



Recognizing and Breaking the Cycle of Trauma and Violence Among Resettled Refugees

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Abstract

Purpose of Review The number of refugees across the globe continues to grow, leaving a large proportion of the global population in a vulnerable state of health. However, the number of robust clinical interventions has not kept pace. This paper provides a general review of literature on the trauma and violence that refugees face, the impact on health outcomes, and some of the promising models for clinical intervention.

Recent Findings Refugees experience a cycle of trauma, violence, and distress that begins before migration and continues during migration and after resettlement. It has been challenging to develop robust clinical interventions due to the cumulative and cyclic effects of trauma, as well as the unique experiences of trauma that each refugee community and each refugee individual faces.

Summary Trauma-informed care is a critical component of health care. Developing stronger guidelines for trauma-informed care will help clinicians better provide inclusive and equitable care for refugee patients.

Keywords Refugees · Violence · Trauma · Trauma-Informed Care · Community partnerships · Resiliency

Introduction

At the end of 2019, more than 79 million people across the globe were forcibly displaced due to war, persecution, or violent conflict [1]. This included more than 20 million refugees, forced to flee their country and unable to return in fear of persecution [1, 2]. Since the enactment of the Refugee Act of 1980, the United States (U.S.) has accepted more than 3.8 million refugees and asylees, and in recent years, the U.S. has received some of the largest numbers of asylum applications worldwide [1, 3]. There

have also been proposals to raise the annual federal refugee admission ceiling from 15,000 in FY2021 to as high as 125,000 in FY2022 [4].

However, despite an increasing visibility of refugees in academic and political discourse, refugees remain some of the most vulnerable public health populations. Refugees face a “triple burden” of infectious diseases, mental health disorders, and non-communicable diseases, compounded by an additional triple burden of exposures to trauma before, during, and after migration—a defined risk factor for poor long-term health outcomes [5, 6]. Studies have shown that refugees experience more types of trauma compared to American-born individuals and other immigrants, develop post-traumatic stress disorder (PTSD) at higher rates compared to other immigrants and Vietnam war veterans, and experience higher rates of chronic disease compared to other immigrants [7, 8, 9, 10]. Refugees are also at an overall higher risk of adverse health outcomes due to the structural barriers they face in host countries [9, 11••].

Even though the refugee population continues to grow and continues to be recognized as a vulnerable population, there is still little guidance on how clinicians can best meet the needs of refugees [12]. Developing robust and agile

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clinical interventions has been challenging not only due to language barriers and cultural differences, but also due to the unique forms of trauma and violence that each refugee community and each refugee individual faces. In 2019, the largest proportion of refugee arrivals in the U.S. came from the Democratic Republic of Congo, Burma, and Ukraine [13]. The past decade has been marked by crises in Syria, South Sudan, Venezuela, Ethiopia, Yemen, and many more, in addition to renewed conflicts in Afghanistan, Iraq, Libya, and Somalia [1]. No single clinical intervention or approach is likely to address such a wide and dynamic spectrum of needs.

Nevertheless, it remains clear that establishing trauma-informed interventions for refugees and refugee communities is critical for improving health outcomes, increasing health care access and equity, and potentially reducing health care costs. This includes building structurally competent tools for assessing trauma, developing interdisciplinary models for care, and creating an inclusive health care environment that welcomes refugees and recognizes them for their strengths and resiliency [14•, 15]. Studies have also shown that the risk and severity of PTSD can be decreased if refugees are connected with mental health services immediately upon arrival [8•, 16••]. This highlights the importance of integrating refugees into a coordinated system of care early on, an area in which physicians and healthcare professionals can play an important role. This paper summarizes some of the recent literature on approaches to understanding and addressing the trauma and violence that refugees experience.

