



# **Transcending Violence:** Emerging Models for Trauma Healing in Refugee Communities

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# I. Summary and Overview

This paper is an introduction and overview of the issues involved in providing mental health trauma services for refugees in the United States. It is intended primarily for people who work in or care about the public mental health system – clinicians, administrators, policymakers, advocates, and consumer/survivors. The goal of the paper is to help people better understand who refugees are, how they differ from others, what their needs are, and how the mental health system could be most helpful. While refugees have many health, mental health, and social support needs, the focus here is on trauma.

Consistent with current national mental health policy<sup>i</sup>, this paper is based on a public health model. The mental health field has traditionally focused on treatment of acute and chronic mental illness. However, it has begun to embrace a new direction, employing basic tools and tenets of public health to identify problems and develop solutions for entire population groups. This approach gathers data to establish the nature of the problem and its incidence and prevalence; identifies risk and protective factors; focuses on interventions designed to impact entire communities; evaluates the effectiveness and generalizability of interventions; and disseminates successful models as part of a coordinated effort to reach out and educate the public.

Perhaps the most fundamental principle of a public health model is to focus on wellness rather than illness. This credo is nowhere more applicable than when working with refugees. As Muecke (1992) states: “Refugees present perhaps the maximum example of the human capacity to survive despite the greatest losses and assaults on human identity and dignity.” The majority of refugees do, in fact, overcome significant challenges, get jobs, raise families,

and adapt well to life in their new country. They deserve our respect as well as our assistance. This paper suggests that there is a key role for public mental health systems to play in healing refugee trauma. It also points to the development of trauma-informed partnerships as one promising strategy for assisting refugees without pathologizing them.

The remainder of the paper is organized as follows. Section II provides background information on the international situation of refugees, the U.S. refugee service system, and the process of refugee migration and resettlement. Section III outlines how a public health framework applies to refugee trauma, and notes some current issues and debates surrounding the adoption of this framework in the refugee service community. Section IV reviews major cultural issues that arise when working with refugee populations. Section V focuses on trauma interventions, including 1) the application of current trauma treatment models to refugees, and 2) new approaches to trauma healing emerging from direct experience with refugee communities. Section VI is a discussion of gender issues. Finally, Section VII suggests ways in which public mental health systems could build trauma-informed partnerships to meet the needs of refugees. ■



# II. Background

## The International Context

According to the United Nations, there are currently 9.9 million refugees displaced from their home countries across the globe (United Nations High Commission on Refugees, UNHCR, 2007). An additional 25 million people are internally displaced (Eschenbächer, 2005), about half of whom (12.8 million) are receiving assistance from UNHCR. The vast majority of refugees come from developing countries: An estimated 8 out of every 10 refugees flee from one poor country to another, often the country next door. Approximately one third of the refugees cared for by UNHCR live in Central Asia, South-West Asia, North Africa and the Middle East, while another third live in sub-Saharan Africa. Europe hosts 25 percent of all refugees, followed by Asia and the Pacific (10%), and the Americas (7%). Although gender and age ratios vary widely according to the nature of the refugee situation, region of asylum, and other factors, approximately 50% of all refugees are women, and 45% are children under the age of 18. Together, women and children comprise about 75% of the world’s refugee population. Women are also over-represented in the older age category (60 years and older.)

While people often use the term “refugee” to refer to anyone who has fled his or her home, the term has a precise legal definition.

Understanding the basic differences between refugees and other newcomers (see below) can help sensitize caregivers to unique aspects of the refugee experience.

## Distinctions between Refugees and Other Newcomers <sup>ii</sup>

The experience of refugees often differs significantly from that of other displaced persons or newcomers to the U.S. According to the UN, a *refugee* is a *person outside of his or her country of nationality who is unable or unwilling to return because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion.* With rare exceptions, refugee status is determined while the individual is still outside the U.S., and whether or not a person is granted refugee status depends on why he or she fled the home country. *Internally displaced persons* are *persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border.* *Asylees* are individuals who, on their own, travel to the U.S. and apply for/receive a grant of asylum, a

Refugee	Forced to flee home; is outside of country of origin; has well-founded fear of persecution
Asylum Seeker	Makes a claim that he/she is a refugee.
Migrant	Moves to a foreign country for a variety of reasons (e.g., work) and for a certain length of time (usually a minimum of one year)
Immigrant	Takes up permanent residence in a country other than original
Economic Migrant	Leaves country of origin for economic reasons
Internally Displaced Person	Like refugees, forced to move, but remains in own country
Stateless Person	Not considered a national by any country or does not enjoy fundamental rights enjoyed by others in their home state

status that acknowledges that they meet the definition of a refugee, allows them to remain in the U.S., and makes them eligible for refugee assistance and services. Persons admitted through the resettlement system or granted asylum may change to permanent resident status after one year, which puts them on the road to citizenship.

Refugees leave their home countries involuntarily, usually do not have a choice about where to resettle, may have little time to plan or prepare for their migration, and cannot return home because of continuing danger of persecution (Peloquin, 2004). Though comprising only 10 percent of annual immigration to the United States, refugees are a distinct component of the foreign-born population in many U.S. metropolitan areas (Singer and Wilson, 2007).

Sources of trauma for refugees may include war, rape or atrocities during conflict or repressive regimes, or “disappearance” of friends and family. Trauma may also result from previous experiences within the country of origin – domestic violence, rape, honor killings, racism, state sanctioned violence, experience in combat, terrorism. While other groups and subgroups, such as disaster victims, may also experience severe trauma, there are major legal and psychological differences between fleeing persecution as a refugee and fleeing disasters as an evacuee. The trauma experienced by refugees is likely to have been prolonged and repeated, consciously caused by other human beings, and exacerbated by forced exile (Brune et al, 2002).

Recent years have seen an increase in the number of international programs addressing refugee trauma, as well as concerns about their relevance and effectiveness (Bracken, Giller, and Summerfield 1997; Watters, 2001). One review indicates that a majority of these projects offer direct psychological services (63%) or psychologically oriented groups (54%), mostly self-help. Thirty-three percent of the projects provide psychiatric services and 63 percent have

staff training programs focusing on trauma (Summerfield, 1999). As an example, a trauma center established in Rwanda in the mid-1990’s provided intensive therapy for traumatized children and their families. By 1996, over 6,000 “trauma advisors” had been trained in basic trauma alleviation methods, assisting an estimated 144,000 children. Similar efforts to train mental health staff have been undertaken in other parts of the world by UNHCR and the World Health Organization (Summerfield 1999). Further discussion about these programs is included below.

## Refugees in the United States

**The U.S. Refugee Program.** The first refugee legislation enacted by Congress, the Displaced Persons Act of 1948, was specifically designed to assist displaced Europeans. Later laws provided for the admission of individuals fleeing Communist regimes in Hungary, Poland, Yugoslavia, Korea, China and Cuba. Most of these refugees were assisted by ethnic and religious organizations, establishing a basis for today’s public/private partnership in refugee assistance.

The current United States refugee program began in 1975 with the fall of Saigon and passage of the Refugee Act of 1980. Since then, approximately 2.5 million people have been resettled in the U.S. The number of refugees entering the U.S. from a particular country or region varies from year to year, with an annual ceiling, designated nationalities, and processing priorities set by the President in consultation with Congress and the appropriate agencies. In 2007, of the 70,000 admissions ceiling, the highest regional allocation was made to Africa (22,000), then East Asia (11,000), Europe (6,500), Near East/ South Asia (5,500) and Latin America (5,000), with an unallocated reserve of 20,000. However, the actual number of refugees admitted may not reflect the allocation; since 2001, admissions have been significantly lower than ceiling numbers (Cultural Orientation Resource Center, 2007).

The Refugee Act of 1980 provides the legal basis for today's refugee admissions program, which is administered by three different departments within the federal government:

- Bureau of Population, Refugees and Migration (BPRM) of the Department of State,
- Office of Refugee Resettlement (ORR) in the Department of Health and Human Services (HHS), and
- Department of Homeland Security (DHS).

Local resettlement programs are state funded; the only state without a refugee program is Wyoming. States contract with nine private organizations (called "voluntary agencies" or "volags") that help newly arrived refugees settle into local communities. The volags also have a network of over 400 affiliates (ethnic, self-help and community organizations) that assist with refugee resettlement. The nine voluntary agencies are:

- U.S. Conference of Catholic Bishops/Migration and Refugee Services,
- Lutheran Immigration and Refugee Service,
- Episcopal Migration Ministries,
- Hebrew Immigrant Aid Society,
- Church World Service/Immigration and Refugee Program,
- International Rescue Committee,
- U.S. Committee for Refugees and Immigrants,
- World Relief, and
- Ethiopian Community Development Center.

The Office of Refugee Resettlement (ORR) is the main coordinating body for resettlement services, working closely with State Refugee Coordinators and Refugee Health Coordinators. Through its Division on Refugee Assistance, ORR oversees numerous state-administered programs for refugees, including cash and medical assistance and targeted preventive health grants. Through its Divisions on

Community Resettlement and Unaccompanied Children's Services, ORR provides economic and social integration assistance and ensures the safety of unaccompanied alien children.

Assisting in the coordination of mental health services to refugees is SAMHSA's Center for Mental Health Services (CMHS) Refugee Mental Health Program (RMHP). Founded in 1980, RMHP provides technical assistance, consultation, mental health and community assessments, treatment, and training for resettlement staff and mental health personnel. In 1995, an intra-agency agreement with ORR was developed to expand consultation to ORR-funded programs.

Particularly relevant to the issue of trauma is the Torture Victims Relief Act of 1998. Under this act, services are provided to torture survivors in all immigration categories – citizens, undocumented individuals, refugees, asylum seekers, and asylees. The majority served are asylum-seekers. Services include treatment of the physical and psychological effects of torture, social and legal support, and research and training for health care providers. ORR supports a national consortium of torture treatment providers as well as capacity building projects to expand the availability of services to torture survivors, within both specialized treatment settings and mainstream provider organizations. There are currently 20 specialized treatment programs for torture survivors in 15 states.

## Specialized Treatment Programs for Torture Survivors

Advocates for Survivors of Torture and Trauma  
Baltimore, MD  
<http://www.astt.org/>

Asian Americans for Community Involvement of Santa Clara County, Inc.  
San Jose, CA  
<http://www.aaci.org/center-for-survivors-of-torture.html>

Center for Psychosocial Rehabilitation of Victims of Torture  
Arab Community Center for Economic and Social Services  
(ACCESS)  
Dearborn, MI  
<http://www.accesscommunity.org/>

Boston Center for Refugee Health and Human Rights  
Boston Medical Center Corporation  
Boston, MA  
<http://www.bcrhhr.org/>

Center for Multicultural Human Services  
Program for Survivors of Torture and Severe Trauma  
Falls Church, VA  
<http://www.cmhsweb.org/programs/psst.html>

Center for Survivors of Torture  
Dallas, TX  
<http://www.cstdallas.org/>

Center for Survivors of Torture and War Trauma  
City of St. Louis Mental Health Board of Trustees  
St. Louis, MO  
<http://www.stlcenterforsurvivors.org/>

Center for Victims of Torture  
Minneapolis, MN  
<http://www.cvt.org/>

Center for Torture and Trauma Survivors  
DeKalb County Board of Health  
Decatur, GA  
<http://www.dekalbhealth.net/PDFs/torture.pdf>

Florida Center for Survivors of Torture  
Gulf Coast Jewish Family Services  
Clearwater, FL  
<http://www.gcjfs.org/svc-survivors.htm>

Heartland Alliance for Human Needs & Human Rights  
Marjorie Kovler Center for Treatment of Survivors of Torture  
Chicago, IL  
<http://www.heartlandalliance.org/kovler>

Legal Aid Foundation of Los Angeles  
Los Angeles, CA  
<http://www.lafla.org>

Lutheran Immigration and Refugee Services  
Detained Torture Survivor Legal Support Network  
Baltimore, MD  
<http://www.lirs.org/What/programs/torturesurvivor.htm>

Massachusetts General  
Harvard Program in Refugee Trauma  
Cambridge, MA  
<http://www.hprr-cambridge.org/>

New York City Health & Hospitals Corporation  
Bellevue/NYU Program for Survivors of Torture  
New York NY  
<http://www.survivorsoftorture.org/survivors>

Torture Treatment Center of Oregon  
Intercultural Psychiatric Program  
Oregon Health & Science University  
Portland, OR  
<http://www.ohsu.edu/psychiatry/clinics/>

Program for Torture Victims  
Los Angeles, CA  
<http://www.ptvla.org/>

Rocky Mountain Survivors Center  
Denver, CO  
<http://www.rmcsdenver.org/>

Survivors of Torture International  
San Diego, CA  
<http://www.notorture.org/>

Tides Center  
Utah Health & Human Rights Project  
Salt Lake City, UT  
<http://www.uhhr.org/>

**Stages of the Refugee Experience.** There are three major stages of refugee experience: the premigratory period, migration or period of flight, and resettlement. Each stage has unique risks and stressors. Caregivers need to be aware that refugees have been through a long process even to get to the point of resettlement, and that there have likely been significant life stresses and losses along the way. This is particularly important from a trauma perspective, since the impact of trauma is cumulative.

In the *pre migratory period*, refugees flee conditions in their home countries and find temporary shelter in refugee camps or communities in neighboring countries. The experience of refugees varies widely. Depending on their situation, they may be fleeing from violence, have prolonged experience with harsh conditions in refugee camps, be exposed to infectious and parasitic diseases, experience malnutrition and exposure to the elements, or be victimized by pirates, border guards, army and resistance units, and others with whom they come in contact.



UNHCR interviews individuals while they are in refugee camps or other temporary shelter to determine whether they should be granted refugee status and to determine the best course of action – voluntary repatriation, integration into the country of asylum, or resettlement into a third country. If resettlement is the best solution, they may be referred to the U.S. Citizenship and Immigration Services (CIS) for determination of eligibility for resettlement in the U.S. If they are deemed eligible, nongovernmental agencies known as “overseas processing entities” do much of the groundwork for *migration* - interviewing, preparing paperwork, arranging medical examinations and background security checks, and gathering information about the refugee’s work history and job skills, family situation, and special needs. The International Organization for Migration generally arranges and covers the costs of transportation, which the refugee must repay after resettlement. Before departing for the U.S., refugees receive a cultural orientation to life in the United States.

During *resettlement* in the U.S., refugees may face significant challenges in finding employment and housing, overcoming racial discrimination and language barriers, and navigating an unfamiliar service system. They may also experience chronic situational stressors

such as fear of being repatriated (Sinnerbrink et al, 1997).

The resettlement experience differs from state to state and community to community and can vary widely for different refugee groups. For example, some refugee groups come to the U.S. without a strong “receiving community” – established communities of earlier immigrants who can help the newcomers adjust. Under these circumstances, it is easy for refugees to remain both linguistically and socially isolated. They may end up living in communities without a strong economic base or with high crime rates. In contrast, some refugees move directly into well established communities that can assist with resettlement. For example, Dearborn, Michigan is currently home to the largest group of Arabs outside of the Middle East, and provides significant support to Arab refugees resettling in that area.

Research has identified four major factors that together account for 62% of resettlement stress: social and economic strain, alienation, discrimination and status loss and violence and threats (Lindencrona et al, 2008). During resettlement, refugees continue to be at-risk for chronic diseases, trauma-related symptoms, and other consequences of their experience during pre-migration and flight. ■



### III. Defining and Responding to Violence and Trauma in Refugee Populations – Adopting a Public Health Framework

Within the field of refugee services, there is a strong push to adopt a holistic, public health model and to focus on wellness rather than illness. Given the risk factors that refugees are exposed to, classic concepts of primary and especially secondary (population-based) and tertiary prevention (case finding and referral) are clearly relevant. Similarly, health promotion and strengths-based approaches support the natural resilience displayed by many refugees. SAMHSA's toolkit *Refugee Well-Being: partnering for Refugee Health and Well-Being* provides an excellent introduction to this approach.

The seminal work of Aaron Antonovsky on “sense of coherence” is particularly helpful in framing refugee mental health and trauma services. Antonovsky conceptualizes health as a continuum, and argues that we need to shift our attention from factors that are “pathogenic” (disease producing) to factors that are “salutogenic” (health producing) (Antonovsky, 1979). He also suggests that people’s ability to create positive health depends on their “sense of coherence” – a combination of the ability to assess and understand their situation, to find meaning in their circumstances, and to actively move in a health-promoting direction (Lindstrom and Eriksson, 2005). Research on the refugee experience is consistent with this framework. For example, there is evidence that a strong belief system, whether grounded in faith or in a political ideology, is a protective factor for refugees and assists in coping with trauma (Brune et al, 2002). Relocation to a new country may challenge one’s existing sense of coherence. Whenever possible, mental health or trauma services should work to support refugees’ resilience by helping them to

understand and find meaning in their experience and to adopt health-promotion behaviors.

Refugee health and mental health concerns also need to be addressed in the context of psychosocial needs such as housing, employment, language skills, and other essential support services. For mental health practitioners, this approach is consistent with the community support and rehabilitation model developed in the 1980’s and 1990’s as a comprehensive approach to meeting the needs of people with severe mental illnesses (Turner, 1979; Saraceno, 1997).

Embracing a public health approach to refugee trauma has several implications. First, it is essential not to pathologize the suffering of refugees or to overgeneralize their experience. Thus while it is safe to assume that all refugees have undergone a challenging journey, and that all may benefit from some forms of assistance, it is inaccurate to assume that all are traumatized or require trauma treatment. The distinction between *trauma-specific* and *trauma-informed* services is extremely helpful in this regard. All services and programs for refugees should be trauma-informed – ie, aware of the pervasiveness of trauma, its impact, and its self-perpetuating nature; familiar with the multiple and complex paths to healing and recovery; and thoroughly incorporating this knowledge into all aspects of service delivery (Fallot and Harris, 2006). Trauma-informed principles such as *safety, trustworthiness, choice and empowerment* will be helpful for all refugees, regardless of their specific experiences. In addition, trauma-specific treatment should be available for those with severe and persistent trauma-related symptoms.

Adopting a public health model also raises the question of focusing on the individual versus the community, and on the relevance of the diagnostic model of PTSD for refugees. These questions are a matter of considerable debate within the refugee system.

### **Focus on the Individual versus the Community.**

The public health model addresses the health of entire populations, and promotes the use of preventive and community-level interventions whenever appropriate. Within the refugee service system, there is reason for concern that an overemphasis on individual trauma healing may divert attention from important social, economic and political issues. In some cases, the adoption of a clinical trauma model has resulted in a shift away from an economic approach to solving community problems. For example, “crisis centers” in Indonesia that focused on a range of community development needs were recently renamed and retooled as “trauma clinics,” and a long-standing concern for human rights, women’s rights and democratization dissolved in a new wave of interest in PTSD (Dwyer and Santikarma, 2007). Similarly, the introduction of trauma programs for survivors of a terrorist bombing in Bali diverted attention from long-term structural inequalities and state repression that had resulted in the mass killing of 5-8% of the island’s population (Dwyer and Santikarma, 2007). Some worry that a focus on trauma may be used as a substitute for effective international political action. As Silove notes, “there is much to be said for the argument that peace and security provide the best immediate therapy for the majority of populations exposed to mass violence and displacement” (Silove, 2007, p 255.) While the implementation of trauma treatment for refugees in the U.S. may not reflect such stark polarities, the concern about focusing on individual pathology versus social factors is still salient.

The public health focus on community-level interventions is supported by evidence that refugees are more concerned with social and economic issues than with psychological

problems. For example, in a study of the major concerns of people tortured for political reasons in South Africa, somatic health problems were identified most often, followed by economic concerns, dissatisfaction with the current political situation, and finally, symptoms of posttraumatic stress (Kagee, 2004). Consistent with this finding, Blackwell (2005) asserts that people whose lives have been constrained or damaged by political violence do not see themselves as sick or as victims. Treating them as such depoliticizes their experience and is inherently problematic, if not re-traumatizing. He and others propose wider use of community interventions such as human rights and truth and reconciliation commissions, which they believe are more respectful simultaneously providing emotional healing and supporting collective resilience (Tummala-Nara, 2007). Some international groups have moved to implement trauma programs that work collectively with all community members, including both “victims” and “perpetrators” (see, for example, [www.FriendsPeaceTeams.org](http://www.FriendsPeaceTeams.org)).

**Relevance of the PTSD Model.** There is also an ongoing debate about how well the Post Traumatic Stress Disorder (PTSD) model applies to the experience of violence in non-western countries. PTSD, first recognized in soldiers returning from Vietnam, results from exposure to a life-threatening event that produces a sense of current threat. Symptoms fall into three clusters: intrusive symptoms, avoidance symptoms, and symptoms of hyper-arousal (Johnson and Thompson, 2007). PTSD was introduced into the *Diagnostic and Statistical Manual-III* to address the need for a common diagnostic category covering the wide range of clinical syndromes associated with a traumatic experience (Fischman, 1998). The rapid growth in the use of the PTSD diagnosis has been criticized as spawning a “self-sustaining trauma counseling industry” and encouraging a culture of victimization, in some cases undermining traditional, non-professional support mechanisms and natural recovery processes (Silove, 2007).

Some argue that the PTSD model is irrelevant to model presumes that trauma is an aberration - an unexpected, isolated or infrequent event that occurs outside the norms of society. In contrast, in war-torn societies violence is an ongoing, routine part of people's everyday experience, even after "peace accords" have been signed (Radan, 2007), and for most refugees traumatic stress is a continuing condition even upon resettlement (van Willigen, 1992). Although some theoretical models of trauma, such as "complex PTSD" and "DESNOS" (disorders of extreme stress not otherwise specified) focus attention on chronic or repeated exposure, few clinical models reflect the complexities of conflict and post-conflict life - situations where perpetrators live alongside victims as neighbors, or where victims are also forced to commit acts of violence against others (Lemelson et al, 2006). Others note that symptoms of trauma are largely culturally determined, and evidence of refugee trauma may be missed altogether if clinicians are looking for symptoms that are normative in western populations. Both the construct itself and the assessment instruments designed to measure it may not accurately reflect non-western cultures (Johnson and Thompson, 2007).

