few months or years of trying to establish a new life for themselves and their families in a new city and a new country (Miller & Rasmussen, 2010; Schweitzer et al., 2011). Many do not have adequate language, skill-set, qualification, or work experience to obtain employment to sustain a middle-income lifestyle. Most are employed in blue-collar jobs such as housekeeping, sushi-making, packing tents, upholstering furniture, and processing meat (private communication, 2017). Hence, it is common for them to work 8-12 hours daily, seven days a week with just a few days of vacation time; some get a few days off for Christmas, New Year, and July 4th (private communication, 2016).

While war-related traumatic experiences are beyond one's control, the lack of control over daily stressors are perceived to be pernicious as well (Miller & Rasmussen, 2010). Refugees resettled in the United States often live in unsafe neighborhoods because of poverty. It is also not unusual to find extended families living together for convenience (such as childcare and meals) and budget reasons. Other factors, such as ignorance of services and support systems that can help them deal with psychological distress, can contribute to daily stressors (Schweitzer et al., 2011).

Third, Miller and Rasmussen (2010) said that daily stressors are pervasive and something that every refugee will have to face during the resettlement. Finally, Burmese refugees come

from a collectivistic society where the extended family is very much involved in caring for one another. Conversely, refugees settling in an individualistic society where people tend to be more private and taught to mind their problems, issues of child physical and sexual abuse or intimate partner violence, or a rebellious teenager can exacerbate post-settlement difficulties (Schweitzer et al., 2011).

Likewise, Hauck and colleagues (2014), in examining the daily experiences of Burmese, Bhutanese, and Iraqi refugees living in central Virginia, observed that the primary stressors emerged from language difficulty and barriers in accessing education, employment, and healthcare. They defined daily stressors as events related to the process of acculturation and recent stressful events as milder stress typically encountered in everyday life, such as seeing a doctor for their illness or reporting a case of school bullying (Hauck, Lo, Maxwell, & Reynolds, 2014). In their study, the researchers acknowledged that the refugees' PTSD symptoms are associated with both violence trauma exposure and post-resettlement daily stress (Hauck et al., 2014). Their conclusion was consistent with other studies' findings that pre-settlement pressures contribute significantly to post-migration everyday experiences (Beiser, 2009; Lindencrona et al., 2008; Major, Quinton, & McCoy, 2002; Miller & Rasmussen, 2010; Schweitzer et al., 2011).

Additionally, they found that depressive symptoms are associated with more recent stressful events (Hauck et al., 2014). While previous traumatic experiences and stressors unique to the refugees' forced migration may influence the development and perpetuation of post-traumatic stress symptomatology, the researchers concluded that it was the daily stressors associated with post-resettlement that likely precipitated the development of depression and anxiety (Miller & Rasmussen, 2010; Schweitzer et al., 2011; Steel et al., 2004; Steel et al., 2011). Conversely, the researchers also concluded that the Burmese's satisfaction with personal freedom

is likely to be related to the absence of violence trauma previously experienced at the hand of their government's discrimination and sectarian oppression in their country of origin (Hauck et al., 2014). Additionally, regarding a salutogenic or protective factor against further deterioration of mental health, their study revealed that most Burmese respondents are actively involved in one community church. These refugees reported receiving help from fellow American and Burmese church members (Hauck et al., 2014).

Loss of Sense of Self. Miller et al. (2002) used semi-structured interviews to converse with a sample of 28 adult Bosnian refugees (mean age 49.37 years) about their life in prewar Bosnia, the journey of flight, and their recent experience in the United States. They found that the participants' exile-related stress primarily involves social isolation, the loss of community and family, which is quickly followed by loss of purpose for life; this is congruent with suicide studies of the refugee population (Nickerson et al., 2011a).

Loss of Place. Displaced people fled their homeland due to constant fear of danger and death, which embodies the relationship between health and location. According to Sampson and Gifford (2010), one of the most significant challenges Burmese refugees must engage in during settlement is establishing a sanctuary place within the unfamiliar physical and social landscape of the new host country. Like people in their neighborhood, these resettled refugees needed a place for purposeful activities to help them recover their education and employment opportunities. They also need a place to relax to help heal their self and cultural dissonance — additionally, a place to socialize and connect with others such as a community gathering place or a church. Since safety is of chief concern to the refugees, refugees yearning for a home that is void of strife and conflict, according to Macintyre, Ellaway, and Cummins (2002) and Milligan and Bingley's (2007) findings. Other researchers also found safety and security are essential to

their recovery and healing process (Torosian, & Biddle, 2005).

Cung remembers his first semester in middle school. He did not understand any English and was teased mercilessly by other children. He said bullying was more rampant when he transitioned to high school, especially when he refused to participate in some of the students' drinking and smoking lifestyle. He reported that he was ostracized like a "pariah dog in Burma." However, things improved when he finally made some friends among some African-American and Hispanic students who protected him from the older and bigger boys. Cung is now studying at a community college and is struggling to choose a major in his studies. His parents would like him to study Medicine or Engineering, but he is unsure. He said he does not even know what he wants to do next week, let alone his future career.

Cumulative Trauma. The term trauma is a psychological wound inflicted on a person in emotional shock (Caruth, 1996). When a person's understanding did not assimilate the shock, it would often manifest in the form of intrusive flashback and recurrent emotional distress (APA, 2013). The three symptom groups are: (1) re-experiencing the traumatic event, (2) avoidance of stimuli that resemble the event and numbing of emotional responsiveness, and (3) increased arousal, emerges from past experiences of trauma (APA, 2013). As defined previously, Cumulative is the combination of current daily stressors and pre-migration trauma (Norredam et al., 2009; Schweitzer et al., 2011), and such pre-migration trauma can take the form of experiences of sexual violence in the country of origin and the transit country.

Finally, Erikson and Yule (1994) formulate trauma as possessing "centripetal and centrifugal tendencies" (p. 186). It tends to draw the individual from the center of group space while at the same time drawing him or her in. The personal and collective trauma of the population of Chin refugees (under the present study) resulted from the shock of displacement and their subsequent

rejection by their adoptive community because of perceived personal deficiency. Their psychological wounds are both individual and collective simultaneously because the trauma experienced pre-settlement and post-settlement also tend to reinforce one another, making the shock and sense of loss even more remarkable because of their collective identity (Alexander, Eyerman, Giesen, Smelser, & Sztompka, 2004). According to Sam & Berry (2006), systems such as "safety, attachment, identity or role, existential meaning and justice" impact the refugee acculturation and adaptation process in the new environment (p. 202).

Figure 2: Summary of Stress and Cumulative Stress Identified from the Literature

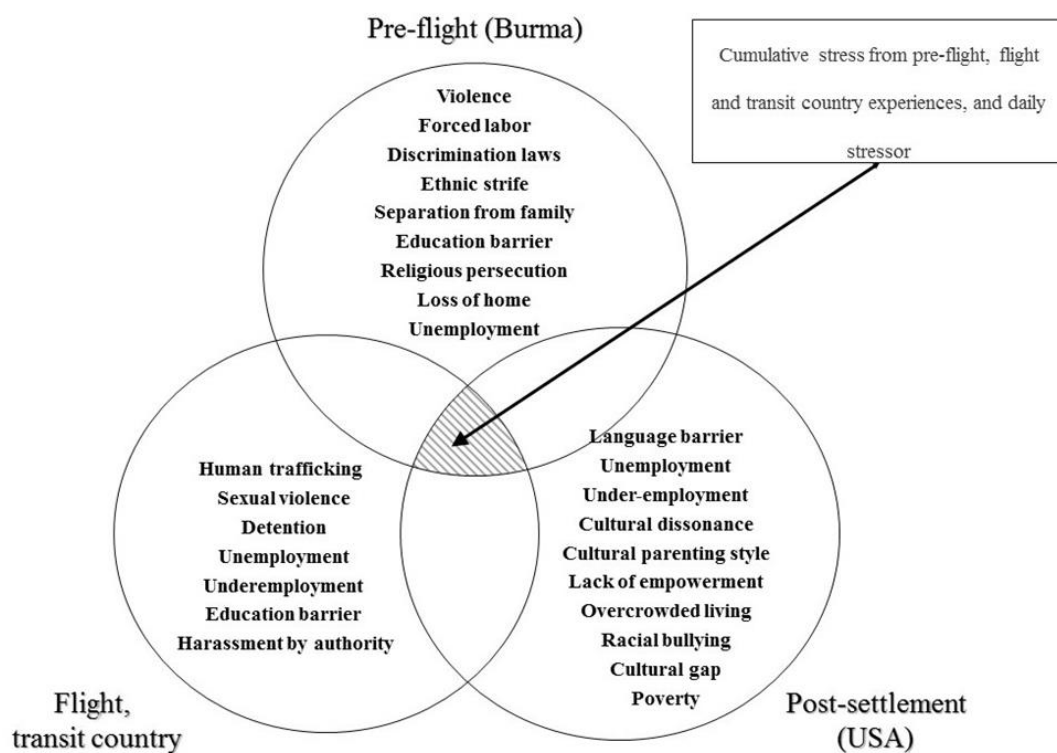


Figure 2 depicted a summary of the stressors, with the intersection of all three circles representing the cumulative stress from the pre-flight, flight, transit country, and daily stressors.

Mental Health of Refugees

Southeast Asian refugees face unrelenting stress from being perceived as foreigners or outsiders because of language, ethnic, cultural distance, and assimilation difficulties (Beiser, 1988; Huynh, Devos, & Smalarz, 2011; Lee, Wong, & Alvarez, 2009; Ng, Lee, & Pak, 2007; Schweitzer et al., 2011). Refugee mental health researchers have established that acculturative stress (Sam & Berry, 2006), in addition to exposure to posttraumatic events (Porter & Haslam, 2005), can lead to psychological distress such as posttraumatic stress disorder and mood disorder. Steel et al. (2009) meta-analyzed 181 studies on refugees who have been affected by war-related trauma and found that the weighted prevalence of PTSD and depression was 30.6% and 30.8%, respectively.

Likewise, the prevalence of post-traumatic stress disorder (PTSD) in the Burmese refugee population reported was in a range of 4.6% to a high of 23% (Cardozo, Talley, Burton, & Crawford, 2004; Refugee Health Technical Assistance Center [RHTAC], 2011; Schweitzer et al., 2011; Shannon, Wieling, McCleary, & Becher, 2015). However, the depression rate ranges from 36% to 42% (Cardozo et al., 2004; Schweitzer et al., 2011; Steel et al., 2004; Steel et al., 2011).

While a high proportion of refugees may indeed present with post-traumatic stress symptoms, interestingly enough, reviewers Miller and Rasmussen (2010) agree with other researchers (e.g., Beiser, 2009; Major, Quinton, & McCoy, 2002; Schweitzer et al., 2011) that it is the experience of daily stressors during post-settlement that are more immediate and pervasive: adjustment, poverty, language barriers, neighborhood crime (Damm & Dustmann, 2014), economic struggles, employment difficulties (Miller & Rasmussen, 2010; Phillimore &

Goodson, 2006), perceived discrimination (Merritt, Bennett Jr, Williams, Edwards, & Sollers, 2006; Williams & Mohammed, 2009), diminishing support services, and urban life (Bhugra, 2004; James, 2010; Shiu-Thornton, Senturia, & Sullivan, 2005; Schweitzer et al., 2011).

Protective Factors

The relationship between religious activities and health outcomes was demonstrated in studies indicating the impact of spirituality/religiosity on more prolonged survival, enhanced wellbeing, healthy behaviors, and lower blood pressure (Harrison et al., 2005; Helm, Hays, Flint, Koenig, & Blazer, 2000; Kaufman, Anaki, Binns, & Freedman, 2007; Koenig, George, Titus, & Meador, 2004; Koenig et al., 1998). As an example, in a correlational study of patients diagnosed with Alzheimer's, the researchers discovered that higher levels of private religious practices such as prayer and Scripture reading predict slower cognitive decline (Kaufman et al., 2007).

According to Park and Helgeson (2006), personal growth can occur in individuals who have experienced a tremendous amount of stress. Borwick et al. (2013), in using a salutogenic approach to explore the experiences the Burmese population from a refugee background, learned of four super-ordinate themes that contribute to the Burmese population's resilience and wellbeing: interpersonal relationships, existential values, sense of future and agency, and spirituality. The participants identified interpersonal relationships as a primary source of strength for support and encouragement to endure in their struggles (Borwick et al., 2013; Shakespeare-Finch, Schweitzer, King, & Brough, 2014). The relationship is also central to how they make meaning of their experience and how they relate to others; it also connects to others within their present adverse and stressful environment (Borwick et al., 2013).

Additionally, from the participants' narratives, spirituality also emerges as a resource from where they draw strength to continue believing that God will see them through the hard

times (Borwick et al., 2013). According to this study, the participants' involvement in church events such as worship and support groups reinforces the importance of belongingness, sense of community, and spiritual health (Borwick et al., 2013). Hence, for this population, their spirituality's health is intimately tied to their ability to manage the stressors. The findings harmonize with other studies identifying religion as a form of support in times of hardship and build a rationale for the current study (Borwick et al., 2013; Khawaja, White, Schweitzer, & Greenslade, 2008; Luster, Qin, Bates, Johnson, & Rana, 2009).

In summary, post-traumatic stress in the refugee population can be conceptualized as psychological stress derived etiologically from their exposure to violence experienced prior to settlement or pre-settlement while, cumulative stress or trauma is post-traumatic stress compounded by daily stressors during post-settlement (Miller & Rasmussen, 2010; Silove, 1999; Schweitzer et al., 2011). Hence, any mental health interventions that can help alleviate the cumulative stress generated from their "lack of safety, attachment, role, existential meaning, and justice systems" will benefit resettled refugees. Murray and her colleagues (2010) proposed the need for the development of culturally appropriate interventions and services for individuals with a refugee background because of their past trauma, the subsequent daily stressors in their adopted country, and the cumulative effects impinging on their safety, attachment, role, and existential meaning.

Psychological Evaluation

Biopsychosocial domains. Among Southeast Asians, psychiatric problems are often manifested across sociocultural contexts as somatic symptoms rather than psychological-affective symptoms (Chung & Bemak, 2007). Some of their physical maladies may reflect the harsh conditions in which they live, such as lack of clean water and malnutrition (or an

unbalanced diet rich in carbohydrates) during pre-settlement, and these may confound the symptoms caused by mental distress (Fink, 2008; Mullany et al., 2007; Shah et al., 2014). Unfortunately, the health problems of the refugees are not only restricted to the physical domains. Refugees often live in limbo for many years with no recreation available to them, and hopelessness or despair is prevalent. Unfortunately, the western-centric approach to the diagnosis and treatment that focus on talk therapy was one of the main reasons for the low uptake of mental health utilization by Asian populations (Augsberger, Yeung, Dougher, & Hahm, 2015; Fung & Wong, 2007).

Cultural idioms. Several researchers have noted that refugees from Burma and other non-Western countries tend to express their feelings of sadness, worry, and stress through somatic symptoms (Lim, Stock, Shwe Oo, & Jutte, 2013; Terheggen, Stroebe, & Kleber, 2001). Additionally, because of their collectivistic thinking and their fear of shame and paranoia, these refugees will describe their distress using cultural idioms such as ‘stuck in mind’ or ‘pain in the head’ (Kohrt et al., 2014; Nichter, 1981/2010; Vukovich & Mitchell, 2015).

Accessibility. Resettled refugees who have tried to access local healthcare services sometimes become frustrated because of social, language, and economic barriers (Vermette et al., 2015). Some healthcare providers do not have access to local interpreters who are fluent in the language and have adequate working knowledge of mental health; this further complicates the psychological evaluation process (Kakuman et al., 2011; Vermette et al., 2015).

Interventions for Trauma

This section will provide a brief review of the various forms of interventions used in the past that helped treat trauma. Culturally appropriate therapy of PTSD and adjustment-related stress are limited to few evidence-based practices (Eshun & Gurung, 2009; Griner & Smith,

2006). But, because refugees resettled here come from a diversity of cultural backgrounds and pre- and post-settlement experiences, their assessments and interventions' cultural appropriateness are critical challenges that mental health workers must consider. These problems may also contribute to some of the refugee population's hindrances utilizing mental health services in their community (Paniagua, 2005; Sue, Zane, Nagayama Hall, & Berger, 2008).

Ten years ago, only four randomized controlled studies occurred with refugees, but today there are many more. Paunovic and Ost (2001) had 16 participants randomized into two groups: CBT (n = 7) and exposure therapy (n = 9). Both treatment groups demonstrate gains on all measures (as cited in Hinton et al., 2005). In a separate study by Neuner, Schauer, Klaschik, Karunakara, and Elbert (2004), Sudanese refugees in the narrative exposure therapy intervention group improved the most on all measures.

Murray et al.'s (2010) review of twenty-two studies with resettled refugees found that the most effective interventions were those that focused on treating culturally homogeneous populations; these studies demonstrated moderate to large outcome effects in reducing posttraumatic stress and anxiety (Murray et al., 2010). Additionally, they agree with Papadopoulos (2007) and Ehntholt and Yule (2006) contentions that psychosocial skills interventions focusing on safety, trust, and other positive changes within the context of communal support is also more likely to rely on the prevalent medical models of psychological distress (Murray et al., 2007). However, they also expressed concern for the lack of such interventions in their literature search that met their empirical requirement, which did not provide a uniform outcome, mainly due to the flawed methodology design. Their review confirms other researchers' findings that the poor timing of the interventions, the lack of cultural competency (Arredondo, Tova-Blank, & Parham, 2008), and the use of low reliability and validity

inventories or those deficient in cultural efficacy, contributed to the inconsistent results (Measham, Rousseau, & Nadeau, 2005; Murray et al., 2010).

Contrary to Crumlish and O'Rourke's (2010) conclusion, Palic and Elklit (2011) found CBT and NET as two targeted interventions that illustrate rigor and efficacy among the refugee population. Likewise, Slobodin and de Jong's (2015) meta-review of pre- and post-intervention studies using various quantitative measurements of post-traumatic stress that included sensitive cultural components came to the same conclusion that CBT and NET yielded large effect-size outcome. The researchers also highlighted Hinton et al.'s (2005) cross-over design study with 20 Cambodian refugees in outpatient treatment for trauma-related symptoms (as cited in Slobodin & de Jong, 2015). The culturally adapted CBT treatment group participants improved across all measures, including a reduction in orthostatic-associated panic attacks (Hinton et al., 2005).

Furthermore, programs that emphasize the roles of community leaders and indigenous wisdom in building community partnerships (Baird et al., 2015), cultural salience, and cultural efficacy were more successful (Nadeau & Measham, 2005; Fung & Wong, 2007) in increasing “the levels of mental health utilization among refugee populations by decreasing stigma and engaging people in culturally meaningful ways” (Murray et al., 2007, p. 582).

It is not unusual for Southeast Asians from a refugee background to rely on traditional superstition, home remedies, and ethnomedicine such as herbs and roots to address their health ailments (Ahn et al., 2006; Berthold et al., 2007; Gozdzia, 2004; Oleson et al., 2012) including psychiatric distress. Their beliefs and values also influence their health-seeking behavior (Oleson et al., 2012; Vukovich, 2016). If the Burmese believe Western medication is ineffective or is harmful, they are likely to stop treatment even before they finish taking the prescribed amount (Oleson et al., 2012). In a focus group study reported by Oleson et al. (2012), the Burmese

participants said they often used traditional medicine concurrently with prescribed medication because they do not have confidence in the Western medicine, seemingly unaware of potential contraindications (Oleson et al., 2012).

Miller and Rasmussen (2010) posit that healthcare practitioners should first evaluate the dynamic context of the population's daily stressors before developing their "psychosocial interventions" (p. 13). Secondly, the practitioners should address the daily stressors that are particularly salient before targeting the trauma (Miller & Rasmussen, 2010). The following step is to identify and strengthen their complementary resources, such as social support (Miller & Rasmussen, 2010). Finally, trauma is not the direct result of conflict exposure (Miller & Rasmussen, 2010). In the Burmese Chin people, the government's overt discriminatory actions, religious persecution, and severe financial hardships form part of their traumatic experiences living in their homeland (Alexander, 2008).

Trauma-Focused Approach

Within the clinical literature, there are hundreds of books and thousands of pages of literature that examines the impact of trauma on the mental health of war veterans (e.g., Cooper, & Clum, 1989; Fontana, & Rosenheck, 2004; Jensen, 1994; Kashdan, Uswatte, & Julian, 2006). Besides, effective interventions such as eye movement desensitization and reprocessing (EMDR; Foa, Keane, Friedman and Cohen, 2009; Jensen, 1994; Shapiro & Solomon, 1995), imaginal flooding (IF; Cooper & Clum, 1989), and direct therapeutic exposure (DTE) have accrued thousands of hours of clinical trials successfully treating PTSD among service members.

There is also a high proportion of mental health interventions originating from the cognitive-behavioral therapies (CBT) such as the narrative exposure therapy (NET), which was successfully adapted to a cultural population (Crumlish & O'Rourke, 2010; Hinton et al., 2005;

Palic & Elklit, 2010). Others, such as stage-oriented, self-trauma, and pharmacotherapy treatment models, are often used as an adjunctive treatment for those experiencing intense traumatic symptoms (Rothschild, 2000).

Psychosocial-Focused Approach

Apart from the CBT and its derivatives, service providers have used music therapy (Baker & Jones, 2006), interpreter-mediated CBT (d'Ardenne, Ruaro, Cestari, Fakhoury, & Priebe, 2007; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005), holistic treatment (Nadeau & Measham, 2005) and group interpersonal psychotherapy (Bolton et al., 2009) to help refugees overcome their daily stressors.

Integrated Approach

Oleson and her researchers (2012) proposed an approach that integrates the community's cultural-based practices and religious values. These practices are especially useful for refugees struggling with adaptation and post-traumatic stress (Oleson et al., 2012). They agree with other researchers who are also advocating for a spirituality-oriented approach or an intervention which incorporates religious coping in treating refugee population from a religious background (Astrow, Puchalski & Sulmasy, 2001; Koenig, Larson & Larson, 2001; Kliwer, 2004; Oleson et al., 2012; Sulmasy, 2009).

Cognitive-Behavioral Therapy (CBT)

CBT is an efficacious intervention for a range of mental health disorders. Practitioners using CBT to treat unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, posttraumatic stress disorder, and childhood depressive and anxiety disorders have broad effect-size outcomes (Butler, Chapman, Forman, & Beck, 2006). Its usefulness is cognitive-restructuring and interoceptive-exposure components in directing the

clients' attention to catastrophic interpretations of anxiety symptoms and panic attacks (Butler et al., 2006).

Reviewer Bradley and his colleagues (2005), in their multidimensional meta-analysis of psychotherapy for PTSD, however, found no difference in improvement rates with studies that used the CBT modalities and those that used CBT and EMDR. Bradley et al.'s (2005) study supported Shepherd et al. (2000)'s conclusion that EMDR was similarly efficacious as exposure therapy. But, as Shepherd et al. (2000) pointed out, in one study, CBT-based trauma treatment protocol was more effective than EMDR.

In a systematic review of 23 clinical trials that included 1,923 patients with 898 in treatment and the rest in the control conditions, Mendes and colleagues (2010) found that for study completers, CBT was more effective than supportive approaches relaxation, counseling, and psychoeducation. But, for the treatment of anxiety in PTSD, CBT, together with exposure therapy and cognitive therapy, were more effective than interventions using supportive techniques alone (Mendes, Marcelo, Ventura, Cristiane de, & Jair de, 2010).

Mendes et al.'s study was replicated by Horrell (2008), who reviewed literature that discussed CBT treatment for the ethnic minority because she was concerned with interpreting differential response to therapy between minority and majority group members. As an example, a lower-scoring on a measure is often interpreted as a deficit before considering the factors such as socioeconomic status, education attainment, acculturation level, and language barrier. Additionally, most studies did not conduct separate analyses to compare the different treatment efficacies between the dominant and minority cultures. Conversely, the researcher argued that research with minority ethnic population must modify even empirically supported treatments because the wide margin of differences between the dominant culture and minority culture may

affect the efficacy of the intervention, from an emic or culturally perspective (Griner & Smith, 2006); O' Dowd, 2007; Sue & Chu, 2003).

Meanwhile, Bisson and Andrew (2009) found that trauma-focused CBT with exposure therapy (TFCBT), stress management (SM), group TFCBT, integrative supportive treatment (IST), and EMDR were more useful for the treatment of PTSD in 33 controlled trials. However, they detected no significant difference in effect size between TFCBT, SM, and EMDR in their review (Bisson & Andrew, 2009).

Protocol. Conversely, the use of a modified CBT with multisensorial reliving purposed to help patients deconstruct their experience by erasing their traumatic memory, resulted in participants re-experiencing dangerously high levels of emotional dissonance (Cahill, Foa, Hembree, Marshall, & Nacash, 2006; Foa & Rothbaum, 1998). This treatment form tended to have high attrition rates because the patients found the exposure intolerant (Cahill, Foa, Hembree, Marshall, & Nacash, 2006; Foa & Rothbaum, 1998; Lester, Artz, Resick, & Young-Xu, 2010; Markowitz, 2010). Unsurprisingly, researchers also learned that the traditional form of exposure did not erase the memory; instead, patients are often re-traumatized by the exposure experience. Contrariwise, in the new treatment model, patients are taught emotion regulation techniques before the downgraded form of exposure, which creates an expectancy in the patients about the trauma memory (Craske et al., 2008; Hofmann, 2008). The combination treatment has yielded a better outcome with better participation (Craske et al., 2008; Hofmann, 2008).

Interoceptive exposure to somatic sensations other than traumatic events is another variation of the new exposure treatment model that has worked with patients with catastrophic cognitions about their physical ailments (Hinton, Hofmann, Pitman, Pollack, & Barlow, 2008; Otto & Hinton, 2006; Wald & Taylor, 2007, 2008). Although variations of CBT revealed some

efficacy in treating refugees with PTSD, their non-compliance, non-response, and high attrition rates revealed that more is needed to find a protocol that is effective and also acceptable to them (Bradley et al., 2005; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008).

In summary, mental health professionals have used psychodynamic therapy, CBT (Paunovic, & Öst, 2001), interpersonal psychotherapy (IPT), narrative exposure therapy (NET; Cook, Schnurr, & Foa, 2004; Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002; Jaycox et al., 2002), cognitive processing therapy, and testimony therapy, with some success in individual and group counseling, to deal with violence trauma.

Finally, to reduce barriers faced by patients who need to access treatment for their trauma, some researchers advocate delivering CBT by telephone (Cuijpers et al., 2009) and video conferencing (Reger and Gahm, 2009). However, a review found that such delivery of CBT tends to be more useful for the anxiety symptoms in PTSD than for PTSD itself because of the lack of therapeutic alliance, which is an essential factor to sustain recovery (Bomyea & Lang, 2011).

Narrative Emotion Therapy (NET)

NET was initially developed for the refugee population who have experienced violence and war-related trauma. It is a specifically tailored treatment intervention that draws techniques from testimony therapy and prolonged exposure therapy (PE); the latter is essentially an adapted form of CBT (Neuner et al., 2004; Schauer et al., 2005). The protocol involves having the individual narrate the story as a "witness" to the trauma using his or her autobiographical memory of the traumatic event. After the narration, the therapist and patient will collaboratively construct a full biography of the experience (Neuner et al., 2004). A study that used NET and culturally-specific CBT (CS-CBT) concurrently in a population of refugees from Cambodia and

Vietnam demonstrates high efficacy in reducing the individuals' anxiety, depression, and PTSD and improved their daily functioning (Palic & Elklit, 2010).

Forgiveness psychoeducational intervention. Strelan & Wojtysiak (2009) argued that despite an abundance of literature on why people should forgive, there is a dearth of literature exploring the actual forgiveness (p. 98). Toussaint, Peddle, Cheadle, Sellu, & Luskin's (2010) replication of Peddle's (2007) intervention is relevant to this study because they taught on forgiveness. They hypothesized that forgiveness's mechanism and motivation could reduce stress and improve psychiatric health (Toussaint et al., 2010). Their RCT study with 24 adult teachers in Sierra Leone adapted a forgiveness education curriculum to the target population's culture and tradition. As part of their assessment repertoire, they used the TRIM-12 (McCullough et al., 1998), GQ-6, and the SWLS to measure the changes. At post-intervention, the intervention group reported lower levels of negative mood improved levels of gratitude and satisfaction with life (Toussaint et al., 2010)

Sharing circles. Vukovich and Mitchell (2015) found good efficacy with their pilot study using a community-based psychosocial approach called "Sharing circles" to treat depression, anxiety, and stress among three vulnerable groups of people in Burma (p. 121). These people groups (under their study) comprise of people living with HIV/AIDS (PLWHA), former political prisoners (PPs), and individuals identified with the lesbian, gay, bisexual, transgender, and queer [LGBTQ] (Vukovich & Mitchell, 2015, p. 123). The six trained therapeutic facilitators conducted eight group sessions utilizing "interactive and narrative tasks, body mapping, role-playing, gestalt psychotherapeutic activities, lifeline, memory book, as well as engagement in meditation and other self-care activities" over eight months (Vukovich & Mitchell, 2015, p. 126).

Metamodel. In another study, Courtois (2008) discusses a contemporary 3-stage oriented model or a meta-model approach premised on a general framework of safety, security, and affect regulation, to treat complex posttraumatic stress disorder (CPTSD). A French neurologist named Pierre Janet (as cited in Van der Hart, Brown, & Van der Kolk, 1989) was the first to suggest this stage-oriented approach. The early stage of treatment, which is often the most tedious and lengthy one, involves the “development of the treatment alliance, affect regulation, education, safety, and skill-building” (Courtois, 2004, p. 418). When the client’s condition has stabilized, the clinician directed treatment towards the processing of trauma in greater detail. This stage, also known as phase two of the approach, allows the patients to function with less posttraumatic impairment by bringing some degree of completion and resolution to their trauma. Finally, the third stage involves consolidating and restructuring life that is less affected by the original trauma.

Religious and Spirituality-Oriented Approach

The word spirituality comes from the word spirit, which is "Ruach" in Hebrew and can denote "giving breath and hope to individuals, families, and communities" in the Holy Scriptures. Therefore, broadly defined, spirituality includes the immaterial features of life that are not commonly perceptible by the human being's five senses). While it is true that spirituality and religion are sometimes used interchangeably because of overlapping meaning (Marier & Hadaway, 2002), some individuals consider themselves as spiritual and yet not religious. Note that this study will not attempt to refine or differentiate these definitions. Instead, this section will explore the literature to help readers understand why religion and spirituality are relevant to mental healthcare. It will provide a brief review of healthcare's historical background, followed by a literature survey of clinical and empirical studies.

A review of existing literature proposes that religious beliefs, cultural practices, and relationships broadly underscore the clients' recovery process from their post-traumatic stress (Emmons & Mishra, 2011; Chun & Lee, 2013; Koenig, George, & Siegler, 1988; Pargament, 1997; Pargament, Smith, Koenig, & Perez, 1998; Rold, Honeycutt, Grey, & Fox, 2011; Wong & Wong, 2006). Nevertheless, reviewer Shaw and his colleagues (2005), in their review of religion, spirituality, and mental health, concluded that a "fine-grained analysis of the religious and spiritual variables associated with posttraumatic growth" is needed to differentiate between the separate contributions of religion and spirituality to growth (p. 7).

Historical Background

The West's religious communities were pioneers in caring for those who struggle with mental illness beginning the 13th century (Koenig, 2005, 2012). The first psychiatric hospital, St. Mary's, was built in London in 1247 by the Priory of the New Order of St. Mary of Bethlehem (Koenig, 2005, 2012). A year later, on the other side of the Atlantic Ocean, resettled Quakers in the New World devoutly followed the steps of William Tuke to establish an asylum called Friends Asylum that provided a more humane treatment of the mentally ill called "moral treatment" (Koenig, 2012, p.2). Over time, psychiatric hospitals mushroomed along with the Northeast settlements in the New World. Unfortunately, the integrated relationship between religion and mental health deteriorated in the 19th and 20th centuries. Scientists and mental health workers found themselves working in different realms from the religious workers and the clergy (Koenig, 2012).

Some researchers attributed the dichotomous relationship to Freud's psychoanalysis (as cited in Koenig 2005, 2012). Others argued that psychologists and other mental health practitioners tend to be considerably less religious during the early development of

psychotherapy, which eventually led to the schism that soon divided the research of spiritual issues and research of mental health (Hill et al., 2000). However, it is beyond this study's scope to delve further into the rationale for the vast divide between religion and spirituality on one side and mental health on the other. Fortunately, in recent decades, the American Psychiatric Association [APA] recognizes that it is necessary and ethical to consider the patient's religion, spirituality, and cultural experiences in clinical treatment (DSM-IV, APA, 1994).

When discussing the helping profession's history, it is easy to overlook the significant change in thinking in mental health goals following World War II. During that period, interventions changed from identifying salutogenic factors such as religious values that improve personal fulfillment and gives meaning to life to factors that primarily help to assuage mental illness. This paradigm shift also encouraged the focus on using salutogenic elements in treatment for psychopathology (Seligman & Csikszentmihalyi, 2000; Spilman, Neppl, Donnellan, Schofield, & Conger, 2012).

Positive Psychology

Seligman and Csikszentmihalyi (2000) asserted that “psychology is not just the study of pathology, weakness, and damage; it is also the study of strength and virtue. [Hence] treatment is not just fixing what is broken; it is nurturing what is best” (p. 7). This contention resounds with Bandura’s (1977) conceptualization of self-efficacy as the individuals’ current belief in their capability and ability to effect behavioral change, which will lead to their desired outcome. Interestingly, other refugee studies researchers in calling for immediate and long-term post-settlement interventions also mentioned the need to enhance and promote the refugees’ resiliency and other positive factors to attend to post-resettlement stress (Hsu, Davies, & Hansen 2004; Kim & Kim, 2014; Murray et al., 2010).

Religious Coping. There has been an upsurge of interest in religious coping (Rold et al., 2011). Research in social and behavioral science among youths indicate that religious teaching prohibiting the use of tobacco, alcohol, and illicit drugs or the conduct of risky sexual behavior and violence is profitable in promoting a healthier lifestyle, which in turn helps to improve their mental health (Koenig, 2001; Mahoney, 2005; Sinha, 2006; Sinha & Rosenberg, 2013; Sinha, Cnaan, & Gelles, 2007). Mahoney (2005) examined relationships and family members' coping mechanisms within a spirituality framework, while Sinha and Rosenberg (2013) explored faith-integrated trauma interventions for youth exposed to community violence.

Other research also shows that individuals who strictly adhere to health-related behavioral prescriptions from their religion are healthier and live longer in population samples of Caucasian (Koenig & Cohen, 2002; Koenig, McCullough, & Larson, 2001; Powell, Shahabi, & Thoresen, 2003), African American (Hummer, Rogers, Nam, & Ellison, 1999; Marks, Nesteruk, Swanson, Garrison, & Davis, 2005), and Hispanics (Ostir, Berges, Markides, & Ottenbacher, 2006). A longitudinal study conducted in Canada also revealed that people who exercise religious coping have a 22% lower risk of depression than those who are not, after controlling for demographics, education, and perceived social support (Balbuena, Baetz, & Bowen, 2013).

An exploratory study of ten adults (two men and eight women) who were Hurricane Katrina survivors found that they relied on God through prayers and reading the Bible (Lawson & Thomas, 2007). The researchers said these elderly respondents perceived their relationship with God as central to their living and identified the following themes as part of their coping strategy: "Constant divine communication, miracles of faith, inspirational reading, and coping by helping and assisting others (Lawson & Thomas, 2007, p. 345). This conclusion also finds support in a meta-review of research on religion and self-regulation because self-regulation is

one of the identified mechanisms resulting from religious practices (Kagimu et al., 2012; McCullough & Willoughby, 2009). Additionally, other studies show that spirituality and religion can positively influence a person's coping with significant life events and daily stressors (Kim & Seidlitz, 2002; Siegel, Anderman, & Schrimshaw, 2001; Spilman et al., 2012; Wood, Joseph, & Linley, 2007).

There appears a movement towards interfacing spirituality and religion in clinical treatment. Young et al. (2007) found from their survey of the American Counseling Association (ACA) members that at least 53% favor integrating spirituality and religion into counseling practice. They also inferred that 68% of the respondents strongly agreed on the need for formal preparatory training to address specific spiritual and/or religious competencies in counseling is essential, with the balance dissenting (Young et al., 2007).

Spirituality. Prosocial behaviorists, who analyzed data from a 20-year longitudinal study of 451 two-parent families across two generations, ascertained that religiosity or spirituality promoted positive family functioning (Mahoney, 2005; Spilman et al., 2012). Another research also discovered that the mother's religiosity moderated the parent-child attachment security by affecting family cohesion, maternal behavioral control, and child adjustment problems (Goeke-Morey et al., 2012). It pertains to transcendent, sacred, holy, or religious experiences that are sometimes unexplained because spirituality often involves the interaction of the character, personality, or disposition of Man with God (Miller & Thoresen, 2003).

