REFUGEE PERCEPTIONS OF POST-MIGRATORY STRESSORS IMPACT ON PRE-EXISTING TRAUMA

by

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Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

Refugees are an ever-growing population across the world. Refugees leave their country to survive from the horrors and traumas many experiences. They arrive in countries oftentimes with little to no language proficiency, housing, finances, or employment. The stressors many of them face mixed with the trauma they experienced pre-arrival can be a heavy burden to carry. The purpose of this case study is to understand the perceptions of post-migratory stressors impact on pre-existing trauma for refugees at Matthew House in Vancouver, Canada. A constructivist approach is taken since the focus is on the situation from the participants' point of views and looks to advance areas of furtherance in the area of social justice for minority populations. The goal is to add to the discussion on how to better assist refugees when they arrive to countries such as Canada so they can find healing and adjust quickly to be an asset to the community.

Keywords: Trauma, Refugees, Postmigration, Stressors

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Dedication

This study is whole-heartedly dedicated to all refugees around the world. To those who have overcome things many of us never imagine facing, you are each true examples of strength and resilience. I pray this dissertation helps give a voice to each of your stories.

Acknowledgements

First and foremost, I thank Jesus Christ my LORD and Savior for this opportunity. I pray this brings Him glory and advances His Kingdom through encouraging others to welcome in the stranger (Matthew 25:35) and being Jesus to each person that needs shelter, safety, healing, and a home. Second, I'd like to thank my church here is Vancouver that has welcomed me in and allowed me to come and complete this research with full love and support. Every Nation Vancouver, thank you for all your support and grace during this process. Your kindness to me will surely spill out to others around the world. Thank you for the provision of housing, food, and family when I moved here. Thank you to many of you ladies that aided in my assimilation; Tara, Jenna, and Leah, and the Goertzen family, I thank you from the bottom of my heart for your generosity. I especially want to thank Dr. Greg Mitchell for his supervision of me during this season and the ladies at Sanctuary Prayer that prayed earnestly over me during this whole process from beginning to end. Thank you for having faith and strength in the times when I lacked it.

Third, thank you to my friends and family that have supported me in my efforts. Thank you especially to my mother who has always pushed me to do whatever God has called me to do no matter how difficult or scary it may be. Thank you to my mentor Cindy Chamberland. Thank you for walking with me over the years as I healed from my own trauma. Thank you for giving me a voice and being one of my biggest blessings to come out of hard times.

I especially want to thank my committee Dr. Thomas Hudgins and Dr. Jeanne Brooks. Dr. Brooks thank you for pushing me to work hard and to "hustle" when it seemed impossible to complete a dissertation all while battling culture shock. Thank you for not only having a heart for

education and the furthering of science but also for the people. You saw each participant the way I did. They were seen as an incredible people with a story that needs hearing.

Lastly, thank you to all my participants. Each of you have changed my life for the better. Listening to your stories of great trials, trauma, and pain grieved me but then to hear how you have overcome to much and care for others who are hurting is such an example of how each of us should live. You have each shown me what strength and loving-kindness looks like. I pray this study changes the lives of thousands of people and that government agencies, charities, and individuals would hear these stories and just like the story of the Good Samaritan would feel such compassion to help that they wouldn't be able to contain it and would immediately step into action. We would see families created and healing take place in the areas of the mind that have become wounded.

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Diagnostic Statistical Manual Volume Five (DSM-IV)

United Nations Refugee Agency (UNHCR)

Chapter One: Introduction

"Refugees didn't just escape a place. They had to escape a thousand memories until they'd put enough time and distance between them and their misery to wake to a better day."

(Hashimi, 2016, p.303)

"To be called a refugee is the opposite of an insult; it is a badge of strength, courage, and victory."

(Tennessee Office for Refugees)

Overview

This chapter will focus on the background for this study including the historical, social, and theoretical variables that have led to this current research problem. The personal motivation for conducting this study and the philosophical assumptions that guide the study will be shared. The problem that exists in the literature and thus has led to this study will be examined alongside the purpose or focus and intention of the research. This chapter will explain the significance of this study and how it could aid in the advancement of pre-existing literature and how this study will impact the lives of refugees personally. Lastly, the main research questions are included alongside definitions of terms pertinent to the study.

Background

Historical

The modern-day refugee crisis continues to skyrocket with great numbers of forcibly displaced people groups around the globe. According to The United Nations Refugee Agency (UNHCR), 82.4 million people worldwide were forcibly displaced by the end of 2020 (UNHCR, 2020). This crisis has caused one in every 95 people on earth to flee their home due to persecution or conflict (UNHCR, 2020). Because of the global-wide Coronavirus pandemic, the

world has experienced how a global crisis impacts the lives of all involved. The statistics around the current refugee crisis are as difficult to ignore for the individual people groups involved as the coronavirus has been for people globally.

Since the beginning of time the world has experienced conflict, violence, persecution, and extremely disturbing events that have influenced the increasing number of forcibly displaced people across the globe. In more recent years the news has been filled with graphic scenes involving refugees. Although refugees have existed for as long as civilizations, the current refugee crisis has increased at alarming rates. For example, in 2011, the Syrian civil war began and the conflict with the Syrian government took its toll on the lives and establishments of the Syrian peoples. Due to the outbreaks of this war, it is estimated between the years of 2011-2018 around 500,000 people had been killed from the war and violence in Syria (The Syrian Observatory for Human Rights, 2019).

In 2016 a war began between Turkey's President Erdoğan and his government and the Fethullah Gülen movement, also known as Hizmet (Immigration and Refugee Board of Canada, 2020). This war deteriorated the Hizmet people's existence in Turkey. All their assets, schools, universities, and hospitals were forcibly shut down and those who financially supported the Hizmet efforts found themselves in danger (JWF, 2019). The Hizmet people began to flee and seek safety in other countries. Abductions and kidnappings of the Hizmet people began to take place "as part of the persecution launched by Turkish President Erdoğan and his government, primarily against participants of … the Gülen movement" (SCF June 2017, p. 4).

In May of 2021, after the removal of US soldiers and military personnel from Afghanistan, the terrorist group, the Taliban, retook the capital and began their attacks. Thousands of people sought to escape the Taliban and sadly hundreds died during suicide bomb

attacks at the Kabul airport (Brunhuber et al., 2021). Pictures and video clips surfaced on the internet and news stations showing Afghans clinging onto airplanes (Holt & Engel, 2021). Fighter jets filled with refugees taking them to safer nations received much cheer. As a result, the refugee crisis is not ending. The numbers of refugees over the years have not gotten smaller but rather increase almost daily. In fact, the refugee population has increased by 172,000 from January 2021 to June 2021 (UNHCR, 2021). This crisis leaves refugees needing the assistance of outside countries to welcome them into their borders.

Social

Refugees go through harrowing events such as those where their very lives are threatened; they are in actual danger, experience torture, see the death of a loved one, and/or live in a time of war (Drozdek & Wilson, 2004). Research supports that after a refugee experiences a traumatic event over 75% will remain resilient whereas roughly five-fifteen% will not recover and will develop posttraumatic stress disorder (PTSD) (Daskalakis et al., 2018). Refugees experience trauma while living in their respective countries, but also in their efforts to leave and resettle. Colborne (2015) has said, when working with refugees, “I don’t aim to diagnose trauma. I assume trauma. We will find it.”

Refugees arriving with untreated trauma carry with them several risk factors in their new country. One study conducted on refugees living in a refugee camp in Turkey found that PTSD ranged between 29.8% and 83.4% and between 27.4% and 70.5% for depression (Acarturk et al., 2016). Refugees often arrive with PTSD, depression, anxiety, or a mixture of the three. Yet, as time passes one can wonder if these symptoms lessen as they become more settled into their new culture. A study on refugees after two decades of resettlement was conducted to see if symptoms had changed. Their findings determined that time did not heal wounds and resettlement does not

equate the end of mental illness among this people group. Rather, 62% met the criteria for PTSD and 51% for major depression in the past year (Marshall et al., 2005). Interestingly, only 30% of the sample was free from PTSD, depression, and anxiety (Marshall et al., 2005).

Refugees arriving with PTSD, depression, and anxiety can impact their adjustment and the advancement of the community they are entering. Untreated trauma does not simply heal on its own. The expression 'Time heals all wounds' does not apply to trauma nor to the lives of refugees. Certainly, refugees can get to a point where they can not only survive but find a way to live life in a way that brings about joy and fulfillment. However, this takes effort and work rather than waiting for time to pass since the occurrence of traumatic events. As Ujernik suggested, the average individual with PTSD "may have been suffering for up to seven years before seeking mental health assistance" (2017, p.83). Marshall et al., added to this stating, "these results indicate that members of refugee communities can have substantial need for mental health services even years removed from their tribulations" (2005).

This is of importance as those who have experienced a traumatic event had a 27% higher risk of developing a psychotic disorder than non-refugee immigrants (Kirkbride & Hollander, 2015). Canada sees "roughly a quarter of a million people arrive and settle each year on economic or humanitarian grounds" (Kirkbride & Hollander, 2015). A study conducted on more than four million people between the ages of fourteen and forty living in Ontario observed higher rates of psychotic disorders in refugees from South Asia and East Africa compared to that of the general public (Anderson et al., 2015). Further studies have shown "that some refugees to Canada had an elevated risk of schizophrenia and schizoaffective disorders" (Kirkbride & Hollander, 2015). A study conducted on civilians with PTSD discovered 56.4% reported some form of suicidality, 38.3% reported ideation, 8.5% reported suicide plans, and 9.6% reported

suicide attempts; of those with attempts 75% had more than one attempt (Tarrier & Gregg, 2004). Those with PTSD can find ways to self-medicate such as drug and alcohol use.

Those who experience a traumatic event come out changed and those that develop PTSD can become almost someone completely different. Just like Robert Louis Stevenson's classic story *Strange Case of Dr. Jekyll and Mr. Hyde* (1886), they may be one person and after the life altering experience, they can seem to be someone completely new, especially to their friends and family members. During World War 1 an English writer, Edith Abbott, wrote about the changes he saw happen to the lives of the returning soldiers. She writes,

> The war has destroyed with a hand more desolating than the Black Death or the most terrible plagues of history. But its consequences do not end with destruction. The people who have taken serious part in it are not the same people as those who went into it…. They are changed peoples. They have passed through an experience which has altered habits, temper, outlook, in five years, more than fifty years of ordinary life would have altered them (Abbott, 1927, p.212).

Refugees with trauma may arrive as someone they themselves do not recognize which is yet another loss to grieve. They may find themselves behaving in ways they didn't back home. Although this was written in assisting war veterans with PTSD, many refugees too come from a war zone. Yet, unlike the American troops, the war zone was their home; they did not travel there trained and ready for a dangerous journey. They did not arrive warmed with weapons and Kevlar vests to protect them. At the end of deployment soldiers that survive the perils of war get to return home. Although due to what they experienced in battle they may forever be changed and home might not feel as safe anymore, a refugee either stays in their home and risks death or leaves their home forever.

PTSD has much in common for these two groups of people and can express itself in similar behaviors. It is important to note that just because a refugee arrives with PTSD, and it is left untreated does not guarantee they will engage in drugs, alcohol, or crime. Yet, it is a risk factor to consider, not to keep refugees out of our Western countries but to recognize the need to help and assist them to have a better quality of life in their new country, mourn the loss of all they had to say goodbye to, and embrace them so they can be an asset to the community rather than seen as a financial burden.

Untreated trauma can increase crime rates. The Kentucky Bar Association discussed the increase in crime for those with PTSD;

> Many symptoms of PTSD can lead to behaviors likely to result in criminal behavior and/or sudden outbursts of violence. Individuals with PTSD are often plagued by memories of the trauma, chronically anxious, and unable to sleep without terrifying nightmares. They often self-medicate with drugs and alcohol in an attempt to calm their nerves and sleep. The emotional numbness many trauma survivors experience can lead the survivor to engage in sensation-seeking behavior in an attempt to experience some type of emotion. Some combat veterans also may seek to recreate the adrenaline rush experienced during combat. “Hypervigilance,” feeling the need to be always “on guard” can cause veterans to misinterpret benign situations as threatening and cause them to respond with self-protective behavior. Increased baseline physiological arousal results in violent behavior that is out of proportion to the perceived threat. It is common for trauma survivors to feel guilt and to resort to self-destructive behaviors, which can sometimes lead them to commit crimes that will likely result in their apprehension, punishment, serious injury, or death (Hunter, 2015).

Not only can crime, suicide, and addiction increase but likewise this can impact children and future generations. Children that were lucky to not experience the traumas of their parents, such as those born post-migration can still experience trauma via their parents. “The social, economic, and spiritual effects of trauma are rarely healed without having effected younger generations through channels such as social learning and co-regulation from a traumatized parent” (Asamoa-Tutu, 2013, p.10). A study on Cambodian refugees discovered links of PTSD for adolescents with parents that had PTSD (Sack et al., 1995). Researchers compared this to the Vietnam War fathers and their children. The father would withdraw from parenting functions and such with their children and the children reflected higher depressive symptoms (Sorrention, 1990).

Children cannot make sense of trauma any better than adults can. In fact, adults can understand why they had to leave everything behind, and they know it won’t be an easy journey to reach resettlement, but their children don’t have a say in these matters and may not grasp the severity of why their family had to flee. This seems to correlate well to what Anna Freud wrote in *War and Children*; she explains that for an adult they can find themselves completely separated from their people and experience and intense longing for them. Yet, they can look back on those memories with great fondness until they are lucky enough to be reunited again. “The psychological situation of the child is completely different… Its memories of the past are spoilt by the disappointment which it feels at the present moment. It has no outlook into the future, and it would be of no help to if it had” (Freud & Burlingham, 2020, p. 29).

A common risk factor for traumatic and depressive symptoms pertained to social relations where a lack of social support and community held a high predictor for these symptoms (Carlsson et al., 2006). When refugees arrive feeling alone depressive symptoms are bound to

increase. Studies have shown the link of PTSD, depression, and anxiety for refugees over the years. Their aim has been to understand not so much where the trauma originated but more so to determine how to help refugees heal and adapt to their new home. Each study has been conducted on differing people groups, wartimes, genders, ages, those in refugee camps and those since left, those resettled recently and those who have resettled years ago, as well as many other considerations. Results regarding mental health symptoms tend to vary, but what stays the same is the need for mental health services for refugees and the many factors that make that difficult (Kaltenbach et al., 2018). Likewise, traumatization is highly linked to psychological distress among ages and cultures (Bean et al., 2007).

Figure 1 (Miller & Rusmussen, 2010)

In Figure one there is a straight line where the arrow leads from exposure to war-related violence and loss to mental health, "reflecting the direct effect that exposure is believed to have on mental health status. The model does not include any intervening variables (such as daily stressors) that might either partly or fully explain the impact of war exposure on mental health" (Miller & Rasmussen, 2010). Therefore, a more realistic model would be more complicated and perhaps mirror that of a toddler's drawing. The lines would be in multiple spots leading to perhaps opening up about needing help, to not being taken seriously, or desiring help and not having the time or resources to get it, then there is the discrimination or traumatizing factors they might experience post-migration, another line may be to self-medicating and coping strategies

whether they be ones that are healthy or unhealthy, and some may even get help for a short time period but for different reasons not continue and perhaps find themselves in the condition they were in prior to getting help.

Survivors of disasters and/or other traumatic events often require immediate psychological assistance and care, but trauma specialized clinicians and services are often scarce and service providers are often busy and cannot take the time for proper assessment (Hansen et al., 2010). Or they believe they do not need or wish to receive help even if offered to them due to stigmas. They may focus on suppressing those memories and feelings they have. In Shannon et. al.'s study in all four groups of people interviewed, each group shared they desired not to disclose information from the past and rather desired to avoid it as these are painful reminders of loss, death, torture, dangers while fleeing, difficulties in refugee camps, and they do not want to think about what is still taking place back home (2015). However, "suppressing and disconnecting the past may be effective strategies for coping with overwhelming stress over the relatively short-term, but they may be impossible to maintain forever" (Beiser & Wickrama, 2004, p.907).

Even those desiring to work with refugees may find some struggles of their own. One concern when it comes to Western clinicians trained in the field of trauma is the limitations Western education has when assisting other cultures. It would be easy for a clinician to try to diagnose and treat PTSD in refugees the way they would someone from the West.

As Miller and Rasmussen (2016) write

> Rapid growth in the field of traumatology has fueled global interest in the study of PTSD. Researchers trained in Western psychiatry and clinical psychology have

> increasingly adopted the trauma-focused framework developed in the West, shifting the focus of research in non-Western societies affected by armed conflict to the study of PTSD (and related psychopathology) and its relation to war exposure,

Researchers have asked the question why those with trauma do not receive the help they need. Gavrilovic et al. observed how in three separate studies there were two common themes: internal and external barriers. External barriers consisted of lack of resources or education on available services (transport difficulties or costs/insurance coverage) (2005). Whereas internal barriers were beliefs or attitudes about mental health services and mental illness (not desiring to discuss the trauma, distrusting services, believing they do not have a problem) (Gavrilovic et al., 2005). These internal and external variables are important to consider when working with refugees. If the general population has difficulties in this area then those who arrive with little knowledge of services available, limited language acquisition, and multiple current stressors have more daunting variables..

Yeung researched Cambodian refugees not receiving mental health care via a local Community Centre. He observed eight barriers for not receiving help; “54.4% I do not have a problem at this time, 2. 28.3% I do not speak English, 3. 28.3% I do not believe mental health professionals can help me, 4. 26.1% I do not know where to get services, 5. 17.4% I cannot afford the cost, 6. 17.4% I am too depressed to talk to anyone, 7. 15.2% I have no transportation, 8. 8.7% I am afraid of being called or looked at as being crazy” (Gavrilovic et al., 2005, p.131; Yenung, 1988). An additional study looked at those with PTSD not receiving treatment via medication and psychotherapy and discovered of 64 patients not receiving medication 25% felt they needed it and of 72 patients not currently in psychotherapy believed they needed counseling

for their emotional problems (Rodriguez et al., 2003). Reasons for not receiving treatment 45% stated their physician did not recommend medication to them and 26% percent did not engage in psychosocial treatment as they did not believe they had a problem that needed treatment (Rodriguez et al., 2003). Anxiety and mood disorders are often comorbid with PTSD, yet if they are not receiving care for PTSD there is a high chance the other areas are not being addressed as well.

Participants in Rodriguez's study found the typical patient with PTSD had "more than 3 current comorbid anxiety or mood disorders and a lifetime history of more than 4 anxiety or mood disorders" (Rodriguez et al., 2003, p. 1234). This information reflecting the great need not only for PTSD treatment but treatment for other diagnoses that are present as well. Research is showing that there is a need for mental health care for refugees. Yet, research reflects there is a missing link between needing treatment and receiving it. When clients do pursue mental health care due to trauma some arrive in a chronic state of hyperarousal which negatively effects their functioning, or they arrive in a state of hypo-arousal which carries the numbness of depression and at times dissociation (Uhernik, 2017). This can be difficult to help a refugee facing these symptoms while more than likely having a language barrier as well.

Refugees have often been victims of torture and were silenced and imprisoned for speaking out against injustice and/or political beliefs. Which then results in refugees who have spent years unable to speak and therefore struggle to being talking about the suffering they experienced even once safety is obtained (Shannon et al., 2015). Refugees interviewed in Shannon et al.'s study spoke of this silencing, "the problem that we faced, if we start talking about it, it would take a year to talk about it" or "they don't know how to explain such emotional pain" (2015). Fear was a major factor of what refugees do not seek mental health care. These

fears included, “the fear of showing emotions and being seen as insane or ‘crazy,’ the fear of alienation from the community, the fear of being taken to the hospital, the fear that they can’t be treated, the fear of losing housing or jobs, and a fear of spies in the community or lack of trust in confidentiality” (Shannon et al., 2015).

This situation hugely is in part to the fear of them being “crazy” and experiencing isolation from their community. This can be incredibly traumatizing as many have experienced great loss and separation against their desire or control. To have mental health concerns that they believe they can hide by keeping it inside or disguising it and this prevents further loss or being categorized in a shameful way. Further studies have shown the stigma refugees have towards receiving mental health care and believing this implies you are crazy. One participant in Saechao et al.’s study said, “people do resent you know, the services, simply because people put titles very easily on people, so if you do need to see a therapist or psychiatrist or psychologist, it means that you are crazy” (2011). These fears can lead to dishonesty in the forms of trying to hide the mental health problems as the source of their concerns and rather tell medical professionals they are struggling with headaches or sleep problems” (Shannon et al., 2015).

There is fear to share what has taken place to them because all their refugee friends have experienced many of the same thing or even what they might consider worst and therefore do not want to disclose what they have experienced as how can they help one another if both are struggling in the same way (Shannon et al., 2015). “For survivors of catastrophe, the past most likely includes not only traumatic and shame-inducing memories, but memories of loss which may invoke nostalgia for a never-to-be-regained past…. A sense of stability and of present—day successes probably helps individuals reconcile memories of what they have been, and hopes for

what they might have been with the people that despite and because of adversity, they have become" (Beiser & Wickrama, 2004, p.909).

Refugees can suppress thinking about and certainly discussing the trauma of the past. One researcher compared this to that of holocaust survivors who over time realized their story did need to be told (Beiser & Wickrama, 2004). Elie Wiesel receiver of the Nobel Peace Prize in 1986 was a well-known survivor of the Holocaust. He wrote regarding the difficulty he faced speaking, or in his case, writing the unspeakable pain he experienced years ago in Auschwitz. His experience of the unspeakable rings true for many refugees when he writes,

> We all knew that we could never say what had to be said, that we could never express in words—coherent, intelligible words—our experiences of madness on an absolute scale. The walk-through fiery nights, the silence before and after the selection, the toneless praying of the condemned, the Kaddish of the dying, the fear and hunger of the sick, the shame and suffering, the haunted eyes, the wild stares—I thought that I would never be able to speak of them. All words seemed inadequate, worn, foolish, lifeless, whereas I wanted them to sear (2011, p.14).

Asking a refugee to put their experience into words can be incredible hard and painful emotionally but even more so as they might not even know how to explain what was experienced.

Refugees may face fear asking for help to a medical professional. Medical professionals might not feel safe, or they might not feel listened to by the professionals. One refugee shared, "the doctors are not listening to us, they give us only 15 minutes or probably the interpreter is not telling them right" (Shannon et al., 2015). This can be concerning as another major symptom

associated with PTSD is difficulty with sleep. “The role of sleep in the psychological adjustment of refugees is essential to consider given the immense non-refugee research demonstrating the importance of sleep disturbance in perpetuating many of the mental health concerns (PTSD, anxiety, and depression) observed in refugee groups” (Lies et al. 2020). This is especially important to consider for refugees as sleep disturbance has been commonly seen among refugees with PTSD (Lies et al., 2019).

Additionally, many refugees do not share what their symptoms are unless directly asked by the doctor. If the doctor does not ask about their difficulty sleeping, they will not share (Shannon et al., 2015). If they are not being asked and they are not disclosing this information they may be suffering in silence in all areas including sleep. Research has shown refugees PTSD symptoms were attributed by post-migration stress and sleep disturbance therefore reflecting the importance approaching the issues of post-migration stress (Lies et al., 2019). Post-migration stress is a vital consideration for community preparation when welcoming in refugees.

Post-migration stressors can seem endless for refugees. Upon arrival they are flooded with needs for food, shelter, finances, language acquisition, community, and so much more. Although they may finally be safe from the harm taking place in their home country, they are not at rest just yet. Their journey for resettlement is far from complete. Therefore, if a refugee arrives with PTSD symptoms and immediately is faced with the stressors to survive in a new country how does one have a positive quality of life? “Post-migration stressors have also consistently been related to PTSD symptom levels among refugees, though the mechanism by which they may affect PTSD symptomatology remains unclear at present (e.g., do they deplete coping resources, thereby leaving people more vulnerable to the impact of prior war exposure? Are some exile-related stressors themselves traumatogenic?)” (Miller & Rasmussen, 2010).

