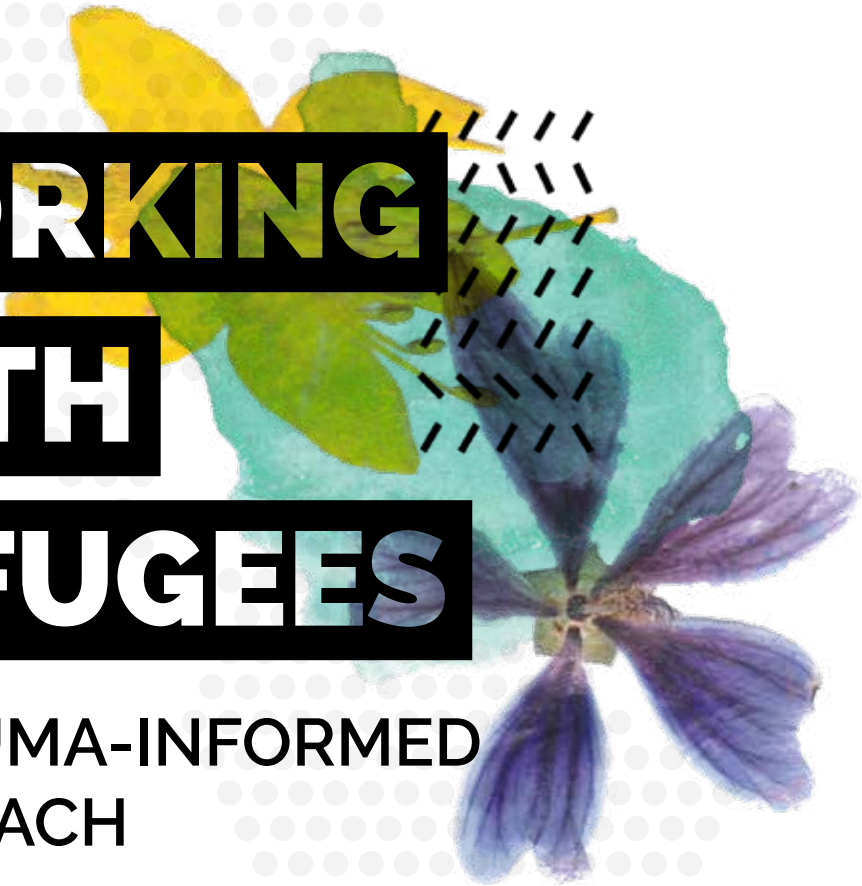
GUIDE TO

# WORKING WITH REFUGEES

## A TRAUMA-INFORMED APPROACH



Centre intégré
universitaire de santé
et de services sociaux
du Centre-Ouest-
de-l'Île-de-Montréal

Québec

This guide is for practitioners who support refugees during their process of integration into Quebec. It aims to strengthen the important work they do on the ground. This guide was produced by Centre d'expertise sur le bien-être et l'état de santé physique des réfugiés et des demandeurs d'asile (CERDA, Centre for Expertise on the Well-Being and Physical Health of Refugees and Asylum Seekers) of the Centre intégré universitaire de santé et de services sociaux (CIUSSS) du Centre-Ouest-de-l'Île-de-Montréal, as part of the Refugee Well-Being and Mental Health project, on behalf of the Ministère de l'Immigration, de la Francisation et de l'Intégration (MIFI).



Québec

## COORDINATION AND EDITING

**Mélanie M. Gagnon, Ph. D., psychologist**

Team Leader, CERDA

Research Practitioner,
SHERPA University Institute

## RESEARCH AND WRITING

**Tamar Wolofsky, M. Sc.**
Research and Knowledge Transfer Professional, CERDA

**Mehdi Azri, Ph. D. (cand.)**
Research Assistant, CERDA

**Esther McSween-Cadieux, Ph. D.**
Project Manager, CERDA

**Annie Jaimes, Ph. D.**
Assistant Professor,
Department of Psychology,
Université du Québec à Montréal (UQAM)

## REVISION

**Christiane Montpetit, Ph. D.**
Executive Coordinator,
Academic Affairs and Research Ethics Department
CIUSSS du Centre-Ouest-de-l'Île-de-Montréal

**Richard Lyke, RP RMFT**

## TRANSLATION

**Magpie Translations**

## GRAPHIC DESIGN

**Julie Brière**

## CERDA

CERDA, at the CIUSSS du Centre-Ouest-de-l'Île-de-Montréal, supports the coordinated efforts of the health care and social services system to promote the establishment of refugees and asylum seekers in Quebec. Specifically, CERDA is mandated to support the 11 CISSS and CIUSSS mandated by the MSSS (the ministry of health care and social services) to evaluate the well-being and physical health of newly arrived refugees. It also acts as an advisor to the MSSS and contributes to the influence of Quebec expertise provincially, nationally, and internationally.

## COPYRIGHT



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## ACKNOWLEDGEMENTS

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Many thanks to the practitioners who participated in the focus groups and shared their experiences, thoughts, and questions with us. Their contributions enriched our perspective and understanding of their work with refugees resettled in Quebec. They do exceptional work with refugees and we hope this guide will meet their needs.

Finally, we would like to acknowledge the collaboration and support of MIFI for this project.

# FOREWORD

This guide is part of a MIFI mandate relating to the welcome and well-being of recently arrived refugees in Quebec. In March 2020, MIFI entrusted the CIUSSS du Centre-Ouest-de-l'Île-de-Montréal and CERDA with the responsibility of carrying out a project on the well-being and mental health of refugees to support community organizations facilitating the integration of refugees into Quebec.

More specifically, this project on the well-being and mental health of recently resettled refugees consists of two main components:

**1)** Conducting a review of mental health care practices and support measures for refugees, particularly in Quebec; and

**2)** Developing and offering activities to transfer knowledge about supporting refugees, especially those who have experienced traumatic events, to support practitioners..

As a tool to transfer knowledge, this guide falls under the second component of this project. In the framework of this component and with the objective of supporting interventions with refugees, a toolkit for practitioners has been developed. This toolkit is composed of several complementary means of transferring knowledge:

**4** recorded webinars, 90 minutes each

**4** info-sheets summarizing the concepts discussed in the webinars

**1** awareness guide which accompanies the themes of the first three webinars

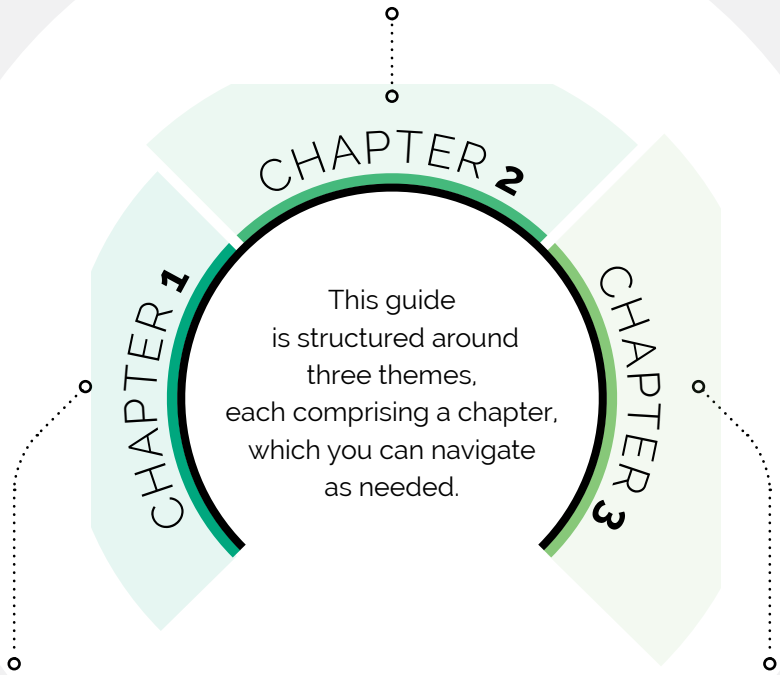
The toolkit is available on CERDA's website: *www.cerda.info*

# CONTENTS OF THE PRACTICAL GUIDE

This guide is designed for practitioners who support refugees in Quebec and who wish to enrich their interventions with key knowledge, both theoretical and practical. This awareness-raising tool does not claim to cover all knowledge about working with refugees. **It is not a guide for evaluating or treating mental health disorders.**

## TRAUMA IN REFUGEES: BETTER UNDERSTANDING, BETTER INTERVENTIONS

The impacts of trauma on different spheres of a migrant's life and their bodymind




### MIGRATION HISTORY, WELL-BEING, AND MENTAL HEALTH OF REFUGEES

Issues relating to the migration history of refugees and how the different phases of migration may affect their mental health once resettled in Quebec

### WORKING WITH REFUGEES: THE TRAUMA-INFORMED APPROACH

Principles and practical application of a trauma-informed approach

1 For the sake of consistency and uniform interpretation, the term "practitioner" refers to anyone working with refugees, whatever their professional title (social worker, nurse, counsellor, psychologist, etc.) or place of work (community sector, health care and social services system, schools, private practice, etc.).