In other words, when conceptualizing spirituality as the relationship between body, mind, and emotions, it also describes the connectedness within the self, with others, and with God. On the other hand, spiritual disciplines are defined as the practices of prayer, meditation, and Scripture reading about improving the individual's spirituality. The role of spirituality as the fifth

force of change in counseling is gaining acceptance (Ratts & Pedersen, 2014; Stanard, Sandhu, Painter, 2000). There is indeed an emphasis on the spiritual and faith concerns observed in the movement of rapprochement and integration in recent years (Castonguay, Reid, Halperin, & Goldfried, 2003).). For example, before 1985, few studies on forgiveness (Fehr, Gelfand, & Nag, 2010; Worthington, 1998), but this number has since improved by over 4,000% (PsycINFO, July 2003).

Maslow (1971) insists that his model's self-actualization component has embedded spiritual and existential meaning significance. Likewise, Cervantes and Ramirez (1992) and Yalom (1980) argue that the human's search for meaning in life entwines with the individual's quest for harmony in his or her inner being. Furthermore, the spiritual self, which is interestingly congruent with Ellison's (1983) claim that humans' search or quest for meaning and purpose in life, is directly linked to spirituality. Elkins, Hedstrom, Hughes, Leaf, and Saunders (1988), who identified various spirituality values as correlating with meaning and purpose of life, an appreciation of beauty in nature, and a balanced awareness that there are death and life, supported this claim of an integrated spiritual and existential meaning. Hence, it is practical and perhaps even imperative that clinicians who work with clients of faith conceptualize issues related to their spirituality, religion, and faith, as part of their treatment planning (Bienenfeld & Yager 2007; Moore-Thomas & Day-Vines, 2008).

Gratitude. Gratitude is a powerful emotion and is an important concept promoted by several world religions (Emmons & Crumpler, 2000); it is also central to the pursuit of happiness according to a Gallup poll taken in 1998 (as cited in Tsang, 2006). In Krysinska, Lester, Lyke, & Corveleyn's (2015) study of trait gratitude and suicidal ideation and behavior among a sample of 165 college students, they discovered that gratitude and religiosity are inversely correlated with

prior suicidal ideation, although not with previous suicidal behaviors. However, when they controlled for psychological risk factors such as depression and stress, the statistical significance of gratitude and religiosity decreased (Krysinska et al., 2015).

In a very recent study, Rosmarin and colleagues (2016) tested their religious involvement model, religious coping, gratitude, and negative emotions. The participants could sustain their grateful attitude using their religious coping (Rosmarin et al., 2016). The outcome of this study by Rosmarin et al. (2016) replicates earlier studies indicating gratitude promotes well-being (Bono & McCullough, 2006; Krause, 2009; Toussaint & Friedman, 2009; Wood et al., 2007).

Finally, Krejtz, Nezelek, Michnicka, Holas, and Rusanowska (2016) found that participants who completed two weeks of “counting their blessings” in their daily journaling could experience enhanced well-being at the within-person level, as well as a reduction of distress from daily stressors. Their results appear to submit that persons who practice acts of “gratitude or gratefulness” can enjoy more positive psychological health (Krejtz et al., 2016).

Guilt and Shame. In general, posttraumatic guilt and shame experienced by refugees are different; Hall and Fincham (2005) theorized that a transgressor’s shame (rather than guilt) tends to be negatively correlated with self-forgiveness, merely because shame is more self-oriented. Thus, transgressors who have shame tend to avoid conciliatory behavior (Hall & Fincham, 2005). On the other hand, transgressors who have guilt are more likely to seek reconciliation because of the other-person orientation (Hall & Fincham, 2005).

However, posttraumatic guilt and shame appear to be both self-oriented and other-oriented because of the compounding process on the emotions (Wilson, Droždek, & Turkovic, 2006). Likewise, both posttraumatic guilt and shame can exist in cumulative or straightforward PTSD. Wilson and his colleagues (2006) postulate that clinicians should assess posttraumatic

guilt and shame across these eight psychological dimensions: (a) self-attribution processes, (b) emotional states and capacity for affect regulation, (c) appraisal and interpretation of actions, (d) the impact of forms of shame and guilt on personal identity, (e) suicidality, (f) defensive patterns, (g) proneness to PTSD, and (h) dimensions of self-structure adversely affected by states of shame and guilt (p. 122).

However, this study is not the scope to include an assessment of post-traumatic guilt and shame, except to delineate these factors as the basis for having positive spiritual constructs. Additionally, Budden (2009) argued that the emotion shame factors into the development and the trajectory of PTSD. In conclusion, the student-researcher proposes that an intervention based on spiritual concepts should include grace and forgiveness to address posttraumatic guilt and shame.

Grace. Grace in Hebrew is חַנּוּן (H2603; Strong's), and is mentioned at least 69 times to mean favor or goodwill or acceptance (Blue Letter Bible, 2015). In the New Testament, it is *charis* or χάρις (G5463; Strong's in Blue Letter Bible), mentioned 156 times in 147 verses (Blue Letter Bible, 2015). One of the most popular definitions of grace is “the unmerited favor of God.” Webster- Merriam Dictionary (n.d.). Additionally, this study utilizes three other definitions of grace, “unmerited divine assistance is given humans for their regeneration or sanctification,” “a virtue coming from God,” and “a state of sanctification enjoyed through divine grace” as contributed by authors such as Warfield, (n.d.), Stott (n.d.), Bridges (n.d.), and Zahl (n.d.). Other definitions included are “the love of God shown to the unlovely,” “the peace of God given to the restless,” “free sovereign favor to the ill-deserving,” “love that cares and stoops and rescues,” “God reaching downward to people who are in rebellion against Him,” and “Grace is unconditional love toward a person who does not deserve it” (as cited in Bufford, 2015).

Forgiveness. Forgiveness is a redirection of negative motivations towards the

conciliatory relationship between the offender and the victim or the person that has been hurt (McCullough, Fincham, & Tsang, 2003). However, forgiveness does not always end in reconciliation (Worthington, 2013). In contrast, the definition of forgiveness is letting go of resentment, and about releasing the offender from the victim's judgment towards God's righteous judgment (DiBlasio, 1998). Grace, also, is forgiveness, plus compassion, mercy, and love. However, like forgiveness, it is not ignoring that offense or wrong has been committed or pretending that the violation did not occur. Nor is it about avoidance, condoning, or excusing the wrongdoing. Christians believe that grace is a form of spiritual awareness to help them to forgive themselves and others.

The extent to which how therapies such as CBT or NT involve a focus on overcoming the adverse effect is associated explicitly with the perpetrators of trauma is not well understood. However, other studies showing that perceived forgiveness from God or victims correlated positively with self-forgiveness after accounting for variance in the time-lapse at the time of offense and time of forgiveness (Hall & Fincham, 2008; Martin, 2008; Van Oyen-Witvliet, Ludwig, & Bauer, 2002). Furthermore, Van Oyen-Witvliet et al. (2002) discovered that positive emotions are often enhanced when the offenders imagine receiving mercy from their victims. This concept of forgiveness is consistent with a conclusion drawn from another study by Hall and Fincham (2008), who found that offenders or transgressors who recognized forgiveness from their victims can self-forgive themselves too.

In contrast, McConnell & Dixon (2012) imply that God's perceived forgiveness does not always predict one's forgiveness. According to Tsang, McCullough, and Hoyt (2005), "religion-forgiveness discrepancy" exists when religious individuals can receive forgiveness from God and others, but struggle with forgiving themselves and others (p. 786). Walker and Doverspike

(2001) agree with this phenomenon of “religion-forgiveness discrepancy” and concluded that self-forgiveness is not always an antecedent to receiving forgiveness from God.

The research finding shows that individuals with a higher level of empathy are more inclined to forgive others. However, according to one study by Woodyatt and Wenzel (2013), empathy did not correlate with self-forgiveness. Conversely, Martin (2008) found that individuals who have experienced God's forgiveness can better forgive themselves. Self-forgiveness is essential because the ability to forgive oneself is associated with psychological well-being (Romero et al., 2006), personal growth (Fisher & Exline, 2006; Woodyatt & Wenzel, 2013), and overall satisfaction with life (Thompson et al., 2005). Also, individuals with higher dispositional self-forgiveness enjoy greater self-confidence (Woodyatt & Wenzel, 2013), better emotional efficacy (Walker & Gorsuch, 2002), and are also more positively engaged with others (Hill & Allemand, 2010/2011; Woodyatt & Wenzel, 2013). Contrariwise, those who have difficulty forgiving self tend to develop negative affect (Thompson et al., 2005), self-blame (Friedman et al., 2007; Wohl, DeShea, & Wahkinney, 2008), rumination (Thompson et al., 2005), hostility (Snyder & Heinze, 2005), and depression in the longer term (e.g., Chan & Parker, 2004; Sternthal, Williams, Musick, & Buck, 2010; Thompson et al., 2005; Wohl et al., 2008).

Self-forgiveness or intrapersonal forgiveness is associated with perceived forgiveness from God (Cornish & Wade, 2015a; Wilson et al., 2006). Using *Stage Models of Self-Forgiveness*, Enright (1991/1996) theorized that for transgressors to experience self-forgiveness, they must progress through a stage model: uncovering, decision, work, and outcome stages. The exact progression of this model is likely to differ across people and cultures. First, transgressors work through possible denial before accepting responsibility in the uncovering stage (Enright,

1991/1996). If transgressors maintain denial, they will not progress through subsequent steps. Consequently, maintaining denial fosters pseudo-self-forgiveness; that is, self-forgiveness that avoids taking responsibility for harmful actions.

In Cornish and Wade's (2015b) genuine forgiveness model, the four "Rs" were used to represent four steps that will move an individual towards genuine self-forgiveness and personal growth. The first step begins with offenders taking responsibility for their actions (Cornish & Wade, 2015). According to the authors, this step in the model is essential for reducing blame-shifting (Cornish & Wade, 2015). The next step is the experience of remorse or regret for his or her actions or taking responsibility (Cornish & Wade, 2015). In most cases, the emotion of global shame, which is also self-oriented, must be resolved, to induce responses such as guilt and regret, which is less maladaptive. The third step is based on acting to move oneself towards restoration (Cornish & Wade, 2015). The authors imply that restoration involves the offending person seeking ways to repair the ruptured relationship, as far as it depends on them (Cornish & Wade, 2015). Accordingly, behavior patterns that can address the offense or violate personal values must be validated. Finally, the last step involves a renewal of compassion or empathy, acceptance of self-respect (Cornish & Wade, 2015, p.98). Cornish and Wade (2015) agree that personal growth can come from a genuine self-forgiveness act. Therefore, it is proposed that factors such as religious coping strategies and spiritual disciplines that contribute to clients' development of agency and efficacy be utilized in interventions (Cornish & Wade, 2015).

Grace, gratitude, and forgiveness. Grace is central to the Christian faith message. It is delineated as a spiritual concept, together with gratitude and forgiveness, to contribute to each person's spiritual and emotional well-being. However, it is difficult for these concepts (grace, gratitude, and forgiveness) to be conceptualized as measurable constructs or variables. Although

it is recommended that grace and forgiveness are latent constructs of multiple dimensions, like spirituality (Miller & Thoresen, 2003), there is a paucity of studies that explore the empirical relationship between gratitude, forgiveness, and wellbeing (Bono & McCullough, 2006). Thus, if spirituality is awareness and the immaterial response to the Divine or God, then a psycho-spiritual framework is the most usual form of template for use in understanding the whole person and his or her trauma

Psycho-Spiritual Framework

Patil et al. (2015) lament that the Western concept of personhood tends to divorce mental health from other health indicators such as somatization. Additionally, there is growing evidence that violence trauma is not always experienced as a fear-provoking outcome but can be experienced as a moral injury resulting in feelings of guilt, shame, or betrayal (Litz et al., 2009) and feelings of disgust and bereavement (Neria and Litz, 2004). Thus, interventions that incorporate spiritual concepts such as forgiveness in practice are growing around addressing moral injury (Fallot & Blanch, 2013; Harris et al., 2011). Hence, if therapists wish to intervene in the aftermath of stressful life events, they should include the person's spiritual domains of experience in their assessment, conceptualization, and intervention (Bray, 2010; Hook et al., 2010). Thus, this study is unique in its quest to use grace to improve levels of gratitude and forgiveness while reducing somatic and psychological distress.

Spirituality-Based Intervention

Studies indicate that the majority of social workers and therapists are not opposed to using some form of spiritual intervention that includes a spiritual or religious discipline or component or concepts in clinical work if clients request them to (Furman, Benson, Grimwood, & Canda, 2004; Hodge, 2006). Reviewer Hodge (2006) found that spiritually modified cognitive

behavior therapy is at least as effective as the traditional approach for depression, a view that was successfully replicated with the same outcome two years later (Hodge, 2008). Like standard cognitive therapy, spiritually-modified cognitive therapy purposes to help clients identify and replace underlying core beliefs with spiritual precepts that harmonize with their worldview (Hook et al., 2011). Additionally, Hook et al. (2011)'s review concludes that the outcomes of six other studies that used spiritually-modified cognitive therapy are on par or superior to those produced by evidence-based approaches. The total effect size renders spiritually modified cognitive therapy an efficacious intervention to treat depression among Christians (Hodge, 2006; Hook et al., 2011).

Christian Devotional Meditation

According to a study that analyzed the trend of people using religious coping such as prayer (Tan, 2007), the researchers found that the association between prayer use for pain management shows an upward trend from 2001 to 2007 (Wachholtz & Sambamoorthi, 2011). Also, meditation produces a clinically as well as physiological changes (Luders et al., 2013) such as the reduction of blood pressure (Barnes, Davis, Murzynowski, & Treiber, 2004; Anderson Liu, & Kryscio, 2008) and the improvement of individuals' immunity to illnesses (Grossman, Niemann, Schmidt, & Walach, 2004; Pace et al., 2009).

Other benefits of meditation include reducing stress and anxiety and a significant improvement in moods (Jain et al., 2007; Vøllestad, Sivertsen, & Nielsen, 2011). According to another study by Wachholtz and Pargament (2008), those who practiced spiritual meditation experienced a more significant reduction in the frequency of migraine headaches, anxiety, and negative affect while concurrently experiencing increased self-efficacy associated with pain. In the same study, participants' daily spiritual experiences and existential well-being also improved.

Similarly, meditation, which included spirituality components, positively influenced spiritual and subjective well-being, according to a randomized study with 84 participants (Wachholtz & Pargament, 2005).

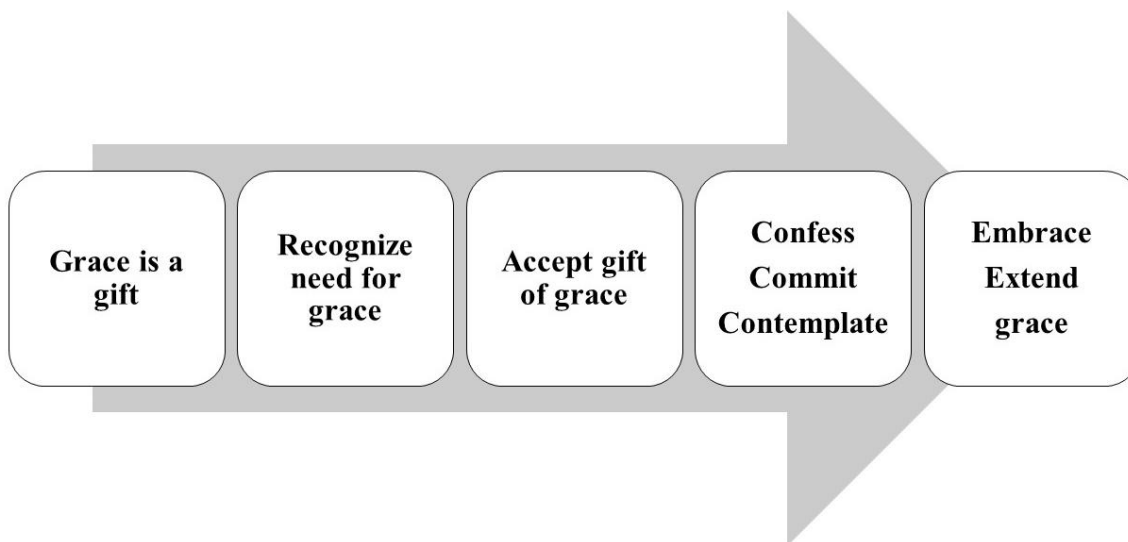
An Overview of GRACE Protocol

GRACE protocol is essentially a strength-based adaptation of the CBT and narrative therapy. Research reveals that Western therapeutic techniques can be culturally adapted, such as the Transcultural Psychosocial Organization (TPO) work among Sudanese refugees in Uganda and displaced persons in Cambodia (Baron, 2002). Other researchers such as Neuner et al. (2004) and Guerin et al. (2004) successfully implemented a community-based program among the refugees from Somalia and Rwanda. Likewise, National Institute for Clinical Excellence (NICE, 2005) proposes that “A randomized controlled trial, using newly developed guided self-help materials based on trauma-focused psychological interventions, should be conducted to assess the efficacy and cost-effectiveness of guided self-help compared with trauma-focused psychological interventions for mild and moderate PTSD” (p. 132).

What is GRACE Protocol?

GRACE protocol is a culturally adapted version of trauma-informed cognitive-behavioral therapy (TF-CBT) using spiritual disciplines. GRACE, a component-based model, is articulated through the short-term psychoeducational approach using spiritual disciplines such as Scripture reading, reflective writing, and prayer to address the unique needs of Chin refugee adults who have experienced post-traumatic stress (PTS), daily stressors, and other adjustment-related difficulties associated with resettlement in the United States.

Figure 3: The Components of the GRACE Protocol



Since spirituality and religion also influence beliefs, goals, and emotions, the participants will use narration or reflective writing to express them (Pargament, Magyar-Russell, & Murray-Swank, 2005; Silberman, 2005). Miller and Thoresen (2003) theorize spirituality and religiousness as “latent and multidimensional constructs” for research (p. 24). Conversely, spiritual constructs such as grace, forgiveness, and gratitude are not just positive psychological characteristics that give meaning and purpose to life but are also spiritual virtues that support wellbeing and functioning (Peterson & Seligman 2004; Toussaint & Friedman, 2009). In this study, spirituality serves as lenses through which these participants perceive and interpret their world, consistent with Ozorak (2005) survey.

Rationale for the Protocol

There appears to be a paucity of psychological work on positive psychological concepts (such as grace, gratitude, and forgiveness) as a bridge between a psychosocial intervention (such as CBT and NT) and spiritual disciplines. Hence, this section purposes evaluating the rationale undergirding each component of the GRACE protocol, with a summary of the theoretical framework:

1. Grace is a gift.

This first step encompasses some of the strategies from psychoeducation and scriptural reading. Participants received a short passage to read daily. The first passage is of grace and forgiveness. In the workshop, the researcher begins with psychoeducation on grace forgiveness. Grace is like compassion, a concept valued in Buddhism and the Judeo-Christian traditions, but with the added spiritual value of forgiveness. Another author defines it as “unmerited favor.” According to Lundberg (2010), forgiveness is a central tenet in almost every major faith tradition globally. The act of forgiveness is construed as an intentional act borne out of cognitive, behavioral, and affective constructs (Zechmeister, Garcia, Romero, & Vas, 2004). Forgiveness of others or interpersonal forgiveness involves one person forgiving another for hurt or transgression.

Theoretical Framework:

The reading of passages from the Bible, the holy book of Christians, is like bibliotherapy, according to Crothes in 1916 (as cited in Heath, Sheen, Leavy, Young, & Money, 2005), which is the reading of books to aid in recovery (Apodaca & Miller, 2003; Heath et al., 2005). This form of intervention is traced back to the beginning of the twentieth century (Betzael & Shechtman, 2010). Apart from reading the scriptural passage, this portion of the protocol also requires the participants to reflect, consider, and discern how to apply the principle.

The basis for this step is the basis found in cognitive-behavioral therapy (CBT) that is in using psychoeducation as a tool to help patients to identify, evaluate, and respond to their wrong thoughts and beliefs, and in this case, their reframing about grace and forgiveness. Like CBT, this step uses psychodrama and narration (or small group discussion) to effect change in thinking, affect, and behavior (Garzon & Hall, 2012).

2. Recognize the need for grace (Right remembering, processing, and reframing).

Step two is journal writing or a written narrative as a form of self-expression. This step follows the cognitive-behavioral format in teaching the participants how to restructure their cognitions of their past and present experiences with narrative writing. Research demonstrates that journal writing as a reflective practice is therapeutic. In this component, the participants will learn how to keep a daily or weekly journal to help process and make sense of their past and present experiences. Moon (1999) identifies several purposes of journaling such as the promotion of “critical thinking or developing a questioning attitude, to enhance the personal valuing of the self towards self-empowerment, to provide an alternative ‘voice’ for those not good at expressing themselves, and finally to foster reflective and creative interaction in a group” (as cited in Boud, 2001, p.1).

Likewise, this step borrowed several techniques from Sansone & Sansone (2010) to enhance feelings of gratitude in individuals: “1) Journaling about things for which to be grateful; 2) Thinking about someone for whom you are grateful; 3) Writing/sending a letter to someone for whom you are grateful; 4) Meditating on gratitude (present moment awareness); 5) Undertaking the “Count Your Blessings” exercise (at the end of the week, writing down three things for which you were grateful); 6) Practicing saying “thank you” in a sincere and meaningful way; 7) Writing thank you notes; 8) If religious, praying about your gratitude” (p.21)

Theoretical Framework:

The theory of narrative or testimony therapy is the framework. However, this step is distinguished from other step-wise protocol that requires participants to recall the negative incident (Cornish & Wade, 2015), which may risk a re-traumatizing experience if not done with a competent therapist clinical setting. Conversely, testimony therapy contextualized within the

Black church's cultural and spiritual practice in the United States has proven beneficial (Griffith, Young, & Smith, 1984). The main principle of testimony therapy is that by testifying or narrating or talking about one's trauma or past traumatic experience, it will diminish their post-traumatic stress symptoms (Combs & Freedman, 2012; Tamasese, Waldegrave, Tuhaka & Campbell 2003).

However, positive psychology emphasizes the need for a more reflexive and expansive account of narrating positive traits (such as grace) within a conceptual framework which recognizes the individual's suffering within the broader collectivistic community context of love and hope (Brough et al., 2013; Seligman & Csikszentmihalyi, 2000). Hence, instead of having the participants recall a traumatic event, they are asked to rightly remember how grace was shown to them when they became believers in the Judeo-Christian faith.

3. Accept the gift of grace.

The research appears to imply that relieving distress often does not result in wellbeing. Still, the emphasis on positive emotions such as gratitude can promote one's ability to develop holistic and spiritual resources to ameliorate negative affect (Eaton, Bradley, & Morrissey, 2014; Fredrickson, Tugade, Waugh, & Larkin, 2003). However, one cannot teach another person to be grateful.

This step uses guided imagery to help the participants imagine accepting grace and healing (Torosian, & Biddle, 2005) because abiding grace can result in gratitude. Of importance is the basic principle of meditation (Benson, 1996; Garzon, 2008). Participants learn to use metaphors and the imaginative world to influence the healing of their embittered heart and receiving transformation from God (Garzon, 2008, 2013; Torosian, & Biddle, 2005). Research alludes that this is incredibly helpful in cases of deeply traumatic events, which can be

impossible to access on a cognitive and conscious level because of the absence of a cultural framework (Cappas, Andres-Hyman, & Davidson, 2005; Alexander, 2004).

Theoretical Framework:

The meditation principle frames the relaxation and imagination step (Benson, 1996; Garzon, 2008). In the workshop, participants are encouraged to imagine “a heart of stone,” which they understand is full of bad memories, feelings of shame, and guilt, and this step helps avoid a re-traumatizing event (Garzon, 2008; Garzon & Burkett, 2002). What is important here is, the participants imagine Jesus standing over them, which presents a very safe and comforting place to be in (Garzon, 2005).

Forgiveness therapy (Enright, 1991; Worthington, 1989), with some variation, forms this step's theoretical basis. Forgiveness involves, first, forgiving themselves (intrapersonal), then forgiving an offender within their community (interpersonal forgiveness), before extending the forgiveness to the people group that promoted the violence in their country of origin (inter-group forgiveness). Conversely, self-forgiveness, or intrapersonal forgiveness, is an expression of goodwill or empathy towards oneself, whereby the self is the offender in a conflict (Cornish & Wade, 2015a; Hall & Fincham, 2005). Other studies defined it as an acceptance of self or the fostering of compassion and love towards self, as opposed to self-hatred, self-loathing, and self-contempt (Enright, 1996; Hall & Fincham, 2005). Self-forgiveness defined for this study involves releasing oneself from one's self-condemnation, guilt, and shame that emerged from the transgression of others (Fisher & Cornish & Wade, 2015a; Exline, 2006; Strelan, 2007). Subsequent training on reflective skills helps the participants narrate their story as they connect forgiveness and self-forgiveness to the concept of grace.

Past studies yield compelling evidence of the benefits of gratitude in promoting wellbeing, better stress-response (Wood, Froh, & Geraghty, 2010), forgiveness and trust (Emmons & McCullough, 2003; Watkins, 2014), enjoyment of simple everyday pleasures (Watkins, Woodward, Stone, & Kolts, 2003), self-efficacy (Wood, Maltby, Linley, & Joseph, 2008), and speedier recovery from traumatic experiences (Kashdan, Uswatte, & Julian, 2006). More critical, forgiveness and gratitude are not only positive psychological characteristics, but they are also human virtues that support subjective wellbeing and functioning (Bono & McCullough, 2006; Emmons, 2008; Peterson & Seligman 2004; Toussaint & Friedman, 2009; Toussaint, & Webb, 2005).

4. Confess, commit, and contemplate (on the gift of grace).

This step is a combination of forgiveness therapy (Enright, 1991; Worthington, 1989), positive psychology, and Christian devotional meditation (CDM; Garzon, 2013), with some adaptation. The emphasis of forgivingness, owing to the background of the participants' past violence trauma and present daily stress, would be on forgiving themselves or accepting forgiveness (intrapersonal), forgiving an offender within their community (interpersonal forgiveness), before extending the forgiveness to the people group that promoted the violence in their country of origin (inter-group forgiveness).

There are two possible parts to STM: the patient or client can meditate on God's character or just on scriptural passages. For both, the client selects a phrase or scriptural passage from a prepared list. After being seated comfortably, the counselor or principal investigator will ask the participant to focus on repeating the words or scriptural passage repeatedly (Garzon, 2013). During the initial training, the mind can wander, and the therapist can guide the participants back gently to focus again on the phrase (Garzon, 2013). The participant can use the controlled

breathing technique in conjunction with the STM (Garzon, 2013).

As an example, if the phrase is “God gives grace,” as the client is breathing in, he can visualize accepting the words, “God gives grace,” while breathing out, he or she can say, “I need grace.” The participants will learn to relax and be more at peace with the knowledge that “God gives grace” during the process of controlled breathing. According to Garzon (2013), it is possible that during the meditation time, that the participants may recall particular painful memory or feelings of distress will surface. The student-researcher should assure the client to contact the researcher or the pastor to process such experiences and continue with the meditation afterward if appropriate (Garzon, 2013).

Theoretical Framework:

In Garzon’s (2013) article, the author postulates that the participant can incorporate scriptural truth meditation (STM) as an adjunct to Christian devotional meditation. The confessing is also a declaration of accountability since each person must confess one’s need to commit to practicing the protocol throughout the five weeks. Participants are encouraged to be accountable to themselves and the other two persons in the triad group to practice the protocol steps that will lead them to the outcome of their recovery (Erford, Savin-Murphy, & Butler, 2010). Participants are encouraged to “confess” to one another through texting/phone calls during the week.

Confessing to do something verbally (outward) involves an act of will, in the form of the individual making an inward commitment. Confessing helps participants examine psychology's contribution to understanding the positive consequences of controlling their personal mental and physical health. Kobasa and her colleagues (1981) have shown that the capacity to tolerate life stress is significantly impaired when commitment is absent (Carr, 2013; Kobasa, 1979; Kobasa,

Maddi, & Courington, 1981; Kobasa, Maddi, & Kahn, 1982). Also, the cognitive model known as a rationalist model developed by Beck (2003), associates commitment to cognition, exemplifying the will of the subject.

Lastly, the definition of the act of contemplation is thinking deeply about an idea or concept. Contemplation is an essential skill of meditation, according to Luders et al. (2013). The participants focus their attention (or self-referencing) on the idea when they think deeply about a scriptural verse or phrase. Likewise, during meditation, the medial prefrontal cortex (MPC), the part of the brain known as the self-referencing center, will process incoming information concerning the individual within the MPC itself. Subsequently, the process from the MPC to the amygdala results in greater empathy towards self and others (Hall & Fincham, 2005; Luders et al., 2013).

5. Embrace and extend the gift of grace.

Trauma often threatens the very foundation of a person's beliefs and his or her sense of living. Such experiences can affect daily functioning and create mental health problems. Yet some who have suffered can make meaning of their experiences and become caring and helpful, and a phenomenon referred to as "altruism born of suffering" (ABS; Staub, 2003, 2005). In this final step, participants reflect on their suffering and learn to transform their past into the present and future altruistic acts. Likewise, this aspect of the protocol is meaningful because individuals who have modified their forgiving levels can perform acts of kindness out of their gratitude for their life. The Daily Spiritual Experience Scale (DSES; Underwood, 2006/2011; Underwood & Teresi, 2002) has a component that measures this in question 13, "I feel a selfless caring for others."

Theoretical Framework:

The theory supports the participant's need to embrace change in their cognition, affect, and behavior. Approving changes that promote increased gratitude, trust in others, and safety feelings can improve the participants' mental health (Cummins, 2012). This final step is also essential because intentional change requires an act of the individual's will, which goes against their natural behavior pattern. For example, the ability to forgive requires the individual to eliminate their desire for vengeance intentionally. Research has established that better mental health leads to more satisfaction with life (Frey et al. 2004).

Also, to bridge from theory to praxis, they extend God's grace to one particular person they have reasonably identified during the workshop. Moreover, embracing change is altruism. Altruism is "unselfish regard for or devotion to the welfare of others" (Webster-Merriam, n.d.). Altruism developing from the initial stages of spiritual transformation can eventually translate to intrapersonal, interpersonal, and intergroup forgiveness. All five steps are summarized in Table 1 below and compiled as a manual in Appendix B:

Table 1: Components of the GRACE Protocol

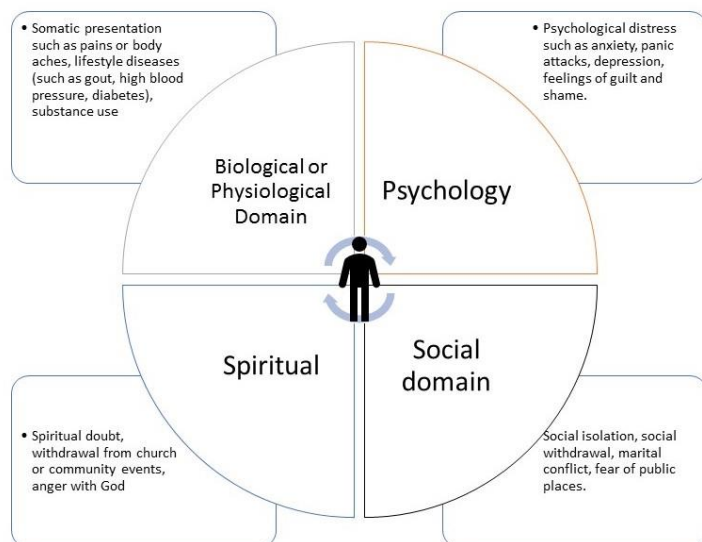
Component of Protocol	Skills Taught/Utilized	Action Plan
Grace is a gift	Psychoeducation, prayer, reflective skills (CBT)	Reading parable from Holy Scripture: Matthew 18: 21-35 Reflect on how grace was shown in the story. The participants will write down their personal reflections on how grace was demonstrated as they read the account each day.
Recognize the need for grace	Cognitive-behavioral therapy (Journaling), Narrative therapy, Testimony therapy.	In the workshop: Recall the incident (narrate the "incident" with two others in the group.

		<p>In the workbook, “Can you remember a time when God showed you grace?”</p> <p>Participants are to write in their workbook their “story” of grace.</p>
Accept the gift of grace	Christian devotional meditation	In the workshop, participants learn to use imagery to “imagine giving the heart of stone (representing resentment, unforgiveness) to Jesus and, in turn, receive the heart of grace (flesh) from Him.”
Confess, commit, and contemplate (Meditate on the gift of grace)	Christian devotional meditation, positive psychology	Confess the scriptural verse (on God’s gift of grace) that is in their workbook.
	Christian devotional meditation	Commit verbally and in writing to living God’s gift of grace
	Christian devotional meditation, positive psychology (cultivating gratitude)	<p>Contemplate (think deeply) on God’s gift of grace</p> <p>A life of grace is one of living right, as one that is “redeeming the time” (When they are ready, they can also write down the person's name that is causing them grief or someone they would like to extend grace to).</p>
Embrace and extend the gift of grace	Altruism and bridging faith and praxis.	<p>Embracing change. Write down one thing they will do differently today) Actions I will take days to enjoy God’s gift of grace.</p> <p>Extending is an altruistic act that they can do during the week for someone.</p>

Summary

This literature review has trekked through the Burmese experience during pre-flight, flight, pre-settlement, and settlement. The researcher has also highlighted several past studies that promoted wellness within the refugee populations. More importantly, she explored interventions that do not focus solely on psychopathologies, such as post-traumatic stress disorder, psychological and spiritual growth, and subjective well-being. Concurrently, she has established that the Chin population faces various threats to their biopsychosocial spiritual domains because of their pre-settlement stress and daily stressor. She then used the literature review findings on best practice interventions for developing strategies to ameliorate the biopsychosocial-spiritual domains under threat (Figure 4).

Figure 4: The Biopsychosocial-Spiritual Domains Under Threat



Essentially, mental health interventions with the refugee population are divided into three broad areas: 1) trauma-focused therapy focusing on ameliorating their pre-settlement trauma; 2) psychosocial-focused therapy that helps the resettled refugees deal with daily stress from cultural adaptation and acculturation; 3) the multimodal approach that allows this population of refugees

deals with both pre- and post-settlement anxiety, as well as posttraumatic guilt and shame. However, the literature review denotes a gap in approaches designed to facilitate forgiveness and gratitude (Bono & McCullough, 2006) while reducing distress.

Besides, few studies have researched interventions that can foster growth in a people group's biopsychosocial and spiritual domains that have experienced post-traumatic stress and daily stressors. Hence, the researcher uses a framework for the protocol that relies heavily on the practice of the spiritual discipline of Christian devotional meditation, the theories of trauma, and cognitive-behavior to construct the faith-driven protocol. In the following chapter, the researcher will delineate the research method to recruit the targeted Chin population members. The population comprises of Chin who has resettled in the United States for at least a year. Several themes thread through this body of work: God's grace, forgiveness, and self-forgiveness fundamentally form the central backbone of this faith-driven protocol.

CHAPTER THREE: METHODS

Refugees are among the United States' strongest, most courageous, and most resilient residents. They have suffered losses beyond the imagination of most Americans and have overcome challenges and boundaries that are not often in our daily perception (Burgess, 2014, p.12).

The literature review reveals the need for complementary or alternative treatments to address symptoms of cumulative stress. The researcher used a working knowledge of cognitive-behavioral therapy, narrative therapy, spiritual disciplines, and Christian devotional meditation to create the GRACE protocol to fill this gap. The current study will use a randomized control pre- and post-test approach to explore how Chin adults from a refugee background with histories of cumulative stress experience a Christian faith-driven protocol.

In this chapter, the researcher described the research design used to examine the effects of the GRACE protocol's daily practice. She also provided the rationale for the portfolio of five measures that she used to establish a baseline before intervention for both the treatment group and the wait-list group. Five weeks after the intervention, she assessed both the treatment and waiting-list groups on the same measures.

Research Design

Participants were randomly assigned to the control group and the treatment or intervention group. All participants were assessed pre-intervention on the day of the seminar. The participants in the treatment group attended a four-hour long workshop to learn the GRACE protocol. More specifically, the study assessed the participants' change in biopsychosocial and spiritual domains as they practice the GRACE protocol for five weeks.

Research Questions

1. Does the GRACE protocol practice for five weeks resulted in reducing somatic and psychological problems as measured by the Refugee Health Screener-15 (RHS-15; Hollifield et al., 2013) at post-intervention?

$$H_{a1}: \mu_{RHS15_{pre-intervention}} > \mu_{RHS15_{post-intervention}}$$

The hypothesis is participants who practice the GRACE protocol will score lower at post-intervention than at pre-intervention on the RHS-15. In other words, they would experience a reduction in their somatic and psychological distress (lower RHS-15 score) after practicing the protocol.

Null Hypothesis: There will be no significant difference in post-traumatic stress (PTS) as measured by the RHS-15 repertoire post-intervention after the participants have practiced the GRACE protocol daily, compared to the pre-intervention scores on RHS-15.

$$H_{o1}: \mu_{RHS15_{pre-intervention}} = \mu_{RHS15_{post-intervention}}$$

2. Will there be an improvement in gratefulness as measured by the Gratitude Questionnaire (GQ-6) among the participants who practiced the GRACE protocol?

$$H_{a1}: \mu_{GQ6_{post-intervention}} > \mu_{GQ6_{pre-intervention}}$$

The hypothesis is participants who practice the GRACE protocol will score higher on the GQ-6 at post-intervention than at pre-intervention. A higher score on the measure translates as an improvement in their experience of gratitude.