Research pertaining to refugees in developed nations currently reflects that post migratory stressors, such as social isolation and unemployment, cause more or the same amount of traumatic stress than pre-migration exposure to violence (Miller & Rasmussen, 2010). Syrian refugees have a high prevalence of mental health problems during the initial resettlement period and longer-term symptoms appear to be determined by the degree of the trauma exposure and the stress experienced post-migration (Lies et al., 2019). "Refugees from war-torn countries have multiple risks because they face additional problems during migration and in the host country, in addition to the direct effects of war-related traumas in the home countries" (Kaya et al., 2019). The lack of assistance mixed with post migratory stressors creates disaster.

Common factors to high levels of depression and PTSD were associated with unemployment, poor language skills, being retired or disabled and living in poverty (Marshall et al., 2005). The trauma many refugees experience is not always pre-trauma. In fact, in one study 34% of participants reported seeing a dead body near where they lived, 28% had been robbed, and 17% had been threatened with a weapon where they believed they were going to be seriously hurt or killed (Marshall et al., 2005). The extent of trauma exposure experienced since arriving in the United States was linked to alcohol use disorder. A study of Darfuri refugees in eastern Chad studied the impact trauma could have on those who are displaced but further observed the correlation of trauma and psychological distress symptoms an individual could have that is not directly associated with the previous trauma but rather due to the hardships refugees face due to the day-to-day changes and resettlement stressors they face. They found that "current stressors account for substantial variance in DSM-IV and locally identified psychological distress and functional impairment—in some cases more than they accounted for by past trauma—belies the important role that displacement stressors play in phenomenology of psychological distress in

post conflict settings" (Rasmussen et. al., 2010). When post migratory stressors are decreased, studies have shown depression symptoms decreased by 1.8 times (Acarturk et al., 2016).

Unemployment may be difficult for refugees. Not simply because of discrimination, certifications, and licensures from country of origin not transferring, limited language speaking and/or writing skills but trauma can impact this as well. An abnormally function hippocampus can impact memory which can make interviews difficult as well as learning a new job. This mixed with an amygdala dysfunction may promote paranoias, exaggerated stress responses, hypervigilance, and fear associations. When this combination takes place and one's prefrontal cortical function is disrupted one's brain is unable to suppress these stress and fear responses properly (Sherin & Nemeroff, 2011). One's stress response has been triggered and their fight (arousal), flight (avoidance) or freeze (intrusions) has been activated (Germer & Neff, 2015). These trauma responses can make relationships, learning a new language, holding a new job, and trying to feel normal again all too difficult for those with untreated trauma.

When natural disasters such as an earthquake, tsunami, tornado, or bushfire affect an area the aftereffects can be just a stressful if not more than the event itself. This has been seen in studies such as one pertaining to the 2004 tsunami in Sri Lanka. Researcher discovered although the event was traumatic and did impact the mental health of the children the stressors appeared to be at least as powerful if not more than the actual event itself. "War and other disaster-related traumatic stressors are events that cannot be altered, although their residual impact on psychosocial well-being may be alleviated, but daily stressors represent ongoing, proximal events or situations that continue to adversely affect children and can be altered" (Fernando et. al., 2010). Vulnerability to the post-migratory factors may partly be mediated by past trauma" (Carlsson et al., 2006, p.56).

Communities preparing for refugees should be aware refugees often will come with PTSD, depression, and/or anxiety. They need to be ready for them to possibly be open for help and yet they might not be. However, just because they do not request help doesn't mean the trauma does away nor should their desire for help take for granted the stressors they face upon arrival. "The fact that the often very brutal past of tortured refugees influences life in exile, even after many years, should not stop us from recognizing post-migratory difficulties that affect mental health and quality of life" (Carlsson et al., 2006, p.56).

Communities should be prepared for what accepting refugees with mental health concerns looks like. One example for doing so it is taking the time to build trust. Refugees may be skeptical that they will be gossiped about behind closed doors or within their communities. They may be embarrassed to disclose information in front of an interpreter to a doctor. Trust and confidentiality must be established and maintained, especially for those who did not grow up in a country where they had civil rights (Shannon et al., 2015). Yet, if trust is built those areas that feel sensitive, dirty, and broken can be brought to the light and healing can begin. One needs stable work and a stable relationship to help the individual feel protected as they shared the trauma from their past (Beiser & Wickrama, 2004).

Likewise, helping refugees understand the need for mental health care services in a culturally sensitive way is a must. If a Western explanation is given as to why these services are important, they may entirely miss the root of the problem for these individuals and be culturally insensitive (Saechao, 2011). Therefore, educating practitioners on cultural practices and ways of explaining in a sensitive way can be helpful when educating refugees on services available. Another study on refugees with depressive disorder shared that health and social services working with refugees should be aware that depression induced from the past can take place

years to even decades after resettlement (Beiser & Wickrama, 2004). Isolation is a concern those working with refugees should be aware of and how this can increase fear and depression.

The fear of isolation for reaching out to get help is a big fear of refugees. This makes sense due to the experiences many have faced including situations where refugees were violently separated for their families and their communities. “To risk such isolation once more for the sake of healing may leave refugees fearing revisiting earlier trauma and choosing to suffer in silence. Providing psychoeducation aimed at destigmatizing the experience of mental health symptoms and offering community-based models of healing may help to address refugees’ fears of being isolated due to mental illness, Community-wide public education efforts may also help address the fears associated with the stigma” (Shannon et al., 2015). Canada favors the younger, highly skilled, English or French speaking applicants for immigration as they may be able to adapt and integrate faster than others, yet the great diversity of Canada may actually allow immigrants to establish support networks more quickly (Kirkbride & Hollander, 2015).

Releasing some stressors from refugees is incredibly helpful for welcoming them in and helping them receive mental health care. Ways that can better the mental health of refugees is policies and programs that target helping refugees locate employment and build a social sphere in their new community (Li et al., 2016). Post-migratory stressors have shown to have a negative impact on mental health and yet consistent employment aids in lowering emotional distress (Kaltenbach et al., 2018). We cannot expect healing to happen on its own and the importance to aid in healing as quickly as possible is a must for those working with refugees to consider as well as government officials who make decisions when it comes to the care and benefits refugees receive post-migration.

When it comes to "whether time heals or not depends on the conditions of its passage" (Beiser & Wickrama, 2004, p.908). If refugees are well supported, educated on services, and stressors are limited they could have the potential to heal these wounds. It does require people seeing a problem and stepping out to help. Wiesel shared when he saw refugees on the news, he knew he needed to help. He said, "how could a Jew like myself, with experiences and memories like mine, stay at home and not go to the aid of an entire people? Some will say to me, yes, but when you needed help, nobody came forward. True, but it is *because* nobody came forward to help me that I felt it my duty to help these victims" (Wiesel, 2011, p.131). No one may be coming forward to help in these areas in certain communities, but when it is noticed it should be especially true to come forward because no one is.

Yet, when refugees were given social support with post migratory stressors, there were lower levels of depressive symptoms and reduced levels of perceived discrimination (Oppedal & Idsoe, 2015). Post-migratory stressors such as gaining employment, language acquisition, locating housing, learning, and adjusting to a new country and culture, all add stress to the new arrival. There are many studies that indicate the relationship these stressors have on the mental health and wellbeing for refugees individually and collectively. Since not all refugees will meet the qualifications for PTSD diagnosis according to the DSM-5, PTSD will not be the focus but rather trauma and traumatic experiences for this study.

Theoretical

This study seeks to examine in-depth the current stressors impact on the trauma refugees have experienced prior to fleeing their country and/or in their effort to find refuge or asylum in a new country. Once a refugee arrives in their host country the nightmare does not suddenly disappear nor does life function smoothly like a dream. This study will focus on the stressors

they face and how this affects them. It will give refugee participants a chance to share what they would want the world to know if they had the world's attention for just five minutes. This study focuses on hearing directly from refugees on what post migratory stressors they face and how this has impacted the trauma they faced prior to their arrival.

Situation to Self

For the last two years I have been working with refugees in a mental health capacity. During my time hearing their stories of great pain and loss I have become aware of the trauma faced in their home countries and the trauma they try to forget. Yet, as their stories continue, they have shared great amounts of stress faced upon arrival in their new country and the lack of support helping them navigate this new beginning. Many still face the nightmares and memories that led to their leaving everything behind, but this must wait as more pressing things must be faced.

My motivation for this study is to help provide a voice to those who feel they do not have one through interviewing refugees specifically on their needs when it comes to post migration and trauma. This study takes a constructivist approach. This approach is appropriate as it aims to help those who do not come from the same advantages or disadvantages seen in different social classes, races or ethnicities, or genders (Pajo, 2018). Constructivism can be defined at the most basic level as a conversation is which words are exchanged and interpretations of language contributes to an understanding of constructions (Hayes & Oppenheim, 1997). It combines "theories of caring and justice as holding potential to address issues of social justice in ways that are both respectful of the human relations between researchers and participants, as well as to enhance the furtherance of social justice from the research" (Pajo, 2018, p.18). This study holds

a focus on allowing the outsider to understand the inside tensions refugees (participants) face on the topic while aiming to aid in enhancing future change.

Problem Statement

According to the UNHCR (2020), at the end of 2020 there were 82.4 million forcibly displaced people around the world with 26.4 million being refugees. Many countries are opening their borders to refugees for safety and asylum. A refugee arriving in a new country differs from those who immigrate to a new country. Although an immigrant is coming from a different country and culture and may likewise not speak the language of their new country well, their journey and status is quite different from that of a refugee. This study's focus is on refugee experiences on the topic, but it should be noted immigrants can likewise share in many of the same struggles that refugees face.

A 2018 study examined the mental health and traumatic event similarities and differences between refugees and immigrants arriving in the United States. The findings showed that refugees who faced psychiatric symptoms were associated with pre-migration trauma (Sangalang, et al., 2019). For both refugees and immigrants, post-migration trauma increased the risk of depressive disorders, but this was doubled for refugees (Sangalang, et al., 2019). Likewise, the post-migratory stressors for refugees were compared to the pre-migratory stressors to see which have a great impact of being associated with PTSD symptoms. The most significant post-migration variable associated with predicting PTSD symptoms was that of immigration status, this included the legal instability and prolonged process of obtaining status had such an effect on refugees that it was comparative to the pre-migratory rate for PTSD for rape/sexual assault survivors (James et al., 2019).

Although the traumas faced by refugees' pre-migration are often expansive the post-migratory stressors cannot be dismissed as being linked to cause further trauma. This study aims to look at the perceptions refugees have on which post-migratory stressors impact their pre-existing trauma. This study is important and furthers the existing literature as no study has focused from the lens of the refugee's perception of these impacts but rather have used varying measures to gather the impacts certain stressors both pre and post migration have on refugees. It is estimated that less than three percent of refugees receive any form of mental health care (Song & Teichholtz, 2018). Current stressors often push the need for mental health care away until things stabilize. This study holds value as it gives a voice to the perceptions refugees have on these stressors and whether they presume there is a need for mental health care. Likewise, if they do presume they need mental health care, it explores what would be necessary for them to receive it.

Purpose statement

The purpose of this case study was to understand the perceptions refugees have as to if, and if so how, post migratory stressors impact pre-existing trauma for them. At this stage in the research, post-migratory stressors will be generally defined as any step or task needed to achieve feeling settled, those illicit feelings of being overwhelmed, stressed, or anxious. The aim of this study is to see if refugees think the post-migratory stressors they face increase, decrease, or do not influence prior trauma experiences and symptoms. This information can then be given to groups and individuals working with refugees to better know how to meet their needs for the future.

The theory guiding this study is phenomenology which is "an approach to personality theory that places questions of individuals' current experiences of themselves and their world at

the center of analyses of personality functioning and change" (APA, 2021). It is appropriate for this study as it explains the experiences from the point of view of the participants through their own words. This study focuses on refugees' perceptions on the post migratory stress impact on pre-existing trauma. This study does not focus on the view of clinicians or those who work with refugees but rather allows the refugee to share in their own words how this phenomenon impacts them on a personal level. Likewise, this data is gathered through interviews with open ended questions rather than quantitative questionnaires.

Significance of the Study

With the growing number of refugees throughout the world there is also a growing amount of research as people try to better understand how to help this large number of displaced people. "Asylum seekers and refugees are often exposed to traumatic events and psychosocial stressors (e.g., extreme violence, separation from family or detention in a concentration camp), not only before and during displacement, but during the post-displacement period as well, after they are resettled in suboptimal conditions in the host country" (Richa et al., 2020). Refugees experience a mean of between seven and fifteen traumatic events with 54% of the population having experienced torture (Carswell et al., 2011). Stressors such as unemployment, perceived underemployment, inadequate housing, homelessness, and victimization have shown to be linked to emotional distress, emotional dysregulation, and specific psychological disorders in refugees (James et al., 2019).

A case study perspective will document refugees' lived experienced and will allow others to see their perspective of pre-migratory to post-migratory trauma and stressors, thus providing some background into those experiences based on memories and extant symptoms. This study will likewise contribute to the literature on refugees and mental health in hopes of providing

insights to aid in future research on practical ways organizations, charities, religious groups, and individuals that work with refuges can best assist them in the resettlement process. This will assist refugees' needs especially due to the case study format with information being gathered through stories during the interview times.

Research questions

This case study will explore the following research questions. The participants in this study will be given the opportunity to elaborate and share what they would like to see implemented to help refugees when first arriving at their host country. This additional information will aid in assisting those who work with refugees to implement changes, if necessary, to give proper care for the refugees they strive to help adjust.

1. **What are the biggest stressors refugees face upon arrival and what if anything makes that easier?**

This question is being asked to compare with the current literature available. Studies conducted on post migratory stressors for refugees have shared the struggles employment, housing, language acquisition, and finances have had on their acculturation process and mental health (Krahn et al., 2000).

2. **How does arriving with their trauma impact refugees' adjustment post-migration?**

Refugees "resettlement tasks were evidenced as stressful and destabilizing and as more salient stressors than past traumas at follow up" (Vromans et al., 2021). Current social, mental, and emotional wellbeing was impacted more from the post migration stressors and traumas over prior traumas (Kim, 2016). Refugees can struggle to receive mental healthcare treatment for numerous reasons but some of which pertain to the migration experience itself. "Refugees and migrants can be exposed to stressful events before departure, during their travel and after arrival,

and they may struggle to fully integrate in the social context of the host countries" (Priebe & Giacco, 2018, p.1). These factors take precedence over researching how to receive the care they need.

3. **What would refugees want people and governments around the world to know regarding being a refugee?**

This question will allow the participants to give insight from their perspective how those assisting refugees in their resettlement process can better assist them.

Definitions

Post-Traumatic Stress Disorder- "The essential feature of PTSD is the development of characteristics symptoms following exposure to one or more traumatic events. Dominating symptoms would include fear-based re-experiencing, emotion and behavioral symptoms with negative cognitions leading to distress" (DSM-V, 2013, p.274).

Trauma- "A state of disruption in which one or more life-enhancing processes are irretrievably lost" (Figley, 2012).

Refugee- "Someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (1951 Refugee Convention).

Immigrant- "Persons who leave their countries purely for economic reasons unrelated to the refugee definition, or in order to seek material improvements in their livelihood. Economic migrants do not fall within the criteria for refugee status and are therefore not entitled to benefit from international protection" (UNHCR, 2020).

Resettlement- "The transfer of refugees from the country in which they have sought asylum to another State that has agreed to admit them. The refugees will usually be granted

asylum or some other form of long-term resident rights and, in many cases, will have the opportunity to become naturalized citizens. For this reason, resettlement is a durable solution as well as a tool for the protection of refugees. It is also a practical example of international burden- and responsibility-sharing" (UNHCR, 2020).

Asylum Seeker- "An individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which the claim is submitted. Not every asylum seeker will ultimately be recognized as a refugee, but every refugee was initially an asylum seeker" (UNHCR, 2020).

Migration- The journey stage a refugee enters upon leaving their home country.

Pre-migration- This refers to the state prior to the journey stage but while their home country status remains unsafe for them.

Post-migration-This is when a refugee has been resettled into a new country.

Post-migratory Stressors-Stressors that "include socio-economic factors, i.e., financial and housing security and work problems; social and interpersonal factors, i.e., family separation, family reunification, lack of social support, changes in social roles, discrimination, and changes in socioeconomic status, process and immigration policies, i.e., detention, time of the asylum-seeking process, limited duration of residence permit, and as a consequence, living difficulties such as family conflict and unstable housing" (Djelantik et al., 2020).

Pre-existing Trauma- trauma that occurred prior to the resettlement phase.

Internally Displaced Worker- These are individuals that "have not crossed a border to find safety. Unlike refugees, they are on the run at home" (UNHCR, 2020).

Summary

In 2020 there were 26.4 million refugees worldwide with 34,400 being resettled in a new country (UNHCR, 2020). Due to the growing number of refugees, especially as seen with the recent events in Afghanistan during the summer of 2021, countries will soon have an influx of refugees needing a safe place to live but likewise coming with much pain that can be seen sometimes externally but often times as internal pain they try to forget. As government organizations, charities, religious institutions, and individuals aim to assist refugees in assimilation they determine the ways to better this process. This study is a relevant next step in an ongoing conversation among scholars that investigate mental health with refugee populations. The purpose of this case study is to understand the perceptions refugees have as to if, and if so how, post migratory stressors impact pre-existing trauma for them. This study will add to the literature on refugees and mental health while likewise increasing awareness on specific needs refugees have that can be used to create a transition that helps meet their needs even deeper than previously aware.

Chapter Two: Literature Review

"You have to understand, no one puts their children in a boat unless the water is safer than the land."

(Shire, 2015, p.102)

Overview

The aim of this case study is to examine the relationship between post-migratory stressors and pre-existing trauma for refugees. What follows is an overview of the relevant literature related to the topic of pre-existing trauma among refugee populations. The first topic discussed is the history of trauma and PTSD. The second topic will discuss what the term " refugee" is, including how one becomes a refugee and the journey many take towards freedom. The third topic will explore refugees' mental health concerns specifically to that of trauma such as PTSD. The fourth topic will explore post- migratory stressors that refugees experience in their host country. The last topic will report the research outcomes on post migratory stressors impact and relationship with pre-existing trauma and mental health concerns for refugees. This section will conclude with the author's comments pertaining to gaps in the literature and how this study will address the gaps in the existing literature.

Theoretical Framework

History of trauma

Trauma is a word that is overused and undervalued in today's society. It has become a word referring to an "unpleasant event" rather than that of a clinical diagnosis (Levers, 2012). A wife comes home from the grocery store and tells her husband how "traumatic" it was with all the holiday shopping. Perhaps a guy tells his friends how "traumatic" it was to breakup with his long-time girlfriend. Although these may be difficult or frustrating events in one's life, they are

more of an unpleasant event rather than a traumatic one. If these examples do not represent trauma well, what is the best way to define it? Definitions for trauma have differed across culture, history, and professionals.

The Diagnostic Statistical Manual (DSM) definition of trauma has become the litmus test for trauma diagnosis. However, today's current criteria were not always the criteria in the past. Even then the definition of trauma is separated from the diagnostic criteria for a trauma diagnosis. Briere and Scott explain the definition of trauma, as mentioned in the DSM-IV, is true but it may not be complete. Rather they define trauma as "extremely upsetting, at least temporarily overwhelm[ing] the individual's internal resources, and produces lasting psychological symptoms" (2015, p.10). Part of the reason for this lack of proper usage for this term stems massively from the history and discovery of trauma itself. "A major problem in the definition of trauma is that it, and the experience of it, produce wordlessness and thoughtlessness" (Valent, 2012, p.656). Weiss furthers this thought by stating "because trauma knows neither time nor place; it is everywhere and nowhere. It overwhelms the present with a past that never ended and fails to have a future because it is an endless repetition of the same" (2020, p.2).

Trauma comes in all sizes, shapes, and depths. "Traumatic events are extraordinary, not because they occur rarely, but rather because they overwhelm the ordinary human adaptations to life" (Herman, 1997, p.33). Traumatic events commonly involve pain, confusion, loss, betrayal of trust, abuse and/or entrapment. Traumatic experiences include abuse (sexual and/or physical), medical procedures, natural disasters, terrorist attacks, accidents, assault, violence, war, divorce, and more. Yet traumatic environments are homes, place of work/study or cultures where domestic violence, addictions, discrimination, conflict, emotional abuse, mental illness, neglect,

shame, or religious domination occur. Experiences and environments of trauma provide great difficulty coping both during and after the threat is gone. Although equally damaging one is by intensity while the other by its cumulative effect (Center for Substance Abuse Treatment, 2014).

Trauma throughout the history of mankind has always existed. However, the definition has evolved over time. “In the U.S. Civil War, nostalgia was emphasized; in World War I, shell shock and cardiac neurosis; in World War II, combat fatigue and digestive symptoms. More generic descriptions were psychic shock and being overwhelmed.” (Figley, 2012). The word trauma originates from the Greek word trōma (τραύμα) meaning to wound or pierce (Kolaitis & Olff, 2017). It may be hard to believe but there was a day when trauma was not a formal diagnosis in the field of psychology.

The father of psychoanalysis, Sigmund Freud, best described trauma in his work, *The Pleasure Principle*, through the example of a solider wounded in battle during Grecian times experiencing what they referred to as a trauma. The cut on his arm, the stab to his chest, or the loss of a leg were all considered trauma on the body (1920). Freud, however, believed this could and should in fact be taken further. The brain being part of the body and a key organ necessary for performing daily functions can experience trauma as well. Caruth studied Freud’s works and writes, trauma is “a wound inflicted not upon the body but upon the mind” (2016, p.4).

Freud, speaking of his patient Anna O, wrote, “Our hysterical patients suffer from reminiscences. Their symptoms are the remnants and the memory symbols of certain (traumatic) experiences” (1910, p.187). Freud found in his workings with “hysterical” patients, such as Anna O, that traumatic events and memories, because of their immensely painful properties, are repressed, or forgotten, in the conscious mind and instead dwell in the unconscious thus creating “foreign bodies” in the psyche (Forter, 2007). In his work with the *Wolf Man*, Freud (1971)

argues that at the age of one-and-a-half his patient witnessed his parents in the act of coitus. Yet, it was not until the age of four that debilitating symptoms began to form, and the disruptive effects of trauma began to illustrate how the residue of a traumatic event continues to traumatize years later (Forter, 2007).

Although Freud focused more on hysteria over trauma one can read his works and see the foundation he was laying. However, these findings of Freud's left room for others to continue the research. One of those researchers being Alfred Adler. Adler's theory for life boils down to five basic elements: love, work, friendship, self, and spirituality (Adler, 1931). According to Adler, these elements must be present for one to be healthy mentally.

He argued that one is not to focus on the individual self but to recognize how humans are social beings and therefore, they should be studied "in the context of how they interact with society as a whole" (Carlson & Englar-Carlson, 2017). Adler claimed no two people are the same, "just as one cannot find two leaves of a tree absolutely identical, so one cannot find two human beings absolutely alike" (Adler, 2013, p.102). Further Adler wrote, "the shock which evokes physical and mental irritations, i.e., the symptoms, is always occasioned by an 'exogenous fact,' a task which is to be solved socially" (Adler, 1973, p.242). Trauma then impacts not only the individual but also their social sphere.

Carl Jung's view of trauma differs from what the Diagnostic Statistical manual (DSM-5) requires a formal trauma diagnosis to include. Those who support Jung's findings on trauma note that the DSM-5 focuses more on the "big bang" of trauma (Wilson, 2004). In other words, what is the event(s) that occurred externally to cause trauma? Instead, Jung focused more on the "inner world of trauma" over the external events. He focused on "the manner in which a range of life-experiences, including separation, loss, traumatic bereavement, rejection, humiliation, neglect

and abuse, impact the intricate world of nascent ego and self-functions, leading to states of splitting, fragmentations (i.e., de-integration), dissociation or alterations in the self" (Wilson, 2004, p. 49).

Jung spoke of this "splitting" as dissociation. He considered trauma to be, "a complex with a high emotional charge which brings about the dissociation of the psyche" (Jung et al., 1968). It is when the trauma becomes so unbearable the response of the brain in handling the weight is to split the psyche. "It is clear that Jung understood that traumatic experiences are necessary but insufficient in themselves to produce symptoms of prolonged stress response" (Wilson, 2004, p.49). Jung began to explain the psychological response to trauma much further than had previously been discussed.

There are several historical accounts of PTSD prior to it becoming a formal diagnosis. For example, Pepys recounts the Great Fire of London of 1666. In his account he discusses the terror and fear he experienced from the fire. Later he recollects, "while we were sitting in the morning at the office, we were frighted with news of fire at Sir W. Batten's by (a) chimney taking fire; and it put me into much fear and trouble, but with a great many hands and pains it was soon stopped"' (Daly, 1983). Pepys was so frightened after the Great Fire that the news of a chimney fire filled him with fear.

PTSD symptoms emerged during the Industrial Revolution among civilians. During this time steam driven machinery had been invented and people were experiencing "civilian man-made disasters" (Crocq & Crocq, 2000). This brought about the diagnosis of railway spine and railway brain which were given due to professionals believing the symptoms displayed by survivors were due to microscopic lesions in the brain or the spine (Crocq & Crocq, 2000).

Later the concept of "shell shocked" first appeared in the British Medical Journal, *The Lancet,* on February 13, 1915. This article was written during the time of the first World War. This article examined the symptomatology of three soldiers and compared the similarities each shared. All three has experienced near death experiences involving bullets being shot around them for an extended amount of time. They write, "they appear to constitute a definite class among others arising from the effects of shell-shock" (Myers, 1915, p.320).

Symptoms such as memory loss and difficulty seeing were common among the three soldiers. One solider described his time after the attack as waking up in the middle of the night and finding himself crying, "not thinking of anything in particular" (Myers, 1915, p.317). Another soldier's condition is described as being in, "an extremely nervous condition. He complains that the slightest noise makes him start. His legs feel weak, and he has pain in the precordial region" (Myers, 1915, p.319).

Shell Shock later became what is known today as Post Traumatic Stress Disorder (PTSD) in the 1980s. Prior to this formal name change, the American Psychiatric Association (APA) added Gross Stress Reaction to the Diagnostic and Statistical Manual of Mental Disorders DSM-I was added by the American Psychiatric Association's diagnostic manual in 1952. GSR was defined as, "a stress syndrome that is a response to an exceptional physical or mental stress, such as a natural catastrophe or battle; it occurs in people who are otherwise normal; and it must subside in days to weeks; if it persists, another diagnosis should be made" (Andreasen, 2010). However, this was later removed from the DSM-II in 1968.

Then in the 1980's DSM-III Post-Traumatic Stress Disorder was recognized. This would end up being especially helpful for veterans, holocaust survivors, and victims of sexual assault. However, in 2013 the DSM-5 did not classify PTSD as an anxiety disorder but rather created a

new category referred to as Trauma-and-Stressor-Related Disorders (Crocq & Crocq, 2000). The PTSD requirements consist of criteria's listed A-H. One must have experienced a traumatic event, be experiencing intrusion and avoidance symptoms, negative alterations in cognitions and mood, marked alterations in arousal, and a duration of symptoms for one month or longer.

At the beginning of the twenty-first century PTSD became the fastest growing diagnosis of American psychology (Horwitz, 2018). It is believed that traumatic experiences are common among most humans. However, even after a traumatic event occurs, over 75% will remain resilient after the exposure of the traumatic event(s) but roughly five to fifteen percent do not recover and eventually develop PTSD (Daskalakis et al., 2018).

Trauma and PTSD can be a lonely and dark journey towards healing. Shirley Porter compared Psalm 23's Valley of the Shadow of Death to PTSD. She writes,

> The valley of the shadow of death is a dark and desolate place. It exists in the shadow of actual or symbolic deaths. The valley becomes the primary residence of those with active PTSD. It is a place of felt isolation and time-lessness. The darkness plays tricks with one's senses and causes fragmented sensory and affective reliving of the most painful experiences of one's life—in a seemingly endless loop. It can make one forget that light exists at all. Hope is elusive. The disorientation and despair that prevail can cause even the strongest person to forget who they are and to doubt their sanity. There are no marked pathways out of the valley—each survivor will have to forge their own. (2018)

Trauma is prevalent in history and society. It is filled with painful experiences that often replay themselves for the survivors. Many of these events involve great loss and grief. Not everyone with PTSD has the proper resources to be formally diagnosed and to receive the care they so desperately need. Refugees are one example of this and are at a higher risk of developing

PTSD with the pre-migratory traumas that cause them to leave their home country as well as the migratory journey.

Related Literature

What Is a Refugee

There are massive differences between an immigrant and a refugee. Although both come from foreign lands, the refugee's journey is filled with new levels of stress and trauma. An immigrant is defined as "a person who is a migrant from another country. Either lawfully, or unlawfully, with intent to take up permanent residence" (Stebnicki, 2016, p.216). A Chinese student studying at a United States university, a Canadian marrying someone from England and moving to the United Kingdom, and an engineer moving from Dubai to the Netherlands are all examples of lawful immigration. A common example of an unlawful immigrant would be individuals from Mexico traveling illegally across the border under fences or in big trucks for the chance of a better life in the United States or a tourist overstaying the allotted time given for their tourism visa. Both scenarios differ from that of a refugee. Rather a refugee as defined by the 1951 Refugee Convention as

> someone who is unable or unwilling to return to their country of origin 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 or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it'. An asylum seeker is a person seeking international protection whose claim

has not been determined by United Nations High Commissioner for Refugees or authorities of the country in which refugee status is being requested (UNHCR).

Over 68% of refugees come from Syria, Afghanistan, Venezuela, Myanmar, and South Sudan (UNHCR, 2020). While 57% of refugees come from South Sudan, Afghanistan, and Syria-- all three of which are considered war torn lands (Duhig, 2020). One in every 113 people on this planet is a refugee (Edmond, 2017). Rising statistics say about every three seconds a person is forcibly displaced or an equivalent of over 35,000 people per day (Edmond, 2017), (UNHCR, 2019). In 2017, "on average, 20 people were driven from their homes every minute last year, or one every three seconds--- less than the times it takes to read this sentence" (Cowling et al., 2019).

This refugee crisis has increasing numbers due to factors such as the war and terrorist group's (ISIS) activity in Syria. Refugees find themselves having to leave their homeland due to difficult situations where fear of death or serious injury exists for themselves and/or their families. At the end of 2017 there were over 25.4 million refugees registered across the globe (UNHRC, 2017). A refugee is not an immigrant or a foreign worker. A refugee is someone seeking safety for themselves and/or their families rather than someone looking for a better paying job, new opportunity, or education options for their children.

Refugees: Trauma, PTSD, and Torture

Refugees facing war, persecution, sexual assault, torture and even seeing someone they loved killed in front of them all are events that would certainly be categorized as traumatic. This mixed with the potential dangers they faced while fleeing their home country increases the number of traumatic events a refugee will face. Studies suggest refugees experience a mean of 15 to 35 traumatic events (Marshall et al., 2005). Although a refugee may arrive at a camp or host

country and seem resilient of what they faced does not mean they did not experience traumatic events, nor does this mean they do not have trauma disorders such as PTSD.

Although trauma does not unite refugees the probability of a refugee having experienced at least one traumatic event is likely. Dr. Kevin Pottie says regarding his work with refugees, "I don't aim to diagnose trauma. I assume trauma. We will find it" (Colborne, 2015). A 2005 study of Cambodian refugees two decades after resettlement found ninety-nine percent (n=483) experienced near death experiences linked to starvation and ninety percent (n=437) lost a family member or friends to murder (Marshall, et al., 2005). After resettlement to the States seventy percent (n=338) reported exposure to violence after settlement (Marshall et al., 2005). This same group of refugees shared high rates of PTSD and major depression (Marshall et al., 2005).

It is fair to say refugees' problems are not simply poor living conditions in their home country nor the trauma they endured prior to post migration. Trauma is not what unites refugees but rather loss of home. "Home, after all, is not a psychological concept, as such. Yet, loss of home is the only condition that all refugees share, not trauma. Refugees are defined not as a group of people exhibiting any specific psychological condition but merely as people who have lost their homes" (Papadopoulos, 2002). Loss impacts everyone it touches. Loss itself can lead to psychiatric illnesses. For example, after the 9/11 attacks on the Twin Towers, a study investigated if losing someone in the attacks led to mental disorder diagnoses. They found that participants that reported a loss from the 9/11 attacks were roughly twice as likely to meet the criteria for one or more mental disorders, including that of PTSD (Neria et al., 2008).

Just as the 9/11 attacks were considered terrorist attacks that impacted Americans, likewise, refugees are often victims of terrorist attacks and activities. Many experience loss from such attacks and thus strive to escape the dangers their home country brings. In April 2017,

Volker Turk, UNHCR Assistant High Commissioner for Protection, spoke at a briefing for the Security Council Counter-Terrorism Committee and shared that refugees are often the first victims of terrorism (Wells, 2017). Terrorism comes with loss, whether it be loss of life, loss of a loved one, loss of home, loss of economic standing, or loss of safety and security. For refugees, just as those impacted by the loss 9/11 brought for them, likewise these losses for refugees can come with mental disorders.

The loss is so severe because everything the refugee once knew is gone. Many lose contact with family members and friends. They lose their homes, memories, and family photos. Their loss extends to loss of businesses or familiar restaurants. It "creates a disturbance (called here "nostalgic disorientation") which is closer to what has been referred to as "ontological insecurity", "existential anxiety", "existential angst", or "dread". The shared themes of these conditions are a deep sense of a gap, a fissure, a hole, an absence, a lack of confidence in one's own existence and consequently in "reading life" which leads to a particular kind of frozenness." (Papadopoulos, 2002). The loss is great for refugees. Many will arrive without their full family (Löbel, 2020).

The conditions refugees face leaves them ten times more likely than the general population to have PTSD (Vallières, 2018). Refugees flee their homelands due to persecution, their lives or the lives of their families threatened, seen someone died, experienced living in a war-torn land, or experienced being tortured (Drožđek, 2010). In the U.S. Department of Justice Office for Victims Crime Report for 2000 reported, "studies have estimated that up to 30 percent of all refugees are torture survivors. If a community has a refugee population, then it is likely torture survivors live there and are suffering from the debilitating aftereffects of torture" (p. 3).

In 2011, this number of refugee torture survivors rose to 35% (Dgani-Ratsaby, 2011) and in 2019 this number once again increased to 40% for women (Abu Sunhaiban et al., 2019).

Many refugees have faced serious situations such as rape, sexual assault, torture, and threated execution (Drožđek, 2010). A 2009 study found as high as 30% of refugees were struggling with some form of trauma-related mental health concern (Steel et al., 2009). The International Classification of Diseases (ICD-10) holds the diagnosis for Complex post traumatic stress disorder (CPTSD). CPTSD has been linked to refugees in Syria who have been impacted by the humanitarian crisis (Vallières et al., 2018). Refugees who were victims of torture have been seen to screen positive for depression (83.8%), anxiety (81.3%), and PTSD (56.9%) (Song et al., 2015).

Refugees arrive at countries willing to grant them refuge or asylum status. Once granted they arrive typically with little to no language speaking, no employment leads, only temporary shelter housing, and most likely will have no social community. This leads refugees feeling stressed, lost, and alone. Avoiding or failing to recognize the complexities of resettlement as well as the past and present losses of trauma can have harmful effects on resettling refugees (Allan, 2015).

The United States Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Act defines torture as, “any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person had committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind” (1987). Refugees are often victims of torture or witness torture being conducted on someone else.

Refugees may not openly disclose they have been a victim of torture due to shame. Yet, signs of torture include, but are not limited to, insomnia and PTSD diagnosis (Tamblyn, 2011). A documentary by Ben Achtenberg, Refuge: Caring for Survivors of Torture interviewed numerous refugees resettled in the United States who all would be classified as victims of torture. In these interviews refugees included their stories of fear when it comes to opening up about torture symptoms as it may impact their immigration status (2013). One counselor included how she has seen many do not trust medical professionals and may go years with bullets still lodged inside them before they feel safe enough to disclose this information in order to receive proper care.

Survivors of torture are linked with higher rates of psychological distress including PTSD. Studies conducted on torture survivors linked African refugees with 94.7% depression and 57.3% for PTSD (Leaman & Gee, 2012). This compared to a study conducted on Syrian refugees which reflected 29.9% were diagnosed with PTSD (Tinghög et al., 2017). If a large percentage of refugees are victims of torture and psychiatric distressing symptoms are present for majority of those survivors how does this impact refuges trying to resettle?

Post Migratory Mental Health

The stressors listed previously bring light to why refugees are not able to fully prioritize getting mental health care for trauma symptoms they may have. Less than three percent of refugees ever receive any type of mental health care (Song & Teichholtz, 2018). Some countries do offer services for refugees such as Canada with the Interim Federal Health Program which provides mental health benefits for refugees. “The Interim Federal Health Program (IFHP) provides limited, temporary coverage of health-care benefits for specific groups of people in Canada who don’t have provincial, territorial, or private health-care coverage” but this is typically only available to them for their first year in Canada (Government of Canada, 2021).

Although this benefit is available refugee mental health concerns often do not surface until after they have been in Canada for two or more years, at which point no longer qualify for this extended benefit (Dharssi, 2018).

Chris Friesen, director of settlement services at Immigrant Services Society of British Columbia (ISS of B.C.) says the biggest gap Canada has for refugee resettlement is in the area of mental health (Dharssi, 2018). He goes on to say, this area "has a direct impact on their ability to learn English, their ability to retain employment, their ability to parent their own children" and this leads to 15-18% of refugees in Canada requiring a formal mental health intervention including that of emergency room help due to trauma concerns (Dharssi, 2018). Even when counseling is available for refugees' multicultural counselors that work with refugees should be aware of the immigration and resettlement process as much of the stressors impacting processing through past trauma are associated in this area (Kuo & Arcuri, 2014). Beiser and Hou says, "the responsibility to integrate newcomers is implicit in the concept of permanent resettlement. However, like most resettlement countries, Canada tends to limit its purview to admitting survivors of persecution but neglecting what happens to them afterward" (2016). A refugee worker stated, "we're seeing very vulnerable populations with a lot of stressors and comorbid problems, some of which are diagnosable under the DSM criteria but then some of the stresses that they are experiencing any human being with strong mental health, would be um, -- feeling like they were falling apart" (Interiano-Shiverdecker et al., 2021).

Refugees arrive with great amounts of distrust of government agencies and officials who were part of what caused them to flee their country. Those they should have been able to trust, their own people, now have become their enemy. How can they trust a new government, culture, city, and individuals who are not their own people? Refugees face many significant experiences,

one of the most significant being humiliated and/or betrayed at the hands of their own people, enemy forces, or politics. Sadly, being "betrayed becomes a major factor controlling the lives of refugees" (Lindert et al., 2016). Dr. Kevin Pottie places great importance found in approaching a refugee with empathy, advocacy, and building of trust that have major impacts on their mental health (Colborne, 2015).

This approach is especially important for medical professionals to keep in mind. Refugees may have been tortured at the hands of individuals in the medical field. They may arrive with pre-existing conditions or with physical symptoms produced from trauma. A 2003 study observed the medical consultations of refugees with PTSD and compared them to those who were receiving treatment for PTSD. The findings indicated that treatment for PTSD among refugees decreased medical concerns and symptoms (Drozdek et al., 2003). Receiving proper medical care for refugees can help with mental and physical symptoms and conditions. However, refugees can struggle to navigate the medical system of their new home.

Post migratory stressors have been seen not to decrease one's trauma or trauma symptoms but actually increase them. "Amidst the stress and upheaval endured in their host country, during migration, and throughout resettlement, refugees and asylum seekers face sudden changes in living conditions and dramatic cultural, social, and economic disruptions" (Satinsky et al., 2019). Anyone who moves to a new country will face adjustments when navigating a new country and new culture. A student moving to study abroad will often have time to research their new country and learn some of the cultural customs of their soon- to- be new home. Refugees, however, are not given time and resources to prepare. There is a state of fight or flight, and this does not stop once they arrive as now they are fighting to keep up and become settled.

A 2005 study on Cambodian refugees in the States discovered higher rates of depression and PTSD among those with having poor language acquisition, living in poverty, unemployment, or being disabled (Marshall et al., 2005). Although two decades have passed for these refugees entering into America, even then this population continues to have high rates of trauma related psychiatric disorders (Marshall et al., 2005). A 2009 study found "that, increased PTSD symptoms were associated with a higher number of traumas, adaptation difficulties, loss of culture and support and reduced confidant support" (Carswell et al., 2011). Several factors continue as risk factors for post-migration mental disorders; "post-migration trauma exposure and stress, including the feeling of not being accepted in the host country, were positively associated with both mood and anxiety disorders" as well as "prolonged unstable residential status and living under a continuous threat of repatriation" contributed to mental health disorders among refugees (Bogic et al., 2012). The lack of stability appears to create further mental health concerns among this population.

Higher rates of mental disorders have been seen in war refugees even several years after resettlement thus requiring substantial levels of support (Bogic et al., 2012). However, post-migration stressors vary in mental health problems among refugees (van Heemstra et al., 2021). Yet, preventative mental health interventions should understand the impact of post-migratory problems for refugees. Even then, many refugees would rather turn to members of their close community over westernized mental health services (Chaze et al., 2015).

Loss of control and overwhelming emotions are characteristics of traumatic experiences and when mixed with the post-migratory stressors the PTSD symptoms do not improve (Nikendei, 2018). Other post- migratory factors can increase these overwhelming emotions such as discrimination. Discrimination can come in numerous forms and for numerous reasons such as

race, immigration status, or religion. A study conducted in Australia found that 22% of the 91 participants had experienced discrimination since arriving in Australia and the main places discrimination occurred were public transport (33%), their neighborhood (30%), and in employment settings (23%). Sometimes the discrimination reported in the study involved violence or assault of some variety (Ziersch et al., 2020).

Discrimination

Discrimination is an important factor for discussion when it comes to refugees. As explained in this section, discrimination is "treating people worse than others because of their membership of a socially salient group. Socially salient groups are groups whose membership is important to the structure of social interactions across a wide range of social contexts" (Oberman, 2020). These would include areas of gender, nationality, race, age, religion, disabilities, sexual orientation, or socioeconomic class. Some have stated that refugees face direct and indirect discrimination. Direct discrimination would be a shop owner posting a sign that says 'refugees not welcome" or a tenant directly stating they will not rent to refugees. Indirect would be where companies, universities, institutions, and governments place equal opportunities but set guidelines that limit the opportunities for others. An example of this for refugees is how restrictions may be placed on them for how they enter the country. Refugees cannot simply arrive in places like the United States or Canada. They must apply and be approved.

The United States changed its policies on entry for many refugee people groups in January of 2017. The changes "prohibited nationals from seven majority-Muslim countries from entering the United States for ninety days: and prohibited individuals from entering into the United States as refugees for 120 days" (Daugirdas & Mortenson, 2017). These changes were to

strengthen the immigration process and increase national security for United States citizens. Even Canada restricts refugees from entering their country unless they can prove they will be able to be fully self-sufficient and be established within three to five years upon arriving in Canada (Government of Canada, 2018). “To judge whether this requirement is fulfilled, ‘factors such as education, presence of a support network (family or sponsor) in Canada, work experience and qualifications, ability to learn to speak English or French and other personal suitability factors such as resourcefulness’ are assessed” (Oberman, 2020). This would not be a form of direct discrimination but perhaps a form of indirect. Although there is no advantage towards a certain people group over another, yet some nationalities or socioeconomic classes would better meet the criteria than others would. These may be forms of indirect discrimination; direct discrimination is the one to focus on as it has links to mental health issues for newly resettled refugees.

Discrimination is a factor many refugees face during the resettlement process. This is especially true for refugees coming from an Islamic background. Research as shown links between Muslim populations and discrimination and social exclusion (Mir et al., 2015). Additionally, they might receive discrimination for lack of knowledge on the trauma they have faced. After all, if someone is not aware of what a refugee has experienced to cause them to leave their country the assumptions one can make may often be incorrect. Majority of refugees are not in countries like those in Europe and North America to live on government assistance or simply have a chance of a “better life.” Rather, they are fighting to survive and if given the option many would choose to stay in their home countries, without persecution, danger, and war, rather than move to another country. Yet, safety is a choice they make for themselves and for their families.

Discrimination can be seen in numerous forms, and this is not the first time in the West we have seen where war survivors have experienced unwanted discrimination and judgement. In the wake of the Vietnam War, veterans returned home with great deals of psychological wounds only to be welcomed by a rather hostile America that blamed them for the unpopular war. Many of these veterans faced being stigmatized, marginalized, and ostracized which led many of these with psychological injuries to participate in illegal behaviors. The State of Kentucky Bar Association speaks on this by stating, "even now, more than thirty years after that war, hundreds of thousands of Vietnam veterans remain incarcerated, homeless, an/or chemically addicted across America…, the side effects of their untreated trauma have cost us in many unforeseen ways. Countless families have been destroyed, jobs lost, and taxpayer dollars spent on treatment that came too late to make a difference for many" (2015, 2011, p. 2).

One area of discrimination those working with refugees need to be aware of is present with employers and landlords or rental agencies. One participant in the study stated, "most landlords they don't like refugee" (Ziersch et al., 2020). Refugees struggle with locating housing, but this includes and additional layer of concern. Refugees may wrongfully be discriminated against due to perceived views that refugees want a "government handout" and do not desire to work but rather continue to receive taxpayers' money. Some countries, such as Canada, seek to approve refugees based on an ability to establish requirement. "Ability to establish can help Canada maximise the benefits, and minimise the costs, of resettling refugees" (Oberman, 2020). Discrimination can impact the resettlement process as it impacts employment, finances, and housing which halts the resettlement process of feeling settled for them and therefore being able to receive care can take longer.

In a study of six groups of first generation immigrates to the States discovered all six groups reported experiencing some form of discrimination occurring in numerous settings such as work and school (Saechao et al., 2011). Discrimination can take place at work, school, or simply walking down the street. A refugee may be in the grocery story wearing a hijab and notice people walking as far from them as possible or "keeping a close eye on them" while they whisper to their friends. This might be due to religious affiliation or even race. Racism is a form of discrimination experienced by refugees. "The experiences of racism can lead to social alienation of the individual, a fear of public spaces, loss of access to services, and a range of other effects that in turn impact adversely on the mental health of the affected individual" (Gopalkrishnan, 2018).

Although discrimination exists there is another side seen and that is when the community rallies around the refugees and helps them adjust to culture. One study stated, "positive interactions with U.S. citizens significantly helped refugees improve their understanding of the U.S. system, increased language proficiency, and reduced instances of alienation or discrimination" (Interiano-Shiverdecker et al., 2021). This was important as these refugees arrive from a collectivistic culture and are incredibly relations and therefore in need of a welcoming community. This same study did include how difficult it was for refugees and Americans to interact and find what unites them rather than the differences "when unwelcoming messages of discrimination isolated refugees and reinforced their stay within the refugee community" (Interiano-Shiverdecker et al., 2021). Communities need to be aware of this desire, perhaps even need, of refugees. Instead of being afraid of the unknown or listening to biases people may have shared regarding their immigration status, nationality or even religion the community should

respond like Wiesel speaks. “The refugees and their misery; the children and their fears; the uprooted and their hopelessness: something must be done about their situation” (2011, p.234).

In a study comparing the views Canadians and Australian’s had on immigrants, Canadians had a high rate of negative attitudes towards immigrants and Australians had a higher level of belief that when someone immigrates to Australia, they are Australian compared to Canadians (Louis et al., 2013). This is part is due to Canada’s identity as a nation. Prime Minister Trudeau wrote about his dreams of and for Canada in his autobiography. Laselva writes, “he one described Canada as a country with two official languages but no official culture, celebrated the fact that Canada was a mosaic rather than a melting pot” (2018, p.5). America refers to itself as a melting pot. When people arrive in America to live, they become American and are often expected to take on some of the culture, celebrations, and personality associated with being American. Canada however being a mosaic means “brightly colored bits of ethnicity, culture, racial identity and language embedded side by side. They may contrast with one another, but together they form a portrait of the nation in the same way the dots on a pointillist painting convey a coherent image” (Schneider, 1998).

This lack of identity as a Canadian may be helpful for refugees in some ways. They arrive and do not need to conform to being “Canadian.” They can stay in their cultural communities and continue to practice their cultural customs and speak their native tongue. Yet, this could carry concerns as there could be a separation of cultures and people groups when it comes to mixing with others. In 2015, The Legatum Prosperity Index named Canada as the most tolerant country in the world. Tolerance can be useful for immigrants and refugees alike but acceptance and embracing others is not the same as tolerance. In a survey of 4,500 adults online, 76% desired to see Canada accept fewer refugees and instead encourage more skilled laborers to

immigrate to Canada (Johnston, 2019). Although a tolerant nation that desires people to maintain their cultural identity and accepted 30,082 refugees in 2019 there seems to still be some concerns with refugees integrating and being accepted by the culture (UNHCR, 2019). Canada has worked to welcome in immigrants and refugees alike, yet even the most tolerant country in the world still can commit discrimination which means no country is exempt from addressing this concern.

Discrimination impacts mental health of refugees and appears to be heavily seen for refugees from Islamic backgrounds. “One explanation may be that Muslim refugees encounter the more dramatic racism and violent threats as a collective. Everyday unfair treatment in working life and society is in turn individual hardships that may, therefore, be more of a mental health burden” (Mölsä et al., 2017, p. 834). Post-9/11 issues surrounding Western views of Muslims has become quite negative (Alemi & Stempel, 2018). “The link between wearing a hijab and discriminatory treatment has been further discussed in the international literature that has portrayed the post-9/11 sociopolitical climate as “demonizing” Islam and noted the increased vulnerability of visible Muslim women” (Jasperse et al., 2012). In a New Zealand survey, 15 percent believed it was OK for a woman to wear a head covering and nearly half (47%) believed there were no place for burqas in New Zealand (Stuart & Ward, 2009).

Additionally, if a refugee themselves have not experienced direct discrimination, if their people have, they too will feel this. “In contrast to personal identity traumas such as sexual abuse, collective identity traumas are traumatic events such as oppression and torture that target the group(s) that the individual strongly identify with” (Kira et al., 2013). These perceived discriminations towards being a refugee and/or being Muslim does play a role on refugees’ mental health. A study of 259 Afghans living in California showed that perceived discrimination

was significantly linked with higher distress among refugees and was even stronger high pre-resettlement traumatic background (Alemi & Stempel, 2018). Kira et al., suggests these forms of discrimination towards Muslim refugees hinders their adjustment into the new society (2013). If discrimination is linked to mental distress and post-migratory stressors are as well, mixing these two with someone who has experienced great deals of trauma can create a cocktail that could make anyone feel completely broken and confused.

One cannot forget to address the area of discrimination for refugees as well as to educate workers and communities on this for when refugees arrive. Mental health can and often is influenced by discrimination. Counselors must keep this in mind when working with refugees and specifically address these areas of concern that may be impacting their adjustment to their new home as well as their mental well-being (Interiano-Shiverdecker et al., 2021). Studies on youth refugees discovered the link to greater mental health and aided in how young refugees deal with discrimination (Oppedal & Idsoe, 2015).

Migration Pattern

Refugees' journeys to get from Syria to Canada or Myanmar to Germany can at times be a long-drawn-out process. Although each refugee has his or her own unique experience and journey there are however identifiable patterns they each share. World Vision's four step process for refugees consists of leaving home, being on the road, seeking refuge in one's own country, and seeking refuge (in their home country or another country) and resettlement (returning home, local integration, resettlement in third country) (2010).

Shultz, et al., developed a figure [Figure 1] to explain the majority of refugees' migration pathway (2020). This pathway expresses the general pattern refugees will experience. This is all initiated by a trigger event such as war, natural disaster, or terrorism, which then pushes them

into displacement and thus the path into motion. The journey to a safer place begins and from there they seek permanent settlement, but this is not always possible and therefore temporary settlement can be arranged, such as a refugee camp or community where they remain here until a permanent settlement is available. This pathway depends on numerous factors and "refugees may enter a cyclical process, including temporary settlements and repeated displacement (Shultz et al., 2020).

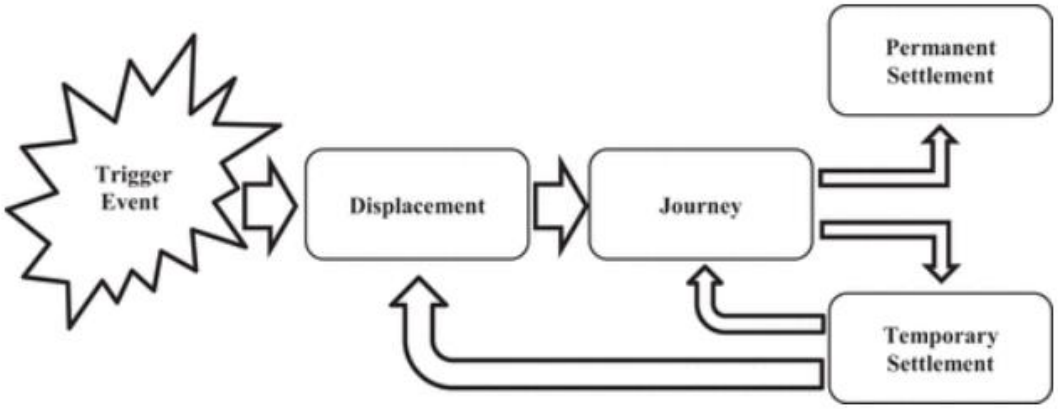

Figure 1. The refugee pathway.

There are many reasons for displacement, as mentioned earlier, but the journey for refugees may be just as expansive. The journey usually is not as simple as boarding a flight to another country, although at times this is a possibility for some refugees. Some borders remain closed to refugees. For example, in 2001 bordering countries closed their borders to Afghanistan nationals seeking refuge in neighboring countries. The UNHCR addressed concerns when countries choose to do this. "In 1938 there was an international conference in Evian (France) and an international attitude of 'Don't let the Jews go out' emerged. Then the drama of the Holocaust happened. We are now in 2001 and at our own crossroads. What are we going to do? Close our borders again" (UNHCR, 2001, p.21)? When countries close their borders to refugees it forces

them to either stay and risk death or take illegal methods to escape and risk dangerous and potentially deadly routes of escape.

The need to be resettled is great for these refugees. In 2015, one million refugees arrived in Europe (Lindert, 2016). In 2016, around 362,000 refugees risked their lives while crossing the Mediterranean Sea on boats (Duhig, 2020). While over 5,000 refugees are considered dead or missing in the Mediterranean Sea from attempting to gain asylum in Europe (Duhig, 2020). The dangers of leaving one's country can be high, but one must weigh if the risk of staying is greater than leaving.

In September 2015, a young Syrian boy's body was washed up onto the short of the Mediterranean Sea. The pictures of this boy circulated newsrooms and articles around the world. Alan Kurdi and his family, except for his father, all drowned while journeying to eventually enter Canada (Armour & DePaul University, 2019). This picture sparked awareness and emotion around the world to the Syrian refugee crisis. This led to political leaders around the world making public statements of awareness and openness to welcoming in refugees to their country (Adler-Nissen et al., 2020). What would it take for a mother to place their child on unsafe boat?

Warsan Shire, a Somali-British writer wrote a poem she entitled Home written from the perspective of a refugee in the journey phase. She writes, "no one leaves home unless home is the mouth of a shark, you only run for the border when you see the whole city running as well". She continues:

> You have to understand, that no one puts their children in a boat unless the water is safer than the land no one burns their palms under trains beneath carriages no one spends days and nights in the stomach of a truck feeding on newspaper unless the miles travelled means something more than [the] journey. no one crawls under fences no one wants to be

> beaten pitied no one chooses refugee camps or strip searches where your body is left aching or prison, because prison is safer than a city of fire and one prison guard in the night is better than a truckload of men who look like your father" (2015).

This poem shows the desperation refugees face that to flee and endure unsafe conditions appear safer and the risk seems better than staying. Yet, it must be noted that the journey can be traumatic for many refugees which only increases the pre-journey trauma.

Refugee youth may have to flee without their parents. Refugee adolescents may become exposed to violent trauma that deems their home unsafe; thus, the decision to leave becomes sudden perhaps without the chance to prepare or say goodbye (Fong, 2007). The unsafe conditions mixed with the increased sense of needing to "grow up" quickly can impact the mental health of youth. Even upon arrival youth may not have a support system they are navigating alone at such a young age.

Refugees do not pack up their homes in nice suitcases or moving trucks. Rather, when fleeing their home country refugees may only be able to take the clothes on their backs and nothing else. They experience great losses and leave behind just about anything that defines their identity (Carlsson & Sonne, 2018). Family photos, heirlooms passed down from generation to generation, or even the simple comforts of home.

Refugees often will find safety in refugee camps. These are portions of land specifically fenced off for refugees to set up tents and temporary housing. Although the conditions might not be ideal, they now are away from the dangers that cause them to flee their home country in the first place. However, the UNHCR created refugee camps to be temporary until one of three things took place. One, they returned to their home country. Two, they integrate into the new

country. Third, they receive acceptance for resettlement in another country such as Europe, Canada, or the United States (Rawlence, 2015).

Once a refugee either is granted asylum or refugee status in their host country one would assume life can begin to gain normalcy again. After all, refugees are no longer risking their lives to find safety. Nor are they temporarily settled in a refugee camp where living conditions are often subpar at best. When a refugee comes to a country such as Canada the possibilities for their and their families' futures are endless. The light at the end of the tunnel finally seems within arm's reach. However, this is such a misconception about refugees and does not encompass the refugee journey.

Many countries have recognized the need refugees have for resettlement and have sought out how to aid in allowing refugees to seek asylum and assimilate into their country's culture. For example, in 2013, Canada resettled 5,781 refugees through government support (What is a refugee, 2014). Likewise, 6,392 refugees were resettled through private sponsorship in Canada via the assistance of faith-based and ethnic groups approved by the government (What is a refugee, 2014). All the escalating wars and conflicts across the globe have led to mass displacement of people during 2015 (Lindert, 2016).

A refugee's journey does not end upon arrival, nor does it become easier. Westerners often can not fully grasp this. The trauma they have endured has not simply disappeared nor is the move and adjustment in the new country a simple one. Rather, the stress of adjusting to a new culture, city and language mixed with pre-existing trauma can be at times unbearable. "Resettlement countries provide relative safety but an often-ambivalent welcome" (Beiser & Hou, 2016).

Post Migratory stressors and mental health

The migration journey varies for each refugee. However, once a refugee has been grated refugee or asylum status in their host country, they can begin the post-migration portion of resettlement. This comes with its own sets of stressors. A refugee arriving at a new country often does not have employment, housing, or a social support there. Additionally, they might not speak with language or speak it well and may not have any finances to help in getting started. This is where refugees become dependant upon the generosity and help from individuals and government agencies. However, even if the refugees do have assistance does this decrease stressor symptoms?

Research supports the claim that refugees suffer many stressors upon arrival in a new country. A study conducted in 2020 observed the post migratory stressors and the mental health disorders of refugees in Sweden. They discovered the highest mental disorder among refugees was depression followed by PTSD and anxiety (Solberg et al., 2020). The study discovered 67% of asylum seekers dealt with sadness with not being reunited with family members, 47% with language acquisition and missing their social life from their home country, while 43% felt excluded from the current host society (Solberg et al., 2020).

Refugees often face employment and financial concerns upon arrival in their new country. Financial strain due to lack of employment can cause for mental health concerns. Yet, the barriers in locating employment for refugees is insurmountable such as language barriers, visa restrictions, discrimination, or lack of skills (Krahn et al., 2000). Even upon securing employment, refugees are frequently “under-employed” meaning they are employed in positions that are below their level of skills and expertise (Li et al., 2016). A refugee who worked as a medical doctor in Syria may now work the graveyard shift at a dog food canning factory to provide for their family.

Refugee children and adolescents coming from countries with lower socioeconomic background “who flee persecution and resettle in high-income countries often endure great physical and mental challenges during displacement and suffer continuing hardships after arrival” (Fazel et al., 2012).

In a 2016 study conducted on Asian and Latino refugees in the United States, the findings reflected the pre-existing trauma refugees arrived with did not impact their current social, mental, and emotional wellbeing as much as the post-migrations stressors and traumas did (Kim, 2016). The authors of the study clarified this could be due to being unable to address these prior concerns currently due to the overwhelming number of present priorities involving resettlement (Kim, 2016).

A big portion of stress for refugees involve lack of social support. Social isolation is a common concern for refugees’ post migration. They have arrived in a new country, typically knowing no one, and have left behind the support system consisting of their friends, families, religious groups, and neighbors. Refugees may find support through community centers and in turn may volunteer at these agencies to provide peer support. Research has supported the belief that refugees being able to offer as well as receive social support produces a positive contribution and value to the individuals involved (Hynie et al., 2011).

Research has shown refugees face traumatic experiences and have a higher risk of being diagnosed with PTSD. Likewise, post-migratory stressors seem to increase traumatic experiences. This is not only due to stressors such as housing and employment but also due to discrimination and lack of social network. However, when refugee resettlement factors and mental health have been prioritized healing can begin. Including, refugee mental health has been

seen to increase once employment has been gained (Mental Health Commission of Canada, 2014).

It is important to note refugees who did receive clinical services after one year of resettlement were more likely to have PTSD and/or depression compared to those who received these services within their first year (Song et al., 2015). Additional studies have claimed refugees who wait longer to receive treatment are at a much higher risk of developing depression (Member Centers of the National Consortium of Torture Treatment Programs, 2015). Yet, improvement for refugees with PTSD was remarkably correlated with secure immigration status (Raghavan et al., 2013).

Refugees face many post-migration stressors resettling into a new country and these stressors have been linked to mental health concerns. A larger number of stressors was associated with a lower amount of effectiveness with completing treatment for refugees (Djlantik et al., 2020). This included refugees with employment or financial concerns and their success being less with receiving treatment. This could be in partly due to stress treatment not being as successful when the stress towards lack of employment or finances rising (Sonne et al., 2016). “Studies that have directly compared the impact of pre-migration and post-migration factors on the psychological well-being of refugees have found that post-migration factors on the psychological well-being of refugees have found that post-migration factors are significantly associated with adverse mental health outcomes over and above the impact of pre-migration trauma (Li et al., 2016).

A study conducted on refugee children and post-migratory struggles and the implications on their emotions discovered when the pre-migratory life stressors were high the presence of daily hassles did not impact their emotional wellbeing (Elsayed et al., 2019). This is believed to

be due in part to one's previous experiences influencing how they will later manage adverse experiences. This begins to function as vaccinations creating immunity. The concept of introducing the body with a controlled dose of a modified version of the disease or pathogen increases and strengthens the body's response when confronted with said pathogen (Rutter, 2012). However, the question then is, can this be true for psychosocial scenarios?

Rutter explored this further by referencing the 1971's study by Baker. This study placed attention on children who experienced happy separations from their caregivers via spending the weekend at grandparent's houses or "sleepovers" with their friends were prone to better coping with hospital admissions (1971). The concept being the children form resiliency through the staying over at friends' houses that then foster resiliency for dealing with difficult separations. Could the same be said for refugees who build resiliency during pre-migration that leads to resiliency in dealing with post-migratory stressors? "Refugees are more likely to be exposed to intentional trauma, threatening circumstances, and stigmatizing cultural beliefs that restrict their access to employment, housing, education, and health care" (Oakley et al., 2021).

Even when resources are available, they might be difficult for refugees to participate in. For example, Muslim refugees have different cultural expectations. It might be hard for Muslim women to be open in front of men due to the patriarchal beliefs of their culture (Karaman & Richard, 2016). Religion plays an important role in the coping for a refugee but also aids in the building of resiliency. For Muslim refugees they can see their relationship with God as a give and take or reciprocal relationship. If one follows the rules set before them and praying to God then in return God gives patients, reassurance, and sustenance when difficult life situations occur. Religion is far more than a coping mechanism for Muslim refugees but rather as a central aspect of their identity (Ravi, 2018).

The challenges refugees face far surpass the trauma they have faced. Many refugees struggle with adjusting to a new culture and the societal expectations the new culture includes. Additionally, aspects of everyday life that were once routine practices, such as language, finances transportation, groceries, and socialization, now are challenges faced daily by refugees.

Refugees, often come from collectivistic cultures compared to most Western cultures where the individual is the focus. Adler's approach to trauma included an impact not just on the individual event but the social sphere leading to collective trauma. Refugees may face continuous and/or collectivistic trauma. For example, if a refugee is a survivor of torture this was not a one-time traumatic event but rather a continuous one. Torture "is a complex series of different trauma types that may include severe physical and sexual abuse and exclusion, such as electrocution and water-boarding, that have been inflicted over prolonged periods to target the individual's personal and collective identity for self-surrender to a captor" (Kira et al., 2015).

This can play a role on a family as they see their loved one struggle with their emotions and may even have strong emotional reactions including violent acts towards loved ones (Abu Suhaiban et al., 2019). Torture can impact memory issues. This can especially prove difficult if the survivor is trying to learn their host country's language. They may study and work hard at learning the language only to forget everything they learned the day prior (Griswold et al., 2021).

Refugees, especially those with backgrounds of torture, may struggle with neurological issues as a result to traumatic brain injuries (TBI). Dr. Daniel Amen specializes in the area of TBI with the use of single photon emission computed tomography (SPECT) an imaging test that focuses on seeing blood flow and activity patterns (Amen, 2013). A study using SPECT found that 44% of new patients had a history of TBI which is important to note as these brain injuries can be linked to issues such as depression, panic attacks, learning difficulties, suicide, and more

(Burton, 2008). Dr. Amen says, “perhaps the most important lesson that I’ve learned from looking at tens of thousands of scans is that brain injuries ruin people’s lives and very few physicians know it. The brain is soft and easily damaged” (2013). “The treatment for TBI is considerably different from that for PTSD. Therefore, a specific and sensitive biomarker is needed that can readily distinguish TBI from PTSD” (Amen et al., 2015).

This is important to note as refugees may have treatments such as talk therapy or medication available to them. However, if the professionals they can seek assistance from do not understand TBI or seek to determine the symptoms they carry are PTSD or TBI related this could impact treatment not being successful and beneficial for those participating. Those with TBI may have symptoms such as “headaches, sleep disruptions, dizziness, nausea, visual disturbance, photophobia, and phonophobia” “increased distractibility, slow processing speed, difficulty concentrating or multitasking”, “increased irritability, emotional lability, anxiety, depression” (Saadi et al., 2021). These can often be mistaken for other illnesses, or the client does not provide this information to the clinician or is never asked (Ferdowsian et al., 2019). Psychiatrists may simply look at the symptoms provided for them on paper and treat the individual with medication.

Researchers such as Ibrahim Kira have focused on what treatment methodologies work for trauma survivors that do not particularly work for refugees. One factor they have recognized as a difference pertains to resettlement and the stressors associated with resettlement. Kira suggests group counseling as an effective form of treatment but stresses the need for external elements to be incorporated into the treatment plan. Incorporating humor, support on navigating their new culture and giving back a sense of control are all elements refugees need in group counseling sessions (Kira et al., 2012).

Although much research exists to support there are stressors post migration for refugees and also traumatic experiences pre-arrival, there is not much information on how these stressors impact pre-existing trauma. More recent studies have discovered post migration stressors do have an impact on refugees while receiving treatment (Bruhn et al., 2018). Likewise, there have been negative effects when past trauma is focused on and not the inclusion of current stressors (Valibhoy et al., 2017). However, a study that focuses specifically on hearing from refugees on how their current life stressors have impacted their pre-existing trauma related symptoms current does not exist.

Once a refugee has been granted a residency permit into a new country they are often rapidly assimilated into the culture, become fluent in the language, have a support system, and become financially independent. Studies have shown that host countries should consider the mental health factors and approach them with timely and appropriate psychological interventions (Schick et al., 2018). Most of the literature on post migratory stressors for refugees and mental health or trauma focus on the interventions necessary for healing and assimilation into the culture. However, there were not many studies focused on the information gathering of what refugees would claim post migration struggles impacted their mental health. Additionally, there did not appear to be any studies where refugees were asked directly to share how these struggles impacted their mental health and what their desire would be for future changes for new arrivals.

The saying “time heals all wounds” does not apply for trauma. Refugees can arrive in a new country and be resettled within the country for 10 plus years, but if their trauma has not been formally dealt with, it will not disappear. “Imagine a stressed bone, which, even if bent, can spring back to its original shape and function. But a fractured bone is a traumatized one, and no matter how well set and healed, a scar and a vulnerability will remain permanently.” (Figley,

2012). The above literature explains how refugees face trauma and arrive with mental health concerns. Additionally, these countries hosting refugees are not successfully meeting the needs of refugees in the area of mental health.

Summary

The history of trauma has existed since the beginning of mankind despite the evolving definition of it. Refugees are not exempt from experiencing trauma and trauma related symptoms. Although there is much research on the impacts of trauma for refugees introduced during pre-migration and the migratory journey, research is needed on how post migratory stressor impact the pre-existing trauma and mental health concerns as well as what post migratory trauma occurs to refugees. This study is instrumental in the growing literature as this case study strives to hear from refugee voices on how they perceive the post migratory stressors impact their mental health specifically in the area of trauma. This study is unique in nature as most studies conducted on the topic are currently quantitative studies and are more symptom related rather than narrative formed.

Chapter Three: Methods

"Taking Mum's hand, I whispered 'Are we really safe, here?"

(Evans, 2004).

Overview

The purpose of this case study was to specifically hear how refugees' perception of how the post migratory stressors they face impact their mental health, specifically the trauma and trauma- related symptoms they have from trauma prior to post migration. First, this chapter will give a discussion on why a case study approach was chosen for this specific study. Second, the research questions from Chapter One will be restated. Third, a description and explanation for the setting, participants, and procedures of the study will be given. This chapter will include a description of the researcher's role in the study and the data collection strategy, including the chosen interview questions with an explanation and rationale for each question being asked, that guide the data analysis being reported in this study. Lastly, the trustworthiness, credibility, dependability, confirmability, transferability, and ethical considerations will be explained in detail.

Design

A qualitative case study was chosen to explore how refugees perceive the post migratory stressors refugees experience impact the pre-existing trauma symptoms they have. Research has shown that refugees face several stressors (employment, language acquisition, housing, immigration, etc.) that make receiving mental health care more difficult (Kirmayer et al., 2011). Current research reflects both the mental health concerns of refugees and stressors that they face. However, current research has not come from the perspective of refugees. This research study grants those working with refugee's further guidance on what needs to be done with the stressors

refugees face so they can receive the mental health care they need while transitioning properly into their new home country.

This study was designed to be a qualitative case study. Qualitative research studies "things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them" turning "the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self" (Creswell, 2018, p.7). Qualitative research aims to approach the investigation with an open mind (Court et al., 2018). Additionally, qualitative research enables the researcher to connect to the study in a personal and passionate way through immersing themselves into the lives of the participants being studied in order to gain deep insight into the how and why of what is being studied. Qualitative research typically is broken down into one of these categories: ethnography, case study, narrative, action research, or phenomenology (Court et al., 2018). These approaches use efforts such as interviews, photographs, and focus groups (Creswell, 2018).

A case study was chosen for this study specifically because it focuses on understanding a phenomenon and includes the participants' stories (Court et al., 2018). This is different from an ethnography study which is aimed to determine how the culture works whereas a case study develops an in-depth understanding of an issue or problem though the use of the case as a specific example (Creswell, 2018). This study aimed to examine the stressors and the impact on pre-existing trauma through the lens of a small group of refugees in Vancouver, Canada. Case studies are studies that look at the history of the event, people, or phenomenon being studied but also relies heavily on direct observations and interviews from those being studied (Yin, 2018). It uses multiple forms of information to report and analyze the case being studied.

Stake explains a case study is more about what is being studied rather than how it is being studied (1995). He uses the example of a sick child being studied by a physician will record symptoms in a qualitative and quantitative way but will err more on the use of focusing on the quantitative data whereas a social worker studies a child because the child was experiencing neglect and the symptoms recorded would be both quantitative and qualitative. But the qualitative symptoms would be more focused on due to the nature of the study (Stake, 1995). A case study is focused more on the case or individual(s) being studied over the methods being studied.