## DEFINITIONS

Definitions of notions and concepts

## DID YOU KNOW?

Complementary information

## TO KEEP IN MIND

To keep in mind during interventions

## CLINICAL VIGNETTE

Illustration of theoretical content with a clinical vignette

## TRAUMA-INFORMED PRACTICE

Short reminders of how to put the trauma-informed approach into practice during interventions

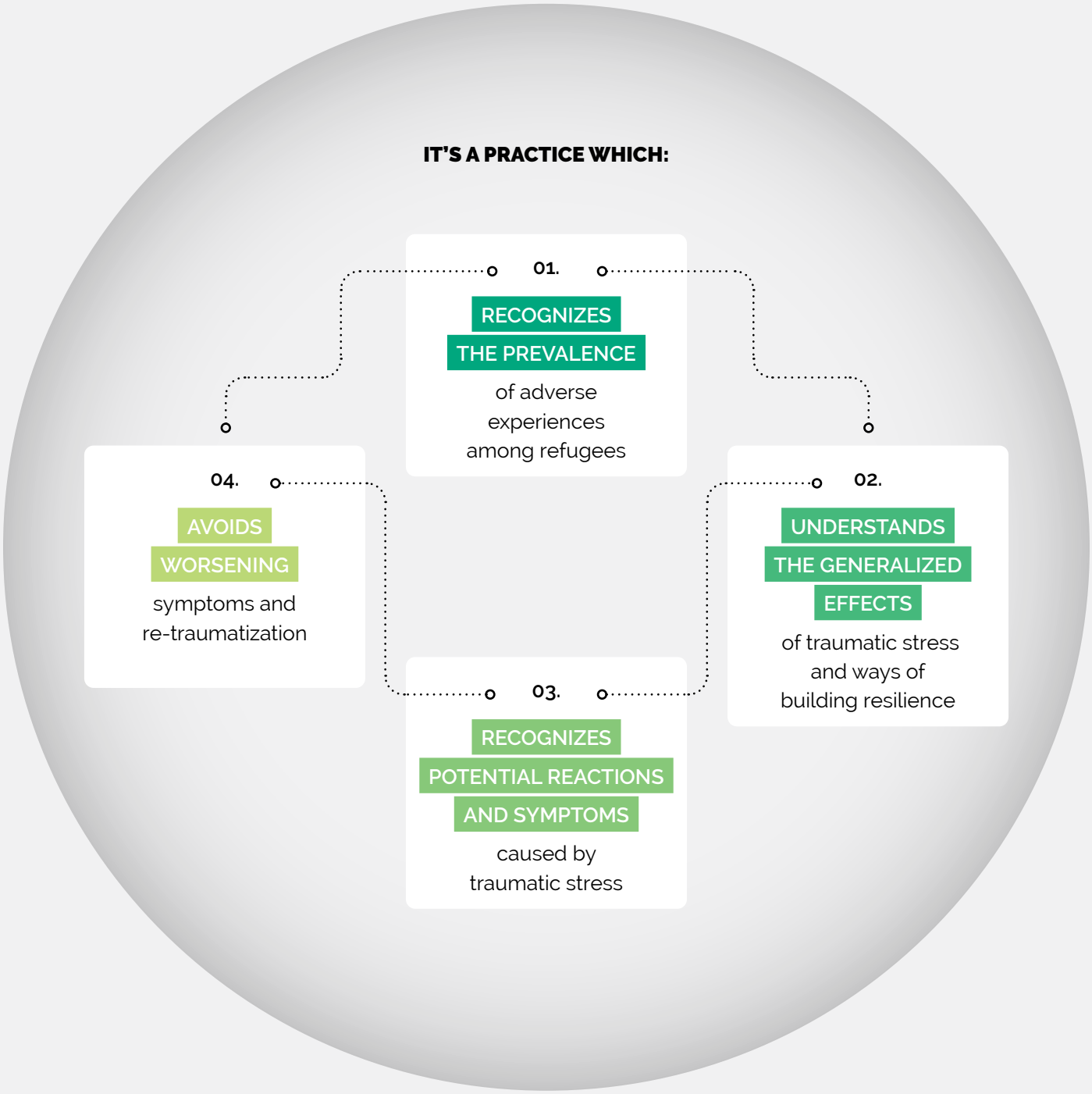
## FOR MORE INFORMATION

Links to external resources

Each chapter presents theoretical concepts and intervention practice. To strengthen connections between theory and practice, a clinical vignette of a family is used throughout the guide. It allows you to follow the migration history of four members of a family who recently arrived in Quebec. Throughout the guide, some concepts and information will be highlighted with an icon. This will help you to spot them easily.

# TRAUMA-INFORMED PRACTICE

What do we mean by "trauma-informed practice"?



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CHAPTER 3

## WORKING WITH REFUGEES: THE TRAUMA-INFORMED APPROACH

# ACRONYMS

| | |
|---|---|
| **APA** | American Psychological Association |
| **CAMH** | Centre for Addiction and Mental Health |
| **CBT** | Cognitive Behavioural Therapy |
| **CERDA** | Centre d'expertise sur le bien-être et l'état de santé physique des réfugiés et des demandeurs d'asile (Centre for Expertise on the Well-Being and Physical Health of Refugees and Asylum Seekers) |
| **CISSS** | Centre intégré de santé et de services sociaux (Integrated Health and Social Services Centre) |
| **CIUSSS** | Centre intégré universitaire de santé et de services sociaux (Integrated University Health and Social Services Centre) |
| **DRC** | Democratic Republic of Congo |
| **DSM-5** | Diagnostic and Statistical Manual of Mental Disorders, 5th Edition |
| **GAR** | government-assisted refugee |
| **IASC** | Inter-Agency Standing Committee |
| **IFHP** | Interim Federal Health Programme |
| **INSPQ** | Institut national de santé publique du Québec (Quebec National Institute of Public Health) |
| **IRCC** | Immigration, Refugees, and Citizenship Canada |
| **ISSOP** | International Society for Social Pediatrics |
| **LGBTQI+** | Lesbian, gay, bisexuel, trans, queer, intersex, plus |
| **MHPSS** | Mental health and psychosocial support |
| **MICC** | Ministère de l'Immigration et des Communautés culturelles (Ministry of Immigration and Cultural Communities) |
| **MIFI** | Ministère de l'Immigration, de la Francisation et de l'Intégration (Ministry of Immigration, Francisation and Integration) |
| **MSSS** | Ministère de la Santé et des Services sociaux (Ministry of Health and Social Services) |
| **NCTSN** | National Child Traumatic Stress Network |
| **PTSD** | Post-Traumatic Stress Disorder |
| **RAMQ** | Régie de l'assurance maladie du Québec (Quebec Health Insurance Plan) |
| **SAMHSA** | Substance Abuse and Mental Health Services Administration |
| **UNHCR** | United Nations High Commissioner for Refugees |
| **WHO** | World Health Organisation |

**REFUGEE HOST CITIES IN QUEBEC**


* In Quebec, 14 cities have been designated by MIFI to host resettled refugees.

**PSYCHOLOGICAL WELL-BEING**
"Well-being refers to the pleasure, happiness experienced, and coping skills of an individual. These may be tied to a feeling of control over one's life and positive interpersonal relationships with the people around the individual as well as mental health." [1] Well-being and health interact: health influences general well-being, but well-being also affects future health [1]. Other writers consider well-being not as the absence of psychopathology but the result of the prevalence of protective factors over risk factors [2].

**PROTECTIVE FACTORS** Set of internal and external elements which reduce the likelihood of disorders developing or reduce the harmful impact of risk factors [5].

**RISK FACTORS** Set of biological, psychological, family, community and cultural elements which undermine a person's well-being and make the person vulnerable to mental health disorders [5].

**RESETTLEMENT PROGRAMME**
The resettlement programme is part of the United Nations High Commission for Refugees' mandate to offer a sustainable solution for refugees. The three main resettlement countries are the United States, Canada and Australia. Over the past two decades, these three countries gave permanent residence to 84.5% of all resettled refugees in the world [3]. In Canada, the resettlement programme includes government-assisted refugees and privately sponsored refugees [4]. Government-assisted refugees receive financial support for one year either from the government of Canada (or Quebec, when it is their final destination). Privately sponsored refugees receive financial support by theirs sponsorships goup. In Quebec, both classes of refugees are covered by RAMQ and for one year by the interim federal healthcare programme (IFHP).

**REFUGEE** is a legal term which, is primeraly an acknowledgement that some people around the world live in life-threatening situations of persecution or conflict. Fleeing diverse situations of extreme violence, they seek refuge in another country. Refugees are protected by international law, under the Geneva Convention Relating to the Status of Refugees. Since 1951, this international agreement has officially defined the term "refugee" to include anyone who "by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside their country of nationality and is unable or, by reason of that fear, unwilling to avail themself of the protection of that country." [6]. Canada has been a signatory to this agreement since 1969. The refugees it hosts are either 1) selected overseas through a resettlement program or 2) recognized inside Canada after a refugee application.

# DEFINITIONS

**MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)** refers to a broad continuum of care and interventions aimed at promoting overall well-being, preventing mental health disorders from emerging, and treating people suffering from emotional and mental distress [7]. This continuum involves diverse practitioners whose complementary approaches offer optimal support [8]. In addition, it helps underscore the connection between mental health problems and psychosocial needs, especially in the field of refugee protection [9].

**MENTAL HEALTH** The World Health Organization (WHO) has defined mental health as, "a state of well-being enabl[ing] people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities." [13] According to the Comité de santé mentale du Québec (Quebec Mental Health Committee), mental health is an individual's state of psychological and emotional equilibrium at a given time, resulting from interactions among biological, psychological, and contextual (including cultural) factors [14]. Mental health is thus not the absence of psychopathology, but rather the state of a human being which varies according to individual and contextual conditions. A person's mental health is not defined or described by the presence or absence of a psychopathological diagnosis.

**TRAUMA OR POTENTIALLY TRAUMATIC EVENT** refers to an event experienced (personal experience or direct exposure to death, serious injury or sexual violence) by an individual or group which triggers a perception that one's life is threatened [10], [11]. In other words, the individual perceives a significant risk of harm to their physical or psychological integrity. Examples of such events are direct exposure to death, serious physical or emotional injury and sexual violence, but also to sustained threats of injury and death. Traumatic events almost always have an element of being trapped or powerless in the threatening situation. Trauma is usually a circumscribed event in a person's life (that is, it has an identifiable beginning and end), although in some case it may be ongoing and cumulative. The origin of the stress is thus external to the person. Trauma triggers a survival reaction which obstructs the person's ability to react to and integrate the emotions experienced during the event [12]. This reaction is called traumatic stress.

**TRAUMATIC STRESS** refers to our natural and adaptive reaction to trauma or a potentially traumatic event which creates traumatic stress. Traumatic stress is intimately connected to the person because it creates their mode of functioning in response to exposure to trauma. Traumatic stress is manifested as a state of intense arousal and fight, flee, and/or freeze survival reaction, which lasts over time. A traumatized person internalized the origin of the stress. This affects the way the person functions in daily life during and following the traumatic experience, notably in relation to their environment.

# INTRODUCTION

Over the past several years, we have experienced an intense crisis in migration, with more than 60 million people uprooted worldwide. While most are displaced within their countries or in neighbouring countries, almost one in five seek refuge in industrialized countries [3]. The refugee resettlement programme is an initiative of the UNHCR. Canada is one of the main countries of resettlement. In Quebec, refugees are sent to one of 14 MIFI-designated host cities (see map on page 11) across the province for resettlement [15].

