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President's Perspective

Mary Kay Bogumill, Ph.D., MPA President

At this moment, our legislative committee is spending long hours working hard on important bills going through this session and they will provide a summary of that work. We are grateful to them and to our Executive Director, Marti Wangen, for helping us stay abreast of pivotal issues thereby keeping us aware of opportunities as well as potential threats to our profession.

Several months ago, MPA Legislative Committee also thoroughly reviewed the Board of Psychologist's (BoP's) draft bill which laid out changes to Montana licensure requirements for psychologists. The BoP had asked for MPA's input. MPA Board asked questions, discussed specifics, clarified the meaning and intent of some language, and finally voted to support their bill. The BoP had spent many hours to carefully research the changes to licensing requirements of psychologists in Montana. The bill was introduced to committee and was very favorably received. Members of the committee seemed to be acutely aware of the shortage of psychologists and the need for our level of work. The resultant changes will make it less difficult to attract more psychologists to work in our state without compromising the quality of practitioner upon which we insist. It also allows for temporary licensure of postdoctoral supervisees. Both changes will help provide relief for overworked psychologists and those needing our skills.

As we get new psychologists to our practices or our communities please remember to introduce them to our Association and trust the value that is here. Each of us is needed to strengthen our Association to move forward with enthusiasm and vitality.

Wishing you all a healthy 2021 and I hope to SEE you sometime soon.

Montana Psychological Association Seeks Federal Advocacy Coordinator

After years of effective and dedicated service, Michael Bütz recently stepped down as our Federal Advocacy Coordinator. MPA is seeking someone that would be willing to take on this role.

The FAC position serves as a member of MPA's Legislative Committee and works to establish and cultivate relationships with each of our state's congressional delegates. The FAC acts as the key contact on the Hill for MPA regarding relevant mental health issues. They also act as the main communicative liaison for MPA regarding federal initiatives and help keep MPA members informed. For example, the FAC would take the lead on responding to, and communicating to membership, all APA *Action Alerts.*

If you believe you may be interested in filling such a position, and would like to be considered, or simply would like more information, please contact Greg Machek at gmachek@hotmail.com.

Inside This Issue

2021 Legislative Transmittal Report

Sarah Baxter PhD. , MPA Legislative Chair

Your MPA Legislative Committee members have been BUSY during the early phase of the MT 2021 Legislative session. There have been several bills that could potentially affect psychologists' scope of practice as well as the process of licensure for colleagues licensed in another state and post-doctoral residents. We have a well-functioning committee of 5 dedicated members, a fact that we are celebrating since for many years we have had at best 1+ people scrambling to find whoever we could weigh in on proposed bills. We did our best, but we are new and improved this year!

With this new, improved model in place we are considering ways to make ourselves even more effective. We are learning early this session that we could use more expertise across a variety of specialties! Not every legislative session is this manic in its energy and process however we can anticipate that coming sessions will bring with them foreseen and unforeseen efforts that will impact psychologists in MT and the people we care for. As such, we are asking you, our colleagues, to consider becoming "content area specialists" so that we can call on you when content specific bills are proposed. For example, we were asked to assist a legislator on a bill that provides mental health services for women who are adopting out a child. If we knew of a colleague who had knowledge in this area, we could have called upon this psychologist to assist with the language for that bill. There have been numerous other times when we have needed particular types of expertise. The downside of working on these pieces of legislation is that things come up quickly and need speedy responses. That said, when it's a content area with which you are familiar, it's fairly simple to put together talking points or advise on appropriate testimony.

Working with a team during such a complex and fast-paced start to the Session has been inspiring and rewarding. If you have any interest in joining our team, please reach out to either Sarah Baxter (sarahbaxterphd@gmail.com) or Michele McKinnie (michelecatherine@hotmail.com) the co-chairs of the MPA legislative committee. Also, if you would ever like an update on the bills we have reviewed, please reach out to either of us.

We are happy to report that there have been several creative bills that attempt to expand citizen access to mental health care. There seems to be bi-partisan understanding of the dire level of need in various underserved parts of our state. We have also worked collaboratively with insurance companies and the Psychiatric Association on a bill establishing mental health parity for Integrated Behavioral Health services. This bill has just passed the Senate (50 – 0) and will now be moving to the House. You can view that bill on the Montana Legislative website (www.leg.mt.gov); just search for SB 217. Additionally, the Montana Psychological Association's website lists all the bills we are following this session and is accompanied by a preference list. To access, go to the MPA website at: www.montanapsychologicalassociation.org. Click on the "Members Only" link (which will only display if your dues are current), and then click on the link: 2021 MPA Legislative Preference List. The list is generated by the state, so it is always current.