Null Hypothesis: There will be no significant difference in levels of gratitude as measured by the GQ-6 repertoire in the participants that practiced the GRACE protocol, measured pre-intervention, and at post-intervention five weeks later.

Ho1: $\mu_{\text{GQ6 Treatment Group at pre-intervention T1}} = \mu_{\text{GQ6 Treatment Group at post-intervention T2}}$.

3. Will there be a lowering of avoidance and a tendency to seek revenge (or an improvement in the motivation to forgive) measured by (TRIM-12) at post-intervention?

Ha1: $\mu_{\text{TRIM12}_{\text{pre-intervention}}} > \mu_{\text{TRIM12}_{\text{post-intervention}}}$

The hypothesis is participants who practice the GRACE protocol will score lower at post-intervention than at pre-intervention. The participants would have a higher motivation to forgive (lower score) after practicing the protocol.

Null Hypothesis: There will be no significant difference in forgivingness levels as measured by the TRIM-12 repertoire post-intervention after the participants have practiced the GRACE protocol daily, compared to the pre-intervention scores TRIM-12.

Ho1: $\mu_{\text{TRIM12}_{\text{pre-intervention}}} = \mu_{\text{TRIM12}_{\text{post-intervention}}}$

4. Will there be an increase in the participants' wellbeing as measured by the Satisfaction with Life Scale (SWLS; Diener et al., 1985) and their spiritual condition as measured by the DSES (Daily spiritual experience scale) practiced the GRACE protocol?

Ha1: $\mu_{\text{SWLS}_{\text{post-intervention}}} > \mu_{\text{SWLS}_{\text{pre-intervention}}}$

The hypothesis is participants who practice the GRACE protocol will score higher on the SWLS at post-intervention than at pre-intervention. In other words, they would experience greater satisfaction with life (higher score) after practicing the protocol.

Null Hypothesis: There will be no significant difference in satisfaction with life levels as measured by the SWLS post-intervention after the participants have practiced the GRACE protocol daily, compared to the pre-intervention scores on SWLS.

Ho1: $\mu_{\text{SWLS}_{\text{pre-intervention T1}}} = \mu_{\text{SWLS}_{\text{post-intervention}}}$

Likewise, if the GRACE protocol is successful in “intervening,” the scores on DSES will decrease.

$$H_{a1}: \mu DSES_{\text{post-intervention}} < \mu DSES_{\text{pre-intervention}}$$

The hypothesis is participants who practice the GRACE protocol will score lower on the DSES at post-intervention than at pre-intervention. In other words, they would spiritual experiences more often (lower score) after practicing the protocol.

Null Hypothesis: There will be no significant difference in daily spiritual experience as measured by the DSES after the participants have practiced the GRACE protocol daily

$$H_{o1}: \mu DSES_{\text{pre-intervention}} = \mu DSES_{\text{post-intervention}}$$

5. What lessons are learned from this randomized control trial (RCT) among an ethnic minority refugee population?

No hypotheses were offered for this question due to its post hoc nature.

Methodology

Selection of Participants

Upon approval from the Institutional Review Board (IRB), the student contacted the pastors and elders of a 200-member church to obtain their official blessing to recruit participants from their church and to set a date for the workshop. Following the approval, the church leaders announced during the Sunday leading service for several weeks before the first day of assessment and workshop. Members were also encouraged to promote the study by personal invitation to their friends. The study begins with a 4-hour one-day psychoeducation workshop on a Sunday afternoon.

Inclusion and Exclusion Criteria. The following inclusion criteria applied to the participants: (a) at least eighteen years of age; (b) of Burmese Chin ethnicity; (c) understands

elementary English or Chin to follow the instructions; (d) currently not receiving any counseling for mental distress; (e) willing to attend the workshop and practice a Judeo-Christian faith-drive protocol. The following exclusion criteria will also be applied to the respondents: the presence of significant psychological distress or pathology (clinically diagnosed) and those below eighteen years of age.

Demographic data. Also included in the survey were questions on years in the United States, transit country, questions on current treatment and prescriptions, physical health (at the time of the study), and demographic data (age, gender, country of birth, and marital status).

Random assignment

A randomized control trial (RCT) is the gold standard in clinical research because the anticipated outcome is usually unbiased and consistent, at least with perfect forms of randomization. Moreover, the RCT is designed for an experimental condition with a focus on internal validity. Additionally, one of RCT's unique strengths is the avoidance of selection bias, which is defined as the systematic differences between baseline characteristics of the intervention and control groups (NICE, 2005).

The consent form portfolio, the five measures, and the demographic survey forms were color-coded, and the papers were randomly given out until everyone had a copy. Since 43 participants were recruited, 22 persons were assigned to the intervention group, and 21 persons to the control group. The pastor explained the random assignment and encouraged the people in the control group to leave the hall. However, there were members of the same family that were assigned to two different groups, so accommodation was made for those to stay together. Besides, some husband and wife teams had to take a turn to watch their young children in the

nursery. More will be discussed about the limitations of the random assignment in the discussion section.

Psychoeducation Workshop

The psychoeducation workshop will begin with an overview of the ubiquitous physiological (or physical symptoms) of posttraumatic stress, daily stress, anxiety, and depression. Following this section is a systematic explanation of the GRACE protocol (which is a combined practice of spiritual disciplines and Christian devotional meditation). Within the protocol steps, the researcher will discuss the concept of spiritual virtues such as grace, forgiveness, and gratitude (Appendix A). The interactive workshop or seminar will also allow participants to act out the protocol using narration, letter writing, and several dyadic exercises (Luskin, 2003). Throughout the workshop, the church pastor or a previously appointed church leader was present to interpret for the researcher and clarify other specific terminologies that may not be present in the Burmese translation. There will be a question and answer and small group discussion (if time permits) during the dinner.

Procedure

After receiving the church elders and deacons' official approval, the researcher visited the pastor with some print-outs for the church noticeboard and a sign-up sheet. Due to the church schedule, there were only two dates for the workshop: April and another five weeks later at the end of May. During that visit, the researcher liaised with the interpreter (recommended by the pastor) to review the PowerPoint and other materials. They also met on the morning of the workshop to run a trial with the PowerPoint and sound system. Two other interpreters from the leadership team were also present to provide additional help with the interpretation.

Assessment. Forty-three participants recruited for the study completed the pre-assessment survey, and they also signed the consent form. The survey packet comprised evaluations of psychological distress, forgiveness, anxiety, depression, life satisfaction, subjective well-being, and spiritual well-being (Appendix D – H). The questionnaire was made available in the English language with verbal interpretation because many from this church could not read the written Burmese language. The student-researcher and an interpreter explained the reason for the survey and answered their questions. On completion of the survey, participants were notified of the date to attend the workshop. To avoid self-assignment to either group, the student-researcher and interpreter emphasized the importance of accepting the date of the seminar assigned to them.

Setting. The intervention-workshop was conducted on a Sunday afternoon immediately after the leading service at 3 pm, followed by dinner in the church basement. After the workshop, participants practiced the protocol daily for five weeks. After five weeks, the participants took post-test assessments. The waiting list control group attended the workshop the same Sunday that the treatment group has completed the intervention but in a different room. All participants were reminded not to share any information about the protocol during the “treatment” period.

Instrumentation

Each refugee has endured the loss of place, material possessions, employment, or education, and at times, even loved ones or his or her purpose for living. Hence, one of the primary considerations with intervening with the refugee population would be the identification and selection process of psychometric measures that can accurately quantify the challenges that the respondents experienced. It appears to be an impossible task for any researchers to undertake to measure a refugee’s level of suffering and psychological torment. Equally, there is a lack of

culturally appropriate screening tools to assess maladaptive responses in newly resettled refugees and those who have been here for an extended period (Shannon et al., 2012; Hollifield et al., 2013; Savin et al., 2005).

Measure for Post-Settlement Stress

The instrument for post-settlement stress assesses specific processes such as biopsychosocial distress and its change.

Refugee Health Screener-15 (RHS-15; Hollifield et al., 2013). Using post hoc analyses that included items as independent variables, the developers of RHS-15 used data obtained from refugees of three primary countries, Iraq, Burma, and Bhutan (Hollifield et al., 2013). The authors' goal for developing this scale was to select items that would efficiently and effectively assess probable diagnostic-level mental health distress such as anxiety and mood disorders. These refugees are likely to come from a heterogeneous range of experiences and cultural orientations (Hollifield et al., 2013). The instrument has demonstrated strong internal consistency and transcultural validity with several refugee populations, such as the Vietnamese and Kurdish refugees (Hollifield et al., 2013). The fact that it has metric properties also submits its administrative efficiency while respecting refugees' voices screened for psychiatric distress (Hollifield et al., 2013).

The first part of the measure has fifteen statements or questions on somatic and psychosocial distress. The Likert scale ranges from 0 (for "not at all") to 5 (for "extremely"). The last four questions of the 15 are: "Had the experience of reliving the trauma; acting or feeling as if it were happening again"; "Been having PHYSICAL reactions (for example, break out in a sweat, the heart beats fast) when reminded of the trauma?" "Felt emotionally numb (for example, feel sad but can't cry, unable to have loving feelings)?" "Been jumpier, more easily startled (for

example, when someone walks up to you)?” Respondents scoring above 12 on questions 1 to 14 and equal or above five on the distress thermometer are considered positive for psychiatric distress

Measure for Spiritual Constructs

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) that oversees the accreditation and certification of more than 20,500 health care organizations and programs in the United States, views spirituality as an essential construct or paradigm for conceptualizing the patients’ illness. JSAHO mandates the administration of spiritual assessment for all patients under the care of all healthcare organizations (as cited in Hodge, 2006). It is important to distinguish spirituality from religiosity because while the former is concerned with the transcendent, or God, it also addresses existential questions about life (Fetzer, 2003). On the other hand, the latter tend to foster and nourish the spiritual life (Fetzer, 2003).

Besides, spirituality is a salient aspect of religious participation. Hence, it is possible to have a form of religiosity, in terms of church attendance, but be void of a strong personal relationship with the transcendent or God (Fetzer, 2003). Research using traditional measures would use religious activities to demonstrate a salient form of religious commitment or religiosity (Fetzer, 2003).

However, researchers Cohen and Hill (2007) found that measures of religious and spiritual experiences, motivations, and identities in the United States are construed more individualistically rather than collectivistically. Some focused more on the Catholic and Jewish faith. Others are more specific in measuring constructs such as God-attachment (Beck & McDonald, 2004; Kirkpatrick & Shaver, 1992; Rowatt & Kirkpatrick, 2002), God-Image (Lawrence, 1997), or religious maturity (Benson, Donahue, & Erickson, 1993). Finally, most of

these measures were designed for research purposes, rather than for the clinical population (Hill & Edwards, 2013).

Daily Spiritual Experience Scale (DSES; Underwood, 2006/2011; Underwood & Teresi, 2002). Underwood and Teresi (2002) developed this assessment to measure subjective experiences, such as God's feelings and awareness. The strengths of this inventory include high internal and test-retest reliability. Another strength is its popularity in evaluating psychological wellness such as quality of life, perceived social support, and positive affect and health-related outcomes (Ng, Fong, Tsui, Au-Yeung, & Law, 2009; Underwood & Teresi, 2002). The measure has several translations, such as Spanish, Hebrew, Chinese (Mandarin), French, Greek, German, Korean, Portuguese, and Vietnamese (Underwood & Teresi, 2002). As a side-note, Ng et al. (2009) have used the 16-item Chinese version (DSES-C) within the context of populations that adhere to Confucianism, Buddhism, and Daoism.

The developers propose to use this measure beyond the Judeo-Christian context by including transcendence experience in daily life (Hill & Edwards, 2013). However, Kalkstein and Tower (2009) caution that populations of other faith as the original sample were primarily a Judeo-Christian population.

Transgression-Related Interpersonal Motivations Inventory (TRIM-12; McCullough et al., 1998). This measure under review has twelve questions that rely on self-reporting. It purportedly measures the nature of interpersonal forgiving across two negative dimensions. The seven questions in the first subscale are called the 'avoidance' dimension. Questions such as "I'll make him/her pay" or "I keep as much distance between us as possible" and "I live as if he/she doesn't exist, isn't around" and articulate the degree of motivation to keep away from the

offender. The second subscale, called 'revenge,' has five statements such as "I'm going to get even," "I want to see him/her hurt and miserable," "I wish that something bad would happen to him/her" express the individual's desire to seek retribution or impose punishment. The Likert scale of 1 for "Strongly Agree" to 5 for "Strongly Disagree" has been reversed to harmonize with the other inventories measuring the degree of well-being and health. The scores range from 7 to 84, with high scores representing more forgiving motivations. The measure shows strong psychometric properties with high internal consistency and a Cronbach alpha of 0.884.

Gratitude Questionnaire-6 (GQ-6; McCullough et al. 2002). This inventory by McCullough et al. (2002) is a shortened version with six out of the original 39 items that express gratitude, appreciation, and feelings of receiving from others. As premised on the exploratory and confirmatory factor analyses, the original inventory was distilled into a single dimension assessing gratitude using six questions. Each response uses the Likert-scale, from one to seven, with one indicating "strongly disagree," and seven indicating "strongly agree." Two items, questions three and six on the inventory, are reversely scored. The total scale score is taken by summing all the six-item responses. The possible scores range from 6 to 42. Correlational analyses by McCullough and his researchers (2002) provided evidence that the GQ-6 has strong psychometric properties, internal consistency, and construct validity of .82. They further claim that the "scale correlates in theoretically expected ways with a variety of affective, prosocial, and spiritual constructs" (2002, p.124). Toussaint and colleagues (2010) used this scale with 24 teachers in Sierra Leone who have experienced civil war trauma.

Satisfaction with Life Scale (SWLS; Diener et al., 1985). The term satisfaction has different connotations for different people in a different context. Andorka and Harcsa (1990) argued that during the cold war years, "way of life" was a term that applies only to observable

behavior (as cited in Sirgy, 2012). Other authors such as Pavot and Diener (2008) and Ozmete (2011) define life satisfaction as different from subjective wellbeing in that the former comprises of the way one evaluates one's quality of life as a whole (together with the affect and attitude regarding one's life (as cited in Sirgy, 2012).

However, the boundaries of these three concepts of subjective well-being: "positive affective appraisal, negative affective appraisal, and life satisfaction" are not as clear. Life satisfaction in this context is more cognitively than emotionally driven when compared to subjective wellbeing, and it directly informs one's sense of wellbeing, according to Diener et al. (1985), the creator of the satisfaction with life scale (SWLS).

The SWLS demonstrates good psychometric and discriminative properties of well-being measures, mental health, personality, and distress (Pavot & Diener 1993, 2008). It is a self-report measure and selected for this study because it is short and easy to score (Likert scale from 1 to 7), thus its popularity for use in various cultures and populations (Anaby, Jarus, & Zumbo, 2010). The SWLS has demonstrated strong internal consistency and moderate temporal stability with Cronbach's alpha of 0.87 and a 2-month test-retest reliability of 0.82, consistent with the yield in other studies in non-clinical settings (Pavot & Diener, 1993, 2008).

Another reason for the selection is its association with psychological distress, which applies to this study. Together with the GQ-6 (McCullough et al. 2002) and SWLS (Diener et al., 1985), this scale is adequate in measuring variations in well-being that are attendant to daily stressors such as housing or employment difficulties, isolation, loneliness, somatic symptoms, and supportive resources. The SWLS inventory is also used as the indirect measure of the increase or decrease of gratitude because the classic "life as a whole" question is only useful for estimating the homeostatic baseline. Moreover, specific life components that positively or

negatively contribute to an individual's well-being are highly abstract and subjective. The scale was used successfully in Sierra Leone in an RCT with participants who have experienced trauma (Toussaint et al., 2010) and displaced people in Kenya (Getanda, Papadopoulos, & Evans, 2015). However, there is a shortage of studies that evaluated the reliability and validity of the SWLS among resettled refugees.

Data Processing and Analysis

After the data from the pre-intervention and post-intervention measures were collected, any personally identifying information was removed from the spreadsheet and stored on a password protected a computer for confidentiality. The researcher entered the data to the statistical package for the social sciences (SPSS) version 24.0 program and used the software to analyze the outcome.

Summary

This section's focus was on the proposed RCT research design and the validity of the standardized instruments, and the method design for collecting data. Many instruments, such as the Refugee Health Screener (RHS-15; Hollifield et al., 2013) and the Harvard Trauma Questionnaire (HTQ), were specifically developed for the refugee population for research. HTQ developed for the Indochinese refugee populations in the 1990s would be a good choice, especially its recent success with Burmese refugees (Lopes Cardozo et al., 2004; Schweitzer et al., 2011). However, due to a lack of resources to score the HTQ individually, the RHS-15 was selected. Furthermore, the symptom questions in RHS-15 are based on PTSD criteria as recorded in the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV; 2000).

Since the emphasis of this exploratory research is on creating and using an intervention to improve the biopsychosocial and spiritual experiences of the target population, the researcher

identified the RHS-15 as the closest instrument for self-reporting and met most of the evaluation criteria regarding the study's purpose, construct, and the previous testing with the refugee population. And ideally, these instruments have been validated for this population group or the least in a cross-cultural situation. Since most of the instruments except one had a translated Burmese version, the questionnaires did not undergo a standard translation and back-translation process with an official translator. Instead, the student-researcher retained a translator-pastor with forty years of experience working among the Burmese Chin population.

CHAPTER FOUR: RESULTS

Refugees must be given particular attention, as they are “not only survivors of some of the most wrenching events of the modern world, but when resettled in America, are also at the locus of American structures and reconsiderations of race, ethnicity, class, immigration, economics, politics, religion, and society (Haines & Rosenblump, 2010, p.392).

This chapter will describe the implementation of the GRACE protocol study design and the findings from the statistical analysis. The first section of this chapter describes the restatement of the purpose of the study. Next, the researcher will explain the demographic make-up of participants involved in the research and the description of the statistical techniques used in the intervention and control group analysis. Subsequently, the student-researcher will advance the biases and limitations observed in the study.

Analysis

The researcher chose to use paired samples T-test for the small sample of pre- and post-data instead of MANOVA because she could not screen out multicollinearity. To use MANOVA, ideally, the dependent variables are moderately correlated with each other. Moreover, this form of parametric test accounts for scores and distribution that are not normal and have values that are “out of range.” Also, as mentioned, the pre- and post sample size is small, and the student-researcher does not have data from previous research for comparison.

Sample Demographics

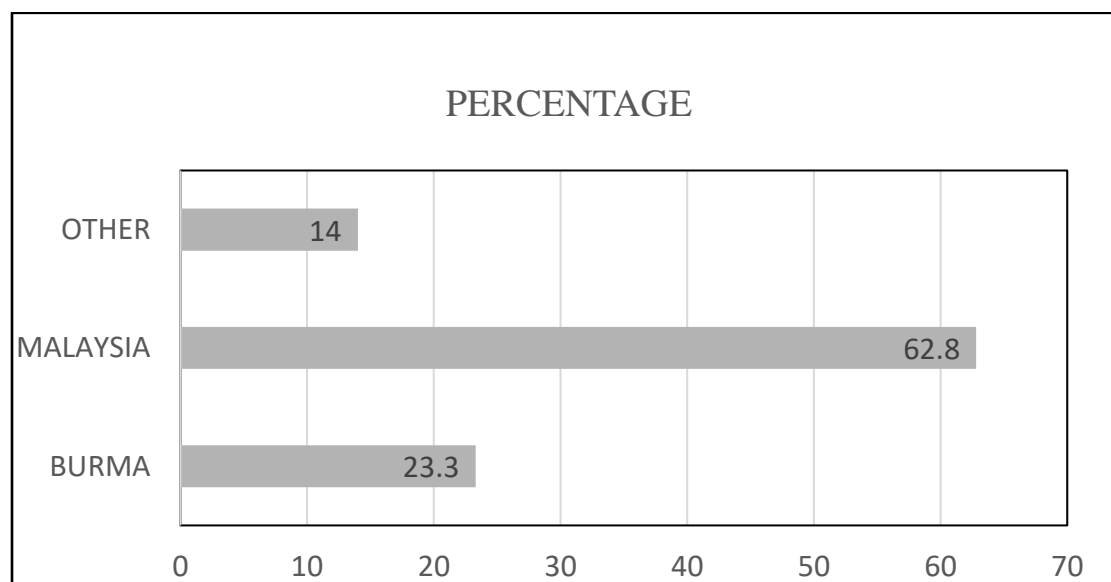
A total of 50 persons signed up to participate on 04/24/2016, but four declined to participate citing work conflict, and three did not sign the informed consent or turned in

incomplete forms for unknown reasons. Of the forty-three persons that completed the pre-intervention assessments, 22 were male, and 21 were female. The average age of men was 42.17 years, and for the women, it was 37.68 years. Although ten participants came directly from Burma, the majority, 33 of them (or 76.8%), transited through either Malaysia or another transit country. (Refugees who resided protractedly in a transit country before their permanent settlement often have more psychological distress and maladaptive responses because of their previous undocumented status).

Table 2: Country of Transit

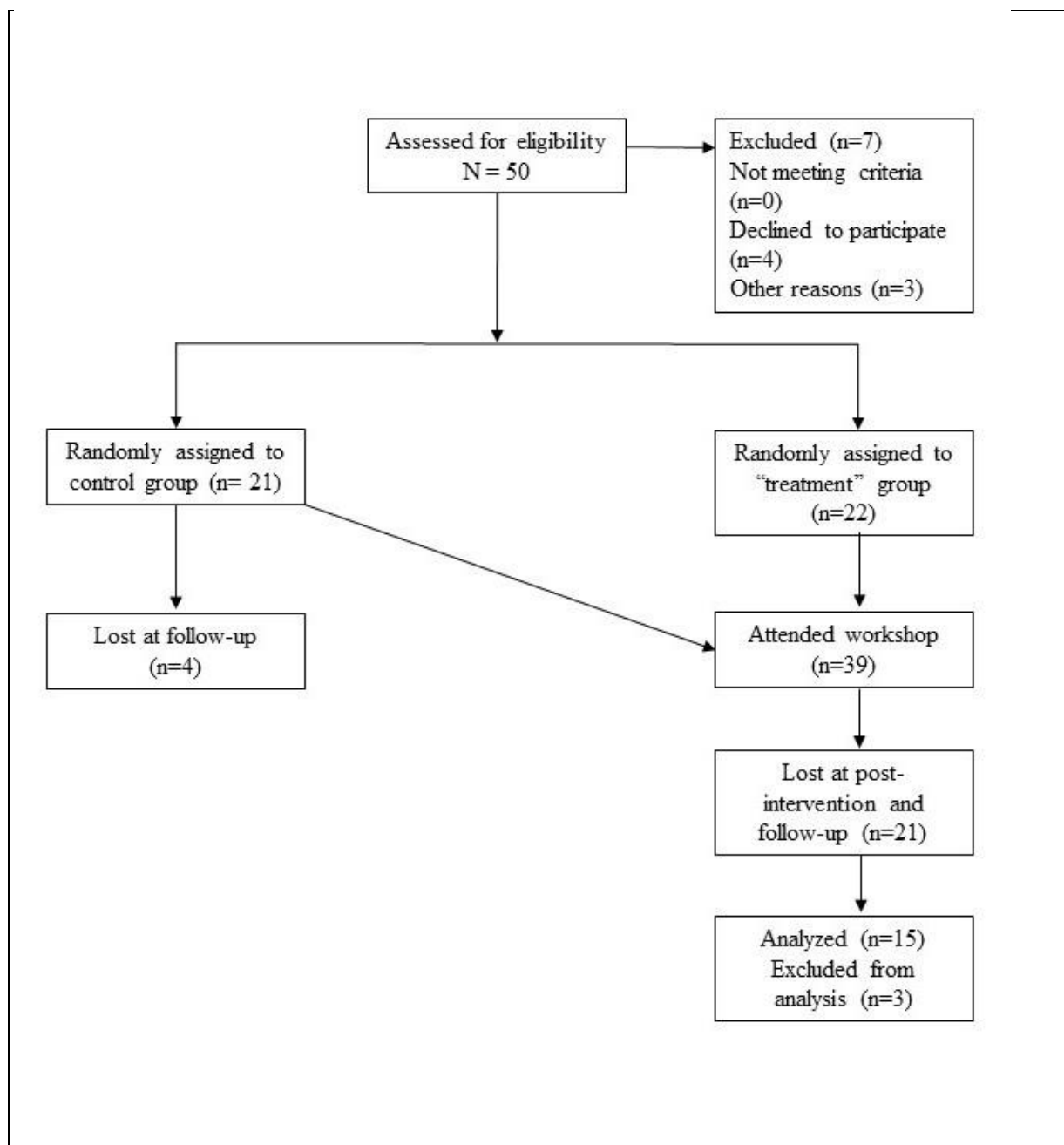
COUNTRY OF TRANSIT BEFORE SETTLEMENT IN THE US					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Burma	10	23.3	23.3	23.3
	Malaysia	27	62.8	62.8	86.0
	Other	6	14.0	14.0	100.0
	Total	43	100.0	100.0	

Figure 5: Percentage of Participants



The 43 participants recruited were randomized into two groups: Treatment group and control group (Figure 6). Seventeen persons from the control group attended the workshop, which confounded the study's randomized control design. (The student-researcher will explain this further in the limitations section).

Figure 6: Flowchart of Study Participants



Of the 39 persons that attended the workshop, only eighteen persons turned up at the post-intervention evaluation on 05/29/2016 and said they practiced the protocol several times over the five weeks. Three persons had to leave before completing their evaluation (on 05/29/2016), and their data was eventually excluded from the analysis.

Restatement of Purpose

It is appropriate at this point to restate the purpose of this study, which is to investigate the effects of practicing a GRACE protocol on the spirituality and satisfaction with life in a sample of resettled Chin refugees from Burma.

Research Question One

1. Does the GRACE protocol practice for five weeks resulted in reducing somatic and psychological problems as measured by the Refugee Health Screener-15 (RHS-15; Hollifield et al., 2013)?

Figure 7: Pre-RHS-15 Scores and Post- RHS-15 Scores

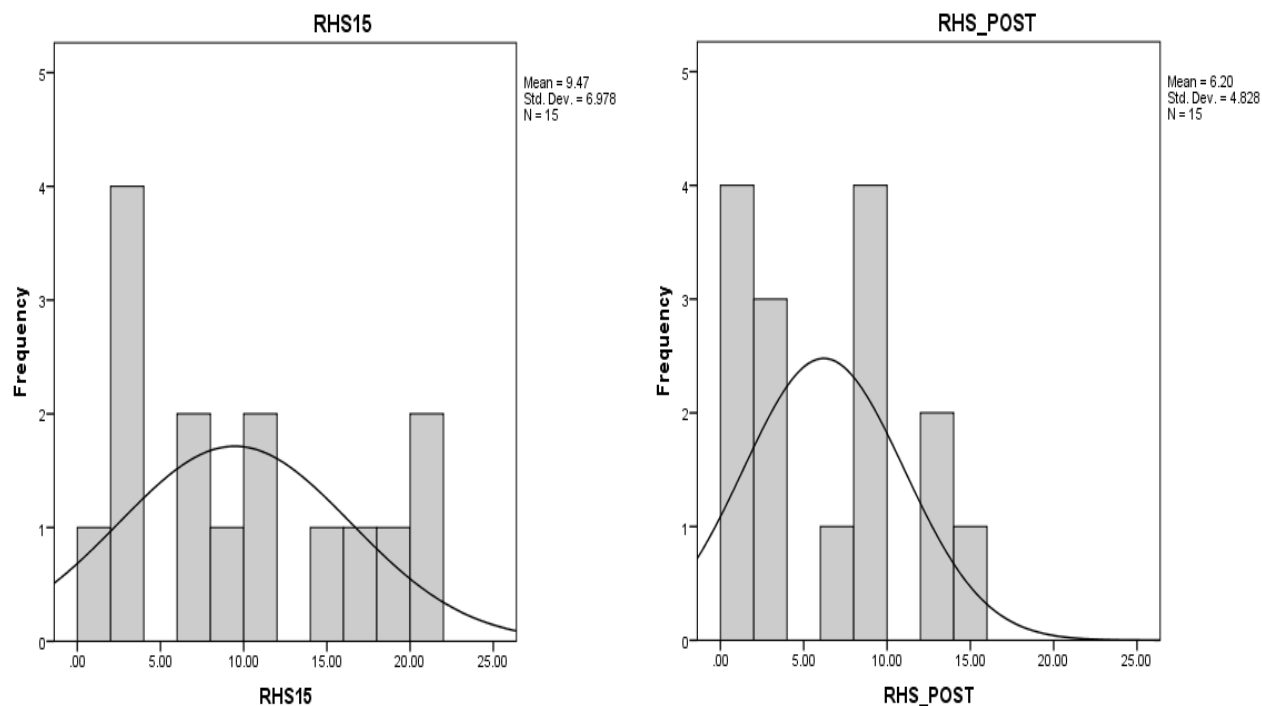


Table 3: Paired T-test Analysis of RHS-15 Pre- and Post-Intervention

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	RHS15 _{PRE}	9.47	15	7.00	1.80
	RHS15 _{POST}	6.20	15	4.83	1.25

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	RHS15 _{PRE} & RHS15 _{POST}	15	.93	.000

	n	\bar{x}	σ	$\sigma_{\bar{x}}$	t	df	Sig (2-tailed)	95% confidence	
								Lower	Upper
RHS15	15	3.27	3.10	0.80	4.08	14	.001	1.55	5.00

The numbers demonstrate a reduction in somatic and psychological problems, with the mean of the RHS-15 at post-intervention (M=6.20, SD=4.83) being lower than that of the RHS-15 at pre-intervention (M=9.47, SD= 7.00). The paired sample T-test analysis also revealed a statistically significant difference in reported somatic and emotional distress (as measured by RHS-15; Hollifield et al., 2013) post-intervention, with $t(15) = 4.08$ at $p = 0.001$ (Table 3). Since t is the calculated difference represented in standard error units, the magnitude of the evidence against the null hypothesis is no significant difference. For the RHS-15 scores before and after the intervention, the t score indicates a significant difference. Hence, the null hypothesis is rejected.

Research Question Two

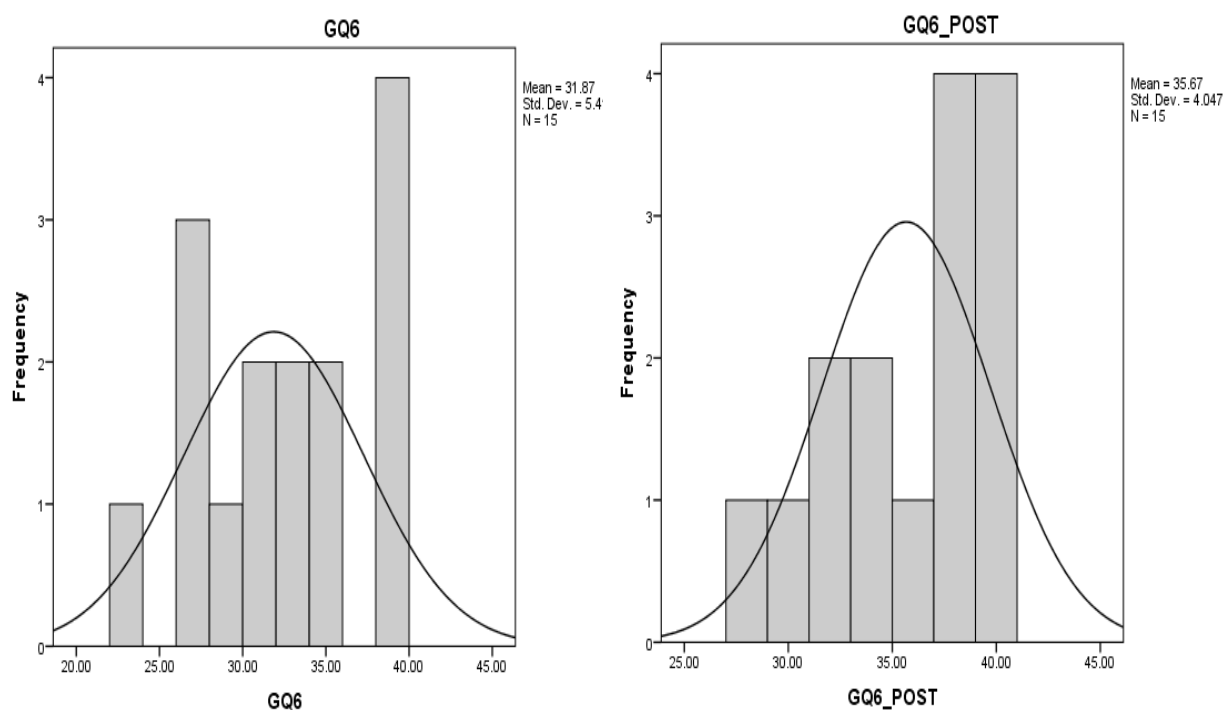
- Will there be an improvement in gratefulness as measured by the Gratitude Questionnaire (GQ-6) among the participants who practiced the GRACE protocol?

Table 4: Paired T-sample analysis of pre- and post-intervention GQ-6 scores

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	GQ6 _{PRE}	31.87	15	5.41	1.40
	GQ6 _{POST}	35.67	15	4.05	1.04

Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	GQ6 _{PRE} & GQ6 _{POST}	15	.62	.014

	n	\bar{x}	σ	$\sigma_{\bar{x}}$	t	df	Sig (2-tailed)	95% confidence	
								Lower	Upper
GQ-6	15	-3.80	4.30	1.11	-3.43	14	.004	-6.18	-1.42

Figure 8: Pre- GQ-6 Scores and Post- GQ-6 Scores

The data from the analysis demonstrate significance in the level of gratitude after the intervention. The null hypothesis is rejected at $t(15) = -3.43$ at $p=0.004$ because of the

significant improvement in gratitude level among those who practiced the protocol.

Research Question Three

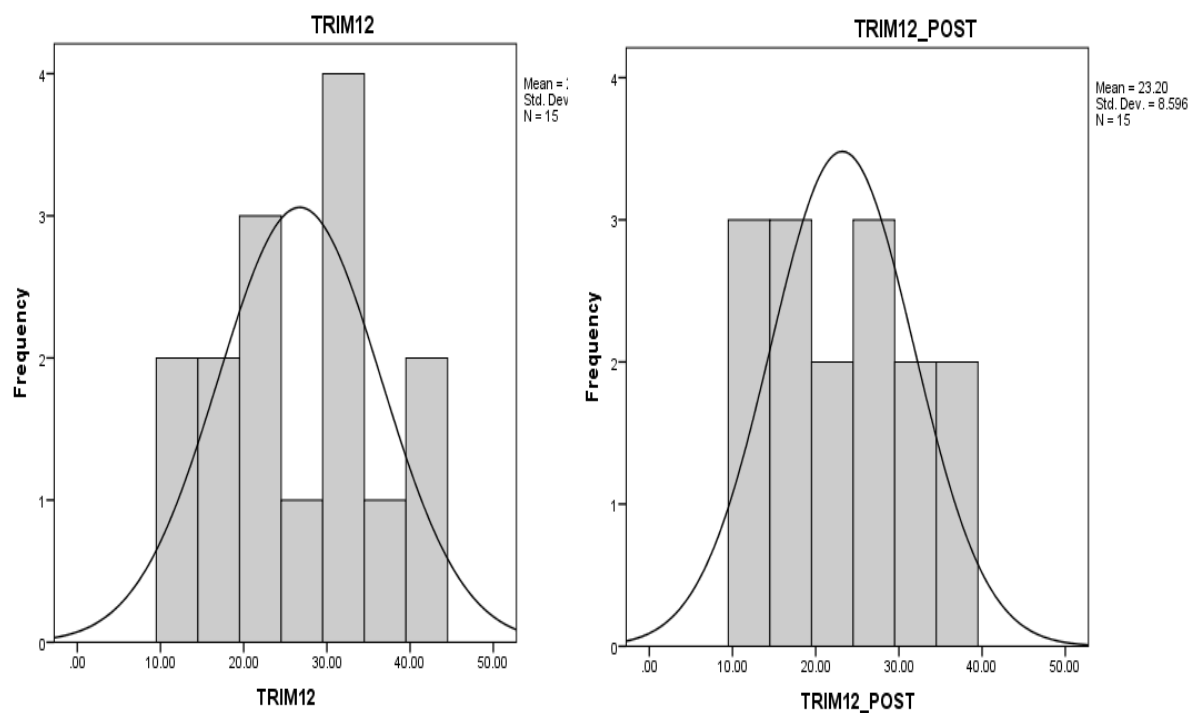
3. Will there be a lowering of avoidance and a tendency to seek revenge (or an improvement in the motivation to forgive) measured by (TRIM-12) at post-intervention?

