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The Refugee Experience: Involving Pre-migration, In Transit, and Post Migration Issues in Social Services

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The Refugee Experience: Involving Pre-migration, In Transit, and Post migration Issues in Social Services

by

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M.S.W Clinical Research Paper

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Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publically present the findings of the study. This project is neither a Master's thesis nor a dissertation.

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Abstract

In this systematic review, I investigate interventions used to address pre-migration, in transit, and post migration stressors amongst the three settings of the refugee relocation process: pre-migration, in transit, and post migration. After a comprehensive search of the literature, nine articles met the inclusion criteria determined for this study. The nine studies were then coded with predefined categories based on intervention setting and the types of issues that were address by the interventions. I found that of the nine studies, eight involved interventions in post migration settings. I also found that eight of the nine studies address pre-migration issues, one of the nine articles included in transit issues, and three of the nine articles included aspects of post migration issues in their interventions. Based on the research included in this study, it is evident that the social services are neglecting to capture the totality of the refugee relocation experience by focusing primarily on pre-migration issues, trauma and torture, in post migration settings.

The Refugee Experience: Involving Pre-migration, In Transit, and Post migration Issues in Social Services

With political, economic, and social conflict occurring across the globe people are fleeing their home countries due to persecution. The United Nations High Commissioner of Refugees (UNHCR) (2011) reported that by the end of 2011, there were a total of 10.4 million people in the world forcibly displaced from their homes or in “refugee like situations” (p.6). The largest percentage of the world’s refugees come from Afghanistan (2.7 million refugees), Iraq (1.1 million refugees), and Northern African countries in conflict like the Democratic Republic of Congo, Somalia, and Sudan (2 million) (2011).

Refugees come from countries where the psychological pain and physical torture they experience is extreme. Refugees plan for a safe departure from their home country hoping to leave the terror and trauma they experienced behind. Ultimately refugees are seeking resettlement in developed countries. The United States of America has resettled over 51,500 refugees in 2011, as well as countries like Canada (12,900), Australia (9,200), Sweden (1,900), and Norway (1,300) also resettled refugees (UNHCR, 2011).

While many refugees believe upon leaving their home country their struggles are behind them, the journey to a new host country can be a long and difficult one; ultimately, many refugees reside in developing countries and refugee camps before ending up in a permanent host country (UNHCR, 2011). A large portion of refugees, 80 percent or 8.4 million, are hosted by developing countries; Pakistan hosted the most refugees in 2011 (1.7 million). Only 22 percent, or 2.3 million refugees, are hosted in developed countries. Refugee camps are another option for refugees in transit. In 2011 the largest refugee camp was the Hagadera camp in Dadaab, Kenya. In the same year, only 532,000 refugees were repatriated to their home countries; and yet, the total number

of displaced people in the world totaled 35.4 million people. During post migration most refugees seek asylum or permanent protection from their host country (UNHCR, 2011). These statistics suggest that the outcome of the relocation process has serious implications on refugees' internal and external worlds; unfortunately for many refugees, risks to their mental health and well being are the biggest consequences of all.

Mental Health and Refugees

Refugees experience a wide range of psychopathology ranging from depression and anxiety to post-traumatic stress and somatization (Fanzel, Wheeler, & Danesch, 2005). Refugees are particularly vulnerable to mental health issues, compared to native citizens (Norredeam, Garcia-Lopez, Keiding, & Krasnik, 2009). Refugees are exposed to a range of stressors across the relocation process, which increase their likelihood of mental illness. These stressors include cultural and religious losses, loss of social support, identity confusion, acculturation, and cultural adjustment. Because of these vulnerabilities, mental illness is particularly elevated in refugee communities (Bhurgra & Becker, 2005).

Refugees' experiences across the relocation process, pre-migration to post-migration, have an impact on refugee's mental health. Refugees experience severe distress, in many forms, throughout the relocation process that influence mental health outcomes. These hardships refugees experience vary depending on the stage of the relocation process—pre-migration, in transit, or post-migration. Due to the prevalence of mental health issues in refugee populations seen across the relocation process, it is important to investigate what factors contribute to and protect against mental health concerns so appropriate treatments can be applied. Regardless of the variants within the

refugee experience, the psychological consequences of the relocation process in combination with the persecution refugees experienced can have vast mental health implications (Porter & Haslam, 2005).

Relevance to Social Work

In order to be competent clinicians, social workers need a comprehensive understanding of the relocation process and how the components of resettlement directly and indirectly relate to the psychological distress seen in refugee populations. Mental health professionals need to be perceptive to the cultural and social stresses refugees experience in order to address refugees' needs, as well as become competent in this area of practice (Bhurgra & Becker, 2005). Through understanding the relocation process, social workers can begin to recognize the obstacles many refugees experience, in turn allowing social workers to better assist refugees (Schmitz, Jacobus, Stakeman, Valenzuela, & Sprankel, 2008). With this knowledge social workers are more competent in their work with refugees by selecting their practice and theories appropriately.

By understanding the totality of the relocation process and the stressors that are common amongst refugees across the relocation process, social workers can tailor interventions to the specific, exhaustive needs of refugee populations with cultural competence. As social workers, there is an ethical commitment to culturally competent care as required by NASW (2008). Especially in narrative therapy, a successful therapeutic modality for cross-cultural therapeutic work, the client is being understood and telling his or her story within a specific sociocultural context. Being able to comprehend, respect, and acknowledge the client's worldview is crucial for multicultural therapy, which requires the therapist to recognize power-dynamics, grasp the client's

worldview, and intervene with appropriate strategies (Cooper & Lesser, 2011). Through a more collective approach of addressing all aspects of relocation, social workers will be more culturally competent and sensitive to the dimensions of migration in treatment. However, when social workers isolate refugees' experiences to trauma, they are neglecting to acknowledge the psychosociocultural components of the relocation process, as well as the resiliency refugees have. By recognizing the continuum of the relocation process (pre-migration, in transit, and post-migration) and the differential between the stages, therapists can provide comprehensive, knowledgeable care and apply appropriate theoretical frameworks with refugee populations.

In order to be culturally competent and provide proper mental health treatments social workers also need an understanding of how refugees' experiences, throughout the relocation process, can contribute to or protect them from psychopathology. Knowledge of the protective and risk factors that can contribute to or alleviate psychopathology within refugee populations is valuable information for social workers. Refugees cope differently and experience different issues based on the phase of the relocation process they are experiencing, as well as the resources available to them (Bhurgra & Jones, 2001; Khawaja, White, Schweitzer, & Greenslade, 2008). Given the prevalence of mental illness in refugee populations (Norredam et al., 2009), it is crucial for social workers to be educated on the aspects or experiences that could put refugees at risk or protect from mental illness.

