Letting the Images Speak for Themselves:

An Art Therapy Grant Proposal Project for

Survivors of Torture

A Capstone Thesis

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Dedication

To the clients of the Philadelphia Partnership for Resilience:

I am privileged to have bore witness to your stories,

To have been offered but a mere glimpse into your experiences—

Despite the senseless violence,

The crippling weight of injustice that threatens to

Break the human spirit,

You embody resilience

When you choose to keep living.

Shukraan, merci, murakoze, terima kasih, thank you.

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Table of Contents

ABSTRACT

Letting the Images Speak for Themselves:
An Art Therapy Grant Proposal Project for Survivors of Torture
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Even upon resettlement, survivors of torture from refugee and asylum-seeker backgrounds often experience a range of physical and psychological consequences rooted in both pre- and post-migration factors that can worsen their mental health outcomes. As a result of torture, individuals are alienated from their personhood, sense of dignity, and intrinsic worth as a human being. The purpose of this capstone grant proposal project was to secure funding for the development of an art therapy program at the Philadelphia Partnership for Resilience, a collaborative which provides legal and social services to immigrant, refugee and asylum-seeker survivors of torture in the Greater Philadelphia region. The literature review highlighted the needs and concerns of survivors of torture, outlining the current interventions utilized in the resettlement context and providing support for the implementation of art therapy with this particular population. A letter of inquiry and a grant proposal were written to meet the criteria outlined by the van Ameringen Foundation, to secure partial funding for an art therapy program for survivors of torture. A synthesis of the literature, reflections on clinical work and on the grant writing process were offered, highlighting the importance of developing culturally sensitive and appropriate interventions for survivors of torture that circumvent the need for verbal expression.

CHAPTER 1: INTRODUCTION

What is dubbed the "refugee crisis" is currently at historic proportions, due to the current global conflicts of political and religious persecution, civil war, genocide, and financial instability. As of the end of 2016, 67.75 million individuals were forcibly displaced, meaning they have no home to return to; of this population, 17.2 million were refugees, 36.6 million were internally displaced individuals who had been forced from their homes but still resided in their country of origin, and 2.8 million were asylum-seekers (United Nations High Commissioner for Refugees [UNHCR], 2017).

Refugees, asylum-seekers and asylees are members of the population most vulnerable to torture, given they are forced to leave their countries of origin out of concerns for their safety. Upon arrival in the U. S., survivors of torture may be fearful of disclosing their torture experience due to a distrust of authorities and concerns for their safety (Burnett & Peel, 2001).

Resettlement is a long and arduous process, even though survivors of torture may no longer face the same dangers and threats to their safety upon coming to the U. S. In addition to the traumas caused by the torture experience and forced migration, which are often dubbed "pre-migration stressors," these individuals must also navigate the challenges of adjusting to life in a novel environment, known as "post-migration stressors" (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997). Financial insecurity, cultural and linguistic differences, changes in family structures, social isolation, discrimination, and other post-migration factors may exacerbate the stressors already experienced by this population (Boehnlein, Kinzie, Ben, & Fleck, 1985). Taken as a whole, survivors of torture from refugee and asylum-seeker backgrounds are thus at

a greater risk of developing mental health outcomes such as unresolved grief and loss, depression, anxiety, post-traumatic stress disorder (PTSD), impaired memory, somatic complaints, chronic pain, insomnia, suicidal ideation and loss of appetite (Basoglu, Jaranson, Mollica, & Kastrup, 2001; Beiser, 1989; Cervantes, Salgado, & Padilla, 1988; Goosen et al., 2011; Tamblyn, Calderon, Combs, & O'Brien, 2011).

As both the physical and psychological sequelae of torture can be exacerbated by both the trauma related to the torture experience and the difficulties in adjusting to the U.S., interventions that view the individual through a more holistic lens, that addresses the systems that survivors of torture interact with and are a part of, can reduce clinical symptomatology (Boehnlein et al., 2004). Additionally, given the traumatic nature of torture and forced migration, refugees and asylum-seekers may not even have the words to describe or process what happened to them. Given that trauma can be body-based, stored in regions of the brain that bypass verbal expression (van der Kolk, 2006), utilizing a nonverbal intervention such as art therapy can be a more viable option in treating survivors of torture. Thus, art therapy can be a more culturally appropriate means of addressing the traumas experienced by survivors of torture. Utilizing the creative process to tap into emotions that may be difficult to put into words, art therapy circumvents verbal modes of expression (Malchiodi, 1999). When words fail, images and the creative process can become powerful tools of emotional expression. When individuals lack the linguistic skills necessary to express themselves, art can provide an alternative pathway to communicating their stories in an immediate and ineffable manner (Klorer, 2005).

The purpose of this project was to submit a grant proposal to the van Ameringen Foundation on behalf of PPR, a collaborative formed through partnerships with three

nonprofit organizations in the Philadelphia region: Nationalities Service Center (NSC), the Hebrew Immigrant Aid Society Pennsylvania (HIAS PA), and BuildaBridge International. Given PPR's affiliation and onsite location at NSC, an organization that provides a range of comprehensive resettlement services for immigrants and refugees such as language classes, employment, housing assistance and health and wellness activities, it is equipped to meeting the multifaceted needs of refugee and asylum-seeker survivors of torture.

The intended art therapy program would provide survivors of torture the opportunity to address their mental health concerns through a less stigmatizing intervention, which may be more accessible and culturally appropriate for individuals from diverse backgrounds. By not having to rely on verbal language, art therapy can provide survivors of torture a nonthreatening way to express and confront their traumatic experiences through the creative process, and ultimately, to reclaim their sense of agency and their voice. The addition of this in-house mental health service provided for PPR clients will enable them to reclaim their sense of agency by beginning to share their stories on their own terms.

CHAPTER 2: LITERATURE REVIEW

Due to the global conflicts of war, genocide, religious persecution, financial instability and other factors that compel individuals to leave their countries of origin, the United States has been reported to house 42.4 million immigrants, defined as individuals born outside the U. S. (Zong & Batalova, 2016). Of that population close to 300,000 were identified as forcibly displaced individuals (UNHCR, 2014). However, this number is most likely under reported. The number of refugees has dramatically increased over the past five years, due to new humanitarian crises, such as the Syrian Civil War and the rise of the Islamic State of Iraq and the Levant (ISIL), creating conditions that force individuals into states of migration and exile. While the Syrian Civil War is currently considered the largest contributor to global displacement, comprising a third of refugees worldwide, unrest in other parts of the world contribute to the crisis, such as conflicts between the Taliban and Afghani government, ethnic violence in South Sudan, Myanmar's oppression of the Rohingya Muslim minority and political violence in the Democratic Republic of Congo (Beauchamp, 2017).

Though distinctions have been made between the "immigrant" and the "refugee," these distinctions may not be so clearly delineated. Refugees are indeed a type of immigrant, though the reasons why individuals choose or are forced to leave their countries of origin may vary. Due to this, census data often do not parse out the distinctions between refugees and immigrants; there may be individuals who come into the U. S. as "immigrants" who have experienced persecution or political violence without being formally recognized as such. Among these diverse individuals of mixed immigration status, ranging from refugees, asylum-seekers, asylees and undocumented

immigrants, it is likely that a portion of this population has experienced torture in their countries of origin, further complicating their mental health outcomes and adaptation to life in the U. S (Center for Victims of Torture, 2015).

For the purposes of this capstone, I focus on statistics related to the state of Pennsylvania, with a focus on the Greater Philadelphia region in order to apply for a grant in this city. Pennsylvania was among the top ten largest refugee-receiving states in the nation, accepting approximately 3,219 refugees annually for resettlement as of the fiscal year of 2016 (Radford & Connor, 2016). The Greater Philadelphia region received over 800 arrivals who had fled contexts of forced migration (Refugees in PA, 2016). Census data typically collapses immigrants and refugees into an overarching category, rendering it difficult to differentiate between individuals fleeing their countries of origin on the basis of persecution, versus others who come to the U. S. for employment, education or other opportunities. Philadelphia housed the largest and fastest growing immigrant population: making up 12% of the city's population, Philadelphia had over 500,000 immigrants in the region with approximately 175,000 individuals residing in the city (Singer, Vitiello, Katz, & Park, 2008). It is unclear as to the actual number of refugees who make up part of this immigrant population.

Survivors of Torture

Torture is an insidious and dehumanizing practice that serves to physically and psychologically "break" the dignity of a person through an intentional infliction of pain and suffering. At the time of this writing, the use of torture had been reported in 141 nations worldwide (Amnesty International, 2016). As an instrument of political and social control, it can be used to "stifle dissent, intimidate opposition, and strengthen the

forces of tyranny" (Gorman, 2001, p. 444). Bustos (1990) reiterated, "The goal is to destroy the individual's personality. Ultimately, it serves to terrorize the entire population and end any resistance to the regime" (p. 333). The core of what makes someone human is obliterated through this intentional perpetration of violence: subjected to cruel and inhumane treatment, individuals are then robbed of their voice and of their sense of agency.

It is difficult to determine reliable estimates of the worldwide prevalence of torture given the stigma, shame, secrecy and silence associated with the act of torture, notwithstanding the difficulty of disclosing one's torture history due to a mistrust of authorities and to foreign parties. For the purposes of this capstone, I focused specifically on survivors of torture who resettled in Western contexts, such as the U. S., due to the nature of the population served at PPR.

Estimates from the past two decades placed the number of refugee survivors of torture living in the U. S. at 400,000-500,000; however, the Center for Victims of Torture (CVT) predicted that there may be as many as 1.3 million refugees who had experienced torture abroad before resettling in the U. S. (2015). According to Campbell (2007), refugees are often members of the population most vulnerable to torture, likely due to the lack of protection from the government in their countries of origin, as well as the persecution they experience that forces them to flee. Both governmental and non-governmental groups utilize torture on the basis of political, geographic, ideological, or economic clashes; it can be used as either a method of punishment, to obtain information, or to incite a confession from targeted individuals (Suedfeld, 1990).

Definitions of Torture

Torture remains a difficult phenomenon to assess and study due in part to the varying definitions of torture used in the literature. Mpinga and colleagues (2015) reiterated the definitional ambiguity in the term "torture" in the current literature. They cited Green, Rasmussen and Rosenfeld (2010)'s literature review, which examined torture over four decades in health science research. The authors found that two-thirds of the 209 texts analyzed in their investigation did not make reference to which definition of torture was utilized.

In funding programs for survivors of torture, as part of grantee specifications, American agencies usually acknowledge and accept one of the three definitions of torture provided by the following organizations: the World Medical Associations' (WMA) Tokyo Declaration of 1975, the United Nations Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT) of 1984, and the U.S.'s Torture Victims Relief Act of 1998 (TVRA) (Rasmussen, Crager, Keatley, Keller & Rosenfeld, 2011).

The first definition by the WMA (1975) describes torture as a "deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason" (para. 2). This definition casts a wide net, and includes perpetrators who inflict torture without necessarily acting on behalf of a state. Campbell (2007) asserted that this definition is too broad, raising the question of distinction between torture and assault. To illustrate his point, Campbell asked, "…Is it torture when a prison guard yells at a prisoner, or slaps that prisoner on a

single occasion, or even perhaps when that prisoner is put into solitary confinement for a single day?" (p. 630). Based on the definition provided by the WMA, these single events would constitute torture.

A more specific definition of torture, which is widely used in the literature, is in Article 1 of the UNCAT (Office of the United Nations High Commissioner for Human Rights, 1984):

> The term "torture" means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions (p. 1).

Several researchers have critiqued this definition (Mpinga et al., 2015; Harper, 2009; McGregor, 2014). They challenge the concept of the "intentionality" attributed to committing an act of torture, which requires a conscious thought process that may not be activated when a perpetrator implements torture mechanically, such as a procedure to be carried out due to orders from on high. Secondly, the U. N. definition posits that torture occurs on behalf of state agencies, when in reality, rebel forces or other non-governmental agents can also commit acts of torture. Semantically speaking, with regard to the "pain and suffering" inflicted upon unsuspecting citizens, what differentiates

torture from other degrading and inhuman acts? Mpinga and colleagues (2015) added an additional caveat, regarding the exclusion of pain or suffering experienced as a result of "lawful sanctions." They argued that this statement ignores the fact that some nations enact laws that justify and allow the use of torture.

The third definition provided by the U. S.'s TVRA of 1998 defines torture as "an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody/physical control" (Section 3, para. 1). The "color of law" is defined as the "appearance of a legal right," (The Free Dictionary, 2016) and refers to occurrences when federal, state or local officials purport or pretend to act within the confines of their official duties in order to deprive others of their rights, privileges or immunities. In reality, they may instead be abusing the power and privileges granted to their role as public officials in order to commit unlawful acts against those subjected to their misconduct and mistreatment (United States Department of Justice, 2015). In this definition, torture is committed at the hands of those who are meant to protect and uphold the rights of citizens: law enforcement officials, judges, healthcare providers and others who act as public officials (U. S. Department of Justice, 2015). Yet, this definition excludes acts of violence perpetrated by rebel forces and other non-governmental agents. As PPR currently uses this definition to determine eligibility into their program for survivors of torture, TVRA's 1998 torture definition is used for the purposes of this capstone grant proposal.

Methods of Torture

Basoglu, Livanou and Crnobaric (2007) investigated the differences between torture and other cruel, inhuman and degrading treatment individuals experience during detainment. They organized various torture-related stressors into the following categories: sexual torture (e.g., rape, fondling of genitals), physical torture (beating, suffocation/asphyxiation, stretching of the body), psychological manipulations (sham executions, witnessing torture of others, threats against family), humiliating treatment (stripping naked, verbal abuse), exposure to forced stress positions (rope bondage, restriction of movement), exposure to sensory discomfort (exposure to extreme heat or cold, to bright light) and deprivation of basic needs (isolation, blindfolding, sleep, water, and withholding food). Certain torture methods may also be culture or region specific, such as "Palestinian hanging," hanging an individual by the wrists tied at the back, and "falaqa," which consists of beating the soles of the feet (Basoglu et al., 2007; Burnett & Peel, 2001).