This qualitative case study approach is specifically a single instrumental study. A single instrumental case study is helpful in this setting as it represents a unique case, and it is intended to inform other cases in the future. An instrumental case study is defined by Stake as being able to "mainly provide insight into an issue or to redraw a generalization" (1995, p.137). This approach was best for this study because the goal was to provide insight into the issue of refugee post migratory stressors' impact on their pre-existing trauma symptoms.

Research Questions

1. What are the biggest stressors refugees face upon arrival and what if anything makes that easier?
2. How does arriving with their trauma impact refugees' adjustment post-migration?
3. What would refugees want people and governments around the world to know regarding being a refugee?

Setting

This study took place in Vancouver, Canada through Matthew House (pseudonym). Matthew House was started to help each newcomer as they enter into their new life in Canada

through assisting them with the needs each refugee has. Ranging from health care services to housing aid, employment assistance and assistance with refugee status documents, this agency aims to meet a complete range of needs. It is operated by refugees who have found themselves established in Vancouver, BC and have partnered with local services to make the transition to Canada as smooth as possible for each newcomer. They currently do not offer mental care services for refugees but desire to do so in the future. The researcher has a close working relationship with this organization and has seen their desire for this type of research and their availability of a refugee pool who will also have additional help, if necessary, after participating in the study. This study will assist them in gaining more information for their team and partners on how to further meet the needs refugees have.

Participants

Participants for this study were chosen based on recommendations from volunteers serving with Matthew House. All participants had received resettlement care through Matthew House. Each member, who had been in Canada for over a year, while in their care was asked if they were interested in participating in this study. Participants who were interested were put in contact with the researcher to book interview sessions and sign a consent form. Participants did not receive any formal compensation. There were no monetary benefit for participating in this study, but participants did help future refugees with how to meet their needs upon arrival.

This study was to be comprised of ten participants. The goal was to have both male and female participants but the composition of the group depended on which refugees were willing to participate in the study. The desire for this study was to have more than ten participants interested in the study and then for the researcher to narrow down the pool to ten participants. The researcher suspected some interested participants would not meet the qualifications of

potential pre-existing trauma. That was best determined through the completion of questionnaires that helped in determining if suspected trauma is potentially present.

Participants booked their date and time at the information meeting. Each participant was to come to the Matthew House location for their interview session. Upon arrival, the participants were asked to complete the Harvard Trauma Questionnaire (HTQ) to examine the traumatic events each participant had experienced in the past. Second, the PTSD Scale-Self Report for DSM-5 was examined with the DSM-5 criteria to determine if PTSD was present in the participant. Third, the Hopkins Symptom Checklist (HSCL-25) was used to determine which depression and anxiety symptoms the participant had experienced within the last week. Lastly, the Comprehensive Trauma Inventory-104 was completed since the researcher desired not to focus as much on the traumatic events but rather the impact of trauma. This allowed the researcher to see what traumatic events the participants had experienced without spending too much time opening those portions of their stories. These studies determined the pre-existing trauma and mental health symptoms for each participant.

Sample questions from each are below:

Harvard Trauma Questionnaire (HTQ)

Please indicate whether you have experienced any of the following events (select yes or no)

1. Combat situation (e.g., shelling and grenade attacks)
2. Forced evacuation under dangerous conditions.
3. Torture, i.e.., while in captivity you received deliberate and systemic infliction of physical or mental suffering.
4. Witness killing/murder.

5. Rape

PTSD Scale-Self Report for DSM-5

1. Have you ever had unwanted distressing memories about the trauma?

Rate each problem with one of the following:

0 = Not at all

1 = Once a week or less/a little

2 = 2 to 3 times a week/somewhat

3 = 4 to 5 times a week/very much

4 = 6 or more times a week/severe

Hopkins Symptom Checklist (HSCL-25)

Please read each one carefully and decide how much the symptoms bothered you during the last week, including today (rate them as not at all, a little, quite a bit, and extremely):

1. Feeling fearful
2. Blaming yourself for things
3. Feeling hopeless about the future

COMPREHENSIVE TRAUMA INVENTORY-104

The list of events below are things that happen to people during war. Please read each item carefully and check either "NO" if the event did not happen to you or circle one of the four items under "Yes" if it did happen to you. If the event did happen to you, circle one of the four numbers next to each item that reflects how frightening the event was for you in terms of it being a threat to your life or safety.

1. Having your home, school, or workplace searched or ransacked.
2. Being beaten in front of family or friends.

3. Watching other people die.

Next, upon completion of these questionnaires the participants were told they would be chosen to move to the final portion of the study. The researcher examined the questionaries to determine which participants met the qualifications and then contacted them to book the interview for the study.

Procedures

Once approval was given by the Institutional Review Board (IRB) the data collection for this study began. The development and review of interview questions were conducted prior to the proposal defense for this study. Once approval from IRB was given participants were to be gathered for an informational meeting regarding the opportunity to participate in the study. Those who expressed interest after the informational meeting were then to be contacted for a screening interview. Participants completed multiple questionnaires (Harvard Trauma Questionnaire (HTQ), Posttraumatic Diagnostic Scale (PDS), Hopkins Symptom Checklist (HSCL-25), Comprehensive Trauma Inventory-104. These questionnaires were to be completed to evaluate if participants meet criteria of present trauma and resettlement stress.

After ten participants were chosen the formal interviews did proceed. Participants were to arrive at the site and be offered nuts, fruit and teas coming from their countries to provide a relaxed environment for interviews. Interviews were to be recorded on multiple devices to ensure quality of recordings. Transcription devices were utilized after each interview and transcribed interviews saved.

Researcher's Role

Bias is something the investigator must be aware of when entering research. To avoid researcher bias I, the researcher reported all details and findings from the study. All questions,

including follow up questions, were phrased for the participant to not provide information to please the researcher but to answer correctly. Participants were made aware their honest responses would be used to help future refugees.

The researcher's relationship with Matthew House is one where the researcher has provided counseling for a leadership member. The participants did not have any connection with the researcher prior to the informational meeting. Prior experiences the researcher has had with refugees in a mental health background could have led to some assumptions and biases.

Data Collection

Once the Institutional Review Board approved the case study proposal and Matthew House approved the use of their space and participants, the study did begin. All interested participants who wished to proceed registered for their first interview stage for vetting purposes. This stage consisted of completion of questionnaires and signing a consent agreement to interview and record the interviews. After participants were narrowed down and selected the interviews were conducted and recorded. Only one interview was conducted per participant. The interviews did allow interviewees to elaborate on their responses regarding post-migration. They shared the struggles they have faced since arriving in Canada and what resources they have found to aid in those stressors. Questions regarding mental health care were asked. These questions helped determine if the participant believed they could use care, think care would help them, or if care was available to them if they would take advantage of the services.

This was a semi-structured interview with seven participants being interviewed one on one with the interviewer. The approximate time for the interviews was to be one to two hours and to be audio recorded. These questions were being used to determine common themes available with responses. After recordings were transcribed using transcription applications they

were then analyzed for common themes. Findings were organized in a case study which was be included in the data analysis section of Chapter Three.

Interviews

Interviewing was the main method of data collection selected. This was the most common utilized with case studies (Creswell, 2018) and therefore is appropriate for a qualitative case study. Interviews are important especially because of their "suggesting explanations (i.e., the "hows" and "whys") of key events, as well as the insights reflecting participant' relativist perspectives (Yin, 2018, p.117-118). This was the best form of gathering data for this study as it gave the participants a chance to give their perspective on the post-migratory process and its implications on their mental health especially for pre-existing trauma prior to resettlement. Interviews were to be conducted at Matthew House in closed rooms with recording devices audio recording all interviews.

Standardized Open-Ended Semi-Structured Interview Questions

1. Please introduce yourself to me by sharing a little about yourself.
2. Tell me about your country of origin.
3. Tell me about your migration timeline getting from _____ to Canada.
4. Please share what adjusting to life in Canada has looked like for you.
5. What are some of the biggest struggles with moving to Canada?
6. What current or past stressors have impacted your quality of life since moving to Canada?
7. In what ways has stress been released from you during your time here? What haves the government, charities, or individuals done to help with your adjustment with moving here?
8. What are some stressors that you needed assistance with and did not receive ?

9. Would you say experiences that took place in your country of origin or during your resettlement process to Canada have impacted you here in Canada? If so, how?
10. Have you experienced any instances or situations in which you were afraid since moving here? If so, can you give an example?
11. How has moving to Canada affected your mental health? Please provide examples.
12. How has locating employment, finances, housing and other resettlement factors impacted your mood since arriving in Canada?
13. Have there been any situations since arriving here that have felt similar, in a negative or uncomfortable way, to situations you found yourself in prior to arriving in Canada?
14. Have you experienced any form of discrimination for being a refugee in Canada? If so, can you share a time this took place?
15. Have you ever received any form of mental health care treatment? If so, when, where and what did you experience from it?
16. Have you received mental health care since arriving in Canada? If so what kind and has it been helpful? If not, why not (has it not been offered, or do you wish not to take part in it)?
17. If the mental health care were free and would not interfere with employment, housing, or other resettlement concerns would you take advantage of this why or why not?
18. If you could change one way governments around the world helped refugees upon arrival, what would that be and why?
19. What would you like to see government agencies implement to help with refugee mental health concerns?
20. Based on what we discussed today is there anything you would want the world to hear on the topic from your perspective?

21. Would you share a funny story about moving to Canada or Canadian culture that you have experienced?

Questions one though three were basic questions being asked of the participants for them to introduce themselves. These questions allowed them to share about who they are and what their origin was. Rather than diving straight into questions regarding trauma, mental health, and stressors, this allowed the participants to feel welcomed and to gather that each question would not be simple yes or no responses but a chance for them to share in great detail what the process has been like for them. Sherry Ricchiardi, a journalist for the International Journalists' Network, often covers stories on refugees. She advises those interviewing refugees to not "start with hard questions". Instead, she recommends to "ask trauma survivors about themselves and get some sense of their lives before asking about their most vulnerable moment" (2018). She adds that instead of focusing on the trauma that took place in their country in the beginning ask them about what it was like before the event(s) took place.

Questions four through six were asked to ease into the questions about adjusting to life in Canada. Since this study focused on the impact adjustment stressors have on refugees pre-existing trauma this allowed them to share what some of those adjustments have looked like. This gave the interviewers and the readers a chance to hear stories of these adjustments.

Questions seven and eight were asked to gain insight on what they had seen as been done for them but what has not. This can be helpful for those working with refugees to hear potential gaps in providing for needs or even in being aware of resources already available that perhaps have not been well explained shortly after arrival in Canada. This is to help in better communication and meeting of needs for those working directly with refugees and something to stress for those who wish to start working with refugees.

Questions nine through fourteen were asked to gain insights in two areas. First, to see how trauma prior to arrival in Canada had been impacted from moving to Canada. Second, to gain insights on potential traumas experienced in country after resettlement. These were more mental health related which is a large percentage of the reason for this study.

Questions 15 through 17 were focused on mental health care availability in Canada. These were asked to see what had been received, what had been offered, and what their feelings were towards mental health care resources.

Questions 18 through 20 were aimed to give refugees a voice. The literature has shown answers to questions about stressors and refugee trauma and mental health (James et al., 2019). However, there has not been literature focused on hearing how refugees would want to see change in the resettlement process and in the area of their mental health. This study allowed them to have a voice which is of special importance as many feel voiceless.

Lastly, question 21 was asked to end on a good note. Dr. Ibrahim Kira does research with refugees who have been victims of torture. He explains the importance of incorporating humor into work with refugees especially when it comes to laughing about their new culture (Kira et al., 2012). Since this study did not provide immediate trauma counseling following sessions, ending the interview on a light note was determined to help after discussing such difficult topics.

Data Analysis

The first portion of this study involved the questionnaires. An Excel spreadsheet was created to enter all responses from each participant. Responses to each question and results for each questionnaire were recorded in the spreadsheet. Key themes and responses were reported through pattern matching to explain the population participant pool.

Pattern matching compares predicted patterns and identifies variances and gaps. Likewise, word count analysis was used to observe frequently used words. These themes were recorded into an Excel spreadsheet. The investigators looked for key themes to compare responses to one another. This helped in determining if participants share similar stressors and mental health desires/concerns.

After the interviews were completed, all interviews were transcribed and were examined for reoccurring themes, also known as thematic content analysis. Common words and phrases were recorded to see themes throughout the interviews. Portions of the interviews were shared to include sentences from the interviews to fully give a voice to the participants.

Trustworthiness

All participants were allowed to review their answers after transcription and give further elaboration if necessary. All responses were used whether conflicting or not. Likewise, responses to some interview questions were compared to the results regarding post-migratory stressors questionnaires completed prior to the interviews to ensure there was full honesty and transparency in the interview. Any conflicting information was reported.

Credibility

Credibility was established in this study through member-checking. “Member-checking continues to be an important quality control process in qualitative research as during the course of conducting a study, participants receive the opportunity to review their statements for accuracy and, in so doing; they may acquire a therapeutic benefit” (Harper & Cole, 2012). Each participant was provided the opportunity to review their responses to all questions. They were allowed to add clarification to questions if they believed it was not answered appropriately. This ensured all participants felt comfortable and confident in all their responses to each question.

Dependability and Confirmability

Dependability was addressed in this study through the lack of influence the researcher had with the participants. The researcher does not work at Matthew House and prior to the study had no contact or relationship with the participants. Although the researcher does not work at Matthew House, she is familiar with the migration process offered and the relationship held with the participants which aids in providing security for the participants. The researcher's experience with refugees, counseling, and stressors aids in developing data collection procedures. Lastly, having an audit trail of all paperwork, interviews, and data analysis ensures dependability.

Transferability

Transferability has ensured the data collection and analysis procedures explained in detail to enable the replication of this study by a future researcher. All pre-interview questionnaires are listed for each replication. Likewise, all interview questions are included, and the open-ended questions provide for more responses for future participants in other parts of the world. The experiences of each participant and the variation of culture, gender, and age all provide a well-rounded view of the topic and the experiences of each participant. Interviewing ten individuals created a greater pool for data.

Ethical Considerations

Refugees are considered a vulnerable people group. To ensure privacy all participants were recorded with pseudonyms as well as one used for the site of the study. Although question two of the interview did ask about their country of origin, these countries were not shared alongside the names. The only people to review the information given in the interviews were those involved in the study directly. All notes, recordings, transcription, questionnaires, consent forms, and data are protected on the researcher's private laptop with password protection. The

researcher did sign consent forms agreeing to insure confidentiality of all information. Lastly, all digital recordings will be destroyed at the conclusion of the research study.

Summary

This paper has served in explaining the methods of this study focused on the post migratory stressors and their impact on pre-existing trauma. This study was a case study involving 10 refugee participants. The participants completed four questionnaires and a recorded interview ranging between one and two hours. The responses were compiled in an Excel spreadsheet and the interview responses used pattern sharing to observe common words and phrases amongst participants. This study was designed to assess the hypothesis that refugees' post-migratory stressors increase posttraumatic symptoms.

Chapter Four: Findings

"Refugees are mother, fathers, sisters, brothers, children, with the same hopes and ambitions as us—except that a twist of fate has bound their lives to a global refugee crisis on an unprecedented scale" (Hosseini, 2016).

Overview

Refugees face many challenges upon arriving in a new country and often arrive with traumas from their past. Ten participants were recruited for this study, but three dropped out, leaving seven individuals who participated in this case study. Each one had experienced at least one traumatic event prior to their arrival in Canada. This was determined through the use of four questionnaires that were focused on traumatic events and trauma symptoms such as PTSD. They engaged in a one-on-one interview answering questions regarding migration, trauma, and the refugee journey. The purpose of this study was to collect qualitative data and examine how post-migration stressors impact traumas each participant had experienced prior to arrival. This was to be focused on the refugee's perspective of these topics as opposed to the perspective of the researcher or those who work with assisting refugees in their migration journey. This study is significant because previous studies have focused more from quantitative data over qualitative regarding this topic and have not entirely focused on the refugee's lens on these topics.

This chapter focuses on the participants that made this study possible, their pre-screening questionnaires reflecting the trauma they had experienced, and the qualitative data collected during the interviews with particular attention given to the many themes observed in the data. The pre-screening questionnaire data comes from the Harvard Trauma Questionnaire, the Hopkins Symptom Checklist-25, the PTSD Scale-Self Report for DSM-5, and the Comprehensive Trauma Inventory-104. These were used as a pre-screening tool to determine in

an objective approach that trauma was present for each participant. PTSD was not qualifier, but many participants did meet the criteria for PTSD per the DSM-5 requirements.

Interview questions were asked to gain insight on how refugees feel post-migratory stressors impact their adjustment and mental health here especially as individuals with trauma. Likewise, questions were asked to give a voice to a population that often does not have one. They can either feel no one would listen to their voice or fear speaking up as this could put them or their families in danger. Themes emerged as the data was explored. Key quotes were chosen and added specially to incorporate that voice into the results of the data analysis.

Participants

Participants were chosen through Matthew House members. Matthew House volunteers contacted members regarding the opportunity to participate in this study. After IRB approval seven participants agreed to participate and completed the consent form, four questionnaires, and a one-on-one interview. All participants come from the same Middle Eastern country, yet vary in age, gender, and trauma exposure. The study was comprised of three females and four males. They varied in ages of ranging from early thirties to early fifties. Arrival in Canada ranged between 2017 and 2019 with all participants settling throughout Vancouver, British Columbia. All participants were married with children. Some arrived with their families, others had their family join them after arrival, and one participant is still waiting for reunion with their family.

All seven participants participated in the one-on-one interview through a web-based video conferencing platform. Each interview was both video and audio recorded. Pseudonyms were assigned to each participant and identifying factors were removed. A participant outline is included below in Table 1.

Table 1

Overview of Participants

Participant	Gender	Age	Year in Canada
Fatima	Female	39	2019
Amir	Male	46	2017
Farah	Female	36	2018
Salma	Female	31	2019
Muhammad	Male	49	2017
Ibrahim	Male	44	2018
Hassan	Male	52	2019

Fatima

Fatima is a female refugee in her thirties that arrived in Canada in 2019. She is a mother, a wife, and works full-time. Fatima selected nine traumatic events on the Harvard Trauma Questionnaire. Individuals taking the Hopkins Symptom Checklist-25 with scores on anxiety and/or depression and/or total greater than 1.75 are considered symptomatic. Anything ≥ 1.75 is now considered a scientifically valid cut-off point. For the Hopkins Symptom Checklist-25 she scored a two for anxiety and a 2.13 for depression with a total score of 2.08. These results placed Fatima as meeting the criteria for anxiety and depression. Additionally, her PTSD Scale- Self Report for DSM-5 scored her as meeting all criteria for PTSD as stated in the DSM-5. A score of 203 was given for the Comprehensive Trauma Inventory-104. She placed many events such as extreme fear or threat on her questionnaire. Selections included having the home, school, or workplace search ed or ransacked, fleeing, or hiding from soldiers or enemies, being in jail,

prison, or a re-education camp for more than three months, and being threatened to be sexually molested or raped (but it did not actually happen).

Table 2

Fatima Results

Fatima Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	9 events
Hopkins Symptom Checklist-25	Anxiety=2, Depression=2.13, Total=2.08
PTSD Scale- Self Report for DSM-5	PTSD Criteria Met
Comprehensive Trauma Inventory-104	203

Fatima first fled to another city to live near her mother-in law when the government discovered her whereabouts and sent 15 police officers at 5 in the morning to search her mother-in-law's house for her. However, she was not living at her mother- in- law's house. When she heard this news, she had to go into further hiding for over two years. Fatima could not go to her children's school, receive medical care or be with her friends. She reached out to a friend from the USA to see if she could help her family escape. They decided to have her mother-in law take her children to the consulate to get passports for her children and said their parents were living in the States, so their grandmother had to be the one to bring them to get their passports.

Once they had passports, they decided to escape but had to choose illegal options to do so. They paid a large amount of money to some men they did not know to walk them to Greece in the middle of the night. Two children had a backpack, she had a backpack, and her husband carried their youngest child. One had clothes, one food, and one shoes. They got on a plastic raft in the water, but none of them were given life jackets.

Once they arrived on land, they had to walk for four hours until they finally saw some soldiers where they could claim refugee status. The soldiers had big guns and pointed their guns at them, but when the soldiers noticed there were children, they lowered their guns. They were then escorted away and placed in jail for three days. She had been told this was part of the process, so she was not concerned. Her family was then taken to a refugee camp where the living conditions were not good.

Her sister-in law mailed their passports to the refugee camp, and they booked their plane tickets to the States. After staying with friends in the States for a few days they took a taxi to the Montreal border and claimed refugee status with Canada. The border guards took them to the YMCA building to stay for three days. From there they moved to Vancouver to stay with friends. They only had her mother-in-law's credit card to use for money, but the conversion rate from her country's currency to Canadian dollars proved to be very little money.

Her friends helped her family with employment, housing, and even helped pay their first month's rent. Members of Matthew House helped by giving extra sheets and such for their house. They focused on their education with learning English and getting schooling done to help her family get better paying jobs. When her husband was studying, she was working to provide for them. Today she is still pursuing further education for certification and pushes her friends in this direction when they arrive.

Amir

Amir is a 46-year-old male refugee who arrived in Canada in 2017. He is married with children and has full-time employment. He arrived in Canada on a tourist visa with his family and they claimed asylum at the airport. For the Harvard Trauma Questionnaire, he listed one traumatic event and scored a 1.3 for anxiety and 1.4 for depression on the Hopkins Symptom

Checklis-25 which did not meet the qualifiers for depression or anxiety. He also did not meet the criteria for PTSD on his PTSD Scale Self-Report for DSM-5. Yet, a score of 70 was given for the Comprehensive Trauma Inventory-104. Several events he listed as extreme fear or threat such as being monitored (repeatedly investigated, or watched and followed, or having to report to officials), being falsely accused of things he did not do or being arrested and having to flee his home or community because of danger.

Table 3

Amir Results

Amir Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	1 event
Hopkins Symptom Checklist-25	Anxiety=1.3, Depression=1.4, Total=1.36
PTSD Scale- Self Report for DSM-5	No PTSD
Comprehensive Trauma Inventory-104	70

Amir was living in another country when the news of the persecution that began to happen to his people back home reached him. They had made friends with others from their country of residence including those working at the local embassy. However, when things changed back home so did the friendships with these workers. They knew they could not go back home and there was fear they might be abducted and forced to return so they decided to take a flight to the States on a tourist visa. However, shortly after arrival Donald Trump took office and the refugee/asylum process changed and was going to be much harder to gain. This led them to choose Canada. Although he was a businessman prior to arriving in Canada it made the most sense to join a trade industry to provide for his family.

Farah

Farah is a 36-year-old female who arrived in Canada in 2018. She is married with children and works a part-time job while she attends school. For the Harvard Trauma Questionnaire, she listed six traumatic events and scored a 1.1 for anxiety and 2.4 for depression on the Hopkins Symptom Checklist-25 which did not meet the qualifiers for anxiety but did for depression. She also did not meet the criteria for PTSD on the PTSD Scale Self-Report for DSM-5 as she had no Criteria C "Avoidance of trauma-related stimuli after the trauma, in the following way(s): Trauma-related thoughts or feelings. Trauma-related external reminders" (APA, 2013). However, during the interview she mentioned working to not think about the past as when she does it is very distressing for her. Although the questionnaire did not place her as meeting the criteria for PTSD, the researcher would claim she has PTSD. A score of 96 was given for the Comprehensive Trauma Inventory-104. Several events she listed as extreme fear or threat were having to lie to protect herself or others (includes signing official statement to protect herself or others), having to flee from home or community because there is no work or because of other discriminations, and not being able to take care of family members because of separation.

Table 4

Farah Results

Farah Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	6 events
Hopkins Symptom Checklist-25	Anxiety=1.1, Depression =2.4, Total=1.88
PTSD Scale- Self Report for DSM-5	No criteria C but did in interview
Comprehensive Trauma Inventory-104	96

One day the police invaded her home, searching for anything they could use to imprison her. They arrested her and took her to the police station. Her husband was at work, but her daughter had to watch her experience all of this. She was accused of being a terrorist and was not sure if she would be released or put in prison right away. She attended court twice knowing the judge would send her to jail eventually; otherwise, the judge would be sent to jail.