This study contributes to the field of social work by compiling existing literature and completing a systematic review to explore what practice-oriented methods social workers are using to help refugees adjust to relocation and cope with their migration

across the relocation process. Social workers need to understand and acknowledge each stage of the relocation process individually, in particular in transit issues, and recognize the impact the journey from home country to host country has on refugee populations and their mental health outcomes. Having this knowledge allows social workers to view resettlement and adjustment issues within the totality of the relocation experience—not only pre-migration and post-migration, but in transit as well.

Literature Review

Refugees

There are many internationally displaced people throughout the world, but it is beneficial to understand the defining characteristics of a refugee, as opposed to economic migrants and immigrants. By definition refugees are no longer able to live safely in their home countries due to a well-founded fear of being persecuted for their “religion, nationality, membership of a particular social group, or political opinion” (United Nations, 2008, p.4). In turn, refugees are forcibly displaced to countries outside of their country of origin seeking safety and protection (2008). Refugees are defined as people who experienced or are at risk of experiencing persecution so much so that a person’s freedom and life would be or was threatened by “the threat of death, or the threat of torture, or cruel, inhuman or degrading treatment or punishment” (2008, p. 3). A caveat is that refugees do not actually need to be persecuted in their countries of origin, but have a risk or tangible fear of being persecuted in the future, resulting in their feeling threatened (2008). The refugee journey is divided into three stages: pre-migration, in transit, and post migration (Bhugra & Jones, 2001, Keyes & Kane, 2004; Khawaja et al., 2008; Miller, Worthington, Muzueovic et al., 2002). The fear and persecution refugees

experience can cause severe distress throughout the relocation process that influences their mental health status.

Torture and Trauma

The “torture, or cruel, inhuman or degrading treatment or punishment” (United Nations, 2008, p.3) refugees endure or are threatened by are crucial components when trying to understand refugee’s schemas, as well as the pathology that comes from these experiences. Torture and trauma are pervasive issues seen in refugee populations. Torture is a significant factor in the development of post traumatic stress disorder (PTSD) and other mental illnesses seen in refugee communities (Man Shrestha, Sharma, Van Ommeren et al., 1998). Around 5-10% of refugees living in the United States have experienced severe forms of torture ranging from electric shock, rape, beatings, and witnessing the torture and execution of others (Pincock, 2003).

A comprehensive study found that across the literature, PTSD ranges in prevalence from 4% to 86% of refugees depending on the study (Hollifield, Warner, & Lain et al., 2002). A three-year research initiative found that PTSD was the most prevalent mental health diagnosis in refugees living in an African refugee camp (Kamau, Silove, Steel et al., 2004).

Stages of Migration

The previous literature on refugees has distinguished three stages of the relocation process: pre-migration, in transit, and post migration (Bhugra & Jones, 2001, Keyes & Kane, 2004; Khawaja et al., 2008; Miller, Worthington, Muzueovic et al., 2002). Pre-migration is the stage in the relocation process when the refugees still live in their home country. The in transit period is the physical relocation of refugees—the time in their

journey between home countries and host countries, often times spent in a refugee camp (Bhugra & Jones, 2001). Post migration is the final stage in which refugees are relocated to a host country, where they could potentially seek asylum. During the post migration stage refugees are acculturating to their new community and society.

Pre-migration. Pre-migration is the stage in the relocation process when the refugees are in their home countries and are deciding and preparing to move to a safe country (Bhugra & Jones, 2001). During pre-migration an obvious cause of distress is physical or psychological trauma, including the death of a loved one, inability to live daily life, and denial of basic necessities (Khawaja et al., 2008). The trauma experienced in pre-migration is a significant factor associated with mental health outcomes seen in refugee populations (Schweitzer et al., 2006).

In transit. In transit is the middle stage of the relocation process and is the physical transition and journey from the refugees' home countries to a safer country (Bhugra & Jones, 2001). In transit refugees are also defined as refugees living in refugee camps, which are where one-third of the refugees in 2011 were living (UNHCR, 2011). While refugee camps are often viewed as an initial point of refuge, within camp violence and illness are ever-present fears and risks. Although refugee camps are seen as a safe escape, these camps are often as dangerous and may have higher mortality rates than countries of origin due to "interethnic strife, sexual violence, and disease epidemics" (Adams, Gardiner, & Assefi, 2004, p.1).

For refugees the in transit process poses a unique threat because protection for refugees is often only temporary. The stress of living in legal limbo is often accompanied with a constant fear (UNHCR, 2010). While in transit, a main source of distress is

instability and fear for the future. Refugees feel unsafe, fear they will be sent back to their home country, or fear they will be killed during their travels (Khawaja et al., 2008).

Post migration. The third and final stage of relocation, post-migration, is when the refugees are living in a developed host country where they are applying for asylum. In post migration, refugees are forced to learn their host country's societal and cultural frameworks and are absorbed within the current context of the communities they live in (Bhugra & Jones, 2001). The primary causes of post migration distress include: social isolation, identity confusion, loss of cultural community and family members, the loss of important life projects, a lack of environmental mastery, poverty and resource accumulation, and the loss of valued societal roles (Keyes & Kane, 2004; Khawaja et al., 2008; Miller, Worthington, Muzueovic et al., 2002). A study involving Bosnian refugees relocated to Chicago found that memories from pre-migration functioned as both a comfort and reference point for how refugees evaluated their experience in Chicago; this contrast of experiences impacted refugees' perceptions of their post migration experiences (Miller, Worthington, Muzueovic et al., 2002). In addition to the journey refugees have undergone to arrive at a host country, there are many factors that impact refugees' ability to have a fluid adjustment.

During post migration culture shock, bereavement, assimilation, acculturation, and deculturation are all salient issues in refugee populations (Bhugra & Jones, 2001). However, post migration adjustment and distress are also important in predicting the psychological well being of refugees. Employment difficulties, isolation from social support, and acculturation are post migration factors that are associated with increased rates of depression, anxiety, and somatiform disorders (Schweitzer, Melville, Steel, &

Lacherez, 2006). Post migration issues not only cause distress, but also contribute to psychopathology seen in refugees.

