ISTSS International Society for Traumatic Stress Studies

Fact Sheet

Refugee Traumatic Stress and Recovery Processes: Clinical Considerations

Developed by the Refugee Trauma and Recovery Program (RTRP) UNSW Sydney, in particular Dr. Belinda Liddell, Dr. Yulisha Byrow, Natalie Mastrogiovanni, and Isabelle Shaw

Overview of Refugee Trauma and Stress

Refugee traumatic events and stressors are often considered in 3 phases:

Pre-Migration Trauma

Refugees are commonly exposed to pre-migration traumatic events in their home countries, including mass violence, torture, witnessing atrocities, death of loved ones and deprivation due to poor access to supplies like food or medical support.[5] Refugee traumatic events often occur simultaneously and/or over extended periods of time. Moreover, many traumatic events are experienced by the whole community.[15]

Displacement-Related Trauma

Refugees are also subject to significant ongoing trauma and stress even after leaving their home countries. By definition, refugees are forcibly displaced – meaning they do not choose to leave their home, and consequently, often take dangerous journeys to seek physical safety. Refugees commonly live in a state of heightened insecurity in camp or community settings and face significant uncertainty in relation to future permanent resettlement pathways.[12] Another common experience is prolonged forced separation from family members, who may remain in insecure or dangerous situations.[16,17]

Post-Migration Stressors

After being forced to leave their homes, refugees face the challenge of building a new life – either in a country of resettlement or in an interim place while waiting for permanent settlement or to return to their home country. [1-4] Common post-migration stressors include:

- Logistical stressors: difficulties accessing employment, housing or schooling, and financial or food insecurity.
- Acculturation stressors: communication difficulties, cultural loss, adjusting to new cultural norms and expectations, and intergenerational conflict.
- Social stressors: isolation, loneliness, or experiencing discrimination.
- Immigration-related stressors: visa insecurity, immigration detention, navigating the legal process of applying for refugee status.

The quantity and specific nature of these post-migration stressors may vary substantially between refugees in different contexts and locations [1].

Trauma-Related Disorders Experienced by Refugees

PTSD and Depression. Cumulative exposure to pre-migration and displacement-related trauma increases risk for psychological disorders like PTSD and depression in refugees.[3,6-8] Estimates from refugee populations around the world report that the prevalence of PTSD and/or depression is one in three refugees,[7,9] although there is a large range of prevalence rates reported across individual studies (<10% - > 90%).

Complex and Compounding Stressors. It is critical to recognize that trauma exposure is not the only factor contributing to the psychological health of refugees. For example, post-migration stressors outlined earlier also adversely affect mental health in their own right,[10,11] while also exacerbating the impact of trauma exposure on psychological outcomes.[4,13,14] Consequently, when refugees seek psychological support for past trauma, they are also likely to be experiencing other stressors that impact psychological functioning. For example, the primary stressor of a refugee client may not be intrusive memories relating to their past torture exposure, but rather that they have insecure housing, are separated from their children or are worried about finding a job to support their family. This has implications for the treatment and care of refugee clients, who may benefit from multi-modal support including access to practical support or social programs to address their immediate concerns and reduce distress.[18]

Other Forms of Posttraumatic Psychopathology. While PTSD and depression have been the most frequently measured psychological disorders in refugees, refugees experience a range of post-traumatic psychological reactions. For example:

- Meta-analyses demonstrate that anxiety disorders and psychosis are observed in 11% and 1.5% of refugees respectively,[9] and somatoform disorders are also commonly reported.[19]
- Prolonged grief is distinguishable from PTSD symptoms in refugees.[20,21]
- Complex PTSD – which is PTSD that occurs alongside disruptions to emotion regulation, interpersonal relationships and sense of self – is also prevalent in refugee populations,[22-25] and may be associated with cumulative trauma exposure and settlement stressors.[26]
- Refugee experiences can result in elevation of other complex emotional reactions – including anger, guilt and shame.[27,28] Refugees may also experience moral injury associated with exposure to traumatic events that transgress moral beliefs.[29]

Clinical Considerations When Supporting Refugees

Refugees may present with complex psychological and practical needs. Below are some key considerations when supporting refugees in the clinic or via other services.

Role of Immigration Policies and Sociopolitical Attitudes Towards Refugees. While refugee rights are protected under international law (United Nations Refugee Convention, 1951, 1967), refugees are often forced to navigate immigration pathways that lack permanent settlement options. Many countries implement policies designed to deter people from seeking asylum, including mandatory immigration detention, administration of temporary visas, processing of asylum seeker claims offshore and restrictions on travel.[30] Temporary protection

visas may also restrict access to financial support, health care, employment, housing or schooling, and therefore contribute to post-migration stress. Research has shown that immigration-related challenges negatively affect the mental health of refugees.[11,31] Refugees may also be subject to discrimination in their new home due to anti-refugee sentiment[32,33] or prejudice based on their cultural background, religion, gender identity or LGBTQIA+ status.[34,35] Negative experiences such as these make it very difficult for refugees to establish a sense of belonging in their new home and recover from their traumatic pasts.

