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Triumphing Over Trauma: Addressing Past Experiences and Mental Health Following Resettlement in the United States

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Addressing Past Experiences and Mental Health Following Resettlement in the United States

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ABSTRACT

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Refugee populations are exposed to an unusually high number of traumatic events in their lifetimes that have the potential to cause long-lasting psychological harm. Millions of people are forcibly displaced by international conflicts, ethnic genocide, targeting of political dissidents, climate disasters, and countless other traumatic events. For the small fraction of refugees who are resettled in wealthy nations such as the United States, they are fortunate to leave behind the harmful and often violent places which they are fleeing from, but they are also leaving behind their families, friends, homes, and traditions. During and following resettlement, refugees continue to face potentially traumatic experiences and are offered minimal resources to assist with coping or access clinical interventions. The goals of the U.S. resettlement system are to provide protection for these vulnerable populations and to enable integration into America's society and economy. These goals are—by some accounts—achieved, but services to refugees reflect an understanding that social services, including medical and mental health assistance, are a low priority. While the Unites States seeks to re-evaluate the social obligations of the government and we grapple with the toxicity of immigration and humanitarian responsibility, now is the moment to address the shortcomings in services to refugees and how addressing trauma can benefit refugees and America.

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Chapter 1: Introduction

Intro

Refugee populations are exposed to an unusually high number of traumatic events in their lifetimes that have the potential to cause long-lasting psychological harm. The United States, in its haste to view the settlement of refugees as an empirical problem—a question of how many refugees are settled, quotas for a given source nation, the cost per refugee, and the time to make them economically stable—fails to adequately recognize the humanitarian and social facets of the resettlement process. Despite being a leader in research of mental health, psychological reactions to trauma, and socio-cultural integration; the U.S. does not recognize the needs of many refugees and does not make available the proper resources for managing mental health following trauma. This reluctance to embrace the importance and consequence of trauma is failing refugees and the communities which they are settled into by hindering social, cultural, and economic integration. The United States has a level of wealth and knowledge that oblige it not only to resettle refugees but also to provide resources to ensure their success post-settlement and level the playing field with other populations.

The Refugee Crisis

At the end of 2019, the United Nations High Commissioner for Refugees calculated that one percent of the world's population was displaced. This seemingly small portion of the globe accounts for 79.5 million forcibly displaced persons, 26 million of whom are refugees. Perhaps more alarmingly, the number of total displaced persons has doubled in the past decade while developed nations have grown increasingly wary of resettlement, widening gap between the

number of refugees and the number who will be hosted in developed countries.[1] This bleak picture diverges from the mainstream debate regarding foreigners in the U.S. but is inextricably linked to the decision of this country and others to limit both refugee and immigrant intake amidst unprecedented displacement.

The United States and other wealthy nations are engaged in debate about the 'problem' of migration. In the U.S., this has manifested itself most visibly in the contention of border policies that restrict who can enter through the southern border. Broadly, these entrants are immigrants, not refugees. Immigrants are people who come to the country legally with the intent of taking up residence. The Immigration and Nationality Act of 1952 provides the modern-day operating definition of the term immigrant, a term which is colloquially and perhaps misleadingly broadened to include more narrow groups such as refugees or asylum seekers. Refugees are legally distinct from immigrants in that they are granted entry to the country for their protection, not due to economic aspirations or other desires. Refugees come from nations that are rendered inhabitable due to their ethnicity, religion, or political beliefs, whereas immigrants include for example those traveling from Central and South America seeking a better life or those from Europe who see a potential for financial success. Many immigrants may have been exposed to the same traumatic events as refugees, though this is not reflected in their legal status. The United States promotes ideals which seem to support migration; concepts like capitalism, globalism, and upward mobility. However, on a more practical and self-interested level, the U.S. is wary of migrants due to the potential for fiscal burden. This concern of dependency is particularly potent regarding refugees due to their inherent need for support.

[1] United Nations High Commissioner for Refugees, "Figures at a Glance," https://www.unhcr.org/figures-at-a-glance.html (accessed Feb 23, 2021).

While the principle of providing refuge for persons displaced from their home dates to the beginning of the twentieth century, when the first and second world wars created unprecedented levels of displacement, codification of refugee status in the United States and abroad did not arise until later that century. Our current understanding of what defines a refugee and to what they are entitled originates from the 1951 Convention Relating to the Status of Refugees and the subsequent 1967 Protocol Relating to the Status of Refugees. The 1951 Convention defines a refugee as "a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him- or herself of the protection of that country, or to return there, for fear of persecution."[2] Under this definition, refugees include individuals being persecuted for either political reasons—such as protesting their government—or non-political reasons including ethnic or religious discrimination. In nations where refugee status is deserved due to fear of persecution, protection is offered as a means of non-refoulment, meaning that an individual cannot be returned to a nation which they fled if their return would risk persecution. By receiving refugees, a nation takes on a responsibility to provide refuge for a population that is likely to have experienced traumatic events.

Refugees—whether combatants, political, or non-political—are often displaced by similar events regardless of what nation they are from. Displacement is typically predicted by some form of genocide, civil war, or insurgency. These forms of conflict which habitually displace people typically arise in nations with weak governments whose state building efforts

[2] United Nations High Commissioner for Refugees, *The 1951 Convention Relating to the Status of Refugees and its 1967 Protocol*,[2011]). https://www.unhcr.org/about-us/background/4ec262df9/1951-convention-relating-status-refugees-its-1967-protocol.html.

fail, leaving them vulnerable to military rule, ethnic cleavages, or the formation of independent militias. Recent examples of conflict in weak states predicting mass displacement are Syria, where a civil war between the government and various forces including political opposition groups and religious extremist groups has been ongoing since the 2011 Arab Spring, and Venezuela, where unsuccessful governing has resulted in a crippled economy and widespread civil unrest. Syria may offer an example which is likely to have both combatant and civilian refugees fleeing violence, whereas Venezuela may present more political refugees or economic refugees. An era has now begun in which climate refugees, peoples displaced by unprecedented and recurring effects of climate change which make their homes inhabitable, are increasingly common and contribute to existing refugee populations.

Physical conflict, economic devastation, and climate threats all display evidence linking them to poor mental health outcomes and lasting effects of trauma. These experiences are common in refugee populations around the world. The plights facing refugees are also at times experienced by other populations which are not granted refugee status such as immigrants or asylees. Refugees, however, are a group which by definition is likely to have encountered these forces and deserve discussions different than those about other forms of migration. I will focus on the refugee crises in Myanmar, the Democratic Republic of Congo, and Afghanistan as case studies of traumatic experiences faced by refugees in select chapters. These countries have some similarities but also many differences in how they represent the experiences of refugees and how national crises predict traumatic experiences. The populations of these three nations include combatants, civilians, political and non-political refugees, and economic refugees. They are valuable case studies for their ability to represent the traumatic outcomes of instability in weak

states. These three nations also represent some of the countries from which the United States has accepted the most refugees in the past twenty years.

All three of these states—the Democratic Republic of Congo, Afghanistan, and Myanmar—have experienced widespread conflict that has impacted and continues to impact civilians. These nations are vastly different in circumstance from one another yet experience similar levels of conflict rivaling the worst in the world. Refugees fleeing these countries not only have high potential for exposure to traumatic experiences, but they also are coming from places with different languages, religions, cultures, politics, and socioeconomic circumstances than are the norm in the nations they are resettled to. Refugees originating as civilians in nations such as Myanmar, Afghanistan, and the Democratic Republic of Congo are likely to have experienced traumatic events in exposure to prolonged conflict and political instability.

Myanmar gained independence from British colonial rule in 1948 and has since been wrought with military dictatorship and ethnic conflict. The nation has gone back and forth between periods of democratic governance and military rule. Especially when under military rule, ethnic groups other than the majority Burmans have been heavily persecuted, with Christians, Muslims, and pro-democracy groups being the most targeted. The government and military have been unable to retain control of their own territory and have resorted to brutal treatment of citizens. Residents of Myanmar were granted refugee status in 2008 and have been one of the largest refugee populations in the United States since. In 2011, the shift to a civilian-lead republic and away from military rule instilled confidence, but the military began an ethnic cleansing of the Muslim Rohingya, one of the most violent moments of Myanmar's history and of recent global events. In 2020, Myanmar held a civilian election in which the military lost

considerable representation. The military response was to remove the previous government and begin harming or murdering civilians and pro-democracy activists.

Afghanistan has experienced uninterrupted conflict for many decades, leaving the country decimated and poor. The country has been occupied by both foreign governments and militaristic terrorist organizations, who have each contributed to the displacement crisis and have prevented the development of the nation or the establishment of legitimacy by the government in Kabul. “During the past 25 years, individuals in Afghanistan have continuously experienced war and civil unrest.”[3] The result has been that the nation’s population ranks extremely poorly by most social indicators such as life span, mortality rates, literacy rates, and drug trade reliance.[4] Afghan refugees have been resettled in the United States for a long time and are still being accepted. Following 9/11, the United States invaded Afghanistan due to the refusal of the Taliban government to comply with demands to assist in locating Osama bin Laden. The U.S. has backed the Afghanistan government and security forces, though they have continually lost ground to Taliban forces. As of 2019, “only 53.8 percent of Afghan districts were under government control or influence, 33.9 percent contested, and the remaining 12.3 percent under the control or influence of the Taliban.” U.S. forces remain in the country, but are scheduled to withdraw soon, raising concerns about the potential for increased civilian casualties or violence. Thousands of Afghanis are injured or killed each year, along with those who are displaced to neighboring countries or resettled.[5]

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[3] Willem F. Scholte et al., "Mental Health Symptoms Following War and Repression in Eastern Afghanistan," *Jama* 292, no. 5 (2004)590. doi:10.1001/jama.292.5.585. https://doi.org/10.1001/jama.292.5.585.
[4] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry* 45 (2009)615. doi:10.1177/1363461508100785.
[5] "War in Afghanistan."https://cfr.org/global-conflict-tracker/conflict/war-afghanistan (accessed Mar 7, 2021).

The current violence and crisis in the Democratic Republic of Congo stems from the after-effects of the Rwandan Genocide, when Hutus fled into the eastern DRC and formed militaristic groups. Today, these groups and others dominate a large portion of Congo territory and the government fails to control this land. Armed groups terrorize communities and brutally harm or displace millions of Congolese. The peaks of conflict were the Second Congo War from 1998 to 2003 between the government and rebel forces and from 2012 to 2013, when the March 23 Movement, a Tutsi rebel group, rebelled against the government. Armed groups have continued to rule much of the country; raping women, recruiting men and children as soldiers, profiting from the country's valuable mineral resources, and terrorizing civilians.[6] Many displaced people have fled to Uganda and to resettlement sites in the Western part of the country while others have been brought to developed countries.[7] Despite having a peaceful transfer of power in 2019 to a new president, the government remains weak and unstable.

In many ways, the long-lasting conflicts in Myanmar, Afghanistan, and the Congo are quite similar. They all rely on the failure of the legitimate government to retain control of the nation. In fact, these three states all rank among the least stable states on the Fragile States Index, a measurement of economic, political, social, and cohesion rick indicators used to evaluate the risk of conflict in that nation.[8] These countries and many others who are producing refugees suffer from similar risk indicators that cause them to commonly be referred to as weak or failed states, a term meaning that their political and economic systems have so little legitimacy or reach that they no longer have control of their territory or people. These states still have many

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[6] "Violence in the Democratic Republic of Congo."https://cfr.org/global-conflict-tracker/conflict/violence-democratic-republic-congo (accessed Nov 14, 2020).
[7] Michael G. Wessells, Alastair Ager and Janna Metzler, "Where there is no Intervention: Insights into Processes of Resilience Supporting War-Affected Children," *Peace and Conflict* 23, no. 1 (2017), 67-75. doi:10.1037/pac0000211.
[8] "Fragile States Index."https://fragilestatesindex.org/ (accessed March 7, 2021).

differences, as highlighted by the fact that in one violence is perpetrated primarily by the military, another by foreign governments and a powerful terrorist organization, and the last by dozens of independent militias. The circumstances that gave rise to these conflicts also differ though they reveal frequent trends such as the withdrawal of colonial powers leaving behind deeply divided populations that are difficult to rule over. One example of the vast differences between conflict zones is wealth; Myanmar is a reasonably wealthy nation, and the Congo has immense resource wealth that is exploited, while Afghanistan is among the poorest nations in the world. This is a factor that determines not only the nature of conflict but also the quality of life and risk or protective factors for individuals.

The ongoing nature of these conflicts and the other humanitarian crises around the world highlights the importance of non-refoulment and the ability to provide permanent resettlement. Afghanistan and Myanmar both have experienced recent events that have perpetuated or worsened the risks to civilians in these nations. The military coup in Myanmar and involvement of foreign forces in the Afghanistan War promise to continue displacing and traumatizing these populations. For resettled refugees, these events mean that they are likely to experience further loss of family members or disruption to communication and that they are unlikely to be able to return to their home. The risks for trauma presented by conflicts around the world affect groups other than refugees, but refugees exemplify the potential for traumatic experiences. The ongoing nature of humanitarian crises means that there is a greater responsibility for wealthy nations to provide assistance to displaced persons.

The Role of the United States

The United States' commitment to the protection of refugees ultimately stems from acting as a signatory to the 1967 Protocol to the 1951 Convention Relating to the Status of

Refugees. What this means is that the nation favored the expansion of services to refugees via increased protections, the removal of geographic restrictions, and lengthened timeframes while embracing the definitions and frameworks laid out in 1951.[9] The country's largely symbolic participation in the formation of these documents illustrated the projection of ideals that are believed to be at the core of America. The embrace of refugees aligns with values such as 'all people are equal' or the famous, 'give me your tired, your poor, your huddled masses yearning to breathe free,' whether believed to be tropes or genuinely rooted values. But America as a nation also holds a different set of values, ones teeming with nationalism, exceptionalism, capitalism, and self-reliance. These concepts may be equally emblematic as those of giving and acceptance, but they are certainly the ones which shine through in the de facto development of policy and perception regarding refugees.

United States refugee policy primarily originates from the Refugee Act of 1980, a piece of legislation that still governs present day procedures for admissions and resettlement. This landmark legislation reflects these two competing American ideals: that of humanitarianism and that of economic self-interest. "The goals of the U.S. resettlement program are twofold: to protect vulnerable populations and to offer them the prospect of long-term integration."[10] The pivotal question is what "long-term integration" entails both for the refugee and for the hosting country. The Refugee Act of 1980 defined this integration as the achievement of self-sufficiency, showing a clear favor for the prioritization of economic self-interest. The idea was—and still

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[9] Silva Mathema and Sofia Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century," *Center for American Progress* (October 26, 2020). https://www.americanprogress.org/issues/immigration/reports/2020/10/26/492342/rebuilding-u-s-refugee-program-21st-century/.

[10] Michael Fix, Kate Hooper and Jie Zong, "How are Refugees Faring? Integration at U.S. and State Levels," (June, 2017)3. https://www.migrationpolicy.org/sites/default/files/publications/TCM-Asylum-USRefugeeIntegration-FINAL.pdf.

is—to make refugees self-sufficient as rapidly as possible to ensure that they contribute to rather than detract from the country's economic growth.[11]

Admitting and resettling refugees who will contribute to American society and will readily integrate is no small task. The first step is that a refugee must be referred to the Department of State by an international partner such as the UNHCR or an embassy. This referral process kicks off rigorous screening and vetting procedures conducted by the Department of State and the Department of Homeland Security. The purpose of this process is to the ensure that the individual is eligible for refugee status, not a security risk, and likely to be successfully integrated.[12] Through this process of screening and vetting, the country can control the flow of refugees in a way that reduces burdens on resettling communities and the nation's infrastructure. Pending the approval of security checks, refugees undergo a medical screening for common diseases and a brief cultural orientation about life in America.[13] Finally, refugees are lent money to fly to the United States, facilitated by one of nine voluntary agencies called VOLAGs, and are placed with a local resettlement partner who assists with integration and job placement. One-time payments are issued to cover food and housing in the short-term, and services to assist with job placement work towards rapid self-sufficiency.[14] The process, although entailing only a few major steps, takes years in totality.

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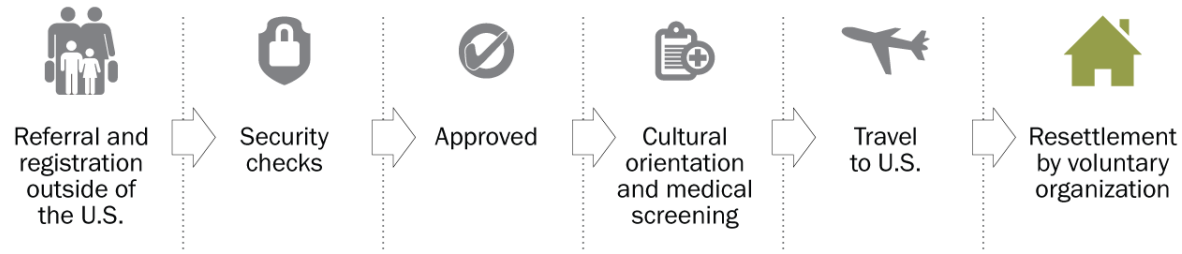
[11] Anastasia Brown and Todd Scribner, "Unfulfilled Promises, Future Possibilities: The Refugee Resettlement System in the United States," *Journal on Migration and Human Security* 2, no. 2 (2014), 101-120. doi:10.1177/233150241400200203. https://doi.org/10.1177/233150241400200203.

[12] Mathema and Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century," *Center for American Progress* (October 26, 2020). https://www.americanprogress.org/issues/immigration/reports/2020/10/26/492342/rebuilding-u-s-refugee-program-21st-century/.

[13] . *Resettlement Process for U.S.-Bound Refugees*Pew Research Center,[2019c]).

[14] Mathema and Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century," *Center for American Progress* (October 26, 2020). https://www.americanprogress.org/issues/immigration/reports/2020/10/26/492342/rebuilding-u-s-refugee-program-21st-century/.

Resettlement process for U.S.-bound refugees



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When the United States refugee resettlement program began, the focus was on mitigating the humanitarian disasters happening in only a handful of countries. Crises such as Vietnam and Cuba saw large numbers of refugees be admitted, but the scope of refugee arrivals has since increased significantly. “In FY 2016, the United States resettled refugees from 78 countries--more than double the number of national-origin groups admitted in FY 1981.”[16] In addition to diversifying, the regional origin of refugees has also changed, shifting away from a previous dominance of Europeans to now be dominated by Asians and Africans.[17] While demographic have changed, the mechanisms and purpose of the resettlement system have remained the same: to enable refugees to become self-sufficient. On this metric, the system is quite effective. “Newly arrived refugees tend to enter into employment quickly in the United States, with employment rates close to those of the U.S.-born population. About half of newly arrived refugees who participate in resettlement assistance programs enter employment within eight months.”[18]

[15] . *Resettlement Process for U.S.-Bound Refugees*Pew Research Center,[2019c]).
[16] Fix, Hooper and Zong, "How are Refugees Faring? Integration at U.S. and State Levels," (June, 2017)1. https://www.migrationpolicy.org/sites/default/files/publications/TCM-Asylum-USRefugeeIntegration-FINAL.pdf.
[17] Jens Manuel Krogstad, *Key Facts about Refugees to the U.S.*,[2019]). https://www.pewresearch.org/fact-tank/2019/10/07/key-facts-about-refugees-to-the-u-s/.
[18] Fix, Hooper and Zong, "How are Refugees Faring? Integration at U.S. and State Levels," (June, 2017)1. https://www.migrationpolicy.org/sites/default/files/publications/TCM-Asylum-USRefugeeIntegration-FINAL.pdf.

Economic metrics may reflect one way that the current resettlement system is quite successful in meeting integration goals. Where the current system falls short is in the provision of services to aid in social, cultural, linguistic, or medical integration and stability. “While economic measures of integration to offer quantifiable metrics of success, such as employment rates or income levels, it remains much harder to evaluate other, more long-term measures of integration, such as civic and political participation.”[19] Under the current system, addressing these facets of integration is not viewed as a governmental responsibility, rather falling to the individual and the host community. This is particularly problematic for resource-intensive responsibilities like trauma management which communities have little ability to absorb.

Why Trauma

The definition of a refugee inherently suggests exposure to traumatic events. To be displaced from one’s own nation and experiencing or fearing persecution is in itself traumatic. Many refugees have also experienced direct harm or trauma through physical violence, loss of family members, loss of property, lack of food and water, or forced labor. While these experiences are shared by some other groups, including immigrants not awarded refugee status, the risk factors which refugees are subject to are in large part unique to this population. There are also further factors during transit and resettlement that continue to heighten the risk of poor mental health. The result has been above average rates of psychological disorders in refugee populations even following resettlement. “High rates of post-traumatic stress disorder, depression, and anxiety have been reported in refugee populations with these disorders often co-

[19] Michael Fix, Kate Hooper and Jie Zong, "How are Refugees Faring? Integration at U.S. and State Levels," (June, 2017)2. https://www.migrationpolicy.org/sites/default/files/publications/TCM-Asylum-USRefugeeIntegration-FINAL.pdf.

occurring."[20] The impact of trauma and the possible avenues to mitigate negative repercussions are deserving of attention because they promise to uplift a vulnerable population.

Trauma is a psychological term referring to the emotional response to terrible events. For many people, this is a singular event such as rape or a natural disaster. In refugees however, this often entails the cumulative experience of many terrible events linked to the sociopolitical status of their home country. Long-term reactions to traumatic experiences "include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea" which can cause "some people have difficulty moving on with their lives."[21] Torture is a practice that frequently results in trauma, defined "by U.S. law as an act which is intended to inflict severe physical or mental pain or suffering and committed by a person acting under the color of law upon another person who he has under his custody or physical control."[22] This thesis does not focus on torture but references various sources which use the term, torture can be an ambiguous concept in international politics but it is apparent most sources operate on this definition or one closely aligned. Facets of the refugee experience including war exposure, lack of stability and security, natural disasters, torture, or ethnic targeting are likely to trigger trauma at rates higher than other populations.

Trauma in refugee populations has been historically overlooked despite displaying evidence of being pervasive and highly impactful. "In the 1970s and 1980s, attention to the psychological consequences of forced displacement and humanitarian emergencies was rather

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[20] Susan S. Y. Li, Belinda J. Liddell and Angela Nickerson, "The Relationship between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers," *Current Psychiatry Reports; Curr Psychiatry Rep* 18, no. 9 (2016), 1-9. doi:10.1007/s11920-016-0723-0.

[21] "Trauma and Shock."https://www.apa.org/topics/trauma (accessed Mar 8, 2021).

[22] "Services for Survivors of Torture."http://www.acf.hhs.gov/orr/services-survivors-torture (accessed Feb 2, 2021).

modest and mental health problems were easily overlooked amidst the plethora of needs."[23] Minimal attention and research dedicated to refugee trauma resulted in an underestimation of psychological illness amongst refugees and a subsequent lack of resources to aid in treating these illnesses. As research and emphasis on the importance of reactions to trauma have increased in recent years, it has become apparent that the scale of the problem is larger than anticipated and that trauma management resources are inadequate.[24] There has also been a realization that responses to traumatic experiences are far more diverse than PTSD, also including anxiety disorders, somatization, depression, or personality change, among others.[25]

Important groundwork has already been laid in analyzing the risks of trauma for refugees after resettlement. One leading researcher, Mina Fazel, produced in 2005 a meta-analysis of serious mental disorders in 7,000 refugees in western countries and in 2012 an analysis of the risk and protective factors for refugees in western nations. This work has been incredibly important in evaluating the prevalence rates of symptoms. These large analyses were informed by data from dozens of studies on particular populations, using these countless small data points to create a macro view of refugee mental health post-settlement. In 2018, editors Nexhmedin Morina and Angela Nickerson, both psychologists, co-edited the book *Mental Health, Pre-migratory Trauma and Post-migratory Stressors Among Adult Refugees*, which compiles academic articles exploring various facets of refugee mental health including current knowledge,

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[23] Peter Ventevogel, "Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action?" in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, eds. Nexhmedin Morina and Angela Nickerson (Cham: Springer International Publishing, 2018)156. doi:10.1007/978-3-319-97046-2_8. https://doi.org/10.1007/978-3-319-97046-2_8.

[24] Craig Higson-Smith, *Updating the Estimate of Refugees Resettled in the United States Who have Suffered Torture,[20*15]).

[25] Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural Psychiatry* 45 (2009)630. doi:10.1177/1363461508100785.

historical perspectives, intervention techniques, and clinical advances. This is perhaps the most comprehensive documentation to date of the many puzzle pieces to refugee trauma. This is a topic that has expanded greatly in recent years, but there is much work to be done in linking the psychological to the political and making apparent the needs of refugees following resettlement.

It is crucial to continue studying the mental health of refugees to ensure that they are receiving the proper resources to aid integration following potentially traumatic pasts. Even while psychological research on refugee trauma has blossomed in recent decades, relatively little consideration has been given to how this translates to the political realm and how western resettlement systems can best manage mental health. This is a crucial question in ensuring the success of resettled refugees. It can currently be observed that "higher risk of mental health problems persists, even years after post-resettlement."[26] Mental health is a predictor not only of physical health but also of successful social and economic integration, the bases of stability and growth for refugee communities and the nation. Akin to improved educational models or investment in prison reform, a choice to embrace mental health promises to increase the ability of individuals to contribute to their community and economy. An investment in mental health accessibility for traumatized refugees will reward the nation in economic growth, law and order, and community contribution. Trauma management is valuable for many populations but has the potential to be exceptionally effective in populations with high prevalence rates of mental disorders, such as refugees. Now, while the Unites States seeks to re-evaluate the social obligations of the government and we grapple with the toxicity of immigration and humanitarian responsibility, is the moment to address the apparent shortcomings in services to refugees.

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[26] Li, Liddell and Nickerson, "The Relationship between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers," *Current Psychiatry Reports; Curr Psychiatry Rep* 18, no. 9 (2016), 1-9. doi:10.1007/s11920-016-0723-0.

Chapter 2: Traumas and Stressors

Intro

An understanding of the trauma faced by refugees, asylees, or asylum seekers begins with an exploration of the experiences preceding mental health screening or evaluation. The events and conditions lived by an individual vary dramatically depending on country of origin, economic status, age, gender, religious and political affiliation, or myriad other factors. Furthermore, these same factors may influence the ways in which an individual copes with or exhibits symptoms relating to their lived traumas. In this way, refugees differ from many other survivors of discrete trauma, experiencing cumulative stressors rather than individual events.[27] It is for this reason that care must be taken in the summation of refugee experiences and generalization of exposure or symptomology.

Much of the research on the mental wellbeing of refugees who have been exposed to traumatic events has failed to acknowledge the trauma exposure and coping of refugees as an experience rather than the precipitation of an event. "Research on refugee mental health has often proceeded from a life events model."[28] This is in large part due to a competitive environment between trauma-focused research and psychosocial research. The trauma-focused advocates, who treat direct exposure to violence as the largest or perhaps only predictor of poor mental health among refugees, have historically dominated this field.[29] While both models are

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[27] Matthew Porter and Nick Haslam, "Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis," *JAMA : The Journal of the American Medical Association* 294, no. 5 (Aug 3, 2005)603. doi:10.1001/jama.294.5.602. http://dx.doi.org/10.1001/jama.294.5.602.
[28] Matthew Porter and Nick Haslam, "Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis," *JAMA : The Journal of the American Medical Association* 294, no. 5 (Aug 3, 2005)603. doi:10.1001/jama.294.5.602. http://dx.doi.org/10.1001/jama.294.5.602.
[29] Kenneth E. Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," *Social Science & Medicine (1982)* 70, no. 1 (Jan, 2010)7. doi:10.1016/j.socscimed.2009.09.029. https://search.datacite.org/works/10.1016/j.socscimed.2009.09.029.

valuable and reveal potentially causal links between the experiences of refugees and trauma, recent literature indicates that there has been an under-emphasis on the role of daily stressors and environmental factors.[30] [31] [32]

The 'life events model' focuses on acute exposure to war. In this model, a single yet extreme experience is responsible for psychological disturbance.[33] While an acute event such as physical assault, death of a loved one, or witnessing the destruction of one's own home is certainly predictive of some trauma, these events do not happen in a vacuum. This 'trauma-focused' study of psychological disturbance excludes many daily stressors that must be considered.[34] The political, social, economic, and emotional contexts surrounding acute exposure are components which often act as predictors of an individual's status and symptomology. For this reason, the life events model is valuable in examining the occurrences which may have catalyzed poor mental health outcomes but cannot be treated as the sole explanatory factor.