Hooberman, Rosenfeld, Lhewa, Rasmussen and Keller (2007) categorized different types of torture, identifying five categories: witnessing torture/trauma, family torture (e.g.. witnessing torture to family, harassment of family), beating and various types of physical assault, rape/sexual assault and deprivation of medical care, food and water. Gender differences emerged with regard to the types of torture experienced: women are typically at greater risk of experiencing sexual assault, while men report significantly more instances of physical beatings (Hooberman et al., 2007; Moisander & Edston, 2003; Sanders, Schuman, & Marbella, 2009).

Barriers to Identifying Survivors of Torture

Besides the definitional ambiguities regarding what constitutes "torture," it can be difficult to identify survivors of torture because they comprise a hidden and often silent segment of the population due to the possible guilt, shame or mistrust they feel in response to their torture history and towards authority figures (Burnett & Peel, 2001). Survivors of torture typically seek medical attention first due to somatic and bodily symptoms, and can go unrecognized as survivors of torture by medical professionals unaware of their histories (Amris & Williams, 2015; Campbell, 2007; Eisenman, Keller, & Kim, 2000; Gorman, 2001). Survivors of torture may also fear the legal implications of disclosing their torture history, whether with regard to their immigration status or concern that such disclosure may endanger the lives of family left behind in their country of origin.

In addition to the shame and guilt associated with torture, survivors of torture can also be unfamiliar and distrustful of psychosocial services provided in typically Western resettlement countries such as the U. S., and may not feel comfortable at having to share such a personal and painful experience with healthcare professionals in order to receive services (Gorman, 2001). This is particularly relevant in instances of sexual violence and rape. Depending on the individual's culture of origin, it can be viewed as unacceptable and taboo to discuss such matters with professionals; in such cases, whenever possible, the client should have the option of choosing the sex of the healthcare worker and interpreter who will provide services (Burnett & Peel, 2001). The shame associated with sexual violence and rape makes this particular form of torture difficult to disclose; in

some cultures, women may be shunned by their broader community and by family members because of their perceived "defilement" (Burnett & Peel, 2001).

Differences in Immigration Status in the Resettlement Context

Though the U. S. census data refer to immigrants as those born outside the U. S. (Zong & Batalova, 2016), the circumstances that propel individuals to migrate are manifold. As noted earlier, placing immigrants and refugees under a single umbrella term is misleading. Kunz (1973) characterizes the refugee as someone who is "pushed" out of his or her country of origin while the immigrant is "pulled" to a new land in the hopes of economic ascension. Differences in immigration status can play a significant role in mental health outcomes and the psychological distress experienced by survivors of torture. For instance, asylum-seekers report higher levels of distress due to the uncertainties regarding their legal status and the possibility of being sent back to their country of origin where the persecution occurred; obtaining asylum is typically associated with decreases in psychological distress (Piwowarzyck, 2007). Additionally, Chu, Keller and Rasmussen (2013) found that non-legal immigration status and limited English proficiency were strongly associated with greater severity of PTSD symptoms. Uncertainty relating to immigration status can exacerbate the negative mental health outcomes experienced by refugee survivors of torture, correlating with more severe PTSD, depression and anxiety (Momartin et al., 2006). It is thus important to differentiate between survivors of torture of varying immigration statuses, as this additional post-migration stressor typically worsens psychological outcomes in this population (Chu et al., 2013; Momartin et al., 2006).

Refugees. Under U. S. Law, a refugee is defined as an individual who is "located outside of the U. S., is of special humanitarian concern to the U. S., demonstrates that they were persecuted or fear persecution due to race, religion, nationality, political opinion, or membership in a particular social group, is not firmly resettled in another country" and "is admissible to the United States" (U. S. Citizenship & Immigration Services [USCIS], 2016, para. 1). In order to be resettled under refugee status, individuals must receive a referral to the U. S. Refugee Admissions Program (USRAP) while residing outside the U. S. (USCIS, 2016). Once in the U. S., refugees have the right to be enrolled in public assistance programs including receiving food stamps and financial assistance, and having access to Medicaid programs. They are eligible for employment immediately upon arrival to the U. S. and are encouraged to reach economic self-sufficiency as soon as possible during the resettlement process. After a year of refugee status, refugees can apply for a permanent residency card (i.e. green card), which can then lead to U. S. citizenship after living in the U. S. for five years with a green card.

Asylum-seekers and asylees. While asylum-seekers also meet the legal definition of a refugee as individuals who have suffered persecution or fear persecution in their countries of origin, these individuals apply for asylum status upon arrival in the U.S. Individuals must apply for asylum within a year of their arrival to the U. S., and are eligible to work in the U. S. if 150 days have passed since the complete asylum application has been filed and no decision has been made on the asylum-seekers' application (USCIS, 2016). "Asylee" is the term used for asylum-seekers whose asylum status has been granted by either a USCIS asylum officer or by an immigration judge with the U. S. Department of Justice's Executive Office of Immigration Review (2009).

Acculturative stress and adaptation to the country of resettlement. In the context of resettlement, refugees and asylum-seekers often find themselves in a position of disorientation and flux; how do such individuals make sense of their new roles in a foreign country, where both cultural and linguistic barriers pose challenges in adapting to the mainstream culture? Adjusting to a novel country can be compounded by a number of psychosocial stressors for this population, often referred to as "acculturative stress" (Joiner & Walker, 2002). For the refugee or asylum-seeker who flees his or her country of origin on the basis of persecution, war or violence, which can be compounded by incidents of torture, their stressors often begin prior to their departure, further complicating their acculturation experience and manifesting as unresolved grief, PTSD, intergenerational conflict, and other psychological and behavioral difficulties (Beiser, 1989; Cervantes et al., 1988). The complex interaction between pre-migration stressors (often related to the torture experience) and post-migration stressors in the context of resettlement can impact the acculturation process for refugee and asylum-seeker survivors of torture.

Upon arrival to the country of resettlement, challenges remain even though individuals have fled to safety. Even the family unit can become an additional stressor within the context of resettlement. For instance, children of refugees, asylum-seekers and immigrants who have higher English language proficiency often act as "bridges" between their families and the host country, serving as translators for family members or having to explain cultural values and norms (Lincoln, Lazarevic, White, & Ellis, 2016). A dramatic shift in family dynamics may occur, creating an inverted hierarchy, where English-speaking adolescents become the "head" of the household due to their ability to access

the host country linguistically and culturally (Codrington, Iqbal, & Segal, 2011). Additional post-migration stressors include social isolation, shame, avoidance, unemployment, insecure immigration status and limited English proficiency, which can negatively impact survivors of torture's mental health outcomes (Boehnlein et al., 1985).

Physical Sequelae

As a result of torture, survivors experience various physical consequences, the repercussions felt immediately or over a prolonged period of time. Following the torture experience, individuals often are unable to receive adequate medical attention in their country of origin where the persecution took place (Burnett & Peel, 2001), thereby complicating their physiological symptoms. Individuals may not have accessed medical services because either they did not know what was available or out of fear of drawing attention from the authorities. Depending on the type of torture experienced, individuals can have fractures and soft tissue injuries, head injuries which can in turn trigger epilepsy, damage done to the ears and eyes, HIV infection and sexually-transmitted diseases due to sexual violence and rape, and other physical expressions of emotional distress such as insomnia, lethargy, headaches, abdominal pain, nightmares and other somatic symptoms that may not have a physical basis (Burnett & Peel, 2001). Chronic and persistent pain, often in the musculoskeletal system, can in turn exacerbate the poor sleep quality and fatigue survivors of torture experience (Amris & Williams, 2015). The prevalence of chronic pain in survivors of torture may even be as high as 78-83%, which may be experienced throughout the body or in specific areas associated with the torture method, such as the feet (in the case of falaqa) or the shoulders and upper body (due to

hanging by the arms) (Olsen, Montgomery, Bjholm, & Foldspang, 2006; Olsen, Montgomery, Carlsson, & Foldspang, 2006; Williams, Pena, & Rice, 2010).

Traumatic brain injury (TBI), which is often a result of physical violence such as being kicked, punched, or struck with a weapon around the head region, is another area of particular alarm among survivors of torture (Begovac et al., 1993; Bradley & Tawfiq, 2006; Keatley, Ashman, Im, & Rasmussen, 2013; Mollica et al., 2014; Mollica et al., 2009). TBI refers to neurological damage incurred after any type of head trauma (Heegaard & Biros, 2007), and can lead to cognitive or affective deficits that impair an individual's psychosocial capabilities or other major areas of functioning (Yi & Dams-O'Connor, 2013). The presence of TBI among torture survivors further complicates their mental health outcomes, making it difficult to differentiate between the cognitive, somatic and affective impairments associated with TBI and psychopathological symptoms derived from PTSD (Keatley, d'Alfonso, Abeare, Keller, & Bertelsen, 2015).

Psychological Sequelae

Torture serves not only to physically "break" the spirit of individuals, but also to also psychologically alienate individuals from their sense of self, disrupting the core of their personality and of their inherent humanity and dignity, transforming them into "victims" who are rendered helpless, powerless and at the mercy of the torturer (Hárdi & Kroó, 2011). What may differentiate torture from other forms of trauma is that it is an ideologically driven tool of social and political control (Silove, 1996), with the intention to damage a person's integrity by violating their body and mind (Viñar, 2005). Yet, individual responses to torture can vary, depending on various factors such as the social context in which torture occurred, the spiritual meaning derived from the experience,

one's political beliefs, genetic predispositions, resilience and individual psychology (Quiroga & Jaranson, 2005, as cited in Isakson, 2008).

The individual psychological consequences of torture have been well-documented, and commonly reported symptoms are confusion, guilt, shame, disorientation, impaired memory, insomnia, sexual dysfunction, depression, anxiety, somatic complaints without physiological bases, and the diagnosis PTSD (Basoglu et al., 2001; Burnett & Peel, 2001; Campbell, 2007; Mollica et al., 1998; Shrestha et al., 1998). In response to both the pre-migration (i.e. torture experience, persecution) and post-migration stressors (in the context of resettlement, such as unstable immigration status, limited English proficiency), researchers placed the rate of suicidal ideation and suicide attempts as higher in refugee survivors of torture compared to the general population (Goosen et al., 2011; Staehr & Munk-Andersen, 2006).

Somatization, depression and anxiety. Survivors of torture frequently report instances of somatic complaints without physiological origins (Burnett & Peel, 2011). Somatization refers to the conversion of psychological experiences or states into physical symptoms without a discernible physiological basis (Moio, 2008). Tamblyn and colleagues (2011) examined data derived from medical records of 61 survivors of torture referred to a clinic in Denver, Colorado to investigate the rate of psychopathology and health conditions in this sample. The sample was predominantly male (71%), from Africa (90%), and spoke a total of thirteen languages. All patients included in the sample had experienced physical torture (71%), witnessed torture inflicted on others (in some cases, family members - 74%) and undergone sexual torture (21%). Of the total sample, 66% reported somatic symptoms such as a headache or abdominal distress without

physiological bases. Individuals who met criteria for PTSD or who had experienced sexual torture were more likely to report somatic complaints. The authors asserted that healthcare providers, who are often the first point of contact for this population, should consider somatic complaints as a "warning sign...to screen for torture and PTSD" (Tamblyn et al., 2011, p. 800).

In working with survivors of torture who report somatic complaints, it can be beneficial to inform clients of the interrelations between physical and psychological symptoms, and how one can exacerbate the other. Burnett and Peel (2001) caution against automatically treating physical symptoms pharmacologically, as medication and sedatives may further complicate the individual's ability to concentrate and function effectively in their daily lives. Thorough medical examinations should be conducted to rule out potential physiological or neurological damage caused by torture or other factors (Campbell, 2007). Such exams should be done with careful consideration, as the torture experience could have been perpetrated by medical personnel in the country of origin. Furthermore, certain components of a medical setting may be reminiscent of the individual's torture experience, rendering the client unable or unwilling to see a physician or seek further medical assistance (Amris & Williams, 2015; Campbell, 2007; Stover & Nightingale, 1985, as cited in Campbell, 2007). Once physiological damage has been ruled out, psychological assessments should be undertaken to explore the basis for clients' somatic complaints.

Another consequence of torture regarding mental health outcomes in survivors of torture is the prevalence of depression and other mood-related disorders, in addition to anxiety. In their investigation into the prevalence of psychiatric disorders in survivors of

torture predominantly from Africa, Tamblyn and colleagues (2011) found that 45% of the sample met criteria for major depression compared to 6.7% of the general U. S. population. Individuals from the sample who experienced sexual torture had a higher likelihood of reporting major depression. The authors also found that 31% of their predominantly African sample of survivors of torture reported anxiety symptoms compared to 11% of the general U. S. population.

In comparing mental health outcomes of 1052 tortured versus non-tortured Bhutanese refugees living in Nepal, Shrestha and colleagues (1998) found that 25% of tortured refugees met criteria for depression compared to 14% of their counterparts, in addition to exhibiting significantly greater levels of anxiety (43% versus 34%).