Trust and Relationship with Authority. Due to having lived under states of political terror or in conflict situations, refugees may distrust authority – including medical and legal professionals seeking to support them. It can take time to establish a foundation of trust and build a relationship in order to engage in meaningful psychological treatment.[18]

Role of Cultural Identify in Psychological Treatment. Refugees are from diverse cultural backgrounds which often hold non-Western perspectives that differ from Western-based understandings of mental health, trauma and psychological treatment. Many refugees are from collectivistic cultures, who place a high value on family and community connectedness as integral to self-identity. These cultural factors may have important implications for post-traumatic stress and trauma recovery.[36,37,10] The family may play a pivotal role in the psychological treatment of refugees. Refugees may be more likely to seek informal support from family or trusted community members, or family may be an important motivator for treatment. For example, individuals may be motivated to address their psychological symptoms to reduce perceived burden on their family.

Mental Health Stigma and Seeking Help. Despite the high prevalence of psychological disorders reported in refugee populations, rates of mental health help-seeking are low amongst refugee communities.[38-41] Under-utilization of services may be attributed to cultural barriers [40] or mental health stigma.[42] For instance, mental health concepts may differ significantly in refugee populations compared to their host societies. Cultural belief systems may affect attributions made regarding the causes of psychological distress (e.g. symptoms may be attributed to physical factors or religious/spiritual determinants rather than to trauma exposure).[42] Furthermore, the Western norm of seeking professional help in times of psychological distress may not be the norm in many refugee populations.[43] Stigma surrounding mental health difficulties is also prevalent in refugee communities and may pose a major barrier to seeking help.[42,44,45]

The Importance of Adopting a Culturally Sensitive Approach. A culturally sensitive approach is critical when working with refugee communities. This can include building relationships with individuals and communities and including refugee voices in the design of research and services. Communication can be enhanced by using professional health interpreters in treatment, and translating materials into diverse written and spoken languages, to enable refugees to fully engage in treatment, research, or other services.

Vicarious Trauma. Vicarious trauma refers broadly to the psychological impact of working with traumatized people and can manifest as burn-out or similar symptoms to PTSD including intrusive thoughts and hopelessness.[46] The nature and extent of refugee trauma and stressors

can place a significant burden on the services, programs, and individuals responsible for their care and treatment. Risk of vicarious trauma is high amongst practitioners and service providers,[47,48] as well as interpreters.[49]

Resilience. Despite being exposed to significant trauma and stress, refugees are highly resilient and resourceful people. Indeed, the majority of refugees will recover from their traumatic pasts. With access to services and interventions that take a strengths-based approach, address traumatic stress and other reactions, and facilitate innate coping, refugees can recover and thrive within a safe and supportive recovery environment.

Psychological Treatment

There are several options for the psychological treatment of refugees to address traumatic stress and other symptoms, with the evidence-base for informing treatment selection and delivery expanding in recent years.

Randomized control trials and meta-analytic studies indicate that trauma-focused cognitive behavioral therapies appear to be effective in addressing PTSD symptoms in refugees.[50] Narrative Exposure Therapy, initially designed to address PTSD symptoms following exposure to multiple traumatic events,[51] is also evidence-based across multiple settings.[52] Recent reviews have additionally highlighted the evidence for Eye Movement Desensitization and Reprocessing effectiveness in reducing PTSD symptoms in refugees.[50,52] However, the strength of evidence in support of these treatment options varies across RCTs. More clinical research is required to understand the application of current front-line PTSD treatments for refugees, including more high quality RCTs with larger participant numbers.

Existing PTSD treatments also take a more traditional trauma-focused approach to addressing mental health symptoms in refugees which may have some limitations as refugees typically face a myriad of ongoing stressors.[53] For example, a study has demonstrated that post-migration stressors were actively present in 39% of psychological treatment sessions at a refugee trauma service.[54] Specialised multi-level interventions are being adapted to accommodate the distinct needs of refugees – including considering the role of ongoing trauma and stress, cultural factors, mental health stigma and their complex needs[55-59] and programs to overcome mental health stigma.[44]

Given that most of the world's refugee populations live in low- and middle-income countries with developing mental health and public health systems, access to psychological treatments with mental health professionals may be limited.[53] The field has therefore been developing a range of "low-intensity" interventions that can be delivered by trained and supervised community members and scaled up to reach a critical mass of displaced people. Developed by the World Health Organisation, these include Problem Management Plus (PM+) World Health [60] or Self-Help Plus (SH+) World Health,[61] and both are currently being tested with refugee populations globally with mixed results.[62-66]

Notes

This article used the term refugee as representative of refugees, asylum seekers and other forcibly displaced people (refer to Refugee Trauma Friday Fast Facts Week 2: Infographic for definitions).

For more a more detailed presentation of the mental health needs and treatment of refugees, including specific needs of children with a refugee background please refer to the ISTSS Briefing Paper focusing on Trauma and Mental Health of Forcibly Displaced populations available here: https://istss.org/public-resources/istss-briefing-papers/trauma-and-mental-health-in-forcibly-displaced-pop

Scan here for references: