Instructor: Karen M. Fondacaro, Ph.D.
Meeting Time: Thursdays 11:30am – 1:30pm
Meeting Place: 114A Dewey Hall
E-mail: Karen.Fondacaro@uvm.edu

Course Description
The goal of this course is to provide comprehensive training in the mental health assessment and treatment of refugees, immigrants and asylum seekers. Connecting Cultures is a clinical-science specialty service of the Behavior Therapy and Psychotherapy Center (BTPC) in the clinical psychology program at the University of Vermont. Connecting Cultures is specifically designed to promote well-being and mental health services for refugees resettled in Vermont. The Connecting Cultures program has four unique components, providing an integrated, culturally sensitive approach to working with these populations, including: 1) community-based outreach services; 2) direct clinical services; 3) mental health research and 4) training. Each of these four integrated components informs and enhances the others. Specifically, a community-based forum is used to provide clinical outreach services (e.g., parenting skills, stress management) and direct services are provided for an array of mental health concerns. Additionally, evaluative research involving understanding refugees’ mental health is ongoing. Finally, an emphasis of the program is to share information with other professionals through a collaborative training format, and to show how research findings and clinical work inform one another.

Course Readings
Please see attached reading list. It is in a pdf-format and we will discuss in further detail during vertical team meeting.

Course Expectations
- Active participation on clinical supervision team
- Students will be prepared to discuss their own cases, in addition to offering feedback regarding other group members’ cases
- Continued professional and ethical development
- Ongoing discussion of professional and ethical conduct will be emphasized during the semester
- Students are encouraged to raise issues as they arise
- Students will consult with instructor in the event of an emergent clinical issue. Additional contact numbers will be provided.
- Students will provide notes for instructor’s signature in a timely manner
- Students will carry client caseloads as agreed upon between the student and the clinic director

**Assessment/Evaluation**

It is the treating clinician’s responsibility to ensure that the Connecting Culture’s comprehensive assessment is completed as follows:

Individuals seeking treatment through the Connecting Cultures program at the BTPC are given a standard clinical assessment which includes a clinical intake interview and the following self-report assessments.

**Clinical Intake Interview**

During the clinical intake interview, the clinician will review the reason for referral, history of current and past psychological problems, social/developmental history, educational history, medical history, current medical treatment information. This interview also includes demographics (gender, age and ethnicity) as well as socioeconomic information. This interview will contain the individual, environmental and immigration factors that will be analyzed to determine their potential influence on treatment outcomes.

The duration of the clinical intake interview is variable, and it is common for it to be divided across multiple visits within a three week period. All eligible clients entering treatment within the Connecting Cultures program in the BTPC will be asked to give informed consent for participation in this research project. If consent is given, the information obtained during the standard clinical assessment (both the clinical intake interview as well as the self-report assessments) will be used for both clinical and research purposes. If consent is not given, the information will still be collected and used for clinical purposes only. The Stigma and Satisfaction Survey is the only additional self-assessment that the consenting clients will complete as participants in this study.

Many clients seeking treatment within the Connecting Cultures program require the use of an interpreter in session. Interpreters are either (a) provided via community organizations, such as the Association of Africans Living in Vermont (AALV), or (b) obtained via phone interpretation services (typically in situations where a client’s local ethnic community is quite small and the client’s concerns regarding a local interpreter’s confidentiality would hinder treatment efforts). Community interpreters will be required to sign a confidentiality agreement.

The self-report assessments are completed on paper by the client as they are read out loud by the clinician and translated by the interpreter if necessary. All assessments are entered into a computer database.
The ASR is an empirically-derived self-assessment of psychological problems for adults ages 18-59. Each item can be endorsed on a 3-point scale: (0) not true (1) somewhat or sometimes true; (2) very true or often true. The ASR yields a quantitative score for 8 empirically-based symptom clusters (syndromes/problems) produced by factor analyses of the correlations among items. The 8 syndromes are anxious/depressed, withdrawn, somatic complaints, thought problems, attention problems, aggressive behavior, rule-breaking behavior, and intrusive behavior. The assessment items can also be scored along 6 Diagnostic and Statistical Manual-IV disorders relating to depression, anxiety, somatic, avoidant personality, attention-deficit/hyperactivity, and antisocial personality problems.