Suicidal ideation, suicide attempts and risk factors. There appears to be a paucity in the literature regarding suicide death rates in refugee survivors of torture and the risk factors associated with this phenomenon. Part of the difficulty in examining suicide attempts and rates is due to the heterogeneous nature of this particular population. Survivors of torture come from a range of backgrounds, and variations on ethnicity, sex, religious and political beliefs can impact one's likelihood to attempt or commit suicide. In examining U. S. mortality and census data, from 1999-2001, Singh and Hiatt (2006) found that foreign-born immigrants had 31% lower mortality from suicide compared to U. S.-born individuals, though this pattern varied substantially by ethnicity and sex. For instance, non-Hispanic whites experienced 15% and Asian immigrant women 38% higher suicide rates compared to their U. S.-born counterparts of similar racial and ethnic backgrounds. While the census data did not specify which types of immigrants they examined (i. e. individuals who came into the country as refugees) and may or may not

have included asylum-seekers or undocumented immigrants, it is most likely that the rates are higher for survivors of torture.

Based on Staehr and Munk-Andersen's (2006) study derived from medical records of 54 asylum-seekers from the Danish Red Cross Asylum Department, the rate of attempted suicide in asylum seekers was 3.4 times higher than the general Danish population. Goosen and colleagues (2011) investigated the rate of suicide deaths among asylum-seekers in the Netherlands from 2002-2007 and found that male asylum-seekers had a higher suicide mortality rate (25.6 per 100,000 people) compared to their Dutch-born counterparts (15.7 per 100,000 people).

Given the alarming rate of suicide deaths in the immigrant population, which may also comprise refugee and asylum-seeking survivors of torture, Lerner, Bonanno, Keatley, Joscelyne, and Keller (2015) investigated the risk factors associated with suicidal ideation in treatment-seeking survivors of torture resettled in New York City. The researchers compiled data from a clinical sample of 267 individuals who sought services at the Bellevue Hospital/New York University Program for Survivors of Torture (PSOT). They found that the pre-migration risk factors associated with higher rates of suicidal ideation were being female and experiencing rape/sexual torture. The post-migration risk factor that exacerbated suicidal ideation in survivors of torture was unstable immigration status, referring to individuals who had not yet begun the asylum application process.

Trauma. Traumatic events are often perceived as frightening, unexpected and can either physically or psychologically threaten the lives of those impacted by it, leaving individuals feeling helpless and vulnerable. With this specific population, the torture

experience serves as the traumatic event that has the potential to rob individuals of their voice both literally and figuratively, due to implications that trauma has on memory and recall of the traumatic experience itself. van der Kolk (2006) examined the neurobiological implications of PTSD, finding that exposure to traumatic reminders was associated to a relative deactivation of Broca's area, the speech center of the brain utilized to communicate one's thoughts and feelings. Individuals with torture experiences may then have difficulty accessing memories related to the traumatic event via language because the trauma itself was stored by mechanisms that circumvent verbal modes of expression. Given that trauma is often related to physiological processes pertaining to hyper- or hypo-arousal, it can lead to what Levine (2010) coined "tonic immobilization," or a fear paralysis in response to a traumatic event. This tonic immobilization, which may have served the evolutionary purpose of promoting survival during the time of torture, becomes maladaptive when this bodily response occurs outside the context of the traumatic event, disrupting daily life. Though the dissociation and altered state of numbness that occurs during trauma enables individuals to survive the ordeal, acting as an analgesic so that the physical or psychological pain is perceived as disconnected from them, they cannot remain in this state across all situations (Levine, 2010). In this manner, biology becomes pathology.

Yet, to automatically assume that refugee and asylum-seeker survivors of torture will develop complex pathology associated with PTSD is erroneous. Mere exposure to torture, which is a traumatic event, may not necessarily impair one's ability to function in daily life. Instead, the perceived uncontrollability and the distress associated with the torture situation may play a larger role in determining the development of

psychopathology in survivors of torture (Basoglu et al., 2007). Basoglu and colleagues (2007) point to the cumulative effect of both the physical and psychological stressors of the torture experience in traumatizing individuals. Experiencing physical pain alone as a result of torture is not the sole cause that triggers traumatic stress in survivors of torture. It is difficult to parse out the single effects of each type of stressor because physical and psychological methods of torture are often used concurrently to "break" the individual in question. For instance, perpetrators may rely on sensory deprivation combined with beating to heighten the sense of uncontrollability and powerlessness for the individual while under captivity.

Tamblyn and colleagues (2011), studied the prevalence of psychiatric disorders in African survivors of torture and found that 48% of their sample met criteria for PTSD, which is high in comparison to the rate of 3.5% found in the general U. S. population. Individuals who had experienced physical or sexual torture had a greater likelihood of having a PTSD diagnosis, based on odds ratios (Tamblyn et al., 2011). Past literature estimated the prevalence rates of PTSD to range from 14% to 38% (Hinton, Ba, Peou, & Um, 2000; Holtz, 1998; Shrestha et al., 1998; Tang & Fox, 2001; as cited in Hooberman, Rosenfeld, Rasmussen, & Keller, 2010).

While torture may often be the precipitating event for the development of PTSD, "many people survive extremely severe torture in relatively good psychological health and never develop PTSD" (Basoglu et al., 2007, p. 284). In this regard, the presence of a traumatic event alone (such as a torture experience) may not necessarily lead to the complex psychopathology associated with PTSD. The hypervigilance, hyperarousal, dissociation, somatization and other factors that occur during the torture experience may

be appropriate responses when individuals are exposed to the extreme distress posed by a dehumanizing act such as torture. It is when these responses occur indiscriminately, even once the danger posed by the torture experience has passed, that they become maladaptive.

Factors Related to Resilience

Past literature on mental health outcomes of individuals who have experienced traumatic events have shown that a variety of factors impact the potential development of PTSD: the severity of the traumatic event (Breslau & Davis, 1987; Foy, Sipprelle, Rueger, & Carrol, 1984), the age at which it occurred, education, previous psychopathology (Green, Grace, Lindy, Gleser, & Leonard, 1990), intelligence (McNally & Shin, 1995), social support (Keane, Albano, & Blake, 1992) and being able to maintain calmness and control when the trauma took place (Hendin & Haas, 1984, as cited in Basoglu et al., 1997). Additionally, cognitive factors that influence the way an individual perceives the traumatic event may contribute to the development of psychopathology. When trauma is regarded as violating one's assumptions of "personal safety, positive self-regard, and perception of the world as meaningful," the individual may struggle with coming to terms with what happened because the world is no longer perceived as a "just and orderly place where people usually get what they deserve" (Basoglu et al., 1997, p. 1421). Yet, what differentiates individuals who develop significant psychopathology as a result of torture from those who manage to resume their lives in relatively "good" psychological health even after such a traumatic event?

Resilience is often defined as a "dynamic process encompassing positive adaptation within the context of significant adversity" (Luthar, Cicchetti, & Becker,

2000, p. 543). Put simply, resilience refers to an individual's capacity to "bounce back" in light of challenges; coping style, self-enhancement, and one's cognitive appraisals of the situation act as protective factors from developing psychopathology in the event of trauma (Bonanno, 2004). For instance, psychological preparedness and commitment to a particular political cause may promote resilience in survivors of torture. Basoglu and colleagues (1997) compared post-trauma psychological functioning of 55 politically active survivors of torture and 34 torture survivors with no history of political activity in Turkey. They found that though the tortured non-activists experienced relatively less severe torture, they exhibited significantly higher levels of psychopathology, with greater symptoms of anxiety, depression and PTSD, compared to their politically active counterparts. The researchers hypothesized that the activist survivors of torture may have been more psychologically prepared for trauma because of "prior experience with traumatic stressors and opportunities for training in mental and physical stoicism during political activity; expectation of traumatic events; and a belief system whereby torture is appraised as merely an instrument of repression used by the regime to protect the interests of the ruling class" (Basoglu et al., 1997, p. 1430). Less psychological preparedness in the non-activist survivors of torture was associated with greater perceived distress during the torture experience.

Taking these findings into account, it is possible that dedication to a particular cause may have provided politically active individuals with more effective coping strategies to deal with the trauma while it occurred and in its aftermath. The authors also surmised that the activists' potential immunization against the psychological consequences of torture was reinforced from having been detained over longer periods of

time and through repeated exposure to different forms of stressors. It is possible that non-activist survivors of torture more closely resemble the civilian population that may have perceived their torture experience as unpredictable and as violating their trust in state authority and beliefs regarding safety and a "just world."

Hooberman and colleagues (2010) investigated the moderating role that coping style may have on resilience variables with 75 refugee survivors of torture in New York City. Coping style was categorized into the following: problem-focused engagement, emotion-focused engagement, problem-focused disengagement and emotion-focused disengagement. Individuals employ problem-focused coping when they attempt to alter or manage the problem, while emotion-focused coping refers to regulating one's affective response to the problem, such as expressing one's feelings to others. Engagement refers to when someone actively deals with the stressor utilizing problem-focused or some emotion-focused strategies (e.g.. seeking social support, regulating emotions and restructuring one's thoughts), whereas disengagement refers to the individual's attempts to escape from feelings of anxiety (e.g.. avoidance, denial and irrational thinking) (Meléndez, Mayordomo, Sancho, & Tomás, 2012).

Hooberman and colleagues (2010) found that the emotion-focused disengagement coping style significantly moderated the relationship between cognitive appraisal and social comparison variables, and that individuals exhibiting that coping style reported greater symptoms of PTSD. Participants who utilized emotion-focused disengagement coping strategies may have been more likely to focus inwardly and be self-critical, thereby blaming themselves for their trauma. For clinical implications, the authors underscore the importance of addressing clients' negative and harmful appraisals of the

traumatic event to reduce potential self-blame. Additionally, participants who engaged in downward social comparison (i.e. comparing themselves to those perceived as "worse off" than them) reported greater levels of distress. The researchers surmise that thinking about others in worse situations may have reminded participants of their own past traumas and may have contributed to survivor guilt, leading to introspection on why these individuals managed to escape with their lives whereas others were not as fortunate. The researchers also suggested identifying individuals who are socially isolated and who utilize a disengagement coping style for treatment, as these factors may be a risk factor in developing more complex psychopathology.

Current Treatments and Interventions for Survivors of Torture

Addressing the traumatic aspects of migration and the torture experience appear to be prevalent in the literature on developing interventions for adult refugees and asylum-seekers, with researchers focusing specifically on PTSD as a primary concern with this population (Basoglu, 2006; Nicholl & Thompson, 2004; Schweitzer, Buckley, & Rossi, 2002; Silove, 1996; Summerfield, 1999; as cited in Nickerson, Bryant, Silove, & Steel, 2011). Despite a heavy emphasis on trauma, prior literature has not specified the nature of the traumatic experience, collapsing different types of persecution experienced by refugees and asylum-seekers into the overarching category of "trauma". As such, it is possible that research conducted on adult refugees and asylum-seekers may actually include individuals who have experienced torture without identifying them as such. Thus, studies that have implemented trauma-focused interventions for refugees and asylum-seekers may also be relevant for survivors of torture.

The term "trauma-focused interventions," refers to "treatments in which the discussion of traumatic experiences represents a key therapeutic strategy" to address symptoms of PTSD (Nickerson et al., 2011, p. 4). To alleviate the pre-migration distresses and psychological consequences of torture, current treatments for survivors of torture tend to adopt a trauma-focused approach, utilizing interventions such as: cognitive behavioral therapy (CBT) (Hinton et al., 2004; Hinton et al., 2005; Hinton, Hofmann, Pollack, & Otto, 2009; Otto et al., 2003), cognitive processing therapy (CPT) (Schulz, Resick, Huber, & Griffin, 2006) and narrative exposure therapy (NET) (Halvorsen & Stenmark, 2010; Neuner, Kurreck, Ruf, Odenwald, & Schauer, 2010) to directly address the traumatic nature of torture through exposure and challenging distorted cognitions derived from the trauma (Nickerson et al., 2011).

Pharmacological treatment is also often used to treat mental health concerns in survivors of torture from refugee backgrounds. As reviewed in McFarlane and Kaplan (2012), Kivling-Boden and Sundbom (2001) examined the potential benefits of at least one month of psychiatric treatment for 27 refugees from the former Yugoslavia, majority of whom met criteria for PTSD. Upon follow-up three years later, the researchers did not find significant changes in symptoms of PTSD for the sample. The authors suggested that the non-significant results may have been due to post-migration stressors such as unemployment and dependence on social welfare, as well as the war in Kosovo which may have reactivated participants' PTSD symptoms. Other studies investigating the treatment effectiveness in outpatient facilities, which included psychoactive treatment, supportive therapy and social group support, yielded mixed results (Boehnlein et al., 1985; Boehnlein et al., 2004). Beyond focusing on addressing symptoms of PTSD, these

studies highlighted the impact that post-migration stressors have on the mental health of survivors of torture. For instance, post-migration stressors related to social isolation, shame, avoidance, unemployment and limited English proficiency can contribute to survivors of torture's negative mental health outcomes (Boehnlein et al., 1985).

Thus, a singular focus on trauma ignores the very pressing realities that refugee and asylum-seeker survivors of torture find themselves in upon migrating to a novel country for resettlement. Post-migration stressors such as acculturation, limited language proficiency, employment, insecure immigration status, housing and other practical matters that tie into daily life, may impact this population's mental health outcomes. In order to treat survivors of torture through a more holistic lens, other treatment models have adopted a wraparound approach that integrates other services beyond traditional mental health programs to meet the various needs of this population in the resettlement context (Nickerson et al., 2011; Raghavan, Rasmussen, Rosenfeld & Keller, 2013).

Multimodal Interventions and Wraparound Approaches

Multimodal interventions include providing additional services beyond traditional mental health interventions, such as resettlement assistance, legal aid concerning immigration status, language classes, employment, and other areas of concern for refugee and asylum-seeker survivors of torture (Nickerson et al., 2011). Such wraparound approaches often integrate various services in one location. Interventions that focus heavily on one aspect of the refugee or asylum-seeker's experience, such as trauma and other pre-migration factors, may fail to recognize the very real impact of post-migration stressors, which may exacerbate survivors of torture's psychological distress beyond their torture history. This holistic method of working with refugee survivors of torture, such as

addressing non-clinical matters like housing, immigration status and employment (Kira, 2002) have suggested a reduction in clinical symptomatology (Boehnlein et al., 2004).