Farah had to flee her country as she was wrongly accused by her government and was sentenced to over two years in prison. She had to use a false identity so she could escape. She traveled to multiple countries in an effort to escape. She finally arrived in Germany and was taken to a refugee camp by herself as her family could not come with her. She shortly after flew to the States where she stayed for two months while waiting for her husband and child to have approved passports and visas so they could journey to Canada together.

Farah applied for a visa to bring her child with her, but it was denied as the US government suspected she might apply for refugee status. Her husband's visa was also denied as he could not get a copy of his passport from the government. She took two buses and a taxi in the middle of the night to arrive at the Montreal border where she claimed refugee status. She was then taken to a refugee camp where she shared a room with 16 other women. Other than their phones, the women were not allowed to have their clothing or other things from their bags.

A few days later she flew to Vancouver. However, after arriving all the shelters were already full. She stayed with a friend in the area until she was able to rent a room in her house. She studied and worked different jobs while she was trying to get her family here. After three years apart she has been reunited with her family.

Muhammad

Muhammad is a 49-year-old male refugee who arrived in Canada in 2017. He is married with children and works full-time. For the Harvard Trauma Questionnaire, he listed two traumatic events and scored a 1 for anxiety and 2 for depression on the Hopkins Symptom Checklis-25 which did not meet the qualifiers for anxiety or depression. He also did not meet the criteria for PTSD on his PTSD Scale Self-Report for DSM-5. A score of 36 was given for the Comprehensive Trauma Inventory-104. Several events he listed as extreme fear or threat were being separated from his family because of war circumstances and being threatened with harm or feeling like he was in serious danger.

Table 5

Muhammad Results

Muhammad Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	2 events
Hopkins Symptom Checklist-25	Anxiety=1, Depression=1, Total=1
PTSD Scale- Self Report for DSM-5	No PTSD
Comprehensive Trauma Inventory-104	36

Muhammad was working in his home country when things changed and due to his affiliations, he was let go by his employer. He worked several different jobs, but each time was let go. He took an opportunity to come on a visa to the States. While in the states he applied for s study visa for himself so he could bring his family over to be with him. However, during that time President Trump changed certain requirements for visas from different countries; and after a year of waiting it appeared the US was not going to approve his visa, so he decided to pursue moving to Canada.

When he arrived across the Canadian border, he called 911 and spoke with the authorities who thought maybe he walked across the border accidently. After taking some documents from him they then sent him to be with his friends in Vancouver. After a month of staying with a friend housing was located and he pursued the opportunity to get certified in his field for work in Canada. He was separated almost three years from his family before they were approved to live in Canada.

Salma

Salma is a female in her 30s that arrived in Canada as a refugee in 2019. She is married with a child and currently is a stay-at-home mother. For the Harvard Trauma Questionnaire, she listed one traumatic event and scored a 3 for anxiety and 3 for depression on the Hopkins Symptom Checklis-25 which did meet the qualifiers for anxiety and depression. She also met the criteria for PTSD on the PTSD Scale Self-Report for DSM-5. A score of 3 was given for the Comprehensive Trauma Inventory-104. One of the events she listed as little fear or threat was fleeing or hiding from soldiers or enemies.

Table 6

Salma Results

Salma Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	1 event
Hopkins Symptom Checklist-25	Anxiety=3, Depression=3, Total=3
PTSD Scale- Self Report for DSM-5	PTSD Criteria Met
Comprehensive Trauma Inventory-104	3

Prior to when things changed in her country, Salma was living in another country with her husband working full-time. She had chosen to go back home on a holiday when everything changed. She left her country and headed back to where she had been living for the last six years. She was pregnant at the time, and the fear for her and her husband involved getting a passport for their baby. If they went to the consulate, they could risk being deported back to their country and face unsafe conditions. However, they could not get a passport from the country they were living in because neither parent had citizenship there. They then had to flee, while she was pregnant, to any other country they could go to for safety for their baby. Where she was going to give birth was uncertain as they were not sure where they would call home. Her husband was employed by a Canadian company in the country they lived in and therefore was offered a job in Canada.

Salma was able to safely give birth to her child in Canada, but due to COVID and the refugee status her family could not come to visit, and her husband had to work. She had to give birth in the hospital alone, which due to previous traumas from childhood, only increased the trauma for her. Although she was safe in Canada, hearing of her friends being imprisoned and seeing videos involving her people being tortured has been difficult for her in Canada. Her husband is employed full-time as she focuses on raising her baby. Although Salma isn't employed currently, she hopes to be in the future.

Ibrahim

Ibrahim is a male refugee in his 40s that arrived in Canada in 2018. He is married with children and works full-time. For the Harvard Trauma Questionnaire, he listed one traumatic event and scored a 1 for anxiety and 1 for depression on the Hopkins Symptom Checklis-25 which did not meet the qualifiers for or depression. He also did not meet the criteria for PTSD on his PTSD Scale Self-Report for DSM-5. A score of 2 was given for the Comprehensive Trauma

Inventory-104. One event he listed as little fear or threat was being in jail, prison, or a re-education camp for more than three months.

Table 7

Ibrahim Results

Ibrahim Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	1 event
Hopkins Symptom Checklist-25	Anxiety=1, Depression=1, Total=1
PTSD Scale- Self Report for DSM-5	No PTSD
Comprehensive Trauma Inventory-104	2

Muhammed was working fulltime in his country when things began to become unsafe. He realized his people were losing their jobs and being imprisoned, so he decided to flee with some friends. He left his wife and children behind as his youngest was only ten days old but had a tumor and needed medical treatment, so he went ahead without them. He and a few friends took a small boat over to Greece. Upon arrival the police took him and his friends to a holding facility for nearly four months. The conditions were not good, so they contacted the United Nations for assistance. Some representatives from the UN came to them. They were able to help them get their papers to leave. During this time his wife was imprisoned with his children.

Muhammad tried to get a job in Greece, but was not able to locate one, so he moved to Iraq in hopes of finding employment there. He worked in Iraq until he heard some of his friends were being kidnapped by his government and taken back home. When he discovered they were searching for him, he used a visa he had for the States and went there. After staying with a friend, he was told he could receive refugee status more easily if he went to Canada. He claimed

asylum in Canada and moved to Vancouver where he worked doing food and grocery delivery services while he took courses in college.

During this time Muhammad was separated from his wife and children. His wife was sentenced to six years in jail, but due to the health issues of her youngest she was allowed to stay out of jail until he got better. His wife and children ran and escaped to Iraq, fearing they might be kidnapped and taken back home. He fought to get his family to Canada, but COVID hit and this moved the timeline further back. After five years he was reunited with them.

Hassan

Hassan is a male refugee in his early 50s that came to Canada in 2019. He is married with children. However, only one of his children is in Canada with him currently. He is still in the process of having his wife and children come to him. For the Harvard Trauma Questionnaire, he listed one traumatic event and scored a 1.1 for anxiety and 1.47 for depression on the Hopkins Symptom Checklis-25 which did not meet the qualifiers for anxiety or depression. He also did not meet the criteria for PTSD on his PTSD Scale Self-Report for DSM-5. A score of 4 was given for the Comprehensive Trauma Inventory-104. One event he listed as moderate fear or threat of being separated from family members during fleeing or migration.

Table 8

Hassan Results

Hassan Results	
Questionnaire	**Score**
Hopkins Trauma Questionnaire	1 event
Hopkins Symptom Checklist-25	Anxiety=1.1, Depression=1.47, Total=1.32
PTSD Scale- Self Report for DSM-5	No PTSD
Comprehensive Trauma Inventory-104	4

Hasan worked for a successful company in his home country. However, when things changed the company closed and he no longer could find employment. He had a court date for sentencing which led him to flee to America. He applied for visas for his whole family but only he and one of his children were approved. After working with attorneys in the States, they decided it would be easier to get his whole family to safety if they went to Canada rather than the States.

He took several buses to the border; but once he got to the border, he realized he had left his passport on the bus. He called 911 and the police came to him, and they took him to the border services agency. After two weeks his passport arrived in the mail. He worked different jobs in a trade industry to provide for him to live in Canada and to send back to his family. He also attended a certification training during this time. He currently lives in Canada with one of his children and is actively waiting for his family to be approved to move to Canada. He is looking for work in the field he is now certified in.

Results

This study examined the perceptions of seven refugees who had experienced trauma prior to arriving in Canada and had lived in Canada for over a year. The perceptions of the migration journey, how previous trauma had impacted their acculturation, and their views on how governments and individuals can assist refugees in the areas of mental health and post-migration were examined. The results detail the data collected from the interviews. All data collection occurred in March and April of 2022.

Individual Interviews

The primary data collection method used was individual interviewing of the seven research participants. The individual interviews were conducted online via a web conferencing

platform. Each interview varied in time due to work schedules of the participants and childcare. These participants were all individuals who held refugee or asylum seeker status in Canada and arrived in Canada over a year ago. Each participant was asked a series of 21 open-ended questions. The questions stemmed from the literature review and the theoretical framework that was used. Informed consent was obtained as well as four questionnaires from each participant prior to the interviews. Each interview was video and audiotaped and then transcribed using a transcription software. After transcription each participant was given the opportunity to review their responses. Two participants chose to review responses; the others declined. Data was analyzed by the interviewer. The researcher first read through all transcriptions and highlighted key themes among the seven interviews. Themes included common responses that were similar, responses that differed, and key quotes that aligned with the previous literature focused on in this study. Individual interview questions are included in Appendix C. A copy of the consent form in included in Appendix B.

Theme Development

There were multiple themes linked to each research question. For research question one, themes such as family separation, medical difficulties, and employment were present among participants. Themes of gender discrimination (in the case of the females), being known as a terrorist, fears of police officers and government officials were present for research question two. Additionally, experiences and responses to mental healthcare for each participant varied. Lastly, research question three had differences and similarities among the responses. Some geared their responses directly towards government officials that could make changes while others addressed the general public on what they would want them to know about refugees. Since each participant

varied in their trauma and migration experiences, this created differences among responses, but clear themes existed among each participant.

1. **What are the biggest stressors refugees face upon arrival and what if anything makes that easier?**

This research question sought out to observe what stressors refugees have impacted that align them with current literature. Stressors are areas for refugees that can add pressure or stress on newcomers such as not speaking the language, not having finances or employment, and difficulty locating housing. This question sought out to see what stressors refugees would include in a qualitative manner that made adjustment difficult while also including what support they did receive that help or did not receive they desired to see. The data reflected separation from family being the primary stressors for the participants. Not all participants were separated from their families, but even those felt this was a big area that impacted mental health and adjustment.

Next, employment was included. Some had difficulties with employment due to language learning. Others took a while to get their work permit which made it financially hard for them and their families. Some felt it was better to focus on education so they could gain better paying employment. Yet, they needed an income, so they had to work which made managing school and employment difficult. Although employment was stressed by each person the experiences ranged for each participant.

Another theme linked to employment and adjustment was the desire to advance Canadian society. Each participant desired to add to society and give back as "taxpayers." There was an ownership to the country they now belong to, and they expressed wanting to use their education and hard work to help Canada and Canadians. Participants received very little financial government support upon arrival. Some expressed limiting this was important to their adjustment

and others felt it was a hardship for them. Despite this they each received the most help and assistance from other refugees that had come before them.

Theme 1: Family Separation

A common theme among participants pertained to separation from family members and its impact on mental health and adjustment. Ibrahim shared, "one of my friends was able to bring his family after getting PR [permanent residency] in 45 days. And I got PR and after getting PR tried to bring family, got two years. I explained to [government] some kidnapping problems in Iraq…. But because of COVID-19 problems, getting family took two years… And my family so many times cried and anxious nearly before nine months we are here together after five years,"

When Muhammad was asked how governments could help refugees he shared,

> the worst thing for Canada that I say that is good [is] if you can reach here inside, everything is good. But they're not helping to reunite with your family. I have to live almost three years separated my family and my kids. I was asking, they need me, my kids need me, but nobody hears it. This is the worst thing about Canada. They don't care about your family or the rest of people who are not here. They're not trying to make it faster. The worst thing is because you know that the family is very important to us. First thing is the family, your son, your kids, your children, and your wife. But this is the worst thing. The reunion process is as I said too long, too long. If you can get inside the lines, the border, everything is fine. But if you're out you're out. No one is helping get you in.

Amir was not separated from his family but has recognized the impact it has had on his friends. "What I see as the biggest challenge to separating their family for today is not easy. It's really stressful. Even for some of them they...separated five years…. I know friends separated

from their family the five years… Even one of my friends he couldn't see his newborn son for years. And he left [his country] and left his wife [pregnant] He never seen his son after four years they came to Canada. First time in Canada he saw the son and he touched the son". Farah stated, "you know I when I left my [child they were] seven years old. Now [they're] ten years old at the airport…. I couldn't believe [they were] my [child] you know [they are] so grown up".

Separation from family also came too in the form of family not able to visit. Salma was pregnant and about to have a baby. "We applied for a visa for my family, for my mom, but the…. Canadian government said that we are not eligible to invite our people, you know, our family because we are refugee right now. So, that was the thing, I was alone". Family separation was mentioned in the literature as a common post-migratory stressor. It was shown to have a link to emotional distress according to Richa et al. (2020). The interviews supported these claims for causing stress on the individuals and families as well as emotional distress during times of separation.

Theme 2: Medical Difficulties

Another theme mentioned was regarding medical concerns and difficulties upon arrival and during their immediate adjustment period. This appeared to be a key stressor for participants. Farah shared two separate incidences that she experienced. First involved her experience taking antidepressants prior to leaving her country. She traveled to the United States prior to Canada. She said, "I was just planning to stay there for two or three days and then come to Canada. So, I ended up with two months and I was taking antidepressants…. I couldn't bring lots of antidepressants because I cannot bring because the police or security at the airport… when they search my suitcase, they [will know] I am planning to stay there. So, I could only [bring] for a month or something. And then I was out of antidepressants in the United States, and I started

shaking… my heart was beating so fast, and I didn't have any insurance in the United States…. That week was terrible time in my life, and it's made me more stressful, more aggressive and everything." When speaking of what Canada could do about this she said, "So, the government, even if we don't have insurance because we come here and then I think they help here at the beginning…. We should have some chance or options to be able to take our medicine. We are already taking; this can be something because it's directly affecting our mental health."

Later into her time in Canada she had to see a doctor for medical concerns. She shared,

> [Back home] the health system is really good. For example, if you can go to any gynecologist without referral. The next day I had to wait five months to see gynecologist…And then I was sending my ultrasound result to some doctors back [home]… I have to mentioned this, in 2016 my father died because of cancer. And I was so sensitive about the health problems because of this. And I thought, what if I have cancer? You know, what if there is something why they don't examine me and why I cannot see a gynecologist.

Salma shared about arriving pregnant to Canada stating,

> I found myself helpless because it was hard to find a doctor. And when I moved here three months later, I found a doctor, family doctor". Hassan needed to receive some medicine for his mental health. He shares:
>
> "Ya, I received it. But here also they didn't follow me. For example, after the interview psychiatrist told me that she's going to sed the report to the walk-in clinic. So that I will be able to take my medicine. And after three days…I went there. They told me that it didn't arrive. Come a few days later, three times I went

> there. At last, I saw no documents, so I called the psychiatrist office. So, they send it. Yeah, it took 20 days nearly to be able to get my medicine. It's urgent for me. But I mean that nobody follows after that. For example, after one month I used it, I decided to leave it, but nobody knows. They also didn't call me to ask do you want to change the medicine.

These stories matched the experiences listed in previous studies. However, several studies claimed fear refugees faced when approached medical professionals while others expressed not feeling cared for or listened to by those in medicine. Participants didn't seem to fear or distrust medical professionals, but they did express not receiving good care especially in areas they deemed urgent. Shannon et al., 2015 expressed this issue in their study feeling they were not listened to and were often hurried for them to see the next client. This mixed with a new medical system that could be confusing for any newcomer, regardless if they are a refugee or not, does add an element for consideration.

Theme 3: Employment

Employment was an area of differing themes. Each shared the importance of employment, but not all agreed on how that should appear. Some felt they should be given the opportunity to study and get jobs closer to what they held back home. Some felt language learning was important and didn't give many opportunities for them, but others arrived speaking English and this was not a concern of theirs. Others took every opportunity to provide for their family. Either way they all agreed in the importance of employment and gaining work visas.

Hassan said,

> Especially for finding a job, for finding my direction I needed help, I needed mentoring. I have many choice[s] in this new country. With the help of my

> previous experience and trainings, but I didn't know what are these, which one would be better. After my acceptance, I am part of this country. In the future I will be a citizen of this country. So, this country will benefit me in a way. The best way the country will benefit me will make me happier and healthier also. I needed such kind of mentoring. I applied WorkBC and Mosaic but couldn't get support for employment. Government of Canada or BC doesn't have any employment services like in Europe". He expressed frustration in the lack of services offered in Canada compared to those experienced by his friends in areas of Europe.

Ibrahim said, "My wife finished four years nursing academic in [our country] but beginning about nursing here. So many works. I learned that Canada needs so many nurse and healthcare workers". The desire to advance society in Canada was a unanimous desire among all seven participants. How they wanted to get there differed, but each participant recognized Canada was their new home and they wanted to become part of its society and culture. Fatima wanted to learn English and find employment quickly. She expressed the need for language learning not just for holding a job, but also so she could help her children with their schoolwork.

She included creative ways of making money upon arrival to provide for her family which was consistent among participants. Amir went into a trade business, others delivered food through Instant Cart or Uber Eats while they learned English, and nearly all participants took courses to gain better employment opportunities. Underemployment, such as being a teacher or a nurse in their home country and going into construction or food delivery matched prior research. This has been said to be linked to emotional distress (James et al., 2019).

Participants stressed the need for work permits to be approved quickly. Without a work permit they have no chance to make money which then had them dependent upon government assistance (if available), assistance from friends, or doing jobs to earn money under the table. If separation from family was present this increased the stress of employment. This could be seen for Hassan who had to send money back home while providing for himself in Canada, as well as for Farah, who has had to help her family while her newly arrived husband seeks employment.

Theme 4: Help from Other Refugees

Majority of participants received very little, if any, assistance from the government upon arrival. However, each credited the kindness and assistance other refugees in Canada had given them. When asked what assistance was given each had examples of what the refugees in their community did for them and expressed thankfulness that led them to pay this forward. Examples ranged from assistance in locating employment, having them live in their house while they search for permeant housing, paying the deposit on a rental or giving things such as sheets and pots and pans to help make their house a home.

Farrah shared when she arrived in Canada it was winter, and she did not have a winter coat. She was cold taking public transport and walking a lot. She said, “one of the people from the community, she offered me her coat.” She accepted help that was offered by others to her “thanks to the community. Otherwise, I couldn’t survive.” There was a clear desire to help other newcomers upon arrival. Ibrahim said, “Nowadays we help each other [our community] we’ll help each other.”

2. **How does arriving with their trauma impact refugees’ adjustment post-migration?**

This research question was asked to see if mental health concerns linked to their traumas impacted them as they worked to gain employment, learn the language, and adjust to a new culture. The participants in the study each had experienced trauma and each participant ranged in what they had experienced. Additionally, three out of seven participants met the criteria of the DSM-5 for PTSD. A key theme emerged regarding their country deeming each of them a terrorist. Even for those that did not have trouble escaping and coming to Canada they were impacted by this label being placed on them. Likewise, each participant lives in Canada but hearing what is taking place back home to their friends and families has played a role on their mental health.

Some expressed not wanting to address or relive the experiences they had faced back home as they want to forget so they can focus on adjusting to Canadian life. There was fear of speaking out about what took place in their country as it might impact their families they left behind. Fears from their experiences have been carried over into Canadian life. A repeated theme involved the fear of police officers and government buildings. Participants had either been arrested and questioned by police officers or heard stories of those close to them that had faced these circumstances. Although they may feel safe in Canada, many expressed concern and fears in this area.

Table 9 reflects the responses of each participant for the Comprehensive Trauma Inventory-104. This is shown to reflect some of the traumatic events those in this study have experienced in light of the themes below. The participants were asked to place a 1-4 for the experiences they had faced. The number meanings are as follows; one(1) means little fear or threat;, two(2), moderate fear or threat; three(3), a lot of fear or threat; and four(4), extreme fear or threat.

Table 9

Comprehensive Trauma Inventory-104 Responses

Questions	Fatima	Amir	Hassan	Farah	Ibrahim	Muhammad	Salma
Having your home, school, or workplace searched or ransacked	4			4		4	
Having your home (or important place like school or workplace) severely damaged or destroyed	4			2			
Fleeing or hiding from soldiers or enemies	4			4		4	1
Having to lie to protect yourself or others (includes signing official statement to protect yourself or	4			4			
Living in the middle of war, and being forced into dual loyalties to survive	4			4			
Being threatened with harm or feeling like you are in serious danger	4	2		3		4	
Death of a family member besides a young baby due to war	4						
Death of friends due to war	4	4					
Having to abandon injured, dead, or dying people	4			2			
Being forced to attend party activities or having ideas or beliefs forced on you (“brainwashing”)	4			2			
Being intimidated or “blackmailed”	4	2		3			
Being humiliated in front of others (stripped naked, insulted, screamed at, beaten)	1			3			
Being beaten in front of family or friends	4						
Being nearly killed by hanging or suffocation, near-drowning, or other intentional injury (like being	4						
Being placed in solitary (isolated) confinement or being deprived of sensations	4						
Being deprived of adequate food or water	4			2			
Being awakened repeatedly and being deprived of sleep	4						
Having medical care withheld when you were very sick	4						
Living in very poor conditions in prison (crowding, problems with sanitation or temperature)	4						
Being forced to work hard or for a long time or under very bad conditions	4						
Being interrogated, physically searched, stopped for identification and questioned	4			2			
Being falsely accused of things you did not do or being arrested	4	4		4			
. Forced to make a confession about yourself or others	4			4			
Being threatened with severe injury or execution	4	2					
Being jailed for less than three months	4						
Being in jail, prison, or a re-education camp for more than three months	4				1		
Any unwanted sexual experience					1		
Being threatened to be sexually molested or raped (but it didn’t actually happen)	4						
Helping ill or wounded people (includes refugees)		4					
Seeing organized violence, mass demonstrations, or horrible events on television		4		1			
Heard about people being abused by harsh methods		4		4			
Heard that children or other innocent people were injured or killed		4		4			
Heard about mass killings and people being put in mass graves		4					
Having very little food, water, or clothing because of poverty or discrimination	4						
Having to live in poor conditions (fleeing, in mountains, poor shelter and hygiene)	3			4			
Having your home, business or important personal property confiscated	4			4			
Being forced to stop work or schooling	4	4		4			
Being monitored (repeatedly investigated, or watched and followed, or having to report to officials	4	4					
Being oppressed (can’t gather publicly, meet friends, speak your opinion)	4			4			
Being lied to or being made to feel uncertain about family member’s whereabouts	4	2					
Feeling like you were abandoned by allies during the war	4	2		4			
Feeling like you were deceived by your own leaders or high-ranking officials	4	1		4			
Being disgraced	4						
Being forced to monitor and report on family or neighbors	4						
Experiencing severe family conflict because of the war	4	1					
Experiencing violence from a family member because of the war	4						
Being moved to a government area or “new economic area”	4	4				4	
Having to flee from your home or community because of danger	4	4		4		4	1
Having to flee from your home or community because there is no work or because of other discrimi	4	4		4		4	1
Raising your children by yourself	4						
Your children were often alone because of war circumstances	4						
Being taken away by enemies, and separated from your family	4	2					
Being separated from your family because of war circumstances	4	2					
NOT being able to take care of family members because of separation	4	2	2	4		4	
NOT being able to see a family member who is dying, or can’t witness burial	4	2				4	
Being beat up or poorly treated in a refugee camp	4						
Thinking you would not ever be able to leave a refugee camp	4			1			
You or family members were denied refugee or asylum status				3			
Separated from family members during fleeing or migration		2	2	4		4	
Total	**203**	**70**	**4**	**96**	**2**	**36**	**3**

Theme 1: Terrorism and Mental Health

The people group interviewed were deemed a terrorist by their own people due to religious sect affiliation. This has impacted their mental health as they hear what the news tells

them. They see on social media where loved ones who have not escaped the struggles they have faced. Even family members have turned on them and will not communicate with them. The word terrorist held a lot of impact on each participant and although none believed this was true of them each appeared to reflect faces and body language of shame, anger, and grief sharing this aspect of their life with the researcher.