Concerns have also been raised about studies that report PTSD to be at epidemic levels in refugee and post-conflict populations - commonly reported at levels of 20-35% and

the experience of many refugees, since the sometimes as high as 99% (de Jong et al, 2000). Although PTSD symptoms are ubiquitous after mass exposure to trauma, in situations of extreme stress symptoms may represent a normal rather than pathological reaction, and "diagnosing" entire populations may be misleading. Moreover, most people exposed to extreme trauma do *not* go on to develop chronic, disabling PTSD. Meta-analyses show that on average only 20% of those who experience traumatic events develop PTSD (Rousseau and Measham, 2007), and an even smaller percentage come for treatment (Chow et al, 1999). Advocates concerned about the over-diagnosis of PTSD suggest that when entire populations are affected by violence, clinical treatment should be seen as an intervention of last resort. Rather than providing trauma treatment to everyone, they argue, it makes more sense to support and enhance indigenous supports and natural recovery processes for all who can benefit, and make more intensive interventions available for those *most* in need. This approach has been borne out in communities such as East Timor, where there has been remarkable recovery from mass trauma - even though very few people received PTSD counseling - but where a sizeable minority continue to suffer severe and disabling symptoms (Silove, 2007). ■



## IV. Understanding Cultural Perspectives

One of the major challenges in providing services to refugees in the United States is recognizing the degree to which our understanding of violence and safety, and our responses to trauma, are culturally determined. In relatively “peaceful” Euro-American societies, violence is seen as something both perpetrated and experienced by individuals (Rousseau and Measham, 2007). Governments, armies, police, and other forms of organized authority are generally considered to be instruments of maintaining safety, not imposing terror. We have little experience in dealing with state sanctioned violence, and may make inaccurate assumptions about what constitutes safety for a refugee.

Our western assumptions also lead us to believe that violence is something “other than ourselves,” and to maintain a sharp dichotomy between victim and aggressor. Thus we may categorize people from violent societies as either “barbaric and uncivilized aggressors” or “defenseless victims dependent on our help” (Rousseau and Measham, 2007). In reality, identities are complex, and often combine several aspects of the experiences of violence. For example, women refugees from Kosovo (many of whom had been raped and tortured) were unlikely to describe themselves as traumatized women, rape survivors or torture victims. Rather, they defined their identity in terms of their role in the armed struggle – ie, as wives and sisters of the Kosovar Liberation Army (KLA) fighters, political dissidents, and as Muslims whose right to practice religion was violated (Gozdziak and Tuskan 2000; Gozdzia, 2002). Effective treatment programs work within the frame of reference adopted by the refugees themselves.

A similar dilemma may result from conflicting social and personal narratives. Under normal situations, we all hold multiple identities and

construct multiple narratives about our experiences. When the narratives conflict, we find ways to resolve the contradictions between them. However, extreme circumstances may violate or change the construction of identity narratives in ways that are irreconcilable. For example, for women who survived rape and violence in Bosnia, both their ethnic identity and their gender identity were involved. As ethnic victims, elements of their stories created a “survivor plot” characterized by absence of guilt, family support, and political action. However as women, the violence they experienced created a “victim plot,” characterized by feelings of guilt and shame, hiding their experiences from family, and trauma symptoms (Skjelsbaek, 2006). During recovery, both of these narratives may play a critical role.

It is also not uncommon for violence and extreme hardship to become a critical part of collective cultural, ethnic or religious narratives. BenEzer describes how this process has occurred with the Ethiopian Jews who immigrated to Israel through Sudan during the 1980s (BenEzer, 2007). Along with their Jewish identity, the Ethiopians understood *physical and emotional suffering* and *bravery and inner strength* as the central themes of their journey and of their identity as a people. The collective narrative about their journey, which is quickly assuming mythic proportions, has created group cohesion and a sense of direction for the future of Ethiopians in Israel. This social narrative may have helped people to cope with the extreme hardships they experienced along the way and may serve as a “protective shield” against future trauma (BenEzer, 2007). However, this social identity could also come into conflict with the personal identity narrative of an individual who has experienced extreme stress and needs assistance. Balancing individual and collective identities may be key in assisting some refugee populations.

A further complication may occur over time, as a particular experience of violence or trauma becomes part of large-group identity (Young, 2007; Rousseau, 2005; Volkan, 2001). For most refugees, violence is a recent or ongoing issue. However, historical trauma may also be relevant for some refugee groups. Often, as an ethnic, religious or national group incorporates a massive trauma into their collective narrative, the experience may come to play a key role in defining their cultural identity (Young, 2007). When an external threat arises, the old trauma may be reactivated. While this may have negative psychological consequences, it may also provide positive support for the threatened identity. Similarly, in times of stress, individual identity often fades into the background and issues of group identity predominate (Volkan,

2001). Clearly, anyone working with refugees needs to be aware of how different situational contexts are likely to affect the meaning ascribed to their experiences.

Finally, understanding the experience of the refugee means constantly staying open to unexpected emotions and interpretations. While we may be trained to focus on healing trauma symptoms, for some refugees the restoration of dignity may be more important than the alleviation of fear and anxiety. Others may choose to focus on an issue that might not even occur to us – for example, the loss of one's youth in a refugee camp may be perceived as a more grievous wound than the experience of violence itself. ■



## V. Clinical and Program Issues

There are a number of critical factors to keep in mind when providing refugee trauma services. First, there is a complex interplay between the stresses experienced during different phases of relocation and mental health outcomes. While exposure to severe traumatic events is often assumed to explain mental health symptoms in refugees, post-migration stressors may also contribute. In one study, resettlement stressors and personal capacity to handle stress accounted for 50% of the variance in mental health symptoms, with pre-resettlement trauma accounting for only 5.5% (Lindencrona et al, 2008). Similarly, a recent meta-analysis found that economic opportunities and permanent private housing were associated with better mental health outcomes (Porter and Haslam, 2005). These findings suggest that meeting basic needs for refugees should be a high priority.

Diagnostically, refugees may suffer from a complex mix of trauma-related problems, including depression, complicated grief, PTSD, psychotic disorders, somatic complaints and health problems (Ferrado-Noli et al, 1998; Kirmayer et al, 2007; Momartin et al, 2004). Groups that have experienced colonization or have been the targets of ethnic cleansing may internalize their rage and show no signs of PTSD, yet have high rates of substance abuse, suicide and violence (Sanchez-Hucles and Gamble, 2006). Severe trauma can also alter an individual's worldview and their capacity to handle stressful situations (Lindencrona et al, 2008).

Our diagnostic lens must be wide enough to see all of these conditions as trauma-related. As Richard Mollica (2006) points out, in many conventional mental health settings symptoms of refugee trauma may be misdiagnosed as a psychotic illness, and the individual may end up involuntarily committed to a mental hospital and strongly advised (or forced) to take psychotropic

drugs without being given appropriate counseling or social rehabilitation. Becoming *trauma-informed* will help mental health programs working with refugees to be aware of the many ways in which trauma can affect mental health.

Finally, practitioners working with refugees may need to abandon common assumptions, including the belief that people who have experienced extreme violence will never recover, and that severely traumatized people do not want to talk about their experiences (Mollica, 2006). They will certainly need to take into account local "idioms of distress," i.e., specific ways in which people from different cultures experience and communicate pain and suffering, as well as traditional ways of coping. The task may seem overwhelming, especially since there is far more literature documenting the problem of violence and trauma among refugees than describing effective ways to treat it (Miller et al, 2006). However, research is beginning to identify ways in which trauma treatment can be modified for refugee populations, and new clinical models are being developed and tested. The following section reviews some promising directions.

### Application of Current Trauma Treatment Models to Refugee Populations

Over the past ten years there has been an explosion of research and theory on trauma (Kirmayer et al, 2007). There is a wide and growing repertoire of therapies for dealing with trauma-related disorders, including psychopharmacology, trauma counseling, psychodynamic approaches, cognitive-behavioral treatments (exposure therapy, flooding, systematic desensitization, EMDR), psychodrama and body-based therapies, Eastern-based interventions (acupuncture, meditation) and a host of others (Pedersen, 2002).