Raghavan and colleagues (2013) examined the psychosocial variables related to reducing clinical symptoms in survivors of torture receiving treatment at PSOT. They evaluated the wraparound approach used at PSOT, which consisted of medical care, psychological, educational, social and legal assistance to survivors of torture.

The study included a multinational sample of 172 participants who met criteria for the definition of torture prescribed by the United Nations Convention against Torture and had been accepted to PSOT following an intake evaluation. The clinical measures employed were the Brief Symptom Inventory (BSI), and the Harvard Trauma Questionnaire (HTQ); the non-clinical variables assessed pre- and post-intervention were: immigration status, employment and income. Immigration status was categorized as: maintained (for those who already had legal authorization to remain in the U. S.), secure (for those who received legal permission during the six months of the study) and insecure (for those who had yet to file for asylum; "undocumented"). The services provided to participants consisted of the following services: psychological (individual and/or group psychotherapy), psychopharmacological (psychiatric evaluations and medication management), medical, social (regarding employment and housing), legal concerning asylum applications and the immigration process and educational (e.g., English language classes).

The researchers found clients reported decreased maladaptive symptoms of PTSD, depression, anxiety and somatization after six months of accessing services and receiving treatment. Seventy-seven of the 172 participants (44.5%) exhibited clinically

significant improvement on at least one of the symptom scales, while ten participants (5.8%) reported clinically significant improvement on all four scales (Raghavan et al., 2013). Utilizing psychological services was strongly associated with improvements in PTSD symptoms, but not for anxiety, depression or somatization. Yet, the mechanisms of therapeutic change are not well understood, as the study's analyses did not examine the content of the services, just the frequency of therapy attendance. Additionally, no distinctions can be made between individual and group counseling with regard to their effectiveness in alleviating symptoms of PTSD. Accessing educational services was strongly related with symptom reduction of PTSD and depression. The authors suggest that providing services that address the practical concerns of clients (e.g., to ameliorate the language barrier) can be complementary in alleviating the various stressors experienced by refugee survivors of torture.

With regard to the non-clinical variables assessed post-intervention, changes in immigration status appeared to be the strongest correlate of clinical improvement. Participants who received legal authorization to remain in the U. S. reported greater improvements in symptoms of PTSD, depression and anxiety. Insecure immigration status may lead to difficulties in gaining employment and housing, compounding the psychological distress experienced by survivors of torture in adjusting to life in a novel environment. The authors suggest that adopting a wraparound approach in treating refugee and asylum-seeker survivors of torture may be a more viable and holistic means of addressing the psychological distress experienced by this population.

Art Therapy

Considering the centrality of the visual arts in various cultures across time being used for healing and communicating with the spiritual (Crumlin & Knight, 1991), art therapy may be a viable option in working with refugee and asylum-seeker survivors of torture. As an intervention that can be used nonverbally, art therapy utilizes the creative process of art making to enable individuals to express emotions that may be difficult to put into words (Malchiodi, 1999). Art therapy has been defined as the psychotherapeutic use of art making as a process to help clients address and explore cognitive, behavioral and emotional conflicts to achieve overall well-being; it encompasses various forms of the visual arts, including drawing, painting, sculpture and other media, such as textiles and fiber arts (American Art Therapy Association, 2013).

Art Therapy and Trauma

As discussed earlier, the traumatic nature of torture can often complicate mental health outcomes in survivors of torture, because trauma is very much body-based and memories associated with the event are often disjointed and stored in regions that bypass verbal modes of expression (van der Kolk, 2006). Though torture and trauma are not synonymous experiences, due to the paucity of art therapy research specifically focusing on survivors of torture, I have included trauma because torture is often regarded as a traumatic experience. When an individual experiences trauma, the higher brain regions associated with executive functions related to planning, abstract thought, inhibition and organizing become less active (van der Kolk, 2006). Specifically, there is decreased activity in the medial prefrontal cortex (mPFC), which "plays a role in the extinction of conditioned fear responses by exerting inhibitory influences over the limbic system by attenuating peripheral sympathetic and hormonal responses to stress" (van der Kolk,

2006, p. 11). Dysfunction of the mPFC may contribute to the individual's inability to regulate emotions and arousal. The internal sensations that arise from triggers may be perceived as overwhelming, or conversely, as separate or disconnected from the experiencer's body. In this regard, addressing an individual's trauma and torture experience verbally may not be viable because a) memories related to the torture history bypass verbal declarative memory and b) speaking about the trauma and experiencing the intense emotions associated with it may be too overwhelming.

The use of nonverbal expressive therapies, such as art therapy, can be an effective intervention in treating survivors of torture because it does not rely on an individual's use of verbal modes of expression to articulate and process the traumatic event (Klorer, 2005). Given how traumatic memories may be stored in the right hemisphere (Schiffer, Teicher, & Papanicolaou, 1995), verbal declarative memory of the trauma itself may be difficult for individuals to retrieve. Refugees and asylum-seeker survivors of torture may not only lack the linguistic skills necessary to express themselves in the host country's language, but they also may not even have the words in their native tongue to express their trauma. Through art making, individuals will have the opportunity to express their feelings even before they are able to find the words to describe them (Klorer, 2005). By circumventing verbal modes of expression, art therapy provides a nonthreatening way for individuals to express and confront their torture experience by using their art product as a metaphor, one that separates them from the traumatic event they encountered. Given that art therapy is comprised of symbolic systems that are body-based, nonverbal and unfiltered, it can provide a tangible, concrete product that can be objectified and distanced from the individual (Belkofer & Nolan, 2016).

Art Therapy with Refugees and Asylum-Seekers

Given the paucity of research on the use of art therapy with adult survivors of torture from refugee and asylum-seeker backgrounds, I will focus on relevant literature pertaining to asylum-seekers and refugees, some of whom may be survivors of torture or may have experienced traumatic events before resettlement. Much of the research examining the effectiveness of art therapy and other creative arts therapies (e.g., dance/movement, music, drama, and poetry therapy) with refugee and asylum-seeker populations focuses on children and youth (Beauregard, 2014; Quinlan, Schweitzer, Khawaja, & Griffin, 2016; Rousseau, Benoit, Lacroix, & Gauthier, 2009; Rousseau, Drapeau, Lacroix, Bagilishya, & Heusch, 2005; Ugurlu, Akca, & Acarturk, 2016), with interventions commonly being school-based. Given the limited literature on art therapy with refugees and asylum-seekers, I will highlight findings and clinical implications from studies conducted with refugee and asylum-seeker children and youth that may be applicable for adult populations as well. Additionally, arts-based research and studies utilizing visual data collection methods to examine the experiences of refugees and asylum-seekers have been included (Boyden & Ennew, 1997; Prag & Vogel, 2013; Sampson & Gifford, 2010; Yohani, 2008). As it can be crucial for individuals who have experienced trauma to tell their stories in their own voice, photographs and other visual depictions can be a powerful means of expression that circumvents language barriers and words.

Children and youth. Due to the stressors associated at different stages of migration, refugee and asylum-seeker children and youth are at a greater risk of developing negative mental health conditions, manifesting in symptoms of depression,

anxiety, PTSD, behavioral difficulties related to attention and aggression (Yule, 1999), traumatic grief (Betancourt et al., 2012), difficulties with social relations, problems related to sleep, somatic complaints, irritability (Almqvist & Brandell-Forsberg, 1997). Additionally, the disorientation elicited from forced migration can serve to disrupt family bonds and cause dramatic shifts in family roles and dynamics, thereby exacerbating mental health outcomes in individuals from refugee backgrounds (Lincoln et al., 2016). The family system can become strained and challenged when dynamics within the unit shift and roles change as a result of adjustment to a new land. As noted earlier, one example is when youth serve as translators for family members or have to explain the cultural values and norms of the host country to parents. Additionally, children and adolescents are often excluded from the decision-making process to migrate and may also experience other burdens such as "disrupted social networks, struggles to fit in, language barriers, and conflict with parents and caregivers" (Lincoln et al., 2016, p. 771). The quality of family life may play a significant role in short- and long-term mental health outcomes for adolescents from refugee backgrounds (Montgomery, 2011).

Rousseau et al. (2009) conducted a controlled trial with a pre- and post-test design that evaluated the effects of a sandplay program on behavioral and emotional symptoms for multiethnic immigrant and refugee children in Montreal, Canada. One hundred and five kindergarten students aged 4-6 with a majority (72%) born in Canada with South Asian origins (64%). The intervention consisted of a sandplay workshop run by three art therapists. The experimental group (n = 52) attended one-hour workshops every second week over a four-month period, totaling ten sessions; materials for the sandplay were

sand trays and figurines. Children visually represented their internal worlds and share their stories with the group.

The pre-test occurred in early December 2004 and the post-test in May 2005, following the 2004 Indian Ocean Tsunami that affected regions of South and Southeast Asia. At post-test, children in the experimental group exhibited a significant reduction in emotional symptoms (anxiety and depression, as reported by parents via phone interview). According to teacher reports, the control group displayed an increase in behavioral and emotional symptoms at post-test, suggesting that the intervention may have served as a protective factor against the children's exposure to the tsunami. Parents reported that the sandplay therapy was "acceptable to them, as they felt it coincided with some of their cultural traditions and did not feel threatened or stigmatized by it" (p. 748).

In working with individuals from diverse cultural backgrounds, it is important to develop interventions that are culturally appropriate and encourage participation. Sandplay therapy may be a viable intervention used to facilitate creative expression for refugees and asylum-seekers of various backgrounds because it may be perceived as less threatening than having to utilize the highly structured, traditional materials often used in the West (i.e. pencils, markers, colored pencils, crayons). Given that art therapy traces its roots from a tradition of Western psychotherapy, even the materials we utilize speak to our inherent cultural biases. For individuals who never received formal education, familiarity with such art materials may not be a given.

Ugurlu and colleagues (2016) reported similar observations regarding a potential lack of exposure to Western art making materials for some of the children in their sample

who did not attend school. In their sample of 64 Syrian refugee children, aged 7-12, living in Istanbul, Turkey, 58% attended school during the time of the study. The participants who did not attend school exhibited greater difficulty utilizing the art materials provided in the beginning of a five-day creative arts therapy workshop compared to their counterparts. The authors investigated the prevalence of post-traumatic stress, depression and state and trait anxiety in their sample, in addition to examining the potential benefits of implementing a creative arts therapy intervention to improve those psychological symptoms. Pre- and post-test measures included: 1) the Stressful Life Events (SLE) Questionnaire, which examined the children's stressful and traumatic experiences; 2) Child Depression Inventory (CDI); 3) State-Trait Anxiety Scale (STAI) to measure the presence and severity of current anxiety symptoms as well as an individual's tendency to be anxious; and 4) the UCLA PTSD Index, parent version, which screens for traumatic exposure and assesses an individual's PTSD symptoms based on DSM-IV criteria. Conducted by three licensed creative arts therapists, the intervention consisted of a five-day workshop where participants received three sessions daily of music, movement and drawing, divided into three aged based groups (7-8, 9-10, and 11-12 years old). Following the Skills for Psychological Recovery (SPR) program, the sessions targeted areas such as: "building problem-solving skills, promoting positive activities, identifying feelings, handling difficult feelings and managing reactions, promoting helpful thinking and rebuilding healthy social connections" (Ugurlu et al., 2016, p. 93-94).

Due to a lack of Arabic interpreters, the researchers only selected 30 children randomly for post-assessment, where they found a reduction of PTSD symptoms,

depression and trait anxiety. Ugurlu and colleagues (2016) acknowledged that the children's pre-test measures were lower than those reported in previous studies conducted with other refugee children. The lower scores could be attributed to the children having greater stability in their living situation in Turkey; the participants did not live in refugee camps, their parents either had secure or temporary employment, and more than half of the children attended elementary school. Within the context of resettlement, this finding highlights the importance of refugee and asylum-seeker families being able to access services and gain self-sufficiency and stability as quickly as possible upon arrival to the host country. When an individual's practical and most pressing needs are met, it may serve to buffer against negative mental health outcomes.

In a literature review examining the efficacy of school-based creative arts therapies programs with refugee and non-refugee children, Beauregard (2014) found that the creative arts therapies improved coping, resiliency and prosocial behaviors, self-esteem and emotion and behavioral problems.

To examine how creative expression can reduce behavioral and emotional difficulties in refugee and asylum-seeker youth, Quinlan, Schweitzer, Khawaja and Griffin (2016) conducted a quantitative non-blinded controlled trial with a pre- and post-test design in Brisbane, Australia. They assessed the effectiveness of a school-based creative arts program known as the Home of Expressive Arts and Learning (HEAL), consisting of visual arts, music, drama and play activities. HEAL also integrated a narrative approach that explores concepts of self-identity and cultural identity. Though the researchers did not focus on art therapy as the primary intervention, this study speaks to the importance of integrating more holistic interventions to treat refugee and asylum-

seeker youth's behavioral and emotional challenges in adjusting to life in a novel country.