Community organizations in each of these 14 cities have been established to welcome and support refugees upon arrival and MSSS-mandated refugee health care teams evaluate the needs of refugees for psychosocial support and physical health and refer them to appropriate resources [15]. While these practitioners provide psychosocial services to this population, they are also the point of entry to specialized mental health services when needs are more specific. Practitioners from these two services are specifically mandated to serve this population and are direct witnesses to the mental health issues with which refugees struggle.

The integration of resettled refugees is strongly influenced by their well-being and mental health [16]–[20]. The events experienced during migration and the conditions of life characterizing displacement often have a negative impact on migrants mental health. The nature of the welcome migrants receive and the difficulty or ease of resettling in a new country can exacerbate past problems, contribute to the development of new problems or alleviate suffering. Access to psychosocial support and mental health care is thus of paramount importance.

Upon arrival and throughout their first years in Quebec, refugees receive psychosocial and psychological support from practitioners in the community and provincial health care providors. Beyond specifically mandated resources, other community organizations and local communities respond to requests by refugees by organizing diverse services and initiatives adapted to their needs. This guide strongly recommends a trauma-informed approach to equip practitioners with the challenges of working with refugees affected by psychosocial and mental health problems.

## DID YOU KNOW?

Since 2015, Quebec has welcomed more than 5000 refugees per year [21].

Over the last decade, Quebec welcomed an average of 18.2% of all refugees resettled in Canada.

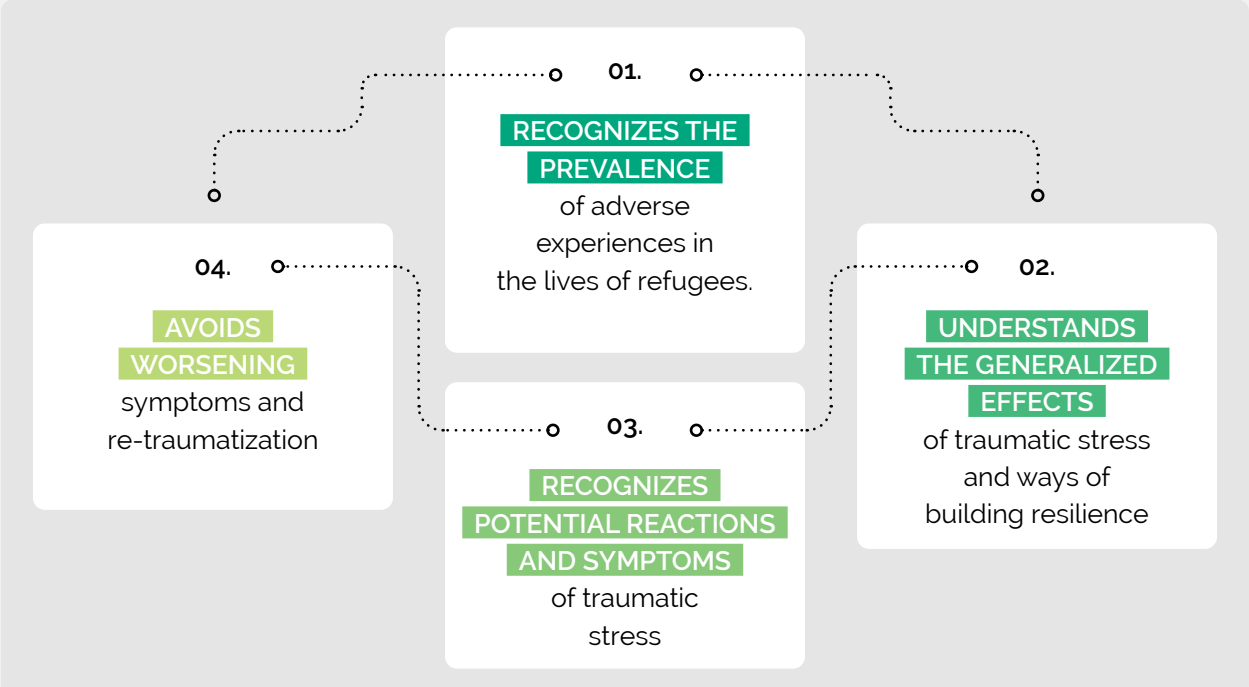
## TO KEEP IN MIND

Whether an event is traumatic is not determined solely by the nature of the event, but by the subjective, and often unconscious, evaluation of the person who experiences it and by the nature of the coping process which follows [22]. The same event may be experienced differently by different people and their reactions will therefore be distinct, mitigated by diverse factors (stage of development, perceptions of the experience, individual characteristics, coping skills, support from people around them, etc.). For this reason, we prefer to use the term potentially traumatic events.

# WHAT IS A TRAUMA-INFORMED APPROACH?

While trauma and potentially traumatic events can arise in the life of any adult or child, refugees are particularly at risk of traumatic experiences. Even though they show resilience, the multiple, experiences they have during migration may have left an imprint on their mental, emotional and physical health. Given the complexity of the experiences and individual differences, appropriate intervention is essential. We offer this guide to familiarize you with **trauma-informed practice** and to provide you with tools that will facilitate your ability to adopt it [12]. This approach takes a broad view of the potential repercussions traumatic stress can have on all spheres of a refugee's life [23].

**TRAUMA-INFORMED PRACTICE ...**



# WHY PROMOTE A TRAUMA-INFORMED APPROACH?

As explained in Chapter 1, resettled refugees are highly likely to have experienced potentially traumatic events before and during forced migration and after arrival in the host country. These experiences may have had considerable impact on their well-being and mental health. As described in Chapter 2, multiple of life can be affected. While it is generally not helpful to question refugees about the details of the traumatic events they have gone through, practitioners frequently observe the consequences: unspoken needs, distrust of institutions and practitioners, reticence to follow advice, diverse symptoms of trauma (somatic symptoms, over-reactions, dissociation/"freezing", thoughts and beliefs that are not connected to the present context and more)[24].

Contrary to trauma-focused interventions (such as psychotherapy), which aim to reduce the emotional charge of memories and flashbacks of the traumatic event, trauma-informed practice focuses on security and trust to meet needs in the "here and now," while recognizing there may be links to past trauma [23], [12], [25].

## WHEN IS A TRAUMA-INFORMED APPROACH USEFUL?

Because it is non-specific, a trauma-informed approach can be practised in all settings where refugees seek support.

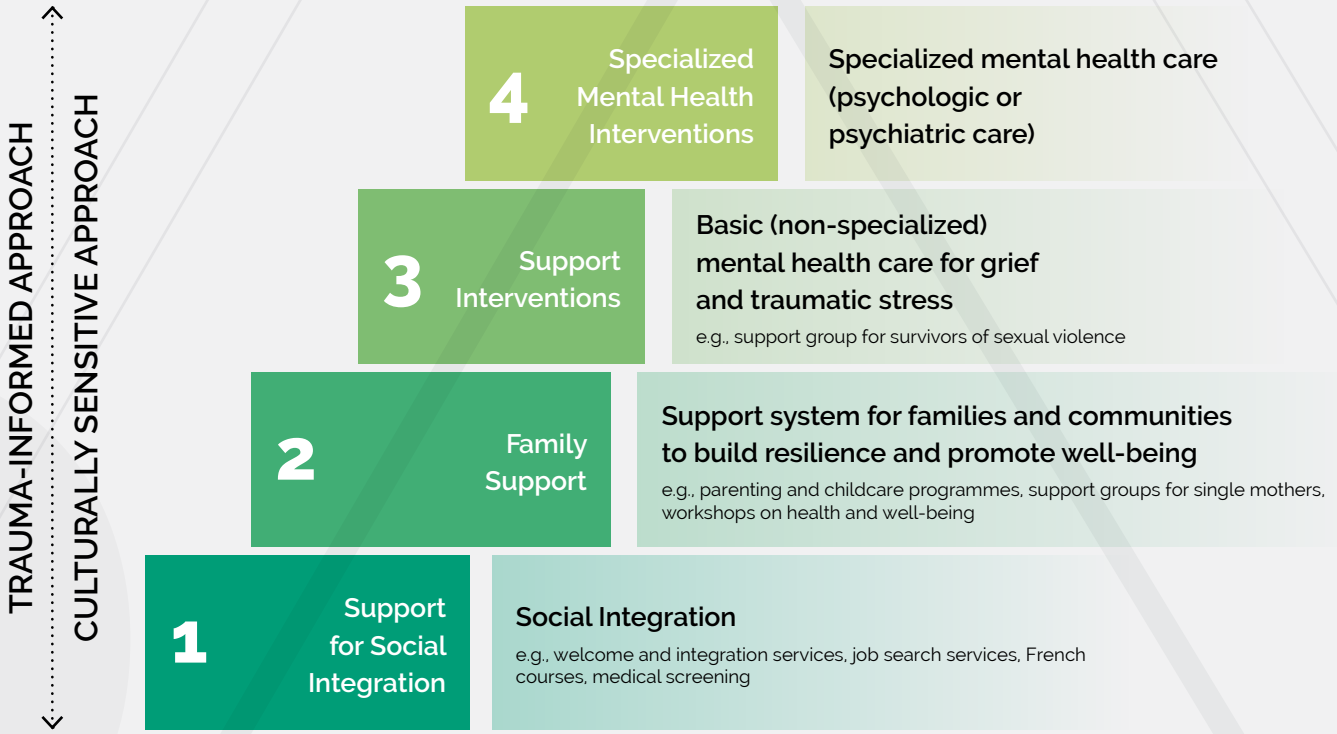
Because each person is affected by trauma differently and needs support and services adapted to their specific situation, psychosocial and mental health interventions are often organized to provide appropriate complementary services, that will meet the specific needs of the refugee population.

## PRIORITIZING A PHASED INTERVENTION MODEL

The pyramid support model we recommend are offers phase appropriate services at different phases of a refugees journey[9]. The first phase is stabilization, assuring the person's security. This is followed by increasingly specialized mental health services. Very few people will need the specialized services at the top of the pyramid [8]. This model emphasizes the importance of establishing trust with refugees gradually; first meeting their basic needs before referring them to specialized services.