Table 5: Paired T-Sample Analysis of Pre- and Post-Intervention TRIM-12 Scores

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	TRIM12 _{PRE}	26.73	15	9.78	2.53
	TRIM12 _{POST_}	23.20	15	8.60	2.22
Paired Samples Correlations					
		N	Correlation	Sig.	
Pair 1	TRIM12 _{PRE} TRIM12 _{POST}	15	.88	.000	

	n	\bar{x}	σ	$\sigma_{\bar{x}}$	t	df	Sig (2-tailed)	95% confidence	
								Lower	Upper
TRIM12	15	3.53	4.63	1.19	2.96	14	.010	.08	4.72

The TRIM-12 (McCullough et al., 1998) was scored with a higher score reflecting a lower tendency to avoid and seek revenge or motivation to forgive. The analysis denotes that the post-intervention (Mean=26.53, SD=9.37) is higher than the pre-intervention (Mean=24.13, SD=10.23). The protocol practice did improve the level of forgivingness, with $t(15)$ equal to 2.22 at $p=.043$ (Statistical significance is set at 95% or $p=.05$).

Figure 9: Pre-TRIM-12 Scores and Post-TRIM-12 Scores

Hence, the null hypothesis was not rejected because a statistical difference was detected in the motivation to forgive at post-intervention.

Research Question Four

4. Will there be an increase in the participants' wellbeing as measured by the Satisfaction with Life Scale (SWLS; Diener et al., 1985) and their spiritual condition as measured by the DSES (Daily spiritual experience scale; Underwood, 2006/2011; Underwood & Teresi, 2002) among the participants who practiced the protocol

Table 6: Paired T-Sample Analysis of Pre- and Post-Intervention SWLS Scores

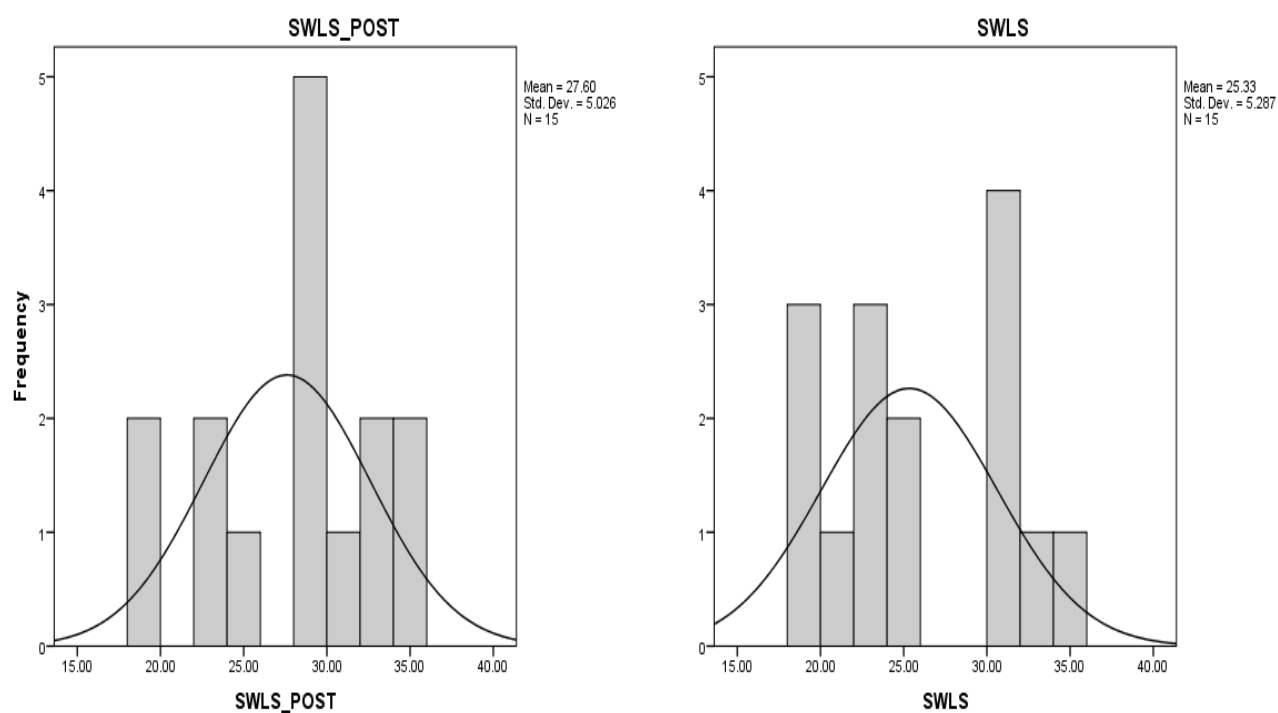
Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	SWLS _{PRE}	25.33	15	5.29	1.37

	SWLS _{POST} _	27.60	15	5.03	1.30
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Paired Samples Correlations				
		N	Correlation	Sig.
Pair 1	SWLS _{PRE} & SWLS _{POST}	15	.64	.010

	n	\bar{x}	σ	$\sigma_{\bar{x}}$	t	df	Sig (2-tailed)	95% confidence	
								Lower	Upper
SWLS	15	-2.27	4.38	1.13	-2.00	14	.065	-4.69	0.16

Figure 10: Pre- SWLS Scores_(n=15) and Post- SWLS Scores_(n=15)



There is a small change in the satisfaction with life scores in the positive direction after the protocol from the pre- (Figure 13) and post-intervention graphs (Figure 14).

From the tables and graphs, the difference in the means at post-intervention is 27.60 (with an SD of 5.03) and at pre-intervention is 25.33 (with an SD of 5.29) only approaches significance.

However, the outcome was not statistically significant, with $t(15) = -2.00$ at $p=.065$. Hence, the null hypothesis cannot be rejected for satisfaction with life.

Table 7: Paired T-Sample Analysis of Pre- and Post-Intervention DSES Scores

Paired Samples Statistics					
		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	DSES _{pre-intervention}	33.13	15	10.21	2.64
	DSES _{post-intervention}	30.53	15	8.73	2.25

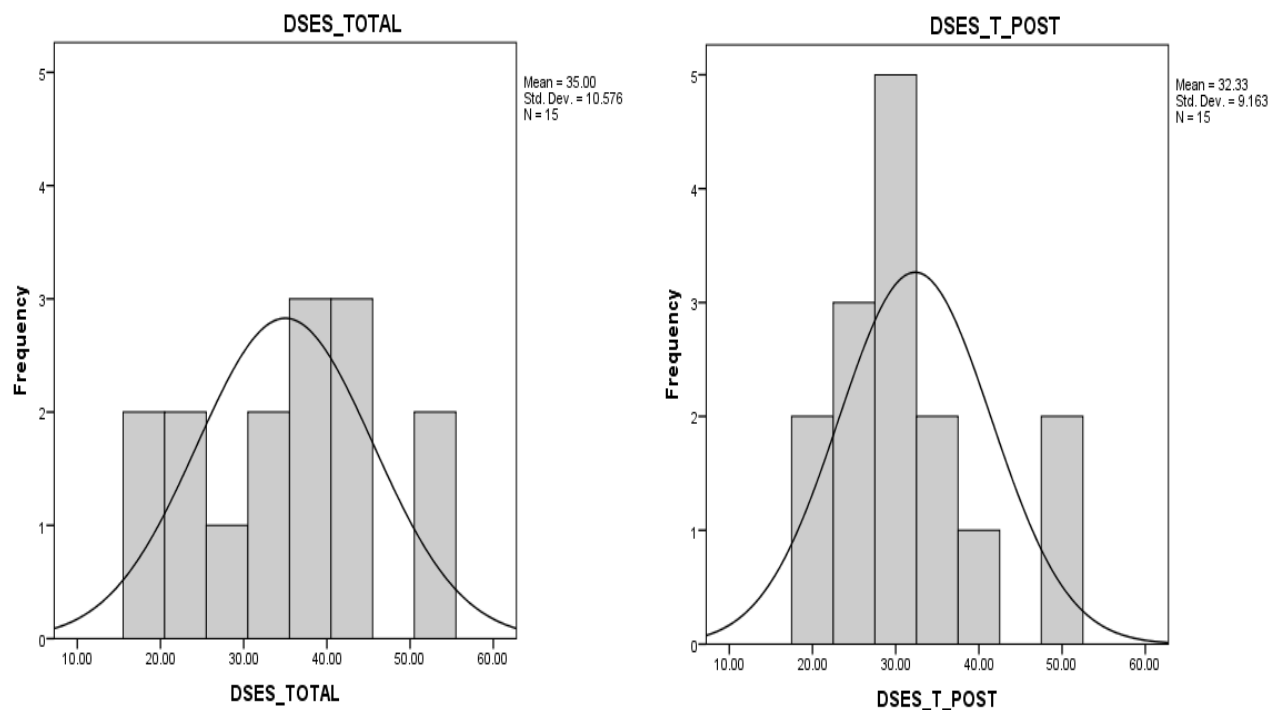
Paired Samples Analysis for Pre- and Post-Intervention				
		N	Correlation	Sig.
Pair 1	DSES _(without Q.16) & DSES _{(without Q.16)_POST}	15	.694	.004
Pair 2	DSES & DSES_POST	15	.666	.003

	n	\bar{x}	σ	$\sigma_{\bar{x}}$	t	df	Sig (2-tailed)	95% confidence	
								Lower	Upper
DSES _(without Q.16)	15	2.60	7.54	1.95	1.34	14	.203	-1.57	6.77
DSES	15	2.67	7.52	1.94	1.37	14	.19	-1.5	6.83

The researcher analyzed the data for DSES by totaling the scores for questions 1-5 and Q.16, which was reversed on its original Likert scale of 1 to 4 (the previous 15 questions were also scored from 5 to 1 with 1 being spiritual experiences of many times). Refer to Appendix C.

(From henceforth, the researcher will use the DSES for the total scores 1-16 throughout to avoid confusion with the DSES_(without Q.16)).

Figure 11: Pre - DSES Scores and Post - DSES Scores



Although there appears to be a small decrease in the mean of the DSES scores after the protocol practice, which means an improvement in the spiritual experiences, it is not significant, with $t(15) = 1.37$ for the DSES scores at a non-significant level of .191. Thus, the hypothesis that the GRACE protocol's practice will improve daily spiritual experience was not supported, and the null hypothesis cannot be rejected.

Research Question Five

5. What are the lessons learned from this randomized control study among an ethnic minority refugee population?

This question will be discussed in Chapter Five under lessons learned.

Further Analysis

Using the larger sample (n=43), the researcher conducted a descriptive analysis of the data collected from the 43 individuals who the workshop. The mean for the spiritual experience (DSES; Underwood, 2006/2011; Underwood & Teresi, 2002) is 37.91 ± 11.28 (Table 8) for the 43 participants, is reasonable given that this is a religious population and their faith is an integral part of their life. (The DSES scoring of the 16 items range from 16 through 94, with the lower scores representing more daily spiritual experiences). The skewness and kurtosis values (Wheeler, 2011) indicate an almost bell-shaped distribution.

Table 8: Descriptive Analysis

		DSES_(n=43)	TRIM12_(n=43)	GQ6_(n=43)	SWLS_(n=43)	RHS15_(n=43)
N	Valid	43	43	43	43	43
Mean		37.91	30.51	30.95	24.93	11.47
Std. Deviation		11.28	10.03	5.37	6.33	8.19
Variance		127.13	100.64	28.81	40.11	67.11
Skewness		0.00	-0.31	-0.19	-0.57	1.04
Std. Error of Skewness		0.36	0.36	0.36	0.36	0.36
Kurtosis		0.03	-0.92	-0.75	0.65	1.18
Std. Error of Kurtosis		0.71	0.71	0.71	0.71	0.71
Range		50	36	20	29	35
Minimum		18	12	19	6	1
Maximum		68	48	39	35	36

Table 9: DSES Scores for Male and Female

	MALE			FEMALE		
	N	Mean	SD	N	Mean	SD
DSES_(n=43)total	22	39.91	9.20	21	35.81	13.00
Possible range	25-53			18-68		

A separate analysis based on gender for the 22 male participants and 21 female participants found that the latter scored greater frequency on daily spiritual experience (Mean = 35.81, SD=13.00) compared to the male participants (Mean =39.91, SD=9.20), which is consistent with Underwood's (2011) overview findings that women are likely to have more spiritual experiences than men, on the average. The mean for the women of this study is also comparable with the findings from Underwood and Teresi's (2002) seminal study with Baptist women reporting a mean of 37.94 ± 15.61 . However, these Baptist women may have differed from this present population because no psychological or somatic issues were reported with the former.

There are two other reasons for the differences in experience by the men and women: (1) Most of the men took the arduous journey to flee Burma and did not send for their women folks till they were safely in the transit or new host country. (2) Most of the women participants (in the research) did not work outside the home and were perhaps, shielded from some of the daily stressors.

On the TRIM-12, the 43 participants reported a mean of 29.91 ± 9.85 on the tendency to avoidance or to seek revenge. The scores reported here are comparable to scores found in other studies with a Malaysian population (Mellor, Fung, & binti Mamat, 2012). Future studies may wish to explore the TRIM–Avoidance and TRIM–Revenge subscales in greater detail. Conversely, the TRIM-12 and GQ-6 scores reported for the 43 participants are slightly lower than the ones noted in other studies such as Dillon (2015) that reported a mean of 36.96 ± 9.70 for TRIM-12 and Macaskill & Denovan (2013) 33.96 ± 5.07 for GQ-6. (However, in these studies, the slightly higher scores reported are expected as the data was obtained from young college students). Likewise, the SWLS scores are higher (Mean 6.82 ± 1.5) than that reported by

internally displaced refugees in Kenya (Getanda et al., 2015). The present results of 24.93 ± 6.33 for the Chin refugees are comparable to the general population survey in Brazil, with a reported mean of 23.95 ± 6.12 (Gouveia, Milfont, Da Fonseca, & de Miranda Coelho, 2009).

This population's somatic and psychiatric distress (as measured by RHS-15; Hollifield et al., 2013) has a mean of 11.42 ± 7.98 can be considered equivalent to that measured for resettled Chin refugees in Colorado, with a mean of 11.460 ± 1.079 (Vukovich, 2016). This current sample's higher standard deviation is expected since it is a mix of Chin resettled for between one year to more than ten years. The sample population in the Colorado study involves only newly arrived Chin refugees.

Table 10: Bivariate Pearson Correlation Analysis

		SWLS	DSES	TRIM12	GQ6	RHS15
SWLS	Pearson Correlation	1.00	-0.18	-0.07	.468**	-0.01
	Sig. (2-tailed)		0.252	0.674	0.002	0.947
	N	43	43	43	43	43

Further analysis with the bivariate Pearson indicates a correlation of .47 between satisfaction with life and gratitude levels for each participant at the significance level of .002. (Similar results are obtained with paired-sample analysis). The correlation between gratitude and satisfaction with life replicates other findings reported by Wood et al. (2007), Szcześniak, and Soares (2011) and Emmons and McCullough's 2003 study. Additionally, it appears the motivation to forgive is inversely correlated but not significantly (which is consistent since TRIM-12 is negatively scored like RHS-15 and DSES).

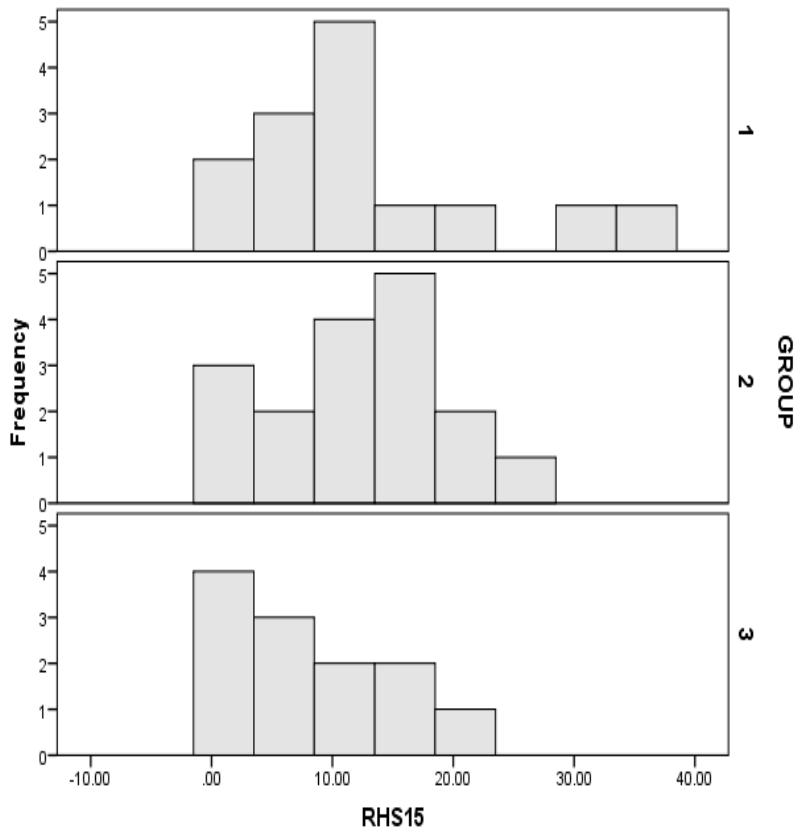
Another interesting fact is, when the data of the RHS-15 scores for the 43 participants were further analyzed across the three different periods (RHS-15₁₋₅, RHS-15₆₋₁₀, and RHS-15_{>10}) or based on their groupings: 1) Group 1 are individuals who were resettled between 1 to 5 years in the United States; 2) Group 2 are individuals who were resettled between 6 to 10 years in the United States; 3) Group 3 are individuals who were resettled in the United States for more than ten years, the findings are tabled below (Table 11 and Figure 18). This analysis's conclusions iterate the researcher's belief that psychological distress remains high, even for those who have been in the country for more than six years but less than ten.

Table 11: Mean RHS-15 Scores of Groups 1, 2 And 3

GROUPING	Number of subjects	Mean	Std. Deviation
Group 1 RHS-15 ₁₋₅	14	13.71	10.00
Group 2 RHS-15 ₆₋₁₀	17	12.41	6.66
Group 3 RHS-15 _{>10}	12	7.83	6.10
Total	43		

Figure 8: RHS-15_(n=43) Across Groups 1, 2 and 3

Future research to tease out the reasons for the difference is needed.



Summary

The preliminary findings from this intervention study support the hypothesis that those who practiced the protocol would rate lower on the psychological distress and higher on a state of gratitude and forgiveness scale at post-intervention. However, since the researcher could not control any external variables that could confound these constructs, she will exercise caution in interpreting these results.

Conversely, the null hypothesis that the protocol's practice will improve the daily spiritual experience and satisfaction with life were not supported. The researcher discusses the findings, conclusions, and lessons learned from the study in greater depth in the following chapter. All the data in this study were analyzed using the SPSS Statistical Package for the Social Sciences (Version 24.0).

CHAPTER FIVE: CONCLUSIONS

It's not easy to start over in a new place,' he said. 'Exile is not for everyone. Someone has to stay behind, to receive the letters and greet family members when they come back.

— Edwidge Danticat, *Brother, I'm Dying*, 1969 –

Summary

The goal of this exploratory study was to study the outcome of using a faith-driven protocol among Burmese Chin refugees who have experienced cumulative stress for post-trauma and daily stressors during their settlement in the United States. As postulated earlier, everyday stressors can impact health trajectories. Forty-three Chin individuals were recruited and randomized into two groups: Intervention and control groups (see Figure 6, p. 89). However, due to unexpected circumstances (see random assignment challenges in the next section), a total of 39 persons attended the workshop. Still, only 15 practiced the protocol and returned a post-intervention assessment. The fourteen (out of the 39) who did not practice the protocol and the control group participants either did not return for the post-assessment or submitted incomplete survey forms. Hence, the student-researcher could not form any conclusion for a randomized-control study.

As hypothesized, the protocol's practice on somatic and psychological distress was a statistical effect, as measured by RHS-15 (Table 12). Likewise, hypotheses 2 and 3 were also supported by the fifteen participants who practiced the protocol endorsing improvement in their levels of gratitude and motivation to forgive (Table 12).

Conversely, the hypothesis that daily spiritual experience and satisfaction with life would improve with the protocol's practice was not supported (see Table 12). Additionally, due to the absence of a control group and the small sample size ($n=15$), the findings are interpreted

cautiously within the context of this one population only. Finally, it is appropriate at this point also to respond to research question five.

Table 12: Summary of Paired Analysis

	PRE-INTERVENTION		POST-INTERVENTION			
	Mean	SD	Mean	SD	t	Significance
RHS-15	9.47	6.98	6.20	4.83	4.08	.001
GQ-6	31.87	5.41	35.67	4.05	-3.43	.004
TRIM-12	26.73	9.78	23.20	8.60	2.96	.010
SWLS	25.33	5.29	27.60	5.29	-2.00	.065
DSES	35.00	10.58	32.33	9.16	1.37	.191

Lessons Learned

Research Question Five: What lessons are learned from this randomized control study among an ethnic minority refugee population?

This study's primary purpose was to examine the feasibility of a faith-driven intervention to ameliorate post-traumatic and cumulative stress with a Christian Chin population from a refugee background using the RCT design. However, in the process, the researcher learned that refugee research does not fit neatly into the standard psychosocial context of trauma and stress. Still, the result is more aligned with ethnic minority research. More importantly, she learned lessons about strategical challenges in recruitment, randomization, intervention implementation, assessment procedures, and retention or attrition of participants.

The researcher had to accommodate the community's unique situation by waiving the randomization process during the workshop (see the next section on random assignment challenges). The researcher recognizes that subjects' rights, welfare, and interests must be her

primary research (ACA Code of Ethics (2014)). Although one may argue that intervention of itself is a function of the *beneficence* principle, it is not ethically sound research practice to coerce participants to stay in the control group or to practice the protocol because of the greater need to respect their autonomy and self-determination (ACA Code of Ethics, 2014).

Random Assignment Challenges. The goal to randomize the participants in this study was not accomplished due to several factors: One, among the participants who showed up for the first evaluation on 04/24/2016, some families traveled to church together because of convenience and distance from the church (this is sometimes known as convenience cluster-randomized method). So, family members were allocated to the “control group” initially that decided to join the “treatment group” by attending the workshop.

Second, potential participants who had to work 05/29/2016 were “dropped” from the control or treatment group. Third, the leaders could not accommodate another workshop for those in the control group due to a scheduling conflict. Thus, the leaders asked everyone interested in learning the protocol to attend the treatment group seminar. The researcher was also unable to arrange for childcare because of a lack of resources, which also means that some spouses had to take a turn to participate. Hence, to adapt to the exceptional situation in the Chin community, the researcher did not intervene with just the treatment group but allowed the participants to move freely between groups (Figure 6, p.95), which is congruent with the foundational principle of *justice* of ACA Code of Ethics (2014). Subsequently, at the second evaluation on 05/29/2016, only those who practiced the protocol turned in their score sheets.

Recruitment. The study recruited around 43 participants, but there was high attrition among the control group (see the section above). The student-researcher did not conduct any analysis with the incomplete forms collected from those who did not practice the protocol or

those from the control group to avoid increasing the likelihood of committing a Type II error, which is to infer a real treatment effect when there was none.

Outreach Challenges. The study was not able to attract younger adults of the community to participate. The average age of the 43 participants who took part in the survey was 41.14 ± 9.55 , and for the group that practiced the protocol, it was 41.00 ± 8.95 . (From the informal interviews with the leaders, the participants who practiced the protocol had more flexible working hours). Perhaps a separate program for children could also supplement this research to attract younger families to participate (Fazel et al., 2009). The researcher would need to seek advice on addressing this with other population groups in future studies.

Language barriers. Also, because some of the participants could not read the Burmese or the Chin scripts on the assessment forms, PowerPoint, and the workbook, there was a heavier reliance on oral translation (which took up longer than the allocated 45 minutes of the four-hour workshop). The shortened time for the PowerPoint possibly impacted the explanation of the protocol. Moreover, some of those who needed help to use the workbook at home did not turn in a post-intervention evaluation, according to the leaders.

Language nuances. The study encountered many difficulties pertaining to communication. Although the measures were translated into the Burmese language (and later into Chin), interpreters were still needed to interpret and explain words that did not have the equivalency in the Chin or Burmese language. There are seven to eight different sub-languages in the primary Chin language. Moreover, even within the Chin Hakha ethnic group (which is the leading group resettled in the United States), subtle differences in the meaning and pronunciation of certain words exist. Language proved to be a difficult problem that the student-researcher could not attend to in this current study.

Measures. An essential ethical consideration with non-native English participants is using culturally validated measures (Knipshcher & Kleber, 2006). Burmese language idioms and semantics were considered when the researcher met with the translator and two interpreters to describe the psychological frameworks for evaluation (Kohrt & Hruschka, 2010; Kohrt et al., 2014). Some measures, such as the Harvard Trauma Questionnaire (HTQ; Mollica et al., 1992), which has 17 questions that assess the experience of the traumatic event and 16 on PTSD symptoms, respectively, were dropped from the repertoire because it will need to be scored by the interviewer instead of self-reported.

Also, requiring the participants to complete five measures when they had no prior experience self-reporting on psychological evaluation may have been too ambitious on the student-researcher who designed the protocol. Additionally, researchers Hollifield et al. (2013) advised caution in extrapolating from standardized scoring approaches because of self-reporting bias and instruments with limited validity and reliability among the refugee population. For instance, on the RHS-15, some individuals who scored high on the first fourteen questions (distress level of ≥ 12) did not mark the distress level or kept it at very low. When this question was posed individually to some of the participants, they responded that they could still cope with God's help, although they had somatic and psychological distress. The researcher would not have known this if she did not ask the participants individually. Another future consideration is, since this population is highly religious, the DSES (Underwood, 2006/2011; Underwood & Teresi, 2002) could have been scaled down in the interest of time, or omitted altogether. Future studies may want to consider using peer-ratings or behavioral criteria (c.f. Tsang, 2006) instead of relying solely on self-reporting.

Timing. The church meets once at 2 pm every Sunday because most of their members

have a second job on Sunday mornings. And since the only time the student-researcher could hold the workshop right after their regular church, it was not convenient or too tiring for some families with young children to stay for the workshop's full length.

Performance bias. At both times, the church and community leaders were present; hence, it was impossible to cancel the exposure to factors other than interest interventions. Also, blinding is not possible, since the participants who stayed back for the workshop understood that they were “selected” for the intervention group and not the control group.

Detection bias. Since the participants practiced the GRACE protocol in their homes' privacy, it is impossible to eliminate the systematic differences between the two groups in how outcomes will be determined. Additionally, since the researcher was present for the assessment pre- and post, it was impossible to reduce the risk that intervention was received.

Attrition and other biases. Attrition bias, which refers to the systematic differences between the people who withdrew from the intervention or control groups, was the hardest to control in this study. Several people could not be present for the whole session of the workshop or to take the post-assessment because of a work schedule conflict, illness, family illness, and other reasons. Moreover, the follow-up efforts were unsuccessful because of language barriers. Hence, reporting and circumstantial biases such as contamination in this setting were observed because of the cultural inclination of sharing information despite advice not to do so.

The student-researcher was also hampered by her limited understanding of the Chin language and had to continually rely on the interpreters, which also restricted her engagement with the participants. Moreover, as in any translation work, inadequate translation in qualitative or quantitative studies can undermine the validity of the research (Mackenzie, McDowell, & Pittaway, 2007). Likewise, as in other research with ethnic minority populations, interpreters can

enrich a study but also bring to the research relationships a complex risk of “transgressing political, social, or economic fault-lines of which the researcher may not be aware” (Jacobsen & Landau 2003, p.103).

Finally, there are issues of breaching confidentiality, power differential, boundaries, vicarious trauma, and other extraneous limitations, including the triadic relationship between the researcher, the interpreter, and the church's leaders. Finally, it is useful to consider in future studies that the researcher has received mental health training, while the interpreters have not.

Conclusions

Past research submits that forgiveness or gratitude can improve subjective wellbeing (Bono & McCullough, 2006; Toussaint & Friedman, 2009; Toussaint, & Webb, 2005). An example of the correlation between gratitude with subjective wellbeing is the study by Emmons (2008). However, since 2012, there is still a dearth of research on forgiveness and gratitude and less still interventional research. Hence, the purpose of this randomized control trial was to utilize a protocol of grace to reduce psychological distress and improves forgiveness, gratitude, and wellbeing among a non-clinical sample of adult Chin refugees. It was hypothesized that the intervention experiment using the practice of a simple protocol on grace would improve forgiveness, gratitude, spiritual experiences, and satisfaction with life.

Other Limitations

Although the preliminary study indicated that the GRACE protocol has the potential for validity in facilitating the participants’ psychological distress and improving gratitude and motivation to forgive, the absence of a control group and the small sample meant a corresponding reduction in statistical power in interpreting the findings. Additionally, the researcher did not conduct any between-group differences analysis as well. (Future replication of

this study is needed to improve its statistical efficacy). Two factors that influence the generalizability of research findings, the sampling context, and RCT's research design, were not fulfilled. Hence, the outcome of this study has limited generalizability and practical implications. However, this protocol may be useful for lay counselors and pastoral counselors who are serving an ethnic minority population in non-clinical settings; they can use this protocol as a bridge to promoting wellness and growth.

Implications for Practice

The study intended to test the useability of a faith-driven protocol as a community-based intervention for populations who are not likely to seek treatment for their pre- and post-settlement distress, and that itself was successful.

Another purpose was to use a spiritually-oriented protocol to test its efficacy, and this pilot study did accomplish that. Since this study demonstrates that the protocol can reduce psychological distress while improving gratefulness and the propensity to forgive, the student-researcher has plans to replicate this study with other Burmese ethnic minority groups and the Syrian refugee population. Likewise, she would like to promote this protocol online to reach faith communities currently not seeking mental health services.

There are at least four primary strengths of the study: The first is the psychoeducation piece that teaches the mechanism of accepting and extending grace and forgiveness. As pointed out by the community (see section after), mental health teaching has made their members more aware of their maladaptive behaviors in response to psychological distress. The second is its adaptability to an ethnic minority population that does not readily access mental health services. There are few interventional studies conducted with an underrepresented population such as the Chin people. The third is the acceptability of the “intervention” because the disciplines are

congruent with their spiritual and religious beliefs, and the overall focus on promoting wellness. Finally, the preliminary data appears to indicate that participants can learn the protocol quickly. Because of this protocol's comprehensiveness, counselors or counselors-in-training could use the material in individual counseling sessions for future research.

Follow-up Visit

The researcher returned to the community in early 2017, where she conducted the workshop to explore the reasons for the attrition, particularly from the control group. The feedback from the leaders was instructive and helped inform the feasibility of future studies. One of their suggestions was to conduct the workshop over two weeks consecutively because of the strain on those who work on Sunday morning before coming to church for two hours and staying back for another four hours for the workshop. Moreover, by shortening the length of the workshop content will give the participants time to role-play. Additionally, the student-researcher would prefer a separate time for the participants to do the assessments because of the church scheduling conflict. Their feedback also touched briefly on the lack of time to build relationships with the leaders and members before the workshop, critical in the Chin culture.

Another reason the leaders gave for the protocol's low uptake was the protocol's complexity among people who are not familiar with psychological interventions. They indicated that the need to practice five steps daily was too demanding for their people who work more than 40 hours per week. The student-researcher will distill the five steps per day to just one step a day for future studies.

Potential Future Modifications

The protocol can be further simplified: In day one, the participant will do the scriptural reading and the self-reflection piece, followed by a short prayer of thanksgiving. On day two, the

participant will “narrate” writing or drawing of their stress, followed by a thanksgiving prayer. For day three, the participants will read day one's passage before writing down their prayer of acceptance of grace. Day four involves confessing their acceptance of grace and forgiveness throughout the day. On Day 5, the participants can work on the second part, committing to practicing grace, forgiving, and gratitude. For Day 6, the participants can begin or end the day by meditating on a short favorite Bible verse or one included in the workbook. Finally, on day seven (as in step five of the original protocol), the participant will write down something good they will do for someone else as their act of grace.

Additionally, the researcher would also appoint a liaison person in the community for future studies (apart from the pastor who was very helpful but also very busy with church duties) to regularly contact the participants to encourage them to practice the protocol. The researcher initially wanted to email/text/call each participant weekly but could not do so because of the language and relationship barriers. Finally, for future studies, she would also arrange for childcare so couples could attend the sessions together or conduct the workshop as a small group study in a home.

Implications for Future Research

There is statistical evidence that the GRACE protocol can produce changes in the participants' experiences (of psychological distress, gratitude, and motivation to forgive), and these changes warrant further investigation. Additionally, the changes in satisfaction with life (measured using the SWLS) were not significant. However, a bivariate Pearson analysis detected a positive correlation between GQ-6 scores and SWLS scores for the 43 participants at 0.47 with significance at $p = .002$. Conceptually, gratitude is correlated with the satisfaction with life scale (SWLS) as per other studies (Toussaint & Friedman, 2009; Watkins, 2004, 2014; Wood et al.,

2010), with one study reporting a contribution of at least 9% to the SWLS scores (Wood, Joseph, & Maltby, 2008). Moreover, as Watkins (2004, 2014) argued, individuals who experience gratitude regularly are more likely to be optimistic about their daily experiences. Hence, a study using the protocol can further clarify the relationship between gratitude and satisfaction with life.

Indeed, a single case study such as n-of-1 will describe the benefit of the protocol better in future studies since this kind of research focused exclusively on the objective and personalized determined experiences of one individual compared to a small sample population. Furthermore, while it is true that future quantitative studies of a new protocol would benefit from a larger sample size to improve statistical significance, the truth is, each refugee population has its unique challenges. Kazdin's (2011) suggestion of a single-case design study, which to a small degree is similar to the n-of-1 research, may be better suited for smaller ethnic minority refugee populations like the Burmese or Bhutanese people group.

Besides, single-case designs involve many observations with a smaller number of participants or fewer subjects. Instead of doing a pre- and post-assessment, the researcher assesses behavior over time before conducting the intervention and observe what happens over time. Kazdin (2011) argues that the wealth of the day-to-day or month-to-month change is lost if the researcher focuses on comparing the treatment group's variation at pre- and post-intervention. Moreover, n-of-1 trials tend to be a more efficient and less costly vehicle to control other clinical conditions.

Although the investigator tried to incorporate appropriate cross-cultural methods such as a video of their homeland, there were other difficulties in adapting some of the measures, constructs, and language from one culture and language to another. Thus, in the future, a mixed-

method study using a combination of the workshop and personalized interview with some of the randomly selected participants or a semi-qualitative study may add value to the research.

Conversely, a study that engages the families in a multiple-family support and education group format may also be beneficial. APA (2010) recommends research employing a multimethod structure for the best outcome. Sue & Chu (2003) suggest longitudinal studies trace the “effects of acculturation and changes in family and community” to expand the researcher’s understanding of ethnic minority populations in the United States (p. 461).

Besides, a Community-Based Participatory Research (CBPR) methods approach (Ellis, Kia-Keating, Yusuf, Lincoln, & Nur, 2007; Johnson, Ali, & Shipp, 2009), which includes the development of an advisory board drawn from the members of the community, is appropriate for future research. This advisory board has a say in the study design, recruitment strategies, translation methods, and implementation (Ellis et al., 2007).

Discussions

In the year and a half, when the student-researcher started researching the Chin refugees and immigration, the world of refugeehood changed drastically. Daily, there is at least one piece of news on refugees' plight and suffering in the media. This and other cases highlight the need for more ethnic minority research, especially interventional experiments. Although the findings in this study implicate the complexity of surveying an ethnic minority refugee population, the researcher has documented these challenges to inform future studies. These challenges about cultural barriers and worldviews are real and inherent in research with less accessible people. More important, the student-researcher (a fellow Southeast Asian) has grown in her knowledge and cultural engagement with this population, even as she attempts to view their refugee experiences through a shared pair of “cultural” lens.

Interestingly, during this period, there appears to be a shifting interest from traumatology to the focus on the refugee populations' salutogenic resources. Perhaps the shift in focus is a function of the governmental and resettlement policies' changes. It is just a change in the general attitude towards naturalistic and spirituality-integrated interventions. This paradigm shift will benefit studies like this one because of its focus on wellness and spirituality practices.

Undoubtedly, another research teasing out factors such as resiliency, which may contribute to protective factors to decrease symptomatology, is useful for explaining the outcomes seen in this study (Fredrickson et al., 2003; Steinhardt & Dolbier, 2008; Toussaint et al., 2010).

While the recent announcements on the travel ban and increased vetting are likely to impact the resettled refugee population's mental health, it is beyond the scope of this project to discuss the dilemma of governmental policies. However, the researcher would like to stress the dire need for counselors to be concerned about the resettled refugees' glaring mental health disparities and other underrepresented populations. And to work with non-clinical underrepresented populations that have a low uptake of mental health services (Augsberger et al., 2015), a community-based program such as this project has the potential of addressing social determinants of health and screening out the more severe cases for clinical intervention (Goodkind, 2005).

The results of this study also expand upon current knowledge of spiritual factors and shed light on the importance of incorporating components of spirituality into clinical treatment. Faith-Driven interventions such as this and other integrated protocols may have the potential of reducing posttraumatic and daily stress among religious refugee populations. Although the activities aimed at “accepting the gift of grace” may be the key ingredient within the protocol

that led to increased forgiveness and gratitude while reducing their somatic and psychological distress, further research is needed to clarify the association.