Pre-migration Trauma

Much of the early literature has focused on forms of trauma that refugees face prior to migration. Over the past few decades, various cross-cultural instruments have been developed to assess refugees for histories of trauma and for symptoms associated with PTSD [17]. These instruments incorporate not only translations for linguistic equivalence, but also cultural expressions and understandings of trauma, distress, and mental health [17]. The Harvard Trauma Questionnaire (HTQ), one of the most commonly used checklists, was initially developed in the 1990s to evaluate trauma and PTSD in refugees from Vietnam, Cambodia, and Laos [18]. The first section of the questionnaire asks about 17 traumatic experiences, including lack of food or water, ill-health without access to medical care, forced separation from family members, brainwashing, and murder of a family or friend [18]. The HTQ has since been adapted for different populations and studies [17]. Developing sensitive and specific tools that can be easily and routinely administered remains

a key challenge. The Refugee Health Screener-15 (RHS-15), for example, was designed more recently to help clinicians screen for common mental health disorders more efficiently [19].

These tools have been important in revealing the strong predictive value of trauma for PTSD, depression, and anxiety [20, 21]. Among Congolese refugees, some of the experiences highly correlated with developing PTSD include rape, witnessing murder, and seeing people carry dead or mutilated bodies [22]. Among Rohingya refugees, some of the most common traumatic events involve torture, beating, confiscation or destruction of property, extortion, or robbery, and being forced to hide [23, 24]. Women and children are especially vulnerable groups. Women are subject to higher rates of PTSD, in part due to higher rates of sexual and gender-based violence, such as rape, intimate partner violence, dowry killing, female genital mutilation/cutting, and forced prostitution [22, 23, 25–28]. Children are at higher risk of poorer developmental and long-term health outcomes, in part because childhood exposure to trauma, especially to intrafamilial and extrafamilial violence, can be more damaging than exposure to trauma as an adult [29–31]. For some refugee groups, the indirect act of witnessing trauma is linked to higher rates of PTSD than the direct act of experiencing trauma, highlighting the different ways that trauma affects individuals [32].

Refugees experience many types of trauma, and the number of traumatic events is linked to higher rates of mental health disorders. [33, 34••] Past exposure to trauma and violence also places refugees at a higher risk of exposure to repeated and new forms of trauma and violence [34••]. These histories of trauma play a key role in understanding refugee health, but they are only one part.

Migration Trauma

Many of these forms of trauma only continue during migration, with some studies arguing that refugees are even more vulnerable to insult and injury during the migratory process [5, 25]. Rohingya refugees fleeing to Malaysia, for instance, will either travel overland for months through Thailand's jungles, which are now littered with hundreds of gravesites, or risk the travel overseas in small, cramped boats across the Bay of Bengal and the Andaman Sea [24]. Such journeys place them at constant risk of dying from sickness or starvation, being tortured or killed by smugglers, or drowning at sea, among other life-threatening dangers [24].

While making these journeys, and later while staying in refugee settlements, women are at an especially high risk of sexual and gender-based violence [26]. Studies have reported that South Sudanese refugees in Uganda experience

higher rates of domestic violence and Somali refugees in Kenya experience high rates of intimate partner violence while staying in refugee camps [35, 36]. Many young girls are abducted from refugee camps to be forced into marriage or to be sold for dowries, and many women are raped or beaten by camp security themselves [35, 37].

States of conflict and upheaval generally leave women vulnerable to forced marriage, sexual exploitation, sexual slavery, and human trafficking [38]. They also leave refugee children and unaccompanied minors vulnerable to abuse, violence, and human trafficking [39, 40]. Crowded housing can place children at increased risk of physical and sexual abuse, and resource constraints, such as a lack of firewood, can place children at further risk by forcing them to venture away from camp in search of fuel [40]. Childhood trauma and refugee status and violence are also considered risk factors for human trafficking during migration and even after resettlement [41]. However, incidences of human trafficking are often difficult to report and under-reported, complicating political action and clinical intervention [41, 42].

