

UN MATTERS

A first person account of the refugee experience: Identifying psychosocial stressors and formulating psychological responses

Psychologists address the U.N. community about global violence and highlight psychology's evidence-based contributions to prevent and mitigate it.

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Historically, reports of the experiences of refugees around the world have been and continue to be profoundly compelling. An essential component of that experience is the psychosocial impact resulting from conditions of refugee life that challenge survival. In this column, we attempt to do justice to the reality of refugee life and the emerging responses by psychologists to the needs of refugees. We first frame the extensiveness of refugees worldwide, then present a moving and provocative first person account of encountering a refugee camp and finally, discuss some emerging responses by psychologists to the trauma of what are so often debilitating circumstances.

The status of refugees

Reports from the United Nations High Commissioner for Refugees (UNHCR) indicate that as of 2013, there were over 10 million refugees worldwide, with more than half of them coming from Afghanistan, Iraq and Somalia (UNHCR, 2012, 2014a). According to a UNHCR report (2014a), the 1951 Refugee Convention defines a refugee as someone who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality, and is unable to, or owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2014b)." Forced displacement from one's homeland to a host country is a global issue and since its inception, the UNHCR has been tasked with providing protection, assistance and humanitarian aid to refugees worldwide.

While temporary refugee camps are hastily erected by nongovernment organizations (NGOs) and local governments around the world, the news media tends to focus intensely on a few "hot spot" camps for refugees. Currently, news reports focus on temporary refugee camps in Jordan and Turkey, whose residents have fled warfare in Syria and have fled incursions from ISIS/ISIL. During previous periods of armed conflict, the Darfur refugee camps in Sudan, were prominently featured in the news as were refugee camps for victims fleeing armed conflict in Kyrgyzstan. UNHCR (2012) professionals respond to "new emergencies in places such as Libya and Côte d'Ivoire, while addressing long-standing displacement in and from countries such as Afghanistan, the Democratic Republic of the Congo, Iraq, Somalia, and Sudan" (p. 5). NGO and humanitarian professionals attempt to recognize and honor diversity among displaced populations including cultural, historical, gender, religious and food practices.

Living in a refugee camp

"The refugees of concern to UNHCR are spread around the world, with half in Asia and some 28 percent in Africa. They live in widely varying conditions, from well-established camps and collective centres to makeshift shelters or living in the open" (UNHCR, 2014c). Have you ever wondered about the living conditions in a refugee camp? What is the treatment of and hardships for children? ...women? ... disabled people? ... elderly people? ... families? Ms. Hadia Zarzour, a former member of Neal Rubin's Div. 52 student group, has translated observations of her friend, Ms. Suzanne Kawmieh, who volunteers time and services in a refugee camp in Syria. Hadia reports that Suzanne is Syrian and has been very active assisting Syrians in a refugee camp located on the border of Syria and Jordan. We are including the translation, with permission, and have made only minor editorial comments in order to improve the grammatical flow and have not altered the content.

In her own words: Suzanne Kawmieh as translated by Hadia Zarzour

In early 2014, I took a short trip to the Syrian-Jordanian border, specifically the Zaatar refugee camp (Jordan), for the first time. I had been working on various humanitarian projects related to Syria; however, the focus had not been the refugees, but on those who were still in Syria.

The Zaatar refugee camp is now the fourth largest city in Jordan and is home to over 150,000 Syrian refugees. A winter storm hit the camp the week before we arrived, flooding and collapsing all of the tents. Refugees were literally left homeless (or more accurately, tent-less). What little clothing and food supplies they had, were destroyed. Our trip was an emergency relief trip to provide winter jackets, food aid, portable heating units and medical supplies.

The refugee camp is in the middle of nowhere — the north Jordanian desert — far from any city or inhabited area. Tall barbed wire fences surrounded the camp and guards would arbitrarily open and close the camp to incoming refugees, volunteers or visitors. When we finally arrived at the camp, the guard would not allow us entry. We showed them our Syrian identification and told him we want to visit relatives. We tried many ways of persuading the 20-something year old guard, who was empowered by his rifle, to let us enter. He would not. So, we sat against the fence on a dirt road and waited. Soon, luxury cars full of wealthy donors from Gulf States rolled up and the guard would wave them through. One after another. Those of us who arrived on foot, were Syrian, and had nothing but our backpacks, were refused entry.