Examining refugee trauma through a psychosocial lens offers insights into the daily stressors that are common in the refugee experience. While these conditions are typically caused or worsened by armed conflict, they include facets such as malnutrition, camp life, disruption of

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[30] Kenneth E. Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," *Social Science & Medicine (1982)* 70, no. 1 (Jan, 2010)8. doi:10.1016/j.socscimed.2009.09.029. https://search.datacite.org/works/10.1016/j.socscimed.2009.09.029.

[31] Porter and Haslam, "Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis," *JAMA : The Journal of the American Medical Association* 294, no. 5 (Aug 3, 2005)603. doi:10.1001/jama.294.5.602. http://dx.doi.org/10.1001/jama.294.5.602.

[32] Alexandra Chen et al., "Minds Under Siege: Cognitive Signatures of Poverty and Trauma in Refugee and Non-Refugee Adolescents," *Child Development* 90, no. 6 (2019), 1856-1865. doi:10.1111/cdev.13320. https://doi.org/10.1111/cdev.13320.

[33] Porter and Haslam, "Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis," *JAMA : The Journal of the American Medical Association* 294, no. 5 (Aug 3, 2005)603. doi:10.1001/jama.294.5.602. http://dx.doi.org/10.1001/jama.294.5.602.

[34] Miller and Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," *Social Science & Medicine (1982)* 70, no. 1 (Jan, 2010)7. doi:10.1016/j.socscimed.2009.09.029. https://search.datacite.org/works/10.1016/j.socscimed.2009.09.029.

communication with family and friends, or extreme poverty. These are not universal conditions, nor are they necessarily experienced daily, but they are defining characteristics of life as a refugee beyond direct exposure to war. Daily stressors have consistently proven to "have powerful effects on mental health outcomes."[35] The importance of daily stressors amongst refugee populations is unsurprising given research indicating that stressors such as poverty or malnutrition predict poor mental health within non-war populations as well. A weakening of social support and personal security risks compromising refugees' mental resilience and decreasing preparedness should a larger traumatic event take place. Furthermore, these daily stressors may erode mental health independent of acute war trauma.

While "greater direct exposure to war events is associated with higher levels of PTSD symptoms," the degree of exposure to armed conflict is not responsible for much variation in PTSD levels within given war-affected communities. What this means is that war events are traumatic, but they do not—in and of themselves—predict PTSD. Rather, high levels of distress or poor mental health symptomology may be prevalent in high-conflict communities due to the daily stressors presented by conflict zones. The degree of exposure to war accounts for even less variation in other outcomes such as anxiety or depression.[36] It is more likely that acute war exposure is a large contributor to a series of compounding experiences, both large and small.

The compounding factors that may exacerbate psychological disturbance amongst refugees can be examined through various models. Frequently referenced to is the 'spirals of

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[35] Kenneth E. Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," *Social Science & Medicine (1982)* 70, no. 1 (Jan, 2010)8. doi:10.1016/j.socscimed.2009.09.029. https://search.datacite.org/works/10.1016/j.socscimed.2009.09.029.

[36] Kenneth E. Miller and Andrew Rasmussen, "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks," *Social Science & Medicine (1982)* 70, no. 1 (Jan, 2010)10. doi:10.1016/j.socscimed.2009.09.029. https://search.datacite.org/works/10.1016/j.socscimed.2009.09.029.

loss' model, in which all adversities interact with one another to create a downward spiral. An event such as war trauma via hostile occupation of one's city or village presents not only violence exposure; but also the possibility of losing one's family members, experiencing physical harm, or losing one's home. Although precipitated by the occupation, this single event kicks off a 'spiral' of loss which presents many causes for psychological harm. "Cumulative adversities usually worsen health outcomes, exerting more powerful effects than any factor alone… risks cannot be simply added up, but the inter-related pathways that lead to the outcomes need to be assessed."[37]

Recurring characteristic of nation states are determinant of highly prevalent risk factors experienced by citizens. States who are governmentally unstable and have failed to develop central leadership often resort to militaristic governing in an attempt to retain control. Colonization or civil war leave behind nations which are poorly governed and deeply fractured, key markers of humanitarian crises. These failed states are often unable to rule over competing ethnic groups and, as a result, certain groups are targeted. Lack of governmental control also enables ethnic classes to militarize or develop extremist wings who further threaten the legitimacy of the government and cohesion of the nation. These political predictors, although not universal, indicate nations at high risk of developing humanitarian disasters which put citizens at risk.

The refugee experience presents key risk factors and protective factors during each stage of displacement. These factors and the effect which they have clearly vary on a country, cultural, and individual level, though there are notable trends across populations. It is quite likely that any

[37] Mina Fazel et al., "Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and Protective Factors," *The Lancet (British Edition); Lancet* 379, no. 9812 (2012)279. doi:10.1016/S0140-6736(11)60051-2.

given individual will experience events or circumstances which can be classified as 'traumatic' during their premigration life, the process of migration, or their new life postmigration. It will never be feasible to accurately chronical all of these experiences, only to explore the existing studies on given populations. The risk factors, events, and stressors experienced cannot be generalized or even typified, but they can be presented and explored.

Premigration Trauma Exposure

Refugees, by definition, are subjected to traumatizing events in their country of origin such as war, persecution, or disaster. With these conditions come both acute traumatic events and recurring daily stressors, both of which have the potential to trigger or contribute to poor mental health symptoms. "Refugees report high rates of torture, including witnessing torture of family members or others, physical beating, rape/sexual assault and deprivation of food and water."[38] Of refugees resettled in the United States, recent reports place the prevalence rate of torture at 44%, suggesting that "there may be as many as 1.3 million torture surviving refugees in the country."[39] When accounting for premigration trauma excepting torture, rates of trauma exposure are likely even higher.

One form of violence exposure which is particularly harmful to mental wellbeing is physical harm. Either from war or other sources of violence, injury is common and can have lasting physical and psychological effects. "Personal injury that was sustained during potentially traumatic premigration events was associated with an increased risk of post-traumatic stress disorder. Head injury, in particular, was associated with a doubling of risk." While personal

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[38] Jason Ostrander, Alysse Melville and S. Megan Berthold, "Working with Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches," *Advances in Social Work* 18, no. 1 (/09/24, 2017)67. doi:10.18060/21282. https://journals.iupui.edu/index.php/advancesinsocialwork/article/view/21282.

[39] Higson-Smith, *Updating the Estimate of Refugees Resettled in the United States Who have Suffered Torture,[20*15]).

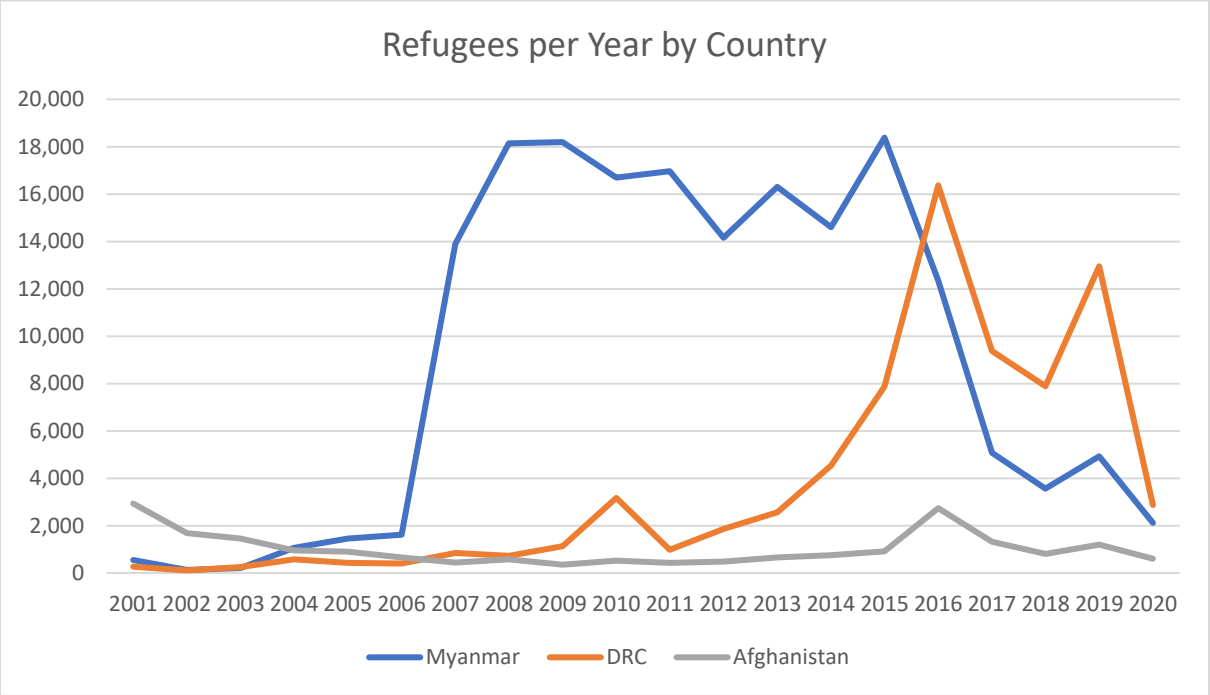
injury is also common in non-refugee populations, harm resulting from family association, religious belief, or cultural cleavages is different than that caused by happenstance to all populations. Personal injury for refugees is frequently repetitive or carries the fear of recurrence unlike many other injury sources. "Cumulative exposure to traumatic events is associated with a broad range of psychological problems in refugee groups exposed to violence during war."[40] To be persecuted is to be attacked for who you are rather than to experience injury by happenstance.

Along with a heightened fear of violence, refugees experience high occurrences of daily stressors in life pre-migration. The fear of harm to oneself and one's family can be a major stressor in itself. Refugees often also experience loss of home, malnutrition, lack of financial resources, or loss of family. The role of these stressors should not be downplayed. Daily stressors cause an individual's response to always be on high, abating the ability to distinguish between real or perceived danger. Some stress in a high-stakes situation can be 'positive' or 'tolerable' stress which keeps an individual on edge but in a way that serves to protect them. However, the severity of stressors facing many refugees results in 'toxic stress,' at which point the psychological response to stressful conditions renders the brain less capable of functioning. Continuous toxic stress causes neurons in the brain to stop connecting and inhibits the ability to engage or cope.[41]

As previously mentioned, the experiences of all refugees can be quite disparate dependent on country, economic status, gender, age, or myriad other factors. Keeping in mind the 'spirals of loss' theory, I will examine traits and stressors of the premigration experiences of

[40] Fazel et al., "Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and Protective Factors," *The Lancet (British Edition); Lancet* 379, no. 9812 (2012)270. doi:10.1016/S0140-6736(11)60051-2.
[41] *Terror & Hope: The Science of Resilience,* directed by Ron Bourke Collective Eye Films, 2020)

refugees from Myanmar, the Democratic Republic of Congo, and Afghanistan. I will seek to highlight key risk and protective factors that affect these populations including how they differ. Of course, the academic evaluation of common risks and stressors may still fail to fully capture the experience of a given group. Myanmar, Congo, and Afghanistan all exhibit the ways that a weak central government which cannot achieve effective state building creates avenues for militia insurgencies and ethnic infighting. The result is frequently trauma inflicted upon civilians in state attempts to retain control over their territory and establish ethno-religious dominance.



[42]

Between 2001 and 2019, refugees from Myanmar—previously called Burma—were the most resettled group in the United States, with 177,700 refugees from Myanmar coming to the country in that time.[43] Refugees have included ethnic majorities, the Burmans, but have primarily

[42] "Admissions & Arrivals - Refugee Admissions Report."https://www.wrapsnet.org/admissions-and-arrivals/ (accessed 1/24/, 2020).
[43] Krogstad, *Key Facts about Refugees to the U.S.*,[2019]). https://www.pewresearch.org/fact-tank/2019/10/07/key-facts-about-refugees-to-the-u-s/.

been from ethnic minority groups such as the Karen, Shan, Chin, Kachin, and Rohingya. After inheriting a fractured country following colonization, the central government has struggled to effectively rule, with particular conflict occurring with non-Buddhist minority groups. Christian and Muslim populations close to Myanmar's borders have experienced the brunt of political and military targeting while the central government attempts state building. The Rohingya have, in recent years, been the most persecuted ethnicity in Myanmar and one of the most persecuted in the world. The Muslim Rohingya came to the US in large numbers during the mid-2010s, but this flow slowed with the Trump administration's restrictions. Thus, Christian groups such as the Karen, Chin, and Kachin offer greater academic research and insight into trauma, migration, and resettlement.

The legacy of colonialism and failed state building has left Myanmar filled with many feuding ethnics groups who are deserving of refugee status. Particular groups have greater representation in the US refugee system, perhaps due to their status as ethnic minorities rather than political dissidents or due to their religious affiliations. Contrasting the experiences of Burman peoples, the ethnic majority, and Karen peoples, the most ethnic minority group with the greatest presence in the U.S., offers valuable comparisons between political refugees and ethno-religious refugees. While both majority peoples and minority groups have been exposed to failed governance and internal warfare for the past seven decades, they come from vastly different socioeconomic and sociopolitical means, with the majority Burmans having greater resources. While Burmans are at times targeted by the government and military, it is for intellectual political opposition rather than ethnic or religious identity.[44]

[44] Isok Kim, "Behavioral Health Symptoms among Refugees from Burma: Examination of Sociodemographic and Migration-Related Factors," *Asian American Journal of Psychology* 9, no. 3 (2018)180-185. doi:http://dx.doi.org/10.1037/aap0000103. https://search.proquest.com/docview/2011586027?accountid=14637.

[45]

"Many Burman refugees have had relatively greater social capitals, such as experience with formal education, greater language proficiency in their native language, and having the normalcy and privilege of their ethnic background being the majority in their own country of origin." In contrast, the minority groups—especially Christians and Rohingya Muslims—have survived with dramatically fewer social capitals, typically lacking any formal education and

[45] , "Who are Burma's Minority Groups?"*BBC News* (2010):

being one of the most persecuted groups.[46] For 66% of Karens resettled in the U.S., no school or primary school was their highest level of education.[47] These ethnic barriers predict greater daily stressors for the Karen and other minority populations prior to displacement. As a result, the ethnic group or region that one is born into can have tremendous effects on mental health from a young age. Poverty, persecution, and lack of education mean that minority refugees in rural areas are not afforded the stabilizing effects that Burmans are, predicting poorer health outcomes.

In addition to structural setbacks inherent to a given ethnicity, minorities in Myanmar have suffered abhorrent torture and abuse from the majority government and military. In a "sample of 179 Karen refugees, 27.4% experienced or witnessed torture and 51.4% reported the torture of family members. More than 85% of Karen participants reported experiencing war trauma." Forced portering, the carrying of supplies for the military, and being used as a human landmine sweep were the two most reported forms of torture. The Karen people sent to assist the military were deprived of adequate food and water during their labor, being left for dead when they were no longer strong enough to be effective laborers. Forced military service or enslavement was experienced by both adults and children. Other respondents described individualized public torture, but more common was fear of violence against oneself and family. "Widespread community fear was frequently reported by participants. It is clear that participants often experienced sudden attacks on their homes and villages by the Myanmar Military, multiple and prolonged displacements, deprivation and sickness during displacement, and living in a constant state of fear and insecurity." The cause for this state of fear comes from military tactics

[46] ibid.
[47] Tonya L. Cook et al., "War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study," *BMC International Health and Human Rights* 15 (2015)

such as the strategic burning of homes and villages, carrying the risk of death but also ensuring loss of community, homelessness, and material loss.[48]

There are countless refugees in camps along Myanmar's borders, many of whose ethno-political status suggests they have likely been exposed to traumatic events. There are approximately 128,000 refugees from Myanmar in camps on the Thailand-Myanmar border, primarily from minority ethnic groups such as the Karen.[49] In a comparison of the Burman and Karen ethnic groups, "all of the Karen participants but one reported having stayed in a refugee camp before U.S. resettlement. Compared with this, fewer than half of the Burman participants reported that they were in a refugee camp before their resettlement."[50] Furthermore, the Karen refugees often spent decades in camps before being resettled. Karen refugees surveyed in the U.S. reported living in refugee camps for an average of thirteen years.[51] Camp living, especially for prolonged periods is impactful for mental health because "longer stays in the refugee camps are associated with stronger increase in anxiety symptoms for Karen refugees, compared with their Burman counterparts."[52]

Myanmar's ethno-religious infighting, spanning seven decades, has been one of the longest and most violent internal conflicts in history. While political dissidents do experience significant hardship and trauma, much of the violence and stressors are concentrated on ethnic minorities who are not Buddhist. "Over 85% of Karen people interviewed experienced life-

[48] ibid.
[49] ibid.
[50] Kim, "Behavioral health symptoms among refugees from Burma: Examination of sociodemographic and migration-related factors,"185
[51] Cook et al., "War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study,"
[52] Kim, "Behavioral health symptoms among refugees from Burma: Examination of sociodemographic and migration-related factors,"186

threatening war trauma in instances where they were not specifically targeted for torture."[53] The climate in Myanmar is conducive to many risk factors. Personal injury, a predictor of PTSD, is likely for those who experience torture, forced labor, or live in an attacked community. Widespread fear is the risk factor predictive of toxic stress levels in which cognitive functioning and mental wellbeing are both compromised. The common conditions for refugees from Myanmar indicate susceptibility both to acute trauma such as torture and to toxic levels of daily stressors.

The Democratic Republic of Congo has been engulfed in internal conflicts agitated by outside actors for the past twenty-five years. Spurred by spillover from the Rwandan genocide in 1994, militia groups have repeatedly clashed with the Congolese forces. While the most conflict-ridden group has been the ethnic Tutsis following the genocide in Rwanda, many other opportunistic rebel forces have been at war with the formal military. The Congolese government has been backed by neighboring nations along with UN Peacekeepers, but has been unable to suppress the armed groups who control much of the country's territory. The weak central government and the prevalence of valuable mineral resources have fueled the efforts of rebel groups to maintain their control over areas, with minerals both incentivizing and funding the defense of territories.[54]

The ability of militias to rule over the country and the fighting over territory have predicted extreme hardship for many parties with no role in the fighting. "Weak governance and the prevalence of many armed groups have subjected Congolese civilians to widespread rape and

[53] Cook et al., "War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study,"
[54] "Violence in the Democratic Republic of Congo," November 12, [cited 2020]. Available from https://cfr.org/global-conflict-tracker/conflict/violence-democratic-republic-congo.

sexual violence, massive human rights violations, and extreme poverty." Like Myanmar, failed attempts at state building have left deep ethnic cleavages. Militarization of ethnic groups has further degraded governmental legitimacy in the eyes of combatants and civilians alike. The fighting and lack of development in the country have also left many individuals with few choices but to join rebel groups as a form of employment. An alarming number of those who have been recruited into militia groups as soldiers, spies, or sex slaves are children. For these reasons, the effect of rebel groups on civilians' lives goes beyond exposure to violence via clashes between forces but also reaches into the personal and community lives of many Congolese.[55]

While many Congolese are engaged in the fighting, far more have been displaced by it, regardless of the degree of their involvement. It is estimated that there are "currently 4.5 million internally displaced persons in the DRC, and more than 800,000 DRC refugees in other nations." Among a sample of 325 Congolese refugees interviewed in the Nakivale Refugee Settlement in Uganda, only 9.6% reported fighting in the combat. Importantly, 14.2% of males reported fighting.[56] While rates of participation in combat only amongst refugees may not be indicative due to the shares of combatants killed or still fighting, it is valuable to recognize that a segment of refugees are combatants and that the trauma sustained by other refugees is reflective of the civilian experience. Combatants and militia members are likely to have experienced personal violence though, distinct from non-combatants, they are also the cause of civilians' trauma.

Refugees from the DRC frequently report experiencing serious harm at the hands of militants. Of respondents in the Nakivale Settlement, 94.7% reported experiencing torture at the hands of soldiers and 89.8% experienced harassment. These alarmingly high rates unfortunately

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[55] ibid.
[56] Herbert E. Ainamani et al., "Gender differences in response to war-related trauma and posttraumatic stress disorder – a study among the Congolese refugees in Uganda," *BMC psychiatry; BMC Psychiatry* 20, no. 1 (2020)5

do not come as a surprise, as the Congolese constitute one of the most frequently tortured groups of refugees. Furthermore, 42.1% of respondents reported imprisonment and 40.6% were injured by a weapon. The rates of torture, imprisonment, and injury are dramatic in light of the fact that only 9.6% of those interviewed fought in the combat.[57]

For women in the Democratic Republic of Congo, rape and sexual assault are defining of the civil war and refugee experience. While a mere 6% of women respondents in the Nakivale Settlement reported fighting in the combat, many sustain trauma via sexual assault. 73.1% of women report experiencing sexual assault while 56% report rape. For over one-half of a population to report personally being raped is astonishing, especially as rape and sexual assault are notoriously under-reported. Meanwhile, among men, rates of sexual assault are high at 58.9%, but only 14.9% of men reported being raped. The alarmingly high reports of rape and sexual assault across both genders indicates the way that sexual violence, often by soldiers, is pervasive and mentally scarring.[58]

Direct personal experiences of torture or rape are both self-indicated to frequently be the subjectively ranked single most traumatic event. 40.4% of females reported being raped as the worst traumatic experience. This is corroborated by the fact that, for women, being raped presented the highest conditional risk of the prevalence of PTSD. What this means is that 97% of women in Nakivale who reported being raped met the DSM-IV criteria for PTSD diagnosis. The PTSD symptoms displayed may be caused or dramatized by other lived traumas, but rape constituted the experience which presented the strongest correlation with PTSD.[59]

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[57] ibid.
[58] ibid.
[59] ibid.

While direct experiences are common, there are also frequent reports of witnessing traumatic events. Bearing witness to these events can be traumatizing because for many the victims of severe harm are family members or friends. Watching someone who one knows and loves be harmed can be extremely detrimental. Among 33.1% of males and 28.7% of females, witnessing a killing or murder of another was ranked as the singularly subjective worst traumatic experience. Witnessing dead bodies was also frequently reported as a subjective worst traumatic experience among both men and women. Unsurprisingly, the total number of traumatic events experienced, including those witnessed, was positively correlated with PTSD prevalence.[60]

Of the 305 participants interviewed in the Nakivale Settlement, 285 (89%) met the DSM-IV criteria for being diagnosed with PTSD. Both prevalence and severity of symptoms were higher in women than men in this given study. Perhaps most importantly, across both genders, the number of potentially traumatizing event types was positively and strongly correlated with the severity of symptoms. This implies that, while 89% of interview respondents exhibit PTSD symptoms, those who have experienced a greater number of traumas or stressors are likely to exhibit more severe symptoms. This demonstrates a system of building blocks or compounding traumas in which, even when conditional prevalence for particular events is high, the coalescence of many events is the greatest predictor of resulting mental illness.[61]

The failure of the Congolese government to establish control over territory and resources has allowed powerful private militias to rule much of the country. The conflict between these militias and the governmental military has placed a massive humanitarian burden on civilians in the country. The minimal resources of the Congolese people means that many have served as

[60] ibid.
[61] ibid.

combatants or their families have. This differs from Myanmar in that many refugees were traumatized by militias rather than the governmental military and that violence is not frequently linked to political dissention. The country experienced a civil war but has since continued to experience conflict between militias while the government has not regained control of much of Congo's territory. The Democratic Republic of Congo is a particularly traumatic and disruptive location due to the intensity of threats to citizens. The presence of militias places civilians into the war as victims rather than bystanders and thus inflicts an unusually large burden on mental well-being.[62] Within this study of displaced Congolese, the experience of trauma was pervasive with almost all respondents experiencing at least one type of trauma and most reporting many traumatic experiences. Perhaps more shocking was that 89% of respondents met the DSM-IV criteria for PTSD, no other diagnosable conditions were tested for. The most prevalent and traumatic occurrences proved to be torture, rape, and witnessing death; all being perpetrated by soldiers.

Afghanistan, akin in severity to Burma and the Democratic Republic of Congo, has been one of the largest humanitarian disasters in recent decades. The conditions of Afghani civilians have been exacerbated by foreign involvement in wars on Afghan soil. In addition to the inherent traumas of war, Afghanistan suffers from a lack of resources due to the prolonged fighting. Series of civil wars and foreign involvement along with competition between the Afghan government and Taliban government to claim territory have inhibited development in the nation. Due to a lack of financial resources and its mountainous terrain, Afghanistan has never developed a strong or effective central government. Having less wealth and resources than Myanmar and the DRC, citizens of Afghanistan experience universally poor conditions. The

[62] "Violence in the Democratic Republic of Congo,"

prolonged warfare has resulted in high levels of war exposure and severe daily stressors for Afghanis.

[63]

It is apparent that, due to the nature of recent wars in Afghanistan, the refugees studied for war-stressors and trauma are merely civilians affected by the wars rather than combatants. Despite being indirectly involved in the war, it is apparent that civilians have experienced many war traumas and have been subjected to extreme violence. One study of 320 adults in the city of

[63] "Afghanistan: Who controls what," June 24, [cited 2021]. Available from https://www.aljazeera.com/news/2019/6/24/afghanistan-who-controls-what.

Kabul noted that "85% had experienced the destruction of their homes at least once during the years of warfare; 49% had one or more family members who had been killed; 53% had at least one family member who had been injured during the war; and 25% had been injured themselves as a result of the violence."[64] Non-combatants in Afghanistan live in poor conditions and are frequently surrounded by warfare even if they are neither combatants nor political dissidents. The hardships experienced by residents of Kabul, the country's capital, illustrate how pervasive sever trauma is in war zones.

While any of the events experienced during a war can be mentally disruptive as a singular and acute circumstance, it is more troubling that many individuals experience repeated traumas. Many Afghanis interviewed report multiple events and "fourteen percent reported experiencing 11 or more traumatic events." While these rates are encompassing of the ten years prior to this 2003 study, they display an alarmingly high prevalence of both acute traumas and severe daily stressors. The most commonly reported events in the 2003 study of 1011 Afghanis in the Nangarhar Province conducted by Willem Scholte were 'no access to medical care,' noted by 70.8% of respondents; 'lack of food or water.' noted by 68.9%; 'recent bombardments by Coalition forces,' noted by 62.2%; 'having to flee,' noted by 60.9%; and 'shelling/rocket attacks from mujahideen or former Soviet forces,' noted by 60.8%. Many other traumatic events were reported by a large portion of respondents. Some more severe experiences such as torture or imprisonment were reported by approximately 15% of respondents. [65] These statistic are corroborated by a 2004 study conducted by Barbara Cardozo, which found that the top reported

[64] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural psychiatry* 45 (2009)615
[65] Willem F. Scholte et al., "Mental Health Symptoms Following War and Repression in Eastern Afghanistan," *JAMA* 292, no. 5 (2004)589

experiences are 'lack of food or water' from 56.1% of respondents; 'ill health without access to medical care' from 54.9%; 'lack of shelter' from 44.1%; and 'need to flee suddenly' from 44.1%.[66]

"The years of warfare in Afghanistan, and the civil war in Kabul in particular, exposed most of the city's population to prolonged, extreme violence."[67] The pervasive violence in Afghanistan, often worst in the eastern region of the country where these studies were conducted, has resulted in high rates of mental illness. "Traumatic events that were associated with high PTSD symptom scores were having experienced a lack of food or water, or a lack of shelter, having been tortured, having had to flee suddenly, having loss of property, having been kidnapped, and having been close to death." These events were also among the most frequently reported experiences. Most respondents reported experiencing multiple kinds of traumatic events on multiple occasions, while Scholte's research has determined that scores of anxiety, depression, and PTSD all increase with increased number of traumatic events. For this reason, it is unsurprising that "mental health symptoms are highly prevalent, especially in those who experienced multiple traumas."[68]

The war zone conditions which have been the norm in Afghanistan for decades have also precipitated severe daily stressors. To begin, education levels are very low, with 88% of females and 44% males not reporting any education.[69] Education is hypothesized to be a protective factor in moderating distress, causing alarm for the ability to achieve financial stability or cope with distress. Civilians in Afghanistan also face environmental conditions which cause toxic stress for

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[66] Barbara Cardozo et al., "Mental Health, Social Functioning, and Disability in Postwar Afghanistan," *JAMA : the journal of the American Medical Association* 292 (2004)579
[67] Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan,"628
[68] Scholte et al., "Mental Health Symptoms Following War and Repression in Eastern Afghanistan,"590-592
[69] ibid.

individuals, either independent of or in tandem with war stressors. Top daily stressors include air pollution, roadblocks, financial problems, and not having enough money for family needs.[70] These stressors have proven to be predictive of myriad issues such as PTSD, anxiety, and depression. In fact, "daily stressors significantly predicted all mental health outcomes, while war experiences had a direct impact only on PTSD."[71] As always, it is important to acknowledge that the majority of the surveyed Afghani population experienced both acute war stresses and myriad daily stressors, meaning that drawing a true causal link is not foolproof. Physical and mental health resources in Afghanistan are also reportedly low, and "Ninety-eight percent of the respondents mention 'Allah' as the main resource for emotional support when feeling sad, worried, or tense."[72] While religion is at times a protective factor for mental health, the lack of reliance on other supports reflects the few available coping resources.