Approaches that have been developed and proven effective with general mental health populations, such as therapeutic communities, are also being applied to trauma survivors (Tziotziou et al, 2006). However, outcome studies on trauma treatment with refugees are scarce, the few follow-up studies that exist show varying levels of improvement over time (Carlson et al, 2005; 2006), and research on the comparative efficacy of different therapies with refugee populations is in its infancy. Emerging clinical models specifically designed for refugees are summarized in the next section. For trauma providers seeking to apply existing clinical treatment models to this population, research suggests that we should consider three priorities when selecting an intervention:

**Priority #1: Support Resilience.** Trauma interventions need to be vigilant about not undermining natural recovery, resilience, and self-healing processes. The impact of trauma is real and sometimes debilitating. However, there is a great deal of variability in the way people react to even very severe trauma. The most typical response to acute psychological trauma is recovery over time (Konner, 2007), and believing that recovery is possible has long been considered an essential element of trauma healing (Herman, 1992).

More recently, the concept of resilience has emerged as a distinct factor in understanding trauma and loss (Bonnano, 2004). Unlike the concept of recovery, which connotes overcoming a temporary loss of normal functioning, resilience implies an ability to maintain a steady level of functioning despite significant trauma. While resilient individuals may experience brief and transitory symptoms, they generally maintain healthy functioning, and retain their capacity for generating positive emotional experiences. There is substantial evidence that many individuals are able to endure traumatic events remarkably well, with little or no apparent disruption in psychological or physical functioning. Some theorists estimate, based on available research, that the vast majority of individuals exposed to violence do not exhibit chronic symptom profiles,

and that the majority show the type of healthy functioning that would imply resilience (Bonnano, 2004).

The concept of resilience as a separate and distinct trajectory from recovery has important implications for intervention. First, it implies that an absence of pronounced distress may be normal for some people - such an absence does not necessarily reflect a delayed PTSD response. Second, it suggests that not all people who experience severe trauma will benefit from treatment, and in fact, treatment may undermine natural resilience for some (Bonnano, 2004). Third, it implies that clinical interventions aimed at entire populations may be misguided. Mollica suggests that our current orientation to violence and trauma focuses too heavily on the negative consequences of traumatic events, and may inadvertently be short-circuiting natural resilience, creating dependency, and creating real disease and illness. He concludes that we need a revolution in our thinking, making the engagement of survivors in their own recovery the “mantra of social recovery” (Mollica, 2006, p. 236).

While research on resilience is in its early stages, it appears to be a multidimensional phenomenon rather than an all-or-none capacity. When resilience is defined as multidimensional, it becomes possible “to see trauma survivors as simultaneously suffering and surviving (Harvey, 2007, p.15). Clinical interventions should recognize that even people who display severe and recurrent trauma symptoms in some areas of functioning may be demonstrating incredible resilience in others. In addition, resilience is not a static trait, but an unfolding process in which strengths and vulnerabilities emerge over time (Tummala-Narra, 2007). Finally, providers need to be aware that what is seen as promoting resilience in one culture may be seen as a liability in another (Tummala-Nara, 2007).

**Priority #2: Respect Cultural Norms.** Some common trauma interventions may be culturally inappropriate for some refugee groups. The very notion of confronting trauma directly reflects a western bias that we need to “face our problems

and overcome them,” and may not be relevant to other cultures (Kinzie, 2007). Moreover, some trauma is so existentially profound and disturbing that bringing up memories may be unnecessarily cruel. For individuals who have endured massive or repeated violence, or who have lost their sense of trust or meaning, other forms of intervention may be called for. Bonds of social support, reconnections with loved ones, and narratives of hope for the future may all be critical for recovery (Kirmayer et al, 2007). Some of the emerging program models that emphasize narrative and story telling, community empowerment and psychosocial supports respond to these needs.

**Priority #3: Treat Severe Symptoms.** Despite the above cautions, there are some refugees who display severe and persistent trauma symptoms who can benefit from intensive trauma treatment. Once a fear response is learned, it persists, being incorporated in the molecular structure of the brain (Barad and Cain, 2006). The original fear response remains available, ready to re-emerge, even after an alternative “safety” response is learned. Since learned fears generalize more readily to new contexts than learned safety does – and since even the passage of time may constitute a new context – there is a biological basis for the phenomenon of chronically relapsing PTSD (Bouton et al, 2007). For those with severe and persistent symptoms, cognitive-behavioral therapies, such as exposure therapy or EMDR, may be especially helpful. Prolonged exposure therapy, which incorporates breathing retraining, prolonged and repeatedly titrated reliving of trauma memories, and repeated in-vivo exposure to trauma-related situations and objects, appears to assist in generalizing the safety response to more situations (Yadin and Foa, 2007). In some cases, especially for people who have suffered for long periods of time, relief of symptoms through psychopharmacology may be a high priority (Kinzie, 2007).

## Emerging Clinical Models and Approaches for Refugee Populations

**Self-Care and Self-Healing.** One of the most powerful emerging model for working with

refugee trauma places self-care and self-healing at the core of the recovery process. Self-healing is part of the body’s natural biological response to injuries of all types. Both biological and physical healing have been shown to occur naturally following all forms of violence (Charney, 2004).

Self-healing is being championed by Richard Mollica, among others. As a medical doctor, he was trained to diagnose and treat, primarily with medications, and he “didn’t know what to do with people who want to help themselves” (Mollica, 2006, p 6). However, once he recognized the power of self-healing, new avenues for treatment and support opened up and his entire clinical approach shifted. He now believes that the key to healing the wounds of even the most severe forms of violence and trauma lies within the individual (Mollica, 2006).

Refugee communities naturally understand and support their own self-healing and empowerment: Self-help groups and advocacy are often among the first responses of refugee communities upon resettlement (Light, 1992; Ranard, 1990). However, supporting self-help does not mean political abandonment (Puggioni, 2005), nor does it mean there is no role for professional help. As Mollica states: “Traumatized people throughout the world voice the same request for help with self-healing” (Mollica, 2006, p.26).

Supporting the self-healing process involves recognizing that each individual’s experience of violence and recovery is unique, and cannot be understood without understanding the person’s own history and personality. It also involves the development and maintenance of trust, despite uneven power relationships and a host country that views refugees with considerable suspicion (Rousseau and Measham, 2007). Other practices that support self-healing include placing oneself as close as possible to the pain and suffering of the individual in order to hear their truth; helping them tell their story in a healing manner; helping them to take a conscious inventory of their own self-healing efforts; learning about and supporting cultural healing practices; and reinforcing the

individual's self-healing efforts in every way possible (Mollica, 2006). Social behaviors such as humor, friendship, and physical exercise can also contribute to self-healing (Southwick et al, 2005).

**Traditional Healing.** Many authors have written about the importance of working within a cultural frame of reference, understanding the ways in which suffering is experienced, understood and expressed with the refugee's culture. It is particularly important to become aware of culturally-specific symptoms; to understand local patterns of help-seeking; and to support cultural healing resources whenever possible (Miller et al, 2006). Valuing traditional healing does not mean that western trauma treatment modalities need to be abandoned or modified to the extent that they are no longer consistent with best practice standards. However, it is important to remember that most evidence-based practices have not been tested or normed on refugee populations.

The cultural specificity of trauma symptoms has obvious clinical significance. It may be crucial for practitioners to know, for instance, that somatic complaints are particularly prominent among Southeast Asian refugees with trauma histories (Hinton and Otto, 2005), that sleep paralysis is a common occurrence for Cambodian refugees with PTSD (Hinton et al, 2005), or that for Afghans, intrusive memories of trauma are not particularly troubling because they fade quickly, while long-term feelings of depression and hopelessness (called "jigar khun") are a major concern (Miller et al, 2006). Understanding the associations of specific symptom patterns to trauma experiences can also be key. For example, dizziness is a very common symptom for Cambodian refugees. There is evidence that Asian groups are particularly susceptible to some forms of dizziness, and in Cambodian ethno-physiology, dizziness is greatly feared. Dizziness may also have critical trauma associations, since it was a common experience during the Pol Pot regime due to overwork, starvation, and malaria (Hinton and Otto, 2006). Obviously, attending to this

particular symptom may be far more important to trauma healing for Cambodian refugees than might be assumed from a western perspective.