Please do not hesitate to reach out to us with any

APASI Small State Organizational Grant Notice - Thank you!

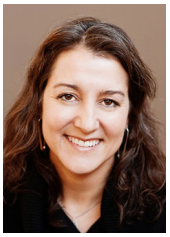
MPA recently received this information from APA —without the organizational grant, MPA members would need to pay double the dues to keep the association offices open.

We are pleased to inform you that the Montana Psychological Association has been awarded a Small State Operational Grant from APA Services in the amount of $13,500 to help fund Executive Director salary and lobbyist services.

APA Services, is providing up to $250,000 for Small State Operational Grants in 2021 to state psychological associations to support the professional needs of psychologists. These grants are administered by the APA Practice Directorate and Committee for State Leaders (CSL). We received 25 applications requesting a total greater than the amount of funds available. CSL weighed important factors such as state's grant history and financial status to ensure that funding was distributed fairly.

Council of Representatives Report

Michele McKinnie, Psy.D. , MPA Council Representative



The APA Council of Representatives met virtually on February 26 & 27, 2021. The meeting agenda was ambitious, with both outward (public interest) and inward (organizational) facing items to be discussed and acted upon. Here is a summary, with some discussion, of the agenda items and the actions taken. As always, I will be happy to share with you in greater detail about any of the items presented below. Please contact me directly at michelecatherine@hotmail.com if you wish more information or context.

Consent Agenda Items

The following items were approved as part of the Consent Agenda (no discussion took place):

Minutes from the August 2020 meeting

A short (about 1 year) extension of the expiration dates (set to expire in 2021) of the following APA Guidelines:

- National Standards for High School Psychology Curricula
- Guidelines for Psychological Evaluations in Child Protection Matters
- Guidelines for Psychological Practice in Health Care Delivery Systems
- Guidelines for the Practice of Parenting Coordination
- Specialty Guidelines for Forensic Psychology
- Guidelines for Assessment of and Intervention with Persons with Disabilities
- Principles for Quality Undergraduate Education in Psychology
- Amendment to Association Rule 50-2: Equal Opportunity Representation
- Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change
- Guidelines for Psychological Practice with Sexual Minority Persons
- Report of the APA Task Force on Human Rights

Action Items

The following items were discussed and voted on by Council members during the meeting:

Resolution on Sexual Orientation Change Efforts: Council was asked to adopt as APA policy this Resolution. This resolution is to augment APA policy on sexual orientation change efforts from 1997 to 2009. **Item passed with 96.5% of the vote; I voted Yes.**

Resolution on Gender Identity Change Efforts: Council was asked to adopt as APA policy this Resolution. This item was proposed in tandem with the above SOCE Resolution and is APA's first policy resolution on the topic of gender identity change efforts. **Item passed with 95.3% of the vote; I voted Yes.**

Standards of Accreditation for Health Service Psychology (HSP): Master's Programs: Council was asked to adopt as APA policy the Standards of Accreditation for Health Service Psychology: Master's Programs and to approve December 31, 2030 as the expiration date for these standards. There was a very lengthy debate about this item among Council members as well as a lot of discussion about this item at the Caucus meetings that preceded the main Council meetings. To provide context there were several issues raised during the debate. The history of this item, initiated in March 2018, the importance of identifying and distinguishing Master's and Doctoral competencies in psychology, the need to consider issues of equity, diversity and inclusion, and the independence of the Commission on Accreditation from any 'lobbying efforts' from any group in APA, including Council or sub-groups of Council.

MPA members who are interested in this item should be aware that opportunities to weigh in on competency standards and distinguishing of the doctoral and master's degrees will arise in the coming year or two. I would be happy to share more details about this item with anyone who has additional questions. **This item passed with 78% of the vote; I voted Yes.**

APA Resolution on Racism: Council was asked to adopt as APA policy the resolution **Harnessing Psychology to Combat Racism: Adopting a Uniform Definition and Understanding**. This resolution is seen as an important first step within APA by creating a foundational document that will allow more specific policies related to racism to be put before Council in the coming year. All the Ethnic Minority Psychology Associations were given the opportunity to provide feedback on this first document and the feedback was incorporated. **This item passed with 99.4% of the vote; I voted Yes.**

Resolution on APA, Psychology, and Human Rights: Council was asked to adopt as APA policy this resolution. The resolution was presented along with the APA Task Force on Human Rights report and it provides strategic guidance to the Association in its efforts to promote and protect human rights. This Task Force was established by the APA Board of Directors in 2016 in the wake of the Independent Review. **This item passed with 98.2% of the vote; I voted Yes.**