While studies with underrepresented populations are often more challenging and complicated because of the cultural and language barriers, there remains a pressing need to advance a model that frames the immigrants' daily stressor experiences. Additionally, a simplified version of psychometric assessment that measures biopsychosocial and spiritual domains would better inform more inclusive and practical research, counseling services, and preventive measures. This researcher hopes to replicate her study with some modifications suggested earlier and more research with other underrepresented populations. Finally, central to the refugee resettlement, successful acculturation, and a positive economic gain is a stable, adequately remunerated, and fulfilling employment, which in turn requires biopsychosocial spiritual health.

REFERENCES

- Altruism. (n.d.). Merriam-Webster Online. In Merriam-Webster. Retrieved May 8, 2017, from <http://www.merriam-webster.com/dictionary/altruism>
- American Counseling Association (2014). *ACA Code of Ethics*. Alexandria, VA: Author.
- Ahn, A. C., Ngo-Metzger, Q., Legedza, A. T., Massagli, M. P., Clarridge, B. R., & Phillips, R. S. (2006). Complementary and alternative medical therapy use among Chinese and Vietnamese Americans: prevalence, associated factors, and effects of patient-clinician communication. *American Journal of Public Health, 96*(4), 647-653.
- Akinsulure-Smith, A. M., Ghiglione, J. B., & Wollmershauser, C. (2008). Healing in the midst of chaos: Nah We Yone's African women's wellness group. *Women & Therapy, 32*(1), 105-120.
- Alexander, A. (2008). Without refuge: Chin refugees in India and Malaysia. *Forced Migration Review, 30*, 36-37.
- Alexander, J. C. (2004). Toward a theory of cultural trauma. *Cultural trauma and collective identity, 76*, 620-639.
- Alexander, J. C., Eyerman, R., Giesen, B., Smelser, N. J., & Sztompka, P. (2004). *Cultural Trauma and Collective Identity*. CA: University of California Press.
- American Psychiatric Association. [APA] (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.
- Anderson, J. W., Liu, C., & Kryscio, R. J. (2008). Blood pressure response to transcendental meditation: a meta-analysis. *American journal of hypertension, 21*(3), 310-316.
- Anaby, D., Jarus, T., & Zumbo, B. D. (2010). Psychometric evaluation of the Hebrew language version of the Satisfaction with Life Scale. *Social Indicators Research, 96*(2), 267-274.

- Ao, T., Taylor, E., Lankau, E., Sivilli, T. I., Blanton, C., Shetty, S., & Lopes-Cardozo, B. (2012). *An investigation into suicides among Bhutanese refugees in the U.S. 2009–2012 stakeholders report*. Center for Disease Control and Prevention.
- Apodaca, T. R., & Miller, W. R. (2003). A meta-analysis of the effectiveness of bibliotherapy for alcohol problems. *Journal of clinical psychology, 59*(3), 289-304.
- Arredondo, P., Tovar-Blank, Z. G., & Parham, T. A. (2008). Challenges and promises of becoming a culturally competent counselor in a sociopolitical era of change and empowerment. *Journal of Counseling & Development, 86*(3), 261-268.
- Astrow, A. B., Puchalski, C. M., & Sulmasy, D. P. (2001). Religion, spirituality, and health care: social, ethical, and practical considerations. *The American journal of medicine, 110*(4), 283-287.
- Augsberger, A., Yeung, A., Dougher, M., & Hahm, H. C. (2015). Factors influencing the underutilization of mental health services among Asian American women with a history of depression and suicide. *BMC health services research, 15*(1), 542.
- Baird, M. B., Domian, E.W., Mulcahy, E.R., Mabior, R., Jemutai-Tanui, G., & Filipe, M. K. (2015). Creating a bridge of understanding between two worlds: Community-based collaborative action research with Sudanese refugee women. *Public Health Nursing, 32*:388–396
- Baker, F., & Jones, C. (2006). The effect of music therapy services on classroom behaviors of newly arrived refugee students in Australia: A pilot study. *Emotional and Behavioral Difficulties, 11*, 249–260.
- Balbuena, L., Baetz, M., & Bowen, R. (2013). Religious attendance, spirituality, and major depression in Canada: a 14-year follow-up study. *The Canadian Journal of*

- Psychiatry*, 58(4), 225-232.
- Bandura, A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, 84(2), 191.
- Barimah, K. B., & Van Teijlingen, E. R. (2008). The use of traditional medicine by Ghanaians in Canada. *BMC complementary and alternative medicine*, 8(1), 30.
- Barnes, V. A., Davis, H. C., Murzynowski, J. B., & Treiber, F. A. (2004). Impact of meditation on resting and ambulatory blood pressure and heart rate in youth. *Psychosomatic medicine*, 66(6), 909-914.
- Baron, N. (2002). Community based psychosocial and mental health services for southern Sudanese refugees in long term exile in Uganda. In T. V. M. de Jong (Ed.), *Trauma, war, and violence: Public mental health in socio-cultural context* (pp. 157-203). New York: Springer.
- Barron, S., Okell, J., Yin, S. M., VanBik, K., Swain, A., Larkin, E.,... Ewers, K. (2007). *Refugees from Burma: Their backgrounds and refugee experiences*. Washington, DC: Center for Applied Linguistics.
- Beck, J. R. (2003). Self and soul: Exploring the boundary between psychotherapy and spiritual formation. *Journal of Psychology and Theology*, 31(1), 24.
- Beck, R., & McDonald, A. (2004). Attachment to God: The Attachment to God Inventory, tests of working model correspondence, and an exploration of faith group differences. *Journal of Psychology and Theology*, 32, 92-103.
- Beiser, M. (2009). Resettling refugees and safeguarding their mental health: Lessons learned from the Canadian Refugee Resettlement Project. *Transcultural psychiatry*, 46(4), 539-583.

- Beiser, M. (1988). Influences of time, ethnicity, and attachment on depression in Southeast Asian refugees. *American Journal of Psychiatry*, *145*, 46–51.
- Beiser, M. N., & Hou, F. (2006). Ethnic identity, resettlement stress and depressive affect among Southeast Asian refugees in Canada. *Social Science & Medicine*, *63*(1), 137-150.
- Beiser, M., & Hou, F. (2001). Language acquisition, unemployment and depressive disorder among Southeast Asian refugees: A 10-year study. *Social Science & Medicine*, *53*, 1321–1334.
- Beiser, M., Hou, F., Hyman, I., & Tousignant, M. (2002). Poverty and mental health among immigrant and non-immigrant children. *American Journal of Public Health*, *92*(2), 220–227.
- Benson, H. (1996). Mind over maladies. Can yoga, prayer and meditation be adapted for managed care?. Interview by Jim Montague. *Hospitals & health networks*, *70*(8), 26.
- Benson, P. L., Donahue, M. J., & Erickson, J. A. (1993). The Faith Maturity Scale: Conceptualization, measurement, and empirical validation. In M. L. Lynn & D. O. Moberg (Eds.), *Research in the social scientific study of religion* (Vol. 5, pp. 1–26). Greenwich, CT: JAI Press.
- Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy: Theory, Research, Practice, Training*, *27*(1), 3.
- Berthold, S. M., Wong, E. C., Schell, T. L., Marshall, G. N., Elliott, M. N., Takeuchi, D., & Hambarsoomians, K. (2007). United States Cambodian refugees' use of complementary and alternative medicine for mental health problems. *Psychiatric Services*, *58*(9), 1212-1218.
- Betzalel, N., & Shechtman, Z. (2010). Bibliotherapy treatment for children with adjustment

- difficulties: A comparison of affective and cognitive bibliotherapy. *Journal of Creativity in Mental Health*, 5(4), 426-439.
- Bhugra, D. (2004). Migration and mental health. *Acta Psychiatrica Scandinavica*, 109(4), 243-258.
- Bienenfeld, D., & Yager, J. (2007). Issues of spirituality and religion in psychotherapy supervision. *Israeli Journal of Psychiatry and Related Sciences*, 44(3), 178-186.
- Bird, J. N. (2013). Talking with lips: settlement, transnationalism and identity of Karen people from Burma living in Brisbane, Australia.
- Birman, D., & Tran, N. (2008). Psychological distress and adjustment of Vietnamese refugees in the United States: Association with pre- and post-migration factors. *American Journal of Orthopsychiatry*, 78, 109–120.
- Bisson J., Andrew M. (2009) Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD003388. doi:10.1002/14651858.CD003388.pub3
- Bisson, J. I, Roberts, N.P, Andrew, M., Cooper, R., Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews Issue 12*. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub4
- Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., ... Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda. *Journal of the American Medical Association*, 289, 3117–3124.
- Bono, G., & McCullough, M. E. (2006). Positive responses to benefit and harm: bringing forgiveness and gratitude into cognitive psychotherapy. *Journal of Cognitive*

- Psychotherapy*, 20(2), 147-158.
- Boothby, N., Strang, A., & Wessells, M. (2006). *A world turned upside down*. Bloomfield, CT: Kumarian Press.
- Borwick, S., Schweitzer, R. D., Brough, M., Vromans, L., & Shakespeare-Finch, J. (2013). Wellbeing of refugees from Burma: A salutogenic perspective. *International Migration*, 51(5), 91-105.
- Boud, D. (2001). Using journal writing to enhance reflective practice. (p. 9-18)..In L. M. English & M. A. Gillen. (Eds.) *Promoting Journal Writing in Adult Education. New Directions in Adult and Continuing Education No. 90*. San Francisco: Jossey-Bass
- Bracken, P. (2002) *Trauma, Culture, Meaning & Philosophy*, Whurr Publishers, England.
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American journal of Psychiatry*, 162(2), 214-227.
- Bray, P. (2010). A broader framework for exploring the influence of spiritual experience in the wake of stressful life events: Examining connections between posttraumatic growth and psycho-spiritual transformation. *Mental Health, Religion & Culture*, 13(3), 293-308.
- Breslau, N. (2009). Epidemiology of Trauma, PTSD, and Other Posttrauma Disorders. *Trauma, Violence, & Abuse*, 10(3), 198-210.
- Brough, P., Timms, C., Siu, O. L., Kalliath, T., O'Driscoll, M. P., Sit, C. H., ... & Lu, C. Q. (2013). Validation of the Job Demands-Resources model in cross-national samples: Cross-sectional and longitudinal predictions of psychological strain and work engagement. *Human Relations*, 66(10), 1311-1335.
- Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V. *Social Science & Medicine*, 69(7), 1032-1039.

- Bufford, R. K. (2015). *Encountering Grace* (power-point). Retrieved from George Fox University: http://digitalcommons.georgefox.edu/gscp_fac/93/
- Burstow, B. (2003). Toward a radical understanding of trauma and trauma work. *Violence against women, 9*(11), 1293-1317.
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: a review of meta-analyses. *Clinical psychology review, 26*(1), 17-31.
- Cahill, S. P., Foa, E. B., Hembree, E. A., Marshall, R. D., & Nacash, N. (2006). Dissemination of exposure therapy in the treatment of posttraumatic stress disorder. *Journal of traumatic stress, 19*(5), 597-610.
- California Department of Social Services (2010). Services for Refugees, Asylees, and Trafficking Victims. Retrieved from <http://www.cdss.ca.gov/Refugee-Services>
- Cappas, N. M., Andres-Hyman, R., & Davidson, L. (2005). What Psychotherapists Can Begin to Learn from Neuroscience: Seven Principles of a Brain-Based Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 42*(3), 374.
- Cardozo, B. L., Talley, L., Burton, A., & Crawford, C. (2004). Karenni refugees living in Thai-Burmese border camps: traumatic experiences, mental health outcomes, and social functioning. *Social science & medicine, 58*(12), 2637-2644.
- Carlsson, J. M., Mortensen, E. L., & Kastrup, M. (2005). A follow-up study of mental health and health-related quality of life in tortured refugees in multidisciplinary treatment. *The Journal of nervous and mental disease, 193*(10), 651-657.
- Carr, A. (2013). *Positive psychology: The science of happiness and human strengths*. Routledge.
- Caruth, C. (1995). Trauma and experience. *Trauma: Explorations in memory, 3*-12.

- Cashwell, C. S., & Young, J. S. (2011). Diagnosis and treatment. *Integrating spirituality and religion into counseling: A guide to competent practice*, 163-182.
- Castonguay, L. G., Reid, J. J., Halperin, G. S., & Goldfried, M. R. (2003). Psychotherapy integration. *Handbook of psychology*.
- Centers for Disease Control and Prevention (CDC; 2013). Suicide and suicidal ideation among Bhutanese refugees--United States, 2009-2012. *MMWR. Morbidity and mortality weekly report*, 62(26), 533.
- Cervantes, J. M., & Ramírez, O. (1992). Spirituality and family dynamics in psychotherapy with Latino children.
- Chan, B. & Parker, G. (2004). Some recommendations to assess depression in Chinese people in Australasia. *Australia NZ Journal of Psychiatry* 38, 141-7.
- Christians, E. A. C., Burma, I., Ling, S. Z. U., & Mang, S. B. L. (2004). *Religious Persecution*. Retrieved from <http://www.burmalibrary.org/docs6/ReligiousPersecution.pdf>
- Chun, S., & Lee, Y. (2013). "I am just thankful": The experience of gratitude following traumatic spinal cord injury. *Disability and rehabilitation*, 35(1), 11-19.
- Chung, R. C.-Y., & Bemak, F. (2007). Asian Immigrants and Refugees. In F. T. L. Leong, A. Ebreo, L. Kinoshita, A. G. Inman, L. H. Yang, & M. Fu (Eds.), *Handbook of Asian American psychology* (pp. 227-243). Thousand Oaks, CA: Sage Publications, Inc.
- Cohen, A. B., & Hill, P. C. (2007). Religion as culture: Religious individualism and collectivism among American Catholics, Jews, and Protestants. *Journal of Personality*, 75, 709-742. doi:10.1111/j.1467-6494.2007.00454.x
- Combs, G., & Freedman, J. (2012). Narrative, poststructuralism, and social justice: Current practices in narrative therapy. *The Counseling Psychologist*, 40(7), 1033-1060.

- Cooper, N. A., & Clum, G. A. (1989). Imaginal flooding as a supplementary treatment for PTSD in combat veterans: A controlled study. *Behavior therapy, 20*(3), 381-391.
- Cornish, M. A., & Wade, N. G. (2015a). Working through past wrongdoing: Examination of a self-forgiveness counseling intervention. *Journal of Counseling Psychology, 62*(3), 521.
- Cornish, M. A., & Wade, N. G. (2015b). A therapeutic model of self-forgiveness with intervention strategies for counselors. *Journal of Counseling & Development, 93*(1), 96-104.
- Council for Accreditation of Counseling and Related Educational Programs. (CACREP; 2015). *2016 CACREP standards*. Alexandria, VA: Author.
- Courtois, C. A. (2004) Complex trauma, complex reactions: Assessment and treatment. *Psychotherapy: Theory, Research, Practice, Training, 2004, 41*(4), 412-425.
- Courtois, C. A. (2008) Complex trauma, complex reactions: Assessment and treatment. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*, 86-100.
<http://dx.doi.org/10.1037/1942-9681.S.1.86> (reprint)
- Craske, M. G., Kircanski, K., Zelikowsky, M., Mystkowski, J., Chowdhury, N., & Baker, A. (2008). Optimizing inhibitory learning during exposure therapy. *Behaviour research and therapy, 46*(1), 5-27.
- Crumlish, N., & O' Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *The Journal of Nervous and Mental Disease, 198*(4), 237-251.
- Cummins, R. A. (2012). Positive psychology and subjective well-being homeostasis: A critical examination of congruence. In *A positive psychology perspective on quality of life* (pp. 67-86). Springer, Dordrecht.

- Damm, A. P., & Dustmann, C. (2014). Does growing up in a high crime neighborhood affect youth criminal behavior? *American Economic Review*, *104*(6), 1806-32.
- d'Ardenne, P., Ruaro, L., Cestari, L., Fakhoury, W., & Priebe, S. (2007). Does interpreter-mediated CBT with traumatized refugee people work? A comparison of patient outcomes in East London. *Behavioral and Cognitive Psychotherapy*, *35*, 293–301.
- De Jong, J. (2004). Public mental health and culture: disasters as a challenge to western mental health care models, the self, and PTSD. In *Broken spirits* (pp. 189-210). Routledge.
- Des Meules, M., Gold, J., McDermott, S., Cao, Z., Payne, J., Lafrance, B., ... & Mao, Y. (2005). Disparities in mortality patterns among Canadian immigrants and refugees, 1980–1998: results of a national cohort study. *Journal of Immigrant and Minority Health*, *7*(4), 221-232.
- DiBlasio, F. A. (1998). The use of a decision-based forgiveness intervention within intergenerational family therapy. *Journal of family Therapy*, *20*(1), 77-96.
- Diener, E., Emmons, R.A., Larsen, R.J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personal Assessment*, *49*:71–75.
- Dillon, M. R. (2015). *Predicting College Students' Propensity to Forgive with Dimensions of Executive Functioning* (Unpublished doctoral dissertation). Middle Tennessee State University.
- Dittmer, L. (2010). *Burma or Myanmar? The Struggle for National Identity*. World Scientific Publishing Company. ISBN-13: 978-9814313643.
- Eaton, R. J., Bradley, G., & Morrissey, S. (2014). Positive predispositions, quality of life and chronic illness. *Psychology, Health and Medicine*, *19*(4), 473–489.
- Edberg, M., Cleary, S., & Vyas, A. (2011). A trajectory model for understanding and assessing

- health disparities in immigrant/refugee communities. *Journal of Immigrant and Minority Health, 13*(3), 576-584.
- Elkins, D. N., Hedstrom, L. J., Hughes, L. L., Leaf, J. A., & Saunders, C. (1988). Toward a humanistic-phenomenological spirituality: Definition, description, and measurement. *Journal of humanistic Psychology, 28*(4), 5-18.
- Ellison, C. W. (1983). Spiritual well-being: Conceptualization and measurement. *Journal of Psychology and Theology, 11*, 330-340.
- Emmons, R. A. (2008). Gratitude, subjective well-being, and the brain. *The Science of Subjective Well-Being*, 469-489.
- Emmons, R. A., & Crumpler, C. A. (2000). Gratitude as a human strength: Appraising the evidence. *Journal of Social and Clinical Psychology, 19*(1), 56-69.
- Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: an experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84*(2), 377.
- Emmons, R. A., & Mishra, A. (2011). Why gratitude enhances well-being: What we know, what we need to know. *Designing positive psychology: Taking stock and moving forward*, 248-262.
- Enright, R. D. (1996). Counseling within the forgiveness triad: On forgiving, receiving forgiveness, and self-forgiveness. *Counseling & Values, 40*, 107-127.
- Enright, R. D. (1991). The moral development of forgiveness. In W. M. Kurtines & J.L. Gewirtz (Eds.), *Handbook of Moral Behavior and Development, Vol. 1.* (pp. 123-152). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Evans, D. (1993). *Spirituality and human nature.* SUNY Press.

- Erford, B. T., Savin-Murphy, J. A., & Butler, C. (2010). Conducting a meta-analysis of counseling outcome research: Twelve steps and practical procedures. *Counseling Outcome Research and Evaluation, 1*(1), 19-43.
- Erikson, K. T., & Yule, W. (1994). *A new species of trouble: Explorations in disaster, trauma, and community* (Vol. 7). New York: Norton.
- Eshun, S. & Gurung, A.R. (2009). *Culture and mental health: Sociocultural influences, theory and practice*. Oxford, UK: Wiley-Blackwell publishing.
- Fallot, R. D., & Blanch, A. K. (2013). Religious and spiritual dimensions of traumatic violence. *APA handbook of psychology, religion, and spirituality, 2*, 371-387.
- Farr, K. (2005). *Sex trafficking: The global market in women and children*. New York: Worth Publishers.
- Fazel, M., Doll, H., & Stein, A. (2009). A school-based mental health intervention for refugee children: An exploratory study. *Clinical Child Psychology and Psychiatry, 14*, 297–309.
- Fazel, S., Khosla, V., Doll, H., & Geddes, J. (2008). The prevalence of mental disorders among the homeless in western countries: systematic review and meta-regression analysis. *PLoS medicine, 5*(12), e225.
- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in Western countries: A systematic review. *The Lancet, 365*(9467), 1309–1314.
- Fernando, G. A., Miller, K. E., & Berger, D. E. (2010). Growing pains: The impact of disaster-related and daily stressors on the psychological and psychosocial functioning of youth in Sri Lanka. *Child Development, 81*(4), 1192-1210.
- Fehr, R., Gelfand, M. J., & Nag, M. (2010). The road to forgiveness: A meta-analytic synthesis

- of its situational and dispositional correlates. *Psychological Bulletin*, 136, 894–914. <http://dx.doi.org.ezproxy.liberty.edu/10.1037/a0019993>
- Fetzer, I. (2003). *Multidimensional measurement of religiousness/spirituality for use in health research: A report of the Fetzer Institute/National Institute on Aging Working Group*. Kalamazoo, MI: John E. Fetzer Institute.
- Fink, C. (2013). *Living silence in Burma: Surviving under military rule*. Zed Books Ltd.
- Fink, C. (2008). Militarization in Burma's ethnic states: Causes and consequences. *Contemporary Politics*, 14(4), 447-462.
- Fink, C., & Fink, C. (2009). *Living silence in Burma: Surviving under military rule*. Chiang Mai, Thailand: Silkworm Books.
- Fisher, M. L., & Exline, J. J. (2006). Self-forgiveness versus excusing: The roles of remorse, effort, and acceptance of responsibility. *Self and Identity*, 5(02), 127-146.
- Foa, E. B., Keane, T. M., Friedman, M. J., & Cohen, J. A. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.
- Foa, E. B., Zoellner, L. A., Feeny, N. C., Hembree, E. A., & Alvarez-Conrad, J. (2002). Does imaginal exposure exacerbate PTSD symptoms?. *Journal of Consulting and Clinical Psychology*, 70(4), 1022.
- Fontana, A., & Rosenheck, R. (2004). Trauma, change in strength of religious faith, and mental health service use among veterans treated for PTSD. *The Journal of Nervous and Mental Disease*, 192(9), 579-584.
- Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. R. (2003). What good are positive emotions in crises? A prospective study of resilience and emotions following the

- terrorist attacks on the United States on September 11th, 2001. *Journal of Personality and Social Psychology*, 84(2), 365–376.
- Fung, K., & Wong, Y. L. R. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *International journal of social psychiatry*, 53(3), 216-231.
- Furman, L. D., Benson, P. W., Grimwood, C., & Canda, E. (2004). Religion and spirituality in social work education and direct practice at the millennium: A survey of UK social workers. *British Journal of Social Work*, 34(6), 767-792.
- Garrett, K. E. (Ed.) (2006). *Living in America: Challenges facing new immigrants and refugees*. Robert Wood Johnson Foundation.
- Garzon, F. (2013). Christian devotional meditation for anxiety. *Evidence-based practices for Christian counseling and psychotherapy*, 59-80.
- Garzon, F. (2011). *Spirituality in Counseling*. Available at:
http://works.bepress.com/fernando_garzon/15
- Garzon, F. (Ed.) (2008). *Pursuing peace: Case studies exploring the effectiveness of Theophostic Prayer Ministry*. Xulon Press.
- Garzon, F. (2005). Interventions that apply Scripture in psychotherapy. *Journal of Psychology and Theology*, 33(2), 113-121.
- Garzon, F. & Burkett, L. (2002). Healing of memories: Models, research, future directions. *Journal of Psychology and Christianity*, 21(1), 42-49
- Garzon, F. L., & Hall, M. E. L. (2012). Teaching Christian integration in psychology and counseling: Current status and future directions. *Journal of Psychology and Theology*, 40(2), 155-159.

- Getanda, E. M., Papadopoulos, C., & Evans, H. (2015). The mental health, quality of life and life satisfaction of internally displaced persons living in Nakuru County, Kenya. *BMC Public Health, 15*(1), 755.
- Gerritsen, A. A., Bramsen, I., Devillé, W., Van Willigen, L. H., Hovens, J. E., & Van Der Ploeg, H. M. (2006). Physical and mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. *Social Psychiatry and Psychiatric Epidemiology, 41*(1), 18-26.
- Goeke-Morey, M. C., Cairns, E., Merrilees, C. E., Schermerhorn, A. C., Shirlow, P., & Cummings, E. M. (2013). Maternal religiosity, family resources and stressors, and parent-child attachment security in Northern Ireland. *Social Development, 22*(1), 19-37.
- Good, J. J. (2010). Integration of Spirituality and Cognitive-behavioral Therapy for the Treatment of Depression. Digital Commons. Retrieved from www.pcom.edu.
- Goodkind, J. R. (2005). Effectiveness of a community-based advocacy and learning program for Hmong refugees. *American Journal of Community Psychology, 36*, 387-408.
- Gouveia, V. V., Milfont, T. L., Da Fonseca, P. N., & de Miranda Coelho, J. A. P. (2009). Life satisfaction in Brazil: Testing the psychometric properties of the satisfaction with life scale (SWLS) in five Brazilian samples. *Social Indicators Research, 90*(2), 267.
- Gozdziak, E. M. (2004). Training refugee mental health providers: Ethnography as a bride to multicultural practice. *Human Organization, 63*, 203-210.
- Grace. (n.d.). Merriam-Webster Online. In Merriam-Webster. Retrieved May 8, 2017, from <http://www.merriam-webster.com/dictionary/grace>
- Griffith, E. E., Young, J. L., & Smith, D. L. (1984). An analysis of the therapeutic elements in a black church service. *Psychiatric Services, 35*(5), 464-469.

- Griner, D., & Smith, T. B. (2006). Culturally adapted mental health interventions: A meta-analytic review. *Psychotherapy: Theory, Research, Practice Training, 43*, 531–548.
- Grossman, P., Niemann, L., Schmidt, S., & Walach, H. (2004). Mindfulness-based stress reduction and health benefits: A meta-analysis. *Journal of psychosomatic research, 57*(1), 35-43.
- Guerin, B., Guerin, P., Diiriye, R. O., & Yates, S. (2004). Somali conceptions and expectations concerning mental health: Some guidelines for mental health professionals. *New Zealand Journal of Psychology, 33*, 59–67.
- Habermas, J. (1975). *Legitimation Crisis*. Boston: Beacon Press
- Hagaman, A. K., Sivilli, T. I., Ao, T., Blanton, C., Ellis, H., Cardozo, B. L., & Shetty, S. (2016). An investigation into suicides among Bhutanese refugees resettled in the United States between 2008 and 2011. *Journal of Immigrant and Minority Health, 18*(4), 819-827.
- Hall, J. H., & Fincham, F. D. (2005). Self-forgiveness: The stepchild of forgiveness research. *Journal of social and clinical psychology, 24*(5), 621-637.
- Hall, D. E., Koenig, H. G., & Meador, K. G. (2004). Conceptualizing "religion": How language shapes and constrains knowledge in the study of religion and health. *Perspectives in Biology and Medicine, 47*(3), 386-401.
- Hall, D. E., Meador, K. G., & Koenig, H. G. (2008). Measuring religiousness in health research: Review and critique. *Journal of Religion and Health, 47*(2), 134-163.
- Harris, J. I., Erbes, C. R., Engdahl, B. E., Thuras, P., Murray-Swank, N., Grace, D., ... & Malec, C. (2011). The effectiveness of a trauma focused spiritually integrated intervention for veterans exposed to trauma. *Journal of Clinical Psychology, 67*(4), 425-438.
- Harrison, M. O., Edwards, C. L., Koenig, H. G., Bosworth, H. B., Decastro, L., & Wood, M.

- (2005). Religiosity/spirituality and pain in patients with sickle cell disease. *The Journal of Nervous and Mental Disease*, 193(4), 250-257.
- Hauck, F. R., Lo, E., Maxwell, A., & Reynolds, P. P. (2014). Factors influencing the acculturation of Burmese, Bhutanese, and Iraqi refugees into American society: Cross-cultural comparisons. *Journal of Immigrant & Refugee Studies*, 12(3), 331-352.
- Heath, M. A., Sheen, D., Leavy, D., Young, E., & Money, K. (2005). Bibliotherapy: A resource to facilitate emotional healing and growth. *School Psychology International*, 26(5), 563-580.
- Helm, H. M., Hays, J. C., Flint, E. P., Koenig, H. G., & Blazer, D. G. (2000). Does private religious activity prolong survival? A six-year follow-up study of 3,851 older adults. *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences*, 55(7), M400-M405.
- Highfield, E. S., Lama, P., Grodin, M. A., Kaptchuk, T. J., & Crosby, S. S. (2012). Acupuncture and traditional Chinese medicine for survivors of torture and refugee trauma: a descriptive report. *Journal of immigrant and minority health*, 14(3), 433-440.
- Hill, P. L., & Allemand, M. (2010). Forgiveness and adult patterns of individual differences in environmental mastery and personal growth. *Journal of Research in Personality*, 44(2), 245-250.
- Hill, P. L., & Allemand, M. (2011). Gratitude, forgiveness, and well-being in adulthood: Tests of moderation and incremental prediction. *The Journal of Positive Psychology*, 6(5), 397-407.
- Hill, P. C., & Edwards, E. (2013). Measurement in the psychology of religiousness and spirituality: Existing measures and new frontiers. In K. I. Pargament, J. J. Exline, & J. W.

- Jones (Eds.), *APA handbook of psychology, religion, and spirituality* (Vol 1). (pp. 51–77). Washington, DC: APA.
- Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing religion and spirituality: Points of commonality, points of departure. *Journal for the Theory of Social Behavior*, *30*(1), 51-77.
- Hinton, A. L. (2002). *Annihilating difference: the anthropology of genocide* (Vol. 2). Oakland, CA: University of California Press.
- Hinton, D.E., Ba, P., Peou, S., & Um, K. (2000). Panic disorder among Cambodian refugees attending a psychiatric clinic: Prevalence and subtypes. *General Hospital Psychiatry*, *22*, 437–444.
- Hinton, D. E., Pich, V., Hofmann, S. G., & Otto, M. W. (2013). Acceptance and Mindfulness Techniques as Applied to Refugee and Ethnic Minority Populations with PTSD: Examples From" Culturally Adapted CBT". *Cognitive and Behavioral Practice*, *20*(1), 33-46.
- Hinton, D. E., Hofmann, S. G., Pitman, R. K., Pollack, M. H., & Barlow, D. H. (2008). The panic attack–posttraumatic stress disorder model: Applicability to orthostatic panic among Cambodian refugees. *Cognitive Behaviour Therapy*, *37*(2), 101-116.
- Hinton, D. E., Chhean, D., Pich, V., Safren, S. A., Hofmann, S. G., & Pollack, M. H. (2005). A randomized controlled trial of cognitive behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: A cross-over design. *Journal of Traumatic Stress*, *18*, 617–629.
- Hodge, D. R. (2006). Spiritually modified cognitive therapy: A review of the literature. *Social Work*, *51*(2), 157-166.

- Hofmann, S. G. (2008). Cognitive processes during fear acquisition and extinction in animals and humans: Implications for exposure therapy of anxiety disorders. *Clinical psychology review, 28*(2), 199-210.
- Hollifield, J., Martin, P., & Orrenius, P. (2014). *Controlling immigration: A global perspective*. Stanford University Press.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., Stevenson, J., & Westermeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *JAMA, 288*:611 –21.
- Hollifield, M., Verbillis-Kolp, S., Farmer, B., Toolson, E., Woldehaimanot, T., Yamazaki, J., Holland, A., St Clair, J., & SooHoo, J. (2013). The Refugee Health Screen-15 (RHS-15): development and validation of an instrument for anxiety, depression, and PTSD in refugees. *General Hospital Psychiatry, 35*, 202-209.
- Hook, J. N., Worthington, E. L., Davis, D. E., Jennings, D. J., Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of clinical psychology, 66*(1), 46-72.
- Horrell, S. C. V. (2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology: Research and Practice, 39*(2), 160.
- Hsu, E., Davies, C. A., & Hansen, D. J. (2004). Understanding mental health needs of Southeast Asian refugees: Historical, cultural, and contextual challenges. *Clinical psychology review, 24*(2), 193-213.
- Hummer, R. A., Rogers, R. G., Nam, C. B., & Ellison, C. G. (1999). Religious involvement and U.S. adult mortality. *Demography, 36*(2), 273-285.
- Huynh, Q. L., Devos, T., & Smalarz, L. (2011). Perpetual foreigner in one's own land: Potential

- implications for identity and psychological adjustment. *Journal of Social and Clinical Psychology, 30*(2), 133-162.
- Im, H., & Rosenberg, R. (2016). Building Social Capital Through a Peer-Led Community Health Workshop: A Pilot with the Bhutanese Refugee Community. *Journal of Community Health, 41*(3), 509-517.
- International Rescue Committee [IRC]. (2016). News & Features. Retrieved from <https://www.rescue.org/latest>
- Jacobsen, K. & Landau, L. (2003). The dual imperative in refugee research: Some methodological and ethical considerations in social science research on forced migration, *Disasters 27*(3): 295–116
- James, K. (2010). Domestic violence within refugee families: Intersecting patriarchal culture and the refugee experience. *Australian and New Zealand journal of family therapy, 31*(3), 275-284.
- Jain, S., Shapiro, S. L., Swanick, S., Roesch, S. C., Mills, P. J., Bell, I., & Schwartz, G. E. (2007). A randomized controlled trial of mindfulness meditation versus relaxation training: effects on distress, positive states of mind, rumination, and distraction. *Annals of behavioral medicine, 33*(1), 11-21.
- Jasinskaja-Lahti, I., Liebkind, K., & Perhoniemi, R. (2006). Perceived discrimination and well-being: a victim study of different immigrant groups. *Journal of community & applied social psychology, 16*(4), 267-284.
- Jaycox, L. H., Stein, B. D., Kataoka, S. H., Wong, M., Fink, A., Escudero, P., & Zaragoza, C. (2002). Violence exposure, posttraumatic stress disorder, and depressive symptoms among recent immigrant schoolchildren. *Journal of the American Academy of Child &*

- Adolescent Psychiatry*, 41(9), 1104-1110.
- Jensen, J. A. (1994). An investigation of eye movement desensitization and reprocessing (EMDR) as a treatment for posttraumatic stress disorder (PTSD) symptoms of Vietnam combat veterans. *Behavior Therapy*, 25, 2, 311-325.
- Johnson, H., & Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review*, 28(1), 36-47.
- Johnson, C. E., Ali, S. A., & Shipp, M. P. L. (2009). Building community-based participatory research partnerships with a Somali refugee community. *American Journal of Preventive Medicine*, 37(6), S230-S236.
- Kagimu, M., Kaye, S., Ainomugisha, D., Lutalo, I., Walakira, Y., Guwatudde, D., & Rwabukwali, C. (2012). Evidence-based monitoring and evaluation of the faith-based approach to HIV prevention among Christian and Muslim youth in Wakiso district in Uganda. *African health sciences*, 12(2), 119-128.
- Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M. R., Desiraju, K., Morris, J. E., Saxena, S., Scheffler, R. M. (2011). Human resources for mental health care: Current situation and strategies for action. *Lancet*, 378, 9803, 1654–1663
- Kamler, E. (2009, October 15–18). *National identity, the Shan and child trafficking in Northern Thailand: The case of D.E.P.D.C. Working paper presented at the International Conference on Shan Studies*. Bangkok: Thailand.
- Kashdan, T. B., Uswatte, G., & Julian, T. (2006). Gratitude and hedonic and eudaimonic wellbeing in Vietnam War veterans. *Behavior Research and Therapy*, 44(2), 177-199.
doi:10.1016/j.brat.2005.01.005

- Kaufman, Y., Anaki, D., Binns, M., & Freedman, M. (2007). Cognitive decline in Alzheimer disease: Impact of spirituality, religiosity, and QOL. *Neurology*, *68*(18), 1509-1514.
- Kazdin, A. E. (2011). *Single-case research designs: Methods for clinical and applied settings*. Oxford University Press.
- Khawaja, N. G., White, K. M., Schweitzer, R., & Greenslade, J. (2008). Difficulties and coping strategies of Sudanese refugees: A qualitative approach. *Transcultural psychiatry*, *45*(3), 489-512.
- Kim, J. (2014). *The Efficacy of Christian Devotional Meditation on Stress, Anxiety, Depression, and Spiritual Health with Korean Adults in the United States: A Randomized Comparative Study*. Available at: <http://works.bepress.com>
- Kim, I., & Kim, W. (2014). Post-resettlement challenges and mental health of Southeast Asian refugees in the United States. *Best Practices in Mental Health*, *10*, 2, 63-77.
- Kim, Y., & Seidlitz, L. (2002). Spirituality moderates the effect of stress on emotional and physical adjustment. *Personality and individual differences*, *32*(8), 1377-1390.
- Kim, H. J., Park, E., Storr, C. L., Tran, K., & Juon, H. S. (2015). Depression among Asian-American Adults in the Community: Systematic Review and Meta-Analysis. *PloS One*, *10*(6).
- Kim, W. J., Song, Y. J., Ryu, H. S., Ryu, V., Kim, J. M., Ha, R. Y., ... & Cho, H. S. (2015). Internalized stigma and its psychosocial correlates in Korean patients with serious mental illness. *Psychiatry research*, *225*(3), 433-439.
- Kira, I. A., Ahmed, A., Wasim, F., Mahmoud, V., Colrain, J., & Rai, D. (2012). Group therapy for refugees and torture survivors: Treatment model innovations. *International Journal of Group Psychotherapy*, *62*(1), 69-88.