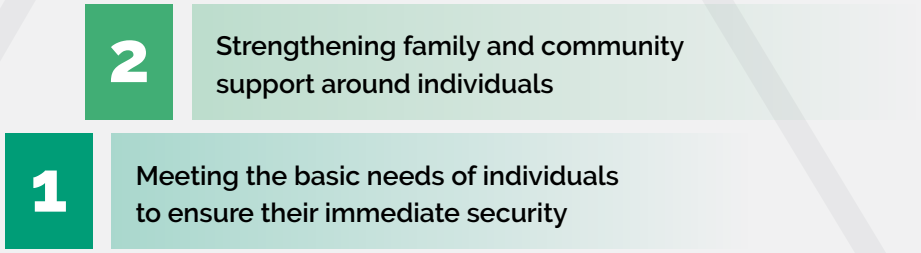
**PYRAMID MODEL**

PSYCHOSOCIAL AND MENTAL HEALTH INTERVENTIONS



This trauma-informed, culturally-sensitive approach is applied across all four levels of the pyramid. This approach uses existing interventions, but takes a new approach to existing practice.

This guide focuses on support offered at the **first two levels** of the pyramid; that is,




Targeted support interventions and specialized mental health services are outside the scope of this guide.

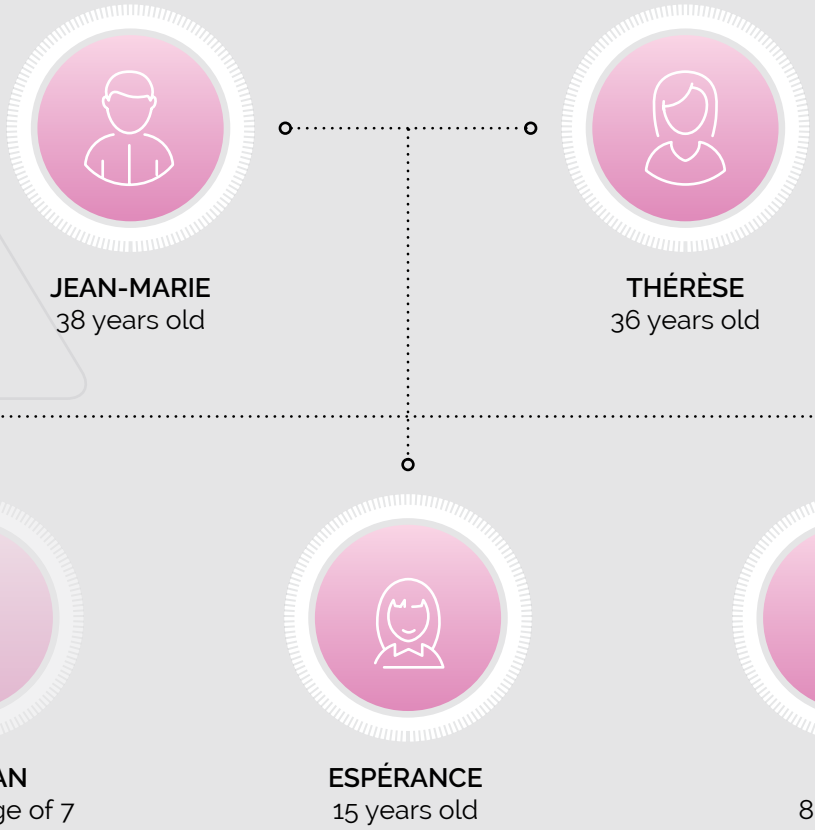
Because this support is often provided by community organizations and primary health care, this guide highlights the essential role these services play in promoting the mental health of resettled refugees. In fact, interventions made at the first levels of the pyramid are as fundamental to the well-being of individuals as more targeted and specialized mental health care. These interventions also play a role in prevention and they reduce the need for services at the upper levels of the pyramid [8].

## MEETING WITH THE KALUNGA FAMILY

Throughout this guide, we will be accompanied by the members of the Kalunga* family. The description of their forced migration, resettlement in Quebec, and integration into the host society will illustrate the concepts presented in the three chapters.

The members of this family, originally from Congo, arrived in Quebec in 2018 as government-assisted refugees. Since they arrived, they have been supported by a community organization mandated by MIFI to welcome and integrate government-assisted refugees into their host city. The family consists of Jean-Marie (38 years old), Thérèse (36 years old) and their children, Espérance (15 years old), Léo (8 years old) and Jonathan (who died at the age of 7). We will also meet the practitioners who have been supporting the Kalunga family since they came to Quebec eight months ago.

## KALUNGA FAMILY



**JEAN-MARIE**
38 years old

**THÉRÈSE**
36 years old

**JONATHAN**
died at the age of 7

**ESPÉRANCE**
15 years old

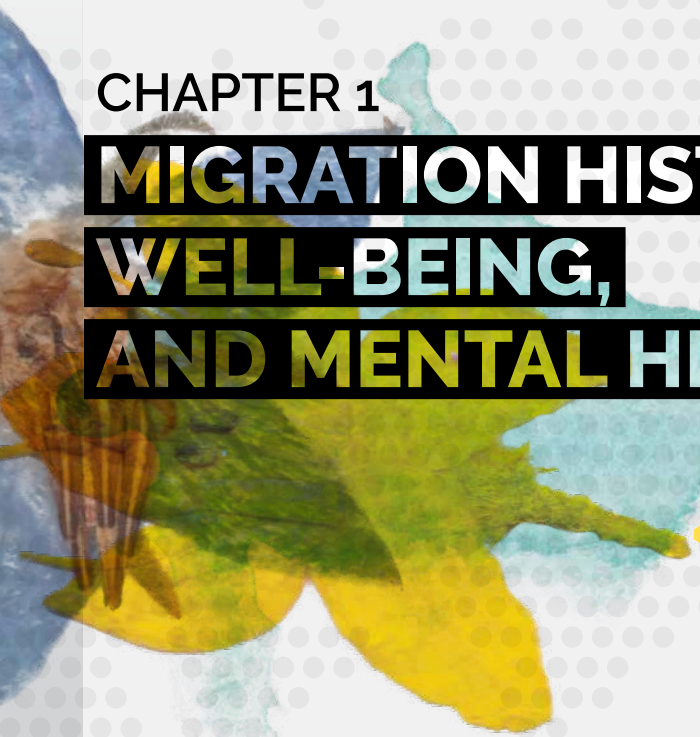
**LÉO**
8 years old

In **CHAPTER 1**, we will present their migration story and accompany them to their first meeting with Inès, who works at the community organization that supports refugees.

In **CHAPTER 2**, we will learn more about how the members of this family were affected by the traumatic events of their migration and resettlement and how these impacts manifest in their lives.

In **CHAPTER 3**, we will look at how the trauma-informed approach is applied with family members.

* Members of the Kalunga family and the practitioners introduced in this guide are fictional; any resemblance to actual persons (living or dead) is entirely coincidental.



# CHAPTER 1
# MIGRATION HISTORY, WELL-BEING, AND MENTAL HEALTH OF REFUGEES

> «They are not heroes or heroines; we have to be careful not to give them this status because a hero or a heroine doesn't have the right to be vulnerable. They should not be put on a pedestal, but we can't help acknowledging the strength and the coping and survival skills which brought these people all the way to us.»
>
> Social worker, psychotherapist

The first section of this guide can help you gain a better understanding of potential experiences at each stage of migration, the possible effects of trauma, and ways to build resilience. We will look at the potentially traumatic experiences refugees may have undergone at different stages of their migration using several clinical examples. We will then highlight the importance of attending to protective factors and developing cultural sensitivity.

# 1.1 POTENTIAL EXPERIENCES DURING REFUGEE MIGRATION

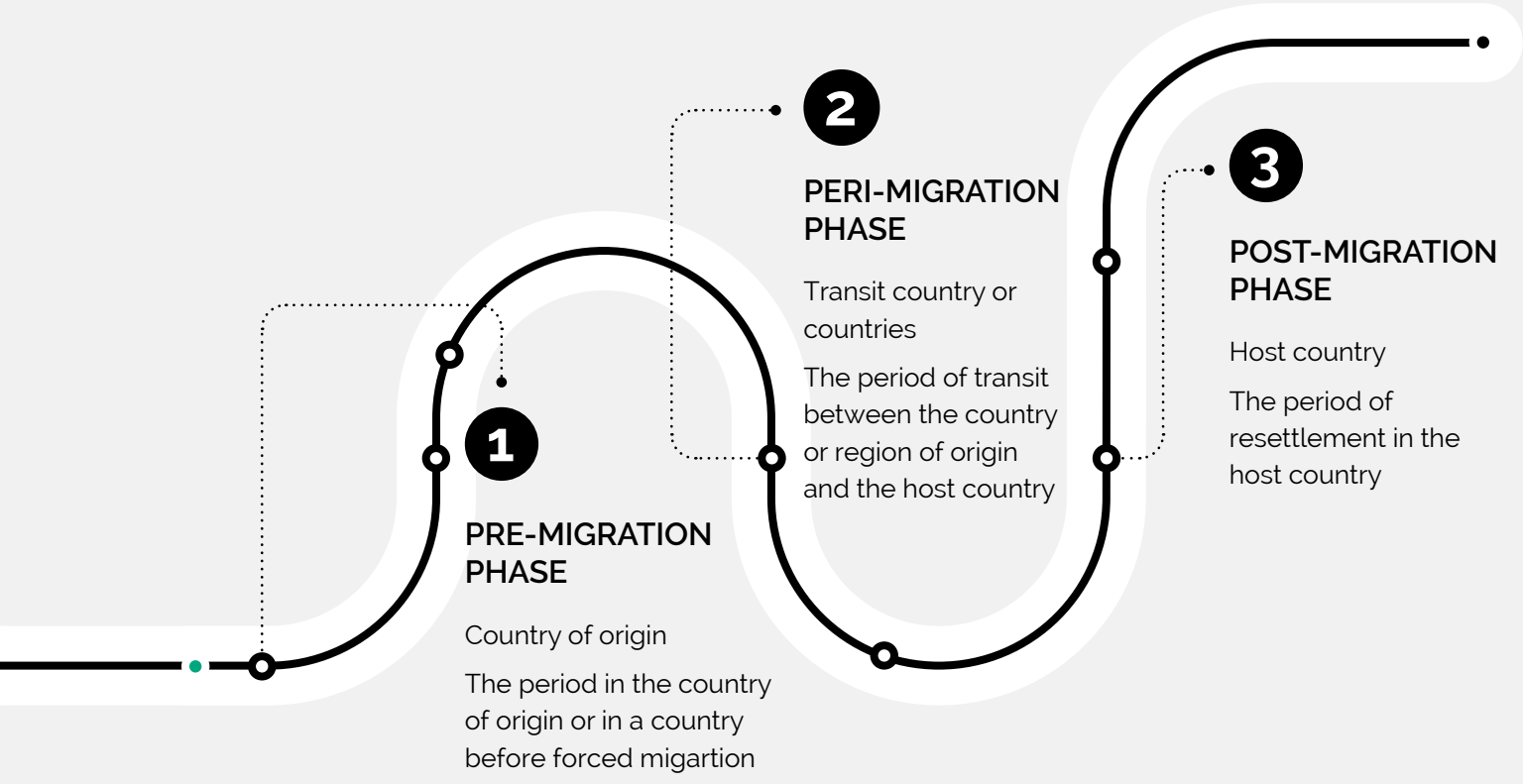
## IN A NUTSHELL

- At each stage of their migration, refugees are at risk of potentially traumatic experiences.
- Refugees are also confronted with many sources of stress which can influence the impact traumatic events have on them and on their functioning.
- The accumulation of these experiences can have an enduring effect, lasting even after they are resettled in Canada.