Professional Practice Guidelines for Evidence-Based Psychological Practice in Health Care: Council was asked to adopt as APA policy these Guidelines and approve December 2030 as the expiration date of these Guidelines. These guidelines are intended to clarify and extend APA's policy on evidence-based practice in psychology (EBPP) by articulating practical considerations and providing illustrative examples of EBPP in health care. **This item passed with 96% of the vote; I voted Yes.**

A Call to Investigate the Creation of an office of "Psychological Consultant to the United States," Dedicated to Psychosocial Approaches to Public Mental Health: Council was asked to support the formation of a task force (TF) charged with exploring the merit of recommending to the U.S. Congress an office of Psychological Consultant (PC) to the United States. The primary purpose of this position would be for the PC's office to work in coordination with APA and government agencies and officials to provide counsel directly to lawmakers on psychosocial dimensions of public mental health care. **This item failed with 18.7% of the vote; I voted No.**

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Council of Representatives Report

Michele McKinnie, MPA Council Representative *(continued from page 3)*

Other agenda items included a presentation from the newly hired APA Chief Diversity Officer Dr. Maysa Akbar, a panel discussion featuring members of APA President Kelly's Task Force on Health Equity, a financial update from APA Treasurer Dr. Jean Carter – this included the presentation of the projected balanced budget for 2021, and a discussion of the Council Effectiveness Work Group recommendations for steps Council can take to become more effective and efficient as a policy making entity within the Association. The next Council meeting will take place in August 2021 around the time of the APA Convention and will again take place in a virtual environment.

2021 Membership Roll

We'd like to thank the following members who have joined or renewed for 2021. If you don't see your name listed, please visit https://mpa14.wildapricot.org/Join-us

Elizabeth Asserson, Ph.D.
Eric Aune, Ph.D.
Camille Barraclough, Ph.D.
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Janet Wollersheim, Ph.D.
Arlis Woods, Ph.D.

Resilience, Childhood Trauma History, and Foster Care Experiences in College Students—Ashlyn Kincaid, MA

Ashlyn Kincaid, MA, is completing her PhD in school psychology at the University of Montana, under the mentorship of Dr. Jacqueline Brown. Her family is involved in the foster care system and has taken in many children over the past 8 years. Through this experience, Ashlyn developed a passion for working with and researching foster children and other disadvantaged youth. She currently works with children, adolescents, and parents at the Clinical Psychology Center in Missoula, MT.

Jacqueline Brown, PhD, Academic and Scientific Coordinator

Introduction

It is estimated that 60% of all adults in the United States have experienced at least one significant childhood trauma event (U.S. Department of Health & Human Services, Administration for Children and Families, Children's Bureau, 2019). A significant trauma event is categorized as the experience of an event that is emotionally painful or distressful, often resulting in lasting mental and physical effects (Substance Abuse and Mental Health Services Administration, 2017). Exposure to traumatic events in childhood leads to a variety of immediate threats to the child, such as injury and death, violation of physical integrity, extreme emotional turmoil (American Psychiatric Association [APA], 2013), and decreased academic functioning (Daignault & Hebert, 2009). In addition to immediate threats to self, there are also long-lasting negative effects of childhood trauma. Adults with multiple traumatic childhood experiences are more likely to engage in risky behaviors, such as smoking (Felliti et. al., 1998), and are at higher risk for dropping out of college before receiving their degree (Duncan, 2000). Overall, as traumatic events in childhood increase, so do the risks for multiple negative outcomes (Substance Abuse and Mental Health Services Administration, 2017).

Some individuals are able to successfully cope with their childhood trauma experiences. These individuals display resilience, since they can "bounce-back" after experiencing adversity. Resilience has been defined as "the capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development" (Masten, 2014). Higher levels of resilience in some individuals may be due to the cumulative effects of protective factors. Protective factors that have been shown to foster resilience in children include nurturing parents, family stability, and connections with adults (Turner et al., 2012). In adulthood, protective factors that foster resilience include self-esteem, a sense of safety, positive outlook, social support, and spirituality (Maschi et al., 2013).