Mental Health in Refugees

A lot of the literature regarding refugees indicates an unusually high prevalence of mental illness in refugee populations (Norredam et al., 2009). Refugees are at a particularly elevated risk for psychiatric disorders like depression, substance use, post-traumatic stress, and psychosis which are often directly related to the physical and psychological torture they experienced (Bhui et al., 2003; Gorst-Unsworth, 1992; Kinzie et al., 1990; World Health Organization, 1999). In a systematic review, Fanzel, Wheeler, and Danesch (2005) found that out of a sample of 6,743 adult refugees who originate from seven different countries, nine percent were diagnosed with post-traumatic stress disorder (PTSD) and five percent met the qualifications for major depressive disorder. Another study using a convenience sample of tortured refugees seeking treatment at a clinic for tortured refugee survivors found that 81.1% had diagnosable anxiety, 84.5% had significant depressive symptoms, and 45.7% had PTSD symptoms (Keller et al., 2006).

While not all refugees meet diagnostic criteria for certain mental illnesses many are significantly distressed by their experiences. In a study of 63 Sudanese refugees resettled in Australia, it was found that less than 5% met the criteria for PTSD, but 25% claimed clinical levels of psychological distress (Schweitzer, Melville, Steel, & Lacherez, 2006). Across the board, mental illness and distress affects refugees, and in turn impacts their ability to transition and develop during relocation.

There are lower rates of mental illness during the initial stage of relocation, pre-migration, than in the later stages of the migration process—in transit and post migration stages. This could be due to refugees being younger in age during pre-migration than the later stages and that acculturation and the discrepancy between expectations and attainment of goals impacts refugees' lives more severely during post migration (Bhugra, 2004). In a study involving Burmese refugees in 2011 it was found that, while exposure to trauma impacted refugees' well being, post migration adaptation was more salient in predicting mental health outcomes (Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). It is important to acknowledge that the severity and onset of mental illness can vary within refugee populations and across the stages of relocation.

Untreated mental illness. It is crucial that mental health symptoms are appropriately treated to best assist refugees in relocation and to achieve optimal functioning; however, access to culturally competent psychiatric care is often a barrier for refugees and prevents initiation of treatment, causing mental illness to go untreated (Redwood-Campbell, Fowler, Kaczorowski et al., 2003). Even if minor psychiatric illnesses go untreated symptoms can be misinterpreted as deviant behavior evoking police involvement, ultimately resulting in legal concerns, hospitalization, and institutionalization. Not only does this impact quality of life, but also creates discrimination against refugee populations (London, 1986). Treatment of mental illness in refugee populations is important for symptom relief, but also to help refugees cope with the stressors of the relocation process and increase optimal functioning throughout the relocation process. In a recent study, it was found that refugees who have untreated PTSD are likely to have a continuation of their symptoms for at least a decade after their

traumatic experience, which significantly interferes with quality of life (Priebe et al., 2009). Barriers to adequate treatment, as well as the effects of untreated psychiatric disorders can result in severe repercussions for refugees in relocation.

Culture and mental illness. When working with cultures different from the clinician's own, it is crucial to be sensitive to cultural norms. Refugees express and view mental illness differently than the general population (Adams, Gardiner, & Assefi, 2004). The psychiatric problems refugees may be experiencing might not be properly described and defined by Western medicine and diagnostics (2004). In a study of Somali refugees, it was found that refugees have "distinct ways of conceptualizing, expressing and treating" mental health concerns (Carroll, 2004, p.119). In the same study three categories of mental health symptoms were identified in interview transcripts: sadness and suffering, "craziness" due to severe trauma, and "craziness" due to spiritual possession. It was also found that Somali refugees prefer to use family support, religious coping, or culturally specific therapists (2004).

Risk factors to mental health. To better understand the mental health outcomes of refugees, the relocation process cannot simply be understood within the context of trauma and persecution but must be viewed within the context of social, economic, and cultural factors that directly influence the development of pathology across the relocation stages (Porter & Haram, 2005). Viewing refugees' mental health within the context of socioeconomic and cultural factors, social workers can begin to recognize how these factors can evolve and may directly, or indirectly, relate to the psychopathology seen within refugee populations. The stresses of the relocation process accompanied by specific risk factors:

a lack of social support, a discrepancy between achievement and expectations, economic hardships, racial discrimination and harassment, and a lack of access to proper housing, medical care, and religious practice can lead to poor self-esteem, an inability to adjust, and poor physical health (p.23)

and can result in negative mental health outcomes (Bhurgra & Becker, 2005). These sociocultural factors and the distressing consequences that arise are often indicative of negative mental health outcomes seen in refugees.

Even across the relocation process, there are specific risk factors to mental health outcomes that accompany each stage. These risk factors predispose refugees to mental health diagnoses. Pre-migration factors that influence the development of psychopathology include: the personality of the individual, the persecution and trauma he or she experiences, and the persecution he or she endured. Migration factors that can potentially contribute to refugees being at greater risk for mental illness include: bereavement and discrepancies between expectations and achievement (Bhurgra & Becker, 2005). In post-migration, social and cultural adjustment can largely impact resettlement. In a meta-analysis, Porter and Haram (2005) found that institution accommodation, cultural access, economic opportunity, locus of displacement, repatriation status, and stage of ongoing conflict were all significant predictors of post migration mental health outcomes. Refugees in the post migration stage and in resettlement can be particularly vulnerable to mental illness if they are not accepted by their host country, experience rejection, alienation, and/or lack self-esteem and social support (Bhurgra & Jones, 2001). A lot of research has been done investigating the

deleterious effects psychosocial factors can have on refugees, in turn contributing to the psychopathology that is so prevalent in refugee populations.

Refugees are vulnerable to and protected by a range of psychosocial components. In some instances these psychosocial factors increase the likelihood of mental illness, and in other instances protect against the development of psychopathology. Psychosocial factors that influence mental health include race, social involvement, racism, employment, poverty, housing, and access to medical care (Bhurgra & Becker, 2005).

Coping, resiliency, and protective factors. It is important to understand risk factors that make refugees particularly susceptible to mental health conditions, but it is also crucial to acknowledge factors that protect and buffer refugees from mental illness and help them cope with their experiences. Factors like acceptance by the host country, social support, language support, and access to housing and employment can be protective factors (Bhurgra & Jones, 2001).

In a study by Agaibi and Wilson (2005), investigated resiliency in relation to traumatic experienced and PTSD (post traumatic stress disorder). The study found that resiliency is multidimensional. They found that personality, affect regulation, coping, ego defense, and utilization and mobility of protective factors and resources all influence the ability to cope in people with PTSD.