### MIGRATION HISTORY

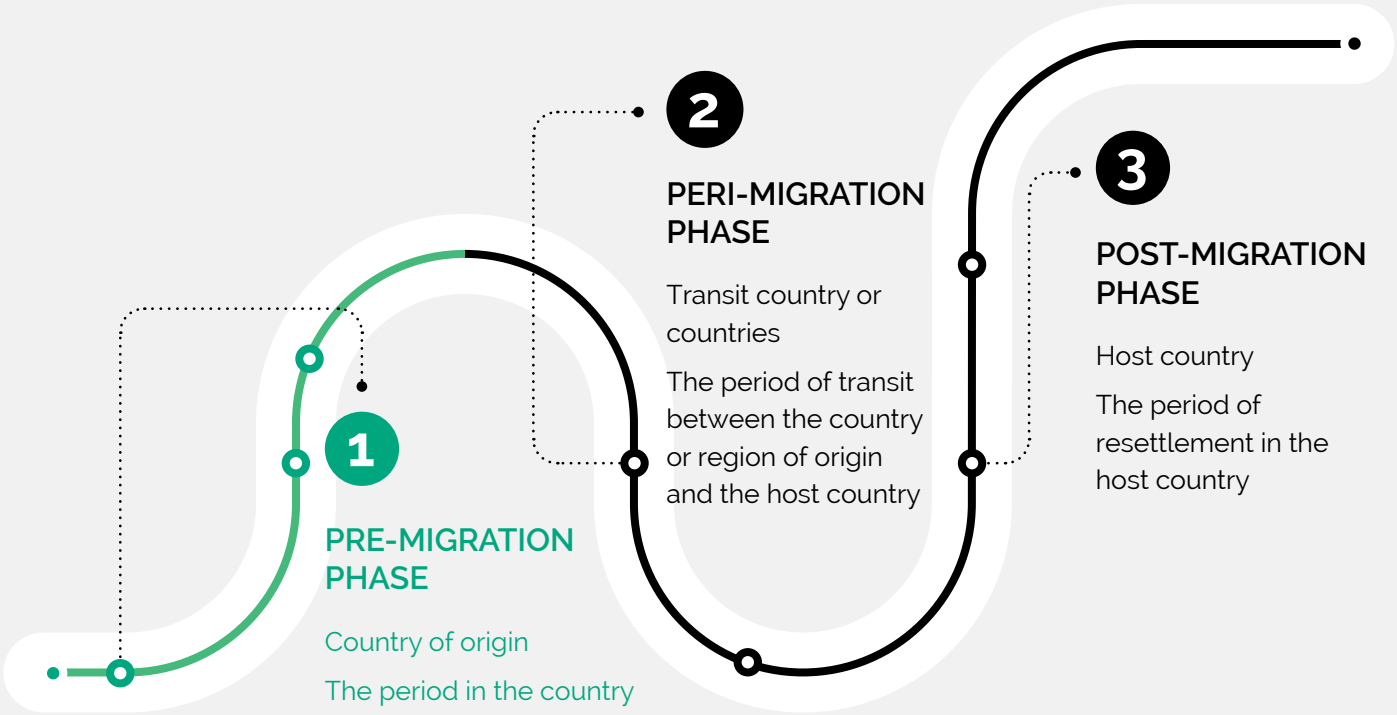
The migration histories of many refugees can be described as having three phases; each having an impact on well-being and mental health. While each migration story is unique, being aware of the full range of what refugees may have undergone and the effects these experiences may have on their well-being and mental health can help direct your interventions.

These phases are obviously not mutually exclusive. That is, the experiences and consequences may occur at different points during the migration.



# PRE-MIGRATION PHASE (PERIOD IN COUNTRY OF ORIGIN OR IN A COUNTRY BEFORE FORCED MIGRATION)

During pre-migration, refugees are likely to have experienced potentially traumatic events threatening their security or that of their loved ones: organized violence, war, torture, kidnap, detention, sexual violence, sexual slavery, etc. Refugees often suffer separation and loss, many times over. These losses can be human, material, or symbolic: the death or disappearance of family members, destruction of home and property loss, and the erosion of feelings of belonging, bearings, and social cohesion [26].




## TRAUMA-INFORMED PRACTICE

Interpersonal violence and human-perpetrated acts of persecution, such as sexual assault and torture, can have a particularly strong impact on people. Such events can severely affect relationships; undermining trust and a sense of security around other people. The impact on relationships can be stressors experienced during migration and upon arrival in the host country (for example, discrimination or meeting a practitioner for the first time) [27].

The following table summarizes possible pre-migration experiences and potential consequences.

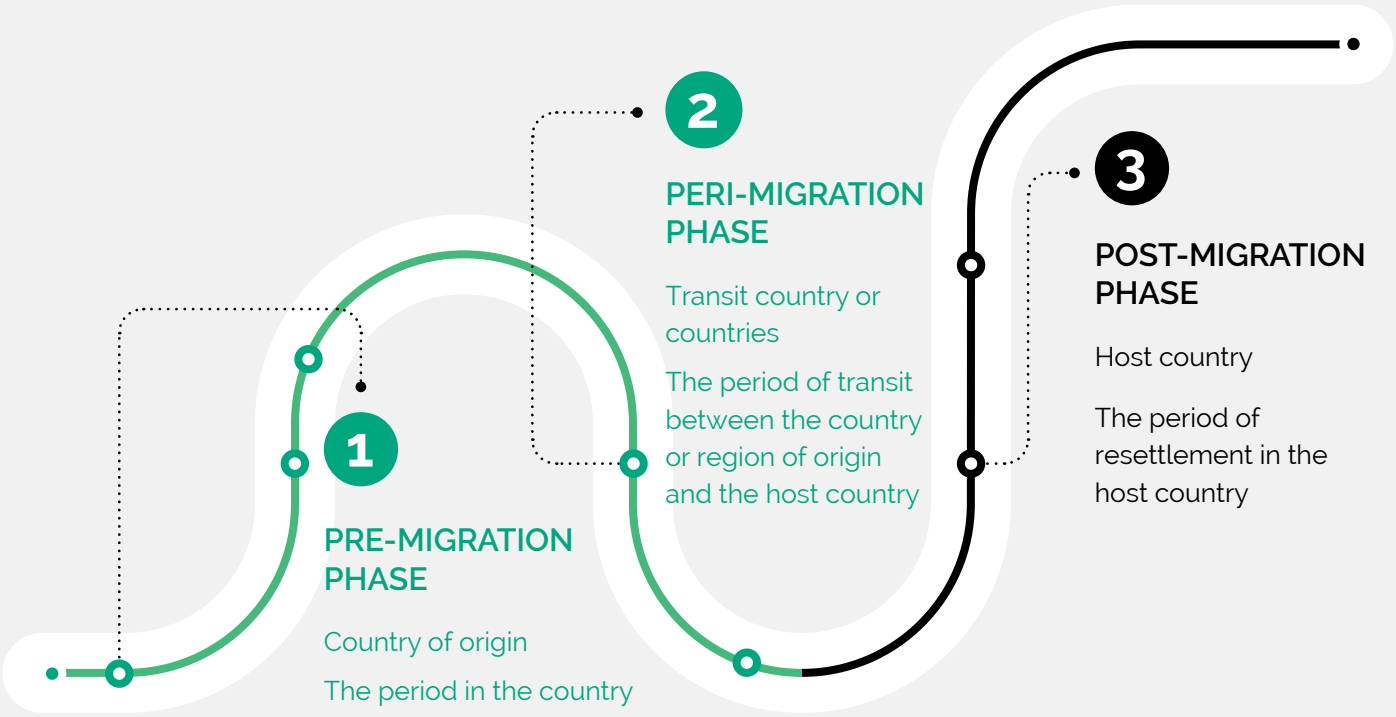
| POSSIBLE ADVERSE EXPERIENCES | POTENTIAL CONSEQUENCES |
|---|---|
| + Armed conflict | + Family separation |
| + Arbitrary imprisonment | + Loss of resources |
| + Destruction of home or material property | + Weakened health |
| + Sexual violence | + Fear, terror, grief, anger |
| + Persecution (e.g., because of sexual orientation) | + Increased sense of insecurity |
| + Torture | + Uncertainty about future |
| + Natural catastrophe (e.g., earthquake, hurricane, drought, famine) | + Temporarily out of school (children) |
| | + Incomprehension (children) |

## THE KALUNGA FAMILY

Jean-Marie and Thérèse Kalunga grew up in the Democratic Republic of Congo (DRC) in a climate of political instability and armed conflict which had affected the country for many years. Thérèse came from a village in the current province of Nord-Kivu where she lived for much of her life. At 19, she met Jean-Marie at the village café. He had recently gotten a job at a garage; she worked in family market gardening. They fell in love: Thérèse for her humour and Jean-Marie for his strength of character. In 2000, they were married in the presence of family. Jean-Marie thought a lot about those who were absent that day, including his father and some of his brothers who had died during the first Congo war (1996-1997). During the time of the birth of their first two children, Jonathan and Espérance, violence worsened in the area. The family's home was burnt during riots between police and rebels. In December 2005, like thousands of other Congolese. the family decided to flee south to Tanzania. They left home, brothers, sisters, and parents behind.