Effective refugee trauma interventions also incorporate cultural traditions. For example, Stepakoff and colleagues used indigenous healing practices (including songs, cultural stories, dance/movement and rituals) in their work with Sierra Leonean and Liberian refugees (Stepakoff, 2007). Working in partnership with traditional healers may at times be indicated. In one case reported by Miller and colleagues (2006), a deeply religious Bosnian Serb refugee made more progress after one meeting with the head of the Greek Orthodox Church, who was sympathetic to her loss and her bereavement, than she had made after months of psychotherapy and medication. It is not always necessary to bring traditional healers into clinical practice - in some cases the community trauma may be so severe that it exceeds the coping resources or knowledge and skills of local healers (Miller et al, 2006). However, being knowledgeable about indigenous healing practices and willing to incorporate them may be crucial to forming an effective clinical alliance and to developing a set of interventions that maximizes the chances of recovery.

**Story-Telling and Narratives.** The value placed on "telling one's story" varies significantly between cultures. Some cultures place great value on a sense of coherence, and will seek persistently to find meaning in their experience, retelling and reshaping the story until it acquires a satisfactory form (Ying, 1997). Other cultures value concealment as one of the key indicators of psychological well being (Whittaker et al, 2005). For refugees, telling their story has additional complications. Refugee status depends on meeting the criteria of a "well-founded fear of being persecuted," and to be credible, a refugee's official personal story must fit with some larger socially accepted account of what is happening to people of a certain background from a certain part of the world. The refugee's story is thus not just his or her own, but necessarily "invokes the voices of

others," and has very real implications for the person's future (Kirmayer, 2007). Refugees may also have had to tell their stories repeated to migration officials, family members, employers, clinicians, and other social service workers.

Practitioners in the field have begun to address these concerns by developing guidelines and models for clinically effective and culturally sensitive storytelling. Rousseau and Measham (2007) propose a model of "modulated disclosure" which focuses on the appropriate timing for disclosure of particular aspects of the traumatic experience. This process recognizes that avoidance and disclosure may represent equally important responses to trauma, and introduces a dialectic between approaching the past and moving away from it. Others, concerned about pathologizing political violence, have developed techniques based on clients giving "testimony" about what happened to them, then providing a written copy to the client for use in pursuit of justice. In this approach, attention to emotional issues occurs in a political context, the client is provided with a form of potential positive action, and the therapist becomes an ally in the struggle for social justice (Blackwell, 2005). Finally, there may be times when it is critical to ask: "When does remembering have worse consequences than forgetting for survivors of extreme trauma?" (Rousseau, 2005). If the desire to forget is strong, it may be essential to explore other mechanisms of repairing trauma (Rousseau and Measham, 2007).

Perhaps the most well articulated approach to helping refugees tell their stories has been developed by Richard Mollica (2006). Based on thirty years of listening to the oral histories of Southeast Asian refugees, Mollica concludes that one of the deepest fears for trauma survivors is that they will be unable to reconnect with the normal world - that those closest to them will remain indifferent and turn away from hearing their truth. Providing an opportunity to tell one's story and *to be heard* is thus critical.

Mollica suggests that there are four components in an effective trauma narrative, each contributing to healing. First, a factual accounting of the events occurs. Trauma survivors can often clearly state the exact date and even hour when the violence began, the motivation of the perpetrators, and extensive details about the violence. Telling the facts of the story invokes conscious memories, which are stored in the hippocampus. In contrast, emotional memories – the memories that encode unconscious fear associations, and that can become intrusive and repetitive – are stored in the amygdala. If the facts of the story are told in such a way as to avoid triggering the emotional memories, biological extinction of the traumatic emotional memories will be enhanced (Mollica, 2006).

Second, every trauma story reveals the survivor's culture, history, traditions, and values. Stories are therefore an important source of information about the survivor's cultural framework. Mollica suggests that mental health professionals and others working with refugees would benefit from training in how to listen, *not* as a clinician or professional, but as a *learner*. Classes which put the trauma survivor in the role of teacher and the healing professional in the role of learner have been quite successful

Third, the trauma story can be a stage on which meaning and transformation may be constructed. How the trauma story is told can make a crucial difference. Trauma stories that focus on the brutal facts of the violence are likely to re-traumatize the teller and possibly turn the listener away. However, if the story focuses on the survival skills and resiliency demonstrated by the survivor, he or she may come to deep new insights about themselves.

Finally, the listener-storyteller relationship is key. Helping refugees to tell their trauma stories in a healing fashion is difficult and takes practice. The listener must be prepared to hear what the survivor needs to reveal, and to empathize with the experience, no matter how painful. This requires visualizing and experiencing what the

person actually endured without becoming overwhelmed. At the same time, the survivor must learn to tell their story in a sensitive way in order not to overload the listener. Mollica suggests that the clinician can assist in this process by acting as a “storytelling coach,” teaching the survivor to tell the entire story, including the context of their lives and their self-healing capacities, to use symbols and metaphors, and to modulate the expression of emotions.

**Psychosocial Approaches.** Approaches that provide a full array of psychosocial needs in addition to clinical treatment are gaining currency with ethnic community-based organizations and others, particularly in developing countries (Loughery and Eybar, 2003; Silove, 2007). One survey identified 185 such projects within Bosnia and Croatia alone (Macinson, 1999). Psychosocial programs address the physical and mental health of a person, their knowledge and skills, the social connections they share, and the specific context of their communities. They often include specialized mental health services, recreational and social support groups, housing and legal assistance, and income generation (employment) activities. One model designed for responding to mass violence proposes five broad psychosocial pillars: security; social bonds and family networks; justice and human rights; roles and identity; and meaning - institutions that both individuals and society attempt to defend and to rebuild if they are destroyed (Silove, 1999).

In developing countries, programs that address economic empowerment are often seen as more responsive to local conditions than typical trauma relief programs (Weyermann, 2007). Psychosocial programs are also more likely to incorporate local cultural practices. One program in Guinea for Liberian and Sierra Leonean refugees incorporated African cultural and healing activities and advocacy to prevent future torture along with other psychosocial modalities. Follow-up assessments found significant reductions in trauma symptoms and

increased daily functioning and social support (Stepakoff et al, 2006).

In the U.S., psychosocial approaches for refugees are also being developed. Community services designed and run by refugee communities almost always follow a psychosocial framework, and mainstream mental health providers are moving in this direction. For example, Khamphakdy-Brown and colleagues (2006) added psycho-educational home visits to supplement clinic-based counseling in their program for refugee and immigrant women, and Goodkind (2006) describes a “mutual learning” program that emphasizes advocacy and resource development for Hmong refugees.

There is little evidence to date about the effectiveness of psychosocial programs for refugees (Macinson, 1999). Many programs use concepts, measurement instruments, and approaches that have not been validated and tested in the settings in which they are being applied, and few of the practitioners who devise and implement the programs have adequate training. Outcome evaluations are rare. Nonetheless, these programs have intuitive appeal, largely because they respond to basic human needs in addition to psychological trauma. Mollica (2006) stresses that unlike many refugee relief systems that create and sustain dependency and unemployment, psychosocial programs emphasize the critical importance of work and of having a chance to help others rather than merely being the recipient of help.

**Religion and Spirituality.** The role of religion and spirituality in recovery from trauma and from serious mental health problems is receiving increased attention in the mental health literature (Blanch and Russanova, 2007). This is new terrain for many mental health workers. In the United States, mental health practitioners are accustomed to a fundamental separation of church and state, and many are uncomfortable with discussions about the divine (Mollica, 2006). However, religion and spirituality may

be particularly important to refugees, who often come from cultures where religion is not segregated from other aspects of life, and who have recently encountered ultimate questions of life and death. To understand the refugee experience and to support their recovery from trauma therefore requires at least a basic understanding of religion and a willingness to address matters of spirit and faith.