Religious coping has been a successful coping style for many refugees (Schweitzer, Greenslade, & Kagee, 2007). A strong belief system, faith based or politically based, can help refugees cope with past traumas (Brune, Haasen, Krausz et al., 2002). Believing in a higher power allows refugees to regain control of their lives and find meaning in their lives; religion can also aid in emotional stability (Schweitzer *et al.*,

2007). Religion proves to be a useful coping mechanism used by refugees to help buffer the stress of relocation.

One of the coping themes refugees identify in testimonies is social support; however, support in general, ranging from social to financial, is covered in the literature (Crabtree, 2010; Schweitzer et al., 2007). Four major forms of coping support have been identified: emotional support, informational support (someone who understands and identifies problematic events), social companionship, and instrumental support (availability of resources) (House, Umberson, & Landis, 1988). House *et al.* (1988) found that “instrumental support” and “informational support” are two major forms of support that help refugees adjust and cope throughout the stages. Social support, in particular support received from within the refugee’s ethnic community, plays a significant role in buffering against mental health conditions (Schweitzer et al., 2006). These forms of social support can act as buffers to the deleterious effects of stress and trauma, as well as increase positive experiences and well being (Cohen & Wills, 1985; House et al., 1988). The literature suggests that support, in various forms, can help refugees cope and act as a buffer to mental illness (Cohen & Wills, 1985).

The existing literature recognizes the relocation process, primarily pre-migration and post-migration, and the stressors of each component; however, there seems to be a gap in the literature about how social workers specifically address each component of the migration process, as well as limited acknowledgement of the in transit phase of the relocation process. Not only does the in transit phase lack recognition, but it lacks credible research, which results in failure to represent the totality of the refugee experience, in turn hindering social workers’ ability to provide competent,

comprehensive treatment options for refugee populations. This study contributes to the existing literature by exploring the extent to which all phases of the relocation process are represented, the types of interventions used across the relocation process, and the outcomes associated with various social work practice.

Conceptual Framework

Ideally research and practice would capture an honest, collective account of refugees' journey; however, the existing literature does not adequately capture a representative sample of the world's refugees (Porter & Haram, 2005). When looking at the complexity of the refugee experience, it is crucial to recognize that refugees are not a homogenous group and therefore have a range of individual experiences and struggles. Also refugees' experiences should not be limited to trauma or mental health concerns. It is imperative to capture issues outside of mental health, for instance social factors that could be impacting a refugee during the relocation process, to improve the dramatic rates of mental illness in refugee populations. To be competent clinicians, social workers need to understand the dimensional aspects of relocation experience and be able to recognize how those dimensions are impacting their clients and their mental health conditions.

Reductionism is when experiences are reduced down to the simplest, most basic and fundamental understanding of a phenomenon (Slife & Williams, 1995) —with the literature on immigrants the understanding has been reduced to traumatic events. As studied in this paper, the refugee experience is much more complex than trauma and evolves over the course of the relocation process. This simplistic view of the refugee experience devalues and mocks the totality of the relocation experience. The refugee experience cannot be simply understood within the context of trauma, war conflict, and

persecution, but rather needs to be understood through resiliency, as well as within the social, psychological, economic, and cultural contexts of all stages of the relocation process (Porter & Haram, 2005). Therapists who use narrative exposure therapy are able to successfully explore trauma while capturing the totality of the refugee experience, unlike other approaches that reduce it solely to traumatic experiences, neglecting the social and cultural factors that occur in post migration and in transit stages of the relocation process.

Narrative Theory

Narrative theory assumes that individuals are active participants in constructing their story based on how they experience their reality. Constructivism as a conceptual framework emphasizes the clients' subjective experience and how they perceive and experience their life and problems. Because narrative theory is a post-modern modality, it is rooted in the philosophy that there are many realities and no universal truths (Cooper & Lesser, 2011). Narrative theory is based on the assumption that people experience themselves and their lives within the social constructions and concepts that surround them, which are combined and reflected in their narratives.

Narrative theory relies on people recounting their own experiences through storytelling to facilitate the therapeutic process. Narrative therapy helps the therapist and the client understand how people interpret, make meaning, and understand their experiences and the world around them through storytelling (Roscoe, 2009). Narrative theory is helpful to gain perspective on the refugee's entire experience—pre-migration, in transit, and post-migration.

While PTSD is the most common mental illness seen in refugees (Adams, Gardiner, & Assefi, 2004), it is crucial not to reduce the refugee experience solely to trauma by using interventions that only address PTSD symptoms. It is also important not to view refugee clients through a framework of trauma because it may not encompass the totality of their experiences. Narrative exposure therapy is one of the most efficacious treatment modalities for PTSD, as well as a respected treatment modality for multi-cultural therapeutic work (Cooper & Lesser, 2011; Paunovic & Ost, 2001). Narrative exposure therapy successfully treats PTSD while allowing refugee clients to include other relevant narratives that occurred to them during the relocation process, which captures the totality of that refugee's experience. Narrative exposure therapy is a helpful modality for treating PTSD especially in cultural populations (Neuner, Onyut, Ertl, *et al.*, 2008) and also allows the client to recount their narrative as they experienced it, highlighting relevant issues across the relocation process.

Dialogue and research should be occurring that truly captures the totality of refugees' experiences despite how different and individualized each refugee experience is. Social workers should be addressing specific components of the relocation process, not just trauma, that are impacting refugees when considering interventions and treatment options. The use of narrative theory to represent the totality of the refugee experience, as well as a focus on resiliency might better represent refugees' experience. By capturing the total breadth of the relocation experience, as the client experienced it, social workers are more competent in determining treatment options and approaching refugee specific concerns. By only focusing research and treatment on trauma solely, social workers fail to capture the totality of the relocation experience; however, narrative exposure therapy in combination with an interdisciplinary approach allows social workers to address

mental health symptoms, sociocultural concerns, as well as other issues that occurred during in transit and post migration.

Method

In this study, I conduct a systematic review, through which I identify and evaluate how social workers are incorporating elements of the relocation process into treatment, case management, and other social work practice when working with refugees. The University of St. Thomas Institutional Review Board approved the methods of this study.

Literature Search

A comprehensive article search of psychology and social work databases was completed to compile articles that addressed the use of pre-migration, in transit, and post migration factors in social work practice. Articles were drawn from the databases Google Scholar, Psycinfo, PubMed, and Psycarticles. Words used to search these databases included combinations of “refugees,” “asylum seekers,” “relocation (process),” “pre-migration,” “in transit,” “post-migration,” “trauma,” “therapy,” “theory”, “case management,” “social interventions,” and “interventions.”