# PERI-MIGRATION PHASE (PERIOD OF TRANSIT)

Peri-migration refers to the period in which refugees are in transit between their country of origin and their future host country. Throughout the entire journey, they can experience other potentially traumatic events: violence; living in a refugee camp or detention centre; hunger and disease; precarious conditions of displacement and survival; family separation, death of loved ones or travelling companions, etc. Refugees very often live, for a prolonged period, in contexts of insecurity, social and cultural rupture, and precarity (malnutrition, unsanitary conditions, etc.), with limited access to health care and education. They often face a significant drop in financial resources, which further increases their vulnerability. Difficult living conditions have strong impacts on the well-being and mental and physical health of refugees.




## TO KEEP IN MIND

Challenges encountered during forced migration can also be a source of learning, strengthening the coping skills of refugees. For example, children who are forced out of school temporarily can learn in other ways, which can be important to them later in their journey.

The following table summarizes possible peri-migration experiences and potential consequences.

| + POSSIBLE ADVERSE EXPERIENCES | + POTENTIAL CONSEQUENCES |
|---|---|
| + Precipitated, urgent or planned departure | + Family separation |
| + Travalling through one or several countries | + Human and material loss, grief |
| + Challenging life and resources in one or more refugee camps | + Physical health problems |
| + A journey filled with dangers: risk of arrest, political instability, etc. | + Fear, anxiety, and insecurity |
| + Precarious living conditions: malnutrition, insanitary, poverty, cold, etc. | + Temporarily out of school (children) |
| + Violence, traumatic stress, loss | + Incomprehension and powerlessness |

## KALUNGA FAMILY IN THE REFUGEE CAMP

In July 2008, after a long journey by bus and foot, the Kalunga family arrived in the Nduta refugee camp in Tanzania. They stayed there for almost 10 years. The parents were not authorized to work outside the camp. Living conditions there were very difficult, particularly access to health care and food. Among other things, this led to significant deficiencies in nutrition. In addition, the children were often not able to go to school. The family's respiratory problems can be attributed to the unsanitary camp infrastructure.

The first year was deeply painful for the Kalungas because Jonathan, the eldest sibling, died of cholera; he was 7 years old. A year after his death, Thérèse found out that she was pregnant. It was an overwhelming moment, between happiness and sadness, linked to the recent loss of Jonathan. She gave birth to Léo, a "miracle baby" to his parents. On top of the difficult living conditions, the insecurity prevailing in the camp was a cause of constant stress. Espérance, the daughter, had to repel advances from residents who offered food and money in exchange for sex. Over time, Thérèse became close to some other women in the camp, becoming their ears and spokesperson for improved living conditions. Jean-Marie became known for his skill as a mechanic. Espérance spent all her time with neighbouring girls and Léo, then four years old, participated in a group run by an NGO for kids of his age. This gave him access to physical activities.

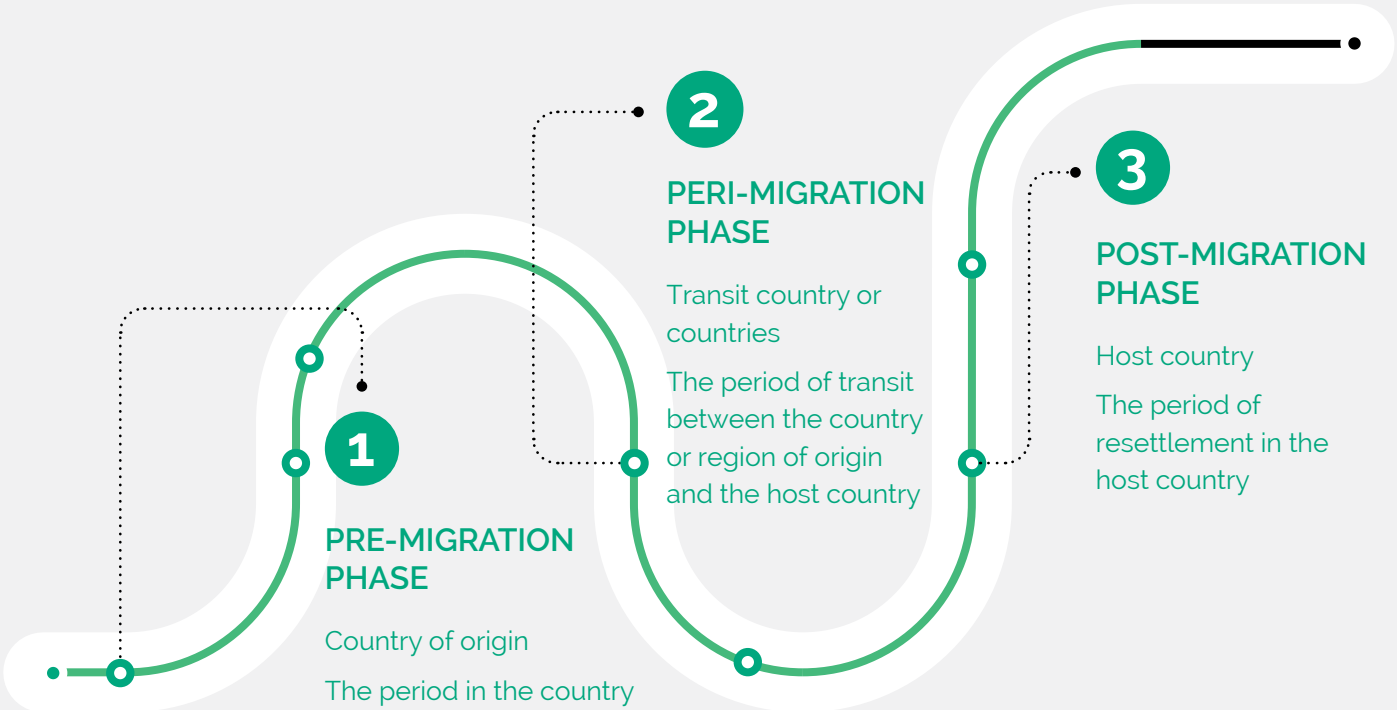
At the end of a long, almost two-year process (applications, interviews, physical exams, courses, etc.) with the UNHCR office in the camp, the family succeeded: they would be resettled in a third country, Canada. The Kalunga family had no idea what to expect in Canada – besides the cold – but they knew their living conditions would improve. Finally, they received authorization to go to the airport and fly to Canada.

# POST-MIGRATION PHASE (PERIOD OF RESETTLEMENT IN A HOST COUNTRY)

Even though arrival in the host country can eventually re-establish a certain measure of security, the process of adapting can itself be a source of stress, disappointment, and sometimes even be experienced as a traumatic event [28]. During the post-migration phase, refugees face new challenges: linguistic barriers, loss of social markers, social isolation, family separation, inadequate housing, downgrading of professional class, difficulty finding work, financial precarity, discrimination, etc. [29]. These challenges can represent a major source of stress for people who have fled persecution [30].

Arrival in the host country can be experienced as a demanding, and sometimes even traumatic, time of survival and accelerated adaptation. Post-migration conditions can have a strong impact on the physical and mental/emotional well-being of refugees. The multiple challenges linked to re-establishing oneself and one's family affect many spheres of a refugee's life: family, social relations, language, employment, nutrition, education, housing, culture, etc.

Upon arrival, refugees must quickly rally to meet basic needs in an unfamiliar context [31]. In addition to their vulnerability as newcomers, they carry the baggage of adversity and loss suffered during migration. Their reception and the degree of their integration into the resettlement country can ameliorate or aggravate the consequences of the traumatic experiences faced during earlier phases of their migration [17]–[19], [22], [32], [33].



The following table summarizes possible post-migration experiences and potential consequences.

| POSSIBLE ADVERSE EXPERIENCES | POTENTIAL CONSEQUENCES |
|---|---|
| Financial precarity | Stress, anxiety |
| Difficulties finding housing or work | Feeling of instability |
| Loss of social support networks | Precarity |
| Lack of access to resources | Feeling of losing one's culture and knowing how to navigate within one's culture |
| Difficulties learning French | Isolation |
| Conflicts from cultural misunderstandings | Loss of self-esteem |
| Conflicts within family | Depression |
| Changing role (parental, professional) | Anger |
| Integration difficulties (work or school) | Barriers accessing health care |
| Identity loss | Internal family tension |
| Discrimination, stigmatisation | |
| Loss of social status | |

## KALUNGA FAMILY IN MONTREAL

The Kalungas arrived at the Montreal airport in January 2018 and were welcomed by resettlement practitioners from an organization based in their future city. The family moved into a two-bedroom apartment. They gradually became acquainted with how things work in their new city: public transportation, groceries, finding their way around their neighbourhood. Espérance and Léo are in school and making progress, and are in a special class to help newcomer students integrate into the French-language classroom. Thérèse is enrolled in a literacy class and works cleaning in the evenings.

Jean-Marie is looking for work, but encountering a lot of barriers. With no prior work experience in Quebec, his attempts to get a job as a mechanic have had no success. He is slowly developing a feeling of discrimination because of his unsuccessful job search. The family found the winter difficult, but are gradually forging community ties, especially with the members of a church they attend.

## TO KEEP IN MIND

The post-migration context or refugees can have a significant effect on symptoms associated with traumatic stress and post-traumatic stress disorder (PTSD). In some cases, it can be a more important determinant than the situation which precipitated the exile [20], [30]. These psychosocial factors (housing, work, isolation, etc.) and their impact are often the focus of interventions by community workers.

# POST-MIGRATION RISK AND PROTECTIVE FACTORS

The accumulation of potentially traumatic experiences throughout migration can undermine the mental health of refugees. The literature nevertheless suggests that **post-migration conditions can have more significant consequences for mental health than pre- and peri-migration experiences**; because they have the potential of exacerbating past traumatic stress [19], [29], [34]. The new socio-economic, social, interpersonal, structural, and socio-demographic conditions can be risk factors and/or protective factors.

The following table summarizes factors during migration which potentially have a harmful effect on the mental health of adult and child refugees [9], [24], [27], [29], [30], [35], [36].

**FACTORS DURING MIGRATION AFFECTING WELL-BEING AND MENTAL HEALTH**

**IN ADULTS**

### 1 PRE-MIGRATION

- Economic, educational and employment status in country of origin
- Rupture of social ties, support network and role
- Exposure to traumatic events
- Involvement in a cause (political, religious, etc.)