Afghanistan has suffered from decades of war while also being an undeveloped and resource poor nation. Hopes of economic and humanitarian growth have been continually crushed by the reality of the nation as the site of both civil wars and international wars. As a result, the country has poor physical health indicators including low life spans and high mortality rates, heavy reliance on the drug trade, and low literacy rates.[73] These structural features of the nation's government, society, and economy fail to provide a stable baseline for individuals to manage the myriad war traumas and daily stressors that come with life in a violent war zone. The result is high rates of poor mental health outcomes and few resources to manage these problems or promote healthy coping.

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[70] Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan,"616
[71] ibid.
[72] Scholte et al., "Mental Health Symptoms Following War and Repression in Eastern Afghanistan,"590
[73] Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan,"615

Having explored the recurring risk factors or events experienced by refugees, it is important to take reports of personal and congregate experiences with healthy skepticism. Cultural barriers and personal stigmatization or conscience inhibit truly accurate reporting of what an individual has experienced or witnessed. This may be especially prevalent in the reporting of rape, domestic abuse, torture, or other personal details like the inability to provide for one's family. Additionally, researching problems such as selection bias, the location of interviewing, or the presence of bystanders have the potential to impact the accuracy of reporting. For all these reasons and more, accounts of trauma documented via academic studies give a basis for which events are frequently experienced but do not accurately encompass all aspects of the refugee experience.

It is also valuable to note the substantial differences between the three nations examined and thus between refugees originating from these nations. All three were determined to be worthy of refugee status due to warfare, but the wars take different forms. Burma has experienced genocidal divisions between ethnic groups. The Democratic Republic of Congo has been home to militia groups which occupy various regions of the country. Afghanistan has had a combination of civil wars and foreign occupation with much of its fighting concentrated in the Eastern part of the country. Furthermore, the conflicts in all three countries have often involved neighboring countries as well as peacekeepers from the UN. In some studies, refugees were interviewed not in their home but in camps or nearby countries. In comparing across countries, it is clear that deplorable conditions are ubiquitous. However, certain forms of traumatic experiences may be more prevalent in specific locations. Additionally, certain traumas or stressors may be predictive of different psychosocial outcomes. While Burma, the DRC, and

Afghanistan do not represent the experiences of all refugees, they offer a glimpse into the experiences common in countries which the U.S. has received large numbers of refugees from.

Migration Trauma Exposure

After the initial traumas of being in a war-torn country, most refugees experience a stressful and dangerous process of being resettled. While the regions of major conflicts often have refugee camps, fleeing to reside in a camp is not typically an enjoyable or safe process. Before reaching a safe host country, migrants are vulnerable to exploitation while also being effectively homeless and often poor. There are also occasionally benefits to migration, such as mental and physical health resources, food security, or heightened physical safety. Migration brings additional risk and protective factors that can ease or exacerbate any traumas experienced pre-migration.

Refugees from Burma typically spend time in refugee camps on the country's borders before being resettled to a foreign host country. This time of living in camps has proven to be fairly destructive due to poor conditions and a lack of resources. As of 2015, a shocking 128,000 refugees from Burma were in camps on the Thai-Burma border, many more have already been resettled.[74] Due to poor conditions, longer stays in the camps are correlated with heightened symptoms of anxiety as well as PTSD. The neglect for physical and mental health, along with low standards of living in camps, complicates the process of determining where traumas were experienced and why mental responses might be more or less extreme. "Given that the Karen refugee participants had spent years in refugee camps along the Thai-Burma border, where these behavioral health symptoms mostly go unchecked, it is possible that the heightened PTSD

[74] Cook et al., "War trauma and torture experiences reported during public health screening of newly resettled Karen refugees: a qualitative study,"

symptoms we found reflect neglected psychosocial and medical attention from both their refugee camp stay and after their arrival in the United States."[75]

In the Democratic Republic of Congo, many of the refugee camps which house people who have fled their homes are located in Uganda. This is because much of the fighting has taken place in the Northeastern portion of the DRC, close to the Ugandan border. However, refugees flee to all areas including internally displaced peoples who seek refuge elsewhere in the country. Some refugee camps in Uganda offer services particular to building mental resilience in children. While mental health resources are often scarce, incorporating psychosocial activities and socioemotional learning into existing children's activities is a manageable project which has shown to have positive effects. Called Child Friendly Spaces, these resources and activities were "found to be highly impactful, therefore, but not in promoting enhanced well-being but rather in sustaining well-being in a context where individual, familial, and community processes alone were unable to protect children from the severe erosion of well-being in the harsh condition of resettlement." The hope in this scenario is to create strategic intervention techniques that provide 'resource acquisition spirals' at a time when people are typically experiencing 'resource loss spirals.' Instead of losing cognitive abilities, coping skills, and support; some camps to serve Congolese refugees have attempted to invert these losses.[76]

Research in Afghanistan has illustrated that displacement in itself is a significant source of trauma. Whether moving to a refugee camp, a neighboring country, or a distant host; being uprooted from one's home and community and being placed in a foreign climate can cause

[75] Kim, "Behavioral health symptoms among refugees from Burma: Examination of sociodemographic and migration-related factors,"186
[76] Michael G. Wessells, Alastair Ager, and Janna Metzler, "Where There Is No Intervention: Insights Into Processes of Resilience Supporting War-Affected Children," *Peace and conflict* 23, no. 1 (2017): 67-75.

distress. “The process of being uprooted has been described to create culture shock, a stress response to a new situation in which former patterns of behavior are ineffective.” While relocation may provide respite from the violence and fear of living in Afghanistan, relocation brings loss of comfort because other environments can be so different. “Culture shock may also lead to a sense of cultural confusion, feelings of alienation, isolation, and depression.” The psychological results of the migration process can worse previous traumas or impede the utilization of help services and delay adjustment. Especially for poorly equipped populations, migration can be a significant source of trauma and distress due to acculturation and loss of familiarity.[77]

As with analyzing home country experiences, the literature cited here does not explain all experiences or resources of a particular country. There may be camps in Burma with the most advanced services in the world and camps in the DRC with the most deplorable conditions. This research seeks to illustrate the potential scenarios that ease or exacerbate stress or trauma and how they manifest themselves in various migration processes. The generalizations presented by each case study exhibit trends which are likely to apply to many refugees. Living in refugee camps for prolonged periods has the potential to be traumatic unless significant steps are taken to provide resources for building resilience. Displacement and migration, even when ‘done properly,’ are emotionally and physically difficult, creating possibilities for further psychological harm.

The structural process of migration carries inherent risk factors tied to the removal of an individual from their family and culture along with the methods of host countries. Prior to

[77] Qais Alemi et al., "Psychological Distress in Afghan Refugees: A Mixed-Method Systematic Review," *Journal of immigrant and minority health; J Immigr Minor Health* 16, no. 6 (2013): 1247-1261.

resettlement, many individuals in war zones rely heavily on their family for support, the migration process often rips away these supports as some family members are left behind or settled to different hosts. “Separation from family represents a significant barrier to positive psychological outcomes in refugees.” The process of migration also entails lots of uncertainty and a lack of control which can be highly distressing. In particular, prolonged detention or lack of security in permanent residence can be difficult. Refugees are admitted to a country without knowing if their stay will be temporary or permanent, they are then obligated to wait until a decision is made to offer them temporary or permanent protection visa. While temporary visas can be renewed, they represent yet another level of uncertainty in the journey to building a new life. “The application of temporary visas rather than permanent protection visas has an adverse impact on mental health, including PTSD, depression, and anxiety disorders.” Research also suggests that prolonged resettlement processes and repeated questioning are both linked to poorer mental health outcomes.[78]

Resettlement Trauma Exposure

Refugees, by definition, are subjected to traumatizing events in their country of origin such as war, persecution, or disaster. Many of the difficulties presented in the migration process continue into the resettlement period. Resettling in western countries—although it has great merits—exacerbates problems such as acculturation, language barriers, difficulty navigating new systems, and financial hardships. After resettlement, the incidence of acute traumas should be far lower than in the country of origin, but daily stressors may be equal or even more prevalent.

[78] Susan S. Y. Li, Belinda J. Liddell, and Angela Nickerson, "The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers," *Current psychiatry reports; Curr Psychiatry Rep* 18, no. 9 (2016): 1-9.

Both practical obstacles and cultural obstacles can be disruptive to a comfortable settlement and assimilation process.

Resettlement broadly falls into two categories: traditional resettlement or new resettlement. “Traditional refugees are culturally and ethnically similar to their host, and are likely to be welcomed and assisted by family and friends who speak their language and can cushion their adjustment.” The result is that there are still things left behind, but the transition is culturally comfortable. In contrast, “new refugees are culturally, racially, and ethnically different from their hosts and are likely to lack kin or potential support groups in their country of resettlement.” By this definition, nearly all refugees settled in the United States or other Western host countries are experiencing new resettlement. While this often comes with economic opportunity and higher standards of living than their previous home, new resettlement is difficult and likely to present many stressors or traumas of its own. The process of becoming acculturated, learning a new language, adapting to new systems and lifestyles, all while building a personal and professional life is tedious and stressful. New settlement stressors can also make it more difficult to address prior traumas due to unease, language barriers, or lack of connectedness to the local systems.[79]

Daily stressors post-migration can not only inhibit proper adjustment to the new location and culture, but they can also predict poor mental health. In fact, some studies claim that “daily stressors in the host country are equally relevant or even better predictors of mental-health problems than exposure to traumatic events prior to departure.”[80] While it can be difficult or

[79] Miriam George, "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice." *Clinical Social Work Journal* , no. 40 (2012)432

[80] Karolin Krause and Evelyn Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in *Refuge in a Moving World* UCL Press, 2020),310

impossible to decipher which time periods or events are responsible for a psychological result, it is logical that the stress of adjusting to a new area can be taxing or harmful.

One particularly destructive daily stressor is poverty. Even among domestically born Americans, extreme poverty is predictive of depression and anxiety. Beyond immediate mental health symptoms, poverty disrupts the brain and leads to life outcomes that lend themselves to greater mental obstacles. “In the United States, poverty is robustly associated with executive function deficits in childhood and adolescence.” A study of refugee families revealed that the same was true, those which were relatively poorer had worse executive function. Poverty predicts poorer mental performance of individuals along with poorer performance in school for adolescents. The mental degeneration predicted by severe poverty leaves refugees more vulnerable to poor mental health along with decreasing opportunities for stability and coping.[81]

Independent of daily stressors, difficulty in acculturation is responsible for considerable stress in recently resettled refugees. “During the initial post-migration period, refugees are confronted by the loss of their culture—their identity, their habits, and their place. Every action that used to be routine will require careful examination and consideration.” This loss of comfort and identity presents multi-faceted problems for refugees. One important obstacle is a lack of social connection which can provide stability and security for individuals with minimal resources. Additionally, slow acculturation means that refugees do not fully understand the resources available to them or the cultural norms surrounding physical and mental health related to trauma. “Refugees are often not sure what help-seeking behavior is appropriate in the host

[81] Chen et al., "Minds Under Siege: Cognitive Signatures of Poverty and Trauma in Refugee and Non-Refugee Adolescents,": 1856-1865.

country." These difficulties in acculturation prevent refugees from receiving personal or professional assistance and support regarding traumatic experiences.[82]

While acculturation in the new resettlement model can be mentally disruptive, there are moderating and protective factors that help to minimize the difficulty of assimilation. "At the cultural level, spirituality and religious beliefs have been reported as a protective factor."[83] Religion serves dual purposes of giving personal stability and faith while also building connections to others who share your beliefs and sometimes your background. For these reasons, religion is effective at moderating the difficulty of acculturation by finding personal peace, forming strong connections, and preserving a part of life and culture from life in the country of origin. From religion or other encounters, social relations are important in maintaining mental health. "Little connectedness to the neighbourhood was associated with depression. The presence of wide kin contacts and the mother often receiving visitors at home were protective."[84] This phenomenon is logical and mirrors what is seen in native born Americans, but it highlights the special importance of building strong social connections within religious or ethnic communities who may feel estranged from the host culture.

Alongside difficulty in acculturation, language frequently proves to be one of the greatest barriers in a smooth transition to new resettlement. Language not only is determinate of how well an individual can navigate a new environment, but it is also predictive of success in school and work, the ability to locate resources, the speed at which one can build social capital, and the potential for upward mobility. "Other stressors stemming from language conflicts include

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[82] George, "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice."430-431
[83] Krause and Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in 313
[84] Fazel et al., "Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors,"276

unemployment and financial hardship. Status loss, in particular for men means losing their traditional breadwinner role, which forces many to end up seeking public assistance to support their families, undermining their self-esteem and dignity." Lack of language proficiency is predictive of daily stressors and can thus create an obstacle to successful integration into a new culture and community. While low language levels predict negative outcomes, refugees provided with adequate English language learning curriculums for both children and adults can integrate more easily and achieve better average psychological outcomes. "Language has been cited as the most important behavioral indicator of acculturation, and possibly a protective factor against negative mental health outcomes for specific subgroups receptive to such strategies."[85]

Post-resettlement, daily stressors and difficulty in acculturation can predict poor mental health due to both direct and indirect impacts. Certain daily stressors such as poverty can be directly linked to disrupted brain functioning while others may simply impede the treatment or resolution of past traumas. It is important to remember that the trauma of the refugee experience is not limited to the country of origin. After resettlement, refugees are still at risk of facing extreme poverty, depression due to social isolation, discrimination or hate crimes due to race and religion, homelessness, lack of medical care, and other traumas. These can be just as harmful or more disruptive than pre-migratory traumatic experiences, along with inhibiting the treatment of previous traumas.

General Risk and Protective Factors

Within a given population and within refugees as a collective group, particular identities or facets of one's life can create additional risk and protective factors for every stage of the

[85] Alemi et al., "Psychological Distress in Afghan Refugees: A Mixed-Method Systematic Review,": 1247-1261.

refugee experience. Characteristics such as age, religiosity, gender, wealth, urban versus rural living, and education level can have profound effects. Across populations, age and gender have proven to be highly consequential in predicting mental health symptomology. The disparities along age and gender are likely attributed to a combination of varied exposure to events and varied resources to cope with potentially traumatic events. The predominant trends suggest that younger refugees and male refugees experience lower rates of psychological symptoms than older refugees and females.

It is accepted that children rebound more quickly from traumatic experiences than adults due to their mental flexibility and their tendency to acculturate quickly. This is owed to a combination of mental state and to systematic advantages such as being in school, where language and culture are rapidly learned. “Some of the best-evidenced protective factors—both in the general resilience literature and with regard to children affected by war and displacement—are cognitive capacity and flexibility, self-regulation and problem-solving skills.”[86] These are attributes typically possessed by children and they enable more rapid language acquisition which protects against anxiety and depression. “Achievement of competence in the host country's language can be associated with a reduced likelihood of depressive symptoms.”[87] In addition to acquiring language quickly, children can easily pick up on new cultures thanks to their flexibility and immersion in the school system. “Many adolescents perceive themselves to be more acculturated than are their parents, and an increasing gap in acculturation during adolescence can generate discord.”[88] While this can drive tensions

[86] Krause and Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in 310
[87] Fazel et al., "Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors,"277
[88] ibid.

within families and communities, the acculturation of children helps them achieve mental stability. The unique abilities of children result in lower rates of mental health problems, as evidenced by the fact that in studies, "older age was significantly associated with higher levels of internalizing and externalizing problems in addition to greater PTSD levels."[89]

While children often have better psychological outcomes, they have their own risk factors. In the country of origin, "military conflict and forced displacement often disrupt family units and dynamics as well as schooling, the coherence of peer and community networks, public infrastructure, the rule of law and the wider economy. In doing so, they may exacerbate daily stressors that also exist in non-conflict environments, such as overcrowded housing, unsafe sanitation, malnutrition and lack of access to education."[90] Conflict zones and the severity of the situations which refugee children are placed in force them to act almost as adults overnight.[91] Whether it is being employed as a child soldier, becoming responsible for younger siblings, or carrying on after the loss of parents, children in conflict zones are confronted with situations far more serious than is appropriate for their age. Along with this, they miss out on educational and social opportunities that often provide for the development of children. "Conflict is now widely understood to affect a child not only by direct exposure to threats and stressors, but by the disruption of the multiple layers of social fabric that support their developmental trajectory."[92]

The stressors and disruptions to development are then often exacerbated by the process of displacement and migration, wherein "accompanied children subsequently separated from their

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[89] Israel Bronstein and Paul Montgomery, "Psychological Distress in Refugee Children: A Systematic Review," *Clinical child and family psychology review* 14, no. 1 (2011)50

[90] Krause and Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in 309

[91] Bourke, "Terror & Hope: The Science of Resilience,"

[92] Wessells, Ager, and Metzler, "Where There Is No Intervention: Insights Into Processes of Resilience Supporting War-Affected Children,": 67-75.

relatives were also at risk of poor mental health. Children whose relatives were in difficult circumstances (e.g., imprisoned), and those who had difficulty contacting their relatives had worse psychological functioning." Some children also experience detention while in transit or after arrival into a host country. Postmigration detention is psychologically harmful for all people, but "detention seems to be especially detrimental to children's mental health… Children are more likely to suffer adverse mental health consequences when detained in restrictive rather than routine reception facilities." After resettlement, children continue to experience some stressors, but they also experience protective factors like attending school. "A perceived sense of safety at school has been associated with low risk of post-traumatic stress disorder, and an increased sense of school belonging was shown to protect against depression and anxiety."[93]

"Refugee children in high-income countries do not usually lack basic material necessities, yet certain factors nonetheless place their healthy development at risk." One of the most significant factors in the development of refugee children is parental presence and experiences. "Boys living with both parents had rates of psychological symptoms five times lower than those living in other family arrangements." Beyond the presence of parents, "good parental mental health, particularly in mothers, is an important protective factor."[94] Mentally healthy parents are able to provide a more stable upbringing for children and to form stronger connections. "Having a supportive parent available who can help to process traumatic experiences, high levels of family cohesion, positive and non-punitive parenting practices and a close child-carer relationship have been associated with better mental-health outcomes in children living in

[93] Fazel et al., "Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors,": 266-282.
[94] ibid.

conflict-affected contexts, as well as in children resettled in high-income countries."[95] While it is common for parents to have some past traumatic experiences, these negative experiences can have detrimental effects on the children as well. "Some types of parental exposures are more strongly associated with children's mental health problems than are children's own exposures, particularly if parents have been tortured or are missing."[96]Another post-resettlement factor that is largely determinate of children's mental health is the financial stability of their family. "Economic circumstances after displacement can affect the child's psychological functioning. Parental worries about financial problems have a particular adverse effect on the mental health of refugee children."[97] Children experience a different set of risk and protective factors than do adult refugees, but they are often able to manage them more easily due to mental attributes and systematic supports.

Gender, like age, has an impact on what an individual refugee is likely to experience and how they are likely to mentally respond to those events or stressors. While it is generally accepted that men are likely to encounter more traumatic events than are women, this is not reflected in rates of psychological complications. In fact, women consistently report higher rates of anxiety and depression than do men. This disparity is not reflective of differing abilities to manage one's own stress, but they are more likely owed to the kinds of traumatic events experienced and the increased burden of daily stressors on women.

Among families interviewed, assuming that they were in similar situations, consistent trends emerged indicating that men have been exposed to more traumatic events on average than

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[95] Krause and Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in 312
[96] Fazel et al., "Mental health of displaced and refugee children resettled in high-income countries: risk and protective factors,": 266-282.
[97] ibid.

women have. Men reported exposure to 5.9 traumatic events compared to only 4.2 traumatic events in women. While the number of events may indicate less burden on women, it is key to examine the types of trauma that are more prevalent within each gender. “Women were significantly more likely to report exposure to family violence and sexual abuse than men, whereas men were significantly more likely to report exposure to combat exposure, torture, imprisonment as well as fleeing the country of origin and staying in an asylum center.”[98] It is also key to account for the role of daily stressors, these stressors can have a profound impact on mental health and have been found to fall more heavily on women, a fact which is not reflected in an analysis only of acute traumatic events. “Men and women have both had to bury their dead, learn to live with their own war-related injuries or care for injured family members, and deal with the loss of their homes and possessions. Daily stressors, in contrast, exert a somewhat greater toll on women.”[99] While there are too many variables to draw a simple conclusion, it is evident that the experiences of men and women differ, with men experiencing a greater number of acute war traumas while women experience more sexual trauma and daily stressors.

As could be expected from varied exposure, men and women also experience different symptomology. There is consensus among many studies that women experience higher rates of emotional difficulties such as depression, anxiety, and somatization.[100] [101] [102] These are symptoms which appear to be linked to sexual or domestic abuse and daily stress. However, men experience higher rates of PTSD, behavioral problems, and enduring personality change than

[98] Sara Skriver Mundy et al., "Sex differences in trauma exposure and symptomatology in trauma-affected refugees," *Psychiatry Research* 293 (2020)3
[99] Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan,"628-629
[100] Bronstein and Montgomery, "Psychological Distress in Refugee Children: A Systematic Review,"50
[101] Krause and Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in 311
[102] Mundy et al., "Sex differences in trauma exposure and symptomatology in trauma-affected refugees,"3

women.[103] [104] These symptoms and diagnoses may be tied to the higher prevalence of war trauma or torture. Once again, daily stressors proved to be extremely consequential, especially in women, reinforcing the important role that they play in causing psychological problems. “For women, daily stressors were a better predictor than war experiences of all mental health outcomes except PTSD; for men, daily stressors were a better predictor of depression and functional impairment while war experiences and daily stressors were similarly predictive of general distress.”[105] While gender alone cannot be determinant of an individual’s experiences or symptomology, it offers a baseline when considering how a population or individual might best be treated for poor mental health.

Conclusion

Refugees from all parts of the world, including Burma, the DRC, and Afghanistan face repeated obstacles and experiences which may trigger trauma. Unlike populations outside of warzones, the difficulties experienced by refugees are almost always ongoing and compounding rather than singular events. For this reason, refugees on average live through a greater number of potentially traumatic events than other populations and rarely have the time, space, or resources to reflect on this or seek help. While resettlement may mean a removal from some sources of trauma, it also means removal from one’s home, family, and culture which can create new sources of stress or worsen existing symptoms. The refugee experience presents many unique traumas and stressors which contribute to this population’s high risk of mental illness or poor mental wellbeing.

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[103] Krause and Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in 311
[104] Mundy et al., "Sex differences in trauma exposure and symptomatology in trauma-affected refugees,"4
[105] Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan,"611

After resettlement, refugees are strong and resilient from their prior difficulties, but they are also frequently in need of assistance. Because of having witnessed a greater number of harmful experiences, they carry a higher likelihood of displaying symptoms of poor mental health. Refugee populations also experience high barriers to accessing resources after resettlement and thus a framework is deserved in the US to make these resources available. Refugees as a population are not weak or victims, quite the opposite—they are resilient and adept—but carry with them a greater need for assistance considering their likely experiences.

Chapter 3: Who Addresses Trauma

Intro

While it is generally understood that trauma management does not receive adequate attention and emphasis, there are myriad services which attempt at remedying trauma. Every step of the refugee experience—predisplacement, migration, and resettlement—offers different kinds and qualities of care for some refugees. The network of trauma management services includes state agencies and actors, international agencies, non-governmental organizations, and clinical services. However, the lack of unity in this political ecosystem, along with these entities inability to communicate effectively, degrades the quality of service. The existence of these resources is not indicative of accessibility, utilization, or efficacy. Despite having services at each point of preflight, flight, and resettlement from many different actors; trauma resources are spread exceptionally thin.

National and international agencies which assist refugees are clear about the severe need to address trauma. Organizations like the United Nations and the Office of Refugee Resettlement acknowledge on their websites the trauma and stress which accompany the refugee experience,

dedicating pages to publicizing resources. Interestingly, these agencies do not offer many services of their own. Rather they provide guidance, and sometimes funding, to NGOs who implement their own services and plans. While the federal government acts as the gatekeeper of who gets to the U.S. and decides which services they 'should' receive, it is not frequently the entity to provide services. The result is a disjointed system of services which do not seem to be equally distributed—as is the case in other forms of refugee assistance.

Country of Origin

In some instances, the treatment of trauma begins in the country of origin or in nearby camps and places of refuge. International organizations play a leading role in the provision of all services to people who are impacted or displaced by war. Services include physical healthcare, education, provision of food and water, hygiene support, family programming, and shelter. Provided by organizations such as the Red Cross, UNHCR, Mercy Corps, or Doctors Without Borders; these health and humanitarian aid services often integrate components of psychological care and mental health programming into other services. For example, Mercy Corps implements trauma and stress mitigation resources and education into their schooling services and family programming.[106] Similarly, some children education resources in camps for Congolese refugees are designated 'Child Friendly Spaces,' as previously discussed. These schools offer resources intended to sustain well-being and resilience in vulnerable children.[107] These resources which are integrated into existing health and education programming are often the first point of contact with mental health services, though they often focus merely on maintaining well-being rather than clinical remediation of trauma.

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[106] Ron Bourke, "Terror & Hope: The Science of Resilience," (2020):
[107] Michael G. Wessells, Alastair Ager, and Janna Metzler, "Where There Is No Intervention: Insights Into Processes of Resilience Supporting War-Affected Children," *Peace and conflict* 23, no. 1 (2017): 67-75.

In recent decades, the international community has become more aware of the large role that traumatic experiences play in the refugee experience. The response has been for the United Nations High Commissioner for Refugees (UNHCR) and Inter-Agency Standing Committee (IASC) to each publish guidelines for mental health and psychosocial intervention in 2013 and 2007, respectively. The organizations, both derived from the UN but with different focuses, agree on most points and seek to establish protocols or guidelines in how best to manage mental health in emergencies. The guidance they provide is intended for their affiliated or member organizations and for other assisting NGOs. It is important to acknowledge that the support services in emergencies are still quite thin and often are focused on PTSD rather than being encompassing. With scarce resources, truly adequate mental health care in emergencies is not typically feasible, but essential, high priority responses should be implemented when possible.[108]

When working with minimal resources, the UNHCR recommends that organizations implement a two-part system for mental health and psychosocial services (MHPSS). One aspect is interventions which are specific to MHPSS problems while the other aspect is taking a MHPSS approach to all activities. Well-resourced organizations may be able to implement interventions, but, for many, the MHPSS approach in their existing relief sectors may be more feasible.[109]

Amongst organizations who adopt an 'MHPSS approach' to existing services, there are tips from the UNHCR and IASC on how to ensure efficacy and reinforce the importance of these efforts. The UNHCR suggests evaluating existing frameworks, services, cultures, and stigmas to

[108] *IASC guidelines on mental health and psychosocial support in emergency settings. Inter-Agency Standing Committee* (b): 2-5
[109] United Nations High Commissioner for Refugees, "Operational guidance, mental health & psychosocial support programming for refugee operations," *UNHCR* (2013): 12

adapt MHPSS for each scenario as needed. [110] "Examples of potentially supportive social resources include families, local government officers, community leaders, traditional healers (in many societies), community health workers, teachers, women's groups, youth clubs and community planning groups, among many others."[111] These existing resources can provide some of the most important social treatments like "family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods." An additional form of well-being protection is ensuring access to physical needs. Typically managed by NGOs, the provision of physical needs is not rehabilitative but can protect well-being amongst vulnerable populations.[112]

For organizations equipped for more direct MHPSS intervention, the UNHCR and IASC again offer guidance on adapting intervention techniques for different settings. While interventions are identified independently of 'MHPSS approaches,' all services to refugees and civilians in emergency situations should be integrated with one another. While resources to meet social and physical needs may be sufficient for many, some refugees may be experiencing greater traumas or stronger reactions which call for greater attention. Intervention is for individuals experiencing a symptom which, "despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services."[113]

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[110] ibid.
[111] *IASC guidelines on mental health and psychosocial support in emergency settings.* 5
[112] *ibid.*
[113] *ibid.*

The first step in implementing a trauma intervention system is to evaluate what is already in place. This includes the frameworks and services that may or may not have adopted a MHPSS approach, such as first aid services, schools, or sexual assault support; along with acknowledging which organizations have access to certain resources. Also included in framework evaluation is a consideration of the cultures and stigmas of the group which is experiencing the emergency, as these can predict acceptance or opposition to various forms of intervention.[114] After evaluating existing resources, it can be determined where to house new mental health services. The IASC recommends taking a trauma-forward and event-based approach to mental health interventions in conflict zones, under the assumption that basic needs and blanket resources are being provided prior to the intervention stage. The focused interventions that have proven to be most helpful while being feasible are psychological first aid and basic care from primary health care workers.[115]

Just as physical first aid focuses on only the most severe and immediate needs of an individual, psychological first aid (PFA) is never intended to be the end solution. It is not a form of therapy but rather a technique for assessing concerns or needs and meeting those which are most urgent. “PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping” by evaluating trauma survivors regardless of their immediate display of symptoms. Rapid intervention may help those who are at heightened risk of mental illness by offering compassionate disaster response to mitigate reactions that will interfere with adaptive coping. Providing comfort and calming down disoriented trauma survivors before gathering and assisting with current needs once again

[114] United Nations High Commissioner for Refugees, "Operational guidance, mental health & psychosocial support programming for refugee operations," 22
[115] *IASC guidelines on mental health and psychosocial support in emergency settings.* 1-13

mirrors the purpose of conventional first aid but focuses only on the psychological not physical. PFA is also responsible for connecting individuals to social supports, providing education on coping, and linking survivors to comprehensive services.[116]

Trauma intervention and mental health support at the time and place of conflict has been repeatedly acknowledged to be wholly inadequate and by no means replaces the need for support in the country of resettlement. The suggestions of the UNCHR and IASC are well-informed but do not have immediate efficacy in the lives of refugees. However, NGOs, focused interventions, and social supports are key components of the refugee experience and may predict the prevalence and severity of mental health disorders amongst resettled refugees. The services available during displacement also are frequently the first introduction to mental health resources or formal clinical health, the context and presentation of these resources can be predictive of trust and comfort towards similar services in the future.