Salma explains how she was in a different country for work while she was pregnant when things changed in her country. “They don’t give passport to our child because when we give our ID to them, they might take our ID and they give us a flight ticket and they might fly us to [our country]…because... we are suspect”. “But we... we’ve heard a lot of bad news…. One of my friends arrested in my country and we saw a lot of bad videos about people you know tortured and especially people they don’t even have any guilt. They’re not guilty. So ya, a lot of peoples are in the jail with their mom... just because... [they are] member of a group. So, some of them are my real close friends. Some of my family members”. Salma speaking about sharing her life updates on social media said, “I didn’t share anything because of you know I still have friends [back home] some of them, their husband or someone, their wife [are in prison]. So, I was guilty about being in Canada because I was the lucky one, maybe living in Canada and eve you know some friends they cross over the river, and I was thinking like that IK was the luckiest one. I don’t have to think negative things about my life. You know everything is good. I came here. I moved here. Yeah… what happened [back home] that was bad, and I was feeling bad because of living here”.

Ibrahim spoke of his wife saying, “when she wake[s] up, sometimes she imagined... that she [back home]. And for example… she doesn’t want to speak with you because if she wants, if she speaks with you our families in [home country] if seen on Facebook, if seen in YouTube, if

seen on Twitter, our [home] governments going after our families…. My wife doesn't want to speak anyone because if seen on Twitter, on Facebook, on YouTube, [our] government after [our] families because our brothers, sisters, and father, mothers, there and [our] government very crazy". Amir spoke of reading things on social media and how it would make him angry. "It make[s] me angry but… if I am not following social media, I fell [I'm' kind of betraying them because I am one of the lucky one[s]".

Fatima explains how being called a terrorist impacted her personally. "I didn't do anything…. I didn't keep a gun in my hands. Just keep pencil, book. I rad book. I didn't put any gun. I didn't use any gun. But they told me you are a terrorist". She later shared how her mother and father believe the government that she is a terrorist and are not speaking to her. Her sister works as a police officer and how her sister holds this view of her and how she had to hide even from her family. Not only does this impact relationships back home but also those here. Farah shared how she doesn't know how to respond when people ask her if she is a permanent resident here. "I just say a permanent resident. I don't want to tell them I am a refugee here because… in Ukraine, in Afghanistan, Syria, there is war. But in [my country] there is nothing. And how can I explain them, why I was in prison. I was in prison. Am I a terrorist? I have never seen a gun in my life. But how they are doing to react to me?... I prefer not to talk about it because I don't know people's reactions". These responses reflected the traumas impact on them even after being aware from their home country. The title of "terrorist" was difficult for each of them. Hearing what was taking placed back home brought upon survivors' guilt for being here while their loved ones remained trapped.

Theme 2: Women's Discrimination

Another theme for adjustment pertained to the discrimination for the female participants. The male participants did not experience examples of discrimination, but each female did. For example, Fatima applied for a job and scheduled an interview, she explains, "You know you know I have a hijab…During the pandemic time it [was] all entirely like this, online. One lady open[ed] the zoom and when she saw me, she just looked down and she just said something and she said she said, okay I'm going to call you". She was never called. Farrah took a job where the workplace was rather hostile which led her to apply for a new job. She shared, "And then I applied to a few places, but you know, at that time I applied teaching jobs…. What I realized is, which made me really sad, as soon as they see me on the computer screen in my hijab, I can see their eyes. And many times, it made me really sad. They didn't even want to talk. They make the interview very short". She did get another interview and when she arrived in person she said, "As soon as they see me wit my hijab, they asked me, 'what are you going to say when kids ask you why you are wearing this hijab'".

Salma lived in another country prior to moving to Canada and wouldn't wear her hijab there. "When I moved here, I thought that country is free, freedom. There's freedom in this country and I'm going to wear my headscarf and I'm going to work…. No one did anything but I feel that people put some distance between me because I'm wearing [hijab]". The link to wearing a hijab and discrimination was discussed in the literature and reflects in this study as the men did not appear to have the same experiences the women did (Jasperse et al., 2012). This certainly plays a role in their adjustment. They each left their country due to their own people discriminating against them. They have arrived in Canada hoping for freedom and belonging and these circumstances can add to the traumas they have faced back home.

Theme 3: Fear around police and government

Fears were there for each participant. The fears differed from police officers, government buildings, and the fear Canada will become like the country they came from. Farrah expressed fear of the homeless population near her home and walking alone at night. A theme that was common among participants pertained to the police for those that had been questioned, searched, or arrested by police back home. There are not many studies surrounding refugees and perceptions of police. However, in 2017 Song et al. conducted a quantitative study to see what perceptions refugees had on police officers in the States. They hypothesized that those who had previous negative experiences with police officers would likewise feel this way in the States. However, this hypothesis was not supported in their study.

Yet this study's findings support their hypothesis and additionally reflects trauma responses lived out in daily life from undealt with trauma. Farah recalled two instances of the police being called that incited fear for her. One she recalls, "then I called 911 and then talk to the police. And even when they asked me about my identity, like my name, my number, anything I feel scared still. Because we were hiding [back home] from everything". Muhmmad also expressed fear of what could happen to him if the police were called. In one instance in Canada, he was refused service and when he stood for his rights to be served the manager became angry and he got nervous. He spoke of his fear, "like I can't say something. And I don't know if I say, if I tried to explain, what will happen. If cops come, if somebody comes, what will happen to me. [Will they] send me back or somewhere else or remove my rights? I don't know". The fear of those placed in positions makes sense for each of these participants given the conditions experienced in their country causing them to flee. However, this brings upon trauma responses in common scenarios.

Theme 4: Mental Health Support

This area varied for the participants. Some have received mental health care since arriving in Canada; others didn't believe they need it, and one shared how it was better to forget. However, key themes emerged around the need for these services. Even those that did not feel they needed help believed it would be helpful if offered to others. Those that did receive help in Canada either had poor experiences surrounding medication (as included in the medical difficulties above) or they received help from those back home.

Salma did receive mental health care while being in Canada. She shared, "I started in September because my symptoms were severe. I had some tantrums, being off, staying at home and I decided to get help. But I'm getting help people from [back home]. I don't get help in Canada because we don't have insurance right now". When asked if this was free in Canada would she take advantage of this she said, "definitely… everyone has family doctor but… everyone should have a therapist also. Especially in Canada, maybe they can, the government can afford that because a lot of people, especially after COVID, some issues happened or some of our traumas came up". "Maybe they can afford at least ten sessions when they move to Canada to explain what happens or how they can deal with their, you know, what happened to them.

Fatima took a different stance from Salma. She believed it was better to focus on the future. She spoke of her "treatment" being staying busy and accomplishing things to advance her future. Farah likewise didn't want to focus on the past as it is too painful. When discussing about her bravery and perseverance in hard times she said, "I hear this a lot, 'you are so brave'. But I don't want to be brave anymore. I just want to be a human…. I just want to be a mother. I just want to be a wife…. I just want to be".

Ibrahim shared “yeah, if someone helps like this, very nice for us.” Muhammad explained the importance of these services being available by people in their native language. This would help them as well as making it affordable to newcomers that already have financial issues.

This was consistent with literature. The literature which has shown low numbers of those receiving mental healthcare upon arrival which was supported by this study. Common responses of why this was not pursued included, language difficulties, cost, interference with language learning classes or employment, and not wanting to relive the past. Those desiring to not focus on the past traumas but rather move forward were the individuals that met the criteria for PTSD. This was consistent with Byrow et al. (2019) study on barriers to mental health seeking. They found those with “greater PTSD severity was associated with lower help-seeking intentions indirectly via mental health stigma and visa security” (2019).

3. **What would refugees want people and governments around the world to know regarding being a refugee?**

This research question held importance as it is what made this study differ from those in previous literature. This was a chanced to give a voice to refugees. Rather than giving them a questionnaire and using that information to process what changes refugees would like to see happen, they were asked to share this in their own words. Some of the responses involved things governments could do to change policies and procedures for refugees while others shared what they would want people to know about being a refugee.

The theme has been shared in the previous two research questions. What these refugees want people to hear is their stories. They want to be heard and seen. There was a desire to not be seen as ungrateful for the generosity bestowed upon them nor to see them as a population wanting to live off government assistance but rather just want safety. Fatima spoke about being a

refugee saying, “We didn’t want to leave… our country you know. Imagine, do you want to leave your country? No. Even, you have a good job. Even you had a good status. Even you have happy, you are happy. You don’t want to leave your country”.

Farah expounded on that by saying, “First of all, refugees don’t want to have social assistance from the government. It is not what we want. Actually, we [don’t] just come to Canada to be like sit at home doing nothing. No, we just come to Canada to be safe. To be free. Not to take advantage of [what] governments are giving us”. There were fears being interviewed that were often expressed before the interviews formally began. Yet, after the interview was completed, many participants wanted their friends to be interviewed. They felt heard and would include how this friend or family member has a story that needs to be heard.

They didn’t ever think they would be a refugee themselves. Each had dreams for the future and were established. Some of them experienced seeing refugees in their country before they themselves became one. Salma shared, “I was thinking different before I was in refugee situation. There was that there are people from [middle eastern country] in my country and they beg for money [in my country] and I was in university and when I saw these people maybe I might think of that. You know, why do they people do this?... And when I moved here as a refugee and whole, I’m thinking whole mind is changed about being you know, people who are refugees”.

Part of feeling heard was hearing their journey, pain, and trauma but also to hear their suggestions on how the adjustment life could be improved. Salma said, “what I felt for immigrants or for refugees, they don’t know that the country where they move very well”. She suggested trainings and assistance in areas such as, “how to register for bank account or how to

find a family doctor… or even career…. So, it should be the assistance should, must be the one way to teach you know the general form of living in that country."

Ibrahim, speaking on how people can help refugees, "wants to change orientation style. And helping people not only with the paperwork but in the life. Must be in the life." "Especially at the first year, very important. For newcomers solving language problems, after that joining life to earn money and to getting jobs. Farah suggested one-way governments could help refugees is to help pay for transportation while they search for housing as it can be expensive and takes away from the money, they need to pay a deposit on a rental.

These practical suggestions are added to the inclusion of needs as seen in the previous two research questions' themes. The desire is not to be given more than the regular individual but to be human. They want to be safe and secure. There is a desire to feel supported, welcomed, and cared for while also balancing a need to add to the society that has welcomed them in so openly. However, when trauma is present and mixed with a constant state of crisis these two needs become nearly impossible. There feelings of safety are shaken by trauma responses and reliving the trauma. The feelings of security where they add to society are difficult when they aren't gaining employment where they can use their education and training for Canadian society. Overall, these things can't be known if no one is listening.

What would refugees want people and governments around the world to know regarding being a refugee? They have a story and want to be provided a space for you to hear it.

Theme within the Theme: Ongoing Trauma Impacts Assimilation

The data observed has shown consistent themes but within them is an overarching theme that reflects when a refugee has ongoing trauma this impacts assimilation. For example, when separation from family is present their focus is less on adjusting to Canadian life but more

focused on the safety of their families. They may have made it to safety, but their families still are not safe, so they deal with reliving the trauma. Ibrahim expressed fear when his wife was in Iraq that she would be kidnapped as they had heard of kidnappings taking place to his people who fled there. Hassan shared how this separation and fleeing his country impacted his mental health, "[it] is difficult for anyone to make a radical change after 50 years old. If I had not to flee, I wouldn't leave my country…. Because of the situation I confronted, I became really depressed last year…. I didn't want to go out from my bed. All day long I slept. [I] didn't want to do anything. It was difficult and tough times."

Employment difficulties can further traumatize these individuals. The participants in this study were let go from their jobs and unemployable in their own countries. They worked as doctors, lawyers, teachers, and businessmen prior to this time. They arrived in Canada and were not receiving a work permit to work, they did not have the language skills for certain jobs, their certifications did not transfer into Canada, and they may have been denied a job for wearing a hijab. This not only keeps them in a crisis state but also has them relive the trauma experienced back home.

This can be seen in the trauma responses and reactions they have towards police officers. Farah shared a time when the police knocked on her window late at night, "When I opened the curtain, I saw the police. I was so scared. I was shaking. You know, because of this trauma. I knew they didn't come because of me. Of course. But I was scared." This response is taking place because trauma's experienced in their home country have not been addressed here in Canada. Therefore, the overarching theme connecting these themes is these people are living in a constant state of crisis, reliving their trauma and this is impacting their assimilation properly.

Summary

The purpose of Chapter Four was to provide insight into the lives of refugees with trauma and explain how post-migratory stressors impact their mental health and adjustment. Data was collected using individual interviews. The transcripts of the interviews were analyzed for key themes and incorporated in the effort to answer the research questions. These themes aligned with previous literature while expounding on pre-existing quantitative literature by providing a qualitative voice of refugees on the topic. This study found key themes such as employment and family separation for post-migratory stressors faced by refugees. Multiple themes were found pertaining to each research question and an overall theme that trauma faced by refugees is impacted by post-migratory stressors when the trauma has not been dealt with.

Chapter Five: Conclusion

"It's strange, how you go from being a person who is away from home to a person with no home at all. That place is supposed to want you has pushed you out. No other place takes you in. You are unwanted, by everyone. You are a refugee."

(Wamariya,2019)

Overview

Refugees flee their countries of origin due to dangerous situations, persecution, and ultimately for their very lives. Conditions refugees face before fleeing their country and often in the act of fleeing can carry great amounts of traumatic events that impact them in many ways. Once they have arrived in a country like Canada their trauma doesn't disappear but is rather carried alongside the list of stressors necessary to adapt, adjust, and survive in their new country. This can be mixed with other traumas, loneliness, and struggles such as those involving finances. Although they have arrived at a place of safety, the refugee's journey with trauma isn't over yet. The journey through this crisis life is riddled with potential for new traumas and trauma responses from untreated trauma.

The problem investigated in this study is despite the trauma refugees face, those working with refugees often do not target the trauma they have faced as part of their adjustment process. When watching the news and seeing the wars in countries like Syria, Afghanistan, and Ukraine or watching the death of children fleeing in rafts to countries like Greece, the trauma refugees arrive with is evident. Yet, the resources governments and others that work with refugees provide, seem almost non-existent. The purpose of this study is to obtain and examine qualitative data to investigate how refugees regard the stressors they face and how this impacts their mental health especially in the area of trauma. The aim of the study was to hear from the refugee's

perspective on this topic as opposed to the many quantitative studies available. The significance of this study is to provide results from a case study perspective that will describe the refugees' lived experiences in the migration process and how their trauma contributes in any way to this process. Likewise. This adds to the literature on refugees and mental health with the goal to assist those working with refugees to aid in helping them adjust in the post-migration phase and to bring about the most healing for each of these new arrivals. This is done from the voice of individual refugees rather than the researcher or those who work with refugees.

Chapter Five includes a discussion of the findings as listed in Chapter Four with a discussion on the findings and implications considering the relevant literature and theories as examined in Chapter Two. Following, is an implications section to include the methodological and practical implications present within this study. Finally, the delimitations and limitations of this study are included preceding recommendations for future research.

Summary of Findings

This case study aimed to answer three research questions through the use of one-on-one interviews. This study successfully answered all research questions, and numerous themes were indicated. Research question one sought to locate what the biggest stressors refugees face upon arrival, featuring key themes such as family separation, medical difficulties, and employment. Part two of research question one focused on seeing what assistance and support refugees received that made the transition to Canada easier. The theme repeated here was they each mentioned the importance of receiving help from other refugees.

Research question two, how does their trauma impact refugees' adjustment post-migration, had key themes involving the link to being perceived as a terrorist and its impact on their mental health, discrimination women face in Canada, fear surrounding police and

government officials' post-migration, and views on receiving mental health in Canada. Research question three covered what refugees would want people and governments around the world to know regarding being a refugee, had a lack of a theme which became the theme as the responses had been shared in the previous two research questions. Yet, it all could be summed up to the desire of being heard.

Lastly, the sub theme within the themes mentioned pertained to refugees arriving to Canada with trauma and in a state of crisis impacting their assimilation. Due to trauma not being addressed and being mixed with stressors that increase trauma in their life, refugees were not allowed to properly assimilate as they focused on surviving over being an asset to the community. Their mental health took a toll and resources to heal these areas were limited.

This study was a case study conducted on a small population of refugees in Vancouver, Canada. The phenomenological side of this pertained to looking at the intimate experiences each refugee faced. Although each one had come from the same country, arrived in the same part of Canada, and each received refugee status, their lived experiences all differed. This brought a richness to the data when answering the research questions. Although all questions were answered, responses at times differed especially in the area of mental health support services.

This provides valuable insight for researchers as well as those working with refugees and those making decisions in the migration and post-migration process for refugees as it reflects the need for multiple voices to be heard in such a way that cannot be conveyed through a questionnaire. This study's primary objective was to provide an opportunity for each participant to speak their lived experience and to share their perceptions of how the stressors from post-migration had impacted their mental health, specifically in the area of trauma. This was successfully accomplished and has opportunities for future research to be built off of its findings.

Discussion

The purpose of this section is to discuss the results of the study as it relates to the empirical and theoretical literature reviewed in Chapter Two. The findings in this study validated and extended the existing literature regarding refugees, mental health, trauma, and post-migratory stressors. This study only increased the importance of addressing the trauma refugees have faced upon arrival while going through their post-migration adjustment process. Areas addressed in this section add to the pre-existing literature of refugees and trauma, refugees' post-migration stressors, and mental health support during the post-migration process for refugees. It has extended this information by adding explanations behind their perceptions of these topics as it pertains to their lived-out experiences. Each category is detailed with references to previous research and how this study adds to the existing research.

Empirical Literature

Trauma and Refugees

If one wants to know if a refugee experiences trauma, they only need to check the daily newspaper or watch the news headlines. The answer is a resounding yes and can often be followed with a long list of events. The research on refugees and trauma, as seen in Chapter Two, reflects great links of trauma and PTSD with refugees from multiple countries and varying situations. One study conducted on Syrian refugees showed 98.5% experienced at least one traumatic event and 86.3% reported experiencing three or more traumatic events" (Mahmood et al., 2019). This study aligns with this literature as each participant had experienced at least one traumatic event according to the pre-screening questionnaires.

At times participants referenced the war in Ukraine, Syria, Afghanistan, and other places. Many referenced their experiences as not being as "bad" as people from those areas or even

comparing their own stories to their friends from their own countries. A common theme recognized by the participants as trauma involved the separation of family. This matches the findings in Knipscheer et al., study where 74% listed forced separation as one of the most commonly reported traumatic events (2015). Likewise, in the trauma domains the human rights abuses were reported in Knipscheer's study by 90% of participants (2015). This study's participants each experienced human rights abuses. Key themes involving the trauma refugees faced prior to arriving in Canada was evidenced in their stories.

The participants of this study included examples of trauma involving imprisonment, hearing of torture and imprisonment of their friends and family left in their country, traumas involving having to flee, conditions and treatment while in prison and refugee camps. The greatest theme was the key link of trauma to the leaders of their country declaring they were terrorists for simply belonging to a community. The pain was not only expressed in their stories but also in their voices and on their faces. Shame, embarrassment, and anger were present emotions. This is consistent with other studies on refugees with trauma. A study on refugee minors found "feelings of guilt and shame as well as trauma symptoms were all associated with the number of traumatic event types subjects had experienced" (Stotz et al., 2015).

This study agreed that trauma is prevalent within refugee communities. This not only can be seen through their stories of how they arrived in Canada, but also this supports the literature that the trauma symptoms do not disappear once they have arrived on Canadian soil. Numerous stories surrounding fear of being questioned about their names or where they came from were shared. Multiple examples involving fear when seeing police officers, going to court for their paperwork processes or seeing soldiers were included in this study as trauma responses live out post-migration from pre-arrival traumas. All these fears were linked to the traumas faced back

home that led to their needing to leave. Each participant had been in Canada for at least three years. Time has not healed these wounds but rather buried them as deep as they can be buried while they try to survive.

Post-migration stress and Refugees

The literature as seen in Chapter Two largely encompassed the stressors refuges face post-migration. Post-migratory stressors

> include socio-economic factors, i.e., financial and housing security and work problems; social and interpersonal factors, i.e., family separation, family reunification, lack of social support, changes in social roles, discrimination, and changes in socioeconomic status, process and immigration policies, i.e., detention, time of the asylum-seeking process, limited duration of residence permit, and as a consequence, living difficulties such as family conflict and unstable housing (Djelantik et al., 2020).

This was consistently seen among all refugee participants. Stressors such as family separation, discrimination, and work problems were included by participants in this study. Although listed in the literature, family separation was not one of the largest post-migratory stressors the researcher believed would be mentioned. However, every participant included the stress family separation played on themselves/their families as well as those who did not face family separation. Refugees have seen this impact their friends who were not able to have family members come visit due to their refugee status.

Not only was this an obvious stressor but likewise an area the participants stressed that governments, especially the Canadian government, could create changes for them. Many gave examples of friends and family members resettling in areas of Europe such as Germany and how it only took a few months for the German government to approve their family reunification.

However, participants shared Canada require permanent residency be achieved by the refugee before the reunification process could begin. This process took years for participants that arrived without their families. One participant was still waiting to be reunified with his family at the time of this study.

Refugee populations often come from collectivistic cultures where family is a larger part of their identity compared to that of many western individualistic societies. This was seen by Kira et al., when they wrote, "refugees and torture survivors went through, and are possibly still going through, a host of different trauma types that include personal and collective identity traumas and which have cumulative effects" (2012). He continues, "the traumatized refugees have become victims of persecution and or torture because of their belonging to a certain group. In collectivistic culture, healing usually takes place within a group context" (Kira, et al., 2012). Refugees struggle to find healing when they do not have their families even more than westerners because of the collectivistic cultures the derive from.

Employment was a stressor mentioned by all participants which aligned with the literature in Chapter Two. Employment is necessary as it is the primary way of providing financially for their families and provides them a way to acclimate into society. However, just as the literature reported, participants explained how language learning, education credentials not being recognized, and the time spent waiting for a work permit all made gaining employment difficult. This study differed from other studies as the wait time for a work permit was stressed over lack of credentials, discrimination in the workplace, and even language acquisition. This could in part be due to the participants not being eligible for many of the financial welfare benefits and therefore needing a work permit quickly to survive. The stress and negative impacts to one's mental health were shared in this study. Just as Hynie stated, "overqualification is

associated with lower self-reported mental health, consistent with other research showing that unemployment affects mental health for reasons beyond economic well-being, having an impact on one's status and sense of self-worth" (2018). participants in this study likewise felt their qualifications could be useful for Canada and desired to give back to Canada over simply earning and income. However, there are not resources assisting refugees with this process available.

Hassan explained that when someone in Canada has a disability but desires to work, they are given assistance. They are assigned someone who helps them locate employment options that fit their skills and take into consideration their disability. He suggested the helpfulness this could provide if done for refugees. If someone saw their skills, education from previous countries, and language level, they could aid them in finding well paying employment. Perhaps too it would prove better for the refugee to pursue education to gain the same credentials in Canada as opposed to taking a job in a different field. There was much confusion and anxiety from participants in not knowing if they were making the right choice for themselves and their families. This was consistent with the literature, but previous literature had not included suggestions from refugees on the problems nor expressed in the form of quotes what refugees are feeling in areas of key stressors such as employment.