Articles that were included in this study met designated definitions of pre-migration, in transit, and post migration categories as defined by the psychosocialcultural stressors of migration stages as noted by existing literature (Bhugra & Jones, 2001; Keyes & Kane, 2004; Khawaja et al., 2008; Miller, Worthington, Muzueovic et al., 2002). Studies that were included in the pre-migration category had methods that addressed issues of physical or psychological trauma, including death of family and friends; see Table 2. Inability to live daily life and access basic necessities were not included in the pre-migration category because these issues could be easily experienced in all stages of

the relocation and are often pervasive issues in refugees' lives; therefore, categorizing these issues to pre-migration seems restrictive (2008). Articles included in the in transit category were studies that addressed refugees living in refugee camps and issues that occurred in transit or at refugee camps, for instance, interethnic conflict, illness, and sexual violence; see Table 2 (Adams, Gardiner, & Assefi, 2004). Studies were also included in the in transit category if issues of instability of legal status or living in legal limbo, fear of being killed in travel, and feeling unsafe in transit were addressed in practice (2008). The post migration category included studies that investigated interventions that targeted isolation from cultural community and social support, cultural factors (cultural confusion, assimilation, deculturation, cultural bereavement, acculturation, culture shock), resource accumulation (poverty and employment struggles), lack of environmental mastery (learning English, adjusting to a new currency), and loss of societal roles; see Table 2 (2001; Keyes & Kane, 2004; 2008; 2002). The issues that occur across the relocation stage were categorized and coded for pre-migration, in transit, and post migration based on research that had been conducted on the issues that influence refugees the most at each stage of the relocation process.

Articles included in this study were written from 1998 to 2013. Both qualitative and quantitative research was included as long as specific interventions or clinical trials were involved to address the specified relocation components. Policy interventions were excluded from this study due to lack of empirical evidence; however, mental health programs and relocation assistance programs were included. Only articles in English went through the inclusion process. This study excluded articles that included economic migrants, college students, and refugee children and adolescents. Dissertations were

excluded because they lack peer review and case studies were excluded because they lack representation and generalizability.

Data Analysis

After articles met the inclusion criteria, the articles were then assessed for which components of the relocation process were addressed based on the issues that were included in the article. Studies that included multiple relocation components were included in both categories. Papers were then categorized into the three relocation settings (pre-migration, in transit, post-migration). Interventions, methodologies, setting, and research design for each article were coded and included in the findings.

Results

After a thorough search for articles, nine articles met the criteria for this study which are cited in Table 1. While most of the interventions took place post-migration, the interventions were focused on pre-migration issues. As shown by Table 2, pre-migration issues addressed in a post migration setting are the most common form of intervention when working with refugee populations. The studies included refugees from Vietnam, Sudan, Bosnia, Cambodia, Rwanda, Somalia, Burma, Congo, Eritrea, Ethiopia, Kenya, and Burundi. Some articles did not specify their studied population.

Intervention Settings

Of the eight studies nine studies involved interventions that took place in post-migration. One of the nine studies had interventions completed in transit, where the data was collected at refugee camps. None of the studies included interventions that were implemented in the pre-migration stage. Most of the interventions took place post-migration.

Pre-migration Issues

Pre-migration issues were the most predominately addressed throughout the relocation process. Eight of the nine studies focused on *physical torture* and *psychological torture* in their interventions. Seven of the nine studies included *death of a loved one* in their interventions. Aspects of pre-migration issues were addressed in eight of the nine studies.

In Transit Issues

In transit issues were approached in one study. The only component of in transit that was addressed by an intervention was *life in a refugee camp*. *Interethnic conflict*, *illness*, *sexual violence*, *legal limbo*, or *fears of travel* were not addressed in the ten studies. Aspects of in transit issues were only included in one of the nine studies included in this study.

Post migration Issues

As far as post migration issues are concerned, two studies included *isolation*, *loss of societal roles*, and *lack of social support* as a component of the intervention. Three studies addressed *cultural issues*, *resource accumulation*, and *environmental mastery* as part of the intervention. A total of three of the nine articles included aspects of post migration issues in their interventions.

Interventions

Narrative exposure therapy was an intervention used in three of the nine studies to address pre-migration issues: *physical torture*, *psychological torture*, and *death of a loved one*. A form of cognitive behavioral therapy was used in three of the ten studies to address a combination of pre-migration and post migration issues (*physical torture*,

psychological torture, death of a loved one, isolation, lack of social support, cultural issues, resource accumulation, and loss of societal roles). Eye Movement Desensitization and Reprocessing was used in one study to address issues of pre-migration and post migration (*physical torture, psychological torture, isolation, lack of social support, cultural issues, resource accumulation, and loss of societal roles*). More generic interventions, biopsychosocial interventions or “treatment as usual,” was used in four of the nine studies to address a combination of pre-migration and post migration issues.

Studies included. In the study by Hensel-Dittmann et al., (2011) data was collected over a three-year period at a refugee outpatient clinic and research center in Germany. The study involved 28 asylum seekers who experienced organized violence in their home country and had a current diagnosis of post-traumatic stress disorder. Participants were randomly assigned to one of the two interventions (narrative exposure therapy or stress inoculation training) and completed ten sessions across an average of 13 weeks. The Clinician Administered PTSD Scale was the main measure in this study that measured intensity in PTSD symptoms. A strength of this study was an outcome follow up completed at four weeks, six months, and one year.

In this study (Hensel-Dittmann et al., 2011), narrative exposure therapy led to a significant decrease in PTSD symptom reduction between the pre-test and six month follow up, as well as between the pretest and one year follow up. No changes in symptomology occurred in the stress inoculation-training (SIT) group. It was hypothesized that SIT was not a helpful intervention because it required more insight and ability to understand abstract concepts. Also SIT may not have been adapted well to the cultural norms of the participants. This study investigates efficacious treatments for pre-

migration issues, trauma and torture, in a post migration setting. While this research is helpful in understanding how to approach trauma through the use of narrative exposure therapy, it fails to include information other than trauma symptomology. Relocation themes of in transit and post migration received no attention in this study.

Hinton et al. (2004) used cognitive behavioral therapy for Vietnamese refugees diagnosed with post-traumatic stress disorder (PTSD) and panic attacks. The study had 12 participants, many of which continued their psychotropic treatments throughout the study. The Harvard Trauma Questionnaire was used to assess PTSD symptoms, as well as the Anxiety Sensitivity Index to measure anxiety symptoms. Participants completed 11 individual CBT sessions that included psycho education, relaxation exercises, and emotional processing. This study showed that culturally adapted CBT led to a significant decrease in symptoms across all measures.