A man was also leaning against the fence next to me. His daughter was seated between us. She was young, about 7 years old. She asked for water; she was thirsty. He told her she had to be strong; there was no water. A little while later, she asked again and received the same response. Yet again she asked, and finally her father told her he would ask the guard for some water. The guard mocked him and beat him with the butt of his rifle. I turned away and couldn't look anymore. I couldn't photograph or document what was going on, though I knew there was no way in hell it was legal to beat refugees for asking for water. The man's wife begged them to let him go. Through her tears, I could hear her tell him they should go back to Syria. "Better to die by bombs and snipers, but with dignity, than here."

Another luxury car approached. A passenger seated in the back rolled down his window and stuck out his camera and tried to take a picture of me ... sitting on the side of a fence on a dirt road, exhausted after walking for so long, in my misery and filth. He wanted his cliché "poor refugee woman" picture. I wanted to spit in his face. I never felt so weak, so humiliated, so violated. I suddenly understood what it must be like to be on the other side of the camera: to have prying journalists want to capture your moment of despair and profit from it. Instead of people helping you out of your despair, they want to save it on their flash drives, show it at banquet dinners and use it as a gimmick. I remembered what one young girl had told me previously, of how a French journalist had asked her to cover her face with a scarf and wanted to photograph her because she had blue eyes. Her mistrust and rage about opportunistic journalists now seemed quite mild.

Soon, another car approached the refugee camp ... another wealthy donor ... another foreigner. This one thought his donation could buy him a wife because Syrian refugee women were so desperate these days. The young girls in the camp told me about these men — how they would hide in fear that they would be spotted. These men would "marry" a young girl and not pay a dowry, only to divorce her a week or so later. "Marriage" provided a religiously permissible cover for them to enjoy their vacations.

We were finally allowed entry into the camp. I saw small bridal "shops" popping up. They displayed bridal wear, dresses, makeup and costume jewelry. A young girl was being fitted into a bright blue dress by her older sisters and mother. She didn't want to marry the suitor; he was several years older. Her mother told her she would grow to love him when he cared for her. This was her ticket out of the refugee camp and the squalor they were left in. She remained silent. They struggled to fit her into a dress she was praying wouldn't fit.

The families of the girls weren't cruel or profiting off the marital exchanges. They just hoped the man would be able to provide their daughters with some semblance of security; something they didn't have in their small tents. Incidents of sexual harassment, and even rape, were common in camps in which no law enforcement existed or method of defense was available. The family from the bridal shop invited us back into their tent. We sat on a muddy floor drinking cloudy tea (from contaminated water). We realized we were from the same former village. We caught up on the past few years we had been apart and they also described their refugee experiences. Soon, other residents from our former village had gathered outside the crowded tent. They shared with us their hardships and pleaded that we do something ... anything. They showed us an expired can of luncheon meat they were given as their food ration for the week and how their children grew ill upon eating it.

One mother showed me her young son who was having "episodes" (i.e., outbursts) and asked me if I knew what was wrong with him; if there was anything I could do to help him. I felt my mouth go dry as I recognized that the boy hadn't been able to forget his traumatic experiences. He could only scream to drown out memories of sounds and events. I knew we couldn't do anything; we weren't equipped with the necessary medication and didn't have a mental health professional on our team. I told the mother, "No, I'm sorry."

A young girl took me aside to her tent and told me about the other girls who had been raped in Syria. How they were seized from their university campuses or homes. She described how they were inconsolable and had given up on life. Some had literally committed suicide. She told me about the physical and emotional wounds they had; how their families were shamed; how they no longer had any sort of future in their traditional tribal families and home towns; how they were disowned. She then asked me if I knew any surgeons who could perform hymen reconstruction for these young women. Perhaps they can put the rape out of their minds; perhaps they can pretend to be virgins, move on with their lives and marry. I told her I was not a health professional, I did not know. But would she be comfortable with me asking the doctors on our team? She refused. They were all

men. Some of them knew her family. I couldn't comprehend the severity of the damage, either physical or emotional. I couldn't refer her to anyone. I couldn't do anything but cry. I felt paralyzed and responsible. These girls needed so much more than just reconstructive surgery, but this was a problem that reached beyond war to deep rooted tradition, tribal affiliations, and what the girls wanted and needed. I had to respect their wishes; they didn't want men involved. Any men. Even men whom I knew would not treat them with anything less than gentleness and respect — men who could help them heal. She gave me her phone number on a piece of paper and told me that if I came across anyone who could help, to please call — somehow. I folded the small piece of paper with the Arabic numerals and placed it in my pocket. I can still hear her pleading with me not to forget them ... not to forget her. I could still hear them pleading for a woman's help with what, to them, was a woman's problem.