Some studies have also found that the risk of PTSD and mental health disorders, as well as the risk of substance use disorders, increases the longer refugees stay in refugee camps [43–45]. These are concerning findings when refugees are spending years living in “temporary” settlements, with lack of clean water, lack of food and nutrition, lack of sufficient shelter, lack of proper infectious disease control, lack of adequate health services, and more—all of which keep refugees in a chronic state of violence, trauma, and deprivation [23, 35, 46].

It is thus important that refugees are properly screened for trauma and mental health upon arrival and resettlement in the U.S. Early linkage to mental health services has been shown to improve mental health outcomes, and some studies have even suggested that there may be a critical period following trauma exposure, after which it may be too late to intervene effectively. [8, 16]. It is also important that refugees continue to receive the proper health screening and services because experiences of distress, violence, and trauma do not end upon resettlement.

Post-migration Trauma

A growing amount of literature has been focusing on forms of violence and distress that continue and arise after migration and during resettlement. In the U.S., many refugee groups continue to face barriers due to racial and ethnic discrimination, restrictive immigration policies, limited English proficiency, limited social support, and economic insecurity, leaving many with limited options for employment, education, affordable housing, health care insurance, and other

opportunities [9, 47–50]. Accessing health care services can be particularly challenging due to barriers in transportation, translation, and cost, exacerbating the existing effects of trauma on increased risk of PTSD and increased risk of chronic diseases such as diabetes and hypertension [49, 51]. Finding employment opportunities can also be especially challenging due to the physical and mental impairments caused by past experiences of trauma and violence [48].

These forms of everyday structural violence leave refugees at higher risk of mental health disorders, and past exposure to trauma can leave refugees at higher risk of experiencing more post-migration stressors [9, 11]. Furthermore, post-migration stressors can sometimes end up having a larger impact on mental health than traumas experienced before and during migration [11]. Studies have found that if refugees receive the proper mental health services but continue to face structural violence and deprivation due to barriers with employment, housing, social support, and other social determinants of health inequity, the effectiveness of those mental health services will be diminished [52]. Studies have also found that greater access to social services and interdisciplinary services, a more secure immigration status, and stable housing and employment can reduce the severity of PTSD symptoms [53].

These findings are very similar to those from the discourse on social determinants of health [54]. However, what distinguishes the refugee experience is the compounding and cyclic impact of trauma and violence. More studies are finding that individuals who experience trauma and violence are more likely to continue experiencing trauma and violence, and in some cases, even factors like education do not necessarily provide a protective role against the effects of trauma and violence [34]. Many refugees continue to experience violence, if not more violence, after resettlement in the U.S, including witnessing someone being killed or severely injured, being beaten by someone other than a family member, domestic violence, intimate partner violence, and resettling in a poorer neighborhood with higher rates of community violence [55–57].

These cycles of trauma continue even past resettlement and down generational lines. Parental trauma has been associated with higher levels of mental health disorders and higher risks of abuse and neglect among children [56, 58, 59]. Some studies have looked at the mediating roles of family functioning, maladaptive parenting, accumulation of family stressors, and severity of parental trauma, among others [60, 61]. However, the mechanisms of intergenerational trauma remain unclear. Many studies have tended to focus on the maternal transmission of molecular and epigenetic biomarkers down generations [62–65]. Researchers have examined patterns of DNA methylation and cortisol metabolism inherited by children of refugee mothers and have identified certain genes, such as *FKBP5*, that may mediate

intergenerational transmission among Holocaust survivors [64, 65]. These studies may provide a foundational understanding of how the effects of trauma and violence can be transmitted in utero, but it is important to be wary of reducing the complexities of trauma and violence into a biological phenomenon.

Refugees are trapped in a cycle of trauma, driven by pre-migration and migration exposures, exacerbated by post-migration stressors, and reiterated by post-migration violence and intergenerational trauma. Clinical interventions must recognize this cycle before they can hope to attempt to break it.