Much has been written about the impact of violence on faith. Intense trauma may constitute a moral crisis, or even be the individual's first encounter with evil. This may destroy the belief in one's own invulnerability or in the world as understandable, and may ultimately result in a collapse of faith (Boehnlein, 2007). On the other hand, faith and prayer may help an individual survive the most horrible conditions, and surviving violence can strengthen the relationship between survivors and their sources of spiritual succor (Mollica, 2006). Researchers who have begun to examine these issues have found relationships between measures of religious coping, severity of trauma symptoms, and post-trauma growth (Ai et al, 2003; Ai and Peterson, 2005; Ai et al, 2005; 2007).

Violence may also affect the individual's relationship to organized religion. At various times in history, organized religions have been

complicit in mass violence, either as active or passive participants. In contrast, there have been times when organized religion has played a significant role in opposing oppression and violence and/or helped to heal the collective wounds of society. In the U.S., religious leaders played a critical role in the fight for civil rights. In a more recent example, a highly regarded Bosnian Muslim cleric issued a decree that Muslim women who had been sexually abused during the ethnic violence should be given the status of martyrs and supported both morally and materially (Mollica, 2006). Without the cleric's action, these women might well have been considered unclean and ostracized from family and society.

There are many ways in which spiritual or religious practices can assist in the recovery process. The relationship with a clergy person or spiritual guide may help to build a renewed sense of trust and healing; the connection with a faith community may be essential to combating isolation; religious practices and prayer can help contain and modulate emotions that might otherwise run out of control; the practice of forgiveness can fundamentally shift the meaning given to the experience (Blanch, 2007). Recently, an entire issue of the *Journal of Refugee Studies* was devoted to this topic (Gozdziak and Shandy, 2002). ■





## VI. Gender Issues – The Need for a Focus on Women

The refugee field has struggled for years with the issue of incorporating gender into theory and practice. In the past decade, the United Nations has emphasized both the special vulnerabilities and strengths of women refugees and the need to address sexual and gender-based violence. In 1995, the U.S. Office of Refugee Resettlement established the *Refugee Women's Network*, a national non-profit organization dedicated to empowering refugee and immigrant women through leadership training, education and advocacy.

In general, women who suffer from a traumatic event are significantly more likely than men to develop mental health problems (Sanchez-Hucles and Gamble, 2006.) Within refugee populations, women have been shown to have higher levels of PTSD severity and more depressive and anxiety symptoms than men (Ai and Peterson, 2005; Keller et al, 2006). In one study, women had twice the risk of experiencing PTSD as men, a difference that persisted after adjusting for age, marital status, being a parent, loss of family members, amount of social support, education level, and level of depression (Ranasinghe and Levy, 2007). Women's vulnerability may also be exacerbated by other gender-related factors. For example, in one study, women with large families and those who were less educated or did not speak English reported statistically higher counts of trauma and torture as well as more associated problems (Robertson et al, 2006).

There are many reasons why the circumstances and needs of refugee women require special attention. Women and girls are often exposed to higher levels of violence than men. Women and children now comprise 80% of international war casualties, and increasingly serve as combatants (Sanchez-Hucle, 2006). They are at special risk

for torture because of their smaller size, the fact that they are less likely to be considered credible reporters of their experience, in retaliation for actions of their family members, or in order to intimidate their male partners (Pope, 2001).

Women refugees are also at high risk for rape and other forms of gender-based violence. While rape has always been a consequence of war, the systematic and widespread use of sexual violence during recent genocides in Bosnia-Herzegovina (Schultz, 2006; Skjelsbaek, 2006) and Darfur (Wagner, 2005) have led to the recognition that rape during wartime may be a conscious tool of terrorism and genocide. In these situations, mass rapes were apparently carried out under orders, with multiple assailants, and were often committed on girls as young as seven and in the presence of the victim's family. The apparent intention was to humiliate or destroy the identity of the victim; in particular, to impregnate and destroy ethnic purity (Skjelsbaek, 2006). Rape was thus used strategically for the purposes of destabilizing populations, destroying bonds within communities and families, advancing ethnic cleansing, expressing hatred for the enemy, or supplying combatants with sexual services. The consequences of state-sponsored rape and terror include not just the terror and trauma of the violence itself, but rage at the impunity of the perpetrators and at the silencing of both individual and community (Radan, 2007).

Women and girls are also extremely vulnerable during migration and in refugee settings, where violence is sometime perpetrated by male refugees or by the very people charged with protecting them, including peacekeepers, camp authorities, and relief workers (Vasquez et al, 2006). Often, refugee camps are controlled by men, and unaccompanied women are

particularly at risk (Khattak, 2007). The abuse may be as flagrant as outright rape and abduction or as subtle as an offer of protection, documents or assistance in exchange for sexual favors. In 2003, the US General Accounting Office reported that “sexual abuse of refugee women and girls is pervasive and present in almost all refugee settings” (US GAO, 2003, p.1).

Violence against women does not necessarily end upon resettlement. Women refugees continue to be vulnerable to gender-based violence, discrimination and exploitation in their adopted homeland (Radan, 2007; Bhuyan, 2005). Struggling to find security in a strange land with different customs, women may easily fall prey to sexism, racism, or gender-based violence in new and unfamiliar forms (Casimiro, 2007). Often, refugees come from male-dominated societies where men are the sole breadwinners and decision-makers, and violence may continue in patterns already established in the home county. In other cases, women relocated in the United States may find it easier to get a job, decreasing their male partner’s traditional power and respect, and increasing the woman’s vulnerability (Vasquez et al, 2006). In still other cases, refugee men who have suffered their own trauma during war or who believe they have failed to protect themselves or their families may become perpetrators (Radan, 2007).

Gender-based refugee trauma programs need to respect these vulnerabilities, creating environments that foster safety first. They also need to view all services in a family context (Vasquez et al, 2006), and to address women’s health issues (Harris et al, 2006). Gender-based programs generally advocate an empowerment

model and a multi-sectoral approach that takes into account prevention of abuses, the physical and psychological consequences of violence, the potential need of the victim for a safe haven, economic needs, legal rights, and community awareness (Rees, 2007). As an example, Medica Zenica in Bosnia-Herzegovina began addressing war-related violence but quickly expanded its programming to include a counseling center, medical services, a hotline, and two safe houses with education, training, and micro-enterprise activities. Its research unit collects and analyzes data on gender based violence to be used in prevention and advocacy programs (Vann, 2002).

In a second example, women in Burundian refugee camps in Tanzania undertook a needs assessment that showed an increased incidence of violence against women. Resulting programs included a drop-in center at which women’s health and protection needs were addressed; community awareness activities that reached out to men as well as women; social forums for women to discuss issues affecting their lives; and training for staff in the camps to alert them to gender based violence (Martin, 2004).

Gender-based trauma programs also need to recognize that women refugees often survive multiple and extreme forms of violence with incredible resilience. In one study of Central American women refugees, a majority of women who had endured extreme poverty, physical and/or sexual abuse, and war-related trauma had survived and built satisfying lives in their new homeland (Radan, 2007). Programs that build on women’s strengths and capacity for self-healing, while also addressing the needs of those with persistent problems, will be most effective. ■

# VII. Developing a Public Mental Health Response to Refugee Trauma

**The Need for a Response.** In general, refugees in the U.S. are few in number, have little political support, and face significant discrimination. They are widely dispersed across the country, and tend to be isolated within their own communities. As a result, it is difficult to garner significant public policy attention to their issues or adequate funds to meet their needs.