The sample ($N = 42$) consisted of high school students from the Middle East, East Asia and Africa who were selected from classes where students would move on to mainstream high schools in six months. The experimental group of 22 either engaged in music or art therapy for at least an hour weekly sessions over ten weeks, separated into smaller groups according to their countries of origin and gender (e.g., Afghan girls' group). A quarter of the experimental group also received weekly 45-minute individual therapy, with the remaining participants only receiving the music or art therapy group intervention. Pre- and post-test measures consisted of a self-report measure for emotional distress, and a questionnaire to assess behavioral difficulties, based on teachers' reports. Participants in the intervention group exhibited a significant reduction in emotional symptoms. Quinlan and colleagues (2016) also reported a moderate effect size for the reduction of "behavioral difficulties, emotional symptoms, hyperactivity and peer problems, suggesting that significant effects may be found if a larger sample were utilized" (p. 5). However, the researchers noted several limitations: in the HEAL group, while the minimum requirement was engagement with the program for at least an hour a week, some students participated in more than others. As the research was conducted in a school, teachers were not blind to treatment allocation because they were involved in identifying which students would benefit from additional psychosocial support. The intervention also lacked a standardized protocol and varied depending on the therapists who led the groups. Additionally, as the modalities were combined in the HEAL group,

future studies could compare the modalities used to assess the effectiveness of each one separately (Quinlan et al., 2016).

Adults. In a qualitative intrinsic case study utilizing art therapy, Fitzpatrick (2002) investigated the refugee experiences of a Bosnian woman resettled in Perth, Australia. Nina (pseudonym) was a 38-year-old Serbian woman, married to a Muslim man, who had two elementary school-aged children. University-educated, Nina had worked as a bank manager before leaving Bosnia due to the political instability and ethnic persecution faced by Muslims, Serbs and Croats of former Yugoslavia. Recruited from an agency for refugees in Perth, Nina was considered by staff as unlikely to be re-traumatized by participation in the research study. She lived in Australia for approximately 15 months at the onset of the study. Data were collected via semi-structured interviews and artwork (drawing, painting and collage) created during sessions to reconstruct her traumatic experiences. Nina was to attend four weekly group art therapy sessions that addressed the dominant themes and issues mentioned in her individual interview, relating to ideas of "home, journey, identity, loss and the challenges of bridging past and present" (p. 153). Fitzpatrick (2002) found that art therapy provided Nina with an empowering way to remember, mourn and reconstruct her traumatic experiences. Creating art enabled Nina to confront some of her experiences indirectly, giving her a concrete means of channeling her inner experience into a form outside of herself, separating her from her trauma.

This study highlights the necessity of being flexible in conducting cross-cultural art therapy. The therapist met Nina at her home when there were scheduling conflicts. The home sessions strengthened the therapeutic relationship, and Fitzpatrick allowed

Nina's husband to participate in these home sessions, which provided a significant opportunity for both individuals to "symbolically revisit home and to express the pride they felt about their country" (p. 155). Nina came from a collectivistic culture that emphasized group harmony and the importance of social and familial bonds for an individual's wellbeing. Due to her cultural background, including Nina's husband in the home sessions may have also been culturally appropriate.

Similarly, Isfahani (2008) found that themes related to loss, home, identity and nostalgia were prevalent in the artwork created by her client, Hanna (pseudonym), an Ethiopian-born Eritrean woman in her twenties who came to the U. K. as an unaccompanied minor at fifteen years old. As the youngest in a family of five siblings, Hanna came to the U. K. following the outbreak of civil war between Ethiopia and Eritrea in 1998, and was forced to flee her home, with the expectation that her mother and siblings would join her soon after. However, Hanna had lost contact with her family over the years and at the time of the study, had been initially denied asylum, exacerbating her mental health conditions and diagnosis of PTSD. Art therapy seemed to provide Hanna with a space to express her anger in a contained and safe manner, whether through the art making or via projected verbalizations on the therapist. In addition to the physical loss caused by displacement and the safety her home provided, Hanna's art revealed losses regarding her connection to her sense of self before her forced migration and separation from her family. Isfahani (2008) also highlighted several factors that facilitated the therapeutic alliance; though from different cultural backgrounds, both women came from Muslim majority countries, where the therapist was well versed on Hanna's religious and spiritual beliefs. Additionally, the therapist's limited knowledge of Arabic helped

promote rapport in the therapeutic relationship, highlighting the importance of learning a few key phrases or words clients' native tongue not only to express interest in their background, but to provide comfort in a language familiar to them.

The importance of externalization in the art therapy process to address trauma was echoed in Kalmanowitz's (2016) study. The author examined the benefits of an art therapy and mindfulness workshop called the "Inhabited Studio" for refugees and asylum-seekers in Hong Kong who had experienced political violence and torture. The intervention consisted of workshops that took place for two full days, a week-break in between, where homework, consisting of art making and meditation, was assigned, and another two full days at the Studio. The workshops emphasized exploration of various art materials, given that the participants had limited prior experience with art making, and an introduction to learning numerous mindfulness meditation techniques. Data was collected via transcriptions of audio and video recordings of the workshops, discussion groups, focus groups; artwork; a semi-structured questionnaire; and individual follow-up interviews.

Kalmanowitz (2016) found that the Inhabited Studio provided participants, who were often in a state of instability and uncertainty due to their status as refugees and asylum-seekers, an opportunity to gain distance from the overwhelming emotions often associated with their traumas. The combination of different modalities, art therapy and mindfulness, provided participants with choice; while some found the art making itself grounding and helped contain their overwhelming affect, others responded more positively to the mindfulness exercises. Given both interventions' emphasis on cultivating individual self-awareness, it took a "culture-specific" approach to healing,

drawing on the participants' existing internal and external strengths, as well as "[drawing] upon their perceptions and understanding of what constitutes healing" (p. 82).

To expand further on the benefits of art therapy and mindfulness with refugees with histories of political violence and trauma, Kalmanowitz and Ho (2016) identified nine features of the Inhabited Studio that met the unique and multifaceted needs of the participants. Instead of viewing participants through the lens of pathology, the authors asserted that the Inhabited Studio placed the "experience of the individual as fitting into a context of wellbeing and suffering" (p. 59). The nine features identified were "safety, doing versus thinking, changing [one's] relationship to [one's] thoughts and feelings, the notion of time in the context of trauma, change and making meaning, flexibility, catharsis, increased self-awareness and self knowledge, [and] coping with loss" (p. 59). Due to the flexible and open structure of the Inhabited Studio, which encouraged creativity, imagination and symbolization, participants were welcome to bring their own content and context to the space. As a short-term group intervention for asylum-seekers and refugees, the Studio was not one that explicitly dealt with trauma, but instead focused on promoting resilience in participants who lived in a state of uncertainty and flux. The authors argued that the combination of art therapy and mindfulness provided participants with tools to cope in their daily lives, to begin to piece together their past and their trauma histories, and to make sense of who they were in the present and future.

Arts-Based Research on Refugees and Asylum-Seekers

Besides utilizing verbal measures and other psychometric assessments of wellbeing and mental health, research incorporating visual data collection methods may be beneficial to circumvent the potential linguistic and conceptual barriers that refugees

and asylum-seekers experience (Sampson & Giford, 2010; Boyden & Ennew, 1997). Arts-based research is a form of qualitative research involving or including the arts in either all or some aspects of data collection, analysis or presentation of findings (Knowles & Cole, 2008). The visual methods employed in this type of research include drawings, paintings and other digital media such as photography and film (Guruge et al., 2015). Of particular note is the use of photography-based projects as a visual medium that allows individuals to "document their everyday realities and identify the needs of their community," such as in the case of Photovoice, which has been used extensively in the field of public health (Guerrero & Tinkler, 2010; Wang, 1999). Several studies have explored the acculturation experiences of refugee youth using photography as a visual data collection method (Sampson & Gifford, 2010; Guerrero & Tinkler, 2010; Prag & Vogel, 2013). Utilizing arts-based approaches may offer refugees and asylum-seekers "creative and aesthetic forms of communication avenues that can complement verbal and/or written communication" (Guruge et al., 2015, p. 2) to provide a more holistic picture of their resettlement experiences and their specific needs. Arts-based research utilizes visual forms of data collection; art therapy research, on the other hand, specifically examines how art therapy as an intervention can impact mental health outcomes, promoting healing that circumvents the need for verbal expression.

Though not within the resettlement context, in a qualitative multiple case study, Prag and Vogel (2013) investigated the benefits of therapeutic photography in promoting posttraumatic growth in Shan adolescent refugees in northern Thailand. Researchers collected data via photographs, accompanying text such as photograph captions and artist statements, informal interviews conducted a year following the intervention and a short

questionnaire. Nine adolescent participants who experienced a traumatic, forced migration from the Shan state were recruited from a community center that provided mental health services in Wiang Wai, Thailand. Participants engaged in a five-week photojournalism workshop that took place once a week after school, led by an English speaking photojournalist who used an interpreter. Workshops focused on teaching photography techniques and assigning specific themes for each week. Participants shared their photographs for constructive feedback; peers and the facilitator discussed each photograph on a technical level then probed for deeper interpretation of the art. Participants wrote captions accompanying each photo. The final culmination of the workshop included a photography exhibit open to the community and displayed at the local temple.

Researchers found six recurring themes from the photographs and their corresponding captions that related to posttraumatic growth: 1) an appreciation for life; 2) the importance of intimate relationships; 3) identifying personal strengths; 4) spiritual strength; 5) new possibilities; and 6) the ability to articulate a social narrative. For the Shan youth, photography provided them with an avenue to express stories of their community instead of focusing on their individual narratives; it "echoes other studies that have shown the importance of a collective identity in the healing process" (Prag & Vogel, 2013, p. 47) in cultures that emphasize the community above the individual. For the participants, who are forbidden to "fly their flag, teach history or speak their language openly and freely without fear of reprisal" (p. 48), this intervention provided an opportunity to construct, deconstruct and reconstruct their narratives.

Despite these promising findings, the authors noted several limitations. For instance, measuring posttraumatic growth pre- and post-test would have been more beneficial in determining how effective the photojournalism intervention was instead of only examining participants' views post-intervention. To verify the interpretation of themes that emerged in the photographs, member checks could have been used. Despite the authors' assertions that the present study expands on theory and research based on therapeutic photography and posttraumatic growth, a photojournalist conducted the intervention, not an art therapist or mental health professional. While a clinical psychologist analyzed the data and conducted the follow-up interviews, the fact that a photojournalist facilitated the therapeutic photography intervention is problematic. Though photojournalists may have extensive training on photography and exhibit technical competence in the artistic form, they are not necessarily trained in mental health or trauma-informed care. For future research, it could be beneficial to include art therapists to deepen the ensuing discussion of the participants' photographs.

In taking into consideration the complex array of factors that influence mental health and psychological wellbeing for refugee and asylum-seeker survivors of torture, the addition of art therapy to the wraparound services provided at PPR appears to be a viable and effective modality for individuals unfamiliar or distrustful of Western psychotherapy. Due to the body-based nature of trauma (van der Kolk, 2006), the ability to externalize one's internal thoughts into a tangible product, and the reflective distance that art making promotes (Belkofer & Nolan, 2016), art therapy can provide survivors of torture opportunities to tell their stories at their own pace and without having to rely on words to convey meaning.

CHAPTER 3: GRANT PROPOSAL

This capstone thesis consisted of writing a grant proposal to secure funding for the development of an art therapy program on behalf of a collaborative, the Philadelphia Partnership for Resilience (PPR), that works with immigrant, refugee, asylum-seeker and asylee survivors of torture in the Greater Philadelphia region. As PPR did not offer onsite mental health services, the development of an art therapy program would provide clients with culturally relevant and appropriate intervention that moves beyond traditional Western treatment models that emphasize verbal therapy and pharmacological treatment. Art therapy may be a viable additional option for survivors of torture, given its primarily nonverbal nature, which provides alternative pathways for expression that escapes the need for verbalization. Additionally, it can be perceived as less threatening and stigmatizing compared to Western psychotherapeutic interventions, due to the centrality of the visual arts across various cultures and contexts over time (Crumlin & Knight, 1991). This chapter will focus on the steps taken in order to write a grant proposal: finding a partnering organization who acted as the grant recipient, the initial grant search process, identifying grants that suited the needs of the agency and were the best "fit," and writing a letter of inquiry/intent (LOI) and a full grant proposal.

The proposed grant aimed to aid in funding an art therapy program that includes a part-time art therapist's salary, benefits, professional development, continuing education (e.g. supervision, conferences), purchasing art supplies and equipment, tokens for public

transport to fund clients' attendance, and interpretation services for clients who have limited English proficiency.

The art therapist will offer individual and group art therapy services to survivors of torture and their families, working onsite at NSC three days a week. Two different art therapy groups are proposed: one where a specific directive will be assigned each session, and one open studio art therapy group, where clients are invited to explore art materials independently and work on projects of their own choosing. The former group, which will focus on specific themes each session, anchored by a directive, serves to promote community, socialization and dialogue between clients, to decrease feelings of isolation and loneliness in the resettlement context. The open studio art therapy group will be modeled from elements of Kalmanowitz's (2016) "Inhabited Studio," which provided participants an opportunity to explore materials and express themselves freely, bringing their own content and context to the space.

Identifying a Partner

Foundations typically provide funding to organizations and not individuals; thus, the first step required seeking out a partnering organization that would act as the grant recipient. Through my clinical internship, in October 2016, I received approval from the project coordinator of PPR, Cathy Jeong, to write a grant on behalf of the collaborative to propose an art therapy program at Nationalities Service Center (NSC), where PPR is located. PPR provides case management and legal and social assistance for immigrant, refugee, asylum-seeker and asylee survivors of torture. As a collaborative, it is made up of partnerships between NSC, the Hebrew Immigrant Aid Society Pennsylvania (HIAS PA) and BuildaBridge International, which offers therapeutics arts groups to survivors of

torture and their families. NSC provides legal, resettlement, health and language services to immigrants and refugees in the Greater Philadelphia area. HIAS PA provides legal and resettlement services to immigrants, and has increased their outreach efforts to asylees and providing assistance to asylum-seekers.