A population where resilience is highly valued, if not needed for survival, are foster children. Foster children have been removed from their family's care, placed into the care of the state, and then placed with foster families who are paid to be their primary caregivers. Separation from parents is extremely traumatizing and may be equally as traumatizing as the death of a parent (Agid et al., 2000). Removal of a child from their family typically happens for reasons that pose immediate safety risks. Safety risks can range from abuse, neglect, parental substance abuse, unsuitable living conditions, parental mental illness, family violence, or the absence of parents (Lohr & Jones, 2016). For these reasons, children who are or have been in foster care are at risk for experiencing a variety of negative health and behavior outcomes. Most of the negative outcomes experienced by individuals who have been in foster care mirror the outcomes experienced by children who have been exposed to trauma. Specifically, both groups experience increased rates of social problems, substance abuse, and mental health problems (Felliti et. al., 1998; Zlotnick et al., 2012).

In addition to negative health and behavior outcomes, foster children are also in a uniquely challenging position academically. Frequent placement changes often result in a change of schools and cause disrupted learning throughout their K-12 education (Ward, 2009). As foster children get older and emancipate from foster care, they are left to make the decision of continuing their education on their own, often without financial or moral support (Morton, 2018). Without support, the transition from primary to secondary education becomes more of an obstacle. In previous research, former foster care students enrolled in college reported that uncontrolled mental health issues and poor emotion regulation skills were barriers to their success at school (Morton, 2018)

College is a difficult transitional time in life for most students, but for those with traumatic pasts, it can be especially difficult. The current study aimed to integrate and compare the trauma history and resilience skills of students with childhood trauma and/or foster care experiences. One goal of this study was to hear from former foster children currently enrolled in college to identify specific themes across participant responses to inform what helped them be successful, what was challenging, and what is needed for future students transitioning from foster care to college. Hearing from former foster children firsthand can give educators, policymakers, and mental health practitioners a glimpse into the major struggles they are facing and highlight key areas for improvement.

Methods

Participants were recruited from a university in the Western United States (n= 161). Permission to conduct the study was obtained by the Institutional Review Board at the university. Participant demographics included students enrolled in a Psychology class who were 18 years or older. Participants completed 2 to 3 online surveys that collected information about childhood experiences (Adverse Childhood Experiences questionnaire; ACE), resilience qualities and behaviors (Academic Resilience Scale; ARS-30), and foster care

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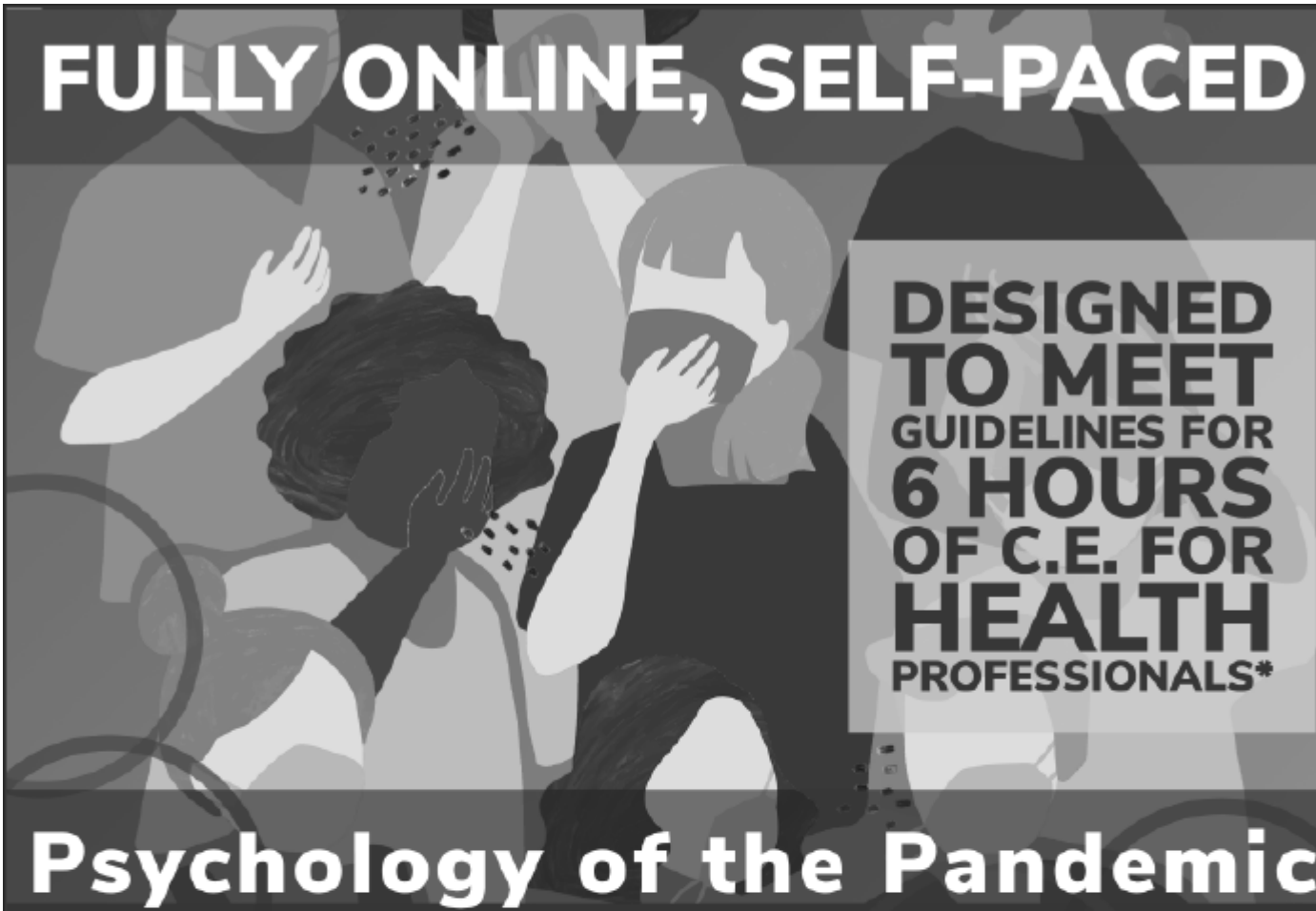