- Kirkpatrick, L. A., & Shaver, P. R. (1992). An attachment theoretical approach to romantic love and religious belief. *Personality and Social Psychology Bulletin*, 18, 266–275.
doi:10.1177/0146167292183002
- Kliwer, S. (2004). Allowing spirituality into the healing process. *The Journal of family practice*, 53(8), 616-624.
- Knight, G. P., Roosa, M. W., & Umaña-Taylor, A. J. (2009). *Studying ethnic minority and economically disadvantaged populations: Methodological challenges and best practices*. Washington, DC: American Psychological Association.
- Kobasa, S. C. (1979). Stressful life events, personality, and health: an inquiry into hardiness. *Journal of personality and social psychology*, 37(1), 1.
- Kobasa, S. C., Maddi, S. R., & Courington, S. (1981). Personality and constitution as mediators in the stress-illness relationship. *Journal of health and social behavior*, 368-378.
- Kobasa, S. C., Maddi, S. R., & Kahn, S. (1982). Hardiness and health: a prospective study. *Journal of personality and social psychology*, 42(1), 168.
- Koenig, H. G. (2012). Religion, spirituality, and health: The research and clinical implications. *International Scholarly Research Network [ISRN] Psychiatry*, pp. 1- 33.
doi:10.5402/2012/278730
- Koenig, H.G. (2005). *Faith and Mental Health: Religious Resources for Healing*. Conshohocken, PA: Templeton Press.
- Koenig, H. G., George, L. K., Titus, P., & Meador, K. G. (2004). Religion, spirituality, and acute care hospitalization and long-term care use by older patients. *Archives of Internal Medicine*, 164(14), 1579-1585.
- Koenig, H. G., George, L. K., Hays, J. C., Larson, D. B., Cohen, H. J., & Blazer, D. G. (1998).

- The relationship between religious activities and blood pressure in older adults. *The International Journal of Psychiatry in Medicine*, 28(2), 189-213.
- Kohrt, B. A., & Hruschka, D. J. (2010). Nepali concepts of psychological trauma: the role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. *Culture, Medicine, and Psychiatry*, 34(2), 322-352.
- Kohrt, B. A., Rasmussen, A., Kaiser, B. N., Haroz, E. E., Maharjan, S. M., Mutamba, B. B., ... & Hinton, D. E. (2014). Cultural concepts of distress and psychiatric disorders: Literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology*, 43(2), 365-406.
- Krause, N. (2009). Religious involvement, gratitude, and change in depressive symptoms over time. *The International Journal for the Psychology of Religion*, 19(3), 155-172.
- Krejtz, I., Nezlek, J. B., Michnicka, A., Holas, P., & Rusanowska, M. (2016). Counting one's blessings can reduce the impact of daily stress. *Journal of Happiness Studies*, 17(1), 25-39.
- Krysinska, K., Lester, D., Lyke, J., & Corveleyn, J. (2015). Trait gratitude and suicidal ideation and behavior. *Crisis*, 36, 291-296. doi: 10.1027/0227-5910/a000320.
- Kuile, S., Rousseau, C., Munoz, M., Nadeau, L., & Ouimet, M. (2007). The universality of the Canadian health care system in question: Barriers to services for immigrants and refugees. *International Journal of Migration, Health and Social Care*, 3(1), 15-26.
- Laddis, A. (2011). Lessons from the natural course of complex posttraumatic disorders. *Journal of Aggression, Maltreatment & Trauma*, 20(4), 426-444.
- Lawrence, R. T. (1997). Measuring the image of God: The God Image Inventory and the God Image Scales. *Journal of Psychology and Theology*, 25, 214-226.

- Lawson, E. J., & Thomas, C. (2007). Wading in the waters: Spirituality and older Black Katrina survivors. *Journal of Health Care for the Poor and Underserved, 18*(2), 341-354.
- Lee, S. J., Wong, N.-W. A., & Alvarez, A. N. (2009). The model minority and the perpetual foreigner. In N. Tewari & A. N. Alvarez (Eds.), *Asian American Psychology: Current Perspectives* (pp. 69–84). New York: Lawrence Erlbaum
- Lester, K., Artz, C., Resick, P. A., & Young-Xu, Y. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. *Journal of consulting and clinical psychology, 78*(4), 480.
- Lim, A. G., Stock, L., Shwe Oo, E. K., & Jutte, D. P. (2013). Trauma and mental health of medics in eastern Myanmar's conflict zones: a cross-sectional and mixed methods investigation. *Conflict Health, 7*(1), 15.
- Litz, B. T., Stein, N., Delaney, E., Lebowitz, L., Nash, W. P., Silva, C., & Maguen, S. (2009). Moral injury and moral repair in war veterans: A preliminary model and intervention strategy. *Clinical psychology review, 29*(8), 695-706.
- Loewy, M. I., Williams, D. T., & Keleta, A. (2002). Group counseling with traumatized East African refugee women in the United States. *Journal for Specialists in Group Work, 27*(2), 173-191.
- Lundberg, M. D. (2010). Repentance as a paradigm for Christian mission. *Journal of Ecumenical Studies, 45*(2), 201.
- Lum, T. Y., & Vanderaa, J. P. (2010). Health disparities among immigrant and non-immigrant elders: the association of acculturation and education. *Journal of Immigrant and Minority Health, 12*(5), 743-753.
- Lundberg, M. D. (2010). Repentance as a paradigm for Christian mission. *Journal of Ecumenical*

- Studies*, 45(2), 201.
- Luster, T., Qin, D., Bates, L., Johnson, D., & Rana, M. (2009). The Lost Boys of Sudan: Coping with ambiguous loss and separation from parents. *American Journal of Orthopsychiatry*, 79(2), 203.
- Lutfy, C., Cookson, S. T., Talley, L., & RoCHAT, R. (2014). Malnourished children in refugee camps and lack of connection with services after U.S. resettlement. *Journal of Immigrant and Minority Health*, 16(5), 1016-1022
- Macintyre, S., Ellaway, A., & Cummins, S. (2002). Place effects on health: how can we conceptualise, operationalise and measure them?. *Social science & medicine*, 55(1), 125-139.
- Macaskill, A., & Denovan, A. (2013). Developing autonomous learning in first year university students using perspectives from positive psychology. *Studies in Higher Education*, 38(1), 124-142.
- Mackenzie, C., McDowell, C., & Pittaway, E. (2007). Beyond 'do no harm': The challenge of constructing ethical relationships in refugee research. *Journal of Refugee studies*, 20(2), 299-319.
- Mahoney, A. (2005). Religion and Conflict in Marital and Parent-Child Relationships. *Journal of social issues*, 61(4), 689-706.
- Major, B., Quinton, W. J., & McCoy, S. K. (2002). Antecedents and consequences of attributions to discrimination: Theoretical and empirical advances. In *Advances in experimental social psychology* (Vol. 34, pp. 251-330). Academic Press.
- Marier, P. L., & Hadaway, C. K. (2002). Being religious "or" being spiritual. *America: A zero-sum proposition*, 289-300.

- Markowitz, J. C. (2010). The cutting edge: IPT and PTSD. *Depression and anxiety, 27*(10), 879.
- Marks, L., Nesteruk, O., Swanson, M., Garrison, B., & Davis, T. (2005). Religion and health among African Americans: A qualitative examination. *Research on Aging, 27*(4), 447-474.
- Marshall, G. N., Schell, T. L., Elliott, M. N., Berthold, S. M., & Chun, C. A. (2005). Mental health of Cambodian refugees 2 decades after resettlement in the United States. *JAMA, 294*(5), 571-9.
- Martin, A. M. (2008). *Exploring forgiveness: The relationship between feeling forgiven by God and self-forgiveness for an interpersonal offense* (Doctoral dissertation, Case Western Reserve University).
- Maslow, A. H. (1971). *The farther reaches of human nature*. New York: Viking Press.
- Massachusetts Refugee Resettlement Program. (2013). *List of ORI Programs and Services*. Retrieved from <https://www.mass.gov/service-details/list-of-ori-programs-and-services>
- McColl, H., & Johnson, S. (2006). Characteristics and needs of asylum seekers and refugees in contact with London community mental health teams. *Social psychiatry and psychiatric epidemiology, 41*(10), 789-795.
- McConnell, J. M., & Dixon, D. N. (2012). Perceived forgiveness from God and self-forgiveness. *Journal of Psychology and Christianity, 31*(1), 31.
- McCullough, M. E., & Willoughby, B. L. (2009). Religion, self-regulation, and self-control: Associations, explanations, and implications. *Psychological bulletin, 135*(1), 69.
- McCullough, M. E., Emmons, R. A., & Tsang, J. A. (2002). The grateful disposition: A conceptual and empirical topography. *Journal of Personality and Social Psychology, 82*(1), 112–127. doi:10.1037/0022-3514.82.1.112

- McCullough, M. E., Fincham, F. D., & Tsang, J. A. (2003). Forgiveness, forbearance, and time: the temporal unfolding of transgression-related interpersonal motivations. *Journal of personality and social psychology, 84*(3), 540.
- McCullough, M. E., Hoyt, W. T., & Rachal, K. C. (2000). What we know (and need to know) about assessing forgiveness constructs. In M. E. McCullough, K. I. Pargament, & C. E. Thoresen (Eds.), *Theory, research, and practice* (pp. 65-88). New York: Guilford Press.
- McCullough, M. E., Rachal, K. C., Sandage, S. J., Worthington, E. L., Jr., Brown, S. W., & Hight, T. L. (1998). Interpersonal forgiving in close relationships: II. Theoretical elaboration and measurement. *Journal of Personality and Social Psychology, 76*, 1586-1603.
- Mckenna Longacre, M. M., Silver-Highfield, E., Lama, P., & Grodin, M. A. (2012). Complementary and alternative medicine in the treatment of refugees and survivors of torture: A review and proposal for action. *Torture, 22*(1), 38-57.
- Measham, T., Guzder, J., Rousseau, C., Pacione, L., Blais-McPherson, M., & Nadeau, L. (2014). Refugee children and their families: Supporting psychological well-being and positive adaptation following migration. *Current problems in pediatric and adolescent health care, 44*(7), 208-215.
- Mellor, D., Fung, S. W. T., & binti Mamat, N. H. (2012). Forgiveness, empathy, and gender—a Malaysian perspective. *Sex roles, 67*(1-2), 98-107.
- Mendes, I., Ribeiro, A., Angus, L., Greenberg, L. S., Sousa, I., & Gonçalves, M. M. (2010). Narrative change in emotion-focused therapy: How is change constructed through the lens of the Innovative Moments Coding System? *Psychotherapy Research, 20*, 692-701. doi:10.1080/10503307.2010.514960

- Merritt, M. M., Bennett Jr, G. G., Williams, R. B., Edwards, C. L., & Sollers III, J. J. (2006). Perceived racism and cardiovascular reactivity and recovery to personally relevant stress. *Health Psychology, 25*(3), 364.
- Michelson, D., & Scare, I. (2009). Psychological needs, service utilization and provision of care in a specialist mental health clinic for young refugees: A comparative study. *Clinical Child Psychology and Psychiatry, 14*, 273–296.
- Migration Policy Institute. (2012). *Refugees and Asylees in the United States*. Retrieved from <https://www.migrationpolicy.org/article/refugees-and-asylees-united-states-0>
- Miller, K. E. (1999). Rethinking a familiar model: Psychotherapy and the mental health of refugees. *Journal of Contemporary Psychotherapy, 29*, 283–304.
- Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American psychologist, 58*(1), 24.
- Miller, K. E., & Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Social science & medicine, 70*(1), 7-16.
- Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75*, 27–39.
- Miller, K. E., Omidian, P., Rasmussen, A., Yaqubi, A., & Daudzai, H. (2008). Daily stressors, war experiences, and mental health in Afghanistan. *Transcultural Psychiatry, 45*(4), 611-638.
- Milligan, C., & Bingley, A. (2007). Restorative places or scary spaces? The impact of woodland on the mental well-being of young adults. *Health & place, 13*(4), 799-811.

- Milosevic, D., Cheng, I. H., & Smith, M. M. (2012). The NSW Refugee Health Service: Improving refugee access to primary care. *Australian family physician*, *41*(3), 147.
- Mollica, R. F., Bennett, D., Blendon, R. J., Donelan, K., Dunn-Strohecker, M., Elias, C., ... & Tor, S. (1993). *Repatriation and disability: a community study of health, mental health, and social functioning of the Khmer residents of Site Two*. Harvard School of Public Health.
- Moore-Thomas, C., & Day-Vines, N. L. (2008). Culturally competent counseling for religious spiritual African American adolescents. *Professional School Counseling*, *11*(3), 159-165.
- Mullany, L. C., Richards, A. K., Lee, C. I., Suwanvanichkij, V., Maung, C., Mahn, M.,....& Lee, T. J. (2007). Population-based survey methods to quantify associations between human rights violations and health outcomes among internally displaced persons in eastern Burma. *Journal of Epidemiology and Community Health*, *61*(10), 908-914.
- Murray, K. E., Davidson, G. R., & Schweitzer, R. D. (2010). Review of refugee mental health interventions following resettlement: best practices and recommendations. *American Journal of Orthopsychiatry*, *80*(4), 576-585.
- Myint-u, T. (2001). *The making of modern Burma*. Cambridge University Press.
- Nadeau, L., & Measham, T. (2005). Immigrants and mental health services: Increasing collaboration with other service providers. *Canadian Child and Adolescent Psychiatry Review*, *14*, 73-76.
- National Institute for Clinical Excellence (NICE), & National Collaborating Centre for Mental Health (NCCMH; 2005). Posttraumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. *NICE Clinical Guideline*, *26*. Available from: <http://guidance.nice.org.uk/CG26/?c=91523>

- Neria, Y., & Litz, B. T. (2004). Bereavement by traumatic means: The complex synergy of trauma and grief. *Journal of Loss and Trauma, 9*(1), 73-87.
- Neuner, F., & Elbert, T. (2007). The mental health disaster in conflict settings: can scientific research help? *BMC Public Health, 7*, 275.
- Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an African refugee settlement. *Journal of Consulting and Clinical Psychology, 72*, 579–587.
- Ng, S.-M., Fong, T. C. T., Tsui, E. Y. L., Au-Yeung, F. S. W., & Law, S. K. W. (2009). Validation of the Chinese version of Underwood's Daily Spiritual Experience Scale—Transcending cultural boundaries? *International Journal of Behavioral Medicine, 16*, 91–97. doi:10.1007/s12529-009-9045-5
- Ng, J. C., Lee, S. S., & Pak, Y. K. (2007). Chapter 4 contesting the model minority and perpetual foreigner stereotypes: A critical review of literature on Asian Americans in education. *Review of research in education, 31*(1), 95-130.
- Nichter, M. (1981). Idioms of distress: alternatives in the expression of psychosocial distress: A case study from South India. *Cultural Medical Psychiatry, 5*, 379–408.
- Nichter, M. (2010). Idioms of distress revisited. *Cultural Medical Psychiatry, 34*, 401–16.
- Nickerson, A., Bryant, R. A., Steel, Z., Silove, D., & Brooks, R. (2010). The impact of fear for family on mental health in a resettled Iraqi refugee community. *Journal of Psychiatric Research, 44*(4), 229-235.
- Nickerson, A., Bryant, R. A., Brooks, R., Steel, Z., Silove, D., & Chen, J. (2011a). The familial influence of loss and trauma on refugee mental health: a multilevel path analysis. *Journal*

- of Traumatic Stress*, 24(1), 25-33.
- Nickerson, A., Bryant, R. A., Silove, D., & Steel, Z. (2011). A critical review of psychological treatments for posttraumatic stress disorder in refugees. *Clinical Psychology Review*, 31(3), 399-417.
- Norredam, M., Garcia-Lopez, A., Keiding, N., et al. (2009). Risk of mental disorders in refugees and native Danes: A register-based cohort study. *Social Psychiatry and Psychiatric Epidemiology*, 44(12), 1023-1029.
- O'Dowd, R. (2007). Evaluating the outcomes of online intercultural exchange. *ELT journal*, 61(2), 144-152.
- Office of Refugee Resettlement. [ORR] (2012). Annual Report to Congress. Retrieved from <https://www.acf.hhs.gov/orr/resource/orr-year-in-review-2012>
- Oleson, H. E., Ann O'Fallon MA, R. N., & Sherwood, N. E. (2012). Health and healing: traditional medicine and the Karen experience. *Journal of cultural diversity*, 19(2), 44.
- Ostir, G. V., Berges, I. M., Markides, K. S., & Ottenbacher, K. J. (2006). Hypertension in older adults and the role of positive emotions. *Psychosomatic medicine*, 68(5), 727.
- Otto, M. W., & Hinton, D. E. (2006). Modifying exposure-based CBT for Cambodian refugees with posttraumatic stress disorder. *Cognitive and Behavioral Practice*, 13(4), 261-270.
- Ozorak, E. W. (2005). Cognitive approaches to religion. *Handbook of the psychology of religion and spirituality*, 216-234.
- Pace, T. W., Negi, L. T., Adame, D. D., Cole, S. P., Sivilli, T. I., Brown, T. D., ... & Raison, C. L. (2009). Effect of compassion meditation on neuroendocrine, innate immune and behavioral responses to psychosocial stress. *Psychoneuroendocrinology*, 34(1), 87-98.
- Palic, S., & Elklit, A. (2011). Psychosocial treatment of posttraumatic stress disorder in adult

- refugees: A systematic review of prospective treatment outcome studies and a critique. *Journal of affective disorders*, 131(1), 8-23.
- Paniagua, F.A. *Assessing and treating culturally diverse clients: Practical guide*. Sage; Thousand Oaks, CA: 2005.
- Park, C. L., & Helgeson, V. S. (2006). Introduction to the special section: growth following highly stressful life events--current status and future directions. *Journal of consulting and clinical psychology*, 74(5), 791.
- Pargament, K. I. (1997). *The psychology of religion and coping*. New York: Guilford.
- Pargament, K. I., Ano, G. G., & Wacholtz, A. B. (2005). The religious dimension of coping: Advances in theory, research, and practice. In R. F. Paloutzian & C. L. Park (Eds.), *Handbook of the psychology of religion and spirituality* (pp. 479–495). New York: Guilford.
- Pargament, K., I., Koenig, H. G., & Perez, L. M. (2000). The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology*, 56, 519–543.
- Pargament, K. I., Magyar-Russell, G. M., & Murray-Swank, N. A. (2005). The sacred and the search for significance: Religion as a unique process. *Journal of Social Issues*, 61(4), 665-687.
- Pargament, K. I., Smith, B. W., Koenig, H. G., & Perez, L. (1998). Patterns of positive and negative religious coping with major life stressors. *Journal for the scientific study of religion*, 710-724.
- Patil, C. L., Maripuu, T., Hadley, C., & Sellen, D. W. (2015). Identifying gaps in health research among refugees resettled in Canada. *International Migration*, 53(4), 204-225.

- Papadopoulos, R. K. (2007). Refugees, trauma and adversity-activated development. *European Journal of Psychotherapy and Counselling*, 9, 301–312.
- Paunovic, N., & Öst, L. G. (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. *Behaviour research and therapy*, 39(10), 1183-1197.
- Pavot, W. & Diener, E. (2008). The satisfaction with life scale and the emerging construct of life satisfaction. *Journal of Positive Psychology*, 3:137–152.
- Peterson, C., & Seligman, M. E. (2004). *Character strengths and virtues: A handbook and classification* (Vol. 1). Oxford University Press.
- Phillimore, J., & Goodson, L. (2006). Problem or opportunity? Asylum seekers, refugees, employment and social exclusion in deprived urban areas. *Urban Studies*, 43(10), 1715-1736.
- Porter, M., & Haslam, N. (2005). Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis. *Jama*, 294(5), 602-612.
- Portes, A., & Rumbaut, R. G. (2006). *Immigrant America: A portrait*. Oakland, CA: University of California Press.
- Poston, J. M., & Hanson, W. E. (2010). Meta-analysis of psychological assessment as a therapeutic intervention. *Psychological Assessment*, 22(2), 203.
- Powell, L. H., Shahabi, L., & Thoresen, C. E. (2003). Religion and spirituality: Linkages to physical health. *American psychologist*, 58(1), 36.
- Power, S. (2013). *A problem from hell: America and the age of genocide*. New York, NY: Basic Books.

- Priebe, S., Bogic, M., Ashcroft, R., Franciskovic, T., Galeazzi, G. M., Kucukalic, A., ... & Schützwohl, M. (2010). Experience of human rights violations and subsequent mental disorders—A study following the war in the Balkans. *Social Science & Medicine*, *71*(12), 2170-2177.
- Pynoos, R., Steinberg, A., & Piacentini, J. C. (1999). A developmental psychopathology model of childhood traumatic stress and intersection with anxiety disorders. *Biological Psychiatry*, *46*, 1542–1554.
- Ratts, M. J., & Pedersen, P. B. (2014). *Counseling for multiculturalism and social justice: Integration, theory, and application*. John Wiley & Sons.
- Refugee Processing Center (RPC). Department of State Bureau of Population, Refugees, and Migration Office of Admissions. (2017). *Arrival reports*. Retrieved from <http://ireports.wrapsnet.org>
- Rhoden, T. F., & Rhoden, T. L. S. (2011). *Burmese refugees: Letters from the Thai-Burmese border*. Chicago, IL: Digital Lycanthrope.
- Rold, M. F., Honeycutt, J. M., Grey, S. H., & Fox, A. J. (2011). Emotional management in the aftermath of Hurricane Katrina: Coping with tragedy through Biblical stories of destruction. *Journal of Communication and Religion*, *34*(2), 128-143.
- Romero, C., Friedman, L. C., Kalidas, M., Elledge, R., Chang, J., & Liscum, K. R. (2006). Self-forgiveness, spirituality, and psychological adjustment in women with breast cancer. *Journal of Behavioral Medicine*, *29*(1), 29-36.
- Rosbrook, B., & Schweitzer, R. D. (2010). The meaning of home for Karen and Chin refugees from Burma: An interpretative phenomenological approach. *European Journal of Psychotherapy and Counselling*, *12* (2), 159-172.

- Rosmarin, D. H., Pirutinsky, S., Greer, D., & Korbman, M. (2016). Maintaining a grateful disposition in the face of distress: The role of religious coping. *Psychology of Religion and Spirituality*, 8(2), 134.
- Rowatt, W. C., & Kirkpatrick, L. A. (2002). Two dimensions of attachment to God and their relation to affect, religiosity, and personality constructs. *Journal for the Scientific Study of Religion*, 41, 637–651. doi:10.1111/1468-5906.00143
- Sakhong, L. H. (2003). *In Search of Chin Identity: A study in religion, politics and ethnic identity in Burma*. Nias Press.
- Sam, D. L., & Berry, J. W. (Eds.). (2006). *The Cambridge handbook of acculturation psychology*. Cambridge University Press.
- Sampson, R., & Gifford, S. M. (2010). Place-making, settlement and well-being: The therapeutic landscapes of recently arrived youth with refugee backgrounds. *Health & place*, 16(1), 116-131.
- Sansone, R. A., & Sansone, L. A. (2010). Gratitude and well being: The benefits of appreciation. *Psychiatry*, 7(11), pp1550 - 5952.
- Savin, D., Seymour, D. J., Nguyen-Littleford, L., Betteridge, J., & Giese, A. (2005). Findings from mental health screening of newly arrived refugees in Colorado. *Public Health Reports*, 120, 224-229.
- Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., & Gray, S. H. (2008). Nonresponse and dropout rates in outcome studies on PTSD: Review and methodological considerations. *Psychiatry: Interpersonal and Biological Processes*, 71(2), 134-168.
- Schweitzer, R. D., Brough, M., Vromans, L., & Asic-Kobe, M. (2011). Mental health of newly arrived Burmese refugees in Australia: contributions of pre-migration and post-migration

- experience. *Australian and New Zealand Journal of Psychiatry*, 45(4), 299-307.
- Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian and New Zealand Journal of Psychiatry*, 40(2), 179-188.
- Seligman, M. E., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist* 56(1):89-90
- Shah, A. Y., Suchdev, P. S., Mitchell, T., Shetty, S., Warner, C., Oladele, A., & Reines, S. (2014). Nutritional status of refugee children entering DeKalb County, Georgia. *Journal of Immigrant and Minority Health*, 16(5), 959-967.
- Shakespeare-Finch, J., Schweitzer, R. D., King, J., & Brough, M. (2014). Distress, coping, and posttraumatic growth in refugees from Burma. *Journal of Immigrant & Refugee Studies*, 12(3), 311-330.
- Shannon, p. J., wieling, e., mccleary, j. S., & becher, e. (2015). Exploring the mental health effects of political trauma with newly arrived refugees. *Qualitative health research*, 25(4), 443-457.
- Shannon, p., im, h., becher, e., simmelink, j., wieling, l., & o'fallon, a. (2012). Screening for war trauma, torture and mental health symptoms among newly arrived refugees: a national survey of state refugee health coordinators. *Journal of immigrant and refugee studies*, 10(4), 380–394.
- Shapiro, f. (1991a). Eye movement desensitization & reprocessing procedure: from emd to emd/r—a new treatment model for anxiety and related traumata. *Behavior therapist*, 14, 133–135.
- Shapiro, f. (1989a). Efficacy of the eye movement desensitization procedure in the treatment of

- traumatic memories. *Journal of traumatic stress studies*, 2, 199–223.
- Shapiro, f. (1989b). Eye movement desensitization: a new treatment for post-traumatic stress disorder. *Journal of behavior therapy and experimental psychiatry*, 20, 211–217.
- Shapiro, f., & solomon, r. M. (1995). *Eye movement desensitization and reprocessing*. John wiley & sons, inc.
- Shaw, a., joseph, s., & linley, p. A. (2005). Religion, spirituality, and posttraumatic growth: a systematic review. *Mental health, religion & culture*, 8(1), 1-11.
- Shepherd, j., stein, k., & milne, r. (2000). Eye movement desensitization and reprocessing in the treatment of post-traumatic stress disorder: A review of an emerging therapy. *Psychological Medicine*, 30(4), 863-871.
- Shiu-Thornton, S., Senturia, K., & Sullivan, M. (2005). “Like a Bird in a Cage” Vietnamese Women Survivors Talk About Domestic Violence. *Journal of interpersonal violence*, 20(8), 959-976.
- Shukla K. (2008). The international community’s responsibility to protect. *Forced Migration Review*, 30, 7-9.
- Sieberer, M., Ziegenbein, M., Eckhardt, G., Machleidt, W., & Calliess, I. T. (2011). Psychiatric expert opinions on asylum seekers in Germany. *Psychiatrische Praxis*, 38, 38–44.
- Siegel, K., Anderman, S. J., & Schrimshaw, E. W. (2001). Religion and coping with health-related stress. *Psychology and Health*, 16(6), 631-653.
- Silberman, I. (2005). Religion as a meaning system: Implications for the new millennium. *Journal of social issues*, 61(4), 641-663.
- Silove, D. (1999). The psychosocial effects of torture, mass human rights violations, and refugee trauma: Toward an integrated conceptual framework. *The Journal of nervous and mental*

disease, 187(4), 200-207.

Silove, D., Steel, Z., Susljik, I., Frommer, N., Loneragan, C., Chey, T., ... & Bryant, R. (2007).

The impact of the refugee decision on the trajectory of PTSD, anxiety, and depressive symptoms among asylum seekers: a longitudinal study. *American journal of disaster medicine*, 2(6), 321-329.

Sinha, J. W. (2006). A faith-based alternative youth education program: Evaluating a participatory research approach. *Journal of Religion and Spirituality in Social Work*, 25 (3/4), 197–221.

Sinha, J. W., & Rosenberg, L. B. (2013). A critical review of trauma interventions and religion among youth exposed to community violence. *Journal of social service research*, 39(4), 436-454.

Sinha, J. W., Cnaan, R. A., & Gelles, R. (2007). Adolescent risk behaviors and religion: Findings from a national study. *Journal of Adolescence*, 30, 231–249.

Sirgy, J. (2012). *The psychology of quality of life: Hedonic well-being, life satisfaction, and eudaimonia* (Vol. 50). Netherlands: Springer Science & Business Media. ISBN 978-94-007-4405-9

Slewa-Younan, S., Guajardo, M. G. U., Heriseanu, A., & Hasan, T. (2015). A systematic review of post-traumatic stress disorder and depression amongst Iraqi refugees located in Western Countries. *Journal of Immigrant and Minority Health*, 17(4), 1231-1239.

Slobodin, O., & de Jong, J. T. (2015). Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? *International Journal of Social Psychiatry*, 61(1), 17-26.

- Snyder, C. R., & Heinze, L. S. (2005). Forgiveness as a mediator of the relationship between PTSD and hostility in survivors of childhood abuse. *Cognition & Emotion, 19*(3), 413-431.
- Sollom, R., Richards, A. K., Parmar, P., Mullany, L. C., Lian, S. B., Iacopino, V., & Beyrer, C. (2011). Health and human rights in Chin State, Western Burma: a population-based assessment using multistaged household cluster sampling. *PLoS medicine, 8*(2), e1001007.
- Spilman, S. K., Neppl, T. K., Donnellan, M. B., Schofield, T. J., & Conger, R. D. (2013). Incorporating religiosity into a developmental model of positive family functioning across generations. *Developmental psychology, 49*(4), 762.
- Spoorenberg, T. (2013). Demographic changes in Myanmar since 1983: An examination of official data. *Population and Development Review, 39*(2), 309-324.
- Spring, M., Westermeyer, J., Halcon, L., Savik, K., Robertson, C., Johnson, D. R., ... & Jaranson, J. (2003). Sampling in difficult to access refugee and immigrant communities. *The Journal of Nervous And Mental Disease, 191*(12), 813-819.
- Stanard, R. P., Sandhu, D. S., & Painter, L. C. (2000). Assessment of spirituality in counseling. *Journal of Counseling & Development, 78*(2), 204-210.
- Staub, E. (2003). Notes on cultures of violence, cultures of caring and peace, and the fulfillment of basic human needs. *Political psychology, 24*(1), 1-21.
- Steel, Z., Frommer, N., & Silove, D. (2004). Part I—The mental health impacts of migration: The law and its effects: Failing to understand: Refugee determination and the traumatized applicant. *International Journal of Law and Psychiatry, 27*(6), 511-528.
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R. A., & Van Ommeren, M. (2009).

- Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: a systematic review and meta-analysis. *JAMA*, *302*(5), 537-549.
- Steel, Z., Momartin, S., Silove, D., Coello, M., Aroche, J., & Tay, K. W. (2011). Two year psychosocial and mental health outcomes for refugees subjected to restrictive or supportive immigration policies. *Social Science & Medicine*, *72*(7), 1149-1156.
- Steel, Z., Silove, D., Brooks, R., Momartin, S., Alzuhairi, B., & Susljik, I. N. A. (2006). Impact of immigration detention and temporary protection on the mental health of refugees. *The British Journal of Psychiatry*, *188*(1), 58-64.
- Steinhardt, M., & Dolbier, C. (2008). Evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology. *Journal of American College Health*, *56*(4), 445-453.
- Sternthal, M. J., Williams, D. R., Musick, M. A., & Buck, A. C. (2010). Depression, anxiety, and religious life: A search for mediators. *Journal of Health and Social Behavior*, *51*(3), 343-359.
- Strelan, P. (2007). The prosocial, adaptive qualities of just world beliefs: Implications for the relationship between justice and forgiveness. *Personality and Individual Differences*, *43*(4), 881-890.
- Strelan, P., & Wojtysiak, N. (2009). Strategies for coping with interpersonal hurt: Preliminary evidence for the relationship between coping and forgiveness. *Counseling and Values*, *53*(2), 97-111.
- Sulmasy, D. P. (2009). Spirituality, religion, and clinical care. *Chest*, *135*(6), 1634-1642.
- Sue, S., & Chu, J. Y. (2003). The mental health of ethnic minority groups: Challenges posed by

- the supplement to the Surgeon General's report on mental health. *Culture, Medicine and Psychiatry*, 27(4), 447-465.
- Sue, D. W., Sue D. (1999). *Counseling the culturally different: Theory and practice*. 3rd New York: Wiley.
- Sue S., Zane N., Nagayama Hall G. C., Berger L. K. (2008). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology*. DOI: 60 10.1-10.24; 10.1146/annurev.psych.60.110707.163651.
- Szcześniak, M., & Soares, E. (2011). Are proneness to forgive, optimism and gratitude associated with life satisfaction? *Polish Psychological Bulletin*, 42(1), 20-23.
- Tamasese, K., Waldegrave, C., Tuhaka, F., & Campbell, W. (2003). Just therapy—A journey: A collection of papers from the Just Therapy Team of New Zealand. *Adelaide, South Australia: Dulwich Centre Publications*.
- Tan, S. (2007). Use of prayer and scripture in cognitive-behavioral therapy. *Journal of Psychology and Christianity*, 26, 2, 101-111. Retrieved from <http://ezproxy.liberty.edu:2048/login?url=http://search.proquest.com/docview/237253648?accountid=12085>
- Teng, E. J., & Friedman, L. C. (2009). Increasing mental health awareness and appropriate service use in older Chinese Americans: A pilot intervention. *Patient Education and Counseling*, 76(1), 143-6.
- Terheggen, M. A., Stroebe, M. S., & Kleber, R. J. (2001). Western conceptualizations and Eastern experience: a cross-cultural study of traumatic stress reactions among Tibetan refugees in India. *Journal of traumatic stress*, 14(2), 391-403.
- Thawngmung, A. M. (2012). *The “other” Karen in Myanmar: ethnic minorities and the*

struggle without arms. Landham, MD: Rowman & Littlefield

- Thompson, L. Y., Snyder, C. R., Hoffman, L., Michael, S. T., Rasmussen, H. N., Billings, L. S., ... & Roberts, D. E. (2005). Dispositional forgiveness of self, others, and situations. *Journal of personality*, 73(2), 313-360.
- Torosian, M. H., & Biddle, V. R. (2005). Spirituality and healing. In *Seminars in Oncology* (Vol. 32, No. 2, pp. 232-236). WB Saunders.
- Toussaint, L., & Friedman, P. (2009). Forgiveness, gratitude, and well-being: The mediating role of affect and beliefs. *Journal of Happiness Studies*, 10(6), 635.
- Toussaint, L., & Friedman, P. (2009). Forgiveness, gratitude, and well-being: The mediating role of affect and beliefs. *Journal of Happiness Studies*, 10(6), 635.
- Toussaint, L., & Webb, J. R. (2005). Theoretical and empirical connections between forgiveness, mental health, and well-being. *Handbook of forgiveness*, 349-362.
- Toussaint, L. L., Peddle, N., Cheadle, A., Sellu, A., & Luskin, F. (2010). Striving for peace through forgiveness in Sierra Leone: Effectiveness of a psychoeducational forgiveness intervention. *Mass trauma and emotional healing around the world: Rituals and practices for resilience and meaning-making*, 2, 251-267.
- Tsang, J.A. (2006). Gratitude and prosocial behaviour: An experimental test of gratitude *Cognition & Emotion*, 20, pp. 138–148
- Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive behaviors*, 38(6), 2219-2223.
- Underwood, L. G. (2011). The daily spiritual experience scale: Overview and results. *Religions*, 2(1), 29-50.