Medical concerns have been apparent within literature pertaining to fears of being seen by a medical professional, disclosing information to a professional, and confusion navigating the medical system (Mangrio et al., 2017). This was supported from this study as many expressed confusions of the systems and fearing being heard and cared for. Although previous studies had touched on the fears surrounding medical concerns for refugees this study advanced that concept in a new way. Participants stressed the desire for someone to walk them through how to get adjusted in Canada. Concepts such as opening a bank account, learning public transit, navigating

the medical system, and such were all suggested to be included in a refugee orientation. Likewise, for this to not only be provided but to have someone walk with them in this. Farah explained when she arrived the shelters were all full. Although given money by the Canadian government to rent a place the amount per month was small and she needed a place immediately. She had to take money away from her rent budget to pay for public transit to visit the available rental options and complete required paperwork to secure housing.

This study added to the area of research on this topic as the refugees not only shared the stressors, they faced post-migration but also gave suggestions to fix these scenarios. Each suggestion given would make life in Canada smoother for future refugees and the general idea was to allow refugees to give back to the society that welcomed their doors to them. This added voice has been missing in the current literature.

Post-migration and trauma in refugees

As previously mentioned, refugees face trauma and post-migratory stressors. The pre-existing literature validates the impact stressors have on trauma and mental health symptoms for refugees. This literature addressed in Chapter Two was primarily gathered through quantitative methods. This study utilized a qualitative approach that gave the refugees the opportunity to voice their perspective on how they see their mental health, specifically their traumas, has been impacted or not impacted by post-migratory stressors. This study has both supported the pre-existing literature while also adding to it.

Details related to mixed emotions on mental healthcare were notable in the data. Each participants seemed to think these services should be available to refugees upon arrival, but many felt they themselves didn't need this care. They compared themselves with others they knew that they felt had experienced worse traumas than them. This was especially seen for those

that didn't feel they had a difficult migration journey. Yet, the impact of being called terrorist by their people, separated from family members (grandparents, aunts, uncles, etc.), and hearing firsthand stories from their loved ones of the imprisonment and torture they have experienced carries with its trauma that does impact any human.

A common desire was to forget; otherwise it puts one in an emotional state that kept one from getting things accomplished. This was of importance to refugees because in ability to get/keep employment, learn English, provide for family members back home, do their schoolwork, and complete paperwork to gain status in Canada would prevent survival here. One must decide which is of more importance, to have their family here with them sooner than later or go to counseling, have food on their table or process their trauma. These finding supported previous literature that explained how refugees would place stressors importance over that of mental healthcare.

Although these stressors are necessary and important trauma can hinder the adjustment process. For example, trauma and PTSD have been linked to memory issues and can impact language learning skills (Griswold et al., 2021). However, as previously discussed in Chapter Two the urgency of post-migratory stressors does impact the drive to seek out mental health care support services.

Additionally, those that did seek out help faced numerous challenges such as seeing doctors for medication and not having anyone follow-up with them to see if the medicine is adjusting well in their system as seen for Hasan. Salma mentioned how she was receiving counselling and EMDR services. However, due to costs she was having to pay to receive these services from those back in her country. Yet, when asked if this was free in Canada would she take advantage of that program she agreed she would prefer that and suggested the government

should be providing some services and benefits for refugees in this area. Although Muhammad likewise felt these services could be more affordable for refugees. Although he did not feel he needed mental health care, he did share how others do and how having a counselor or psychiatrist that speaks their language would be of importance.

This study supported the previous findings as seen in Chapter Two. It reflected the need for mental healthcare treatment for refugees and the concerns such as cost, and language difficulties carry. It likewise supported refugees lack of receiving mental healthcare. Song & Teichholtz's 2018 study stated it is estimated less than three percent of refugees ever receive any form of mental healthcare treatment. This finding was consistent with this study. However, this study provided a space for refugees to share as to why that was the case. It appeared the biggest hurdle being the post-migratory stressors.

Theoretical Literature

Previous studies examined the topics surrounding refugees, post-migratory stressors, and trauma. However, these studies had not focused on the refugee's perspective of these topics as it pertains to their own lived experiences and carried personal stories. These studies did not provide the space for refugees to share their struggles and address how they believe this could be changed for future refugees by government officials. This is especially important as refugees arrive in places like Canada with trauma and are faced with needing to get settled, provide for their families, and do the necessary requirements for family reunification. Yet, just as was seen after the Vietnam war, soldiers would arrive home and no longer be in battle. Yet, the battle taking place in their minds continued and adjusting to everyday life showed to be difficult. Refugees continue to be given a new "home" and the war, torture, and trauma continues to take place in their mind.

Implications

This case study provided results that hold theoretical, empirical, and practical implications. The purpose of this section is to describe all three implications as it relates to refugees but the primary audience being those that work with refugees in assisting them with their migration or post-migration journey.

This study provided results that have theoretical implications for researchers in the field of refugees and trauma. This study intended to observe from the perspective of the refugee how the stressors faced upon arrival impact the trauma they faced before arriving. A phenomenological case study was chosen for this study based on what the study sought out to do. This theory was suitable for explaining and understanding the specific population studied.

The implications for this study add to the pre-existing literature on trauma, and refugees' post-migration. Specifically, this study holds implications for those working with refugees. Refugees were once regular people living regular lives. Each one had a schedule where they got their kids to school, worked a 9-5 job, shopped in the same grocery stores, and celebrated the birthdays, weddings, and new babies of loved ones around them. Then a day comes when their lives are not normal. Their very lives become in danger. Many have been wrongly imprisoned, tortured, experienced dangerous conditions due to war, and so much more. Their normal lives become a fight for their lives.

Even once they escape the people and city that has become unsafe, their story does not go back to the way it was before. Their life is not the same narrative; this time it is in English, not Arabic. A new story begins while the old one somehow does not fully disappear. The refugee's needs have placed them in a season of crisis. Crisis is defined as "a state of feeling; an internal experience of confusion and anxiety to the degree that formerly successful coping mechanisms

fail us, and ineffective decisions and behaviors take their place. As a result, the person in crisis may feel confused, vulnerable, anxious, afraid, angry, guilty, hopeless, and helpless. Perceptions often are altered, and memory may be distorted" (Crisis Intervention).

"The Chinese character for 'crisis' is made up of two symbols: one for despair and the other for opportunity" (Wright, 2011, p.106). Crisis is supposed to be a temporary phase. The despair is what has been lost and the stress of knowing what to do next. The opportunity provides a sense of hope in the passing of the loss. A loss of a job would be a crisis state to a family where the primary breadwinner is no longer employed. However, the moment a new job is secured the crisis symptoms begin to dissipate. In fact, the job may even pay more and serve to be a blessing. This is different from trauma.

Trauma is a wounding of the mind that impacts the entirety of the person. It is "the response to any event that shatters your safe world so that it's not longer a placed of refuge. Trauma is more than a state of crisis" (Wright, 2011, p.154). Both the crisis and the trauma do not end once the refugee arrives in a place like Canada. For example, if an active school shooter goes to a local high school but some students escape, the crisis isn't over as long as there are other students in the building with the shooter. This is the same for refugees whose families are separated from them. They hear the stories of imprisonment and torture. They experience the fears and anxieties of their families in hiding being discovered or kidnapped and taken back home. The refugee in Canada continues to have crisis from their country as long as their families are not with them. The very trauma that made them flee is now the one holding their family captive and they wait from afar with them as they too struggle to survive.

Just as the students facing a school shooter experienced trauma so the trauma of their experiences does not end if they change schools. They continue to be hypervigilant if the trauma

has not been dealt with. Giving them a change of scenery or removing the shooter does not heal the wounds experienced. Refugees are no different.

Therefore, this study has special importance and significance for those working with refugees that aim to help them adjust to life post-migration. Providing a refugee with a visa for them is vital, but if workers do not acknowledge the trauma refugees have arrived with and the continuation of their trauma, then workers will not see true healthy adaption to their new environment. The first way this study reflects this is through listening to their stories. Allowing them to be heard is of importance and it is through hearing them the struggles get discovered. Changes such as aiding in orientation upon arrival, assistance in finding employment, and providing an easier family reunification process can be heard.

However, it is not just hearing the struggles but hearing the implications the struggles hold. It is through these stories heard in this study that provided insight into how trauma symptoms, such as hypervigilance, remain but are also increased due to stressors. Those helping refugees can not provide for their basic needs and let it remain but rather must address what is underneath. If the mental health of refugees is not addressed, both through trauma interventions and aiding in post-migratory stressors that increase trauma, those working with refugees are putting a Band-Aid on a gaping wound trusting it to not become infected.

This study takes place shortly after Russia invaded the Ukraine, thus increasing the refugee population now with Ukrainian refugees. News stations across the globe began reporting the war between the Ukraine and Russia on February 20, 2022. The Ukrainians were seen fleeing to countries such as Poland, Moldova, and Romania. The IOM, UN Migration, estimates almost 6.5 million people are internally displaced in Ukraine (2022). United Nations High Commissioner for Refugees, Filippo Grandi shared about the women and children that have been

affected by this war saying they were, “forced to flee extraordinary levels of violence, they have left behind their homes and often their families, leaving them shocked and traumatized” (UNHCR, 2022). Rather than refugees being from Middle Eastern countries, as commonly seen, the western public has been faced with the idea that a refugee crisis could take place in a western country.

The current refugee crisis has not decreased but war and persecution continue to increase, and peace appears to decrease as time goes on. Trauma can be seen in the current news headlines when missiles are being launched into people’s homes, churches, and businesses. The pictures of Russian military tanks in cities can be seen and children fleeing to nearing countries holding only what they can carry has tugged at heart strings for many. It is easy to see the trauma Ukrainians are currently facing. This mixed with the pain and uncertainty of if they will ever be able to return to their country is something each refugee can relate to.

The aforementioned update in the news was added because Canada has already welcomed its arms to over 3,000 Ukrainian refugees (Carbart et al., 2022). Yet the question of preparation to address the trauma still exists. This study took the voices of refugees who share what they have seen done for them and/or for those they know in the area of trauma. This study, as well as others like it, is important for government decision makers to consider. Simply providing a safe plot of land does not mean a refugee is truly safe and cared for. Especially if we are not caring for the person as a whole.

This study reported findings that can assist governments, charities, and individuals specifically focused on assisting refugees in their post-migration journey. The implication for the field of trauma is to also recognize the importance of how stressors of refugees increase trauma symptoms, especially if the stressor is linked to people back home. THE DSM-5 is the source of

diagnostic criteria for mental illnesses. Yet, some have suggested CPTSD (Complex Post Traumatic Stress Disorder) be added to it. The ICD-11 recognizes the distinction between PTSD and CPTSD. Yet it recognizes CPTSD to include the PTSD criteria but have added elements that would place the traumatic event(s) in a way that escape was difficult or impossible (Hyland et al., 2018). This can be seen for those who experienced childhood abuse within their homes. This could also be seen for refugees who likewise experience abuse and trauma and yet escaping is very difficult and even at times impossible. Since the traumas continue even after their arrival a further look into CPTSD for participants could be useful. Many in this study did not feel they themselves had mental health concerns, trauma, or PTSD. Yet, listening to their stories and observing their questionnaires reflects otherwise.

Many churches and Christian charities seek out to help new coming refugees acclimate into their new country. The implications for this study can certainly be relevant to them. In Matthew 25:35, Jesus said, “I was a stranger and you welcomed me” (ESV). The church either doesn’t welcome in the stranger due to our own fears, political views, or not being aware of what they can do. For those churches that do, they often provide things such as housing, meals, food, language learning, and financial assistance. One area the church has not been addressing these concerns is in the area of their mental health. The church should provide mental health support services when working with refugees. This is not to stop or diminish the work that is already being done but rather to add to the richness of their pouring out.

As Ibrahim stated in his interview, “we believe that prophet Jesus will come and will share peace and healthy life… I believe that He will come again ad will share peace”. The world needs peace and peace comes not simply from external resources, but true peace comes from within. This peace must be sought after, and the church can help aid in that peace through

helping refugees heal from their traumas. They can listen to their stories and be the voice for those without one. They can fight for causes and concerns that someone needs to hear, and they can welcome the stranger into their families.

Delimitations and Limitations

The purpose of this section is to inform the reader of the delimitations and limitations of this study. Reporting the accuracy and dependability is done to strengthen the confidence of the reader in the data analysis and themes resulting from this study. This likewise is to be used as a guide for future studies.

Delimitations

Delimitations are choices made by the researcher to describe the boundaries set for the study. First, the researcher chose to place limits on the participants to be 18 years or older, have experienced trauma, and to have lived in Canada for at least one year. Participants under the age of 18 surely would provide a different perspective on the topic but this was chosen as adults would have different perspectives than children especially as many will understand what is happening in their country and will be the ones to make the decisions to leave as opposed to children that will have had less of a choice to leave.

Trauma was chosen as necessary to be present to fully address the topic at hand as to how post-migratory stressors impact the pre-existing trauma they arrive with. The best way the researcher thought to be certain trauma was present involved the completion of questionnaires prior to the interviews. This was likewise chosen to minimize the risk of trauma responses when trying to determine that trauma had been experienced. Likewise, this provided the opportunity to focus on post-migration stressors impact on the trauma rather than the traumatic event(s) themselves.

Lastly, the rationale behind interviewing participants who have resided in Canada for at least one year was chosen to focus on the struggles experienced outside the initial arrival timeframe. This allowed the researcher to hear if struggles dissipated over time or if they remained the same. It allowed the participant to share if there were times in their post-migration journey that were more difficult than other times. An example of this would be hearing employment and family reunification struggles and the timeframes that had drawn this process out. Overall, this was chosen to give a more accurate snapshot of post-migratory stressors impact on their trauma as there was a longer timeframe to compare this to.

Limitations

Limitations are flaws, shortcomings, constraints of the study that can be used for consideration in future research. One limitation of this study was the small number of participants. Although the original design of this study was to have ten participants only seven were interviewed. Ten participants were chosen to participate and three dropped out prior to the start of the study. One reason for this was fear of reliving the traumas they faced in their country. Another reason pertained to fear of sharing struggles while their migration status was not solidified at the time. Lastly, there was fear of speaking out against the leaders of their country and its potential impact on their loved ones back home. These fears and concerns were very real for participants and should be considered for future studies.

Another limitation would be all participants were from the same country. Although each had faced different migration journeys and levels of trauma a future study could benefit from observing those from multiple countries to see if common themes emerge from the refugee life as opposed to their country of origin. The participants were highly educated individuals. Not all

spoke English prior to arriving in Canada but many had lived in other countries, owned businesses, and held multiple degrees. This could have influenced some of the experiences faced.

When seeking to conduct this study the hope was to have a mixture of male and female participants. However, there was concern that due to the researcher being female, male participants may not feel comfortable discussing such topics. However, more male participants participated than female. The limitation to this is male participants weren't as open in sharing their stories and traumas as the females were. The questionnaires for pre-screening had several selections overlooked that were later stated as having experienced in the interviews. If a male researcher had interviewed the male participants perhaps the responses would have been more forthcoming and detailed. Yet, this could simply be the gender differences regardless of the researcher's gender.

Another limitation was the availability of the participants. Since the participants work long hours, they were not available for the interview until later in the evening. Leaving majority of interviews starting time between the hours of 7:00pm and 9:00pm. Each interview ranged in time but on average just over an hour of time was used. When interviewing refugees, one must consider their work schedules alongside the availability of the researcher.

Lastly, when using transcription software, the accents and broken English made proper transcriptions difficult. Thus, the researcher had to go through and make several adjustments to correctly sort through the data and include accurate quotes. This is an added time to include when organizing a future study.

Recommendations for Future Research

A recommendation for future research would involve interviewing participants from numerous countries and marital statuses. This would especially be important to compare the

responses of a refugee from the middle east as compared to one from the Ukraine. Seeing if skin color makes a difference in the adjustment. Likewise, there was not an active war in the country the participants originated from. Comparing their responses to someone where active war is being experienced would provide a bigger picture of the refugee experience on the topic.

Interviewing those that work with refugees in the area of aiding them in their adjustment would likewise be a recommendation. This would allow the researcher to hear what those working with refugees see as the biggest areas of concern and to hear their views of how to help refugees in the area of mental health. Comparing these responses to that of refugees would provide insight into if workers aren't hearing the concerns and assistance refugees are requiring help with.

Lastly, research might search deeper into why refugees do not believe they need mental health care, but would recommend it. Many participants included fears of having to relive experiences while others stated they did not feel it would help. Additional research questions focused on fleshing these concerns would be of great help when encouraging refugees to receive mental health care services and treatments.

Summary

The goal of this case study was to examine the shared lived experiences of refugees and observe the impact post-migratory stressors have on pre-existing trauma. The study provided the opportunity for refugees to share their personal stories of trauma, adjustment difficulties, and continued trauma responses and mental health concerns post-migration. This study specifically provides an opportunity for their voice to be heard. Findings showed refugees living in a continued state of crisis mixed with untreated trauma increases trauma responses rather than these symptoms dissipating once they have been removed from their unsafe environment back

home. Trauma is not a new phenomenon. Neither are refugees. Yet, we must continue to learn from their lived experiences to help them and others like them. As participant Ibrahim shared, "be strong… all prophets are refugee. For example, prophet Jesus, refugee. Prophet Moses refugee… So may difficult times make you strong". These difficult times have made refugees strong. But if we focused on their healing, I believe we will see even greater strength among people groups that have great value necessary to our communities and our lives. Perhaps we will see a Moses go from being a refugee to being a great leader if we do.

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APPENDICES

LIBERTY UNIVERSITY.
INSTITUTIONAL REVIEW BOARD

April 12, 2022

Christine Krauter

Jeanne Brooks

Re: IRB Approval - IRB-FY21-22-764 REFUGEE PERCEPTIONS OF POST-MIGRATORY STRESSORS' IMPACT ON PRE-EXISTING TRAUMA

Dear Christine Krauter, Jeanne Brooks,

We are pleased to inform you that your study has been approved by the Liberty University Institutional Review Board (IRB). This approval is extended to you for one year from the following date: April 12, 2022. If you need to make changes to the methodology as it pertains to human subjects, you must submit a modification to the IRB. Modifications can be completed through your Cayuse IRB account.

Your study falls under the expedited review category (45 CFR 46.110), which is applicable to specific, minimal risk studies and minor changes to approved studies for the following reason(s):

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral

history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your stamped consent form(s) and final versions of your study documents can be found under the Attachments tab within the Submission Details section of your study on Cayuse IRB. Your stamped consent form(s) should be copied and used to gain the consent of your research participants. If you plan to provide your consent information electronically, the contents of the attached consent document(s) should be made available without alteration.

Thank you for your cooperation with the IRB, and we wish you well with your research project.

Sincerely,

G. Michele Baker, MA, CIP

Administrative Chair of Institutional Research

Research Ethics Office

Consent

Title of the Project: Refugee Perceptions of Post-Migratory Stressors Impact on Pre-existing Trauma

Principal Investigator: Christine Krauter, BS, MA, MAR, Liberty University

Invitation to be Part of a Research Study

You are invited to participate in a research study. To participate, you must be 18 years or older, have refugee status, speak conversational English, have lived in Canada for a minimum of one year, have experienced prior trauma and agree to be interviewed by a female interviewer. Taking part in this research project is voluntary.

Please take time to read this entire form and ask questions before deciding whether to take part in this research.

What is the study about and why is it being done?

The purpose of the study is to give refugees a chance to speak on how trauma they experienced prior to arriving in Canada and post-migratory stressors have impacted their resettlement process. The goal would be to provide insight from the perspective of a refugee on how to better assist refugees in their migration process with special attention placed in the area of mental health.

What will happen if you take part in this study?

If you agree to be in this study, I will ask you to do the following things:

1. Complete four questionnaires focused on trauma and post-migration stressors. This will take approximately 30 mins.
2. Be asked open-ended questions via a one-on-one interview. This will be audio recorded to later be transcribed. This will take approximately 1-1.5 hrs.
3. Once interviews are complete, they will be transcribed, and participants will be able to look over their responses a few days after the interview and voice if there are any changes they'd like to be made.

How could you or others benefit from this study?

Participants should not expect to receive a direct benefit from taking part in this study.

Benefits to society include increased knowledge for those working with refugees in the area of post-migration and mental health.

What risks might you experience from being in this study?

The risks involved in this study are minimal, which means they are equal to the risks you would encounter in everyday life. It must be noted that there is potential for a trauma response to happen as topics are discussed. Should this occur a list of counselors will be provided of who they can contact for assistance.

How will personal information be protected?

The records of this study will be kept private. Published reports will not include any information that will make it possible to identify a subject. Research records will be stored securely, and only the researcher will have access to the records.

- Participant responses will be kept confidential through the use of pseudonyms. Interviews will be conducted in a location where others will not easily overhear the conversation.
- Data will be stored on a password-locked computer and may be used in future presentations. After three years, all electronic records will be deleted.
- Interviews will be recorded and transcribed. Recordings will be stored on a password locked computer for three years and then erased. Only the researcher will have access to these recordings.

Is study participation voluntary?

Participation in this study is voluntary. Your decision whether or not to participate will not affect your current or future relations with Liberty University, Journey Home Community, or Turkish Newcomer Society. If you decide to participate, you are free to not answer any question or withdraw at any time without affecting those relationships.

What should you do if you decide to withdraw from the study?

If you choose to withdraw from the study, please contact the researcher at the email address included in the next paragraph. Should you choose to withdraw, data collected from you will be destroyed immediately and will not be included in this study.

Whom do you contact if you have questions or concerns about the study?

The researcher conducting this study is Christine Krauter. You may ask any questions you have now. If you have questions later, **you are encouraged** to contact her at. You may also contact the researcher's faculty sponsor, Jeanne Brooks.

Whom do you contact if you have questions about your rights as a research participant?

If you have any questions or concerns regarding this study and would like to talk to someone other than the researcher, **you are encouraged** to contact the Institutional Review Board, 1971 University Blvd., Green Hall Ste. 2845, Lynchburg, VA 24515 or email at irb@liberty.edu.

Disclaimer: The Institutional Review Board (IRB) is tasked with ensuring that human subjects research will be conducted in an ethical manner as defined and required by federal regulations. The topics covered and viewpoints expressed or alluded to by student and faculty researchers are those of the researchers and do not necessarily reflect the official policies or positions of Liberty University.

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. You will be given a copy of this document for your records. The researcher will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact the study team using the information provided above.

I have read and understood the above information. I have asked questions and have received answers. I consent to participate in the study.

☐ The researcher has my permission to audio-record me as part of my participation in this study.

_____

Printed Subject Name

_____

Signature & Date

Standardized Open-Ended Semi-Structured Interview Questions

1. Please introduce yourself to me by sharing a little about yourself.
2. Tell me about your country of origin.
3. Tell me about your migration timeline getting from _____ to Canada.
4. Please share what adjusting to life in Canada has looked like for you.
5. What are some of the biggest struggles with moving to Canada?
6. What current or past stressors have impacted your quality of life since moving to Canada?
7. In what ways has stress been released from you during your time here. Such as what has the government, charities, or individuals done to help with your adjustment with moving here.
8. What are some stressors that you needed assistance and you did not receive it?
9. Would you say experiences that took place in your country of origin or during your resettlement process to Canada have impacted you here in Canada, if so, how?
10. Have you experienced any instances or situations in which you were afraid since moving here? If so, can you give an example?
11. How has moving to Canada effected your mental health? Please provide examples.
12. How has locating employment, finances, housing and other resettlement factors impacted your mood since arriving in Canada?
13. Has there been any situations since arriving here that have felt similar, in a negative or uncomfortable way, to situations you found yourself in prior to arriving in Canada?
14. Have you experienced any form of discrimination for being a refugee in Canada, if so, can you share a time this took place?

15. Have you ever received any form of mental health care treatment? If so, when, where and what did you experience from it?
16. Have you received mental health care since arriving in Canada? If so what kind and has it been helpful? If not, why not (has it not been offered, or do you wish not to take part in it)?
17. If the mental health care were free and would not interfere with employment, housing, or other resettlement concerns would you take advantage of this why or why not?
18. If you could change one-way governments around the world helped refugees upon arrival, what would that be and why?
19. What would you like to see government agencies implement to help with refugee mental health concerns?
20. Based on what we discussed today is there anything you would want the world to hear on the topic from your perspective?
21. Would you share a funny story about moving to Canada or Canadian culture that you have experienced?