The United States government supports the efforts of the United Nations and NGOs financially but is not involved in what services are provided. Federal spending on foreign aid is tremendous and much of this goes to the UN or other international organizations. Additionally, many aid organizations are led by Americans, though they do not act as proxies of the federal government. Despite many contact points of the U.S. in the provision of humanitarian aid in conflict zones, there is little to no influence or emphasis on the creation of trauma programming. What takes place overseas is typically removed from the actions of the government as a host country.

[116] "About PFA," -01-30T08:55:34-08:00 [cited 2020]. Available from https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa.

One of the final steps in the overseas treatment process and the beginning of the resettlement process is a medical screening. It is apparent that these exams reliably take place as per the experience of resettlement agencies in the US.[117] [118] These exams are likely not an indicator of overall physical or mental health, as they are seeking to diagnose only certain problems. “The overseas medical screening guidelines are intended to provide panel physicians guidance on the overseas pre-departure presumptive treatments for malaria and intestinal parasites.” All guidance on these screenings references methods and risks for malaria and parasites, indicating that a holistic evaluation of health does not take place.[119] The narrow-sighted nature of this screening is problematic in light of the fact that resettlement agencies reference these as a tool for evaluating physical and mental health when they are in fact too specific to be of utility.[120] [121]

Services in conflict zones rightfully prioritize the most immediate needs and those which are physically observable. Both in first aid or medical services and in predeparture screening, resources are preserved by focusing on dire physical needs with the assumption that long-term physical and mental illnesses can be addressed after resettlement. This is a reasonable approach, but it places the responsibility on the host country to meet the needs of refugees. If a country, like the United States, is willing to host many refugees but lacks potency in their social and medical services, private organizations must fill these gaps.

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[117] . "Interview of Grace Dun." (2020):
[118] Author, "Interview of Gabrielle Lodge," (2021):
[119] "Refugee Health Guidelines | Immigrant and Refugee Health | CDC," -02-26T02:41:39Z/ [cited 2021]. Available from https://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html.
[120] . "Interview of Grace Dun."
[121] Author, "Interview of Gabrielle Lodge,"

Case Study – Beatrice

Beatrice (name changed to protect identity) grew up in South Sudan but was forced to flee with her husband and baby after her mother was raped and killed during the war. She describes how soldiers would go from house to house killing and raping people. She fled to Imvepi Refugee Settlement in Uganda. "When we reached the border I was just remembering what we had witnessed, what happened to us and to our friends, how we were running, stepping over the dead bodies just to safe our lives. We arrived exhausted, with nothing." In Imvepi, her and her family have each other, along with minimal clean water and food, but resources are extremely scarce. With food and water restricted, it is necessary to share with neighbors at times. Beatrice and the 100,000 other residents of Impevi are not receiving mental health services, as the resources are too scarce to even guarantee survival.

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State Services

Upon arrival in the United States, the role of the federal government is minimal, with state agencies being the primary point-of-contact. Refugee services are one of the many instances in which the United States federal system is perplexing. While the choices of how many refugees ought to be accepted in a given year, from which countries or conflicts they will originate, and who is granted refugee status lay with various federal institutions, provision of refugee services is handled by state-level offices—though often with federal funding. As such, the federal government welcomes a certain number of refugees to be settled but every state has different resources to accommodate the needs of these refugees. Some states are well equipped, others

[122] "The life of South Sudanese refugees in Uganda on hold: Beatrice's story," -08-17T14:43:31+00:00 [cited 2021]. Available from https://www.oxfam.org/en/life-south-sudanese-refugees-uganda-hold-beatrices-story.

poorly equipped, and many rely heavily on independent resettlement agencies such as Catholic Charities or USCRI to whom they divert their funding.

There have been federal government provisions passed through Congress regarding refugee resettlement since the 1950s, but for much of that time there was not yet a unified process. It was not until the Refugee Act of 1980 that the Office of Refugee Resettlement (ORR) was formed as an agency within the Department of Health and Human Services (HHS). The ORR is still housed under HHS and is responsible for resettlement. In addition to establishing the Office and Director, the Refugee Act of 1980 states that health care ought to be provided to refugees and shall be funded by the federal government. This called for the implementation of a new system for resettlement and health services—which did not at this point include mental health—and laid a groundwork for the development of future services.[123] Due to the structure of refugee resettlement and the reliance on state-coordinated efforts, legislation directly addressing trauma has been scarce or non-existent, coming instead as recommendations or guidance contained in HHS/ORR guidelines for states and VOLAGS.

The ORR continued to refine the means through which physical and mental health problems could be diagnosed and treated during the settlement process. While the right to a comprehensive health assessment, complete with referral or follow-ups was established in 1980, it was never clear what this ought to look like. The first set of guidelines regarding arrival health screenings arrived in 1996, though they were underdeveloped at this time. “The guidance for the mental health assessment includes performing a general assessment of orientation to place and date, and encouraging additional screening tests and referrals to primary health services or

[123] Edward M. Kennedy, "Refugee Act of 1979," , no. 96th Congress (1980):

mental health programs as indicated." It was articulated that the providers conducting screenings should be familiar with mental illness but offers little additional information on the subject. The result of this scant guidance is inconsistency between states, clinics, and clinicians. While state resettlement agencies are directed to conduct screenings for both physical and mental health, not all do, and the rigor or processes can differ significantly.[124]

Direction originating from the ORR to refugees themselves has been minimal, illustrating the disconnected nature of ORR's resource provision. Their website lists references to other agencies or national non-profits that address mental health, though these are also not always 'boots on the ground' organizations. ORR directly provides only webinars, no physical resources.[125] While some may find these webinars helpful, they are difficult to locate and likely fall short of most individual's needs. In a field where clinical or community services have illustrated to be most helpful, referrals and web resources are inadequate provisions. The Office of Refugee Resettlement is forthright in acknowledging the importance of refugee's mental health and the critical role that this plays in resettlement but does not in itself provide resources to address the issue.

More substantial assistance is provided regarding victims of torture, though the availability of resources can be disparate between states. Despite the lack of a clear and singular definition of torture, programs to assist individuals with highly traumatic backgrounds were conceived. Torture survivor services became codified in the 1990s, a time with extremely high levels of displacement. Concerningly, while displacement and torture or violence towards

[124] Patricia Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators," *Journal of immigrant & refugee studies* 10, no. 4 (2012)381
[125] "Office of Refugee Resettlement (ORR)," [cited 2021]. Available from http://www.acf.hhs.gov/orr.

civilians have been continued to increase, the provisions for victims have not. “The Torture Victims Relief Act of 1998 recognizes the need that many torture survivors have for rehabilitation, and outlines the authorization of U.S. funding to provide treatment and social and legal services for torture-exposed refugees, research, as well as training to support health care providers working with these refugees.”[126]

A subsidiary of the ORR, The Services for Survivors of Torture Program provides approximately $10.5 million annually towards grants to agencies who address local needs within a state or region. These funds are used to “provide trauma-informed, holistic, and strengths-based services to torture survivors and their families to promote rehabilitation.”[127] While this program has the potential to enable a robust trauma-management network with a presence in all regions, not all states receive Services for Survivors of Torture Program (SSTP) funding. In a survey of 44 states (the remaining states lacking resettlement coordinators or not responding), 15 reported receiving SSTP funds in 2010, though it is apparent that there are 17 recipient states in total. With approximately one third of state resettlement agencies receiving this funding, torture-related trauma services are distributed disproportionately across the country. Considering that resources for trauma are spread thin, SSTP status can be determinant of service quality: “two thirds of the states with a SSTP reported screening for exposure to torture, while fewer than one third of states without SSTP do.”[128]

The ORR under the Department of Health and Human Services is the primary governmental voice of guidance and oversight during the resettlement process. However, all

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[126] Jason Ostrander, Alysse Melville, and S. Megan Berthold, "Working With Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches," *Advances in Social Work* 18, no. 1 (2017)68
[127] ibid.
[128] Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators,"385-386

actions of the ORR appear to be quite disconnected from the population which they serve. Services are dependent on state-level infrastructure and the capacities of individual local resettlement agencies. This system is consistent with American federalist philosophy but results in unpredictable and inconsistent services with many variables. Just as the pre-displacement life of every refugee is unique, so too is their experience being received in the US. The role of the ORR is to provide funding and guidance, but when funding is unequally distributed and guidance is non-binding, services are found to be inconsistent across states.

A key component to the resettlement of refugees in all countries and states is ensuring short-term medical care to address urgent issues and reduce the potential for spreading disease. These services can be especially crucial for individuals experiencing wounds and injuries, or who have contracted diseases such as tuberculosis or HIV/AIDS. The importance of physical health has determined that all refugees are entitled to healthcare services regardless of where they are resettled to. While this is an initiative which focuses on physical health, low barriers to seeing a physician allow for a heightened chance to detect and address mental obstacles. The universal access to short-term health insurance provides an opportunity for mental health interventions which may be more equitable across populations.

In the United States, refugees are granted a transition period with state funded health insurance. A program called Refugee Medical Assistance is a variant of Medicaid specifically for refugees.[129] Medicaid is managed jointly by the federal and state governments to provide health coverage to low-income people. While each state has their own subset of the program and delivers resources, they are funded by the federal government and behave similarly to one

[129] "Office of Refugee Resettlement (ORR),"

another. Refugee Medical Assistance is delivered by the states to refugees who resettle in that state. However, the benefits of Refugee Medical Assistance last for only eight months after arrival.[130] [131] Despite being short-lived, Refugee Medical Assistance is one crucial way that the government provides services for refugees that could not be easily provided by non-profits.

Refugees, as Medicaid recipients, have access to mental health services such as clinical psychiatry and counselling at the referral of a physician. For refugees experiencing more severe and evident mental illness, this is a logical trajectory. In a perfect world, with all puzzle pieces meshing nicely; a case worker from the state or VOLAG should coordinate for a refugee to meet with a physician to follow up on any concerns from the screening process, the physician would write a referral to a mental health professional, and there would be many months remaining to build rapport or prescribe medication through multiple counselling sessions—potentially with the help of a translator. The harsh reality is that if any step is missed—a case worker drops the ball, the client cannot communicate with the clinicians due to language, or cultural barriers cause mistrust of the system—the eight-month period is too short for much recourse. In fact, it may be twelve months until cultural trust is built, at which point the health care privilege has expired and the refugee is not even aware of the available resources.

Refugee Medical Assistance, like other forms of refugee programming focuses only on the most immediate and urgent moments. This conserves scarce resources and provides the most necessary supports. While the impulse to prioritize the immediate may be effective in the realm of physical health, mental complications cannot often be addressed in such a short time. Eight months is an incredibly short period for an individual to obtain sufficient assistance with mental

[130] Ostrander, Melville, and Berthold, "Working With Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches,"68
[131] . "Interview of Grace Dun."

health obstacles. The difficulty of receiving treatment is perhaps, in some instances, exacerbated by potentially low levels of support available in the state or city of resettlement. Refugee Medical Assistance is one of the largest and most essential components of the resettlement process yet still falls short of what is needed.

The structure of resettlement services varies dramatically from one state to another, and this variability is especially apparent in the provision of trauma management resources. While the federally funded channels of resettlement for every state cannot be easily explored, there are widespread trends and disparities which can be examined on a local level. In the Capital District of New York, the Albany office of United States Committee for Refugees and Immigrants (USCRI) is responsible for resettlement and case management processes. While this region has its own USCRI office, other areas of New York State utilize different agencies and offices to facilitate resettlement of refugees. The state of Maine has only one local resettlement agency which has two offices in different cities. Catholic Charities Maine (CCM) is a religious agency specializing in social services that provides refugee assistance and has other Catholic Charities branches for many states and regions. VOLAGs and local resettlement agencies, funded by the federal government, provide the short-term resources necessary for refugees to be settled in the United States.

In many ways, the medical screening process kicks off the effort to manage trauma among arriving refugees. Medical screening is not only the moment at which trauma should be detected but it is also an introduction to the system of case managers, clinicians, referrals, and western concepts of health. “The goal of mental health screening during the domestic medical

examination is to identify and triage refugees in need of mental health treatment."[132] While screening has the potential to be a valuable tool and is a key component of the ORR's process for resettlement, screening looks different dependent on the state. Not all states screen for mental health symptoms even if they screen for physical health. Of those that do screen for mental health and trauma, there is no uniform system for doing this. Some states utilize multilingual questionnaires, of which there are many, to determine if a referral to a mental health professional is appropriate; while others use interviews, which may be more comfortable but less systematic.[133]

Despite receiving guidance from the ORR indicating that all refugees ought to be screened for both physical and mental health, there are disparities between state resettlement procedures. "Only half of U.S. states reported providing any mental health screening to recently arrived refugees, and of those, less than half directly asked refugees about war trauma or torture exposure."[134] These disparities could be due to differences in funding or in the agency which coordinates case management and screening. The idea that funding may determine level of rigor in screening is supported by the fact that "states with larger resettlement numbers are more likely to screen for mental health symptoms, torture, and war trauma. For example, 72.2% of large resettlement states screen refugees for mental health symptoms while only 46.2% of small resettlement states screen."[135] While this is neither surprising nor profound, both the scarcity and

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[132] *Domestic mental health screening guidelines - immigrant and refugee health. Centers for Disease Control and Prevention* (2019a):
[133] Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators,": 380-394.
[134] Ostrander, Melville, and Berthold, "Working With Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches,"67
[135] Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators,": 380-394.

disproportionality of screening resources highlight the flaws in the ORR's approach wherein they provide guidance rather than services or oversight.

Beyond the existence of screening, the US system allows for flexibility regarding how and where such screenings take place. "22 states (64.7%) reported that the primary venue for screening is their county public health clinics, 10 states (29.4%) use primary care offices, five states (14.7%) contract with private clinics for mental health screening, and four states (11.8%) screen at their voluntary resettlement agencies."[136] The flexibility to structure their own methods given the landscape of resources in each area can be beneficial for states and VOLAGs to deliver services. Given that there are insufficient clinics in the US to serve refugees, other locations can be leveraged to offer similar services.[137] While flexibility can be a benefit for the logistics of conducting screenings, it also creates variability in who conducts the screening and their qualifications, the method used, and the comfort of the environment.

Through interviewing employees of resettlement agencies in Maine and New York State, it is apparent that the two states take different approaches to screening processes. USCRI Albany conducts screenings while Catholic Charities Maine does not.[138] CCM relies instead on data from overseas screenings which have been previously explored.[139] While valuable as an indicator of specific diseases, these overseas screenings are not comprehensive and do not address mental health, thereby decreasing their value as a source of information. While the system of New York State may still be imperfect and may vary in different agencies across the state, the choice of one

[136] ibid.
[137] Ostrander, Melville, and Berthold, "Working With Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches,"68
[138] . "Interview of Grace Dun."
[139] Author, "Interview of Gabrielle Lodge,"

state to offer in-house screening while another does not illustrates the disparities between state trauma management networks.

Perhaps even more significant than the setting in which screenings are conducted is the actual method of screening. Some states utilize a conversational interview, potentially with a translator, while others use a questionnaire adapted for many languages. Each of these approaches is critiqued for different reasons. “Only four states utilize a formal standardized questionnaire, such as the Harvard Trauma Questionnaire” which is efficient and consistent. However, these questionnaires do not convey trust and humanity, possibly masking or deterring honest responses. Other states use “structured questions” but their interviews are not systematically administered.[140] The inconsistency of this system; being dependent on language, the interviewer, the choice of questions, and the rigor of the interview; makes these less reliable albeit more personal and human. While both systems of screening have weaknesses, questionnaires are often praised for their consistency and reliability, making them the preferred system.

When asked why their state does not take initiative on screening, refugee coordinators cited many of the same reasons. “The most frequently reported barriers were the lack of culturally sensitive services (90.2%), mental health stigma (75.6%), lack of trust (73.2%), inadequate transportation (73.2%), and cost (53.7%).” While it is apparent that cost is a deterrent to fulfilling screening obligations, the primary deterrents were those of cultural education and comfort. “These barriers underscore the need for brief, culturally validated instruments for screening refugees in the public health setting.” Along with improved processes, it is important

[140] Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators,"387

that the physicians, nurses, or mental health professionals are trained not only in their medical discipline but also in their cultural role. “Training about the effect of war trauma, torture, and effective processes for screening refugee survivors is essential for refugee health coordinators and screening clinics as it may enhance the likelihood that refugee survivors will be identified and receive mental-health care early in their resettlement process.”[141] HHS and the CDC give guidelines which recommend that clinicians ought to educate themselves via the Cultural Orientation Resource Center Website on the backgrounds and beliefs of their populations along with advocating for medically trained interpreters, but these are non-binding pieces of advice.[142]

Some states, including Maine, do not report conducting their own screening but instead direct refugees to a nearby hospital or clinic where they can receive a physical checkup under temporary healthcare provided to them.

> However, deferring a mental health screening until refugees are referred to their primary care physicians may not be appropriate either as some refugees may not establish primary care until long after they have resettled. The fact that most refugees have medical coverage through refugee medical assistance or state Medicaid in their first eight months makes it even more imperative that screening and referral for assessment and treatment takes place early in the resettlement process.[143]

While screening ought to take place early-on to begin intervention while refugees are offered healthcare, it can still take a long time for an individual to recognize and communicate their feelings and experiences.

The system of federal guidance and state-level VOLAG execution leaves many gaps. States receive different levels of funding and each agency has the ability to act with reasonable autonomy. As a result, the services available are different in every state and many do not truly

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[141] ibid.
[142] *Domestic mental health screening guidelines - immigrant and refugee health.*
[143] Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators,"392

follow federal guidelines. Refugee Medical Assistance as a short-term healthcare plan is the most uniform aspect of refugee mental health resources but this is effective only for eight months and relies on successful screening and referral to take place. Furthermore, no service coordinated by government entities directly addresses the linguistic and cultural barriers to accessing trauma management. Refugees must be aware of how American systems define what they are feeling or experiencing and how various treatments may help, not to mention having physical accessibility and interpretation.

Non-Profits

While the services provided by the federal government and government-backed agencies during resettlement can be lacking, there are many other stakeholders who can support refugees. Non-profits, with both private and governmental funding can provide case management, community support groups, mental health education, or create directories to resources; thereby filling gaps in the governmental program for resettlement. With this comes benefits, such as community trust and greater flexibility, but also drawbacks, such as minimal funding and lack of cohesive planning. It is important to note that some of the mentioned non-profits also function as a resettlement agency and thus act in both federally prescribed capacities and as independent entities.

The Albany office of United States Committee for Refugees and Immigrants (USCRI) offers in-house social services independent of their responsibilities as a VOLAG. Case managers and social workers from USCRI's resettlement process are crucial in connecting individuals to resources within and outside of the USCRI office including internal programs and local non-profits. This is typical of resettlement agencies, as "social workers often initiate all other types of

support received by refugees."[144] One internal resource offered by USCRI was the Refugee Family Strengthening Program which addressed emotional issues, domestic conflict, and other mental stressors. I say *was* because the Family Strengthening Program was recently terminated due to an end in funding. The program began operating in 2016 following the receipt of a five-year grant from the Office of Family Assistance (an office within the federal Health and Human Services agency) and the grant was not renewed at its termination.[145]

The Refugee Family Strengthening Program was open to all kinds of immigrants including refugees, asylum seekers, and undocumented immigrants; relying on both internal referrals and community intake. While family-centered, the program also served couples or singles. The program assisted with managing previous traumas but also focused largely on refugees' ongoing stressors and difficulties in the acculturation process. A large component of this work is providing education about how systems here work, along with education about emotions and feelings to normalize these concepts and define them in a way that is relatable. The Refugee Family Strengthening Program was a service which was accessible culturally and physically, along with the ease of referrals from other USCRI programs, bringing many merits. However, its discontinuation due to funding illustrates the unpredictability of these resources and the ways that voids can be created or left unfilled.[146] The fickle nature of federal politics and funding can be make-or-break for local programming such as that of USCRI. To begin programs such as family strengthening, requires the dedication of resources and nonrenewal of federal funding leaves the organization and the refugee community in the lurch.

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[144] Miriam George, "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice." *Clinical Social Work Journal* , no. 40 (2012)432
[145] . "Interview of Grace Dun."
[146] ibid.

In the Portland region of Maine, where the largest portion of the state's population lives and most refugees settle to, there are myriad non-profits to serve the immigrant community. While Catholic Charities is a non-profit organization, it is contracted with the federal government to provide resettlement services and does not tend to refer refugees to its internal services. However, they have relations with external non-profits which can assist with cultural adjustments, case workers, and services which extend beyond the first few months post-resettlement. A robust array of non-profits can allow for more agile resources, though it also often indicates insufficient funding for formal resources and will still leave gaps.

In discussing with Gabrielle Lodge from Catholic Charities Maine's resettlement office, CCM frequently refers their clients to the external organization Maine Access Immigrant Network (MAIN). A 501(c)(3) non-profit, MAIN is a small organization which serves the Portland immigrant community with social work and community programming. Through MAIN, refugees can be assigned a case worker and be connected to more community resources such as counsellors or health clinics.[147] The organization prides itself on multilingual services, having begun as a Somali culture group, and the cross-language offerings of MAIN make it valuable in navigating healthcare systems. MAIN offers community health workers that can educate immigrants in what services they are entitled to and how to access those. Case workers can then help to facilitate clinical or community supports.[148] The use of private organizations' case workers is one way to supplement federal or state governments and VOLAGs in the resettlement process.

[147] Author, "Interview of Gabrielle Lodge,"
[148] "MAIN | Health care access and social services for the Portland, Maine immigrant community," [cited 2021]. Available from http://main1.org/.

Catholic Charities also relies on Gateway Community Service to offer case management.[149] Gateway is valuable in their ability to offer holistic mental health services including in-house counselors, referrals to prescribers of medication, symptom management including developing coping skills, and mediating daily stressors such as housing or employment.[150] Gateway Community Service also partners with local ethnic and natural support groups to help clients find their place or access resources that are more comfortable for them. These local groups include the Maine Association for New Americans and Maine Access Immigrant Network.

The Maine Association for New Americans (MANA) is a non-profit based in Portland, Maine that provides services to all immigrants, the majority of whom are refugees. Funded through private donations, MANA began by providing services for professional integration and leadership opportunities. With the realization that trauma and mental health were unacknowledged barriers to personal and professional advancement for refugees, the focus of MANA shifted to address trauma and mental health. Current programming centers around building resilience through community conversations, educating the local immigrant community, and developing stress management systems. Despite being a small organization, MANA is run primarily by immigrants from the communities which it serves and can provide adapted services due to high levels of connectedness and trust.

MANA takes a different approach than some of the other services referenced by focusing their in-house programming on resilience and storytelling. This approach has been influenced by a few primary factors: daily stressors are often hugely impactful but under addressed, immigrant

[149] Author, "Interview of Gabrielle Lodge,"
[150] "Adult Case Management," January 13,Available from https://www.gatewaycommunityservice.org/adult-case-management/.

populations are resistant to clinical settings due to personal and cultural stigmas, the trust and comfort that is often lacking in clinical approaches is a key component to realizing one's own mental state. Under the program 'Resilient New Americans,' MANA seeks to use workshops and discussion to increase awareness about and comfort with the concept of mental illness and self-care by spinning traumatic experiences into histories which have strengthened individuals.

The idea of resilience-building is not one unique to refugee communities, but refugees—by definition—have needed resilient tendencies to survive and continue functioning. Learning to leverage these tendencies into a mental mindset applicable for daily life is something which can be taught. In the context of mental health, "resilience refers to the ability for an individual to not just survive but to thrive in the presence of risk and adversity." It will not always mediate prior traumas, but it has potential to build resistance to post-settlement traumas and daily stressors. This approach is especially potent in refugee populations because it can be practiced on an individual or community level. "Resilience is not a personal attribute but arises from the interplay between individuals, their families, communities and societies."[151]

MANA has chosen resilience strategies as a primary tactic for approaching mental health due to the observations and research of Maine's immigrant population which is refugee heavy. "I think it's especially fruitful to do it here, because of that sort of disproportionate number of people you know who've been forced to migrate in a very explicit way, like their legal status is tied to that forced migration," says Abbie Yamamoto, MANA's Executive Director. The state's immigrant community is primarily refugees and asylum seekers, thus they have higher incidences of trauma and lower comfort with western medical concepts and treatments. MANA

[151] Karolin Krause and Evelyn Sharples, "Thriving in the face of severe adversity:; Understanding and fostering resilience in children affected by war and displacement," in *Refuge in a Moving World* UCL Press, 2020),315-317

is also in-tune to the landscape of Maine's resources and can observe the holes in services. The Portland region has available clinicians for severe mental illness but a void for residents who are struggling in less noticeable or dramatic ways. "It might be like kind of the threshold might be really sort of, I guess it's high, like you have to be like, acutely threatening to kill yourself right now in order for them to feel like you're in crisis, you need to be taken in."[152]

Through an in-depth understanding of the local refugee population's needs, cultures, and sentiments; non-profit organizations like MANA can offer services to remedy mental illnesses such as depression or anxiety. These services are not a direct replacement for clinical work with individuals, which is still needed and lacking, but act as an entry-point for many. The work of MANA is informed by academic research on immigrant mental health and their own data by surveying immigrants in the Greater Portland area, much in the way that screening questionnaires do. This individual-level data is used to inform community-wide programming that fits the concerns, comfort level, and languages of the target population.

Non-profits, utilizing both public and private funding streams, are a necessary piece in the patchwork of refugee trauma resources. Unlike government agencies or resettlement offices, non-profits have a high degree of connectedness to their community, as the leaders and staff of these organizations are frequently immigrants themselves with existing personal or professional ties. Non-profits are also more agile due to their small size and lack of mandates. A shift in community needs or organizational mission can be quickly acted upon and clients can be

[152] Author, "Interview of Abbie Yamamoto," (2020a):

managed on a truly case-by-case basis. Despite these benefits, non-profits are often insufficiently staffed and funded to be the end-all of refugee programming after resettlement.

Case Study – Apollo Karara

Apollo was a mayor of a large district in Rwanda during the genocide which occurred in that country. Following the 1994 genocide, Apollo led reconciliation efforts in various districts, causing him to become politically targeted. He fled Rwanda and came to settle in Portland, Maine, where he still lives.

When Apollo arrived fifteen years ago, Portland had no organizations to assist with mental health or even community building. As an educated and respected man in his previous life, he quickly sought to learn English and begin anew, never considering that mental health was a subject to be aware of or that he may benefit from counselling. He would learn years later that he suffered from PTSD and had typical symptoms.

In an effort to find work, Apollo became connected with a church and attended a party where he met a family who could mentor him. Without robust social services or non-profits, church friends became the only way to become acquainted with community resources or acculturate. His family friends from church enabled him to practice self-help and eventually begin to recognize mental health symptoms. He would later come to found MANA to assist in connecting other refugees in his place with community resources. A large part of this work is explaining and destigmatizing concepts of health and well-being.

Despite being educated and ready-to-learn, Apollo had no grasp of western mental health concepts and this prevented him from accessing counselling and resources until years after his resettlement. While Portland now has a network of community organizations to support and educate refugees, countless communities around America experience the void of resources that Apollo witnessed upon his arrival. In these conditions, many refugees will fail to recognize or remedy their traumas due to lack of awareness and lack of resources.