• Hopkins Symptom Checklist (HSCL-25; Parloff, Kelman, & Frank, 1954)
The HSCL-25 is a 25-item measure evaluating current mental health symptoms, in particular anxiety and depressive symptoms. The HSCL-25 has been well-established as an appropriate measure for use within refugee populations. This scale has been found to be internally consistent in refugee populations with Cronbach’s alpha coefficients of 0.92 for the total scale, 0.79 for the anxiety scale and 0.88 for the depression scale.

• Harvard Trauma Questionnaire (HTQ; Mollica & Caspi-Yavin, 1991)
The HTQ is a 30-item list which consists of 16 symptoms derived from the DSM-III-R criteria for PTSD, and 14 items derived from clinical experience with trauma survivors. Participants are asked to indicate to what extent they have suffered from each of the symptoms during the previous month. The scale is a 4-point Likert scale: (0) have not suffered at all; (1) suffered somewhat; (2) suffered quite a lot; (3) suffered severely. Sum scores for vigilance, avoidance, and intrusion are formed. Vigilance includes items such as the feeling of being on guard and of not having anybody to rely on (15 items, Cronbach’s alpha .91), avoidance consists of avoiding activities that reminded the person of traumatic events (10 items, Cronbach’s alpha .81), and intrusion includes items such as recurrent thoughts about the trauma and having nightmares (5 items, Cronbach’s alpha .79). The HTQ has been used in multiple refugee groups, including but not limited to Indochinese, Bosnian, Cambodian, Vietnamese, Iraqi, and East African populations.

• Alcohol Use Disorders Identification Test (AUDIT, World Health Organization, 1992)
The AUDIT is a brief assessment used to identify persons with hazardous patterns of alcohol consumption, and asks questions that are consistent with ICD-10 definitions of alcohol dependence and harmful alcohol use. The AUDIT was developed on multicultural samples with varying cutoff points yielding sensitivities for problem drinking indices that were in the mid 0.90's.
Specificities across countries and across criteria averaged in the 0.80’s. Cultural appropriateness was an important consideration in the development of the AUDIT and many studies have found the assessment a valid and reliable measure of current alcohol use disorders and several reports have found the measure to have high internal consistency.

- **Stigma and Satisfaction Survey**
  These questions have been developed at the BTPC and relate to the existing knowledge and attitudes towards mental illness as well as the client’s perception of satisfaction with services provided at the BTPC.

  The YSR is similar to the ASR in that it is an empirically-derived self-assessment of psychological problems with items endorsed on a 3-point scale yielding a quantitative score for 8 empirically-based psychological problems and 6 DSM-IV-oriented mental disorders. It differs in that it is specifically designed for children ages 11-18.

- **Child Behavior Checklist (CBCL; Achenbach, T.M. & Rescorla, L.A., 2001)**
  The CBCL is similar to both the YSR and the ASR in that it is an empirically-derived self-assessment of psychological problems with items endorsed on a 3-point scale yielding a quantitative score for 8 empirically-based psychological problems and 6 DSM-IV-oriented mental disorders. It differs in that it is specifically designed to be completed by the parents of children ages 6-18.

- **UCLA Posttraumatic Stress Disorder (PTSD) Reaction Index for DSM-IV (Pynoos et al., 1998)**
  The UCLA PTSD Reaction Index for DSM-IV is a revised version of the DSM-III-R scale that is geared closely to DSM-IV criteria for assessing PTSD in children. This new version has child self-report and parent’s report about their child forms. There are twenty items (PTSD symptoms) that map directly onto the DSM-IV criterion B (intrusion), criterion C (avoidance), and criterion D (arousal) for a PTSD diagnosis.