### 2 PERI-MIGRATION

- Migration journey (how dangerous it is, duration)
- Exposure to difficult living conditions (e.g., refugee camp)
- Rupture with family and community networks
- Uncertainty of migration outcome

### 3 POST-MIGRATION

- Uncertainty of immigration or refugee status
- Unemployment or underemployment: barriers to employment (difficulties obtaining recognition of professional qualifications)
- Loss of social status
- Loss of family and community support
- Fear for members of family remaining in country of origin and possibility of family reunification
- Difficulties adapting, integrating, learning the language
- Status of conflict in country of origin: continuing or resolved

Many factors influence the way in which refugees, both children and adults, experience and react to potentially traumatic events. Some **risk factors can harm mental health and impede resilience**, while **protective factors can improve health and strengthen resilience**. It is important to identify the different factors in order to understand each person's experience.

**IN CHILDREN**

### 1 PRE-MIGRATION

- Age and stage of development at time of migration
- Interruption of education
- Separation from extended family and support networks
- Exposure to violence (as victim or witness)
- Head injury

### 2 PERI-MIGRATION

- Separation from a guardian, non-accompanied migration
- Exposure to violence
- Exposure to difficult living conditions (e.g., refugee camp)
- Bad nutrition
- Uncertainty of future

### 3 POST-MIGRATION

- Stress related to adaptation of the family
- Difficulties at school
- Problems adapting (identity conflict with host society; intergenerational conflict in family)
- Discrimination or social exclusion (at school, with peers)

The following table summarizes protective factors which can have a positive influence on the well-being of refugees (adults and children) throughout migration [19], [24], [27], [29], [30], [35], [36].

**PROTECTIVE FACTORS**

### INDIVIDUAL FACTORS

- Good self-esteem
- Cognitive abilities
- Education
- Involvement in a cause
- Good temperament
- Coping skills
- Maintaining religious beliefs

### SOCIAL DETERMINANTS OF HEALTH

- Access to safe environments
- Food security (water, food)
- Access to adequate housing
- Access to health care
- Employment and training opportunities
- Cultural sensitivity of practitioners
- Interpretation during meetings

### FAMILY AND COMMUNITY FACTORS

- Integration opportunities
- Participation as volunteer
- Presence of adequate services
- Lasting and supportive relationships
- Family reunification
- Presence of family
- Sense of belonging to a social circle (e.g., community group, religious community, colleagues at work, etc.)

## DID YOU KNOW?

A study carried out in Canada shows that discrimination is a more significant determinant of mental health than exposure to pre-migration trauma. This data suggests that the upsurge in xenophobia, anti-refugee expression, and perceived or real feelings of discrimination can further undermine the mental health of refugees [37]. Conversely, a sense of belonging to a social circle (e.g., community group, religious community, colleagues at work, etc.) is an important protective factor [20].

# 1.2 MENTAL HEALTH STATUS OF REFUGEES

## IN A NUTSHELL

Overall, studies conclude that refugees run a higher risk than the general population of suffering from diverse mental health problems relating to their exposure to war, violence, torture, forced migration, and exile. They have a higher rate of anxiety, depression, PTSD, and overall psychological distress.

## MENTAL HEALTH

The impact of adverse experiences during forced migration on the mental health of refugees, taking post-migration living conditions into account, is now well established in the literature. Refugees are at **higher risk of presenting rates of depression, PTSD, and somatic symptoms than the general population** [27], [38]. Research data suggests that multiple exposures to traumatic experiences is associated with the onset and severity of symptoms and mental health disorders [29], [39]. For example, people who lived in refugee camps are at have a higher risk of depression and anxiety because of the extremely stressful living conditions in these environments [29]. People who have been tortured seem to be at a higher risk of developing PTSD symptoms [32].

The literature also shows that refugees not only use health care and social services less than other Canadian residents [15], [27], [40], [41], but they are also at higher risk of receiving lower quality care, wrong diagnoses, and inappropriate treatment [42], [43]. There are diverse reasons for this (lack of knowledge of services, linguistic and cultural issues, fears associated with public institutions, taboos around mental health, etc.).

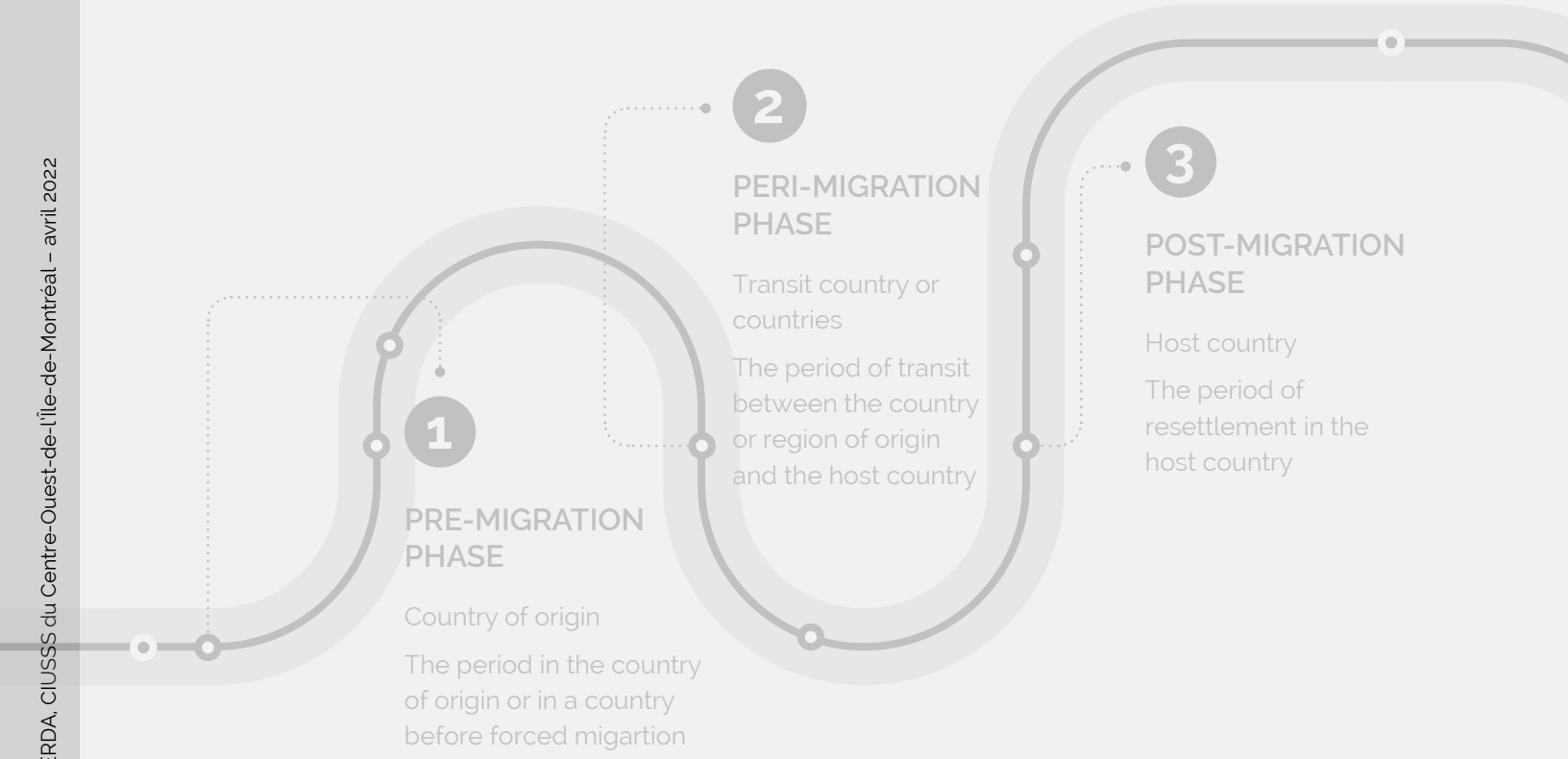
Alongside the structural factors listed above, experiences of racism and discrimination are cross-cutting factors which contribute to weakening the mental health of refugees [19], [44], [45]. **The dynamic interaction among these factors influences the mental health of refugees throughout their lives.**

## TRAUMA-INFORMED PRACTICE

Our reactions, ways of being and of seeing the world are the result of a series of events and things learned throughout our lives. In the context of working with refugees, it is indispensable to keep in mind the possibility that they have had difficult experiences throughout their migration, because these may be at the root of reactions and behaviours that are challenging and "don't seem to make sense (within the Canadian cultural context)".

## TO KEEP IN MIND

In most cases (estimated at around 80%), refugees presenting PTSD symptoms recover over time and increase their stability during resettlement [24]. This observation runs counter to the belief that all refugees have PTSD with lasting symptoms. Despite the high rate of PTSD among refugees, one should not lose sight of the fact that post-traumatic stress is a normal coping response and that most affected adults and children recover when a sense of security and a more stable life are re-established [18], [24].



# 1.3 QUESTIONING A REFUGEE'S MIGRATION STORY

## IN A NUTSHELL

Systematic questioning of the traumatic experience and symptoms is not recommended when unnecessary: it can worsen symptoms associated with traumatic stress. It is important for practitioners to be aware that the refugees they are supporting with psycho-social services may have lived through traumatic experiences during their migration and to be aware of the consequences of those experiences. However, it is also important to keep in mind that it is often unnecessary to know the details of their story and all that they have gone through.

Seeking to know everything about the forced migration may force refugees to speak about painful experiences they are not yet ready to confront or to repeat tragic stories they have already told many times. This could erode the support relationship and affect their process of integration and feeling of well-being. Thus, practitioners should adopt a trauma-informed practice; able to listen and offer support with empathy in the context of trauma, without forced disclosure.