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[153] Author, "Interview of Apollo Karara," (2020b):

Medical Services

In the realm of trauma and mental illness, what many individuals ultimately need is clinical diagnosis which can be followed-up with prescription or counselling. Clinical services are perhaps the most systematized processes of treatment and are viewed as most legitimate from a western perspective. However, this 'legitimacy' is reflective of the western-forward narrative of health which is carried in this country. Thus, medical services can be problematic in their adaptation to outside languages and cultures, creating barriers that may prevent refugees from fully participating. Trust and comfort are paramount in mental health, creating questions on how to make clinical resources most accessible to recently resettled individuals. While medical attention is an extremely crucial step in psychological services, there are logistical obstacles to overcome in providing this.

Following arrival in the US, it seems typical that the local resettlement agency will refer refugees to medical clinics or hospital branches at which they will meet with a primary care physician. Much as is the case with native-born populations during a yearly physical, this is an opportunity to identify symptoms of illness, discuss any discomforts, get caught up on immunizations, and respond to questions about mental well-being: including thoughts of self-harm, anxiety, depression, or domestic struggles. To accomplish this, resettlement agencies rely on their local hospital systems. There is effort made to minimize obstacles in accessing health services such as selecting a facility close to where the refugee is living and working with health centers that can provide interpreters when needed. Facilitating a quick referral after resettlement helps ensure that a meeting with a physician and subsequent clinicians can take place while the individual is covered by Refugee Medical Assistance.

In the Albany region of New York, USCRI utilizes referrals to a local health center along with county health clinics to provide mental health services to refugees. Whitney Young Health Center small clinics are leveraged as a point of contact for offering trauma and stress therapy. During the referral, USCRI educate their clients on how mental health services can help them and explain what this means. They also coordinate with providers to ease cultural and linguistic problems and to get priority for prompt scheduling.[154] These clinics are locally accessible, though they still have other barriers. For example, they list only two mental health therapy staff on their website, both of whom speak only English.[155] The Albany USCRI office also refers clients to the Albany County Department of Mental Health's Integrated Clinic for mental health treatment. They can provide assessments and therapy for individuals or group therapy, in addition to planning treatments and medication. Having a governmental resource is an extremely valuable asset for a community and offers a low-barrier opportunity for refugees to access treatment regardless of their healthcare coverage.[156] The multi-tiered system of governance in the United States means that states, counties, or municipalities have opportunities to provide the services which the federal government does not. In this case, federal refugee healthcare assistance ends after eight months but Albany County has more sustainable resources.

The City of Albany is also trying to get an in-house councilor which would be another means of increasing access to resources.[157] Local governmental health resources can be valuable in offering services to refugees beyond the expiration of Refugee Medical Assistance. While government intervention can ease some barriers to access, it still leaves cultural and linguistic

[154] . "Interview of Grace Dun."
[155] "Home," [cited 2021]. Available from https://www.wmyhealth.org/.
[156] . "Interview of Grace Dun."
[157] ibid.

obstacles largely unaddressed. In addition to the medical resources explored above, it is possible for refugees to access nearly any of the resources available to native-born Americans. The largest obstacle to this is awareness and navigating the system. It is for this reason that certain services or organizations must be tailored to refugees and other immigrants to provide referrals, case management, and interpretation. Medical services offer so much to refugees but are not well-utilized without a framework around them.

Conclusion

Organizations tailored towards the needs of refugees exist at every step of the resettlement process. From international organizations in emergency zones to mental health professionals in the United States, there are many stakeholders in the refugee trauma landscape. Most of the agencies which offer services for mental health also operate in other capacities which, on one hand allows for the mediation of daily stressors but it also means that resources are spread thin. While many of the resources available to refugees, such as health screenings or Refugee Medical Assistance are tailored to the first few months after resettlement, there are programs such as those within USCRI, county clinics, and private non-profits that can extend indeterminately. These resources are extremely valuable especially given the timeline in which refugees need assistance. While the first few days and months may be the most urgent in meeting immediate needs; emotional, psychological, and daily stressor needs may become more prevalent after a period of being resettled. Furthermore, language and cultural barriers often delay or inhibit an acknowledgement of what an individual feels and needs, along with how to navigate the systems to meet those needs.

The individualized nature of mental and emotional wellness makes it a realm that cannot be addressed by a single system. While the government offers a preliminary system for meeting

these needs, the services sponsored by the government ultimately fall short of adequate for many individuals. Thus, a robust system of clinics, community groups, and non-profit organizations are able to provide services in the void of federal aid. While these still may be inadequate, they offer different forms of accessibility and different kinds of trauma management services that can serve a wider variety of needs including diagnosis and prescription, counselling services, cultural and religious support, education, or alleviation of daily stress.

Chapter 4: Steps to Manage Trauma

Intro

With many organizations all offering services and tackling different facets of refugee trauma, there are varying forms of mental health services. The resources and abilities of hospitals differ from those of non-profits or the government, and no single service is an end-all solution. The organizations and resources available adopt many different philosophies and focuses on how to treat mental health, creating a multitude of options which can adapt to the needs of individuals. While these services may be flexible, they are in some instances still lacking in accessibility and efficacy. This is a result of the stigmatization of mental health, the necessary-only approach to refugee services, and the cultural barriers to foreigners accessing medical resources.

While the most rigorous and researched method for trauma management in refugee populations has been clinical diagnosis, assistance comes in many other forms as well. Some refugees may require prescriptions or counselling while others may find greater benefit in community support groups, social services to alleviate daily stressors, or more traditional culturally adapted services. Different approaches can be better fits depending on whether an

individual is experiencing PTSD, anxiety, depression, or somatic disorders; and other times one approach may simply ‘click’ better than another for personal, linguistic, or cultural reasons. Not every form of trauma management is available in every moment, but each service has its own merits and weaknesses.

Clinical Diagnosis and Prescription

Medical resources are the starting place in realizing and addressing mental health concerns for refugees. Despite the flaws in the screening and referral processes, these systems offer the first opportunity for professionals to recognize what an individual is feeling and analyze what their symptoms or thoughts may mean. It can be difficult for mental health professionals to narrow a specific diagnosis for individuals due to the fickle nature of mental functioning. While a simple series of questions or even one’s disposition may act as a ‘red flag’ and potentially allow for diagnosis, there are obstacles in distilling a singular mental illness or identifying all symptoms. These are barriers inherent to mental health which are magnified by cultural and linguistic barriers within refugee populations. Individuals from other cultures often lack an understanding of American mental health definitions, feel stigmas which prevent sharing, do not trust health professionals, or cannot properly express what they feel.

First, it must be clarified that displacement or refugee status does not, in itself, predict or guarantee mental illness. Refugees are frequently subjected to poor conditions including injury, loss of loved ones, or persecution; but most refugees find ways to manage this stress. As a result, refugees are collectively quite resilient. “Exposure to persecution and displacement does not unequivocally lead to psychopathology. In fact, most refugees do not report clinically significant

psychological symptoms following resettlement."[158] In health screenings and primary care physicals, refugees ought to be treated as an at-risk population but cannot be generalized to presume the presence of psychological symptoms. While lived traumas are not directly determinant of a clinical diagnosis, non-symptomatic refugees may still benefit from other political and social supports to mitigate trauma.

One obstacle to clinical diagnosis is the emphasis placed on PTSD, especially in the context of refugees. Much of the academic and field work surrounding refugees relies on the assumption that PTSD will be the most prevalent disorder experienced after resettlement. There are questionnaires that identify only PTSD and extensive research on the topic. This is largely reliant on a narrative of causality between war experiences and post-traumatic stress. An overemphasis on only one disorder reduces the adaptability of clinical trauma response systems, creating a risk of misdiagnosis or overlooking other disorders. While post-traumatic stress is prevalent and deserves great attention, the trauma-focused framework of refugee mental health overemphasizes this plight while failing to address others.[159]

Mental health diagnoses have also been complicated by the failure of some individuals' symptoms to fit cleanly into a single diagnosis. Both within guides such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and in refugee-specific research, it has been found that there are outlying symptoms especially prevalent in heavily traumatized groups. Multiple means of addressing and diagnosing these symptoms have been suggested. "[T]here have been

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[158] Angela Nickerson, "Pathways to Recovery: Psychological Mechanisms Underlying Refugee Mental Health," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),91

[159] Peter Ventevogel, "Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action?" in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),157

attempts to identify a separate diagnosis to encompass the complex pattern of distress and very high levels of comorbidity described above in populations exposed to repeated and protracted traumatic experiences." One option to identify these outlying symptoms is a new title for disorders which are incongruent with current definitions. "The concept of disorders of extreme stress not otherwise specified (DESNOS) was put forward as a potential diagnosis covering a broader spectrum of symptoms." Other symptoms have been proposed as additions to the current definitions of PTSD or enduring personality change, yet these additions are slow to be adopted and recognized by industry leaders such as the DSM.[160]

Trauma Management Prior to Resettlement

The presence of NGOs in conflict zones and neighboring areas allows for a provision of services even where resources are spread thin. As previously noted, there are particular systems of treatment that are well suited for conflict zones and camps such as games or psychological first aid. International agencies like the United Nations High Commissioner for Refugees and the Inter-Agency Standing Committee give guidance on what they recommend ought to be provided for refugee trauma resources. This guidance includes suggestions of integrating mental health awareness into existing services along with psychological supports when necessary. Various forms of intervention prior to resettlement can help to mitigate symptoms in severe cases of trauma though they do not negate the need for subsequent interventions.

For mediating trauma and preventing it from worsening, simple activities to provide mental stimulation can be utilized. These activities have the potential to be educational when accompanied by an observer who can explain stress and mental functioning. Part of the

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[160] Jessica Carlsson and Charlotte Sonne, "Mental Health, Pre-migratory Trauma and Post-migratory Stressors Among Adult Refugees," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),17-18

intervention and education approach is to build acceptance and awareness of mental functions while also mediating immediate distress. During a crisis or conflict, this can help to stabilize individuals, but it also provides a distraction and a time for personal reflection and resilience-building. The use of mentally stimulating games or activities intertwined with education provides a groundwork for other interventions, but is not a treatment for trauma unto itself.

Psychological First Aid (PFA) is also used as a method of immediate intervention during conflicts. This practice focuses on calming individuals and connecting them to the resources with which they are comfortable. This relies on trained professionals but does not entail counseling or diagnosis. For these reasons, it requires minimal resource to implement psychological first aid and it can offer positive results by offering these services to a wide array of refugees, regardless of symptomology following trauma. PFA is a necessary form of intervention for short-term stability but does not seek to remedy mental health problems beyond immediate distress. This makes it a good candidate to segue into more pointed and clinical services which work towards reducing rates of clinically recognized symptoms.[161]

Intervention beyond PFA, educational games, or medical services is ultimately needed but can be scarce in lower income countries where conflict is common or camps are located. With minimal financial resources which are dedicated to the most immediate needs, it is difficult to expand on high-level interventions like those which may be available in wealthy countries. Low intensity interventions have been adapted for low- and middle-income countries with refugee populations which cannot afford to staff and research clinical supports. While these

[161] "About PFA" National Child Traumatic Stress Network [cited 2020]. Available from https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa.

interventions have not received the same level of academic research as those in developed countries, they have proven to have merits while expending minimal resources.[162]

Clinical resources are preserved by utilizing group formats, leveraging non-therapist staff who can be trained in a short period of time to execute treatment methods, or applying transdiagnostic treatments that are not specific to only a single disorder. These treatments are focused on only some individuals and on specific types of problems, but they are not highly specialized. Group treatment has been applied to interpersonal psychotherapy and cognitive behavior therapy both with positive and lasting effects. In the case of the group interpersonal psychotherapy, facilitators with a high school education but no mental health experience underwent a two-week training led by psychological researchers before leading 16-session group therapies. The results were evaluated at a six-month follow-up and indicated that only a small portion of participants met the diagnostic criteria for major depressive disorder compared to a control group receiving usual care. The adapted cognitive behavior therapy also relied on brief trainings for volunteer community health workers to work with mothers experiencing depression. Similarly, the intervention reported significant and lasting benefits in reducing prevalence of major depressive disorder.[163]

In addition to expanding services which rely on workers who are not mental health specialists, resources can be preserved while increasing assistance by implementing transdiagnostic methods. Rather than focusing on a singular mental illness or symptom, these approaches target several complaints at once while adapting to individual clients. One model for

[162] Katie S. Dawson and Atif Rahman, "Low Intensity Interventions for Psychological Symptoms Following Mass Trauma," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018), 341-356.
[163] ibid.

transdiagnostic work, the Common Elements Treatment Approach (CETA), utilizes an eight-to-twelve-week series of individual sessions administered by a non-specialist. The counsellors implementing CETA follow a progression which is flexible but emphasizes bring forward complaints, relaxing the individual, and using exposure techniques for cognitive restructuring. These are steps which are applicable to many mental illnesses and do not require a mental health professional to implement. "When trialed with displaced Burmese people residing on the Thai-Myanmar border, CETA significantly reduced depression, posttraumatic stress, functional impairment, anxiety symptoms and aggression." Transdiagnostic interventions can preserve resources by not specializing and addressing the needs of refugees whose symptoms may deviate from a single diagnosis.[164]

Services in a refugee's country of origin or in a nearby camp will never be the standalone solution to refugee trauma. Not only are the conditions often not suitable for rehabilitation and other services take precedent, but resources are scarce considering the reality that developed countries of resettlement are far more capable of providing these services. However, the protracted time between displacement and resettlement offers an opportunity for interventions which are efficient in their use of money, time, and staff. "One of the major barriers to accessing mental healthcare is the often limited capacity for interventions to be scaled-up by local government ministries or non-government organizations who often have small budgets for mental health and psychosocial support."[165] Not all individuals will respond to any one system and non-professional counsellors, group treatments, or transdiagnostic processes will not be an

[164] ibid.
[165] ibid.

end solution; but these systems offer examples of what the UNHCR and IASC advocate for and the types of services which are realistic yet effective.

Questionnaires for Diagnosis

Regardless of predeparture interventions, it is necessary at some point to systematically determine the presence or lack of mental health symptoms in a refugee. Both overseas and upon arrival, questionnaires are one of the common ways to diagnose individuals and initiate treatment. Questionnaires can be administered in nearly any setting and by nearly any facilitator, though these contexts may have influence on the responses of clients. Mental health screening questionnaires are also easily translated or adapted into additional languages, making them especially valuable in the context of refugees. One potential drawback of questionnaires is that they typically focus on only one mental illness and fail to identify others—the result being misdiagnosis or overlooked symptoms. Standardized questionnaires offer a resource-efficient means to screen refugees for mental illness and prompt diagnosis when applicable, with the potential to be used in many contexts.[166]

Myriad screening instruments are available, and each has different strengths or weaknesses. Two of the most utilized and the current 'gold standard' of refugee questionnaires are the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist.[167] [168] [169] [170] The

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[166] David P. Eisenman, "Screening for Mental Health Problems and History of Torture," in *Immigrant Medicine*, 2007), 633-638.
[167] Angela Nickerson et al., "A critical review of psychological treatments of posttraumatic stress disorder in refugees," *Clinical psychology review* 31, no. 3 (2011): 399-417.
[168] Marija Bogic, Anthony Njoku, and Stefan Priebe, "Long-term mental health of war-refugees: a systematic literature review," *BMC International Health and Human Rights* 15 (2015)
[169] Tracy Chu, Allen S. Keller, and Andrew Rasmussen, "Effects of Post-migration Factors on PTSD Outcomes Among Immigrant Survivors of Political Violence," *Journal of Immigrant and Minority Health* 15, no. 5 (2013): 890-7.
[170] Angela Nickerson et al., "Emotion dysregulation mediates the relationship between trauma exposure, post-migration living difficulties and psychological outcomes in traumatized refugees," *Journal of affective disorders* 173 (2015): 185-192.

Harvard Trauma Questionnaire focuses on only PTSD with adaptations in English, Bosnian, Cambodian, Dari, Khmer, Laotian, and Vietnamese. The Hopkins Symptom Checklist measures both anxiety and depression, a rare instance of a transdiagnostic instrument. Hopkins is available in English, Amharic, Bosnian, Cambodian, Dari, Khmer, Laotian, Pashto, Tibetan, and Vietnamese. Even with translation, the flaws in questionnaires' utility are immediately brought into question. Many refugees will have mental illnesses different than the one(s) which they are being asked about. The questionnaires are also not accessible to individuals who speak French, Lingala, Burmese, Pashto, or Dari, along with countless other languages spoken by frequently displaced populations.[171]

Questionnaires have the potential to introduce great assets, such as systemization and efficiency, but they also bring with them obstacles. The benefit of systematic instruments like questionnaires is that they ask an array of clinical questions, ones which inquire about particular experiences rather than rely of self-diagnosis, without the need for a trained mental health professional present. They also can be adapted for additional languages with relative ease when needed, decreasing the reliance on the consistency of clinical and translation staff for an efficient evaluation. Questionnaires, despite potential problems of specificity, allow a means to screen refugees for unsuspected and remediable mental health disorders, making them a valuable tool in trauma management. High risk individuals can complete a questionnaire regardless of the presence or lack of symptoms; preserving resources while screening otherwise overlooked populations.[172]

[171] Eisenman, "Screening for Mental Health Problems and History of Torture," in 633-638.
[172] ibid.

The Role of Primary Care Physicians

The American healthcare system relies heavily on Primary Care Physicians (PCP) to kick off the medical and mental health process. Primary care doctors touch on mental health in physicals for all populations but for refugees this is a process that starts from scratch. “A mental status examination must be in the repertoire of all physicians because of the high prevalence of emotional distress in this population. Many traumatized patients cannot present their emotional distress to the physician in a coherent fashion without being emotionally retraumatized.” The sensitive nature of mental health, especially in refugee communities, means that physicians must be adept at discussing these topics with clients. “Very few patients can state directly that their life is ‘broken’ or that their world has been ‘shattered’ by horrific violent experiences,” but tools like specific questions or questionnaires can determine traumatic experiences or negative thoughts without further harm or discomfort.[173]

Physicians are trained to detect and diagnose symptoms of both physical and mental illnesses. In refugees, there is a probability that these may be more prevalent than in other populations due to their exposure to stressful and violent situations. “Such patients may present with varied and complex symptoms including headaches, abdominal pains, sleep difficulties, traumatic brain injury, body aches and pains, psychosomatic illness, depression, anxiety, PTSD, and injuries to eyes, ears and mouth.”[174] It is the role of the doctor to examine these potential symptoms and use them to evaluate the condition of a refugee to determine if they require medication, counselling, group treatment, or other forms of intervention. “A refugee’s experience of trauma/torture and displacement may present challenges to clinicians who are

[173] Richard F. Mollica, "Assessment of Trauma in Primary Care," *JAMA* 285, no. 9 (2001): 1213.
[174] Patricia Shannon, Maureen O'Dougherty, and Erin Mehta, "Refugees' perspectives on barriers to communication about trauma histories in primary care," *Mental health in family medicine* 9, no. 1 (2012): 47-55.

unfamiliar with refugee trauma and its clinical consequences."[175] For this reason, it is extremely important that physicians have a grasp on refugees' political and cultural backgrounds in addition to their understanding of mental health.

One of the most important things is for physicians, and clinicians of all kinds, to understand is the political context of where an individual comes from to best grapple with what they might have experienced. While it may be infeasible to readily comprehend every aspect of a given population, a quick web search or conversation with the interpreter before meeting the patient can yield information about the kind of political and social environments the patient came from. Certain sociopolitical climates and struggles are very prominent in many populations while others might be specific to a particular origin. For example, refugees from both Vietnam and Syria both may share the experience of fleeing via boat and the potential for exploitation and death that comes with this, despite being part of conflicts that happened decades apart. Other risk factors like loss of home and material possessions might be nearly ubiquitous, as they are inherent to the refugee experience. These pieces of context lend insight into what can be observed about the individual. "Physicians tend to focus on the physical complaints of refugees without reference to emotional well-being and the socio-political context of those symptoms." The ability to connect political background with both physical and mental observations makes PCPs an even more valuable resource.[176]

One commonly reported gap in physician processes is a failure to inquire about specific experiences of a refugee. It is sometimes assumed that a refugee does not want to talk about their

[175] Sondra S. Crosby, "Primary Care Management of Non–English-Speaking Refugees Who Have Experienced Trauma: A Clinical Review," *JAMA* 310, no. 5 (2013)520
[176] Shannon, O'Dougherty, and Mehta, "Refugees' perspectives on barriers to communication about trauma histories in primary care,": 47-55.

past, which is fully possible, but more commonly they are not comfortable bringing it up. Unless explicitly shut down, PCPs should take initiative in beginning the conversation about mental health.[177] Many refugees may not consider that their mental health is relevant to physical health or that it can be addressed by a physician, especially refugees who are unaware of what mental health is. While language and differing beliefs about healthcare—especially that of mental health—create barriers to communication, research shows that refugees want to talk about their trauma with a professional and they want to learn about the impact of trauma and stress on their health.[178]

The necessity of cultural awareness is visible in the process of a physician initiating the mental health conversation rather than avoiding the topic. Refugees are frequently coming from states—like Myanmar, the DRC, or Afghanistan—where they do not have a voice. They have been repressed and their voices suppressed by militaristic governments, tribal warfare, or militia rule. Individuals with these pasts should be empowered to share their experiences even when they are not comfortable broaching the subject. When there is a tendency to defer to authority, it becomes even more imperative that the doctor initiates the conversation.[179] In addition to becoming aware of the political and cultural history of an individual through research or simply inquiring, there are other methods that can help PCPs initiate mental health discussions and gain accurate diagnoses. When possible, an interpreter can be used to ease language barriers. Some refugees may be comfortable with an in-person interpreter from the hospital staff or a social worker, though often anonymous phone interpreters are better because they mitigate the feeling

[177] Crosby, "Primary Care Management of Non–English-Speaking Refugees Who Have Experienced Trauma: A Clinical Review,"522
[178] Shannon, O'Dougherty, and Mehta, "Refugees' perspectives on barriers to communication about trauma histories in primary care,": 47-55.
[179] ibid.

that a community member is hearing private details. Especially on topics that are highly stigmatized, such as torture or sexual health, anonymity can ease anxiety about sharing details.[180] Questionnaires can also be used to lower the barriers to initiating conversation as their formulaic nature makes breaching touchy subjects easier. Written or scripted questionnaires reveal important information and begin conversation without requiring the physician to make direct inquiries about the patient's personal and past life.

Sometimes, when a refugee is hesitant to be honest with a medical professional, non-profits and community members can step in to educate on the value of medical and mental health care. This includes speaking with the individual refugee to articulate that what they share cannot be used against them and will help to stabilize their life and speaking with the doctor to make clear that the individual is struggling but hesitant to share fully or to bring cultural awareness. After a relationship can be established between the healthcare professional and the refugee, that channel of trust can allow for open conversation and the introduction of medication or intervention.[181]

Medication can be prescribed by physicians or by psychiatrists to treat mental illnesses. There are countless medications which are dependent on specific use cases, but there is consensus that this is often an essential component of treatment. "[P]sychotropic medication can restore basic psycho-physiological functioning so that people are better able to cope with daily stressors and to engage in community activities." The use of medication is especially effective for individuals with PTSD symptoms, though nearly all mental illnesses can be treated with

[180] Crosby, "Primary Care Management of Non–English-Speaking Refugees Who Have Experienced Trauma: A Clinical Review,"525
[181] Author, *Interview of Apollo Karara*, 2020).

medication of some form.[182] The psychotropic medications used to treat refugees are the same ones used for American-born populations of all kinds. Medication, while not a universal treatment, is among the most valuable tools in alleviating symptoms of mental illness following trauma. It is not always a standalone solution, but it can also restore functioning to levels that allow an individual to build community connections and better access other supports.

Forms of Intervention

Refugee populations are frequently subjected to experiences which are different than those of native-born Americans. While some treatments, like medication, are applicable to both groups, not all interventions designed for western populations have the same efficacy when reconciling the different experiences of refugees. In response to this unique set of stressors, additional forms of intervention have been devised which target refugee populations. Both western models and refugee-specific models of intervention have proven to have positive effects in populations who have experienced war trauma. Professional interventions are typically administered in clinical settings by counsellors or psychiatrists, making them systematic and pointed.

Proponents of trauma-focused clinical interventions argue that they are the most effective form of treatment for common mental illnesses. Studies on various forms of therapy have shown that trauma-focused interventions are more effective against PTSD than psychosocial or multimodal treatments. Despite being less culturally adapted, “trauma-focused interventions, such as cognitive behavior therapy, are thought to alleviate symptoms by facilitating extinction learning, processing the traumatic memories, altering maladaptive appraisals of threat, and

[182] Kenneth Miller et al., "Daily Stressors, War Experiences, and Mental Health in Afghanistan," *Transcultural psychiatry* 45 (2009)631

overcoming avoidance behavior." While trauma-focused approaches may be effective, refugees experience a complex array of psychological reactions which demand a diverse selection of interventions. Focusing only on PTSD and putting trauma forward will not serve all peoples. Clinical interventions offer a possibility for effectively managing trauma in refugees which is proven to have positive results.[183]

Cognitive Behavioral Therapy (CBT) is among the most common PTSD interventions across many populations. Held as the leading form of psychotherapy by many experts, CBT helps to recognize negative or harmful thoughts and behaviors. Rather than discussing past experiences, CBT focuses on an individual's current emotional and psychological status, using these as a lens to explain their current actions. This approach is applicable not only to PTSD but also to other common disorders such as anxiety, depression, substance use, eating disorders, or OCD. "Evidence demonstrates that cognitive-behavior therapy is effective for a wide range of disorders including PTSD. However, most research on CBT has focused on Western populations, and research is just beginning to examine whether CBT is effective for ethnic minority and refugee groups." Preliminary studies which examine the efficacy of this intervention conclude that it is effective in refugee populations but that the administering therapist must understand the population. It is necessary to identify the target cultural group and tailor to their language, religion, and cultural norms.[184]

Narrative Exposure Therapy (NET) is an intervention which is well-adapted for use in either high- or low-income countries with positive results in both. While it is delivered by

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[183] Nickerson et al., "A critical review of psychological treatments of posttraumatic stress disorder in refugees,": 399-417.

[184] Devon E. Hinton and Anushka Patel, "Culturally Sensitive CBT for Refugees: Key Dimensions," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),202-205

qualified counsellors rather than social workers or volunteers, it does not require long-term work with a psychiatrist. “NET has proven to reduce traumatic stress symptoms to a clinically significant extent, even in refugees who live in unsafe and threatening environments.” NET is a trauma-focused intervention method that creates narratives out of scattered memories with the hope of remedying dysfunctional memory processes and confronting past experiences. “Within four to 14 individual sessions of 90 min, the client and therapist create a written autobiography containing the major emotional memories of the survivor from birth to the present.” Addressing and accepting these past traumas helps individuals to exit the toxic stress of ‘fight or flight’ mode and reconcile with how they currently feel, often bringing an end to dissociation such as emotional numbing or sensory detachment. “Two decisive strengths of NET include its low dropout rate and its high potential for dissemination, including by lay counselors in low-income countries and war and crisis regions.” While still administered in a clinical manner, NET has the benefit of being applicable both in low-income countries and wealthy host nations such as the United States.[185]

Trauma Systems Therapy (TST) is a clinical intervention which relies on schools as a trusted entry-point for reaching child refugees experiencing aftereffects of trauma. It has shown to be effective for PTSD and depression both in older populations and in school-age children. “TST is both an organizational model that guides the collaboration of care providers within service delivery systems to provide integrated treatment to traumatized children, as well as a clinical model that explicitly focuses on trauma-related emotional dysregulation.” In childhood settings, TST relies on educating both the child refugee and those around them about emotions

[185] Frank Neuner, Thomas Elbert, and Maggie Schauer, "Narrative Exposure Therapy (NET) as a Treatment for Traumatized Refugees and Post-conflict Populations," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),184-194

and coping to ensure that healing continues after the end of counselling.[186] TST offers a method of mediating emotions following traumatic experiences, especially in children, through individual sessions with a therapist.

Clinical trauma interventions administered by mental health professionals offer specific and verified ways to mitigate symptoms and work towards greater stability. While interventions can take many forms, they typically take place in a medical setting with a psychiatric counsellor or therapist who has experience coaching individuals through a specific process or plan as specified for that form of therapy. The greatest obstacles to these interventions are the need for many hours of one-on-one treatment with a professional, which is costly, and cultural inhibitors for refugees who are not comfortable with the mental health concepts and treatments which are ascribed to them. Clinical intervention techniques offer an important form of treatment when healthcare funding and local resources allow.

Group Treatment and Resilience

While clinical intervention is common for refugees experiencing more severe symptoms, group treatment systems have been utilized across many populations with positive results. Although they are typically lower in intensity, group treatments are also lower in resource expenditure, making them a good fit for non-profits who do not have the staffing or funding that governments and medical systems are privy to. As such, group treatments have been used in camps by organizations such as Mercy Corps and in local organizations such as USCRI, MANA, and MAIN. Because group treatment interventions do not typically require therapists or

[186] Molly A. Benson et al., "Trauma Systems Therapy for Refugee Children and Families," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),243-246

counsellors as the primary administrator, they can be more easily adapted and applied at a community level.