A strength of Hinton et al. (2004) is incorporating cultural considerations into interventions when treating anxiety and PTSD symptoms in refugee populations. Culture should be a consideration in all treatments and approaches when working with refugees (Adams, Gardiner, & Assefi, 2004). However, similar to Hensel-Dittmann et al. (2011), this study takes place in a post migration setting and approaches pre-migration issues, in turn reducing the refugee experience to PTSD and anxiety symptoms.

In the study by van Wyk, Schweitzer, Brough, Vromans, and Murray (2012), 62 Burmese refugees engaged in standard interventions provided by a resettlement agency in Australia. This intervention included social assistance, therapeutic interventions, assessments, and referrals to outside resources. The efficacy of these interventions was measured by mental health outcomes as well as post migration living difficulties. The

Harvard Trauma Questionnaire was used to measure PTSD symptoms, the Hopkins Symptom Checklist was used to measure depression, anxiety, and somatic symptoms, and the Post migration Living Difficulties checklist was used to measure post migration stressors. It was found that participants had a decrease in PTSD, somatization, depression, and anxiety post intervention.

Wyk, Schweitzer, Brough, Vromans, and Murray's (2012) research, unlike a majority of the other studies included in this systematic review, adequately addresses multiple components of the relocation process. The mental health interventions included components of pre-migration and post migration issues. An unusual finding of this study concluded that post migration difficulties, number of traumas, and number of connections with resources were not related to mental health outcomes, which findings conflict with other studies that have found post migration adaptation was more salient in predicting mental health outcomes (Porter and Haram, 2005; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011). This may suggest that mental health symptoms may not always be the most reliable outcome measures. This theory is supported by Schweitzer, Melville, Steel, & Lacherez's (2006) research stating that while refugees may not be presenting with diagnostically significant levels of mental illness, they may still be experiencing clinical levels of psychological distress.

One of the nine studies, Onyut et al. (2004), involved a mental health program implemented in a Ugandan refugee camp primarily hosting Rwandan and Somali refugees. The mental health program included the training of refugees in narrative exposure therapy and supportive counseling so they could provide services to other refugees in the camp at a low-cost, accessible alternative to mental health treatment. The

Posttraumatic Diagnostic Survey was used as an outcome measure to monitor participants' PTSD symptoms and the Hopkins Symptom Checklist 25 to monitor co-morbid depression symptoms. Two treatment groups were selected, narrative exposure therapy and supportive counseling, and the 561 participants engaged in four to six sessions of therapy lasting a maximum of two hours per session. This study concluded that by training other refugees to provide therapy more refugees can be reached more feasibly than longer term, expensive, and highly specialized trauma therapies that simply cannot address the magnitude of need seen in refugee communities.

This study is unique because it takes place in a refugee camp and addresses primarily pre-migration issues. Providing mental health interventions in refugee camps may potentially mediate the instability of life in transit (Adams, Gardiner, & Assefi, 2004; Khawaja et al., 2008) by providing refugees with support and consistency. Another strength of this research model is that refugees are facilitating therapy to other refugees as an important cultural component involved in this intervention. Because refugees express and conceptualize mental illnesses differently than the general population (Adams, Gardiner, & Assefi, 2004; Carroll, 2004), having therapists with comparable cultural backgrounds and perspectives is a strength of this intervention model that should be incorporated in future interventions. This study adequately addresses crucial components of the relocation process in a unique, but feasible manner. However, this study could be strengthened through helping refugees process in transit issues in an in transit setting through therapeutic interventions.

In the study by Otto and Hinton (2006), refugees from Cambodia living in the United States engaged in exposure based cognitive behavioral therapy in a group setting

to alleviate PTSD symptoms. They modified CBT to be more culturally sensitive through the use of Cambodian metaphors and cultural examples in their development of a manualized treatment protocol to address PTSD symptoms in a group setting. This study found that the culturally adapted CBT group therapy treatment that was developed was helpful in the treatment of PTSD in Cambodian refugee populations.

While this study solely addresses PTSD symptoms in a post migration setting and fails to address other relevant relocation stressors in their intervention, Otto and Hinton's (2006) research highlights the importance of culturally adapted intervention for refugee populations. Culturally sensitive treatments like the one adapted by Otto and Hinton (2006) may be successful with refugee populations because their experiencing might not be properly described and defined by Western medicine ideology (Adams, Gardiner, & Assefi, 2004). Tailoring therapy to specific cultures common amongst refugee populations may make interventions more successful, especially since Palic and Elklit (2009) found that the traumatic symptoms refugees experience often manifest with more complexity than those symptoms strictly outlined according to the Diagnostic Statistical Manual's diagnostic category of PTSD. Another strength of this study is the use of group therapy. In settings like refugee camps, group therapy may be a practical way to providing services to large groups of refugees when there are limited clinicians. Not only should future studies replicate culturally adapted therapy models like Otto and Hinton (2006) do, they should also focus on the use of group therapies as a way of making therapy more accessible in limited settings like refugee camps.

Raghavan, Rosenfeld, Rasmussen, and Keller (2012) investigated an interdisciplinary (psychiatry, medicine, social work, psychology, education) treatment in

a sample of 172 refugees living in New York over a six-month period. Symptom reduction of PTSD and depression were the outcome goal for this study. The Harvard Trauma Questionnaire was used to measure trauma symptoms and the Brief Symptom Inventory measured depressive symptoms. A variety of therapeutic services were provided in this intervention, as well as social services addressing housing, employment, and legal issues. Educational services, including teaching English, were significantly associated with improvements in depressive and PTSD symptoms. This study concluded that clinical and nonclinical interventions (an interdisciplinary approach) play a significant role in the improved outcomes for refugee populations.

In the interdisciplinary approach depicted in Raghavan and colleagues', (2012) research covers the gamut for resource availability. This type of study models a “one stop shop” idea for refugee treatment. Unlike most of the other research included in this systematic review, this research look specifically at how additional biopsychosociocultural services correlate with improved mental health in refugee communities and proving many services are needed when taking a holistic approach to refugee recovery. This study models that simple services, in this case English coursework—a post migration issue, can directly impact mental health and well being of refugees, which supports findings by Schweitzer and colleagues, (2011) who found that post migration adaptation was more salient in predicting mental health outcomes than treatment of trauma.

Starmark, Catani, Neuner, Elbert, and Holen (2013) researched the use of narrative exposure therapy versus treatment as usual for 81 refugees and asylum seekers in psychiatric units in Norway. The outcomes being measured were PTSD symptoms and

depression. The Clinician Administered PTSD Scale, Hamilton Scale for Depression and the MINI Neuropsychiatric Interview were used to measure depression and PTSD symptoms. Both treatment forms showed significant symptoms relief; however, NET was a significantly better treatment option for treating PTSD.