Models for Trauma-Informed Care

Many studies have focused on exploring effective psychological therapies to help refugees combat PTSD, depression, anxiety, and other mental health disorders [53, 66]. More recently, Mental Health First Aid (MHFA) training programs have also been developed to increase mental health literacy among community members, decrease stigma, and provide tools for helping individuals in moments of crisis [67]. Many MHFA programs have had promising results, and some have found that bilingual MHFA programs augmented with cultural orientations can be more effective [52, 68, 69, 70•]. However, few programs have yet been developed for refugees.

As more research has come out revealing the multidimensional impacts of trauma, more interventions are focusing on how to incorporate mental health services into a more comprehensive care continuum, one that attempts to address not only the psychological sequelae but all manifestations of trauma—material, physical, social, cultural, and so on. Many studies draw upon a social-ecological framework that incorporates a more holistic understanding of the effects of trauma at different time points before, during, and after migration, as well as at different levels of institutions and systems [52, 70•]. The challenge has been integrating such frameworks into a robust model for trauma-informed care.

One of the primary challenges with developing interventions comes from language and cultural barriers. Without proper communication and interpretation, not only is it challenging to conduct a thorough clinical assessment, but it also leaves refugees vulnerable to under-diagnosis and misdiagnosis, discouraging refugees from returning to the hospital to seek care again [71]. It is especially challenging to communicate about illness across cultures because each culture draws upon their own explanatory models, their own words, beliefs, and stigmas for illness, pain, and injury [72]. In the 1980s, the concept of “cultural idioms of distress” arose as a framework for better understanding

how different people experience different forms of distress [73]. It was developed in response to earlier notions of “culture-bound syndromes” that categorized certain illnesses as specific to certain groups of people [72]. Cultural idioms of distress instead sought a more fluid understanding of illness. Since many studies have incorporated cultural idioms of distress into their methodology, and in 2013, the DSM-V also replaced “cultural bound syndromes” with “cultural concepts of distress.” [71, 73–76] Many anthropological studies, for example, have looked at how conceptualizations of “thinking too much” differ among countries and sub-populations, in order to better understand varying perceptions of etiology, somatization, and treatment [77]. Most studies have focused more on gathering different expressions for distress, such as the Somali word *buqsanaan*, which translates to “loud noise” and refers to a “jammed mind,” or the Rohingya word *unniyashi lager*, which refers to a feeling of suffocation, or the word *waajara galip* that Darfur refugees use to mean “pain in the heart.” [73, 74, 76] But there are many different expressions for distress and many different understandings of mental health, making it critical that clinicians and trained professional interpreters seek translation not just for semantic understanding but also for cultural understanding.

Cultural idioms of distress are only one part of a larger effort to build cultural competency, a term that first arose during the Civil Rights Movement to address racial and ethnic disparities [78]. Cultural competency is a core part of many interventions that work with refugee communities and seek to be culturally sensitive and culturally immersive [72]. In the past decade, however, there has been a shift away from cultural competency to structural competency, which recognizes that racial and ethnic disparities are not only due to cultural barriers, but also due to economic, sociopolitical, and systemic forces [79]. The discourse on structural competency, however, is still developing.

Building these competencies requires community partnerships to be leveraged as bridges for linguistic and cultural comprehension. In the academic space, community-based research has become the keystone of collaborative and equitable processes of knowledge creation [80]. In the clinical space, many interventions involve sharing resources with trusted community leaders, community health workers, and local volunteers, such as from a local place of worship, who can then relay resources to refugees in their community [81•, 82]. Various peer-to-peer educational programs, for example, have been developed to tap into community members who share common beliefs and values with refugee communities and who can then serve as “peer educators” within those communities [81•, 83]. These community partnerships help establish a line of communication that refugees can trust.