Group treatments can also build off existing cultural and religious frameworks to assist in gaining participants and comfort. This is an area which other forms of intervention struggle with greatly and offers a large benefit to group treatment programming. “Group-based interventions grounded in cultural competency and spirituality could more effectively provide support to refugees.”[187] Especially when programming is conducted by organizations who are led by individuals from the communities that they serve, ethno-political and religious comfort are much greater in group responses than clinical settings. Community organizations focused in trauma, such as MANA, have a duality of insights into both the constituents which they serve and the concepts of refugee mental health. This allows for data to be collected on the most-needed forms of programming and to implement this.

MANA focuses on resilience-building, one common form of group treatment. “Resilience is the absence of psychological distress in the face of highly disruptive or life-threatening events, not only at a single point in time, but also as a stable trajectory across time despite transient perturbations in functioning.” The idea is not that an individual immediately has no stress, but rather to decrease stress and change the narrative of how they approach disruptive events. This is a “dynamic rather than static process of harnessing biological, psychosocial, structural, and cultural resources in order to sustain well-being.” By hosting peer support groups in which participants share stories of their past experiences and what they continue to struggle with, there is an opportunity for the other group members to share that they have experienced similar

[187] Miriam George, "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice." *Clinical Social Work Journal* , no. 40 (2012)433

hardships or obstacles. This serves multiple purposes by normalizing mental health, making clear that individuals are not alone and what they are experiencing is 'normal,' and creating dialogue about coping mechanisms and self-care. Contrary to clinical intervention, group treatment acknowledges that both positive and negative mental health outcomes are, in large part, rooted in cultural, family, and peer predictors.[188]

While group treatments have merits in their ability to form community and religious bonds while addressing trauma, the evidence in support of their efficacy is less robust than that of clinical intervention.[189] This may be in part because these systems of trauma management are far less uniform and performed at a local level. One organization may structure their peer support groups, story sharing, and group activities differently than another, compared to clinical interventions which are systematic. There is also likely to be a lack of scientific review regarding the success of community groups compared to clinical work. Group treatments may not be the 'gold standard' of intervention techniques, like CBT, but they offer a format which may be better suited for individuals who would not respond as well to clinical work. They also can be implemented with fewer resources, making them extremely valuable in light of the minimal long term healthcare services available to refugees.

Cultural and Linguistic Sensitivity

While various clinical settings for diagnosis do face significant logistic and academic problems, perhaps the greatest obstacle for the refugee population is that of culture. Individuals from outside of the Western world and particularly from developing countries frequently have a

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[188] Wai Kai Hou, Brian J. Hall, and Stevan E. Hobfoll, "Drive to Thrive: A Theory of Resilience Following Loss," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice* (Cham: Springer International Publishing, 2018),112-114

[189] Ventevogel, Peter "Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action?" 158

low comfort level with American medical systems. There are high barriers such as language competency, low education levels, and disorientation that can inhibit a quick adaptation to a new system of physical and mental care. “Language problems as well as a lack of understanding of how the healthcare system is organized influence help-seeking behavior can lead to conflicts with healthcare professionals”[190] The result is a lack of trust and a hesitancy to return to a mental health professional, much less to be honest. Many languages do not have words which translate into common terminology such as “stress,” “anxious,” “depressed,” or “rape;” making it difficult for some individuals to communicate to their provider or even with an interpreter. These cultural and linguistic barriers further complicate the process of reaching a conclusive and treatable diagnosis. While medical systems may be oriented to satisfy scientific success, this is often at odds with cultural success.

Many of the obstacles to accessing any form of intervention pertain to cultural norms. Language, stigmatization, awareness, and religion all pose potential barriers to accessing the same resources which are utilized by, or even commonplace to, native-born Americans. Communicating modern forms of western medicine to individuals who are unfamiliar with American definitions and treatments of mental health is difficult to do. In many cultures, the concept of mental health is synonymous with being “crazy” and explaining the existence or importance of various disorders can be difficult. While language, culture, and religiosity have the potential to hamper mental health efforts, they also offer unique opportunities for interventions and can act as protective factors in some scenarios. Cultural differences are one of the important ways in which managing trauma in refugees deviates from other populations.

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[190] Jessica Carlsson and Charlotte Sonne, "Mental Health, Pre-Migratory Trauma and Post-Migratory Stressors among Adult Refugees," in *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, eds. Nexhmedin Morina and Angela Nickerson (Cham: Springer International Publishing, 2018) 24.

Language presents a difficult and diverse obstacle to proper mental health care. Refugee populations speak countless languages and interpretation may not always be accessible or adequate. Refugees from Myanmar are likely to speak Burmese, though they could speak other languages or dialects. While many refugees from the Democratic Republic of Congo can communicate in French, resources for interpretation in Kituba, Lingala, Swahili, or Tshiluba may be less accessible. Pashto are Dari and the official languages of Afghanistan which are commonly spoken. When accounting for all languages spoken by refugee populations, it is impossible to provide linguistically adapted services for everyone. There are various means of accommodating language barriers but reaching full accessibility and comfort is difficult.

Both Maine and New York report providing interpreters during social work and for medical services. USCRI Albany has their own interpretation staff while Catholic Charities Maine frequently relies on staff from local organizations or the healthcare provider.[191] [192] However, language translation is not the same as being comfortable. Not only does the presence of an interpreter add another human to trust with sensitive information, it also furthers the cultural disconnect from medical systems and processes. In one anecdote, a refugee saw a therapist with a translator present for months, openly discussing both her symptoms and difficulties in her new life but never explaining her previous experiences. After six months, she disclosed to the translator that she had been raped and it was another month before she told the therapist, with the encouragement of her translator.[193] This is not a problem only of language but a common scenario which originates from the intersection of personal shame, linguistic discomfort, and cultural barriers.

[191] Author. "Interview of Grace Dun." (2020):
[192] Author, "Interview of Gabrielle Lodge," (2021):
[193] Author, "Interview of Abbie Yamamoto," (2020a):

Governmental and medical resources seem to align linguistic accessibility with cultural comfort which is not accurate. Providing both language accommodation and cultural comfort is extremely difficult but should be the aim, and language should not be equated with culture.

> Traditionally, interpreters have been used to address cultural and linguistic barriers in health care, but creating culturally accessible care requires moving beyond linguistic interpretation. Culturally sensitive care must address the community/client's distrust of mental health systems of care, stigma around mental illness, and providers' lack of cultural knowledge so that they can tailor treatment approaches to a patient's cultural understanding of the illness and treatment.[194]

Community organizations are better able to conduct programming and services in ways which are adapted both for language and culture. This is in part due to scale and the ability of small organizations to serve smaller populations with whom they are more familiar. It is also due to the community bonds which are more common in non-profits that allow them to easily relate to and communicate with their target groups. For example, the Maine Association for New Americans holds programming and advertises in many languages. Regardless of the language spoken during the events, individuals can connect to others who speak the same language and can share similar experiences. Having a grassroots voice in appropriate languages allows for education and destigmatization to take place in otherwise insular populations.

The communication of western medicine poses a problem in many communities across the United States. It can be difficult for refugees who lack experience with the U.S. system to understand that healthcare professionals can treat more than dire physical injuries and that mental health is not synonymous with ‘being crazy.’ Furthermore, western medical systems tend to be ungiving in their view of how clients ought to be treated. “Until recently, the explicit objective of intervention techniques has been the imposing of cultural norms of the dominant

[194] Benson et al., "Trauma Systems Therapy for Refugee Children and Families," in 248

society on minority clients."[195] As a result of this Wester-centric lens through which mental health services are implemented and the scarcity of resources necessary for culturally adapted health care, mental health services are still not entirely accessible to refugees who need them. "Many communities do not offer culturally-appropriate and linguistically accessible services to treat trauma and torture in any or all of the refugee groups resettling in their area, a violation of refugee rights to adequate healthcare."[196]

A lack of culturally adapted interventions is problematic because these approaches have proven to be far more effective than those intended to serve broad populations.[197] Frequently, the academics who research and innovate new interventions are not refugees themselves or familiar with the cultures with whom their work will be utilized for. Similarly, and perhaps more importantly, few doctors originate from the communities which they serve, further widening the cultural divide. Creating culturally adapted approaches does not mean devising entirely new interventions, it simply means that social workers and clinicians "need to consider refugees' contextual information—including whether they are acute/anticipatory, traditional/new, and their host country stats—when analyzing their help seeking behaviors."[198] Additionally, existing treatments can be modified to better accommodate a new population. This includes the incorporation of local spiritual and ritual practices into clinical treatment.[199]

One effective adjustment to interventions is to partner with organizations that can more easily connect with target populations. By "embedding comprehensive services into community

[195] George, "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice."433
[196] Jason Ostrander, Alysse Melville, and S. Megan Berthold, "Working With Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches," *Advances in Social Work* 18, no. 1 (2017)67
[197] Hinton and Patel, "Culturally Sensitive CBT for Refugees: Key Dimensions," in 202
[198] George, "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice."433
[199] Hinton and Patel, "Culturally Sensitive CBT for Refugees: Key Dimensions," in 201-219.

and school settings, integrating cultural values and understanding into appropriate evidence-based practices, and building cultural knowledge," mental health resources are made more culturally accessible. For example, schools are one resource with higher levels of trust than medical services, this creates an opportunity to provide services to children or to communicate with parents about what they or their child may be experiencing.[200] The same is true of cultural community groups, an effort that is visible in Maine, where Catholic Charities refers refugee clients to Maine Access Immigrant Network, an organization which began not as social services but as an ethnic support group, to assist with accessing health services. These efforts also empower the refugee community through education and providing resources for refugees to participate in the health ecosystem rather than simply act as clients of the Wester-centric health system.

The logistical and cultural barriers faced by refugees in accessing and reaching conclusive diagnosis slows the treatment process. While these obstacles are examined through the lens of services on American soil, the same struggles exist in overseas treatments. Like all fields, clinical psychiatry, including that of refugees, is continually evolving and improving. While current methods and definitions may not be able to efficiently detect, diagnose, and remedy all refugees' problems; clinical approaches still offer great merits and are sure to continue adapting. The obstacles to clinical diagnosis are particularly disruptive in light of the short time, eight months, in which refugees are allowed state health insurance. Barriers to accurate clinical treatments still exist but they have the potential to be remedied by greater

[200] Benson et al., "Trauma Systems Therapy for Refugee Children and Families," in 245

healthcare coverage, cultural adaptation, and the evolving ability to diagnose symptoms which are prevalent in refugees.

What is needed in addressing linguistic or cultural obstacles to trauma management is not one singular solution, but rather many approaches to break down barriers between parties. Much of this is already being done in some communities—reliance on ethnic groups, education via community leaders, the provision of interpreters, and so on—but there is still a need for growth. In particular, clinical interventions must adapt to better meet the needs of refugees and to be explicable. Treatments must not only be effective, but they must be understood and articulable to make clear that they are an important component of overall health. Also needed is an increase in community education to make clear that mental health is not equated with craziness but rather a logical consideration following traumatic histories to ensure long-term physical health, personal growth, and professional success.

Conclusion

The United States is among the world leaders in mental health management and research, though this advancement does not trickle down to refugee populations as effectively as it should. The trauma of the refugee experience makes it more difficult to narrow down specific diagnoses than in other populations. Furthermore, the tools to diagnose and treat mental health conditions are not particularly adapted for refugees, rather they are ‘translated’ which does not always account for cultural barriers. What is necessary is that connections are made between the populations who need help and those who can provide the help: “It's education, it's building trust between professional and the victim. Until you can open up your channel to what's happening

that help. That is something you can use to let people open up."[201] Social workers, physicians, and counsellors can be extremely knowledgeable and be prepared with the best interventions in their field, but this is ineffective if they do not know the population which they are dealing with.

Clinical work, including visits to physicians and interventions led by therapists, are the gold standard of mental health care in the lens of professionals and researchers. However, myriad other services assist in treating trauma within refugee populations. Significant progress has been made in increasing accessibility to resources but there remains great work to do in this effort. Little has been done to remedy the cultural barriers to accessing clinical care even when it is locally available and covered under Refugee Medical Assistance. For a country with robust mental health infrastructure and the ability to resettle thousands of refugees each year, the United States falls short of being able to implement adequate interventions to treat refugees clinically, leaving many refugees without treatment or seeking the assistance of local organizations to manage their trauma.

Chapter 5: Funding and Governmental Support

Intro

The United States—having long been the largest resettling nation—is, on paper, a hallmark of global humanitarianism and support for refugees. In reality, the reception of refugees is not as rosy as we would like to believe it is—especially in the realm of trauma and mental health. The U.S. has always lacked a united system for refugee services. An absence of evolution in legislation and funding has continued to dramatize this void of structure. The goals set out in the Refugee Act of 1980—the preeminent U.S. refugee legislation and the framework for the

[201] Author, "Interview of Apollo Karara," (2020b):

current system—have been unfulfilled and even undermined over the past four decades by a withdrawal of funding and a lack of legislative progress. Trauma management, like other facets of health and quality of life, has been neglected as a low-priority component to the resettlement process despite the risk of hindering acculturation, education, employment, and socialization.

The Refugee Act of 1980 was the result of a need to systematize the reception of refugees, a process which had been ad hoc for decades and lacked unitary structure. The landmark legislation stated what the goals of refugee resettlement were, and how those goals ought to be accomplished. The determination was that the United States should take in persecuted individuals from the most deserving of conflicts and provide the resources necessary to become self-sufficient. This would be accomplished primarily by leveraging existing non-governmental organizations in each state who had already been facilitating resettlement for decades with minimal involvement of the federal government. This detached federalism was to be maintained, with local agencies receiving grants which would allow them to provide an array of services to settlers in their region.[202] This all sounds good and well, but the reality is that self-sufficiency received heavy emphasis, in line with narratives of bootstrapping and individualism, which is a halfhearted ideology in supplying social services. The Refugee Act determined that what refugees needed was a job to support their family without requiring governmental assistance.[203]

This legislation was brazenly progressive and yet highly flawed. Little attention was paid to the long-term needs of refugees like socialization, language learning, or mental health; despite the impact of these on self-sufficiency. These are admittedly facets which are easy to ignore and

[202] Edward M. Kennedy, "Refugee Act of 1979," , no. 96th Congress (1980):
[203] Anastasia Brown and Todd Scribner, "Unfulfilled Promises, Future Possibilities: The Refugee Resettlement System in the United States," *Journal on Migration and Human Security* 2, no. 2 (2014): 101-120.

have thus never received much attention. Having been proposed in 1979 and passed in 1980, the Refugee Act of 1980 occurred in a moment of political realignment marked by the election of Ronald Reagan as President. Almost immediately after its passage, the program began to erode. The anti-welfare narratives pushed during this time period caused defunding or shrinking of social programs for both native born citizens and refugees. The following years precipitated a gradual dissolution of the Refugee Act, a process which has never been compensated for with new legislation. While some minor legislation has been passed, relatively little has been done to expand on refugee services, and trauma management has received virtually no expansion. The refugee policy landscape originates from well-meaning but flawed policy in 1980 and has not expanded appropriately since then.[204]

To say that trauma management has been totally defunded and dissolved would be misleading. After all, the various services available have already been explored. However, trauma services are grossly underprioritized and underfunded across the country, especially in states with lower resettlement numbers. The Services for Survivors of Torture Program receives only a miniscule portion of the Office of Refugee Resettlement budget while Refugee Medical Assistance covers healthcare costs only for the first eight-months.[205] The void of resources for mental health, trauma, and torture exemplifies that addressing these needs of refugees is a low priority. These are struggles which are often not visible and whose harm to the personal and economic integration of refugees cannot be quantified, making them easy to ignore.

Refugees have specific needs during resettlement and these needs do not end after only a few months. Services like language-learning programs, housing assistance, community-building,

[204] ibid.
[205] *Congressional budget justification. Administration for Children and Families* (2020a):

and trauma management are essential in many refugees' trajectories towards a stable American life. These programs require funding which they do not receive due to the short-term self-sufficiency focus of resettlement programs and the lack of expansion upon refugee assistance policy in the past four decades. The current provisions of the federal government are highly necessary ones but address only the most pressing demands, leaving many voids. Many needs of refugees, including trauma management or mental healthcare, are dramatically under-addressed by legislation and funding.

Federal Funding Structure

The provision of refugee services experiences a federalist disconnect, as is true of other governmental services. Federal actors decide the nuts and bolts of resettlement such as how many refugees to intake, from which nations and groups, where to place these refugees, and how much funding will be approved for resettlement and transition costs. It is local branches of non-governmental agencies such as USCRI or Catholic Charities who implement resettlement programming. It is necessary that the provision of services takes place on a local scale, typically concentrated to a single metropolitan area. This creates accessibility for refugees and allows some degree of flexibility for local agencies, but it also places them at the mercy of decisions made by the President or Congress. Both the throughput and funding of a given resettlement agency is contingent on federal decisions which are highly unpredictable.

Most funding for refugee services, including trauma management, travels through the Department of Health and Human Services. This Department contains the Administration for Children and Families, within which the Office of Refugee Resettlement (ORR) administers most refugee supports. Programs coordinated by the ORR include Refugee Cash Assistance and Refugee Medical Assistance, which focus on transitional costs within the first eight-months after

resettlement; and Services for Survivors of Torture, which delivers grants intended for trauma management. These programs are forms of 'Refugee and Entrant Assistance,' services provided by the ORR for individuals who do not receive Temporary Assistance for Needy Families, Supplemental Security Income, or Medicaid programs; yet demonstrate need for assistance with food, housing, medical services, or other necessities.[206]

All the programs mentioned, and even the daily administrative and infrastructure costs of resettlement agencies, are contingent on the number of refugees that they are resettling.[207] Each refugee program is granted a certain portion of the ORR budget and each state is awarded these funds proportional to historical and projected resettlement. For example, a budget is created for what New York should spend on Transitional and Medical Services, in 2019 this was $11.5 million. Maine has a smaller number of refugees resettled each year and thus received only $1.8 million for Transitional and Medical Services in 2019.[208] These budgets are to last the entire fiscal year and are anticipatory of what will be necessary to meet the needs of newly resettled refugees. This system is egalitarian because some agencies, like those based in metropolitan areas of Texas, Minnesota, Georgia, or other high resettlement states, are responsible for delivering the same level of service to a large population as the agencies in a small resettlement state.

One major flaw in this system is what happens when resettlement, and therefore funding, drops. As seen following the 9/11 attacks and during the Trump presidency, executive action can tank refugee admissions overnight. The effect is that both administrative and per capita funding

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[206] *ibid.*
[207] Silva Mathema and Sofia Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century," *Center for American Progress* (2020)
[208] *Congressional budget justification.*

for resettlement processes are suspended, leaving agencies gutted. In the case of 9/11, the moratorium on refugee entrants was a temporary move and funds were allocated to sustain resettlement programs during this pause in refugee reception. The Trump administration, in contrast, implemented policies to intentionally dismantle the resettlement system and bar people from entering the country with the intent of demonizing refugees and financially crippling the system. "Low admissions levels translate to reduced funding available for the operation of the program, starting a domino effect on the entire system… and making it harder to simply restart once the numbers rise again."[209]

Following 9/11, the Bush administration's response included curtailing refugee arrivals to strengthen security protocols. They implemented a three-month moratorium on arrivals, which left 20,000 refugees overseas who were already approved to come to U.S. in limbo. Even after the moratorium was lifted, refugee arrivals were low for years to come, decreasing the flow of funding to resettlement agencies who were compensated per capita. Despite this slowdown, the administration viewed this as a temporary move and took action to minimize harm to the resettlement system. Funding was made available to the national resettlement agencies for administrative costs and to maintain resettlement operations at the previous year's level. This was done as to not lose important infrastructure. The Bush administration retained a 70,000-refugee ceiling and increased this to 80,000 in its final year, exhibiting strong support for the continuation and growth of the program despite a temporary slowdown caused by 9/11. This did not completely mitigate harm to the resettlement system, and most resettlement agencies were

[209] Mathema and Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century,"

still forced to cut staff. But it did mean that, by 2004 when refugee arrivals were rising again, resettlement agencies had not lost all capacity to ramp back up.[210]

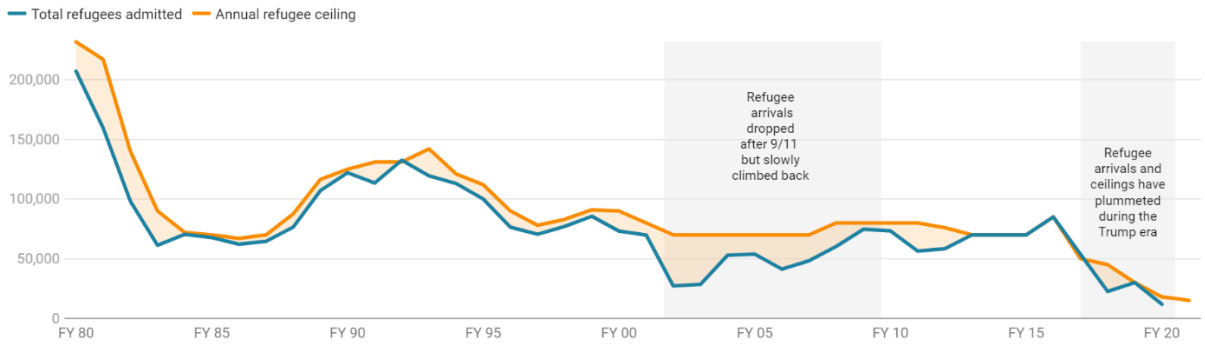
The other period of program shrinkage was the Trump administration and its attacks on the refugee system. This period has some similarities to the period following 9/11 in that executive action allowed a rapid slowing or even pause to resettlements and funding. Dissimilarly, the Bush administration prioritized retaining critical infrastructure during the slowdown whereas the Trump administration manipulated executive action to cripple the infrastructure. Not only have families been separated, refugees held in limbo for years, and deserving individuals denied entry or deported after having previously qualified to remain in the country; but resettlement programs have been devastated by the lack of throughput and withdrawal of funding.

Shortly after coming into office, President Trump signed two Executive Orders both titled 'Protecting the Nation from Foreign Terrorist Entry Into the United States,' the second order being necessary due to court challenges of the first. The revised order: E.O. 13780, "ordered the suspension of the refugee admissions program for 120 days, the reduction of the refugee admissions ceiling for FY 2017 from 110,000 to 50,000, and the development by the State Department of a proposal to increase state and local involvement in decisions about where refugees should be resettled."[211] After this came yet another order which further reiterated similar restrictions while the prior orders were addressed in court. These executive orders

[210] ibid.
[211] Michael Fix, Kate Hooper, and Jie Zong, "How Are Refugees Faring? Integration at U.S. and State Levels," (2017)6-7

collectively were regarded as the ‘Muslim ban’ or ‘travel ban,’ due to the restrictions placed on travel from several Muslim-majority countries.

After the initial slashing by more than half of the FY 2017 refugee entrant cap, the Trump administration continued to decrease annual arrivals each year in office. For 2021, the quota has been set at only 15,000 refugees, the lowest since the program’s inception.[212] Furthermore, these already dismal caps have never been fulfilled. In FY 2018, the first cap which President Trump rightfully decided (2017’s cap had been decided under President Obama and slashed post-facto by Trump), only 22,500 refugees entered—approximately half of the 45,000-refugee quota.[213] In subsequent years, refugee admission quotas have continued to go unfulfilled. The dropping refugee ceiling and the failure to utilize all the available resettlement slots illustrates the federal-level breakdown of the refugee system, one which predicts devastation for state and local resettlement.



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Refugee services are typically funded through grants or reimbursements which are awarded proportional to the number of refugees resettled. That means that the Trump

[212] Submitted on Behalf of the President Of The United States, "Report to Congress on Proposed Refugee Admissions for Fiscal Year 2021," *United States Department Of State* (2020):
[213] Jens Manuel Krogstad, "Key facts about refugees to the U.S." *Pew Research Center* (2019):
[214] Mathema and Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century,"

administration attacks on resettlement numbers not only harmed individuals living in humanitarian disasters but also tanked funding for resettlement processes. The result has been staffing cuts within local agencies or the shuttering of entire offices. “Since fiscal year 2017, national resettlement agencies have closed or zeroed out the budgets of approximately 134 partner sites across the country—a 38 percent decrease in overall resettlement capacity.” Shuttered offices or miniscule budgets mean that the refugees settled in these areas lack case workers, employment services, medical assistance, and cultural liaisons. Services which are deemed not essential to immediate resettlement and job placement (like trauma and mental health) are the first to experience cuts and are infeasible to begin implementing during this attack on the system. The internal war against refugee resettlement waged by the Trump administration entailed the latest and most egregious defunding of refugee resources in the program’s forty-year history.[215]

But even in the good times, the periods when resettlement was growing or steady, funding has often come under attack or has failed to keep up with the rising number of refugees. Shortly after the passing of the Refugee Act of 1980 and the inception of a centralized resettlement process, funding began eroding. Some of these cuts have targetted programs that focus on qaulity of life, including mental health. Only two years after the passing of the Refugee Act, the duration of Refugee Cash Assisstance and Refugee Medical Assistance support was halved from 36 months to only 18. In 1991, it shrank again to only eight months, the duration at which it remains.[216] It was not only RCA and RMA that shrank considerably in the first decade after their inception, so too did compensation for state social services which were originally

[215] ibid.
[216] Brown and Scribner, "Unfulfilled Promises, Future Possibilities: The Refugee Resettlement System in the United States,"108

incentivized to support refugees during integration. “The Refugee Act of 1980 stipulated that the federal government would cover all public assistance costs incurred by states for the first 36 months a refugee was in the United States, but this reimbursement was cut entirely in 1990 as part of a broader government drive to reduce expenditure on social welfare programs.”[217] The erosion of federal funding for refugee transition costs decreased the availability of services to refugees and further strained the states, municipalities, and non-profits who absorbed the burden of these services.

After recovering from 9/11, the refugee resettlement program was burdened by high volumes and low funding during the Obama administration. Between FY 2006 and FY 2015, the number of refugees utilizing Refugee Cash Assistance and Refugee Medical Assistance doubled due to higher resettlement numbers and shifting demographics to groups who largely qualified for these programs. In the same timeframe, funding increased by only one third, resulting in a gap between supply and demand for transitional services.[218] In moments like this when funding cannot keep up, trauma and mental health services are easy to sideline due to their invisible nature and the voicelessness of refugees who need assistance.