Grant Search

The next step involved identifying grants that suited the needs of the agency and aligned with its mission and capacity to carry out the project. During this initial search process, there were no funding opportunities found when searching through the Drexel Library database and government websites. In order to identify potential grants that met the needs of the agency, I used the Regional Foundation Center, housed in the Free Library of Philadelphia, which provides free access to the Foundation Directory Online, the most comprehensive database of U. S. funding agencies, their grants and past grantees.

I searched for specific "fields of interest," consisting of the following keywords: "immigrants and refugees," "arts and culture," "mental health" and "human services." Based on these findings, I searched for funding agencies interested in giving either to Pennsylvania nonprofit organizations, some of which were further specified to the Greater Philadelphia region, or nationwide. As PPR is a collaborative formed through partnerships with three different nonprofit organizations, I also conducted a search on "Nationalities Service Center" and "BuildaBridge International" to note the foundations that had provided funding to these organizations in the past. To organize the results, I created a table that provided an overview of potential grants that PPR could be eligible for which included the following information: grant name, keywords, deadline, funding

amount, whether a letter of inquiry/intent is requested, the proposal requirements, region of interest, past grantees and website of the funding agencies.

From the list of twelve grants, based on discussions with my thesis advisor and the project coordinator of PPR, we narrowed down our interest to two grants. I ultimately decided to apply to the van Ameringen Foundation given its emphasis on mental health and slightly more substantial funding amount.

van Ameringen Foundation Grant. Providing art therapy to a vulnerable and at-risk population such as refugee and asylum-seeker survivors of torture aligns with the van Ameringen Foundation's commitment to "[increasing] the accessibility of the poor and needy to mental health services" (van Ameringen Foundation, Inc., 2012, para, 1). With a strong emphasis on mental health and social welfare, the van Ameringen Foundation strives to encourage and attract innovative and practical programs that target the following areas: to "increase the accessibility of the poor and needy to mental health services, to "offer preventative and early intervention strategies" and finally to "advocate for systemic change with local or national impact" (van Ameringen Foundation, Inc., 2012, para. 1). The Foundation provides funding for organizations within the Philadelphia region and metropolitan New York. The van Ameringen Foundation requires all interested organizations to submit a letter of inquiry (LOI) which summarizes the request and the dollar amount for the request prior to submitting a full proposal. Through consultation with PPR, I wrote an LOI on the organization's behalf (see Appendix A).

The van Ameringen Foundation invites organizations to submit a full proposal and schedules a site visit based on the LOI. A full proposal was written in the hopes that we would be contacted based on the submitted LOI (see Appendix B).

CHAPTER 4: DISCUSSION

The purpose of this grant proposal project was to present art therapy as a viable and culturally sensitive intervention to meet the complex psychosocial needs of refugee and asylum-seeker survivors of torture, in order to improve their overall wellbeing and provide alternative pathways to healing that circumvent verbal expression. At the start of this capstone, I did not realize how relevant this endeavor would be in the current political climate in the U. S. Though what has been dubbed the "refugee crisis" is at historic proportions, with more than 65.3 million individuals displaced from their homes (UNHCR, 2015), the changes in the political administration and the steady rise of xenophobia and hate crimes against persons of color and of various religious faiths (Farivar, 2017) may now directly impact refugees and asylum-seekers resettled in the U. S. While working on this capstone, I became increasingly aware of the multilayered experiences that refugee and asylum-seeker survivors of torture have; moving beyond the lens of trauma and psychopathology, torture is rooted in a larger sociopolitical and cultural framework, and must be situated in its proper context.

At the time of this writing, individuals from six Muslim-majority nations, Syria, Sudan, Somalia, Libya, Iran and Yemen, were barred entry into the U. S. unless they possessed a "credible claim of a bona fide relationship with a person or entity" in the U.S. for 90 days (Lee, 2017). Additionally, refugees from any country were denied access into the U. S. for the next 120 days, which will take effect until October of 2017. As refugees and asylum-seekers are members of the public most vulnerable to experiencing torture, it is possible that many survivors of torture are currently being denied access to the U. S. due to the enactment of the partial travel ban. For survivors of torture in the

process of resettlement in the U. S., they may experience discrimination and social isolation due to their status as refugees or asylum-seekers (Ellis et al., 2010; Montgomery & Foldspang, 2007). Hate crimes and attacks against Jews and Muslims have spiked in several key U. S. cities in 2016 (Farivar, 2017), some of whom may be refugee and asylum-seeker survivors of torture of these origins or faiths. In the current political climate, refugee and asylum-seeker survivors of torture may find themselves in hostile environments, threatening their sense of safety even upon resettlement.

Based not only from findings in the literature, but also on my clinical internship experiences at PPR, I learned of the importance of adopting a systems perspective in best understanding the needs and concerns of refugee and asylum-seeker survivors of torture. The interventions commonly utilized through a Western clinical lens, such as pharmacological treatment, appear insufficient in improving the mental health outcomes of survivors of torture (Kivling-Boden & Sundbom, 2001). The combination of psychoactive treatment, supportive therapy and social group support in outpatient facilities yielded mixed results (Boehnlein et al., 1985; Boehnlein et al., 2004). In addition, the overemphasis on psychopathology, with its focus on deficits and deviations from the norm, may be irrelevant or make little conceptual sense to individuals from diverse backgrounds. The ways in which we frame mental health in the U. S. may not align with individuals from refugee or asylum-seeker backgrounds, who may possess different conceptualizations of wellbeing (International Counseling and Community Services, 2015). Thus, it appears that interventions that incorporate services that address post-migration concerns would be more beneficial in improving the overall mental health and wellbeing of refugee and asylum-seeker survivors of torture. Multimodal and

wraparound interventions, which include providing additional services beyond traditional mental health treatment, can alleviate the various stressors experienced by refugee and asylum-seeker survivors of torture (Nickerson et al., 2011; Raghavan et al., 2013). Such approaches address the multifaceted needs of survivors of torture; learning English, gaining employment and housing, and receiving legal authorization to stay in the U. S. were factors that predicted improvements in their mental health (Raghavan et al., 2013).

Beyond recognizing the value of utilizing art therapy with refugee and asylum-seeker survivors of torture, this grant proposal project also taught me the importance of developing nuanced interventions that are culturally relevant and appropriate for individuals unfamiliar with the mental health models utilized in the U. S. and borne from Western psychotherapeutic tradition. In order to best serve individuals from refugee and asylum-seeker backgrounds, it is critical for mental health professionals to have a "clear understanding of refugee pre-migration trauma, issues in post-migration adaptation, the influence of dominant cultural and political values on refugees, and familiarity with human rights issues as they pertain to refugees" (Bemak & Chung, 2017, p. 305).

Reflections on Clinical Work

My findings in the literature directly informed the clinical work I conducted with the clients at PPR, helping me situate them in the various contexts and systems they were a part of. As the art therapy intern for PPR, I served as the sole individual providing mental health services onsite, and witnessed the impact that the social and legal services had for our clients. Given that PPR provided a range of services to survivors of torture to aid them on resettlement, their immigration status and other post-migration concerns, I was inspired to pursue this grant project to develop an art therapy program that would

continue after the end of my internship. It seemed like a natural fit to provide mental health-related services at an organization that already addressed the clients' post-migration concerns through their wraparound approach. In addition to meeting the concrete needs of clients, PPR also provided wellness groups and activities that promoted social support and community, taking a more holistic approach in addressing the challenges and concerns of their clients.

Through this clinical internship, I witnessed firsthand the gaps in the current mental health services provided to individuals from refugee and asylum-seeker backgrounds; whether it was limited access to facilities that provided consistent interpretation, the overemphasis on pharmacological treatment, or a lack of cultural understanding and sensitivity to the clients' backgrounds, while many PPR clients required additional psychosocial support, they were not receiving adequate treatment. Additionally, the stigma related to mental health often prevented clients from seeking psychological attention. Thus, developing an art therapy program at PPR seemed like a more viable option not only to address the clients' mental health concerns, but also to offer a modality that could be perceived as potentially less stigmatizing and threatening.

Due to the clients' familiarity with the therapeutic arts facilitated by BuildaBridge, and with the individual art therapy sessions I provided onsite at NSC, I witnessed firsthand the benefits such a program could reap if continued in the future. Over time, once my role as the art therapy intern had been clarified and clients became accustomed to the therapeutic space provided by art therapy, they began to view me as separate from their case managers, and utilized our sessions as an opportunity to verbally or visually express their emotions or to simply take time for themselves. Telling their

stories when they felt ready and at their own pace were regarded as important factors in helping survivors of torture "move on" and begin to heal (Isakson & Jurkovic, 2013). Even for my clients with limited English proficiency, utilizing art making as our primary intervention minimized the need for telephonic interpretation. Whether it be making paper beads to create bracelets as transitional objects, or weaving on cardboard looms to reflect on supports they had in their communities, art therapy provided my clients with a much-needed respite amidst the stresses in their day-to-day lives. Through the kinesthetic, repetitive motions of weaving, for example, clients would become more open to sharing their concerns and verbally expressing their frustrations regarding resettlement and other challenges they experienced. In other cases, clients worked in silence alongside me. Through gesturing, modeling, and physically and emotionally holding space for them, even if my clients did not feel ready to verbally articulate or process what we worked on in therapy, they kept coming back to sessions. Providing them with a space to openly air their disappointments, disillusions and frustrations over their current predicament through art, words, or both, helped build rapport, trust and acceptance in the therapeutic relationship.

Throughout this capstone process, I learned how crucial it was to situate the clients I served within a holistic framework, and to collaborate with their case managers to receive a more complete and nuanced understanding of the additional post-migration stressors they were experiencing. In addition to their torture experience, the clients I worked with were often resettled into contexts of deep poverty due to limited resources and financial constraints. Upon arrival to the U. S., despite fleeing persecution, their security, whether emotional or financial, was not a guarantee. Financial burdens of rent,

gaining employment, enrolling their children in school, and of navigating a system they were unfamiliar with were salient factors that impacted their mental health. In light of their very practical and real concerns about their living situation and financial struggles, at times, therapy felt like a luxury that seemed irrelevant to their current situation. How could I expect clients to focus inwardly and express their emotions regarding their traumatic experiences via art making when they had very pressing "real-world" concerns? How could I encourage them to discuss their feelings when they required assistance on other matters in their lives, such as applying for asylum or receiving work permits? Even the emphasis on emotions and on the self, revealed a culturally laden bias born from a Western psychotherapeutic tradition, one that often prioritized verbal, emotional or behavioral expressiveness (Doby-Copeland, 2013).

Last fall, I had asked a client from the Democratic Republic of the Congo to create a symbol that represented her or an aspect of her identity; after the interpreter explained my directive, she looked at me, puzzled, and said that others who knew her well, such as friends or family members, would be better at describing her. In that moment, I realized that my question revealed my bias as an individual who had been educated in a Western, typically individualistic framework. For my client, who came from a collectivistic background, it did not seem to make sense for her to define herself independently from the community she was a part of. This vignette highlights the need to develop a culturally responsive mental health model in working with individuals from refugee and asylum-seeker backgrounds, one that acknowledges the conceptual variations in understanding the self, the mind and the psyche across cultural contexts.

Within the practice of art therapy, which is born from Western psychotherapeutic traditions that often prioritize the individual and emphasize intrapsychic processes, there exists an inherent bias and "norm" that is dependent on the context in which this field came from. To borrow from Dopy-Copeland (2013), in the development of multiculturally competent art therapy, it is important to acknowledge the assumptions we make regarding psychopathology and deviations from our prescribed "norms." Instead of viewing the individual in a vacuum, where the responsibility for therapeutic change is placed solely on that person, it is crucial to contextualize clients' behaviors amidst the backdrop of their environment, experiences, cultural background, and other factors that shaped their identity. In adopting a systems perspective, not only does it recognize the impact that systemic oppression has on individuals' lives, it also offers a more holistic understanding of human beings and the complex interplay between different facets of their identities.

It is thus crucial to adopt an intersectional framework, to situate individuals within the various contexts and identities they possess. As Talwar (2010) asserted, in our work as art therapists, we need to take into account the complex, multifold identities that both our clients and we possess; beyond the confines of race, culture, ethnicity and other visible identities, we also need to acknowledge the impact of "invisible" markers such as socioeconomic status, sexual orientation, gender, religion, political affiliation and other factors. As Talwar (2010) argued, "Identity is not a fixed category, but rather a complex set of intersections that shift and change" (p. 15). Even the theories and what we consider to be "knowledge" within the domain of art therapy are inevitably shaped by the personal histories and sociocultural realities of past researchers; when we attempt to

assess and treat individuals based on the instruments and research developed by our founders, we assume that they are applicable to all populations, regardless of an individual's social context. In interacting with clients from differing backgrounds than our own, we should not approach assessments, interventions and interpretations of their images through the dominant and "universalist" lens we typically employ that unintentionally privilege a specific population.

At my internship, I was forced to confront my own biases and assumptions regarding their identities as "refugee and asylum-seeker survivors of torture." One of the clients I worked with was a man from Sierra Leone in his early thirties, who had attended a field trip to the Penn Museum that was organized for PPR clients. During the trip, as we walked through various exhibits, I was struck by his insight and vast knowledge of the arts. At one point, we stood in front of a mask from Sierra Leone, which, according to the description, was used to initiate members into a "secret society" that only certain individuals would be invited to. The client pointed to the caption, shook his head, and informed me that the "secret society" was in reality not at all a "secret"—it was actually an institution for higher education and learning. He articulated his concerns regarding how easily the public accepted information as fact because it derived from a museum. I felt angry, as if on his behalf—who gave others the right to speak for an entire group of people only to spread misinformation? What must it have felt like to see a part of one's culture displayed in a museum, for public consumption, only to be exoticized and regarded as the unknown "Other?"