As we left, we passed through a military checkpoint. Guards had their automatic weapons visible and one huge tank sat on the side. We turned and waved to the family and neighbors. They stood in a crowd. They weren't allowed to leave the refugee camp. It's like one big open air prison. They could only get so close to the checkpoint. Once we crossed, that was it. Our passports were returned and we left the camp. I couldn't look back, I had to walk out and keep going down the dirt road. It was a long dirt road that led away from the barbed wire, the tragedies, the hushed pleas and the expired food.

Psychosocial stressors and refugee camps

Although it is difficult to do justice to such a moving and evocative first person account, Suzanne's personal narrative highlights many compelling psychosocial issues of interest to international psychologists (e.g., pre- and post-migration/resettlement stressors; effects of involuntary detainment within refugee camps; effects of limited opportunities to participate in the host country's activities, such as employment or education; and effects of insecure housing and insecure residential/immigration status). Suzanne's narrative also highlights troubling issues of interest to clinical psychologists (e.g., PTSD, anxiety, suicide, vulnerability/powerlessness, depression and effects of rape). Collectively, these stressors have the potential to exacerbate PTSD symptoms that have been found to be pervasive among refugees. (Drozdek, Kamperman, Tol, Knipscheer, & Kleber, 2013; Yakushko, Watson, & Thompson, 2008).

According to Kruse, Jaksimovic, Cavka, Woller, and Schmitz (2009), PTSD is the most common psychological disorder that has been studied among war refugees. Moreover, they and other researchers (e.g., ter Heide, Mooren, Knipscheer, & Kleber, 2014; Yakushko et al., 2008) assert that due to witnessing and experiencing:

1. Repeated exposures of war, violence, rape and bombings.
2. Torture, death, disappearance and/or wrongful imprisonment of relatives or loved ones.
3. Involuntary relocation.

Complex PTSD is often persistent and chronic, and might complicate the efficacy of treatment interventions.

Yakushko et al. (2008) offer some examples of refugees' experiences, noting "80 percent of Cambodian refugees reported losing a friend or family member, 20 percent of Vietnamese refugees reported exposure to major trauma with 5.5 percent reporting imprisonment or torture, and 60 percent of Indochinese refugees reporting some form of trauma with over one fourth reporting having been tortured" (p. 170). In addition to the experiences of overt trauma, most refugees arrive at a temporary refugee camp with limited personal possessions, having left photographs and keepsakes behind. Another stressor, therefore, becomes the possibility of "statelessness," or being without a recognized legal status in a host country. Camp stressors (e.g., overcrowding, unsanitary conditions, limited or non-traditional food supplies and transiency), along with feelings of helplessness and powerlessness, contribute to short term and long term emotional distress, and eventually complicated PTSD, if not treated early (Yakushko).

Clinical interventions

Trauma-focused cognitive behavior therapy (CBT) and eye movement desensitization and reprocessing (EMDR) have proven to be effective psychological interventions for Western clients who have experienced trauma but the evidence-based efficacy for refugees residing globally is in its infancy and is under-investigated (ter Heide et al., 2014; Drozdek et al., 2013; Yakushko et al., 2008). A growing number of researchers (e.g., Kruse et al., 2009; Drozdek et al.; ter Heide et al.) agree that trauma-focused, multimodal, multicomponent interventions that are also culturally adapted and linguistically appropriate, are proving to be effective for refugees experiencing complicated PTSD. Increasingly, Western psychologists are learning to appreciate the relationship between the collectivist nature of many of the refugees' cultures with designing and implementing intervention models. Most psychological interventions that are reported in the literature have occurred in settings in Western countries, after refugees have resettled permanently, rather than within the temporary confines of refugee camps. Drozdek et al. (2013) have used group interventions effectively while Kruse et al. (2009) and ter Heide et al. (2014) have experienced positive outcomes with individual interventions. We briefly discuss both types of interventions.

Individual interventions with refugees

Krause et al. (2009) used an individual psychotherapeutic intervention with Bosnian refugees while implementing seven core elements (i.e., treatment relationship, feelings of safety, psychoeducation, cognitive restructuring, progressive muscle relaxation, skill building/regulation of affect and self-perception/caring of oneself). ter Heide et al. (2014) report treatment success using EMDR on an individual basis with a refugee population, noting "EMDR may be a suitable approach for refugees because it does not include homework assignments, may minimize language issues because speech is not always necessary, and has been found efficacious with patients from non-Western cultural backgrounds" (p. 147). Otto and Hinton (2006) and Schulz, Resnick, Huber and Griffin (2006) have demonstrated the efficacy of CBT and adapted cognitive processing therapy with refugee populations.