The resettlement system has also failed to account for the evolving and growing pool of refugees. Prior to the Refugee Act and in the early days of the resettlement program, only specific conflict regions such as Vietnam or Cuba would be deserving of refugee status. The United States has recently accepted refugees from Asia, Africa, Europe, Central and South America, and the Middle East.[219] There are refugees recently settled in the United States from

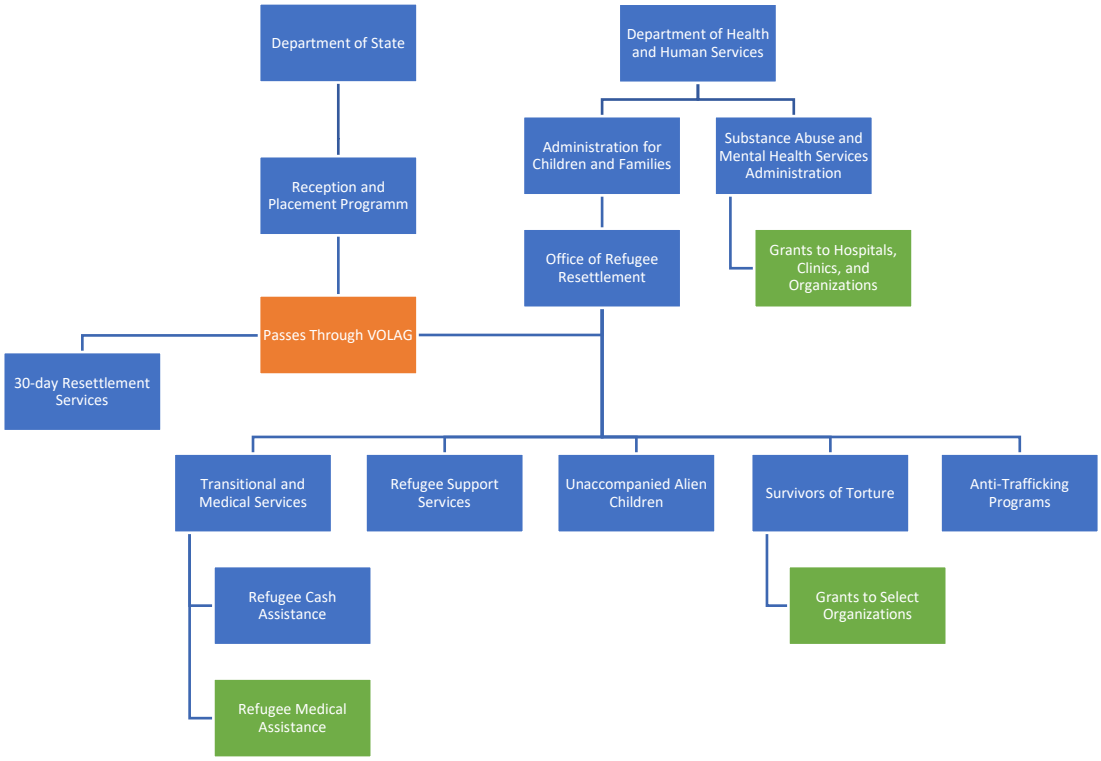
[217] Fix, Hooper, and Zong, "How Are Refugees Faring? Integration at U.S. and State Levels,"8-9
[218] ibid.
[219] "Admissions & Arrivals - Refugee Admissions Report," [cited 2020]. Available from https://www.wrapsnet.org/admissions-and-arrivals/.

dozens of national origins and the resettlement system was not designed to accommodate this. Every year, refugees speaking hundreds of languages are resettled, many of whom have little English ability, and there are often not many other speakers of the same language to assist with interpretation.[220] The increased diversity of languages and cultures heightens the barriers to accessing trauma resources by preventing communication and hindering cultural mediation. A failure of the resettlement system to adapt for the diversification of refugees slows down processes of integration, healthcare, and job placement, while burdening local service providers who do not have access to the resources applicable for all populations. As the U.S. enters an era in which refugee admissions are promised to increase dramatically, it will also experience a demographic shift. During the Trump presidency, the more Christians than Muslims were resettled, which was contrary to previous trends. Going forward, this will likely shift back to predominantly Muslims, and with that will come the need to adjust services accordingly. Additionally, the expansion of the admissions pool indicates an increase in the number of refugees who have experienced traumatic events and it is a disservice not to provide resources to these individuals.

Both growth and shrinkage risk placing strains on the resettlement system just as shifts in demand affect any organization. However, the root of the harm caused to resettlement agencies which hinders the effective allocation of services is the lack of commitment to sufficiently funding resettlement endeavors. The Refugee Act of 1980 put forth a system in which the federal government held the cards and would take responsibility for moderating the flow of refugees and for awarding funds to provide those refugees with much needed transitional services. While the relationship between the federal government, states, and local agencies has remained consistent;

[220] Fix, Hooper, and Zong, "How Are Refugees Faring? Integration at U.S. and State Levels,"1

the federal government has not upheld their responsibilities in this system. Funding has been revoked from purposes for which it was promised, admissions have fluctuated unexpectedly to the point of shuttered offices or overwhelmed services, and budgets have failed to adjust for the effects of inflation; resettlement offices are not provided with the support which they were promised for delivering services.



The funding for refugee resettlement and transition programming all originates from the federal government, but from two primary sources. The Department of State provides funding for the Reception and Placement (R&P) Program, while transitional costs originate from the ORR, part of the Administration for Children and Families in Health and Human Services.[221] [222]

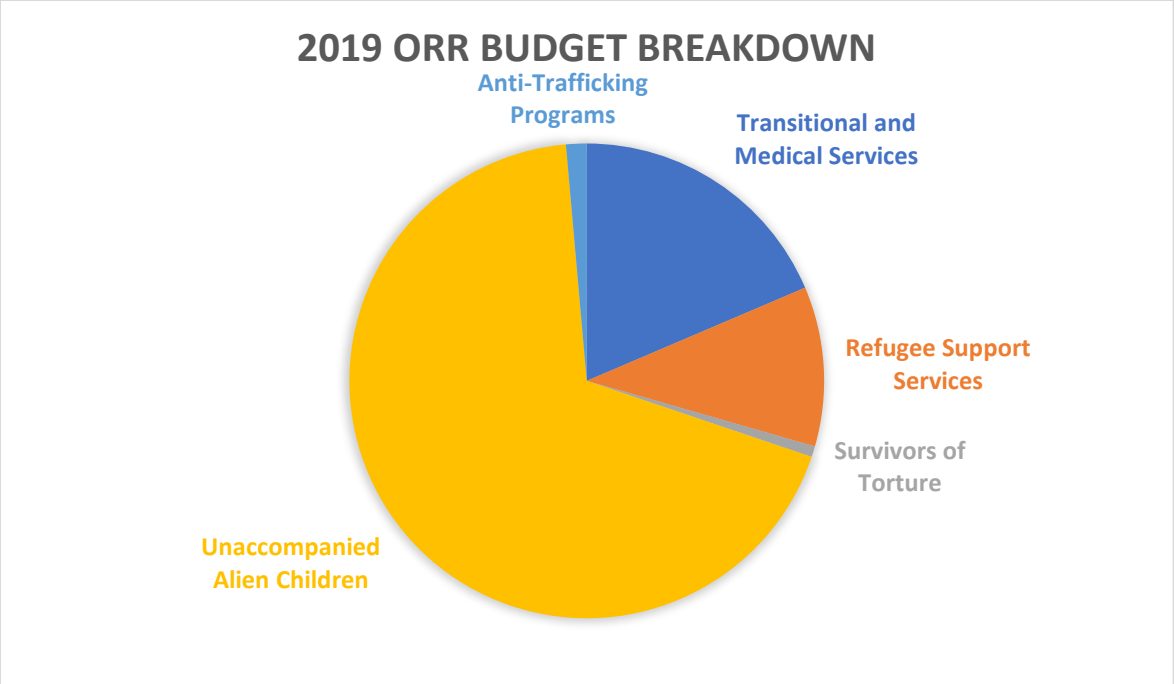
[221] *Congressional budget justification.*
[222] Fix, Hooper, and Zong, "How Are Refugees Faring? Integration at U.S. and State Levels,"7

Both of these funding streams feed into VOLAGs, the nationwide agencies like USCRI or Catholic Charities who have regional offices to manage resettlement and transition programs.

The Reception and Placement (R&P) Program provides funding for resettlement agencies to meet the most immediate needs. These services are applicable only for the first 30 days in the United States. R&P assists with needs such as, "purchasing food and clothing, finding affordable housing, enrolling children in school, receiving English as a Second Language instruction and employment assistance, applying for social security cards, and navigating social services." These services do not include any provision for trauma management or mental health assistance, though the case worker assisting with these other immediate needs could be of use for these purposes. R&P is supported by one-time grants per refugee to provide these services. Any additional costs are absorbed by the resettlement agency themselves. For this reason, these programs suffered because of budget cuts and unpredictable refugee flows until the Obama administration, when they were adjusted for inflation.[223] These are highly necessary services, but they are not a conventional means for addressing trauma.

Funding beyond the first 30-days is delivered via various programs within the ORR. Every year, the ORR is authorized to receive a budget titled 'Refugee and Entrant Assistance Appropriations' from Congress which is to be used for all of their programming. In recent years, this budget has been approximately two billion dollars annually. The ORR funding is then broken down by state and by intended purpose. The following chart displays the breakdown of the ORR budget by purpose on a national level, prior to being specified by state.

[223] ibid.



[224]

The federal government is woefully underfunding refugee resettlement programs due to a failure to introduce legislation which restores previous budgetary cuts, accounts for inflation and cost of living, mediates unpredictable admission numbers. These factors have crippled the resettlement system, with trauma programming being one of the most vulnerable victims. Trauma and mental health slip between the cracks of physical health, social services, and personal or professional integration; thus being easy to neglect when funding is scarce. Despite budgetary instability, the ORR does still provide funding to all states with resettlement programs to manage Transitional and Medical Services and Refugee Support Services, both of which offer avenues for addressing trauma. These pathways to treatment are still inadequate and at the mercy of lackluster funding, but they constitute what is currently available for refugees via federal funding.

[224] *Congressional budget justification.*

Refugee Medical Assistance and Refugee Support Services

ORR transitional services have struggled to keep up with the needs of refugees due to lack of funding and unpredictable admissions. These programs are funded proportional to the number of refugees resettled, but unlike R&P, do not receive a set payment per individual. This means that when the budget does not correspond with the number of refugees, the funding per capita decreases, yet when admissions drop, so too does the funding. This is a double-edged sword for the resettlement agencies providing transitional assistance, because they want higher resettlement numbers, but they have seen that funding does not keep pace with these increases. This is not a new problem, "since 1980 states, local communities, and voluntary agencies have been under increased pressure to make up for funding shortfalls." One previously cited example of underfunding transitional services was the doubling of refugees using Transitional and Medical Services between 2006 and 2015 while the funding increased by only one-third.[225]

Cash assistance and medical assistance are combined into a single budgetary program called Transitional and Medical Services. These complementary programs are provided for eight-months by state agencies or replacement designees, whom the ACF calls 'Private Replacement Providers.' These providers are then reimbursed for cash and medical expenses from the Transitional and Medical Services budget. Refugee Medical Assistance (RMA) provides basic level healthcare, identical to that provided under Medicaid, to refugee populations who do not qualify for Medicaid under their state's guidelines. RMA mirrors other facets of the refugee resettlement program by focusing on the most immediate needs but not extending for long enough to facilitate a full adjustment to America's lifestyle, systems, and economy.

[225] Fix, Hooper, and Zong, "How Are Refugees Faring? Integration at U.S. and State Levels,"9

Because Transitional and Medical Services are always for eight months and are paid as a reimbursement for costs incurred, their budgetary allocation is proportional to the number of refugees settled in each state. Some states receive little or no funding because they have few or even zero resettled refugees. Other states, those with large resettlement numbers, are granted large budgets.[226] When the national Transitional and Medical Services budget is too small for a given year, due to funding cuts or failure to accommodate for increased resettlement and inflation, both large and small states receive less money per capita to provide these essential services. Following the expiration of RMA, refugees are recommended to utilize the health insurance Marketplace to determine eligibility for other governmental plans or to purchase insurance.[227]

'Refugee Support Services' refers to programs to help refugees get on their feet after resettling in the United States. This includes resources and case management to find and maintain a job, along with addressing any barriers that might prevent this such as cultural adaptation, language learning programs, and childcare. Despite placing heavy emphasis on job placement, in relation to trauma management the means may be greater than the end. For some refugees who lack robust social supports or are not receiving adequate case management or medical management, Refugee Support Services may provide programs that reduce daily stress or address underlying traumas. Jobs themselves may be either a risk or a protective factor for different individuals, but assistance with ESL, day care, or citizenship can alleviate some of the greatest stressors in refugees' new lives.[228]

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[226] *Congressional budget justification.*
[227] "Office of Refugee Resettlement (ORR)," [cited 2021]. Available from http://www.acf.hhs.gov/orr.
[228] "Refugee Support Services," [cited 2021]. Available from https://www.acf.hhs.gov/orr/refugee-support-services.

The funding for Refugee Support Services, although also proportional to the number of refugees resettled, works differently than that of Transitional and Medical Services. Refugee Support Services utilize a five-year service duration, compared to the eight-month duration of RCA and RMA. "States can provide services to refugees who have been in the country up to 60 months (5 years), with the exception of referral and interpreter services and citizenship and naturalization preparation services, for which there is no time limitation." This enables funding to be calculated differently to account for the population being served. Rather than being reimbursed according to the number of refugees resettled, coordinating state agencies and replacement designees are awarded funds based on yearly resettlement records but to accommodate for a wider constituency of service recipients.[229]

Refugee Medical Assistance and Refugee Support Services each provide necessary resources early in resettlement. These are the ORR services which most directly translate to alleviating trauma. Despite being the most applicable, these services are still underfunded, composing only one third of the already small ORR budget. The funding is spread thin when considering the trickle-down to the refugee coordinator for each state and then often to agencies or offices which serve different regions. Lastly, it is important to note that there is not a separate budget for longer-term social work and case management to assist with accessing medical resources or forming community networks, two forms of trauma mediation. Annual budgeting for refugee services assists with the basic necessities of resettlement but does not extend far beyond this, especially in relation to trauma or mental health.

[229] ibid.

Governmental Grants

While the ORR budget covers the programs which ought to be provided relatively equally across the nation, there are also grants from the federal government that are awarded by request to individual states or offices. The Administration for Family and Children utilizes different funding cycles—often one, three, or five years—to deliver funding for individual programs offered at a particular agency. These can be grants for more targeted and specific purposes. For example, the Services for Survivors of Torture program provides grants to some states specifically for torture services. Other grants are made to support a particular initiative which is tailored to the needs of the community being served. Grants offer a more adaptable way for resettlement offices to run pilot programs including trauma management with the assistance of the federal government.

The Services for Survivors of Torture Program (SSTP) is one of the most common funding sources for trauma management. SSTP is a program within ORR which, despite the ambiguity in the term 'torture,' is highly targeted to treat trauma. SSTP receives the smallest portion of ORR's budget.[230] Unlike other segments of the ORR budget, not all states with a Refugee Coordinator receive funding correspondent to the number of refugees settled there. Funding instead goes to individual programs, including those at hospitals or non-profits. As such, some states may have multiple programs which receive funding while others have none.[231]

STTP grants are not distributed formulaically, rather they require an application process which demonstrates a large population in need and a means to assist them. Services in states with

[230] *Congressional budget justification.*
[231] "Services for Survivors of Torture," [cited 2021]. Available from http://www.acf.hhs.gov/orr/services-survivors-torture.

large resettlement numbers are far more likely to receive these grants.[232] Community organizations, VOLAGs, and healthcare providers can receive "Direct Services for Survivors of Torture grants," which "are designed to provide holistic, strengths-based, and trauma-informed services to survivors of torture and their families to assist them in the healing and recovery process." Receipt of these grants is uncommon given the small budget of SSTP, with only 34 programs funded by the ORR in 22 states. The grants awarded by SSTP are on three year cycles but can be applied for repeatedly if desired.[233] Despite being a small program, SSTP has proven to assist with defraying the cost of proper resettlement or at least be correlated with better resourced states, with "two thirds of the states with a SSTP reported screening for exposure to torture, while fewer than one third of states without SSTP do."[234] SSTP is too small of a program in budget and volume of awards to largely impact the nationwide resettlement process, but it promises to increase highly essential resources for those who settle in an area served by an SSTP grantee.

Funding for refugee programming is not necessarily isolated to the ORR. While it funds the bulk of services for refugees, including those for physical and mental health or for trauma, various other agencies within the federal government award grants which serve refugee communities. Federal grants for specific programming purposes are awarded for a few years then re-evaluated to determine if they are deserving of renewed funding in the current situation. While the three- or five-year grants which are commonly awarded provide more stability than the one-year funding intervals for resettlement programs, it is impossible to determine how many rounds

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[232] Patricia Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators," *Journal of immigrant & refugee studies* 10, no. 4 (2012)386

[233] "Services for Survivors of Torture,"

[234] Shannon et al., "Screening for War Trauma, Torture, and Mental Health Symptoms Among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators,"388

of funding a grant will deliver. It is common to implement a program on a multi-year grant but for the program to not last beyond a single funding cycle, causing a community to lose a service and an agency to re-distribute their staffing and priorities.[235]

USCRI Albany experienced this with their Refugee Family Strengthening Program. The agency was awarded a five-year grant from the Office of Family Assistance to implement the Refugee Family Strengthening Program until 2020. The Office of Family Assistance called for another round of funding and USCRI applied again but was not awarded renewed funding. It is typical to require re-application to a previously awarded grant and this is not because the Office of Family Assistance has run out of the fund, but because they must reevaluate recipients and rewrite their contract. This cycle, it is possible that the political and pandemic conditions at the end of 2020 impacted the renewal of grants. The loss of a single grant can be the sole determinant of whether or not an agency is able to provide specialized services like trauma management and domestic counseling. When the Refugee Family Strengthening Program at USCRI learned that it would not be receiving continued funding from the Office of Family Assistance, they began to evaluate private sources of funding.[236]

Private Grants

The failure of the federal government to adequately fund resettlement programming forces many refugee support services into the private realm. These organizations can provide services which are not offered at all by the federal government or extend services beyond the short timeframe of governmental assistance. Local level programming is often funded through private grants issued by organizations focused on refugees or on a geographic region. For

[235] . "Interview of Grace Dun." (2020b):
[236] ibid.

example, when the Refugee Family Strengthening Program at USCRI ended its federal funding cycle, they began looking for private grants to continue the program despite a withdrawal of funding. Similarly, non-profits such as MANA and MAIN receive grants from various other organizations to support specific projects or operational costs. Private grants allow local level services to exist without the support of federal or state agencies.

The Maine Association for New Americans (MANA) is a great example for examining the reception of private grants because they do not receive zero federal funding. MANA receives grants primarily from local organizations focused on community development initiatives in New England. These have come in different sums and for different purposes. In the past year, response to the COVID-19 crisis and racial injustice have each prompted the creation of additional grants, some of which have benefited community-building organizations.[237]

Grantor	**Elmina B Sewall Foundation**	**Maine Community Foundation**	**Haymarket People's Fund**	**Grass Roots Fund**
Organization Purpose	Assists organizations across Maine in cultivating social equity and community resilience	Seeks to improve quality of life for people in Maine	Strengthens social justice across New England, focusing on empowering communities and fighting injustices	Provides funding and guidance to organizations in New England across all sectors of community services
Grant Purpose	Rapid Response Fund to assist with COVID-19 programming	Two grants recently received; one for COVID-19 response work, the second for the Investing in Leaders of Color program to support community non-profits working towards equity	To sustain operating and programming costs necessary for promoting multi-cultural communities and addressing racial disparities	General programming or COVID-19 response

238 239

[237] Author, "Interview of Abbie Yamamoto," (2020):
[238] "Maine Association for New Americans," [cited 2021]. Available from https://www.mana-maine.org.
[239] Author, "Interview of Abbie Yamamoto,"

Local organizations also receive donations from individuals and local businesses which help defray operating costs. For example, this winter MANA received a donation from local brewery Allagash Brewing Company as a 'thank you' for their work to support the immigrant community during COVID-19. Most non-profits have a donation button on their website and use marketing initiatives to solicit donations from community members. While these revenue sources may be unpredictable and small, they support operating costs that allow non-profits to serve their communities.

Private grants are not always regionally exclusive, in fact many foundations fund non-profits across the entire nation who focus on a specific topic. Organizations like the Global Whole Being Fund focus on refugee issues while the Bristol-Myers Squibb Foundation focuses on mental health access. Others, including for-profit corporations, regularly issue grants that focus on racial or economic justice, which many community-level refugee organizations qualify for. These non-governmental funding sources introduce billions of dollars in funding that can be utilized by local organizations. These funds are distributed across the country and are not typically recurring, so they do not guarantee a consistently high level of services for all communities, but they increase accessibility for refugees.

Non-governmental grants from local and national foundations or businesses offer one means of compensating for lackluster government funding of refugee services. Private funding is applicable both for independent non-profits, like MANA, and for government contracted resettlement agencies to run additional programming, like the USCRI Refugee Family Strengthening Program. While grants often come in relatively small values, there are endless sources of funding and grants are available for nearly any purpose, making them quite flexible for organizations with the resources to apply. For small non-profits, grants and donations can

sustain entire budgets of staffing, operating expenses, and specialized programming. Private grants should not be as essential as they are, currently bearing the burden of programming which could be government-run, but they offer an invaluable form of supplemental funding for trauma management services. An increase in the support of governmental grants or the formation of agencies which provide social and medical services for refugees would alleviate the pressure on non-governmental organizations and provide greater equity across the country.

Conclusion

The Refugee Act of 1980 established the resettlement system as we know it. 40 years later, legislation has overwhelmingly failed to evolve. Perhaps more importantly, funding has come under attack and has failed to adjust when admissions and costs change. Despite resettling more refugees than any other nation, the US is failing to provide for these individuals. A study conducted by the Committee on Foreign Relations found that "resettlement efforts in many U.S. cities are underfunded, overstretched, and failing to meet the basic needs of the refugee populations they are currently asked to assist," recommending that " the Federal Government do more to support and resource the local communities who bear the responsibilities of receiving this increased flow."[240] When services are underfunded, it not only harms the individual refugees, but it also risks crippling or destabilizing local resettlement offices.

The hesitancy to properly fund the resettlement and transition process stems from the fiscal ethos of the United States which conventionally balks at expending resources on social services. It could also be that the current system, despite objectively failing refugees on trauma care, cultural integration, and transitional assistance, has largely met the goals set out in the

[240] Committee on Foreign Relations, "Abandoned Upon Arrival: Implications for Refugees and Local Communities Burdened by a U.S. Resettlement System That Is Not Working," *United States Congress* (2010):

Refugee Act of 1980. “The goals of the U.S. resettlement program are twofold: to protect vulnerable populations and to offer them the prospect of long-term integration.” Until the Trump administration, funding was scarce, yet vulnerable populations were received at a satisfactory rate and, on economic metrics, were successfully integrated. “Newly arrived refugees tend to enter into employment quickly in the United States, with employment rates close to those of the U.S.-born population. About half of newly arrived refugees who participate in resettlement assistance programs enter employment within eight months.” In a system that prioritized self-sufficiency from the beginning, the erosion of services has been justifiable despite imperiling refugees’ integration.[241]

Today, progressives are championing the move of President Biden to increase the refugee cap from 15,000 to 125,000 annually. But intake must not be confused with proper transition. With the heightened refugee cap, significantly more funding must be allocated for assistance programs to avoid further degrading the quality of services to refugees. To accept up to ten times the number of refugees without reforms to the resettlement system, which was already weak and suffered innumerable wounds under Trump, would predict poor quality of services for those who are resettled in the United States. Governmental response to refugee trauma management remains woefully underfunded. While billions of dollars are spent in total both abroad and on U.S. soil for the assistance of refugees, these funds are spread thin and allocated to only the most immediate of needs, not to lasting support such as mental health. The quotas set by the president and the funding allocated by Congress are detached from the experiences of local resettlement offices and have not allowed for an expansion or even maintenance of services. The new presidential administration promises to remedy this plight, but the reality is that policy reform

[241] Fix, Hooper, and Zong, "How Are Refugees Faring? Integration at U.S. and State Levels,"1-3

and increased spending will both be necessary and might be hard to attain. Private funding streams currently fill the voids in government provisions, as has been the case with the delivery of services as well, but this system continues to fall short of the federal government's responsibility to provide processing, orientation, placement, and resettlement assistance.

Trauma management has remained easy to ignore due to high cost of delivery, cultural barriers, and the privacy of mental health; but it remains an essential component of resettlement. When refugees are unable to access the resources that they need, their chances of successful integration are harmed. Refugees offer great benefits to the United States, but they require support, and this is one instance where they receive nearly none because it is a low priority and easy to ignore. It is crucial for refugee communities and the success of the United States' resettlement program to increase funding and service levels for social programs that will relieve the burden on local resources and bring the American Dream within reach for refugees.

Chapter 6: Conclusion

Intro

The United States has a remarkably impressive resettlement program which has historically resettled more refugees than any other nation. Despite this statistical success, the U.S. is driven by federalist and laissez-faire policies that all but absolve the federal government from the responsibility to provide direct services to residents except for defense. The result is a massive amount of capital dedicated to efforts which exacerbate global trauma and humanitarian harm coupled with minimal capital for alleviating it. Actions like offensive war efforts abroad, militarization of the borders, mass deportation, and strict legal migration policies cause harm to migrant groups while few resources are dedicated to remedying these harms. The country has

reached a moment in which the role of the federal government in people's lives and well-being has been called into question, with this comes an opportunity to debate the commitments owed to refugees.

It is widely acknowledged that refugee crises are often the result of weak or failed states that lack control over their borders and citizens. Dramatized by colonization, poverty, or militia groups; weak nations like the DRC, Myanmar, and Afghanistan are primed for conflict and humanitarian crisis. These countries do not typically have the resources to provide meaningful support for their citizens or those resources are utilized to inflict harm. The United States also at times causes trauma and fails to responsibly manage it. Especially in recent years, the United States has invested heavily in the militarization of its borders and creating additional obstacles to migration. This, coupled with a historically heavy emphasis placed on strong vetting processes, means that fewer people are entering the country than would be optimal. Those who are resettled here do not have access to the resources that they need.

This begs the question of what the obligation of the country is to refugees and their trauma. The United States claims to be a world leader in providing refuge, but what does this truly mean? Research continually tells us that what is good for refugees is good for the country, including in economics and healthcare. Bringing more immigrants and refugees to the country grows the American economy. But what resources are necessary to reap these benefits and how does the country ensure that it supports refugees the same way that they support it? The United States is committed to resettlement but not always to holistic integration and the obligations that come with this.

Direct services to refugees, or even whether or not to accept refugees, is a toxic subject. America needs workers yet tends to despise those with different skin colors, languages, cultural

practices, or religions than those of the current majority. This toxicity has fueled fierce debate and contributed to ongoing traumatization of refugee populations through social discrimination, hardline policies, and the deprivation of integration services. Refugees are distinct from other immigrant populations in that their status, unlike that of asylum seekers or economic migrants, validates their entitlement to some services. While refugees are offered transitional resources, these are not always adequate, as has been displayed through the lens of trauma care. Refugees and other migrants are admitted to the country but granted as few rights and resources as possible, with high barriers to citizenship or personal and professional integration due to the toxicity of immigration in American politics.

Steps have already been taken by the newly elected Biden administration to reform some of the most perverse facets of the refugee system. One of the most critical of these actions was a declaration to speed up refugee admissions and plans for a capacity of 125,000 for next year. President Biden also used an executive order to command the Department of Homeland Security to revive part of Central American Minors, a program to consider refugee status for family members of legal residents living in at-risk areas.[242] During the Trump administration's tenure, refugees who had already been screened and promised admission were never admitted to the country. These policies induced unnecessary trauma to refugees who were legislatively excluded and politically demonized. However perverse the cause, Trump's policies also sparked important debate regarding what, if anything, is owed to refugees in his attempts to stop migration to the country. This is a debated that deserves to live beyond President Trump's removal from office.

[242] "Breaking Down Biden's Immigration Actions Through Abbreviations," February 16, [cited 2021]. Available from https://www.cfr.org/in-brief/breaking-down-bidens-immigration-actions-through-abbreviations.

While rolling back Trump-era policies and rhetoric promises to positively impact the mental well-being of refugees and allow them to integrate more readily, some of the Biden administration's proposed policies present risks. Ramping up resettlement presents a possibility of straining the already crippled trauma management mechanisms in the United States. Increased resettlement means more people with trauma from experiencing globalization, climate change, civil wars, and genocide. Also, more resettlement and fair migration will affect what kinds of people come into the country; they will come from an increased number of cultures with more diverse languages and religious beliefs. These refugees will require case managers, interpreters, culturally informed medical personnel, and education about treatment systems—the United States lacks the legislation and budget potential to accomplish these goals.

Even the most progressive components of President Biden's proposed reforms fall short of enabling widespread expansion of refugee services. The country has been persuaded that Joe Biden is the man to resolve our crippled refugee and immigration practices. News headlines since the election have touted that 'fixing immigration systems will be harder than simply rolling back Trumpian policies,' a statement almost ironically obvious. The United States is at a breaking point regarding immigration including refugees. A point at which we are forced to grapple with what is owed to refugees as we hopefully exit the era of simply arguing whether we should allow entrants. Dramatic reform to the resettlement system is needed, but first we must identify what is promised to refugees and what is currently being provided.

The Role of The United States

Refugees can originate from nearly any region of the world with dozens or hundreds of conflicts ongoing at any moment. There are currently 79.5 million forcibly displaced persons in

the world and only a small portion of these have been or will be resettled to developed nations.[243] In fact, as of 2019, "less than 0.25 percent of the global refugee population was resettled, and around 80 percent of the refugee population was hosted in developing countries."[244] Different than general populations, refugees are highly likely to be exposed to ongoing and compounding traumas. Phenomena such as globalization, climate change, civil war, genocide, and persecution touch the lives of millions of people who are displaced from their homes against their will. Frequently reported and highly harmful experiences include loss of family members, rape, loss of home, forced labor, and physical attacks. These take place not from a baseline of stable daily life but from a place of instability and insecurity. Countries like Myanmar, Afghanistan, and the Democratic Republic of Congo are engulfed in sociopolitical situations that predict continued and widespread trauma, with limited opportunity to escape. There are already millions of displaced persons and the number of refugees continues to increase. The refugee experience presents myriad traumatic experiences and severe daily stresses which makes this population different from others.