The study by Starmark et al. (2013) depicts that narrative exposure therapy in a post migration setting can properly address issues that develop in pre-migration. While this is helpful practice knowledge, this study is similar to Hensel-Dittmann et al., (2011) in that future research should include a qualitative measure that codes for other relocation themes that are apparent in refugees' narratives. This type of methodology would be an addition to existing literature because it would shed insight on how narrative exposure therapy captures the breadth and totality of the relocation process while addressing PTSD.

Another study consisting of 20 refugees living in Amsterdam looked at Eye Movement Desensitization and Reprocessing therapy (EMDR) versus stabilization (ter Heide, Mooren, Kleijn, de Jongh, & Kleber, 2011). Participants were divided into two group completing 11 sessions of either EMDR or stabilization, which was a combination of cognitive behavioral therapy and the interpersonal processing model that focused on the "here and now" effects of trauma. The EMDR group was focused on reducing the disturbances that come with traumatic memories. A structured diagnostic interview was completed, the World Health Organization Quality of Life questionnaire was used to measure quality of life, the Hopkins Symptom Checklist was used to measure symptoms of anxiety and depression, and the Harvard Trauma Questionnaire was used to measure trauma symptoms. This study concluded while both groups improved that there was no

statistical difference between EMDR and stabilization groups in treating pre-migration and post migration issues.

This study (ter Heide et al., 2011) provides evidence that interventions that focus solely on pre-migration issues or trauma do not ease the impact of post migration stressors or have an influence on refugees' quality of life. Future studies investigating potential confounding variables that mitigate the effects of EMDR and stabilization would be helpful for clinical understanding. For instance, perhaps sociocultural concerns or other relocation stressors were conflicting the efficacy of these treatment types. This type of future research might help develop a hierarchy of refugee needs. For example, maybe trauma cannot be addressed because refugees are preoccupied with housing or cultural adaptation. In addition, the findings in this study may suggest EMDR and stabilization are not culturally appropriate treatments to be using with refugee populations. While this study used pre-migration and post migration issues as outcome measures, trauma focused therapies like EMDR are not beneficial in improving trauma symptoms or post migration concerns.

In another study involving 20 Bosnian refugees living in Chicago, participants completed six sessions of 90-minute testimonial psychotherapy (Welne, Kulenovic, Pavkovic, and Gibbons, 1998). This study found a significant decrease in PTSD symptoms, diagnoses, and severity post-treatment. The measures used in this study were PTSD Symptoms Scale, the Beck Depression Inventory, and the Global Assessment of Functioning Scale. There was also a significant decrease in depressive symptoms after intervention, as well as a significant increase in global assessment of functioning.

This study, while beneficial in addressing PTSD and depressive symptoms in relation to pre-migration issues, reduces the refugee experience to trauma. Perhaps the depressive and PTSD symptoms are in relation to the refugees' in transit or post migration experiences. By reducing the refugee experience to pre-migration issues, researchers are neglecting other components that may be contributing to the client's symptomology or psychological distress. Future studies of this nature would benefit from incorporating in transit and post migration issues in to treatment to see if there are any correlates to in transit and post migration issues and PTSD and depressive symptoms.

Discussion

The purpose of this study was to investigate how the social services are approaching clinical needs of refugees during the three stages of relocation: pre-migration, in transit, and post-migration. This study included systematic review methodology and only studies that met specified criteria were included. The studies included were then analyzed individually and collectively.

General Findings

Nine articles met the criteria and were included in this study. Articles were categorized based on the setting in which the intervention occurred (pre-migration, in transit, and post-migration) and coded based on interventions that addressed pre-migration issues, in transit issues, and post migration issues. Notably, most of the interventions frequently occurred in a post-migration setting, and most interventions addressed pre-migration issues.

Pre-migration, in transit, and post migration issues were addressed using different interventions across the relocation process. Narrative exposure therapy, cognitive

behavioral therapy, eye movement desensitization and reprocessing, and more generic interventions such as biopsychosocial interventions or “treatment as usual” were used as interventions amongst the studies included in this review. In the included studies, the main pre-migration issues that were addressed in interventions were *physical torture*, *psychological torture* and *death of a loved one*. This study found that pre-migration issues were the most prominent issues approached across the relocation process. Only one component of in transit issues, *life in a refugee camp*, was addressed in one of articles included in this study. Three studies addressed post migration issues— *isolation*, *loss of societal roles*, *lack of social support*, *cultural issues*, *resource accumulation*, and *environmental mastery*— as part of the intervention. The interventions were primarily focused on pre-migration issues, as opposed to post migration and in transit issues.

Addressing the Totality of the Refugee Experience

The data analyzed in this study illustrate that there is a lack of attention and research in the social services that address the totality of the refugee experience. Most of the interventions in these studies occurred during post migration and were primarily focused on pre-migration issues, with a few exceptions. This data supports that a bulk of the services and resources are directed toward pre-migration issues in post migration settings.

While trauma is connected to mental health outcomes in refugees (Man Shrestha, Sharma, Van Ommeren et al., 1998), their experience and relocation process should not be reduced to trauma, torture, and strictly pre-migration stressors. More importantly, the stressors of the relocation process should be considered and addressed when understanding refugees’ presenting mental health symptoms. It is also crucial to consider

that refugees may not be presenting with diagnostically significant levels of mental illness, but may still be experiencing clinical levels of psychological distress (Schweitzer, Melville, Steel, & Lacherez, 2006). Also there have been direct correlations between relocation stressors and predictions in mental illness. For instance, in a study by Schweitzer et al., (2011) post migration adaptation was more salient in predicting mental health outcomes, as opposed to trauma and torture experiences. Perhaps by incorporating and addressing relocation stressors in social service interventions throughout the relocation process, a decrease in mental health rates in refugees populations will be seen, as will an increase potentially be seen in refugees' ability to successfully adapt and transition during the relocation process.

This study finds that research, in particular, is neglecting the totality of the refugee experience and reducing the refugee experience to trauma, torture, and pre-migration issues. Unfortunately a majority of the research and literature on refugee communities that did not meet the criteria for this study simply administers mental health measures and regurgitates mental health statistics seen in refugee populations. While mental health statistics are helpful and important, because refugees are not a homogeneous group, it does not help practitioners when it comes to addressing symptoms that are often confounded by culture and the migratory experience (Adams, Gardiner, & Assefi, 2004; Bhurgra & Becker, 2005). In order for practitioners to understand the symptoms of diagnoses and appropriately address them, it is crucial to understand the complex situational and cultural contexts refugees present with; therefore, more research should be dedicated to culturally competent practices.