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Resilience, Childhood Trauma History, and Foster Care Experiences in College Students (continued from page 5)

experiences. The questions specifically posed to former foster children inquired about relationships, supports, and protective factors in relation to their foster care experiences and how these have supported or inhibited their success. Data were collected using an anonymous, online, self-report survey.

Results and Discussion

The current study found that reporting zero adverse childhood experiences was associated with higher academic resilience scores. On the other hand, reporting one or more adverse childhood events resulted in lower academic resilience scores. These results suggest that adverse effects on academic resilience may occur even when an individual has only one adverse childhood experience. Additionally, it was hypothesized that students who report foster care experiences would have a significantly higher mean score on the ACE questionnaire than those who did not report foster care experience. The results showed that students with foster care experience scored significantly higher on the ACE questionnaire than students without foster care experience. This finding supports previous research stating that foster children experience the same negative physical and mental health risks as childhood trauma victims (Zoltnik et al., 2012).

A few participants reported being in foster care as children (*n* = 5). They were asked to share significant challenges and success stories in relation to their foster care experiences and being in college. The most commonly reported challenge was social difficulties (60% of participants), whereas resilience and family/social support were the most commonly reported contributors to success (40% of participants). When asked to note what supports participants wish were available to them on campus, one participant wrote about wanting social support groups to meet people with similar backgrounds and struggles. The number of times social support was mentioned in different contexts indicates that it is a complex factor and an important asset upon which to focus. Those who have social support report that it is a significant success factor in their lives and journey through college, whereas those who either do not have or have minimal amounts of social support indicate that it is a significant challenge.

Results from this study suggest that creating support groups on college campuses for students with similar background of abuse, trauma, and foster care experience could be very beneficial to building resilience, as well as boosting social support for this at-risk population. Additionally, previous research has found that experiencing childhood trauma events decreases academic functioning (Daignault & Hebert, 2009), and in the current study, experiencing childhood trauma events decreased academic resilience scores. College students with backgrounds of abuse, trauma, or foster care experience could benefit from additional supports on campuses such as academic advisors who are trained to work with this population. Mental health professionals could also fill this role by being aware of the struggles this population may be facing in regards to their school work. Mental health professionals who work with college students should attempt to leave space in their work to discuss academic challenges and offer support by way of building academic resilience skills. Lastly, previous research has found that as traumatic childhood experiences compound, individuals are more likely to experience substance abuse issues and struggle with mental health issues that can jeopardize their ability to thrive in college (Feliti et.al., 1998; Morton, 2018). College campuses should be equipped with mental health support for students from trauma backgrounds, and mental health providers should be aware of the effects adverse childhood events can have on college students.

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Considerations for Psychological Practice with Refugee Children and Families

Diana Diaków, Amy Violante, Emily Brooke, Anisa Goforth, Ph.D.

Sameer (not a real child) is a 10-year-old boy whose family recently received international protection in the United States. He lived in the Democratic Republic of Congo, where there was a government coup, and his father, mother, and siblings moved to a refugee camp in Kenya. As a child, he experienced internal and international forced displacement intertwined with hunger, outbreaks of infectious diseases, limited access to medical care, violent conflicts, human trafficking and many other adverse events. He has been living in the refugee camps since he was two years old. He was resettled in Missoula with his family, where he attends an elementary school and is the only Black child in his class. His school counselor recommended that he received therapy to help him cope with the transition.