Many refugees are made more resilient by their pre-migration experiences, but that does not preclude them from needing resources for mental health education and rehabilitation. The migration process and life in a new culture can present additional stressors which exacerbate previous traumas or slow the healing process. For these reasons, it is necessary to provide trauma management resources to refugees in the period following their resettlement in the United States. To do so increases the possibility for successful integration, benefiting the refugee and the host country. This responsibility currently lies primarily with non-state organizations because the

[243] "Figures at a Glance," June [cited 2021]. Available from https://www.unhcr.org/figures-at-a-glance.html.
[244] Silva Mathema and Sofia Carratala, "Rebuilding the U.S. Refugee Program for the 21st Century," *Center for American Progress* (2020)

government chooses not to take on the task of managing individuals' mental health. The United States has neglected to focus much on health and social services for refugees, preferring instead to focus on the necessary resources for self-sufficiency. This is in-line with general governmental philosophy in the country, wherein economic growth is prioritized over individual well-being. To deviate from this philosophy for refugees would require justification. It is my opinion that the hardships frequently faced by refugees prior to and sometimes during resettlement make them deserving of enhanced support in order to better provide for the self-sufficiency and societal integration that the resettlement system promises.

The Office of Refugee Resettlement provides cash and medical assistance along with resources for self-sufficiency including case management, English language learning, and job placement. These services provide considerable benefit to refugees and exhibit a dedication of the federal government to enabling self-sufficiency. However, the ORR does not provide funding or programming for social integration services such as cultural groups, connection to local resources, or help navigating the housing system. Services for individual and community well-being are placed at a lower priority than those for self-sufficiency, reflecting an economics-first approach which risks failing to address the true needs of refugees in achieving successful integration.

The United States resettlement system, in place since 1980, is one of the most successful in the world, yet it fails to meet the needs of many refugees. Based in individualist and anti-welfare sentiments, the federal government has chosen to offer barebones services to refugees even when there is demonstrated need for more resources. Budgets are tight for resettlement agencies and there is limited oversight. The result is that low-priority services like trauma management go unaddressed, to the detriment of refugees and the country. This is not for a lack

of trying. In fact, it appears that local resettlement offices are doing all that they can, yet they do not receive the necessary guidelines or funding from the federal government. Because the federal government controls admissions, funding, and policy; it is the responsible of the President, Congress, and the ORR to ensure that these variables correlate with one another and are satisfying the needs of refugees and their receiving communities.

Policy Recommendations

It is easy to place blame on the Trump administration for inflicting trauma upon immigrant populations and decimating refugee services. While this is accurate, the resettlement system has been weak for decades, being unable support receiving communities or refugees themselves. Therefore, I suggest that what is necessary is not a reversal of President Trump's actions but rather an expansion of refugee services back to and above their intentions at the creation of the resettlement program in 1980. The Refugee Act at its inception reflected the anti-welfare narrative of the times and defined role of resettlement as sheltering individuals from persecution and allowing them to become self-sufficient. As we enter an age of discussing expansions to public healthcare, student loan forgiveness, stimulus checks or even universal income, and other social safety nets; now is the moment to re-evaluate the emphasis placed on self-sufficiency during immigration or resettlement. We reference the American Dream—the potential for happiness and upward mobility—but neglect to even mention the largest barriers to this such as the resources to achieve stable mental health and a resilient mindset.

My recommendation to the Biden Administration is to view the reform of refugee policy not as an undoing of Trump-era harms but as an elevation of American refugee services to the level that they should be at. The resettlement process itself is wrought with stress-inducing interviews, evaluations, and separations which could be reformed. More importantly, the United

States lacks a uniform system to mitigate and rehabilitate trauma in the months and years following resettlement. If the goal is self-sufficiency, refugees ought to be given resources to level the playing field with other Americans seeking the same. When starting from a disadvantage, this means providing the language learning, social integration, and trauma management services necessary to achieve self-sufficiency and social stability.

The first step in trauma management during resettlement should be ensuring that all refugees are screened for mental health symptoms. This currently relies on a haphazard system in which the ORR states that resettlement agencies are obligated to conduct these screenings, yet fails to provide the funding, guidance, and oversight to ensure that this takes place. The result, as seen in academic studies and anecdotally, is that only some states screen for mental health symptoms and there are inconsistencies within the states as well. To eliminate the inconsistencies between local agencies, the federal government should include mental health evaluation by professionals in the pre-arrival screening process.

> This can begin by consolidating the US State Department's workup of prospective refugees, which currently entails multiple clinical evaluations and interviews, into one exam that includes a robust behavioral health screening component… This would reduce the burden placed on domestic agencies, especially in low-resource areas, that might not have access to specialists and culturally informed providers during the resettlement process.[245]

Streamlining the screening process not only ensures that every refugee receives mental health evaluation, but it also relieves other stressors. This proposal would decrease the stress of the disjointed interview system and relieve responsibilities from local agencies who have proven to be overburdened and underfunded.[246]

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[245] Amir Afkhami et al., "Addressing the Invisible Affliction: An Assessment of Behavioral Health Services for Newly Resettled Refugees in the United States," *Journal of international migration and integration* 20, no. 1 (2019)254

[246] Committee on Foreign Relations, "Abandoned Upon Arrival: Implications for Refugees and Local Communities Burdened by a U.S. Resettlement System that is not Working," *United States Congress* (2010):

Once in the United States, there are additional changes to the services of resettlement agencies that would help to better connect refugees with the resources that they need. This responsibility falls on both the federal government for its role in funding and oversight and on local agencies for creating programming that meets their community's needs. Resettlement agencies should be mandated to have a program dedicated to trauma which is funded through the federal budget as an expansion of Refugee Support Services, which provides 5-year transitional services such as job placement, ELL, and naturalization services. This is the proper place to house trauma services because "policies and programs that support refugees to find employment and build social capital and connection in their new communities could substantially reduce mental health symptoms and adjustment difficulties."[247]

Trauma management programs in Refugee Support Services would be able to utilize information from the improved screening system to connect individuals with healthcare providers who are prepared to address their potential needs. Like existing aspects of Refugee Support Services such as vocational training or childcare, trauma management will not be needed by every refugee, but it is essential that it is made accessible and is informed by systematically collected information provided before the individual even arrives. It is important that a program such as this is implemented and that it is reviewed by ORR to ensure it is practiced. Currently, even the scant programs that do exist are often applied unequally between agencies due to the lack of ORR supervision. More oversight will be necessary to ensure that federally required services are consistently delivered.[248]

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[247] Susan S. Y. Li, Belinda J. Liddell, and Angela Nickerson, "The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers," *Current psychiatry reports; Curr Psychiatry Rep* 18, no. 9 (2016): 1-9.

[248] Afkhami et al., "Addressing the Invisible Affliction: An Assessment of Behavioral Health Services for Newly Resettled Refugees in the United States,"254

I also recommend restoration of the original 36-month duration for Refugee Medical Assistance and Refugee Cash Assistance. Eight months is too short a duration of social safety nets for individuals with no connections, English skills, or job prospects. This need was recognized in 1980 at the passing of the Refugee Act, when refugees were granted RMA and RCA for 36-months, but commitment to long-term care has been weak since the decrease to eight-months. The duration of care is especially relevant for mental health because trauma has proven to have long-lasting impacts. Refugees experience mental disorders at a higher rate than the general population and this holds true even years after resettlement. "The findings indicate generally high prevalence rates of depression, PTSD and other anxiety disorders among refugees 5 years or longer after displacement, with prevalence estimates typically in the range of 20% and above."[249] While services cannot be provided indefinitely, the restoration of 36-month RMA and RCA funding would enable refugees to access needed care for mental health while alleviating financial burden and stress during the early years of resettlement.

A final recommendation is to recognize the importance of minimizing harm and distress in the resettlement process. As has been discussed; separation, uncertainty about status, and outright discrimination on the basis of race or religion are traumatic experiences. So too is the economic precarity which most refugees face upon resettlement. These are obstacles which the United States government can resolve through the implementation of humane policies. Research regarding the impact of transit and migration exhibits that "moving away from policies that have detrimental effects on refugee mental health, such as prolonged detention and ongoing temporary protection, may remove additional stressors experienced by refugees and result in better mental

[249] Marija Bogic, Anthony Njoku, and Stefan Priebe, "Long-term mental health of war-refugees: a systematic literature review," *BMC international health and human rights; BMC Int Health Hum Rights* 15, no. 1 (2015): 29.

health outcomes."[250] Improving these mental health outcomes helps individual migrants by improving their lives, but it also decreases the waste of resources on assisting these individuals and allows them to better contribute to society.

A commitment to minimizing migration trauma and socioeconomic stress is crucial because the United States presents itself as the solution when, in fact, current detrimental practices make it part of the problem. "Two consistent risk factors predicting higher rates of mental disorders have emerged from the cumulative body of research: past traumatic experience and the post-migration socio-economic situation"[251] The United States frequently has little control over the political state of other nations, but the President and Congress have significant control over the immigration systems and socioeconomic precarity. Bills are actively being presented regarding the former, but it is important that these succeed and continue to be pushed. The latter can be addressed through job training, minimum wages, and social services.

The Refugee Act of 1980 states: "The objectives of this Act are to … provide comprehensive and uniform provisions for the effective resettlement and absorption of those refugees who are admitted." The current refugee program takes this to mean that the United States owes refugees a safe home but little more. Going forward, the nation must implement policy changes that expand the resettlement system to a new standard of well-being and integration beyond absorption. The country has witnessed forty-years of a shrinking and struggling system without the introduction of revised policies to bring refugee resettlement up to twenty-first century standards. I urge President Biden to not only reverse traumatic Trump-era policies, but to implement a comprehensive single screening procedure for all refugees prior to

[250] Li, Liddell, and Nickerson, "The Relationship Between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers,": 1-9.
[251] Bogic, Njoku, and Priebe, "Long-term mental health of war-refugees: a systematic literature review,": 29.

arrival, a mandate for trauma-specific programming at resettlement agencies overseen by ORR, and a restoration of 36-month RCA and RMA benefits to mediate transitional stresses and guarantee access to healthcare. These policies will ensure that refugees have a strong basis upon which to build their lives in America and that the burden of refugee services will not rest so significantly on resettling communities.

Next Steps

Policy reform to provide increased services for addressing trauma in refugee populations is, in my opinion, an aspirational but essential goal. In our divided political climate, or crisis if you will, this realistically will not fly. Afterall, just a few months ago nearly half of the country voted in favor of a man who slashed refugee arrivals and programs. Now that the boogeyman of immigration—Donald Trump—is gone, America is left with broken systems that reflect his legacy and our apathy towards refugees. Trump epitomized the threats to immigration and refugee programs, sparking fierce discussion or perhaps fighting over the protection of these systems. With Trump removed from office, this tenacity must continue but it ought to revolve around reckoning with the true role of our government, not simply protecting these age-old institutions. We are trying to salvage a refugee system which will never be perfect.

It is my opinion that services direct to refugees should be expanded, but in a climate where this may be unpopular, I am calling on the Biden administration to push through detention and deportation reform, minimum wage increases, and healthcare accessibility reform. These are the blanket policies that will stop the exacerbation of refugee traumas. I do not believe that in our divided state any administration could achieve fundamental reform of the refugee system, but I believe in the ability of the Biden administration to return humanity to immigrants and elevate them with policies that have popular support.

After decades of stagnancy in refugee reforms, the failures of the Trump administration have brough this issue to the forefront. Joe Biden campaigned on a promise to ‘do the right thing’ for refugee and immigrant communities, thus far having gotten straight to work undoing Trump’s actions. But simply reversing the perverse policies of the Trump-era does not fix the problems which America has been ignoring for decades. There may not be a ‘right thing’ for Biden to do or a consensus on what America owes to the refugees who it resettles, but the core principle must be that America owes these groups dignity and humanity. In the short term, this means bringing an end to activities which exacerbate trauma and mitigating harm through quality-of-life legislation.

Bibliography

"Admissions & Arrivals - Refugee Admissions Report." Worldwide Refugee Admissions Processing System. Accessed 1/24/, 2020. https://www.wrapsnet.org/admissions-and-arrivals/.

"Adult Case Management." Gateway Community Services. https://www.gatewaycommunityservice.org/adult-case-management/.

Congressional Budget Justification: Department of Health and Human Services, 2020a.

Domestic Mental Health Screening Guidelines - Immigrant and Refugee Health, 2019a.

"Emotional Wellness." Administration for Children and Families. Accessed Dec 21, 2020. https://www.acf.hhs.gov/orr/emotional-wellness.

"Fragile States Index." The Fund for Peace. Accessed March 7, 2021. https://fragilestatesindex.org/.

"Home." Whitney M. Young, Jr. Health Center. Accessed January 12, 2021. https://www.wmyhealth.org/.

. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC, e.

"The Life of South Sudanese Refugees in Uganda on Hold: Beatrice's Story." Oxfam. Accessed Jan 25, 2021. https://www.oxfam.org/en/life-south-sudanese-refugees-uganda-hold-beatrices-story.

"Health Care Access and Social Services for the Portland, Maine Immigrant Community." Maine Access Immigrant Network (MAIN). Accessed January 11, 2021. http://main1.org/.

"Maine Association for New Americans." Accessed Feb 8, 2021. https://www.mana-maine.org.

"Office of Refugee Resettlement (ORR)." Administration for Children and Families. Accessed Jan 2, 2021. http://www.acf.hhs.gov/orr.

"President's Fiscal Year 2020 Budget." Department of Homeland Security. Accessed Feb 4, 2021. https://www.dhs.gov/news/2019/03/18/president-s-fiscal-year-2020-budget.

"Refugee Health Guidelines | Immigrant and Refugee Health" Centers for Disease Control. Accessed Jan 9, 2021. https://www.cdc.gov/immigrantrefugeehealth/guidelines/refugee-guidelines.html.

"Refugee Support Services." Administration for Children and Families. Accessed Feb 5, 2021. https://www.acf.hhs.gov/orr/refugee-support-services.

Resettlement Process for U.S.-Bound Refugees: Pew Research Center. 2019d.

"Services for Survivors of Torture." Administration for Children and Families. Accessed Feb 2, 2021. http://www.acf.hhs.gov/orr/services-survivors-torture.

Torture Victims Relief Act of 1998, 105 U.S.C. § 320 (1998).

"Trauma and Shock." American Psychological Association. Accessed Mar 8, 2021. https://www.apa.org/topics/trauma.

United Nations Issues: U.S. Funding to the U.N. System. Congressional Research Service, 2020.

"Violence in the Democratic Republic of Congo." Council on Foreign Relations. Accessed Nov 14, 2020. https://cfr.org/global-conflict-tracker/conflict/violence-democratic-republic-congo.

"War in Afghanistan." Council on Foreign Relations. Accessed Mar 7, 2021. https://cfr.org/global-conflict-tracker/conflict/war-afghanistan.

"Who are Burma's Minority Groups?" *BBC News*, November 18, 2010. https://www.bbc.com/news/world-asia-pacific-11620652 (Accessed January 4, 2021)

Administration for Children and Families (ACF). "Unaccompanied Alien Children (UAC) Program Fact Sheet." Accessed Feb 3, 2021. https://www.hhs.gov/programs/social-services/unaccompanied-alien-children/program-fact-sheet/index.html.

Afkhami, Amir, Amir Afkhami, Katy Gorentz, and Katy Gorentz. "Addressing the Invisible Affliction: An Assessment of Behavioral Health Services for Newly Resettled Refugees in the United States." *Journal of International Migration and Integration* 20, no. 1 (Feb 15, 2019): 247-259.

Ainamani, Herbert E., Thomas Elbert, David Kani Olema, and Tobias Hecker. "Gender Differences in Response to War-Related Trauma and Posttraumatic Stress Disorder – a Study among the Congolese Refugees in Uganda." *BMC Psychiatry; BMC Psychiatry* 20, no. 1 (2020): 17.

Alemi, Qais, Sigrid James, Romalene Cruz, Veronica Zepeda, and Michael Racadio. "Psychological Distress in Afghan Refugees: A Mixed-Method Systematic Review." *Journal of Immigrant and Minority Health* 16, no. 6 (2013): 1247-1261.

Author. *Interview of Abbie Yamamoto.* 2020a.

———. *Interview of Apollo Karara.* 2020b.

———. *Interview of Gabrielle Lodge.* 2021.

———. *Interview of Grace Dun.* 2020c.

Benson, Molly A., Saida M. Abdi, Alisa B. Miller, and B. Heidi Ellis. "Trauma Systems Therapy for Refugee Children and Families." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 243-259. Cham: Springer International Publishing, 2018.

Bogic, Marija, Anthony Njoku, and Stefan Priebe. "Long-Term Mental Health of War-Refugees: A Systematic Literature Review." *BMC International Health and Human Rights; BMC Int Health Hum Rights* 15, no. 1 (2015): 29.

Terror & Hope: The Science of Resilience. Directed by Bourke, Ron. Collective Eye Films, 2020.

Bronstein, Israel and Paul Montgomery. "Psychological Distress in Refugee Children: A Systematic Review." *Clinical Child and Family Psychology Review* 14, no. 1 (2011): 44-56.

Brown, Anastasia and Todd Scribner. "Unfulfilled Promises, Future Possibilities: The Refugee Resettlement System in the United States." *Journal on Migration and Human Security* 2, no. 2 (2014): 101-120.

Cardozo, Barbara, Oleg Bilukha, Carol Crawford, Irshad Shaikh, Mitchell Wolfe, Michael Gerber, and Mark Anderson. "Mental Health, Social Functioning, and Disability in Postwar Afghanistan." *JAMA: The Journal of the American Medical Association* 292, (2004): 575-84.

Carlsson, Jessica and Charlotte Sonne. "Mental Health, Pre-Migratory Trauma and Post-Migratory Stressors among Adult Refugees." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 15-35. Cham: Springer International Publishing, 2018.

Cheatham, Amelia. "Breaking Down Biden's Immigration Actions through Abbreviations." Council on Foreign Relations. Accessed Feb 21, 2021. https://www.cfr.org/in-brief/breaking-down-bidens-immigration-actions-through-abbreviations.

Chen, Alexandra, Catherine Panter-Brick, Kristin Hadfield, Rana Dajani, Amar Hamoudi, and Margaret Sheridan. "Minds Under Siege: Cognitive Signatures of Poverty and Trauma in Refugee and Non-Refugee Adolescents." *Child Development* 90, no. 6 (2019): 1856-1865.

Chu, Tracy, Allen S. Keller, and Andrew Rasmussen. "Effects of Post-Migration Factors on PTSD Outcomes among Immigrant Survivors of Political Violence." *Journal of Immigrant and Minority Health* 15, no. 5 (2013): 890-897.

Chughtai, Alia. "Afghanistan: Who Controls What." Al Jazeera. Accessed Jan 24, 2021. https://www.aljazeera.com/news/2019/6/24/afghanistan-who-controls-what.

Cook, Tonya L., Patricia J. Shannon, Gregory A. Vinson, James P. Letts, and Ehtaw Dwee. "War Trauma and Torture Experiences Reported during Public Health Screening of Newly Resettled Karen Refugees: A Qualitative Study." *BMC International Health and Human Rights* 15, (2015).

Crosby, Sondra S. "Primary Care Management of Non–English-Speaking Refugees Who have Experienced Trauma: A Clinical Review." *JAMA: The Journal of the American Medical Association* 310, no. 5 (2013): 519-528.

Dawson, Katie S. and Atif Rahman. "Low Intensity Interventions for Psychological Symptoms Following Mass Trauma." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 341-356. Cham: Springer International Publishing, 2018.

Eisenman, David P. "Screening for Mental Health Problems and History of Torture." In *Immigrant Medicine*, 633-638, 2007.

Fazel, Mina, Ruth V. Reed, Catherine Panter-Brick, and Alan Stein. "Mental Health of Displaced and Refugee Children Resettled in High-Income Countries: Risk and Protective Factors." *The Lancet (British Edition); Lancet* 379, no. 9812 (2012): 266-282.

Fazel, Mina, Jeremy Wheeler, and John Danesh. "Prevalence of Serious Mental Disorder in 7000 Refugees Resettled in Western Countries: A Systematic Review." *The Lancet (British Edition)* 365, no. 9467 (Apr, 2005): 1309-1314.

George, Miriam. "Migration Traumatic Experiences and Refugee Distress: Implications for Social Work Practice." *Clinical Social Work Journal* no. 40 (June 12, 2012): 429–437.

Hadley, Craig and Crystal Patil. "Perceived Discrimination among Three Groups of Refugees Resettled in the USA: Associations with Language, Time in the USA, and Continent of Origin." *Journal of Immigrant and Minority Health* 11, no. 6 (2009): 505-12.

Higson-Smith, Craig. *Updating the Estimate of Refugees Resettled in the United States Who have Suffered Torture*, 2015.

Hinton, Devon E. and Anushka Patel. "Culturally Sensitive CBT for Refugees: Key Dimensions." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 201-219. Cham: Springer International Publishing, 2018.

Hollifield, Michael, Teddy D. Warner, Janis Jenkins, Nityamo Sinclair-Lian, Barry Krakow, Valorie Eckert, Pary Karadaghi, and Joseph Westermeyer. "Assessing War Trauma in Refugees: Properties of the Comprehensive Trauma Inventory-104." *Journal of Traumatic Stress* 19, no. 4 (2006): 527-540.

Horn, Rebecca. *Measuring Psychosocial Wellbeing in Democratic Republic of Congo*. World Bank, Washington, DC, 2014.

Hou, Wai Kai, Brian J. Hall, and Stevan E. Hobfoll. "Drive to Thrive: A Theory of Resilience Following Loss." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 111-133. Cham: Springer International Publishing, 2018.

Refugee Act of 1979, 96 U.S.C. § 643 (1980).

Kim, Isok. "Behavioral Health Symptoms among Refugees from Burma: Examination of Sociodemographic and Migration-Related Factors." *Asian American Journal of Psychology* 9, no. 3 (2018): 179-189.

Krause, Karolin and Evelyn Sharples. "Thriving in the Face of Severe Adversity:; Understanding and Fostering Resilience in Children Affected by War and Displacement." In *Refuge in a Moving World*, edited by Fiddian-Qasmiyeh, Elena, 306-322: UCL Press, 2020.

Krogstad, Jens Manuel. *Key Facts about Refugees to the U.S.*. Pew Research Center, 2019.

Li, Susan S. Y., Belinda J. Liddell, and Angela Nickerson. "The Relationship between Post-Migration Stress and Psychological Disorders in Refugees and Asylum Seekers." *Current Psychiatry Reports; Curr Psychiatry Rep* 18, no. 9 (2016): 1-9.

Lipson, Juliene G. and Patricia A. Omidian. "Afghan Refugee Issues in the U.S. Social Environment." *Western Journal of Nursing Research* 19, (1997): 110+.

Maizland, Lindsay. "Myanmar's Troubled History: Coups, Military Rule, and Ethnic Conflict." Committee on Foreign Relations. Accessed Mar 7, 2021. https://www.cfr.org/backgrounder/myanmar-history-coup-military-rule-ethnic-conflict-rohingya.

Mathema, Silva and Sofia Carratala. "Rebuilding the U.S. Refugee Program for the 21st Century." *Center for American Progress* (October 26, 2020).

Miller, Kenneth E. and Andrew Rasmussen. "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks." *Social Science & Medicine (1982)* 70, no. 1 (Jan, 2010): 7-16.

Miller, Kenneth, Patricia Omidian, Andrew Rasmussen, Aziz Yaqubi, and Haqmal Daudzai. "Daily Stressors, War Experiences, and Mental Health in Afghanistan." *Transcultural Psychiatry* 45, (2009): 611-38.

Mollica, Richard F. "Assessment of Trauma in Primary Care." *JAMA* 285, no. 9 (2001): 1213.

Mundy, Sara Skriver, Sara Louise Wilms Foss, Stig Poulsen, Carsten Hjorthøj, and Jessica Carlsson. "Sex Differences in Trauma Exposure and Symptomatology in Trauma-Affected Refugees." *Psychiatry Research* 293, (November 1, 2020): 113445.

Neuner, Frank, Thomas Elbert, and Maggie Schauer. "Narrative Exposure Therapy (NET) as a Treatment for Traumatized Refugees and Post-Conflict Populations." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 183-199. Cham: Springer International Publishing, 2018.

Nickerson, Angela. "Pathways to Recovery: Psychological Mechanisms Underlying Refugee Mental Health." In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 91-109. Cham: Springer International Publishing, 2018.

Nickerson, Angela, Richard A. Bryant, Ulrich Schnyder, Matthis Schick, Julia Mueller, and Naser Morina. "Emotion Dysregulation Mediates the Relationship between Trauma Exposure, Post-Migration Living Difficulties and Psychological Outcomes in Traumatized Refugees." *Journal of Affective Disorders* 173, (2015): 185-192.

Nickerson, Angela, Richard A. Bryant, Derrick Silove, and Zachary Steel. "A Critical Review of Psychological Treatments of Posttraumatic Stress Disorder in Refugees." *Clinical Psychology Review* 31, no. 3 (2011): 399-417.

Ostrander, Jason, Alysse Melville, and S. Megan Berthold. "Working with Refugees in the U.S.: Trauma-Informed and Structurally Competent Social Work Approaches." *Advances in Social Work* 18, no. 1 (/09/24, 2017): 66-79.

Peterson, Sarah. "About PFA." National Child Traumatic Stress Network. Accessed Dec 14, 2020. https://www.nctsn.org/treatments-and-practices/psychological-first-aid-and-skills-for-psychological-recovery/about-pfa.

Porter, Matthew and Nick Haslam. "Predisplacement and Postdisplacement Factors Associated with Mental Health of Refugees and Internally Displaced Persons: A Meta-Analysis." *JAMA : The Journal of the American Medical Association* 294, no. 5 (Aug 3, 2005): 602-612.

Sangalang, Cindy C., David Becerra, Felicia M. Mitchell, Stephanie Lechuga-Peña, Kristina Lopez, and Isok Kim. "Trauma, Post-Migration Stress, and Mental Health: A Comparative Analysis of Refugees and Immigrants in the United States." *Journal of Immigrant and Minority Health* 21, no. 5 (2019): 909-919.

Scholte, Willem F., Miranda Olff, Peter Ventevogel, Giel-Jan de Vries, Eveline Jansveld, Barbara Lopes Cardozo, and Carol A. Gotway Crawford. "Mental Health Symptoms Following War and Repression in Eastern Afghanistan." *JAMA: The Journal of the American Medical Association* 292, no. 5 (2004): 585-593.

Shannon, Patricia, Hyojin Im, Emily Becher, Jennifer Simmelink, Elizabeth Wieling, and Ann O'Fallon. "Screening for War Trauma, Torture, and Mental Health Symptoms among Newly Arrived Refugees: A National Survey of U.S. Refugee Health Coordinators." *Journal of Immigrant & Refugee Studies* 10, no. 4 (2012): 380-394.

Shannon, Patricia, Maureen O'Dougherty, and Erin Mehta. "Refugees' Perspectives on Barriers to Communication about Trauma Histories in Primary Care." *Mental Health in Family Medicine* 9, no. 1 (2012): 47-55.

Unsettled: Seeking Refuge in America. Directed by Shepard, Tom and Jen Gilomen. WGBH, 2019.

Song, Suzan J., Charles Kaplan, Wietse A. Tol, Andrew Subica, and Joop de Jong. "Psychological Distress in Torture Survivors: Pre- and Post-Migration Risk Factors in a US Sample." *Social Psychiatry and Psychiatric Epidemiology* 50, no. 4 (2015): 549-560.

Steel, Zachary, Tien Chey, Derrick Silove, Claire Marnane, Richard Bryant, and Mark Ommeren. "Association of Torture and Other Potentially Traumatic Events with Mental Health Outcomes among Populations Exposed to Mass Conflict and Displacement: A Systematic Review and Meta-Analysis." *JAMA: The Journal of the American Medical Association* 302, (2009): 537-49.

Submitted on Behalf of the President of the United States. *Report to Congress on Proposed Refugee Admissions for Fiscal Year 2021*, 2020.

Tota, Kenneth. *Maine Replacement Designee* Office of Refugee Resettlement, 2017.

United Nations High Commissioner for Refugees. *The 1951 Convention Relating to the Status of Refugees and its 1967 Protocol*, 2011.

———. "Figures at a Glance." Accessed Feb 23, 2021. https://www.unhcr.org/figures-at-a-glance.html.

———. *Operational Guidance, Mental Health & Psychosocial Support Programming for Refugee Operations*. 2013.

Ventevogel, Peter. "Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action?" In *Mental Health of Refugee and Conflict-Affected Populations: Theory, Research and Clinical Practice*, edited by Morina, Nexhmedin and Angela Nickerson, 155-180. Cham: Springer International Publishing, 2018.

Wessells, Michael G., Alastair Ager, and Janna Metzler. "Where there is no Intervention: Insights into Processes of Resilience Supporting War-Affected Children." *Peace and Conflict* 23, no. 1 (2017): 67-75.