Although the public mental health system is theoretically available to all in need, it is based on a diagnostic system that is not relevant or helpful to many refugees. Moreover, mental health services are organized and financed as part of the overall health care system, which favors professionally-oriented inpatient and clinic-based services rather than the flexible and informal outreach services needed by refugees. In general, the mental health workforce is not trained to respond to refugees, and recruitment of culturally and/or linguistically competent professionals is difficult, especially in rural areas. Moreover, the mainstream mental health system is chronically underfunded and is not designed to meet the many non-mental health needs of refugees - including housing, legal services, adult education and ESL, vocational services, etc - needs which may far overshadow the need for mental health services. Given this situation, it is not surprising that refugee mental health has not become a priority issue for public mental health systems.

However, our knowledge about the violence experienced by many refugees should give us pause. Childhood trauma can have severe and long-lasting health and mental health consequences, even in adulthood, and leads to increased utilization of social services across the lifespan (Felitti et al, 1998). Children who experience or witness violence are at risk for becoming violent in adulthood. For adults,

untreated trauma from a wide variety of sources may affect people's ability to perform the tasks of daily living (Jennings, 2003). There is every reason to assume that the violence experienced by refugees will have similar effects. Common sense suggests that an investment in addressing refugee trauma will prevent significant disabling and costly problems in the future.

**Trauma-Informed Care.** When the issue of refugee mental health was first raised on a national level (Neider et al, 1988), trauma was rarely discussed in state mental health systems. Two decades later, the situation is quite different. Although much of the public mental health system remains focused on the treatment of biological disorders, both state and federal mental health policymakers have recognized trauma as an escalating public health crisis, and a new emphasis on trauma healing is emerging in many mental health and social service systems (Witness Justice, 2007).

Over the past decade, a model of "trauma-integrated services" was developed within the public mental health system specifically for people with complicated needs who were not being well served by traditional mental health and substance abuse programs (Salasin, 2004). This approach combines empirically tested "trauma-specific services" with a broad effort to make systems more "trauma-informed." While not designed specifically with refugees in mind, the trauma-integrated model is based on acknowledging the pervasive impact of violence, building on people's natural strengths and capacities, and empowering individuals to define their own problems. The increasing focus of state mental health systems on trauma-informed care provides a platform on which effective and sensitive refugee trauma services could be built. Although clearly some

modifications will be necessary to reflect the unique experience of refugees and the cultures from which they come, the principles of trauma-informed care are consistent with the basic needs of refugees reviewed above.

In a trauma-informed organization, all staff are aware of the impact of trauma and of the many paths to recovery, and all programs and policies are designed to be sensitive to the impact of violence. Because *staff* are trauma-informed, people are not automatically assumed to have a biological mental illness or to need psychiatric services. And because *programs* are trauma-informed, people are not inadvertently retraumatized by policies or procedures that recreate or resemble previous traumatic events. Trauma-specific clinical services are available for those who need and want them, but they are not seen as a substitute for other needed services. Thus everyone who walks in the door benefits, whether or not they choose to identify themselves as a trauma survivor.

Trauma-informed care is not a stand-alone clinical intervention. Rather, the principles of trauma-informed care are meant to be applied across an entire organization – whether a mental health agency, a school, or a social service provider. A protocol for organizational self-assessment and planning for trauma-informed care has been developed and applied across a number of different organizational contexts. The principles of trauma-informed services in the table below are drawn from that protocol (Fallot and Harris, 2006).

### Principles of Trauma-informed Services <sup>iii</sup>

#### Domain 1: Program Procedures and Settings

- 1A: Safety – ensuring physical and emotional safety
- 1B: Trustworthiness
- 1C: Choice – maximizing consumer choice and control
- 1D: Collaboration – maximizing Collaboration and sharing power
- 1E: Empowerment – prioritizing empowerment and skill-building

#### Domain 2: Formal Service Policies

#### Domain 3: Trauma Screening, Assessment and Service Planning

#### Domain 4: Administrative Support for Program-Wide Trauma-Informed Services

#### Domain 5: Staff Trauma Training and Education

#### Domain 6: Human Resources Practices

**Building Trauma-Informed Partnerships.** The construct of trauma-informed care has the potential to help build effective partnerships between mental health/trauma providers and other key refugee services and supports. The development of trauma-informed interagency partnerships that embrace a holistic view of health and well-being is one possible strategy for meeting refugee needs without pathologizing their experiences.

Partnering with refugee advocacy and support organizations (called “Mutual Assistance Organizations” or MAAs) is a top priority, consistent with the principles of choice, collaboration and empowerment. Many refugee groups have developed strong national and local MAAs providing a whole range of social support, self-help and advocacy services (see, for instance: [www.cdss.ca.gov/refugeeprogram](http://www.cdss.ca.gov/refugeeprogram) or [www.searac.org/maa](http://www.searac.org/maa)). Linking with and supporting these organizations could provide the mental health partner with a strong grounding in the culture and values of refugees and the refugee partner with needed services and technology. Principles of trauma-informed care, based on values of consumer empowerment and choice, make a natural bridge between mental health providers and MAAs.

Partnering with refugee providers and their social service networks is also a top priority. Refugee service providers often recognize the need for mental health services. In many cases, they are also aware that traditional psychiatric care and/or trauma treatment is not indicated. They may *not* know that other forms of mental health care, such as trauma-informed services, are even available. Relationships built over time, with both agencies working together to become trauma-informed, would create the foundation

for ongoing consultation and community-level responses. Trauma-informed social services would be a tremendous support for most refugees. Ongoing partnerships could also facilitate better linkages between arriving refugees and state social services and health care, since refugees are eligible for TANF, medical assistance, etc (with actual eligibility requirements varying from state to state.)

Finally, partnering with primary health care providers is essential. It is beyond the scope of this paper to review the myriad health issues facing refugees. However, it is important to note that in some cases, critical health problems may be misdiagnosed as psychosomatic trauma. For example, it is well known that Vitamin D deficiency may be a serious problem, especially for dark-skinned people and/or veiled women who are relocated to a northern climate (Bensen and Smith, 2007). Vitamin D deficiency may also cause PTSD-like symptoms. A trauma-informed partnership between primary health providers, mental health providers and the refugee community could be a powerful stimulus to the development of a holistic, public-

health approach to refugee health, trauma recovery and well-being.

**Conclusion**<sup>iv</sup>. Refugees are “normal” people exposed to extremely stressful events, and transitory resettlement and adjustment problems are common. In addition to stresses and/or traumas in the country of origin or during flight, negative experiences during resettlement may increase risk of mental health problems. Because of the unique experience and the cultural disorientation experienced by some refugees, non-conventional interventions and solutions need to be considered.

Adaptation to a new country is also a long-term process that may continue over the lifetime of the refugee. Special supports may be needed at vulnerable points in time, even long after the refugee has mastered a new language and found a comfortable social and professional niche. The development of trauma-informed partnerships between refugee groups and services, social service providers, and mental health and health care providers is one way to begin building a truly trauma-informed community support system for refugees. ■



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<sup>i</sup> Both *Achieving the Promise: Transforming Mental Health Care in America (2003)* and the *Surgeon General's Report on Mental Health (1999)* recommend that a public health approach is needed to transform the Nation's mental health system.

<sup>ii</sup> Adopted from John Tuscan, *The Refugee Experience*. Presentation at Refugee Mental Health Program, Charlotte, NC, April 2008

<sup>iii</sup> Adopted from Falot, R.D and Harris, M. (2006) Trauma-Informed Services: A Self-Assessment and Planning Protocol

<sup>iv</sup> Adapted from John Tuscan, *The Refugee Experience*. Presentation at Refugee Mental Health Program, Charlotte, NC, April 2008