Strengths and Limitations of Study

A strength of this study is that, shown by the limited number of articles that met the inclusion criteria, the concept of reducing the refugee experience to trauma and equally addressing pre-migration, in transit, and post migration issues through social services seems to be young topic in the literature. This systematic review re-conceptualizes and broadens existing definitions and ideologies of the refugee experience. By becoming more culturally sensitive, taking an interdisciplinary approach, and addressing all stressors of the relocation process through therapies, like narrative exposure therapy, the social services will be more targeted toward the needs of refugee populations.

A limitation of this study is that with the defined exclusion criteria there were not a lot of studies that were included. While this study focuses on micro practice, future studies of this nature would benefit from including policy related studies, as policies directly impact refugees' lives and the relocation process. While it is important to address relocation stressors in therapy, it is also crucial to make sure refugees are receiving services at each stages of the relocation process. As shown by this study interventions that take place in pre-migration and in transit are extremely rare. A potential way to increase services in transit would be through policy interventions not discussed in this project. Through the inclusion of policy related studies, social workers would benefit from seeing the intersection between micro and macro practice and how both can appropriately address relocation stressors.

Research Implications

Not only is it crucial to be addressing pre-migration, in transit, and post migration stressors in social serves, but there is also a need for interventions to be occurring at each

of these levels. There is a lack of data concerning interventions used to address in transit and post migration stressors. It is important for researchers to expand their conceptualization of the refugee experience to more than trauma and emphasize in transit and post migration stressors as well. Future research should investigate correlations between addressing in transit issues and post migration stressors with mental health or distress outcomes.

Because the data is limited in pre-migration and in transit settings, research in these areas would benefit social workers' understanding of refugee populations. What would be an invaluable addition to the literature would be clinical trials that take place in refugee camps. For instance researching the efficacy of different treatment modalities like group therapies, as seen in Otto and Hinton (2006) in refugee camps, would contribute to the literature because it is a way of making therapy available to more refugees in settings where services may be limited.

Future research on the relocation process should broaden the scope of the aversive effects of the relocation process to more generic mental health terminology, rather than diagnostically significant criteria. As Schweitzer, Melville, Steel, & Lacherez's (2006) noted, perhaps mental health symptoms are not the most reliable outcome measures, given that while refugees may not be presenting with diagnostically significant levels of mental illness, they may still be experiencing clinical levels of psychological distress. Future studies might benefit from using distress measures, rather than mental health measures to provide a more accurate depiction of the refugee experience.

Future studies should develop culturally adapted therapy models like Otto and Hinton (2006) do. There is a lack of attention in research regarding culturally specific

treatments. There is plenty of data stating how refugees conceptualize and understand mental health and treatment differently than people who ascribe to Western medicine (Adams, Gardiner, & Assefi, 2004). Data collection on culturally tailored therapies would be a complement to the existing literature on therapy frameworks currently used with refugees. Using research as a way to expand traditionally thought of settings and concepts would be a great benefit to the literature because it may depict how culturally tailored therapies through the use of different modalities may influence treatment.

Practice Implications

Given the findings of this study, there are several ways to improve approaches for improving social service interventions with refugee communities. One proposal is a model similar to Onyut, et al. (2004), in which refugees are trained to provide treatments so interventions in locations like refugee camps are more feasible and accessible. It is likely that through early intervention of trauma refugees would psychologically benefit and perhaps alleviate the distress seen in post-migration. The model depicted in Oyut et al.'s (2004) work is a feasible way of providing services in transit, which, as shown by the evidence in this systematic review, is often a stage during the relocation process that is ignored. Another proposal for feasible treatment options in refugee camps would be a group therapy model seen in Otto and Hinton (2006). In settings like refugee camps, group therapy or therapy by trained refugees may be a practical way to providing services to large groups of refugees when there are limited clinicians.

Research including a multidimensional, interdisciplinary approach to resettlement through providing resettlement assistance and resources in combination with mental health services would be a welcome addition to the literature (Raghavan, 2012; Wyk et

al., 2012). Studies by Wyk et al. (2012) and Raghavan et al. (2012) include models of social services worth replicating because these models approach resettlement and the relocation process interdisciplinary.

Culturally sensitive treatments like the one adapted by Otto and Hinton (2006) and Oyut et al. (2004) may be successful with refugee populations because their experience might not be properly described and defined by Western medicine ideology (Adams, Gardiner, & Assefi, 2004). Tailoring therapy to specific cultures common amongst refugee populations may assist clinicians in addressing refugee specific issues, especially since Palic and Elklit (2009) found that the traumatic symptoms refugees experience often manifest with more complexity. Through the use of culturally specific therapy models and social service interventions clinicians may see better results and outcomes with refugee populations.

In addition to including pre-migration, in transit, and post migration stressors into the social services and intervening with social services at each of these levels, it is also important to enact and advocate for legislation and policy to assist refugees with the relocation process. At a macro level social workers can advocate for refugees to make seeking asylum easier, faster, and less distressing. This could include advocating for better resettlement benefits and reducing unnecessary hurdles refugees have to cross to attain benefits, assistance, and employment. At a national level it could also involve improving the detention process. Oftentimes when refugees come to the United States they are held into detention until their fear of prosecution can be substantiated, often resulting in legal proceedings (Jesuit Refugee Service, 2010). Social workers can also pursue international interventions such as addressing the United Nations to make refugee

camps safer and encourage countries to incorporate more mental health and social services. Social workers not only have an obligation to address resettlement issues with refugees at a micro and mezzo level, but also at a macro level.

Social workers need to be perceptive to the cultural and social stresses refugees experience across the relocation process in order to address refugees' needs. By understanding the totality of the relocation process and the stressors that are common amongst refugees across the relocation process, social workers can tailor interventions to the specific, exhaustive needs of refugee populations with cultural competence, in turn to better assisting refugees and advocating for micro and macro interventions, as well as systemic changes. With this knowledge social workers are more competent in their work with refugees by selecting their practice and theories appropriately.

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Table 1.

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Pre-migration	In Transit	Post migration
Physical torture	Refugee camp	Isolation
Psychological torture	Interethnic conflict	Lack of social support
Death of a loved one	Illness	Cultural issues
	Sexual Violence	Resource accumulation
	Legal limbo	Loss of societal roles
	Fear of travel	Environmental mastery