After our conversation, his case manager informed me this particular client was an award-winning journalist and had recently published a book on the Ebola crisis; he

was forced to leave Sierra Leone because of his outspoken criticism of the government. I immediately felt guilty for my amazement at this client's accomplishments, as it forced me to confront my inherent assumptions and biases when thinking about refugees and asylum-seekers. To borrow from Talwar (2010), I believe it is my responsibility, as a future art therapist, to engage in a process of self-reflexivity; I need to reflect critically on how my personal history, assumptions and potential biases are created in the context of a sociocultural environment specific to me. I want to honestly examine how my privilege and personal history inevitably shape how I relate to and interact with those I serve.

In working with survivors of torture from asylum-seeker and refugee backgrounds, I learned the importance of cultural humility, which Sue and Sue (2016) have expressed as a "way of being" as opposed to a "way of doing." Though possessing the awareness, knowledge and skills to work with diverse clients is fundamental in cultural competence, cultivating an attitude of openness and collaboration with clients is crucial in developing cultural humility. At PPR, while I conducted background research to better understand the clients' countries and cultures of origin, when we entered the therapeutic space together, I regarded them as the chief experts of their experience.

It was critical for me to understand that torture, used as a tool for political and social control, also represented a grievous human rights injustice. Ignoring the context torture occurs in may "depoliticize issues such as state violence and hence may devalue the fundamental issues of causation, impunity and prevention" (Turner, McFarlane, & van der Kolk, 1996, p. 544). Especially in working with survivors of torture, it is important to adopt a social justice approach to art therapy, where we actively engage and act to work "toward equal access and opportunity for all people" (Sue & Sue, 2016, p.

749). Beyond focusing on the intrapsychic factors influencing the clients I served, it was critical for me to validate their outrage and anger towards their perpetrators, and to acknowledge what happened to them as a violation of their inherent dignity as human beings. As Gipson (2015) asserted, being culturally competent is insufficient in truly addressing the social inequities experienced by those we serve, especially those whose intersectional identities are marginalized. We need to move beyond the confines of the therapy office to advocate for change and reform on a systemic scale.

Reflections on the Grant Writing Process

I ultimately was unable to submit the van Ameringen grant proposal on behalf of PPR, as we discovered midway through the process that another department in NSC was applying for the same grant. As PPR exists as a collaborative formed by three nonprofit organizations, one of which included NSC, we were not eligible to apply for the van Ameringen Foundation grant because we would then be competing internally for the same funds. Despite the disappointment and frustration I felt upon learning that I could not apply on behalf of PPR, I gained many insights during this grant writing process.

Firstly, I was fortunate that my internship site was willing to serve as my partnering organization, as the project coordinator was familiar with the work I was doing as an art therapy intern and saw the value of developing an art therapy program onsite at NSC. I learned the ins and outs of the organization fairly early on during my internship, which lent itself to the grant writing process when I had to reflect on the agency's mission and values, as well as their capacity for carrying out the project at hand. I learned of the importance of collaborating with my partnering organization through frequent correspondence with the project coordinator, in order to ensure that I was fully

capturing PPR's mission and values in the LOI and proposal. To make the case that PPR would be best equipped at creating and developing an art therapy program to meet the multifaceted needs of survivors of torture, I had to educate myself on the range of social and legal services PPR provided for its clientele, and to conceptualize where art therapy would fit within this existing framework. Working directly with the project coordinator and case managers of PPR further reaffirmed my desire to secure funding for an art therapy program with this collaborative, as I witnessed firsthand the program's commitment to administering culturally responsive services that placed clients at the forefront of their decision making.

When it came to researching funders, the Regional Foundation Center served as a helpful tool for finding foundations interested in funding programs related to education, mental health, community arts, immigrants and refugees. However, what proved to be the greatest challenge was identifying foundations that would provide the amount of funds necessary to develop and implement an art therapy program; many of the grants I found were sufficient in financially supporting smaller projects, which could be in the form of workshops or community engagement projects, but not to develop and sustain an entire program. Aside from the amount of funding provided, the van Ameringen Foundation grant appealed to me also because of its interest in mental health and refugee communities, a combination that proved to be rare during my grant search. From my clinical work, it became evident that the current mental health system in the U. S. was inadequate in addressing the needs of individuals from refugee and asylum-seeker backgrounds. Creating and developing nuanced and culturally responsive interventions is critical in promoting resilience and healing for survivors of torture.

The lack of funders in this arena of refugee mental health signaled to me the importance for mental health professionals to engage in the realm of social justice and advocacy. Doing so will not only bring attention and awareness to underserved populations, but also promote change on a larger scale, so that there can be more funding opportunities in the realm of refugee mental health. It is thus important to advocate for mental health interventions that may be considered "alternative" from the typical ones utilized in the U. S., such as verbal therapy and pharmacological treatment, in order to meet the multifaceted needs of survivors of torture.

While writing the LOI, I initially experienced difficulty organizing and structuring it in a manner that would make the objectives and rationale clear to the reviewer. As a writer, I tend to prefer utilizing metaphors and vignettes to illustrate my point as opposed to explicitly spelling out my arguments or viewpoint. I knew that my writing preference would not necessarily lend itself to writing a convincing LOI, which needed to be succinct, clear and explicit in outlining why developing an art therapy program for PPR was an endeavor worth funding. While the LOI criteria listed on the van Ameringen Foundation website provided guidance on what elements to include, I was still unsure on how to proceed. Through consulting the Grantspace website, an online self-service tool provided by the Foundation Center, I researched LOI templates and examples that gave me a better understanding on how to format and structure my LOI. By creating sections that clearly delineated which portion of the LOI prompt I was addressing, it provided me with a structure on how to compose my LOI so that it was clear not only for me, but for the reviewer as well.

Writing the proposal forced me to reflect on how to evaluate the impact that art therapy would have through measurable and quantifiable outcomes, in order to justify providing funding for such a program. In the mental health profession, we are often cognizant of the importance of documentation and utilizing clinical language that lend credence to our profession, in order to convince service providers of the benefits art therapy can reap for those we serve. While so much of art therapy centers on the intangible, of utilizing another mode of expression that casts aside the centrality of words, it is important to develop clinical language that showcases this modality's unique benefits through measurable outcomes.

Lastly, the grant writing process reiterated to me the value of being flexible. So much of this capstone project entailed collaborating with others, and I relied heavily on my partnering organization to supply documents that would be added to the grant application. Given that there were so many moving pieces during this process, I had to learn to trust others to supply the materials I needed and to partially relinquish my need for control. Though I was unable to submit the grant application on behalf of PPR, the skills that I cultivated in this process are ones I can utilize in future endeavors, whether to propose an art therapy program for other organizations or facilities that could benefit from it, or to further legitimize the field of art therapy by evaluating its benefits through measurable outcomes that appeal to service providers.

Implications for Future Research

One of the key challenges I encountered during this capstone was differentiating between immigrants, refugees, asylum-seekers and asylees due to the conflation of these terms in the media, census data, and other resources. While refugees are a type of

immigrant, there are differences between individuals who have fled contexts of forced migration versus international students, working professionals and others who chose to come to the U. S. for economic aspirations. Statistics on asylum-seekers and asylees are even more difficult to parse out, as many of these individuals arrive undocumented and are typically not represented in census data. It is thus important to define these terms and utilize them appropriately; the words we use have power, and they shape and inevitably influence the public's perception through the media. When we conflate immigrants, refugees, asylum-seekers and asylees, we fail to acknowledge how these varying immigration statuses carry different circumstances.

Additionally, it is crucial to examine survivors of torture in their own right, as the literature on trauma with refugees and asylum-seekers is often conflated with torture. The consequences of torture should be investigated as its own unique phenomenon with its own set of circumstances. While torture can serve as a traumatic event for an individual, its use as a tool for political and social control, the intentionality behind that action, and the fact that it is perpetrated by those in power, create a host of consequences specific to this experience.

Future research examining the implications of art therapy specifically for refugee and asylum-seeker survivors of torture will be critical in providing support that this modality can mitigate the cultural and linguistic barriers that tend to prevent individuals from seeking mental health treatment. While there were a handful of quantitative studies that examined the benefits of the creative arts therapies for children and youth of refugee backgrounds (Quinlan et al., 2016; Rousseau et al., 2009; Ugurlu et al., 2016), research

conducted with adults tended to be qualitative with a broader focus on trauma (Fitzpatrick, 2002; Isfahani, 2008; Kalmanowitz, 2016; Kalmanowitz & Ho, 2016).

To lend further support for administering the creative arts therapies with refugee and asylum-seeker survivors of torture, more research needs to be conducted to showcase the unique benefits this modality offers to this population. While multiple case studies and qualitative research provide an understanding of individual experiences of migration, trauma and the challenges of acculturation and resettlement, the addition of quantitative or mixed-methods research can lend further support for art therapy's effectiveness as a mental health intervention for refugee and asylum-seeker survivors of torture. Beyond examining art therapy's potential effectiveness, conducting research on survivors of torture's attitudes towards receiving art therapy versus other psychosocial interventions could be another avenue for future research.

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Appendix A

Letter of Inquiry

Philadelphia Partnership for Resilience (PPR)
Nationalities Service Center
1216 Arch Street, 4th Floor
Philadelphia, PA 19107

Mr. Hugh Hogan, Executive Director
van Ameringen Foundation
509 Madison Avenue, Suite 2010
New York, NY 10022-5517

Dear Mr. Hogan:

I am submitting the following as an initial inquiry for the van Ameringen Foundation to consider a full proposal for an art therapy program for the Philadelphia Partnership for Resilience (PPR).

Introduction
To address the multifaceted needs of immigrant, refugee, asylum-seeker and asylee survivors of torture and their families, PPR offers comprehensive and culturally sensitive legal and social services through in-house programs and referrals to outside agencies. As the only program specifically for survivors of torture in Philadelphia, PPR is a collaborative built on partnerships with Nationalities Service Center (NSC), the Hebrew Immigrant Aid Society Pennsylvania (HIAS PA) and BuildaBridge International.

Given the stigma, shame, secrecy and silence often associated with acts of torture, individuals who have experienced it often bear the mental and physical consequences alone. Through intensive case management, legal assistance, mental health and health referrals, social support and group work, we hope to help our clients rebuild their lives and heal from the physical and psychological wounds of torture.

The Activity and the Need It Serves

PPR seeks to develop an art therapy program onsite at NSC to provide mental health services to survivors of torture and their families. The program will consist of offering both group and individual art therapy sessions, conducted by a master's level art therapist. Art therapy groups will be offered twice a week, with an emphasis on promoting social support, increasing clients' sense of self-efficacy and confidence through the creative process, fostering a safe and non-judgmental environment to share their stories and reflections, and to create a sense of community between individuals who have experienced torture. Themes will revolve around resettlement, identity, the concept of "home," and identifying strengths and supports clients have in the current context. Individual art therapy sessions will be tailored to meet specific client needs, ranging from: alleviating stress related to both their trauma history and acculturative challenges; reducing anxiety; addressing aspects of their torture history; identifying client strengths, areas of growth, sources of support and coping strategies; promoting emotional expression through the creative process; providing opportunities for choice and autonomy in art-making; and boosting self-esteem through increased mastery of various art materials.

The Center for Victims of Torture (CVT) predicts that as many as 1.3 million refugees living in the United States have experienced torture in their countries of origin. Refugees and asylum-seekers are often members of the population most vulnerable to torture, likely due to the lack of protection from their governments, as well as the persecution they experience that forces them to flee their countries of origin.

Due to the traumatic nature of torture, which may then be exacerbated by the stresses related to adjusting to life in a novel country, survivors of torture are at a greater likelihood of developing negative mental health outcomes such as: impaired memory, insomnia, depression, anxiety, and post-traumatic stress disorder (PTSD). Most Western mental health interventions are based on verbal therapy and pharmacological treatment. Such treatment models may not be culturally relevant or appropriate for this population, who may lack the linguistic skills necessary to express themselves in English and whose symptoms may not align with traditional Western diagnoses. As a result, the use of nonverbal expressive therapies, such as art therapy, can serve as an effective intervention to address the complex mental health needs of survivors of torture. Additionally, given the centrality of the visual arts across time and various cultural contexts, art therapy can serve as a less stigmatizing and culturally relevant intervention for clients from an array of backgrounds. Art therapy utilizes the creative process of art making to enable and empower individuals to express emotions that may be difficult to put into words.

Statement of Agency Capacity

From October 2016, we piloted art therapy services through our collaboration with BuildaBridge International, where a second-year Drexel University art therapy and counseling graduate student provided individual art therapy sessions to PPR clients. By not having to rely on verbal language, art therapy provided a nonthreatening way for survivors of torture to express and confront their traumatic experiences through the creative process and ultimately, to reclaim their sense of agency and their voice.

The addition of this in-house mental health service provided PPR clients with opportunities to reclaim their sense of agency by beginning to share their stories on their own terms. Due to PPR's partnership with BuildaBridge International, clients have already been exposed to the value of the therapeutic arts, and have been receptive to engaging in art therapy, as evidenced by the high attendance to the individual art therapy sessions and the consistent turnout for therapeutic arts groups at NSC. Due to the social and legal services provided through PPR, clients are already familiar with coming to NSC for case management and will benefit from receiving mental health services onsite in a space familiar to them. Referral systems, clinical intake assessments, clinical documentation and other protocols have already been put in place to implement a future art therapy program for PPR clients through work done by the current BuildaBridge art therapy intern.