- Underwood, L. G. (2006). Ordinary spiritual experience: Qualitative research, interpretive guidelines, and population distribution for the Daily Spiritual Experience Scale. *Archive for the Psychology of Religion*, 28(1), 181-218.
- Underwood, L. G., & Teresi, J. A. (2002). The Daily Spiritual Experience Scale: Development, theoretical description, reliability, exploratory factor analysis, and preliminary construct validity using health related data. *Annals of Behavioral Medicine*, 24, 22– 33.
doi:10.1207/S15324796ABM2401_04
- United Nations International Children's Emergency Fund [UNICEF]. (2016). Retrieved from <http://www.unicef.org.uk/Documents/Media/UPROOTED%20Report.pdf>
- United Nations High Commissioner for Refugees [UNHCR] (2014). Retrieved from <http://www.unhcr.org/en-us/statistics/country/556725e69/unhcr-global-trends-2014.html>
- United Nations High Commissioner for Refugees [UNHCR] (2016). Retrieved from <http://www.unhcr.org/en-us/figures-at-a-glance.html>
- U.S. Census Bureau (2010). The Asian Population in the United States. Retrieved from http://www.census.gov/content/dam/Census/newsroom/facts-for-features/2014/cb14-ff13_asian_graphic.pdf
- U.S. Department of State. FY14 refugee admissions statistics. U.S. Department of State, Refugee Processing Center [RPC]; 2014. Retrieved from <http://www.wrapsnet.org/admissions-and-arrivals/>
- U.S. Department of State. (2012). Migration and Refugee Assistance 2012. Retrieved from <chrome-extension://oemmndcbldboiebfnladdacbfdmadadm/https://www.state.gov/documents/organization/181379.pdf>

- U. S. Department of Health and Human Services (HHS), National Institutes of Health (NIH), National Institute of Mental Health. (NIMH; 2016). *Post-traumatic stress disorder*. Retrieved from <https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>
- Van der Hart, O., Brown, P., & Van der Kolk, B. A. (1989). Pierre Janet's treatment of post-traumatic stress. *Journal of Traumatic Stress, 2*(4), 379-395.
- Van Oyen-Witvliet, C., Ludwig, T., & Bauer, D. J. (2002). Please forgive me: Transgressors' emotions and physiology during imagery of seeking forgiveness and victim responses. *Journal of Psychology and Christianity, 21*, 219.
- Van Wyk, S., & Schweitzer, R. D. (2014). A systematic review of naturalistic interventions in refugee populations. *Journal of Immigrant and Minority Health, 16*(5), 968-977.
- Vermette, D., Shetgiri, R., Al Zuheiri, H., & Flores, G. (2015). Healthcare access for Iraqi refugee children in Texas: Persistent barriers, potential solutions and policy implications. *Journal of Immigrant Minority Health, 17*:1526-1536
- Vinson, G. A., & Chang, Z. (2012). PTSD symptom structure among West African War trauma survivors living in African refugee camps: A factor-analytic investigation. *Journal of traumatic stress, 25*(2), 226-231.
- Vøllestad, J., Sivertsen, B., & Nielsen, G. H. (2011). Mindfulness-based stress reduction for patients with anxiety disorders: Evaluation in a randomized controlled trial. *Behaviour research and therapy, 49*(4), 281-288.
- Vukovich, M. M. (2016). *Exploring ethnocultural differences in distress levels of newly arrived refugees during early resettlement: A mixed methods study*. (unpublished doctoral dissertation) University of Denver).

- Vukovich, M., & Mitchell, G. V. (2015). Sharing Circles: Learning from a community based psychosocial intervention model implemented with vulnerable populations in Myanmar. *Intervention, 13*(2), 121-134.
- Wachholtz, A. B., & Pargament, K. I. (2005). Is spirituality a critical ingredient of meditation? Comparing the effects of spiritual meditation, secular meditation, and relaxation on spiritual, psychological, cardiac, and pain outcomes. *Journal of behavioral medicine, 28*(4), 369-384.
- Wachholtz, A., & Sambamoorthi, U. (2011). National trends in prayer use as a coping mechanism for health concerns: Changes from 2002 to 2007. *Psychology of Religion and Spirituality, 3*(2), 67.
- Wald, J., & Taylor, S. (2008). Responses to interoceptive exposure in people with posttraumatic stress disorder (PTSD): A preliminary analysis of induced anxiety reactions and trauma memories and their relationship to anxiety sensitivity and PTSD symptom severity. *Cognitive Behaviour Therapy, 37*(2), 90-100.
- Wald, J., & Taylor, S. (2007). Efficacy of interoceptive exposure therapy combined with trauma-related exposure therapy for posttraumatic stress disorder: A pilot study. *Journal of Anxiety Disorders, 21*(8), 1050-1060.
- Walker, D. F., & Doverspike, D. (2001). The relationship between forgiveness experiences and the masculine gender role among Christian men. *Journal of Psychology and Christianity.*
- Walker, D. F., & Gorsuch, R. L. (2002). Forgiveness within the Big Five personality model. *Personality and Individual Differences, 32*(7), 1127-1137.

- Warfa, N., Curtis, S., Watters, C., Carswell, K., Ingleby, D., & Bhui, K. (2012). Migration experiences, employment status and psychological distress among Somali immigrants: a mixed-method international study. *BMC Public Health, 12*(1), 749.
- Watkins, P. C. (2014). *Gratitude and the good life: Toward a psychology of appreciation*. New York, NY: Springer.
- Watkins, P. C. (2004). Gratitude and subjective well-being. In R.A. Emmons, M.E. McCullough (Eds.), *The psychology of gratitude* (pp. 167–194). New York, New York: Oxford University Press.
- Watkins, P. C., Woodward, K., Stone, T., & Kolts, R. L. (2003). Gratitude and happiness: Development of a measure of gratitude and relationships with subjective well-being. *Social Behavior and Personality, 31*(5), 431-452. doi:10.2224/sbp.2003.31.5.431
- Wheeler, D. J. (2011). Problems with Skewness and Kurtosis, Part One. Retrieved from <https://www.spcpress.com/pdf/DJW231.pdf>
- Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of behavioral medicine, 32*(1), 20-47.
- Wohl, M. J., DeShea, L., & Wahkinney, R. L. (2008). Looking within: Measuring state self-forgiveness and its relationship to psychological well-being. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement, 40*(1), 1.
- Wong, P.T.P., & Wong, L.C.J., editors (2006). *Handbook of multicultural perspectives on stress and coping*. New York: Springer.
- Wood, A. M., Froh, J. J., & Geraghty, A. A. (2010). Gratitude and well-being: A review and theoretical integration. *Clinical Psychology Review, 30*(7), 890-905.
doi:10.1016/j.cpr.2010.03.005

- Wood, A. M., Joseph, S., & Maltby, J. (2008). Gratitude uniquely predicts satisfaction with life: Incremental validity above the domains and facets of the five factor model. *Personality and Individual Differences, 45*(1), 49-54.
- Wood, A. M., Joseph, S., & Linley, P. A. (2007). Coping style as a psychological resource of grateful people. *Journal of Social and Clinical Psychology, 26*, 1108–1125.
- Wood, A. M., Maltby, J., Gillett, R., Linley, P., & Joseph, S. (2008). The role of gratitude in the development of social support, stress, and depression: Two longitudinal studies. *Journal of Research in Personality, 42*(4), 854-871. doi:10.1016/j.jrp.2007.11.003
- Woodyatt, L., & Wenzel, M. (2013). Self-forgiveness and restoration of an offender following an interpersonal transgression. *Journal of Social and Clinical Psychology, 32*(2), 225-259.
- White, M. (2012). Cultural definitions of health care: a case study of Burmese refugees in Indianapolis. *Journal of the Indiana Academy of the Social Sciences, 15*.
- Wilson, J. P., Droždek, B., & Turkovic, S. (2006). Posttraumatic shame and guilt. *Trauma, Violence, & Abuse, 7*(2), 122-141.
- Worthington Jr, E. L. (2013). *Forgiveness and reconciliation: Theory and application*. Routledge.
- Worthington, E. L. (Ed.). (1998). *Dimensions of forgiveness: A research approach* (Vol. 1). Templeton Foundation Press.
- Worthington, E. L. (1989). Religious faith across the life span Implications for counseling and research. *The Counseling Psychologist, 17*(4), 555-612.
- Yalom, I. D. (1980). *Existential psychotherapy* (Vol. 1). New York: Basic Books.
- Young, J. S., & Cashwell, C. S. (2011). Integrating spirituality and religion into counseling: An introduction. *Integrating spirituality and religion into counseling: A guide to competent*

practice, 1-24.

Young, J. S., Wiggins-Frame, M., & Cashwell, C. S. (2007). Spirituality and counselor competence: A national survey of American Counseling Association members. *Journal of Counseling and Development: JCD*, 85(1), 47.

Zechmeister, J. S., Garcia, S., Romero, C., & Vas, S. N. (2004). Don't apologize unless you mean it: A laboratory investigation of forgiveness and retaliation. *Journal of Social and Clinical Psychology*, 23(4), 532-564.

APPENDIX A

CONSENT FORM

FLOURISHING NOT JUST SURVIVING: A GRACE-CDM PROTOCOL FOR RESETTLED BURMESE CHIN REFUGEES

Sally Goh
Liberty University
Counselor Education and Supervision

You are invited to be in a research study examining the use of a Christian faith-driven program to reduce stress. You are selected as a possible participant because of your refugee experiences leaving Burma and settling here in the United States. I ask that you read this form carefully and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Sally Goh and the Counselor Education and Supervision department of Liberty University.

Background Information:

The Christian faith-driven program, GRACE-CDM involves Bible reading and meditating on biblical verses on a daily basis. This study also hopes to measure any improvement of positive characteristics such as forgiveness, gratitude and spiritual health after you have practiced the techniques you learned in the workshop for three weeks.

Procedures:

If you agree to be in this study, I would ask you to do the following things:

1. Read this consent carefully and sign it as your agreement to participate in this study.
2. Stay back after church (on a date arranged with your pastor) to attend the evaluation and answer the questions in your assessment packet. (You will be given an assessment packet which contains questions on your health, and this will take approximately 30-45 minutes to complete. An interpreter who is fluent in Chin and Burmese will be in attendance during the evaluation to explain the procedure of completing the forms. Please feel free to ask your questions in English, Chin or Burmese).
3. Attend the workshop on the date allocated to you, to learn the techniques of the program (you will be given a workbook to guide our study together). The teaching workshop will take about 4-5 hours (from 5pm to 10pm) on a Sunday evening with a dinner and several bathroom breaks in-between.
4. Your church pastor or another leader will be present to interpret (in Burmese Chin) for me (the researcher), and you have the freedom to ask questions during the workshop.
5. During the workshop, you will be placed in groups of three and asked to share something about your life in Burma or in the United States, according to the workbook. You will also be instructed to share only things that you are comfortable sharing, and no one will be forced to share anything if he/she does not wish to.

ခွင့်ပြုလက်ခံသည့်စာချုပ်

အသက်ဝမ်းကျောင်းပြုခြင်းသာမဟုတ် ၊ ကြီးပွားတိုးတက်ခြင်းဟူသည့်

ပြန်လည်အခြေချသည့် မြန်မာနိုင်ငံသားချင်းလူမျိုး ဒုက္ခသည်များအတွက် Grace-CDM ကျင့်စဉ်

Sally Goh

Liberty University

Counselor Education and Supervision

မိတ်ဆွေကို ခရစ်ယာန်ယုံကြည်ခြင်းကို အခြေပြုသည့် ကျင့်စဉ်သုံးခြင်းဖြင့် စိတ်ဖိစီးမှုလျော့ချခြင်း ကို လေ့လာသည့် သုတေသနတွင် ပါဝင်ရန်မိတ်ဆွေပါသည်။ မိတ်ဆွေသည် ပါဝင်နိုင်သည့်အကြောင်းမှာ မြန်မာပြည်ကို စွန့်ခွာလာခဲ့ရပြီး U.S. နိုင်ငံတွင် ပြန်လည် အခြေချသည့် ဒုက္ခသည်အတွေ့အကြုံများကြောင့် ဖြစ်ပါသည်။ ဤစာချုပ်ကို ဧည့်သည်အဖြစ်ရရှိရန်နှင့် သဘောတူကြောင်းလက်မှတ် မရေးထိုးမှီ သိလိုသောမေးခွန်းများကို မေးမြန်းနိုင်ပါကြောင်း မေတ္တာရပ်ခံအပ်ပါသည်။

ဤလေ့လာရေးသည် ကျွန်မ Sally Goh နှင့် Liberty University ရှိ Counselor Education and Supervision မှ ဦးစီးဦးရွက်ပြုလုပ်ပါသည်။

နောက်ခံအကြောင်းအရာများ

ဤလေ့လာရေး၏ ရည်ရွယ်ချက်မှာ လက်တွေ့ကျသည့်ပုံစံအဖြစ် GRACE-CDM ဟု ခေါ်သော သမ္မာကျမ်းစာဖတ်ခြင်းနှင့် ကျမ်းစာပိုဒ်များပေါ် တရားထိုင် (သို့) စိတ်ငြိမ်းအေးရန် လေ့ကျင့်သည့် ကျင့်စဉ်သည် ဖိစီးမှုနှင့် စိတ်သောကများ လျော့ချခြင်းတွင် ထိရောက်မှုမည်မျှရှိသည်ကို စမ်းသပ်ခြင်းဖြစ်ပါသည်။ ထို့ပြင် ဤကျင့်စဉ်ကို မိတ်ဆွေမှ သုံးပတ်တိုင် နေ့စဉ်ကျင့်သုံးခြင်းမှ ရရှိလာသည့် ကောင်းမွန်သော ထူးခြားသည့်လက္ခဏာများဖြစ်သည့် ခွင့်လွှတ်နိုင်ခြင်း၊ ကျေးဇူးသိတတ်ခြင်းနှင့် ဝိညာဉ်ရေးဆိုင်ရာ ကျန်းမာမှု စသည့် အရာများ၏ တိုးတက်မှုများကိုလည်း အကဲဖြတ်တိုင်းတာမည်ဖြစ်ပါသည်။

ညွှန်ကြားချက်များ

ဤလေ့လာခြင်းတွင် ပါဝင်ရန် မိတ်ဆွေမှ သဘောတူလက်ခံပါက အောက်ပါအချက်အလက်များကို လုပ်ဆောင်ပေးပါရန် မေတ္တာရပ်ခံအပ်ပါသည်။

၁။ ဤခွင့်ပြုလက်ခံသည့်စာချုပ်ကို သေချာစွာ ဖတ်ရှုပြီးလျှင် လက်မှတ်ရေးထိုးခြင်းဖြင့် ဤလေ့လာခြင်းတွင် ပါဝင်မည်ဖြစ်ကြောင်း အတည်ပြုပါ။

၂။ မိတ်ဆွေ၏ သင်းအုပ်ဆရာနှင့်သတ်မှတ်ထားသောနေ့၊ ဘုရားရှိခိုးပြီးသည့်နောက်တွင် အကဲဖြတ်သည့် အစီအစဉ်တွင် တက်ရောက်ပြီး ပြင်ဆင်ထားသည့်စာအိတ်ထဲရှိ မေးခွန်းများကို ဖြေဆိုပေးပါ။ စာအိတ်ထဲတွင် မိတ်ဆွေ၏ ကျန်းမာရေးနှင့်ပတ်သတ်သော မေးခွန်းပါရှိပြီး မေးခွန်းများအားလုံးဖြေဆိုရန် ပျန်းမျှ ၃၀ မိနစ်ကြန့် ကြာနိုင်ပါသည်။

6. After the workshop, you will be asked to not share what you learned in the workshop with others who have not attended the workshop – this is to protect the integrity of the experiment.
7. You will be instructed to practice the techniques that you learned in the workshop daily for three weeks according to the instructions given in the workbook. The practice will take 10-15 minutes to complete.
8. You will also be receiving a Bible verse daily (via text messaging or email) to encourage you.
9. You will be reminded (via text messaging or email) to return for the second evaluation in three weeks' time.

Risks and Benefits of being in the Study:

The study has several risks:

During the workshop or when you are practicing the program, you may recall certain incidents that may make you uncomfortable. If this should happen, please do not hesitate to contact your pastor or the researcher (myself) immediately. The researcher can do further assessments, and if it is necessary (and only if you wish), you will be referred to a counselor/therapist of your choice, in your area.

At any time, you can choose to withdraw from this study without any negative repercussions to yourself or your family or your relationship to the church.

The benefits to you are 1) a decrease in stress and mental distress; 2) a decrease in some physical problems that are associated with your mental distress; 3) a greater enjoyment of your work (or school) and life in the United States; 4) an improvement in your spiritual health

Compensation:

You will not receive payment or compensation for participating in this study.

Confidentiality:

The records of this study will be kept private. In any sort of report I might publish, I will not include any information that will make it possible to identify you. Research records will be stored securely, and only the researcher and her professor will have access to the records.

1. Your information (forms) will be stored in a locked filing cabinet that only my professors (Dr. Garzon, Dr. Mwendwa and Dr. Pride) and I (the researcher) have access to.
2. Any data used for analysis will be stored in my laptop and computer, which is password protected.
3. I will also ask all participants in the workshop to keep the confidentiality of information shared by the researcher and others; however, I cannot guarantee that everyone will abide by this. So I ask that you share only things you are comfortable sharing with your church members or friends.

Voluntary Nature of the Study:

၃။ သတ်မှတ်ထားသောနေ့တွင် သင်တန်းကို တက်ရောက်ပြီး ကျင့်စဉ်အကြောင်းကို သင်ယူပါ။ မိတ်ဆွေကို အထောက်အကူပြုရန် လမ်းညွှန်စာအုပ်ကိုလည်း ပေးမည်ဖြစ်ပါသည်။ ဤသင်တန်းသည် ၄ နာရီမှ ၅ နာရီ (တနင်္ဂနွေနေ့၊ ညနေ ၅ နာရီ မှ ၁၀ နာရီထိ) မျှကြာပြီး ညစာလည်း ပါဝင်မည်ဖြစ်ပြီး သင်တန်းအတွင်းတွင် နားချိန်များကို မကြာခဏပေးသွားပါမည်။

၄။ မိတ်ဆွေ၏ သင်းအုပ်ဆရာ (သို့) အသင်းတော်မှ ခေါင်းဆောင်တစ်ဦးလည်း ကျွန်ုပ်တို့အား ပြသည့် ချင်းဘာသာစကားဖြင့် ဘာသာပြန်ပေးမည်ဖြစ်ပြီး အကဲဖြတ်သည့် အချိန်နှင့်သင်တန်းချိန်များတွင် သိလိုသောမေးခွန်းများကို အချိန်မရွေးမေးမြန်းနိုင်ပါသည်။

၅။ သင်တန်းအတွင်းတွင် မိတ်ဆွေသည် သုံးယောက်တွဲအဖွဲ့များတွင် ပါဝင်ပြီး သင်တန်းစာအုပ်တွင်ပါရှိသည့် မိတ်ဆွေ၏ မြန်မာပြည် (သို့) U.S. နိုင်ငံမှ အတွေ့အကြုံများကို မိမိအဖွဲ့အတွင်းတွင် ဝေငှရပါမည်။

၆။ သင်တန်းပြီးသည့်အခါ သင်တန်းအတွင်း အချင်းချင်းထံမှ သိရှိခဲ့သော အတွေ့အကြုံအကြောင်းအရာများကို တခြားသင်တန်းတွင် မပါဝင်သူများနှင့်လုံးဝ မဆွေးနွေးရပါ။ အဘယ့်ကြောင့်ဆိုသော် ဤလက်တွေ့စမ်းသပ်ခြင်း၏ ရှိသားဖြောင့်မတ်မှုကို ဖောင့်ရှောက်လိုခြင်းကြောင့်ဖြစ်ပါသည်။

၇။ သင်တန်းတွင် သင်ယူခဲ့သော ကျင့်စဉ်များကို လမ်းညွှန်စာအုပ်တွင်ပါဝင်သည့်အတိုင်း မိတ်ဆွေသည် ၃ ပတ်အတွင်းတွင် နေ့တိုင်း ကျင့်ဆောင်ရမည်ဖြစ်ပါသည်။ ဤအလေ့အကျင့်သည် ၁၀ မိနစ်မှ ၁၅ မိနစ်မျှ ကျန့်ကြာနိုင်ပါသည်။

၈။ မိတ်ဆွေကို နေ့တိုင်း text messaging သို့ Email အားဖြင့် ကျမ်းပိုဒ်တစ်ပိုဒ်ပို့ခြင်းဖြင့် အားပေးပါမည်။

၉။ ၃ ပတ်အကြာတွင် ဒုတိယအကြိမ် အကဲဖြတ်ခြင်းကို တက်ရောက်ရန် text messaging သို့ Email ဖြင့် မိတ်ဆွေကို သတိပေးနှိုးဆော်ပေးပါမည်။

လေ့လာရေးတွင်ပါဝင်ခြင်း၏ နစ်နာခြင်းများနှင့်အကျိုးကျေးဇူးများ

ဤလေ့လာရေးတွင် နစ်နာခြင်းများရှိပါသည်။

သင်တန်းအတွင်း (သို့) ကျင့်စဉ်များကို ပြုလုပ်စဉ်အတွင်းတွင် သင့်ဘဝမှ ကသိကအောက်ဖြစ်စေမည့် အချို့သောဖြစ်ရပ်များကို ပြန်လည်သတိရလာနိုင်ပါသည်။ ထိုကဲ့သို့ ဖြစ်လာလျှင် မိတ်ဆွေ၏ သင်းအုပ်ဆရာ (သို့) ကျွန်ုပ်တို့ ချက်ချင်းဆက်သွယ်နိုင်ပါသည်။

မိတ်ဆွေမှ အလိုရှိပါက ကျွန်ုပ်တို့အနေဖြင့် လိုအပ်မည့် ချင့်ချိန်အကဲဖြတ်ခြင်းများကို ပြုလုပ်ပေးနိုင်ပြီး သင့်အတွက် သင့်လျော်မည့် အကြံဉာဏ်ပေးနိုင်သူနှင့် လွှဲပြောင်းတွေ့ဆုံစေပါမည်။

ဤလေ့လာရေးတွင် ပါဝင်မှုကို ရပ်တန့်လိုပါက အချိန်မရွေး ရပ်နိုင်ပါသည်။

ဤလေ့လာရေးတွင် ပါဝင်ခြင်းဖြင့် ရရှိလိုနိုင်သည့် အကျိုးကျေးဇူးများမှာ

- ၁။ စိတ်မိစီးမှုနှင့်သောကများ လျော့နည်းလာခြင်း
- ၂။ စိတ်မိစီးမှုကြောင့်ဖြစ်သော ကိုယ်ခန္ဓာတွင်ခံစားရသော ရောဂါများ နည်းပါးလာခြင်း

၃။ မိတ်ဆွေ၏ အလုပ် (သို့) ပညာဆည်းပူးရာတွင် (သို့) U.S. နိုင်ငံတွင် အသက်ရှင်လုပ်ရှားမှုများအပေါ်တွင် ပို၍နှစ်သက်မွေ့လျော်လာခြင်း

၄။ မိတ်ဆွေ၏ ဝိညာဉ်ခွန်အားပိုမိုတိုးတက်လာနိုင်ခြင်း တို့ဖြစ်ပါသည်။

ဤလေ့လာရေးတွင် ပါဝင်ခြင်းဖြင့် ရရှိလာသော ရောဂါဝေဒနာခံစားခြင်း (သို့) စိတ်ထိခိုက်နာကျင်ခြင်းများဖြစ်လာခဲ့သော် Liberty University မှ ဆေးကုသခြင်းနှင့် ငွေဖြင့်လျော်ပေးခြင်းတို့ကို ပြုလုပ်ပေးမည် မဟုတ်ပါ။ သို့ ပေမယ့် ပေါ့ဆမှုကြောင့်ဖြစ်သည်ဟု အခိုင်အမာပြောဆို နိုင်သော တရားဥပဒေဆိုင်ရာ အခွင့်အရေး မိတ်ဆွေထံတွင် ရှိပါသည်။

အလျော်အကြေးပေးခြင်း

ဤလေ့လာရေးတွင် ပါဝင်ခြင်းဖြင့် မိတ်ဆွေကို အဖိုးအခကြေးငွေ (သို့) အလျော်အကြေးပေးခြင်း ပေးမည်မဟုတ်ပါ။

ယုံကြည်စိတ်ချခြင်း

ဤလေ့လာရေးမှ ရရှိသော မိတ်ဆွေ၏အချက်အလက်များကို ပုဂ္ဂလိကကိုယ်ပိုင်အနေဖြင့် သိမ်းဆည်းထားပါမည်။ မိတ်ဆွေကို တိုက်ရိုက် ကိုယ်စားပြုမည့် သက်သေအထောက်အထားများကို ကျွန်ုပ်တို့အနေဖြင့် အသုံးပြုမည် မဟုတ်ပါ။ သုတေသနမှ ရရှိသော မှတ်တမ်းများကို လုံခြုံစွာ သိမ်းဆည်းထားမည်ဖြစ်ပြီး ထိုအရာများကို ကျွန်ုပ်တို့အနေဖြင့် မိမိတို့၏ပါမောက္ခသာလျှင် တွေ့ရှိနိုင်ပါမည်။

၁။ မိတ်ဆွေ၏ အချက်အလက်များသည် အလုံအခြုံသောစိတ်ထားသော အံ့ဆွဲတွင် သိမ်းဆည်းထားမည်ဖြစ်ပြီး ကျွန်ုပ်တို့အနေဖြင့် မိမိတို့၏ ပါမောက္ခ Dr. Garzon သာလျှင် ဖွင့်ရန် သော့ရှိပါသည်။

၂။ အသုံးပြုရန် လိုအပ်သည့် အကြောင်းအရာများကိုလည်း ကျွန်ုပ်တို့၏ Computer တွင် Password တပ်ထားခြင်းဖြင့် သိမ်းဆည်းထားပါမည်။

၃။ သင်တန်းတွင်ပါဝင်သောသူအားလုံးကိုလည်း သင်တန်းတွင်းမှ ကျွန်ုပ်တို့အခြားလူများဝေငှသည့် အကြောင်းအရာများကို ပြင်ပသို့ မပေါက်ကြားစေရန် မေတ္တာရပ်ခံထားပါသော်လည်း အယောက်တိုင်းက လိုက်နာနိုင်မည်ဟု အတိအကျအာမ မခံနိုင်ပါ။ ထို့ကြောင့် မိတ်ဆွေ၏ ဘုရားကျောင်းမှ အသင်းသူ အသင်းသားမိတ်ဆွေများထံ ရင်ဖွင့်နိုင်သည့် အကြောင်းအရာများကိုသာလျှင် ဝေငှနိုင်ပါသည်။

စေတနာကို အစေခံထားသည့် လေ့လာရေး

လေ့လာရေးတွင် ပါဝင်ခြင်းသည် စေတနာအလျောက်သာလျှင် ဖြစ်ပါသည်။ မိတ်ဆွေမှ ပါဝင်လိုခြင်း မလိုခြင်းသည် မိတ်ဆွေ၏ အသင်းတော် ၊ Liberty University နှင့် ကျွန်ုပ်တို့အကြားတွင်ရှိသော လက်ရှိနှင့်ရှေ့ ရှောက် ပတ်သက်မှုများကို မထိခိုက်ပါ။ မိတ်ဆွေမှ ပါဝင်လိုပါက မိတ်ဆွေ မဖြေဆိုလိုသော မေးခွန်းများကို ဖြေစရာမလိုပါ။ ထို့ပြင် အချိန်မရွေးလည်း ပါဝင်ခြင်းမှ အထိအခိုက်မရှိ အားနာစရာမလိုပဲ ရပ်ဆဲနိုင်ပါသည်။

ဆက်သွယ်ရန်နှင့်မေးခွန်းများရှိပါက

ဤသုတေသနကို စာတမ်းပြုစုသူသည် ကျွန်မ Sally Goh ဖြစ်ပါသည်။ မိတ်ဆွေမေးမြန်းရန် မေးခွန်းများရှိပါက ယခုမေးနိုင်ပါသည်။ နောက်မှ မေးမြန်းစရာများရှိပါက Sally Goh ကို 434-229-5478 သို့ မဟုတ် sgalau@liberty.edu ဖြင့် ဆက်သွယ်နိုင်ပါသည်။ ဤလေ့လာရေးနှင့်ပတ်သက်၍ မေးခွန်းများ၊ စိုးရိမ်စရာများရှိပါက ၊ ထို့ပြင် ကျွန်ုပ်တို့မဟုတ်ပဲ တစ်စုံတစ်ယောက်နှင့် ဆွေးနွေးလိုပါက Institutional Review Board, 1971 University Blvd, Suite 1837 သို့ မဟုတ် irb@liberty.edu ထံတွင် ဆက်သွယ်ပါရန် တွန်းအားပေးပါသည်။

ဤစာချုပ်မိတ္တူတစ်ဆောင်ကိုလည်း မိတ်ဆွေမှ သိမ်းဆည်းရန် ပေးမည်ဖြစ်ပါသည်။

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University, your church, or myself. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

Contacts and Questions:

The researcher conducting this study is Sally Goh. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at 434-229-5478 or sgalau@liberty.edu, or her advisor, Dr. Fernando Garzon at fgarzon@liberty.edu

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd, Room #134, Green Hall, Lynchburg, VA 24515 or email at irb@liberty.edu.

You will be given a copy of this information to keep for your records.

Statement of Consent:

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

Signature: _____ Date: _____

Signature of Investigator: _____ Date: _____

IRB Code Numbers:

IRB Expiration Date:

ခွင့်ပြုသည့် အတည်ပြုချက်
 အထက်ပါဖော်ပြထားသည့် အကြောင်းအရာများကို အချွန်သည် ဖတ်ရှုပြီးနောက် နားလည်သဘောပေါက်ပါသည်။ အချွန်ထံရှိသော
 အရာများကိုလည်း မေးမြန်ခဲ့ပြီးသလို အဖြေများကိုလည်း ရရှိခဲ့ပါသည်။ အချွန်သည် ဤလေ့လာရေးတွင် ပါဝင်ရန် သဘောတူပါသည်။
 လက်မှတ် _____ ဇန. ခွဲ _____
 စမ်းသပ်သူ၏ လက်မှတ် _____ ဇန. ခွဲ _____

IRB Code Numbers: (လေ့လာခြင်းကို အသိအမှတ်ပြုပြီးသည့်နောက် ဤနံပါတ်ကို ဤလေ့လာရေးနှင့်အညီ ထားရမည်။)

IRB Expiration Date: (လေ့လာခြင်းကို အသိအမှတ်ပြုပြီးသည့်နောက် သက်တမ်းကုန်ဆုံးသည့်နေ့ ရက် (အသိအမှတ်ပြုသည့်နေ့မှ တစ်နှစ်တိုင်) ကို လေ့လာရေးအသွယ်အစီအစဉ် သို့မဟုတ် ပြန်လည်ဆန်းစစ်နေသည့်အချိန်မှစ၍ ထည့်ရမည်ဖြစ်ပါသည်။ အချွန်များ၏လက်ရှိအခြေအနေအထားကို ပေါ်အနီးမှ တရားဝင်ထိန်းသိမ်းရေးအဖွဲ့ ၏ ပြဌာန်းထားသည့် အမိန့် အတိုင်း ရိုက်နှိပ်ခံစားစေရမည် ဖြစ်ပါသည်။)

Note: The title was changed (with permission) to A FAITH-DRIVEN PROTOCOL ON GRATITUDE, FORGIVENESS, AND STRESS FOR CHIN REFUGEES FROM BURMA: AN EXPLORATORY STUDY to reflect the study better.

APPENDIX B

GRACE-CDM Protocol (Workbook)

Instructions:

- 1) Use this booklet for the workshop and for your daily devotion for the next five weeks. There are no correct and incorrect answers.
Zarh nga chungah, Ni fa tin mah ca uk hi devotion caah rak hmang. Na ttial mi cungah hmaan le hmaan lo um lo.

- 2) Mark the calendar below each day after you complete the five steps. (Do not worry if you miss a day or a few days
Step pa nga na dih bakin mah calendar chungah hmak rin peng.(Ni khat /hnih te na tloh soal ahcun poi lo)

Week #1: 04/24/2016 – 04/30/2016

Step 1: Grace is a gift (Veneih nak ti mi cu Pathian sin in a ra mi laksawng a si)

Read Luke 18: 9-14. The Parable of the Pharisee and the Tax Collector

Also He spoke this parable to some who trusted in themselves that they were righteous, and despised others: 10 “Two men went up to the temple to pray, one a Pharisee and the other a tax collector. 11 The Pharisee stood and prayed thus with himself, ‘God, I thank You that I am not like other men—extortioners, unjust, adulterers, or even as this tax collector. 12 I fast twice a week; I give tithes of all that I possess.’ 13 And the tax collector, standing afar off, would not so much as raise his eyes to heaven, but beat his breast, saying, ‘God, be merciful to me a sinner!’ 14 I tell you, this man went down to his house justified rather than the other; for everyone who exalts himself will be humbled, and he who humbles himself will be exalted.”

Rel Luka 18: 9-14. Farasi Mi le Ngunkhuai Khawltu Bianabia

9Anmah kha kan tha tiah aa ruat i midang vialte kha ze i a rel lomi hna sinah Jesuh nih hi tahchunhnak bia hi a chim. 10“Mi pahnih cu Biakinn i thlacam awkah an hung kal; pakhat pa cu Farasi mi a si i a dang cu ngunkhuai khawltu a si. 11Farasi pa cu a dir i hi bantukin thla a cam: ‘Maw Pathian, kei cu midang bantukin hak a kaumi, lih a chimmi, nu le pa sualnak a tuahmi, ka si lo caah nangmah cu kan lawmh; cun khi ngunkhuai khawltupa bantuk zong khi ka si lo caah kan lawmh fawn. 12Zarh khat chungah voi hnih lengmang rawl ka ul i chawva ka hmuhmi vialte cheu hra cheu khat kan pek,’ tiah a ti. 13Sihmanhsehlaw ngunkhuai khawltupa cu lamhlatpi ah khin a dir i vanlei hmanh zoh ngam loin a tang aa cum i, ‘Maw Pathian, kei misual cungah hin zaangfahnak ngei ko,’ tiah a ti. 14Hihi kan chimh hna: Farasi mipa kha si loin hi pa tu hi a sualnak ngaihthiam in inn ah a tinmi cu a si. Zeicahtiah amah le amah aa ngantermi cu thumh an si lai i mi tangah aa dormi cu mi ngan ah ser an si lai,” tiah a ti. *

As you read the parable, reflect (think upon) the theme of grace and write in your own words how grace was shown in this story. How was grace shown? Who received grace?

Pathian Vel ruatbu tein hi bianabia tuanbia hi rel law, nangmah biafang tein hi tuanbia ah Vel a langh/aa phuan daan tial tuah. Zei tin dah vel neih nak ai langh? Ho nih dah velngeihnak a cohlang?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 2: Recognize our need for grace (Velngeihnak kan herhtuk mi hi hngal law).

Can you remember a time when God showed you grace? Pathian nih na cungah velngeihnak/zaangfahnak a langh lio caan nai thei maw?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 3: Accept the gift of grace (Parhian sin a ra mi velngeihnak laksawng hi cohlang ko).
(Write down your prayer of acceptance of grace)

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 4: Confess, commit, and contemplate or meditate on grace daily. (Pathian velngeihnak kha biatak ten ruat)

Day #1

Ephesians 2: 1-2

And you *He made alive*, who were dead in trespasses and sins, ²in which you once walked according to the course of this world, according to the prince of the power of the air, the spirit who now works in the sons of disobedience,

Efesa 2: 1-2 Hlanah cun nawl nan ngaih lo ruang le nan sual ruangah thlarau lei in nan rak thi.
*Cu lioah cun vawleicung phunglam thalo kha nan rak zul; van le vawlei kar i a ummi thlarau thawnnak uktu nawl kha nan rak zul; cu thlarau nih cun Pathian nawl a ngai lomi kha atu cu a uk hna.

Day #2

Ephesians 2: 3 Among whom also we all once conducted ourselves in the lusts of our flesh, fulfilling the desires of the flesh and of the mind, and were by nature children of wrath, just as the others.

Efesa 2: 3 A ngaingai ti ahcun, kan dihlak hin anmah bantu cu kan rak si i kan i chuahkehpimi kan pumsa duhnak zulh khan khua kan rak sa i kan pum le kan lungthin duhnak he aa tlakmi paoh kha kan rak tuah. Midang cio bantu kin kannih zong Pathian thinhunnak ing ding kan rak si.

Day #3

Ephesians 2:4-5 But God, being rich in mercy, because of the great love with which he loved us, even when we were dead in our trespasses, made us alive together with Christ— by grace you have been saved

Efesa 2:4-5 Sihmanhsehlaw Pathian nih a kan zaangfahnak cu a tam tuk i a kan dawtnak cu a ngan tuk hringhran caah a nawl kan ngaih lo ruang i thlarau lei in kan thih ko lioah khan Khrih sinah cun a kan nunter. Khamh nan sinak cu Pathian vel thawngin a si.

Day #4

Ephesians 2: 6 and raised us up together, and made us sit together in the heavenly places in Christ Jesus,

Efesa 2: 6 Khrih Jesuh he kan i pehtlainnak thawngin vancung khua i amah sin i uktu si ve dingah, amah he cun a kan thawhter.

Day #5

Ephesians 2: 7 "...that in the ages to come He might show the exceeding riches of His grace in His kindness toward us in Christ Jesus.

Efesa 2: 7 7 Khrih Jesuh thawngin a langmi a dawtnak chung i a ummi a vel cu zeitluk in dah a ngan ti kha a zungzal in hmu hna seh ti a kan duh caah, hi cu a tuah.

Day #6

Ephesians 2: 8-9 For by grace you have been saved through faith, and that not of yourselves; it is the gift of God, not of works, lest anyone should boast.

8 Nannih cu vel an ngeih hna caah an khamh hna i khamhnak nan hmuh cu amah nan zumhnak thawngin a si. Khamhnak nan hmuhmi cu nanmah tuahmi a si lo, Pathian laksawng a si. 9 Hi kongah hin nan i porhlawt khawhmi zehmanh a um lo, zeicahtiah nanmah tuannak thawngin nan hmuhmi a si lo.

Day #7

Ephesians 2: 10. For we are His workmanship, created in Christ Jesus for good works, which God prepared beforehand that we should walk in them.

Efesa 2: 10 Kannih cu Pathian kutchuak kan si i Pathian nih thil tha tuah dingah a rak kan tinh bantuakin Khrih he kan i pehtlainnak thawngin thil tha cu kan tuah khawhnak hnga a kan ser thanmi kan si.