Group interventions with refugees

In the Netherlands, Drozdek et al. (2013) used a group intervention model to treat Iranian and Afghan refugees in a long term day treatment program for PTSD. Clients ranged in age between 18 years and 70 years and spoke Farsi or Dari. Their treatment model incorporated components of CBT with imaginal exposure, empowerment and socially supportive interventions as well as exploration of coping styles. Psychotropic medication and non-verbal therapies (e.g., art therapy, music therapy) were incorporated as adjuncts to group therapy. The non-verbal therapies were effective with clients who experienced difficulty in the verbal expression of traumatic experiences. The short-term and long-term outcomes of this model were positive for the reduction of PTSD, depression and anxiety symptoms.

Stressors and permanent resettlement

For those individuals and families who are fortunate enough to leave a temporary refugee camp and immigrate to a host country (typically a Western one) with the intention of permanent settlement, other stressors arise as they relate to adjustment. These might include adjustments to new mores, additional rules, different languages and atypical lifestyles as well as managing stressors arising from their insecure legal residency status and/or potential for "statelessness" (Yakushko et al., 2008). The often irreversible relocation to a host country gives rise to the possibility of significant loss of and grief for relatives, friends, neighbors and the former lifestyle. Upon arrival in the resettlement country, a series of issues might impact adjustment. These issues might include personal health and mental health challenges due to torture, poverty, untreated war-related injuries, unsanitary living conditions in the temporary refugee camp or an insecure immigrant status. These pre-existing relocation stressors, compounded by the new environment of the host country, along with a diminished social and legal status and any social oppression or prejudice arise from members of the new host country, will contribute to acculturation stress.

Interventions to facilitate refugee resettlement

"Intervention work with immigrants must include considerations of the psychosocial factors that influence immigrants' experiences of stress and coping" (Yakushko et al., 2008, p. 174). Local psychologists and psychologists contracted by NGOs will provide therapeutic interventions but must also collaborate with other professionals in order to provide a full complement of support and adjunct services to the refugee population in the new resettlement country. Gilbert (2009) and Yakushko et al. recommend that professionals examine each refugee's individual and family resources for successful social, cultural and economic integration; explore family dynamics from the family's cultural background including gender, age, disability and household composition; assess motivation for adaptation which includes the acquisition of the new language and lifestyle; evaluate problem-solving and coping skills; and identify transferable employment skills.

All professionals are advised to take a long-term perspective of the post-migration process in order to facilitate a refugee's successful resettlement. This process includes providing culturally and linguistically appropriate short-term and long-term psychological services focused on PTSD symptom reduction and cultural adaptation; advocating for bilingual interpreters, if necessary; understanding the host country's refugee resettlement policies, practices, laws and resources; facilitating access to the country's legal system, educational system, language classes, health care system and employment services, among others, as well as locating adequate housing.

Conclusion

By providing a first person account of the refugee experience, we hope we have offered an intimate, though disturbing, window into understanding the reality of what refugees typically encounter. Successfully confronting multiple and complex psychosocial stressors related to warfare, torture, rape and forced dislocation of refugees require multimodal interventions used within a culturally and linguistically appropriate context. Services may be provided by psychologists and other professionals to address the complexity of issues related to acculturative stress. Yet, in spite of everyone's best effort, not all outcomes will be positive. Gilbert (2009) asserts that NGO professionals face the possibility of encountering a lack of clarity in their role, confused demands and difficulty in navigating complex political situations in the host country. Gilbert continues to assert, "These dilemmas are rarely discussed explicitly, but permeate every aspect of the refugee and counselor interaction (p. 50)." These are the types of challenges and conditions that international psychologists encounter and are learning to confront.

- [Toolkit \(22\)](#)
 - [Guidelines \(18\)](#)
 - [Bibliography \(14\)](#)
 - [Chart/Table/Figure \(13\)](#)
 - [Letter \(13\)](#)
 - [Summary \(13\)](#)
 - [Bylaws \(12\)](#)
 - [Convention/Conference Program \(12\)](#)
 - [Manual/Handbook \(10\)](#)
 - [Policy/Procedure \(9\)](#)
 - [Speech/Transcript/Script \(8\)](#)
 - [Directory \(7\)](#)
 - [News Responses \(7\)](#)
 - [Database/Electronic Product \(5\)](#)
 - [Form/Application \(5\)](#)
 - [Blog \(4\)](#)
 - [Event Calendar \(4\)](#)
 - [Survey/Survey Results \(4\)](#)
 - [Obituary \(3\)](#)
 - [Minutes \(2\)](#)
 - [Presentation \(2\)](#)
 - [Task Force Report \(2\)](#)
 - [Agenda \(1\)](#)
 - [Call for Comment \(1\)](#)
 - [Opinion/Editorial \(1\)](#)
- [Show fewer resources](#)