As psychologists in Montana, we may have the opportunity to work with refugee families and children, like Sameer. Considering the various factors that refugees encounter in their journey, we have an important role to play in supporting them through culturally responsive assessment and intervention. The purpose of this article is to provide some context to the refugee experience in Montana, and provide psychologists with specific considerations when working with refugee children and families. The focus of this article is on refugee children and their families, but we want to acknowledge that each family's experiences during forced displacement is unique, and it is our responsibility as psychologists to understand the lived experience of each of these families.

Refugees in Montana

Among the 80 million forcibly displaced persons (FDPs), there were 26.3 million refugees across the globe (The United Nations Higher Commissioner for Refugees [UNHCR], 2020). The term *refugee* applies to those individuals who have sought international protection in a foreign country as a result of experiencing fear of being persecuted (The Universal Declaration of Human Rights, 1948). Importantly, not all FDPs receive assistance and legal status, and there are many different terms. For example, FDPs may be considered immigrants, migrants, or stateless persons. Further, they may be identified as internally displaced persons, if they remain within the borders of their homelands, or as asylum-seekers, if they are in the process of obtaining international protection.

According to the Refugee Processing Center, 392 refugees resettled in Montana between 2002 and 2019. Most refugees within the state were resettled in Missoula, due to the location of the International Rescue Committee (IRC) office in the city, as well as the resources provided by Soft Landing Missoula, a local organization that works to provide assistance to refugees after their arrival in Missoula through the IRC (Soft Landing Missoula, n.d.; International Rescue Committee, n.d.).

Around half of the refugees now residing in Montana originate from the Democratic Republic of the Congo (DRC) (Refugee Processing Center, n.d.). While the DRC is home to approximately 250 ethnic groups, those with a history of persecution within the country, such as the Tutsi, Banyamulenge, and Hutu, predominantly characterize refugees from the DRC (Cultural Orientation Research Center, 2014). A majority of refugees practice Christianity, with many belonging to Pentecostal or Seventh Day Adventist denominations. Eritrea, an east African nation known for its extremely repressive government, is the second most common country of origin amongst Montana's FDPs, followed by Belarus, Iraq, and Syria. Overall, Montana includes refugees from diverse nations and cultures.

Forced Displacement: A Journey to a New Home

Forced displacement involves an arduous and turbulent journey from an area that is no longer safe to a new location to be called home. The length of this journey can span for many years and depends on numerous factors, including access to humanitarian aid, hazardous border crossings, immigration policies and law in receiving countries. For Sudanese, Somali, and Eritrean forcibly displaced persons, it can be up to nearly 40 years in exile (Devictor & Do, 2016).

The experience of displacement can vary, yet there are some similarities in the stages of FDPs' experience: 1) pre-migration, 2) migration, and 3) post -migration stage (Chu et al., 2012). The pre-migration stage includes the impetus of war and other life-threatening circumstances that force a family to leave their home behind and look for shelter. Before an individual obtains a refugee status, and thus legal rights and social benefits, they are likely to spend years being internally displaced, or living in crowded refugee camps in low-resource countries (UNHCR, 2020). At that stage of displacement, refugee families have limited or no access to public education, health services, shelter, legal assistance, water and sanitation (Sullivan & Simonson, 2016; Anagnostopoulos et al., 2015). Additionally, the delivery of humanitarian assistance to forcibly displaced persons en route has been continuously challenged by socio-political factors, funding, and recently, the pandemic. These factors further jeopardize the safety of fleeing families and may contribute to adverse experiences such as homelessness, detention, deportation, or imprisonment (Lorek et al., 2009).

In Montana, most psychologists encounter children and families at the post -migration stage, in which FDPs have been resettled to their new homes with the international assistance (e.g., the International Rescue Committee). Apart from settling in a new community, refugee families are also re-establishing their family roles, responsibilities, and expectations given a new environment. For example, refugee parents may have challenging work schedules, very limited social support and financial resources available to them, and thus some of the older children may be expected to supervise younger siblings or cook (Lewig et al., 2010). Further, upon resettlement to the USA, some refugee families may be navigating significant cultural differences including gender norm expectations and language barriers, while recovering from complex traumas (Tyrer & Fazel, 2014). These acculturation experiences may be particularly difficult to navigate. For instance, a Somali mother may encounter cultural norms surrounding dating and relationships where her 16-year-old daughter may want to date her male friend, a cultural norm not as common in Somalia. This is not an exhaustive list of displacement-related challenges, and it is important that psychologists recognize the complexity and uniqueness of each refugee's journey.