Step 5: Embrace and extend gift of grace (Cohlang law, midang cung zongah Pathian velngeihnak laksawng kha pe ve)

Write down something you will do for someone as your act of grace during the week.

I will pray for His grace on my family and my future generations.

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Week #2: 05/01/2016 – 05/07/2016
Step 1: Grace is a gift (Velneih nak ti mi cu Pathian sin in a ra mi laksawng a si)

Read Luke 15: 11-24

Then He said: “A certain man had two sons. And the younger of them said to his father, ‘Father, give me the portion of goods that falls to me.’ So he divided to them his livelihood. And not many days after, the younger son gathered all together, journeyed to a far country, and there wasted his possessions with prodigal living. But when he had spent all, there arose a severe famine in that land, and he began to be in want. Then he went and joined himself to a citizen of that country, and he sent him into his fields to feed swine. And he would gladly have filled his stomach with the pods that the swine ate, and no one gave him anything.

“But when he came to himself, he said, ‘How many of my father’s hired servants have bread enough and to spare, and I perish with hunger! I will arise and go to my father, and will say to him, ‘Father, I have sinned against heaven and before you, and I am no longer worthy to be called your son. Make me like one of your hired servants.’”

“And he arose and came to his father. But when he was still a great way off, his father saw him and had compassion, and ran and fell on his neck and kissed him. And the son said to him, ‘Father, I have sinned against heaven and in your sight, and am no longer worthy to be called your son.’

“But the father said to his servants, ‘Bring out the best robe and put it on him, and put a ring on his hand and sandals on his feet. And bring the fatted calf here and kill it, and let us eat and be merry; for this my son was dead and is alive again; he was lost and is found.’ And they began to be merry.

“Now his older son was in the field. And as he came and drew near to the house, he heard music and dancing. So he called one of the servants and asked what these things meant. And he said to him, ‘Your brother has come, and because he has received him safe and sound, your father has killed the fatted calf.’

“But he was angry and would not go in. Therefore his father came out and pleaded with him. So he answered and said to his father, ‘Lo, these many years I have been serving you; I never transgressed your commandment at any time; and yet you never gave me a young goat, that I might make merry with my friends. But as soon as this son of yours came, who has devoured your livelihood with harlots, you killed the fatted calf for him.’

“And he said to him, ‘Son, you are always with me, and all that I have is yours. It was right that we should make merry and be glad, for your brother was dead and is alive again, and was lost and is found.’”

Rel Luka 15: 11-24.

Jesuh nih cun a thawh than hna i, “Voi khat ah fapa pahnih a ngeimipa a rak um. 12A ngakchia deuh pa nih khan a pa cu a thawh i, ‘Ka pa, atu hin ka co hnga a simi ro cu ka pe ko,’ a ti.

Cucaah an pa nih an unau cun ro cu a cheuh hna. 13Ni tlawmpal hnuah khin ngakchia deuh pa nih cun a thilri cu a zuarh i a man tangka cu aa lak i an inn cun a kal. A hla ngaingaimi ram ah a kal i khika ah khan duhduh in khua a va sa i a tangka cu a va sawksam dih. 14A ngeihmi vialte cu a hloh dih. Cun cu ram ah cun mangtam a tlung ciammam i a tawro in a thu. 15Cucaah cuka ram mipa pakhat sinah khan kuli va tuan awkah a kal i cu pa nih cun vok cawnggh awkah a lo ah a

rak kalter. 16Vok nih an eimi bekawng hmanh kha tam lenning ti a duh, asinain ahohmanh nih ei awk zeihmanh an pe lo. 17A donghna ah cun a lung a hung fim i, 'Ka Pa kuli vialte hmanh nih ei cawk loin ei awk an ngei, kei vial hika ah hin rawltam in ka thi cuahmah. 18Ka tho lai i ka pa sinah ka kal lai i, "Ka pa, Pathian sin le na sinah ka soal cang. 19Na fa ti awk ka tlak ti lo; na kuli pakhat bantukin ka chia ve ko," ka ti lai,' a ti. 20Cucaah a tho i a pa sinlei kir ah cun aa thawh. "Lamhlatpi i a rat lio kha a pa nih cun a rak hmuh; a zaang a fak ngaingai i a hei tlikhnawh i a kuh i a hnamh. 21A fapa nih cun, 'Ka pa, Pathian sin le nangmah sinah ka soal cang. Na fapa ti awk ka tlak ti lo,' tiah a ti. 22Sihmanhsehlaw a pa nih khan a sinum kha a auh hna i, 'Khulrang in puan tha bik kha rak pu u law aih u. A kutdong ah kutdonghrolh hrolh u law a ke ah kedan danh u. 23Cun va kal u law cawfa a thau bik kha va la u law va that u, lunglawm ngaiin puai tuah u sih. 24Zeicahtiah hi ka fapa hi a rak thi, sihmanhsehlaw atu cu a nung than; a rak tlau, sihmanhsehlaw atu cu ka hmuh than cang,' a ti. Cun cuticun puai tuah hram cu an thawk. As you read the parable, reflect (think upon) the theme of grace and write in your own words how grace was shown in this story. How was grace shown? Who received grace?

Pathian Vel ruatbu tein hi bianabia tuanbia hi rel law, nangmah biafang tein hi tuanbia ah Vel a langh/aa phuan daan tial tuah. Zei tin dah vel neih nak ai langh? Ho nih dah velngeihnak a cohlang?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 2: Recognize the need for grace (Velngeihnak kan herhtuk mi hi hngal law).

Can you remember a time when God showed you grace? Pathian nih na cungah velngeihnak/zaangfahnak a langh lio caan nai thei maw?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 3: Accept the gift of grace (Parhian sin a ra mi velngeihnak laksawng hi cohlang ko)

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 4: Confess, commit, and contemplate (or meditate on the gift of grace) daily. (Pathian velngeihnak kha biatak ten ruat).

Day #1

John 1:16-17 And from his fullness we have all received, grace upon grace. For the law was given through Moses; grace and truth came through Jesus Christ.

Johan 1:16-17 A liam in a liammi a vel chung cun thluachuahnak kha pakhat hnu pakhat a kan pek lengmang. 17Pathian nih Phungbia cu Moses thawng khan a kan pek, sihmanhsehlaw vel le biatak cu Jesuh Khrih thawng khan a ra.

Day #2

2 Corinthians 12:7 And lest I should be exalted above measure by the abundance of the revelations, a thorn in the flesh was given to me, a messenger of Satan to buffet me, lest I be exalted above measure.

Rel 2 Korin 12: 7 Sihmanhsehlaw ka hmuhmi thil khuaruahhar a tam ruangah porhlaw ruamkai in ka um sualnak hnga lo ka pum ah hin hling pakhat a ka chiah i cu hling Satan lamkaltu cu porhlaw in ka um sualnak hnga lo a ka dawntu dingah a hman.

Day #3

2 Corinthians 12:8 Concerning this thing I pleaded with the Lord three times that it might depart from me.

Rel 2 Korin 12: 8 Hi kong ah hin voi thum thliahmah Bawipa sinah thla ka cam i, ka lakpiak ko tiah ka nawl.

Day #4

Read 2 Corinthians 12:9 And He said to me, “My grace is sufficient for you, for My strength is made perfect in weakness.” Therefore, most gladly I will rather boast in my infirmities, that the power of Christ may rest upon me.

Rel 2 Korin 12: 9 A ka lehnak cu, “Ka vel hi na caah a za ko, zeicahtiah ka thawnnak cu derthawmnak ah hin a lang,” ti a si. Cucaah cun Khrih thawnnak nih a ka huhphenh ti kha ka hngalh nakhnga, ka derthawmnak ah hin lunglawm tein kaa porhlaw cang.

Day #5

2 Corinthians 12:10 Therefore I take pleasure in infirmities, in reproaches, in needs, in persecutions, in distresses, for Christ’s sake. For when I am weak, then I am strong.

Rel 2 Korin 12:10 Ka derthawmnak ah siseh, nihsawhnak le harnak le hremnak le temhinnak ka hmuhmi ah siseh, Khrih ruangah kaa lawm ko; zeicahtiah ka derthawm tikah hin ka thawn a rak si.

Day #6

Read Hebrews 4: 14 Seeing then that we have a great High Priest who has passed through the heavens, Jesus the Son of God, let us hold fast our confession. 15 For we do not have a High Priest who cannot sympathize with our weaknesses, but was in all points tempted as we are, yet without sin.

Rel Hebru 4: 14-15 Cucaah kan zumhnak hi fek tein i tlaih ko u sih. Pathian umnak hrimhrim ah a hung lutmi Tlangbawi Ngan kan ngei i amah cu Pathian Fapa Jesuh kha a si. 15Kan Tlangbawi Ngan hi kan santlaih lonak ah kan cung i zaangfahnak a ngei kho lomi tlangbawi a si lo. Kan Tlangbawi Ngan hi kanmah bantuk tein tukforhnak a ing vemi a si, sihmanhsehlaw sualnak zehmanh a tuah lomi a si.

Day #7

Read Hebrews 4: 16 Let us therefore come boldly to the throne of grace, that we may obtain mercy and find grace to help in time of need.

Rel Hebru 4: 16 Cuaah cun ralthat in hmaiah fong u sih law, vel a umnak Pathian bawitħudan cu fuh u sih. Khika ah kan herh lio caan te ah Pathian zaangfahnak le vel cu kan hmuh lai.

Step 5: Embrace and extend gift of grace

I will pray for His grace on my church family daily

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Week #3: 05/08/2016 – 05/14-2016

Step 1: Grace is a gift (Velngeihnak hi Pathian sin ra mi laksawng asi)

Read Matthew 22: 1-10

And Jesus answered and spoke to them again by parables and said: 2 “The kingdom of heaven is like a certain king who arranged a marriage for his son, 3 and sent out his servants to call those who were invited to the wedding; and they were not willing to come. 4 Again, he sent out other servants, saying, ‘Tell those who are invited, “See, I have prepared my dinner; my oxen and fatted cattle are killed, and all things are ready. Come to the wedding.”’ 5 But they made light of it and went their ways, one to his own farm, another to his business. 6 And the rest seized his servants, treated them spitefully, and killed them. 7 But when the king heard about it, he was furious. And he sent out his armies, destroyed those murderers, and burned up their city. 8 Then he said to his servants, ‘The wedding is ready, but those who were invited were not worthy. 9 Therefore go into the highways, and as many as you find, invite to the wedding.’ 10 So those servants went out into the highways and gathered together all whom they found, both bad and good. And the wedding hall was filled with guests.

Rel Matthai 22: 1-10.

Jesuh nih mizapi cu bianabia in a chimh than hna. 2“Vancung Pennak cu, a fapa caah nupi thit rawl danghnak a tuahtu siangpahrang he aa lo. 3A sawmmi kha, ra cang u, tiah va chimh awkah a sinum kha a thlah hna tikah, an ra duh lo. 4Cun a sinum a dang kha a thlah than hna i, ‘Rawl danghnak cu timh a si dih cang. Ka cawtum hna le ka sañil thauthau hna cu ka thah cang hna. Zeizong vialte timh a si dih ko. Cuaah khulrang in rawl danghnak ah cun ra cang u,’ nan va ti hna lai, tiah a ti hna. 5Sihmanhsehlaw a sawmmi hna nih khan zehmanh ah an rak rel lo i a cheu

cu an lo ah an kal, a cheu cu an chawdawr ah an kal, 6a cheu nih cun a sinum hna kha an rak tlaih hna i an rak velh hna i an rak thah hna. 7Siangpahrang cu a thin a hung i a ralkap kha a thlah hna i cu lainawngmi hna cu a thah hna i an khua kha a duah hna. 8Cun a sinum kha a auh hna i, 'Nupi thit rawl danghnak ka tuahmi cu timh dih a si cang; asinain ka sawmmi hna cu upatnak hmuh awkah an i tlak lo. 9Cucaah zatlang lam ah khan va kal u law nan hmuhmi paoh vun sawm hna u,' tiah a ti. 10Cucaah a sinum hna cu zatlang lampi ah khan an va kal i an hmuhmi hna paoh kha, a chia a tha thlu loin, an va pumh hna i rawl danghnak khaan cu mi an khat dih.

As you read the parable, reflect (think upon) the theme of grace and write in your own words how grace was shown in this story. How was grace shown? Who received grace?

Pathian Vel ruatbu tein hi bianabia tuanbia hi rel law, nangmah biafang tein hi tuanbia ah Vel a langh/aa phuan daan tial tuah. Zei tin dah vel neih nak ai langh? Ho nih dah velngeihnak a cohlang?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 2: Recognize the need for grace (Velngeihnak kan herhtuk mi hi hngal law).

Can you remember a time when God showed you grace? Pathian nih na cungah velngeihnak/zaangfahnak a langh lio caan nai thei maw?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 3: Accept gift of grace (Parhian sin a ra mi velngeihnak laksawng hi cohlang ko)

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 4: Confess, commit, and contemplate (or meditate on grace) daily. (Pathian velngeihnak kha biatak ten ruat).

Day #1

Read Hebrews 12: 3-4 For consider Him who endured such hostility from sinners against Himself, lest you become weary and discouraged in your souls. You have not yet resisted to bloodshed, striving against sin.

Rel Hebru 12: 3-4 A inmi thil kha ruat hna hmanh u, misual mi nih kha tlukin an huatnak a in peng ko kha ruat hmanh u. Cucaah cun lungdong in maw ngol sual lai u ci. Zeicahtiah sualnak nan dohnak ah hin thihnak tiang ngaingai cu nan ing rih lo.

Day #2

Read Hebrews 12: 5 And you have forgotten the exhortation which speaks to you as to sons: “My son, do not despise the chastening of the Lord, Nor be discouraged when you are rebuked by Him;

Rel Hebru 12: 5 Pathian nih a fale bantuakin an chawhnnak hna, lung thawnnak bia kha nan philh cang dahra? “Ka fapa, Bawipa nih an chimhhrin tikah zeirello in um hlah, an sik tikah na lung dong hlah.

Day #3

Read Hebrews 12: 6-7 For whom the Lord loves He chastens, and scourges every son whom He receives.” If you endure chastening, God deals with you as with sons; for what son is there whom a father does not chasten?

Rel Hebru 12: *6-7 Zeicahtiah Bawipa nih a dawtmi hna cu dan a tat tawn hna i fa i a cohlanmi hna cu a chimhhrin tawn hna,” tiah pei a um kha. Harnak nan inmi cu nan pa nih an pekmi hna

harnak a si ti bantuakin ing ko u, zeicahtiah nan innak nih khan, Pathian nih a fale bantuakin an ti hna, ti kha a langhter. Fa a simi paoh cu a pa nih a velh bal lomi aho tal an um maw?

Day #4

Read Hebrews 12: 8-9 But if you are without chastening, of which all have become partakers, then you are illegitimate and not sons. Furthermore, we have had human fathers who corrected us, and we paid them respect. Shall we not much more readily be in subjection to the Father of spirits and live?

Rel Hebru 12: 8-9 A fale dang vialte kha dan a tat hna i nannih cu dan an tat tung hna lo ahcun, nannih cu fa taktak si loin lakfa nan si ti sullam tu a si hnga. Minung kan pale kong hi ruat hmanh u, an kan chimhhrin i kan upat hna, cucaah cun nunnak kan hmuh nakhnga, thlarau lei kan Pa chinchin cu zeitluk in dah a bia kan ngaih chinchin awk a si.

Day #5

Read Hebrews 12: 10-11 For they indeed for a few days chastened us as seemed best to them, but He for our profit, that we may be partakers of His holiness. 11 Now no chastening seems to be joyful for the present, but painful; nevertheless, afterward it yields the peaceable fruit of righteousness to those who have been trained by it.

Rel Hebru 12: 10-11 Minung kan pale nih cun anmah nih ahmaan ti i an hmuhning in an kan chimhhrin i caan tawite ca lawng a si tawn; sihmanhsehlaw Pathian nih a kan chimhhrin cu kanmah ca tha dingah le a thiannak kha kan i hrawm khawh ve nakhnga caah a si. Dantatnak kan in tikah kan in lioah cun kan lung a kan lawmhtertu si loin kan ngaih a kan chiattertu a si. Sihmanhsehlaw cu bantuk dantatnak innak nih a chimhhrinmi hna cu daihna laksawng dinnak nunnak kha an hmu.

Day #6

Read Hebrews 12: 12-13 Therefore strengthen the hands which hang down, and the feeble knees, and make straight paths for your feet, so that what is lame may not be dislocated, but rather be healed.

Rel Hebru 12: 12-13 Cuaah a thlepmi nan ban kha hler hna u law a dermi nan khuk kha fehter hna u, * cun a ping a pang ah nan ke hlang sual lo tein um u. Cu ti nan tuah ahcun a beimi nan ke kha a rawk lan lai lo i hmasa i thawnnak a rak ngeihmi kha a ngei than kho lai. *

Day #7

Read Hebrews 12: 14-15 Pursue peace with all people, and holiness, without which no one will see the Lord: 15 looking carefully lest anyone fall short of the grace of God; lest any root of bitterness springing up cause trouble, and by this many become defiled;

Rel Hebru 12: 14-15 Midang he rem i zuam u law nunnak thiang in nun i zuam u, zeicahtiah nunnak thiang ngeih loin ahohmanh nih Pathian cu an hmu kho lai lo. 15Pathian vel kha ahohmanh nih nan mertak sual nakhnga lo i ralring u. A khami thingkung, a hung thang i mi tampi harnak a petu bantuk kha ahohmanh si sual hlah u.

Step 5: Embrace and extend the gift of grace

I will encourage.....

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Week #4: 05/15/2016 – 05/21/2016

Step 1: Grace is a gift (Velngeihnak hi Pathian sin ra mi laksawng asi)

Read Matthew 20: 1-16

“For the kingdom of heaven is like a landowner who went out early in the morning to hire laborers for his vineyard. Now when he had agreed with the laborers for a denarius a day, he sent them into his vineyard. And he went out about the third hour and saw others standing idle in the marketplace, and said to them, ‘You also go into the vineyard, and whatever is right I will give you.’ So they went. Again he went out about the sixth and the ninth hour, and did likewise. And about the eleventh hour he went out and found others standing idle, and said to them, ‘Why have you been standing here idle all day?’ They said to him, ‘Because no one hired us.’ He said to them, ‘You also go into the vineyard, and whatever is right you will receive.’

“So when evening had come, the owner of the vineyard said to his steward, ‘Call the laborers and give them their wages, beginning with the last to the first.’ And when those came who were hired about the eleventh hour, they each received a denarius. But when the first came, they supposed that they would receive more; and they likewise received each a denarius. And when they had received it, they complained against the landowner, saying, ‘These last men have worked only one hour, and you made them equal to us who have borne the burden and the heat of the day.’ But he answered one of them and said, ‘Friend, I am doing you no wrong. Did you not agree with me for a denarius? Take what is yours and go your way. I wish to give to this last man the same as to you. Is it not lawful for me to do what I wish with my own things? Or is your eye evil because I am good?’ So the last will be first, and the first last. For many are called, but few chosen.”

Rel Matthai 20: 1-16.

“Vancung Pennak cu mitsur dum a ngei i zingkate in a dum chung i riantuantu ding kawl awkah aa thawhmipa he aa lo. 2Ni khat ah hawi nih an hmuh cio tawnmi ngun tangka phar khat kan

phalh hna lai, tiah a ti hna i mitsur dum chungah cun riantuan awkah khan a thlah hna. 3Cun cu hnu suimilam pathum, zinglei suimilam pakua tluk ah khin chawdawr hrawngah khan a vaa chawk i zehmanh a tuah lo mi tlawmpal kha a va hmuh hna. 4Annih cu, ‘Nannih zong ka dum ah rian va tuan u law a tawkzawn in kuli man cu kan pek hna lai,’ a ti hna i 5cucaah an kal. Cun cu bantuk thiamthiam cun chun suimilam hleihnih le zanlei suimilam pathum ah khan a tuah than. 6Cun chawdawr ah khan a va kal than i cuka ah cun mi a cheu an rak dir ko rih kha a hmuh hna, cu ah cun zanlei suimilam panga a si dengmang cang. ‘Zeicahdah chun nitlak zei tuah loin nan um sawhsawh ko?’ tiah a hal hna i, 7‘Ahohmanh nih rian an kan fial duh lo caah a si,’ tiah an leh. ‘A si ahcun, nannih zong ka dum ah va kal u law rian va tuan u,’ tiah a ti hna. 8‘Zanlei a hung si tikah dum ngeitu nih cun a dum ukto kha a kawh i, ‘Rian tuantu kha au hna law an tuan man kha pe cio hna, hmanung bik i fialmi kha a hmasa bik ah pe hna law hmasa bik i fial mi kha hmanung bik ah pe hna,’ tiah a ti. * 9Suimilam panga ah tuan aa thawkmi pawl kha ngun tangka phar khat cio a pek hna. 10Cucaah hmasa bik i rak fialmi pawl kha an tuan man lak awk i an rat tikah tam deuh kan hmu lai, tiah an i ruah; sihmanhsehlaw annih zong ngun tangka phar khat cio pek an si ve ko. 11Phaisa cu an i lak i rian tuan a fialtu hna cungah khan an zai. 12An i thawh i, ‘A hmanung bik i na fialmi hna tham cu suimilam pakhat lawng pei an tuan ko cu, kannih cu chun nitlak pei ni lin lakah kan tuan cu, asinain kanmah na kan pek zat thiamthiam na pek ve ko hna,’ an ti. 13Cun annih lak i pakhat cu dum ngeitu nih khan a thawh i, ‘Ka kawh, kan hleng hna lo. Hawi hmuh cio tawnmi ngun tangka phar khat hmu dingin pei nan hna a tlak ve ko kha. 14Cucaah nan tangka cu i lak u law inn ah va tin ko u. A hmanung bik i ka fialmi hna nanmah zat pek ve cu keimah nawl pei a si ko cu. 15Keimah tangka cu keimah nih ka duhduh in hman awk a si ko lo maw? Zeicahdah mi ka zaangfah hna hi nan hnah a chuah?’ tiah a ti. 16Cuticun a hmanung bik kha a hmasa bik an si lai i a hmasa bik kha a hmanung bik an si lai,” tiah Jesuh nih a ti. *

As you read the parable, reflect (think upon) the theme of grace and write in your own words how grace was shown in this story. How was grace shown? Who received grace?

Pathian Vel ruatbu tein hi bianabia tuanbia hi rel law, nangmah biafang tein hi tuanbia ah Vel a langh/aa phuan daan tial tuah. Zei tin dah vel neih nak ai langh? Ho nih dah velngeihnak a cohlang?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 2: Recognize need grace (Velngeihnak kan herhtuk mi hi hngal law).

Can you remember a time when God showed you grace? Pathian nih na cungah velngeihnak/zaangfahnak a langh lio caan nai thei maw?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 3: Accept gift of grace (Parhian sin a ra mi velngeihnak laksawng hi cohlang ko)

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 4: Confess, commit. and contemplate (or meditate on grace) daily. (Pathian velngeihnak kha biatak ten ruat)

Day #1

Read Romans 3: 19 Now we know that whatever the law says, it says to those who are under the law, that every mouth may be stopped, and all the world may become guilty before God.

Rel Rom Cakuat 3: 19 Nawlbiam chung bia cu Nawlbiam tang i a ummi hna caah khan a si ti kha kan hngalh; cu tiin a sinak cu mi nih silhnalh khawhnak zehmanh an ngeih khawh nakhnga lo le wawlei cu a ningpi in Pathian biaceihnak hmai i a dir ding a si kha a langh nakhnga caah a si.

Day #2

Read Romans 3: 20 Therefore by the deeds of the law no flesh will be justified in His sight, for by the law is the knowledge of sin.

Rel Rom Cakuat 3: 20 Nawlbiam zullhnak thawngin ahohmanh Pathian hmai i thiam a co khomi an um lo. Nawlbiam nih a tuahmi cu, an sualnak hngalhter kha a si ko. *Zeitindah Pathian Nih Mi Cu Miding Ah A Rel Hna

Day #3

Read Romans 3: 21 But now the righteousness of God apart from the law is revealed, being witnessed by the Law and the Prophets, 22 even the righteousness of God, through faith in Jesus Christ, to all and on all who believe.

Rel Rom Cakuat 3: 21 Sihmanhsehlaw atu cu nawlbia he i pehtlaihnak thawngin si hleng lo tein Pathian he i pehtlaihnak lam kha kan caah a hung awng i cu lam cu nawlbia le profet hna nih ahmaan tiin tehte an khaanmi lam kha a si. Cu lam,

Day #4

Read Romans 3: 22b-24 For there is no difference; 23 for all have sinned and fall short of the glory of God, 24 being justified freely by His grace through the redemption that is in Christ Jesus,

Rel Rom Cakuat 3: 22-24 Pathian he i remnak lam cu Jesuh Khrih zumhnak thawngin a si i Jesuh Khrih a zummi ca paoh ah a si dih. Ahohmanh i thleidan ding a si lo, *23 zeicahtiah mi vialte cu kan sual dih cio ko i Pathian sunparnak kha kan bau dih cio ko. 24 Sihmanhsehlaw kannih a kan tlantu Jesuh Khrih thawngin Pathian nih a vel cu a lak tein a kan pek i amah Pathian he cun a kan remter.

Day #5

Read Romans 3:25 whom God set forth as a propitiation by His blood, through faith, to demonstrate His righteousness, because in His forbearance God had passed over the sins that were previously committed,

Rel Rom Cakuat 3: 25 Jesuh Khrih cu Pathian nih a thi in ngaihthiamnak sertu ah a tinhmi a si i cu ngaihthiamnak cu Jesuh Khrih zumhnak thawngin hmuh ding a si. Pathian nih cu bantuakin minung he remnak a tuah cu a dinnak kha langhter a duh caah a si. Cu a langhterung cu hitihin a si: hlan lioah cun a lung a sau caah mi nih an tuahmi sualnak kha i hmuhter duh loin a um;

Day #6

Read Romans 3: 26 to demonstrate at the present time His righteousness, that He might be just and the justifier of the one who has faith in Jesus.

Rel Rom 3: 26 cun atu caan ah cun Pathian ding a si kha aa langhter i Jesuh Khrih a zummi paoh kha a luatter hna.

Day #7

Read Romans 3: 27-29 Where is boasting then? It is excluded. By what law? Of works? No, but by the law of faith. 28 Therefore we conclude that a man is justified by faith apart from the deeds of the law. 29 Or is He the God of the Jews only? Is He not also the God of the Gentiles? Yes, of the Gentiles also,

Rel Rom 3: 27A si kun ahcun, kan i uan khawh awk zeital a um maw? Um hlah. Zei ruangah dah? Nawlbial kan zuluh ruangah maw? Si hlah. Sihmanhsehlaw kan zumh ruangah a si. 8Zeicahtiah minung cu Pathian he remter a sinak cu zumhna thawng lawnglawng in a si, Nawlbial nih, tuah u, a timi tuahna thawngin a si lo, tiah pei kan ti cang kha. 29Asiloah, Pathian cu Judah mi hna Pathian lawng maw a si? Jentail mi hna Pathian tah a si ve lo maw? Si hen ta!

Step 5: Embrace and extend the gift of grace

I will confess my unforgiveness towards, and ask God for forgiveness and grace. (If appropriate, I will go and seek to be restored in our relationship).

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Week #4: 05/15/2016 – 05/21/2016

Step 1: Grace is a gift (Velngeihnak hi Pathian sin ra mi laksawng asi)

Read Matthew 18: 21-35

Then Peter came to Him and said, “Lord, how often shall my brother sin against me, and I forgive him? Up to seven times?”

22 Jesus said to him, “I do not say to you, up to seven times, but up to seventy times seven. 23 Therefore the kingdom of heaven is like a certain king who wanted to settle accounts with his servants. 24 And when he had begun to settle accounts, one was brought to him who owed him ten thousand talents. 25 But as he was not able to pay, his master commanded that he be sold, with his wife and children and all that he had, and that payment be made. 26 The servant therefore fell down before him, saying, ‘Master, have patience with me, and I will pay you all.’ 27 Then the master of that servant was moved with compassion, released him, and forgave him the debt.

28 “But that servant went out and found one of his fellow servants who owed him a hundred denarii; and he laid hands on him and took him by the throat, saying, ‘Pay me what you owe!’ 29 So his fellow servant fell down at his feet and begged him, saying, ‘Have patience with me, and I will pay you all.’ 30 And he would not, but went and threw him into prison till he should pay the debt. 31 So when his fellow servants saw what had been done, they were very grieved, and came and told their master all that had been done. 32 Then his master, after he had called him, said to him, ‘You wicked servant! I forgave you all that debt because you begged me. 33 Should you not also have had compassion on your fellow servant, just as I had pity on you?’ 34 And his master was angry, and delivered him to the torturers until he should pay all that was due to him.

35 “So My heavenly Father also will do to you if each of you, from his heart, does not forgive his brother his trespasses.”

Rel Matthai 18: 21-35: Ngaihthiamnak A Ngei Lomi

21Cun Peter cu Jesuh sinah khan a ra i, “Bawipa, ka unau pakhatkhat nih ka cungah sualnak tuah seh law voi zeizat dah ka ngaihthiam lai? Voi sarh tiang maw?” tiah a hal. *

22Jesuh nih cun, “Sihlah, voi sarh si loin voi sawm sarh voi sarh, * 23zeicahtiah Vancung Pennak cu hi bantu hi a si: Siangpahrang pakhat nih a sal hna rian tuanning kha zoh aa tim. 24Aa thawk kate ah khin a salpa pakhat cu a sinah an ratpi i cu sal nih cun tangka talen * thong hra a bat. 25Cu sal nih cun a leiba chamnak a ngeih lo caah a bawipa nih cun cu pa cu a nupi he a fale he a ngeihmi thil vialte he leiba chamnak dingah cun sal ah zuar si hna seh, tiah a ti. 26Cu salpa cu a bawipa hmaiah cun a khuk aa bil i, ‘Zaangfahnak tein ka ngang rih tuah. Cham dih kan zuam ko lai,’ tiah a nawl. 27A bawipa nih a zaangfah i cucaah a leiba cu a ngaihthiam i a kalter.

28“Mipa cu a va chuak i a sal hawi pakhat, tangka tlawmte a rak batu kha a va fuh. Amah cu a tlaih i a or in a dih i, ‘Na ka batmi kha ka cham dih,’ tiah a ti. 29A sal hawi nih cun a khuk aa bil i, ‘Ka ngang rih sawh. Cham dih kan zuam lai,’ tiah a nawl. 30Sihmanhsehlaw a duh lo. Thong ah khan a leiba a cham dih hlantiang a thlak. 31Cu thil cu a sal hawi midang nih khan an hmuh tikah an ing a puang ngaingai i an bawipa sinah khan an va kal i an va chimh. 32Cucaah an bawipa nih kha sal kha a kawh i, ‘Sal thalo, na ka nawl caah na ka batmi vialte kan ngaihthiam dih. 33Na cung i zaangfahnak ka ngeih bantu kin pei na sal hawi cungah na ngeih ve awk a si cu,’ tiah a ti. 34An bawipa cu a thin a hung ngaingai i a salpa cu a leiba a lim khawh dih hlantiang thong ah a thlak.

35“Nannah nih nan u nan nau kha nan lungchung taktak in nan ngaihthiam hna lo ahcun cu bantuk cun vancung khua i a ummi ka Pa nih nannah zong cu an tuah ve hna lai,” tiah a ti hna. As you read the parable, reflect (think upon) the theme of grace and write in your own words how grace was shown in this story. How was grace shown? Who received grace?

Pathian Vel ruatbu tein hi bianabia tuania hi rel law, nangmah biafang tein hi tuania ah Vel a langh/aa phuan daan tial tuah. Zei tin dah vel neih nak ai langh? Ho nih dah velngeihnak a cohlang?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 2: Recognize the need for grace (Velngeihnak kan herhtuk mi hi hngal law).

Can you remember a time when God showed you grace? Pathian nih na cungah velngeihnak/zaangfahnak a langh lio caan nai thei maw?

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 3: Accept gift of grace (Parhian sin a ra mi velngeihnak laksawng hi cohlang ko)

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

Step 4: Confess, commit, and contemplate (or meditate on grace) daily. (Pathian velngeihnak kha biatak ten ruat)

Hebrews 4:16 Let us then with confidence draw near to the throne of grace, that we may receive mercy and find grace to help in time of need.

Day #1

Hebrews 4: 11 Let us therefore be diligent to enter that rest, lest anyone fall according to the same example of disobedience.

Rel Hebru 4: 11Cucaah Pathian dinhnak chung i kan luh khawh nakhnga fak piin i zuam u sih. Annih nih Pathian nawl kha an rak ngaih lo i an luh khawh lo bantuk khan kannih cu pakhat hmanh um sual hlah u sih.

Day #2

Read Hebrew 4: 12 For the word of God is living and powerful, and sharper than any two-edged sword, piercing even to the division of soul and spirit, and of joints and marrow, and is a discerner of the thoughts and intents of the heart.

Rel Hebru 4: 12 Pathian bia cu a nung i a thawng. Kap hnih har vainam nakin a haar deuh. Hlang lak in a cheu khawh, nunnak le thlarau an i tonnak tiang, hliahcang le thlik an i tonnak tiang a cheu khawh. Minung lungthin duhnak le ruahnak vialte kha a hngalh dih.

Day #3

Read Hebrews 4: 13 And there is no creature hidden from His sight, but all things are naked and open to the eyes of Him to whom we must give account.

Rel Hebru 4: 13Pathian sinin thuh khawhmi thil zehmanh a um lo. Sermi thil vialte hi an dihlak in a hmaika ah an lang dih hirhiar i amah sinah cun kan kong cu kan i chim cio lai.

Day #4

Read Hebrews 4: 14 Seeing then that we have a great High Priest who has passed through the heavens, Jesus the Son of God, let us hold fast our confession.

Rel Hebru 4: 14 Cucaah kan zumhnaak hi fek tein i tlaih ko u sih. Pathian umnak hrimhrim ah a hung lutmi Tlangbawi Ngan kan ngei i amah cu Pathian Fapa Jesuh kha a si.

Day #5

Read Hebrews 4: 15 For we do not have a High Priest who cannot sympathize with our weaknesses, but was in all points tempted as we are, yet without sin.

Rel Hebru 4: 15 Kan Tlangbawi Ngan hi kan santlaih lonak ah kan cung i zaangfahnak a ngei kho lomi tlangbawi a si lo. Kan Tlangbawi Ngan hi kanmah bantuk tein tukforhnaak a ing vemi a si, sihmanhsehlaw sualnaak zehmanh a tuah lomi a si.

Day #6

Read Hebrews 4: 16 Let us therefore come boldly to the throne of grace, that we may obtain mercy and find grace to help in time of need.

Rel Hebru 4: 16 Cucaah cun ralthat in hmaiah fong u sih law, vel a umnak Pathian bawithudan cu fuh u sih. Khika ah kan herh lio caan te ah Pathian zaangfahnak le vel cu kan hmuh lai.

Day #7

Romans 5:1-2 Therefore, since we have been justified by faith, we have peace with God through our Lord Jesus Christ. Through him we have also obtained access by faith into this grace in which we stand, and we rejoice in hope of the glory of God.

Rel Rom Cakuat 5: 1-2 Atu cu zumhnak thawngin thiamcoter kan si caah kan Bawipa Jesuh Khrih thawngin Pathian he kan i rem. 2Jesuh Khrih nih cun kan zumhnak thawngin Pathian velngeihnak chungah cun a kan luhipi i cu chungah cun atu hi kan um. Cucaah Pathian sunparnak kan i hrawm ve lai ti kan i ruahchan i kan tha a nuam.

Step 5: Embrace and extend the gift of grace (Cohlang law, midang cung zongah Pathian velngeihnak laksawng kha pe ve)

I will share my testimony with

..... sinah tete ka khaan lai

Day #1

Day #2

Day #3

Day #4

Day #5

Day #6

Day #7

APPENDIX C**The Daily Spiritual Experience Scale****(DSES; Underwood & Teresi, 2002)**

The DSES instrument can be accessed at <http://www.dsescala.org/> (Removed to comply with copyright).

APPENDIX D**Transgression-Related Interpersonal Motivations Measure****(TRIM-12; McCullough, Rachal, Sandage, Worthington, Brown, & Hight, 1998)**

TRIM-12 can be accessed at <http://local.psy.miami.edu/faculty/mmccullough/forgiveness/TRIM-12.pdf>. (Removed to comply with copyright).

APPENDIX E**The Gratitude Questionnaire-Six Item Form****(GQ-6; McCullough, Emmons, & Tsang, 2002)**

GQ-6 can be accessed at

https://ggsc.berkeley.edu/images/uploads/The_Gratitude_Questionnaire.pdf (Removed to comply with copyright).

APPENDIX F

Satisfaction with Life Scale

(SWLS; Diener, Emmons, Larsen & Griffin, 1985)

SWLS can be accessed at <http://labs.psychology.illinois.edu/~ediener/SWLS.html> (Removed to comply with copyright).

APPENDIX G**REFUGEE HEALTH SCREENER - 15 (RHS-15)**

RHS-15 can be accessed at http://refugeehealthta.org/wp-content/uploads/2012/09/RHS15_Packet_PathwaysToWellness-1.pdf (Removed to comply with copyright).