Interdisciplinary collaborations are also critical for creating a network of continuous medical, social, and legal support for refugees. Within the hospital, community partnerships play an important role in achieving stronger care coordination between case managers, psychologists, and other members of the care team to connect refugees to health care services early on, help refugees navigate the health care system, and connect refugees to community resources [84–86]. Studies have shown that refugees with access to stable, uncrowded housing have improved mental health outcomes, indicating the importance of clinical interventions that address structural barriers and social determinants of health inequity [87]. The Refugee Wellbeing Project at the University of New Mexico, which matches refugee families with university student advocates who help refugees navigate community resources, has also found that its program helps lower levels of anxiety and depression among some groups of refugees [70•]. Outside the hospital, more and more medical-legal partnerships are also being formed to bring together clinicians and attorneys to advocate for their patients and clients [88]. Many medical students have established student-run asylum clinics that connect immigration attorneys with physicians, who volunteer to provide pro bono forensic evaluations documenting the sequelae of trauma and helping corroborate the narratives of asylum seekers [89]. Studies have shown that when asylum seekers receive a medical forensic evaluation by a physician, they are more likely to be granted political asylum [90]. In 2001, UC San Francisco also created the first Trauma Recovery Center (TRC) to provide survivors of trauma and violence with individual and group psychotherapy, medication management and support, case management, legal advocacy, and other services important for healing [91•, 92]. The TRC model recognizes that trauma and violence can incapacitate an individual from initially seeking help and instead uses an assertive outreach approach to bring survivors into the TRC [91•, 92]. The TRC in San Francisco has been shown to increase engagement in mental health services, increase access to care, and decrease health care costs [91•]. Since, more TRCs have been established across California, Ohio, and Illinois [92].

All of these components of building robust clinical interventions are important components of trauma-informed care. Trauma-informed systems involve realizing the impact of trauma, recognizing the histories of trauma, recognizing the signs and symptoms of trauma, responding to the effects of trauma, and resisting re-traumatization. [14•, 15, 93, 94] This is where clinicians can make the greatest impact. Trauma-informed care involves using structurally competent screening tools to assess for trauma and developing multidisciplinary interventions to connect refugees to medical, social, and legal services. It involves building an inclusive health care environment that is free of xenophobia

and racism and that recognizes that some routine practices, such as breast examinations or imaging scans, can be potential triggers [15]. Most of all, it involves moving away from a focus on the pathology induced by trauma to the resiliency created by trauma. Many clinical and community interventions have been focusing on strengthening family and community bonds, using a strengths-based approach, and creating spaces for shared reflection and collective identity building [35, 80, 91•, 95, 96•]. However, there are currently no clear sets of guidelines or protocols for creating a trauma-informed system. But it is critical that approaches to trauma-informed care are taught to staff and implemented in all health care and social care spaces, in order to create a health care system in which all refugees feel safe and welcome.

Conclusion

In 2015, the body of a 3-year-old Syrian boy washed up on the shores of a Turkish beach, and the photo captured the world [97]. The Syrian refugee crisis filled major headlines and brought the world's attention to mass humanitarian crises across the globe. Many countries have since opened their doors to refugees fleeing a past of persecution, violence, and victimization. However, past histories of trauma do not fade away upon resettlement. Refugees continue to experience high rates of physical and structural violence, exacerbating already existing effects of prior trauma and leaving refugees in a chronic state of vulnerability. The COVID-19 pandemic has only further exposed some of those inequities [12].

But there are many opportunities for intervention, from mental health screenings immediately upon arrival, to community-based support networks, to trauma-informed care in the hospital. If clinicians know how to recognize the physical and mental manifestations of trauma and violence, the hospital can serve as a nexus for connecting refugees to medical and social services and for keeping refugees engaged in a continuum of care. But more guidance is needed on how to develop effective trauma-informed protocols and programs for various refugee communities and individuals. What remains important is that refugees are not pathologized due to their past and continuing exposures to trauma but recognized for their potential and resiliency in the face of trauma.

Declarations

Conflict of Interest The authors declare that they have no conflict of interest.

Human and Animal Rights This article does not contain any studies with human or animal subjects performed by any of the authors.

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