Forced Displacement and Well-Being

Refugee children may experience mental health challenges as a result of their journey of forced displacement. Symptoms can include anxiety, fear, depression, and PTSD, as well as other socio-emotional and cognitive difficulties (Montgomery & Foldspang, 2008). Refugee youth may also experience problems with emotion regulation and deficits in attention and memory (Jabbar & Zaza, 2014). Although refugees do experience traumatic stress associated with forced displacement (Jabbar & Zaza, 2014), psychologists may underestimate the impact of other risk factors such as acculturative stress, or the discrepancies between children's and their parents' acculturation experiences (i.e., the child may be more acculturated to U.S. culture while the parent may not).

There are also additional factors from the displacement process that affect refugee youth. For example, children may experience disrupted access to education before the resettlement to the USA, as well as acculturative stress associated with school norms and expectations in a new country (e.g., riding the school bus, sitting at desks all day). These stressors can increase the likelihood of refugee children experiencing academic and mental health challenges (Jabbar & Zaza, 2014).

In the post-migration stage, refugee families may also experience stigma

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and discrimination associated with their ethnic or religious backgrounds (Link & Phelan, 2001). Indeed, it is important to recognize that within the refugee community, there are groups that are at higher risk of being bullied and socially stigmatized including people who identify as Muslim, Arab, or Black (Montgomery & Foldspang, 2008). Thus, when working with refugee children, psychologists may

need to recognize the intersectionality of identities that may bring unique challenges. For example, a Somali Muslim student who is also Black may experience discrimination and microaggressions based on immigrant status, ethnic membership, religious background, and/or race.

Implementing Culturally Responsive and Trauma-informed Care

Even though the prevalence of PTSD in the refugee population ranges from 19 to 54%, psychologists may need to recognize that refugees experience complex adverse experiences, not just traumatic stress (Bronstein & Montgomery, 2011; Anagnostopoulos et al., 2015). Symptoms of trauma may vary not only due to individual differences, but also cultural and migration-related experiences. For example, a refugee who was a child soldier in Sudan might have experienced abuse, neglect, and exploitation, while also being separated from their family. Hypothetically, this child may have a generalized fear of male figures and authorities, which might impact their trust for health providers, teachers, and even other non-familial adults; difficulties in trusting others, especially authority, are a common challenge faced by refugees (Trickett et al., 2011; Attanayake et al., 2009). Noteworthy, families may be experiencing intergenerational trauma following persecution (Sullivan & Simonson, 2016).

Psychologists should support the monitoring for mental health challenges as part of prevention efforts. While using trauma-informed mental health interventions (e.g., TF-CBT), it is important to implement them in a culturally responsive way by using materials that are responsive to language, literacy, and cultural needs of a refugee children (Hinton et al., 2012). An example of cultural adaptation for Muslim Arab refugee youth may be to focus on the youth's relation to their family first, rather than focusing on the youth's personality, intrapsychic feelings, attitudes, and thoughts (Dwairy, 2009).

Mental health providers can also use relaxation techniques and narrative exposure therapy (e.g., KidNET) to address trauma-related symptoms (Catani et al., 2009). Psychologists can integrate play modalities into therapy as they foster children's social and cultural learning, as well as help bicultural, displaced children negotiate their native cultural identity and an emerging sense of belonging to a host community (Marsh, 2016). At each stage of providing mental health support, psychologists should ensure that the child and family understand limits of confidentiality, clarify their role as mental health providers, and outline the purpose of any interaction as refugees' perceptions of and experiences with mental health services may vary (Hassan et al., 2016). Noteworthy, psychologists should strive to carefully explore refugee clients' ties to their native culture as it may be a source of resilience, or a trigger for trauma.

Psychologists should also engage in self-reflection on their own biases and possible beliefs in serving refugee clients, and seek consultation from culture mediators, and those who have more experience with this population, either locally, nationally, or internationally. Professional networks such as American Arab, Middle Eastern, and North African Psychology Association (AMENA-Psy) and services (e.g., Bridging Refugee Youth and Children's Services [BRYCS]) provide useful resources on how to support refugees across a variety of settings.

Supporting Family-Provider Collaboration

Psychologists play an important role in fostering family-provider collaboration, as it is essential in supporting refugee children's well-being and academic success. For example, educators and mental health providers may be noticing that refugee parents attend parent-teacher conferences irregularly, are late with returning paperwork, or are not coming to appointments, which is causing concerns from teachers or school administrators. However, there may be numerous reasons for these behaviors including: language barriers, limited literacy in a native language, deportation-related fears associated with the completion of documents, confusion about the format of the meetings, lack of transportation, limited resources to provide care for children while visiting school, and many others. Given that refugee families' experiences with structured education as well as healthcare systems may vary, it is important that psychologists assist them with understanding the new environment and recognizing that the family-provider relationship is essential for children's success (NASP, 2019). This assistance can include providing both written translation of all documents, and oral interpretation (e.g., in-call language assistance), flyers shared with parents regarding the meeting structure and expectations, tele-appointments or calls. As for language assistance, it is important that psychologists refrain from using children as

Common Challenges Experienced by Refugee Youth	
Anxiety, fear, depression, PTSD, grief, trauma	Significantly disrupted academic history including missing school records
Emotion regulation problems including disruptive behaviors	"First" experiences (e.g., school bus, desks)
Attention and memory deficits	Bullying or discrimination at school
Limited language proficiency and literacy	Worries about separation from family members
Difficulties trusting others	Anxiety over deportation

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interpreters for their parents, because that may perpetuate some of the acculturative stressors, such as age-inappropriate responsibilities and risk of imprecise information exchange (NASP, 2019).

Fostering Connections

Psychologists can also support refugee children and families in connecting with the community. To support refugee children's sense of community, foster their language acquisition, and promote positive multi-cultural identity development, psychologists can advocate for creating multilingual libraries and creating culture-exchange events, such as food sharing, story-telling circles, craft making (Diaków & Goforth, 2021). Psychologists can also encourage refugee children to enroll in extra-curricular activities, which do not only provide new educational and creative experiences, but also encourage peer socialization (Marsh, 2016). Furthermore, psychologists can train other health providers, school staff, and provide support to the community-based agencies (e.g., workshops, consultation) regarding preventing and combating racism, discrimination, xenophobia. It is important that psychologists encourage open dialogue about these topics, and model cultural humility and responsiveness within the work as well as local community (Dunn et al., 2014).

Conclusion

Although refugee children and families may share similar needs, it is crucial to practice cultural humility and recognize that each refugee story is unique. As psychologists, we are able to offer resources that can support refugee children and families' individual resilience and facilitate recovery from trauma, assist the families in settling down in a new community, and promote welcoming and diverse community.

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1. True or False: The Board of Psychologist's bill regarding change in licensing requirements of psychologists in Montana will make it easier to attract more psychologists to work in Montana without comprising the quality of services provided and will also allow for temporary licensure of postdoctoral supervisees.
    a. True
    b. False

2. True or False: The APA Resolution entitled *Harnessing Psychology to Combat Racism: Adopting a Uniform Definition and Understanding,* is seen as an important first step to create a foundational document that will allow for more specific policies related to racism to be put before the Council in the coming year.
    a. True
    b. False

3. According to Turner and colleagues (2012), which of the following protective factors have been shown to foster resilience in children?
    a. Nurturing Parents
    b. Family Stability
    c. Connections with Adults
    d. All of the Above

4. According to Morton (2018), former foster care students enrolled in college reported which of the following as barriers to their success in school?
    a. Poor Emotional Regulation Skills and Lack of Connection with Adults
    b. Uncontrolled Mental Health Issues and Poor Emotional Regulation Skills
    c. Substance Abuse and Lack of Connection with Adults
    d. Uncontrolled Mental Health Issues and Substance Abuse

5. According to the Refugee Processing Center, how many refugees resettled in Montana between 2002 and 2019?
    a. 302
    b. 392
    c. 285
    d. 892

6. Which of the following is NOT a common challenge experienced by Refugee Youth?
    a. Anxiety over deportation
    b. Bullying or discrimination at school
    c. Attention and memory deficits
    d. Struggles with substance abuse
    e. Difficulty trusting others

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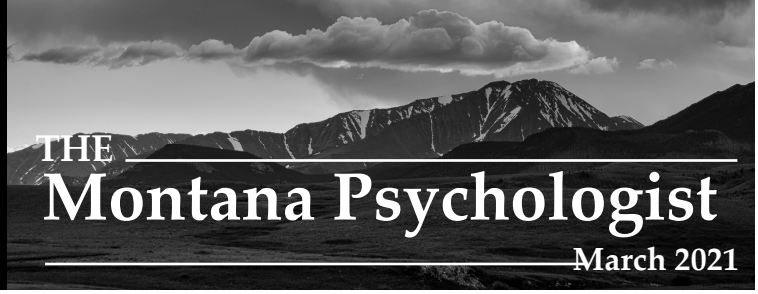

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