Budget

As part of our initiative to address the multifaceted needs of survivors of torture, PPR seeks funding in the amount of $50,000 from the van Ameringen Foundation to develop an in-house art therapy program at NSC. The proposed budget will encompass the following:

1. Hiring a part-time art therapist, who will provide services three days a week
2. Purchasing art supplies and equipment
3. Providing tokens for public transport for clients who attend individual and/or group sessions
4. Interpretation and/or translation fees

Conclusion

Through the development of an art therapy program onsite at NSC, PPR strives to "increase the accessibility of the poor and needy to mental health services," which directly aligns with the van Ameringen Foundation's mission. By providing art therapy services, which are more culturally appropriate and less stigmatizing to immigrant, refugee, asylum-seeker and asylee survivors of torture compared to traditional Western interventions, PPR hopes to meet the complex and multifaceted needs of those we serve. Torture serves to alienate individuals from what makes them human, robbing them of their voice, dignity and sense of self. Not only can art therapy serve to address the traumas experienced by survivors of torture, but it can also provide them with an alternative means of telling their stories without having to put them into words, visually and at their own pace.

We appreciate your time in reviewing our aspiration to gain funding for this program and would greatly value the opportunity to submit a full proposal to the van Ameringen Foundation.

Thank you for your time and consideration.

Appendix B

Proposal

Background

Since its inception in 2009, the Philadelphia Partnership for Resilience (PPR) was created as a collaborative between Nationalities Service Center (NSC), the Hebrew Immigrant Aid Society Pennsylvania (HIAS PA) and BuildaBridge International (BaB) to meet the complex needs of adult immigrant, refugee, asylum-seeker and asylee survivors of torture. PPR provides extensive case management, referrals to comprehensive mental health and health services, and legal and social assistance. However, the mental health of those PPR serves continues to be a growing concern due to the stigma and misconceptions often attached to mental health. Additionally, given the ongoing global crises of war, genocide, and religious and political persecution, there is an increased demand to address the complex needs of survivors of torture.

Statement of Need

Refugees, asylum-seekers and asylees are members of the population most vulnerable to torture; the Center for Victims of Torture (CVT) predicts that as many as 1.3 million refugees in the United States have experienced torture in their countries of origin. Often perpetrated by government officials or those in positions of power, secrecy, silence, and shame often accompany the torture experience, denying individuals their voice and sense of dignity. Such individuals are often alienated from their families and broader community, and may be fearful of disclosing their torture experience out of concerns for safety and distrust of authorities, even upon resettlement in the U. S.

When refugees arrive in the U. S., in addition to the pre-migration stressors related to their torture history, resettlement is a long and arduous process. Financial insecurity, navigating cultural and linguistic challenges, changes in family structures, potential social isolation and other post-migration factors exacerbate the stressors already experienced by this population. Asylum-seekers experience additional challenges due to their insecure immigration status, often existing in a state of limbo, unable to move forward with their lives until they receive the necessary documents to work, receive an ID, social security number, and thus become eligible for other benefits. Coupled with the torture experience and the trauma associated with forced migration, this population is thus at a greater likelihood of developing complex psychopathology. As such, survivors of torture are vulnerable to developing negative mental health outcomes such as: depression, anxiety,

post-traumatic stress disorder (PTSD), impaired memory, somatic complaints, chronic pain, insomnia and loss of appetite.

Traditional Western psychotherapeutic treatments, which tend to emphasize pharmacology and verbal therapy, may not be culturally appropriate or sensitive in meeting the needs of survivors of torture. As opposed to viewing survivors of torture through a strict clinical lens that emphasizes psychopathology, approaches that emphasize holistic conceptions on mental health may be more appropriate in addressing the complex needs of this population. Given the traumatic nature of torture and forced migration, refugees and asylum-seekers may not even have the words to describe or process what happened to them. Art therapy can be a more culturally appropriate means of addressing the traumas experienced by survivors of torture as it is a primarily nonverbal intervention. When words fail, images and the creative process can become powerful tools of emotional expression. When individuals lack the linguistic skills necessary to express themselves, art can provide an alternative pathway to communicating their stories in an immediate and ineffable manner.

Program Design & Objectives

PPR seeks funding for an art therapy program at NSC in order to provide onsite mental health services to those we serve. The program will consist of offering individual and group art therapy services to survivors of torture and their families, conducted by a part-time master's level art therapist who will work onsite three days a week.

Art Therapist Job Description

Interested applicants for the position of part-time art therapist at PPR must meet the following requirements:

- Master's Degree in Art Therapy from an American Art Therapy Association approved program
- Bilingual or multilingual (Arabic and/or French preferred)
- Demonstrates clinical and cultural competence in Art Therapy
- Must be a self-starter, independent, and possess good organizational skills
- Must have at least one year of clinical experience, preferably in working with culturally diverse populations

Individual Art Therapy Sessions

Referrals

The art therapist will work closely with PPR case managers to identify clients who require additional mental health services beyond those they receive offsite at other facilities.

Clients who are experiencing high levels of distress due to both the resettlement process and their torture history will be referred to art therapy services. When clients are first referred to PPR, in intake session, the case manager evaluates their torture history, mental health, and levels of distress, utilizing measures such as the Refugee Health Screener-15

(RHS-15). Translated into over 20 languages, the RHS-15 been used to evaluate symptoms of depression, anxiety, PTSD and emotional distress, and is often reevaluated every six months. There are a total of 15 items scored on a 0 to 4 severity scale. The screening is positive when the total score of questions 1-14 is greater than or equal to 12 (maximum is 46) or their distress thermometer is greater than or equal to 5 (maximum is 10). Those whose screenings are positive and who express interest in receiving additional psychosocial support will be referred to the art therapist for individual sessions.

Case managers will be required to fill out a referral form for art therapy services, detailing basic information on the client and reasons for referral (see attached referral form). Before working with the identified clients, the art therapist will review the clients' files to receive background on their torture history. Doing so will not only help the art therapist inform treatment, but also minimize harm by not forcing clients to retell their torture experiences during the initial art therapy clinical intake, given the amount of times survivors of torture are required to tell their torture history to receive services.

Structure

Through the referral process, the part-time art therapist will work with 8-10 clients a week based on referrals from the case managers at PPR. Individual art therapy will consist of 45-50 minute sessions scheduled weekly or biweekly, depending on client needs and availability, and will be conducted onsite at NSC.

Objectives

While treatment goals will be developed based on specific client needs, they can include the following:

- Alleviate stress related to both trauma history and acculturative challenges
- Reduce anxiety, especially for asylum-seekers in the process of applying for asylum
- Extensive psychotherapeutic work revolving on trauma and torture history
- Identify client strengths, areas of growth, sources of support and coping strategies
- Promote emotional expression through the creative process
- Provide opportunities for choice and autonomy in art-making
- Increase self-esteem through promoting mastery of various art materials
- Empower clients to tell their stories when they feel ready and at their own pace

Art Therapy Groups

Structure

All PPR clients will be invited to attend art therapy groups, which will be offered twice a week. The groups will run for 90 minutes. Two different types of groups will be offered to PPR clients.

Art Therapy Group

The art therapy group is structured so each session focuses on a specific art therapy task/directive which clients will be encouraged to explore, process and share with the group. Themes of potential tasks/directives will revolve around the following: resettlement, identity, the concept of "home," and identifying strengths and supports clients have in the current context. Clients will be encouraged to attend the group as consistently as possible to create a sense of community and trust, as well as to arrive on time to foster an atmosphere of consistency and mutual respect of the group process.

Objectives

By participating in the art therapy group, the identified goals for clients are the following:

- Build a sense of community by encouraging clients to share their stories by discussing their artwork or reflections they have about others' work
- Increase clients' sense of self-efficacy and confidence through increased mastery over art materials and processes by demonstrating basic art techniques
- Provide an opportunity for clients to reduce anxiety and stress through art making
- Foster a safe and non-judgmental environment where clients have the opportunity to share their stories and reflections
- Utilize the nonverbal nature of art therapy to encourage creative visual expression so clients with more limited language proficiency can share their narratives and insights through an alternative means
- Promote social support through the creation of the group and minimize social isolation by providing clients with opportunities to connect with and support each other

Open Studio Art Therapy Group

The open studio model refers to the creation of a shared art making space where art materials are provided but no specific theme or task is assigned to the group; the art therapist plays a supportive role, offering guidance and assistance when called upon. Unlike art therapy groups, which typically have a directive or specific theme that drives the content of the group's creative process and resulting artwork, the open studio encourages individuals to engage in independent artwork of their own choosing. Each individual is responsible for deciding what he or she wants to create and explore, and is encouraged to realize their unique vision without constraints from the facilitator. The art therapist's role within this context is to create an environment for curiosity, openness and safety by taking a non-judgmental stance. The art therapist will interact with clients primarily on an individual basis, demonstrating how to use various materials and suggesting initial project ideas for those unfamiliar with the creative process. The door to the open studio will be propped open and clients can drop in based on their convenience and availability, encouraged to spend as little or as much time as they are able to engage with art making. Client's children will also be welcomed to attend the open studio to accommodate client needs.

Objectives

By participating in the open studio art therapy group, the identified goals are the following:

- Promote sense of autonomy and control by inviting clients to engage in independent art projects of their choosing
- As a starting point for those unfamiliar with art making, encourage creativity and experimentation by introducing clients to a range of art materials (acrylic paint, watercolors, markers, colored pencils, pencils, found objects, textile arts, collage, mixed media) each week to foster an "artist identity"
- Foster a sense of community by encouraging clients to share their artwork and reflections at the end of session
- Increase self-efficacy and confidence through increased mastery over art materials, processes and techniques
- Reduce stress and anxiety through engagement with the creative process
- Encourage peer interaction and social support by providing opportunities for clients who are more comfortable with art making to assist peers who may experience difficulty

Qualifications and Capabilities of PPR

Since 2009, PPR has existed as a hub for adult immigrant, refugee, asylum-seeker and asylee survivors of torture and their families, as the only program for survivors of torture in Pennsylvania. Through its partnerships with HIAS PA and BaB, PPR clients receive a comprehensive range of both legal and social assistance. As of October 2015, PPR has served 455 primary survivors of torture from 40 different countries, in addition to providing services to their families. PPR has focused on outreach and training social service providers, medical personnel and community-based organizations on how to identify and screen for torture histories, as well as providing extensive programming at NSC to engage clients in group work/social support and intensive case management.

Onsite at NSC, groups offered are the following: Advisory Council meetings, where all PPR clients are invited to provide feedback on their experiences with the program; Life Skills seminars; outings to events in the Philadelphia community; psychoeducation; men and women's support groups, facilitated by master's level Social Work interns; and men and women's trauma-informed yoga. Through PPR's collaboration with BaB, clients have already been exposed to the value of the therapeutic arts and would greatly benefit from receiving art therapy services on an individualized basis onsite at NSC.

NSC piloted an art therapy program through our partnership with BaB and Drexel University's Art Therapy and Counseling Program from October 2016-June 2017. Through close collaboration with external mental health supervisors and PPR case managers, the art therapy intern developed referral forms, clinical intake assessments, progress notes and other protocols to establish an art therapy program at NSC. Under a trauma-informed framework, it is crucial to provide clients with a sense of consistency and predictability in their environment. The art therapy intern also provided individual art therapy sessions and groups to PPR clients as part of her three day a week internship requirement at NSC.

If awarded the van Ameringen Foundation Grant, offering art therapy services at NSC will provide clients with an increased sense of safety, given that they are already familiar with the space from receiving social and legal services onsite.

Program Evaluation

By implementing an art therapy program that is run by a dedicated art therapist, PPR clients will be given opportunities to tell their stories when they feel ready and at their own pace, utilizing a primarily nonverbal means of expression to circumvent potential language barriers in a nonthreatening and contained manner. To document and evaluate progress, the art therapist will be responsible for writing clinical progress notes (see attached) and evaluations of clients served. Treatment plans will be developed in collaboration with clients to tailor them to meet clients' specific needs. Both individual therapy and group sessions will be documented.

For individual art therapy sessions, the first session typically consists of psychoeducation into the nature of therapy and mental health, expectations regarding treatment and an opportunity for clients to ask questions about their treatment. Both a verbal clinical intake assessment and a battery of art therapy assessments will be conducted to document client history and provide insight into client's presenting problems. At intake, the art therapist and client will develop a list of goals the client expects to work on in therapy, which will help inform treatment. Reviews of treatment plans will be conducted every three months to track and evaluate client progress, ensuring that client goals are met.

Art therapy assessments will be administered to better understand an individual's mental health through assessing color usage, line quality, observing the client's creative process, and the individual's verbal explanation of the image. Based on client's personal interpretation of the art and the art therapist's clinical judgment, art therapy assessments will provide an additional means of understanding the client's mental health concerns. Art therapy assessments will be conducted at intake and then every three months to evaluate and re-assess client progress.

The resulting art created in both individual and group sessions will be saved, photographed or otherwise documented, stored in locked filing cabinets onsite as part of HIPAA requirements and ethical guidelines. Clients will be invited every three months to complete self-reports and questionnaires regarding their progress in art therapy.

Budget

Part-time art therapist salary	Includes compensation, medical & other standard benefits as offered to other part-time staff	$25,000.00
Supervision by a Licensed Professional Counselor (PA) who is a board-certified, registered art therapist		$ 2,500.00

Art supplies, consumables	Supplies that need to be replaced regularly (e.g., paper, colored pencils, pencils, oil pastels, chalk pastels, glue, paints, yarn, modeling clay)	$ 3,000.00
Art supplies, equipment	Storage equipment, art cart to transport supplies easily	$ 300.00
Conferences, conventions and continuing education		$1,500.00
Tokens for public transport for individual sessions & groups		$5,184.00
Interpretation services for individual sessions & groups		$11,516.00
Miscellaneous translation fees	For art therapy tasks, flyers, & brochures	$ 1,000.00
Total		**$50,000.00**