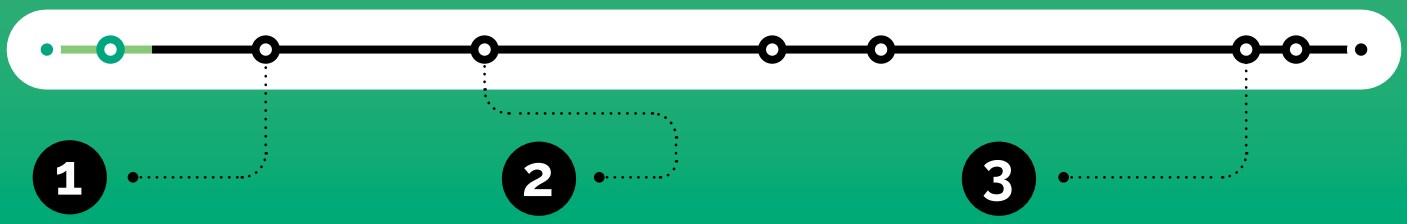
**It is important not to intrusively question refugees.** Prompting disclosure can worsen symptoms and weaken the bond of trust, which is essential to a beneficial intervention. Some experiences will be disclosed gradually over time, as trust develops.

### TO KEEP IN MIND

The way in which a person treats and reacts to a potentially traumatic event is influenced by subjectivity and personal interpretation. Family and social support, as perceived by the individual, which is an important protective factor, will also affect this interpretation.

In some situations, it may be necessary to question certain aspects of the migration history in order to offer appropriate support. The following table summarizes some of these.

**MIGRATION FACTORS**



### 1 PRE-MIGRATION

- Summary of event or series of events which precipitated departure from country of origin
- Current situation in country of origin (as compared to time of departure)
- Preparation or lack of preparation of migration
- Family's social status in country of origin
- Family context before displacement (stability, security, conflicts)

### 2 PERI-MIGRATION

- Living conditions in the country of transit or refugee camp
- Conditions of the journey (e.g., long trip by foot, inflatable boats, etc.)
- Places the family lived before coming to Canada
- Countries the family crossed between country of origin and Canada and means of transport

### 3 POST-MIGRATION

- Current needs for safety and support
- Acknowledging grief and loss experienced (members of family, previous living conditions, country of origin)
- Involvement of family in meaningful activities (e.g., work, education, community activities, etc.)
- Invite awareness of changes in parent-child relationships since migration
- Current social status of family relative to status in country of origin
- Contact with loved ones who remain in country of origin

## FIRST MEETING WITH THE KALUNGA FAMILY

The first time the Kalungas visited the community organisation, they met Inès, a community worker supporting newcomers. The entire family arrived 20 minutes late for their first meeting with Inès.

Thérèse seemed to act as head of the family; an impression confirmed from the beginning of the meeting. In her words, she is the "pillar of the family." She left little space in the conversations for other family members or the community worker. She complained about the cold and expressed her expectations for her family, especially around housing and the children's education.

Jean-Marie was more withdrawn; speaking little, with brief and rather nonchalant responses. When Inès asked him how he felt and how his first months in Quebec were going, either Thérèse responded or Jean-Marie remained silent. Thérèse said he was often sad, that he drank a lot of alcohol and he wanted to find work but could not because "employers didn't want foreigners like him." He seemed to agree with a nod and sighs.

Espérance appeared very grown-up and obedient. She responded very politely, with frank and brief replies when the question of school or friends arose. She had moments when she seemed "absent" during the meeting, staring at nothing. On the other hand, Espérance seemed very invested when Inès asked her what she liked and when she talked about theatre. Inès found Espérance endearing and brilliant, but felt concerned and helpless in the face of Espérance's "absences".

Inès had difficulty interacting with Léo. She felt that he was clinging to his father and avoided looking at her most of the time. This calm and withdrawn state alternated with a state in which he became agitated and did not stop pacing around the office. Thérèse reported that he has difficulty concentrating, learning, and he cries a lot because he is worried about his father. At home, Léo eats compulsively and has started wetting his bed again.

# FOR MORE INFORMATION: CULTURAL SENSITIVITY

A trauma-informed practice with refugees requires developing general cultural skills to allow the delivery of helpful support. Traumatic experiences, their manifestations, expressions, evaluation, and treatment are rooted in cultural representations [46], [47] which may complicate interventions [48]. The cultural sensitivity of practitioners and the presence of an interpreter during the consultation help ensure interventions are helpful.

To learn more about cultural skills in interventions, you can consult the following resources:

**The DSM-5 cultural formulation interview guide** gives several examples of questions which can be adapted in intercultural interventions to help the person express their understanding of their own difficulties, their causes and importance in their lives [10]. While DSM-5 is a tool for clinicians, its content can help formulate some questions:

*https://psycnet.apa.org/record/2015-37696-000*

Practitioners, as well as refugees, have their own cultural universes. Thus, it is important in intercultural interventions to think about how one's own culture interacts with the other's. **Cultural sensitivity and cultural humility** are two concepts which can help shape safe and respectful intercultural interactions. For more information:

*https://muse.jhu.edu/article/268076/pdf*

Centre for Addiction and Mental Health (CAMH)'s website provides accessible, **multilingual resources** on mental health, which can help people who are hesitant or would like to know more about mental health. We suggest the info-sheet, "Asking for help when things are not right," available in several languages:

*http://www.camh.ca/-/media/files/mi-index-other-languages/english-asking-for-help.pdf*

## WRAP-UP

In this first chapter, we explored possible migration experiences and the potentially traumatic effects they may have on refugees. In addition to risk factors leading to poor mental health, we looked at ways of providing support and strengthening resilience, such as focusing on what is needed in the present and cultural sensitivity. In the next chapter, we will look in detail at why traumatic events can affect the well-being of refugees in the post-migration phase. To this end, we will present a neurobiological approach, which explains how trauma affects the brain.

CHAPTER 2

# TRAUMA IN REFUGEES: BETTER UNDERSTANDING, BETTER INTERVENTIONS

> « Just because I fled a country at war, for example, does not automatically mean that things stayed there. Things follow me. And whether during migration or in the post-migration period because people are often in survival mode when they arrive. It's "Oh! We want to do our things quickly." And then after, when they come back to earth, ouf! Then the skeletons start to come out of the closet and they may need support at that time. »
>
> Social worker (25)

As we saw in the previous chapter, refugees may have significantly adverse, even traumatic, experiences during their forced migration. These experiences can have considerable impact on their well-being and mental health. This second chapter aims to further deepen your understanding of the repercussions of trauma on refugees. Specifically, this chapter has three goals:

1. to understand the impact of trauma on brain function;
2. to become familiar with the diverse reactions and symptoms associated with traumatic reactions;
3. to understand resilience and post-traumatic growth.

Before beginning, we will briefly return to the distinction between trauma and traumatic reactions. A traumatic event is a life event perceived by the person as threatening or harmful to their integrity or that of a loved one, the potentially traumatic stressor.Trauma refers to what happened internally in the past; the person's internal response to the event which caused a shock or psychic injury to the person. Experiencing such an event can cause strong physical and psychological trauma informed protective reactions [10] which many people have difficulty overcoming.

- Physical, sexual, and psychological violence
- Wars and attacks
- Torture and persecution
- Unexpected discovery of bodies
- Exposure to scenes of violence
- Forced expulsion from home, village, or country
- Brutal or forced displacement
- Military arrest
- Natural catastrophe

In short, any horrific event where we cannot take ourselves to safety and that overwhelms our ability to tolerate the situation.

**Traumatic reactions refer to a person's trauma informed reactions in the present,** after the trauma event is over.

In other words, traumatic events can lead to trauma which can lead to traumatic reactions. Whether or not an event gives rise to traumatic stress depends on subjective factors, in addition to the natural or human cause of the event; notably, the person's subjective evaluation of the event, their age and developmental stage, the resources they can access, and, finally, the quality of their coping process [22].

## TRAUMA-INFORMED PRACTICE

While the trauma happened in the past, traumatic reactions live on in the present. Trauma-informed practice is more about paying attention to a person's reactions to trauma than questioning the details of the traumatic event they have gone through.

How you address and characterize a person is also important. Characterizing them as victims can have the effect of locking them into their traumatic experience. While acknowledging the trauma's place in the person's past, framing trauma reactions as best attempts to protect in the past, and seeing this experience is part of a life history which combines issues from the past, current challenges, and personal strengths. Thus, we must recognize that the person is experiencing traumatic reactions but not define them by their post-traumatic symptoms [12], [25].

**TRAUMA ≠ TRAUMATIC REACTION**

# 2.1 IMPACT OF TRAUMA ON THE BRAIN (NEUROBIOLOGY OF STRESS)

## IN A NUTSHELL

When humans are faced with a situation perceived as a threat, they are biologically programmed to protect themselves from this danger. The brain mobilizes all its resources to trigger a reaction: either fight, flight or freeze to optimize chances of survival.

Someone who has gone through a traumatic experience has an activated internal alarm system, which may continue even when they are no longer facing real and immediate danger to their life. Things reminding them of the trauma can then trigger a danger response, but the resulting strategies can sometimes be inappropriate in the present situation and become a source of distress and out-of-context behaviour.

## BRAIN FUNCTION UNDER DANGER

A perspective which is sometimes forgotten is that trauma responses are primordial in their effect on the brain and resulting impact on the behaviour of the person we are supporting. To understand this, we will look at the neurobiology of stress. This will help us understand **how traumatic experiences modify cerebral structures** and affect physical and emotional reactions. In fact, when a person goes through a traumatic experience, their perception of the world and their behaviour change. We can try to understand why by demystifying how certain structures of the brain work.

Our brain is in touch with our environment through our five senses (sight, hearing, touch, smell, taste). Our sensory system is the gateway for all external stimulus around us. Normally, information the brain receives from our experiences is first filtered by the thalamus. We can think of the thalamus as a triage centre. **If it does not detect a danger signal, the information is then sent to our frontal lobe.** This is the brain's conductor, controlling our most complex behaviour such as decision-making, planning, reasoning, memory, language, etc. We can think of this as our brain using **the slow lane for learning**; processing and consolidating information when there is no immediate threat. The information processed by the frontal lobe is also stored and filed in our internal hard drive, the hippocampus. If we later have a similar experience, our brain can then easily recall that there was no danger and inform us of that [49], [50].

However, when the thalamus detects danger, our brain reacts differently. It takes **the fast lane to process the information**; switching from learning brain mode to survival brain mode [51]. We then rely more on our limbic system then our prefrontal lobe. But how does the brain modify its behaviour to allow us to react more rapidly?

## DID YOU KNOW?

The limbic system encompasses a "set of cerebral structures situated in the middle and deep area of the brain, playing a major role in memory and emotions, as well as behavioural development." [52]

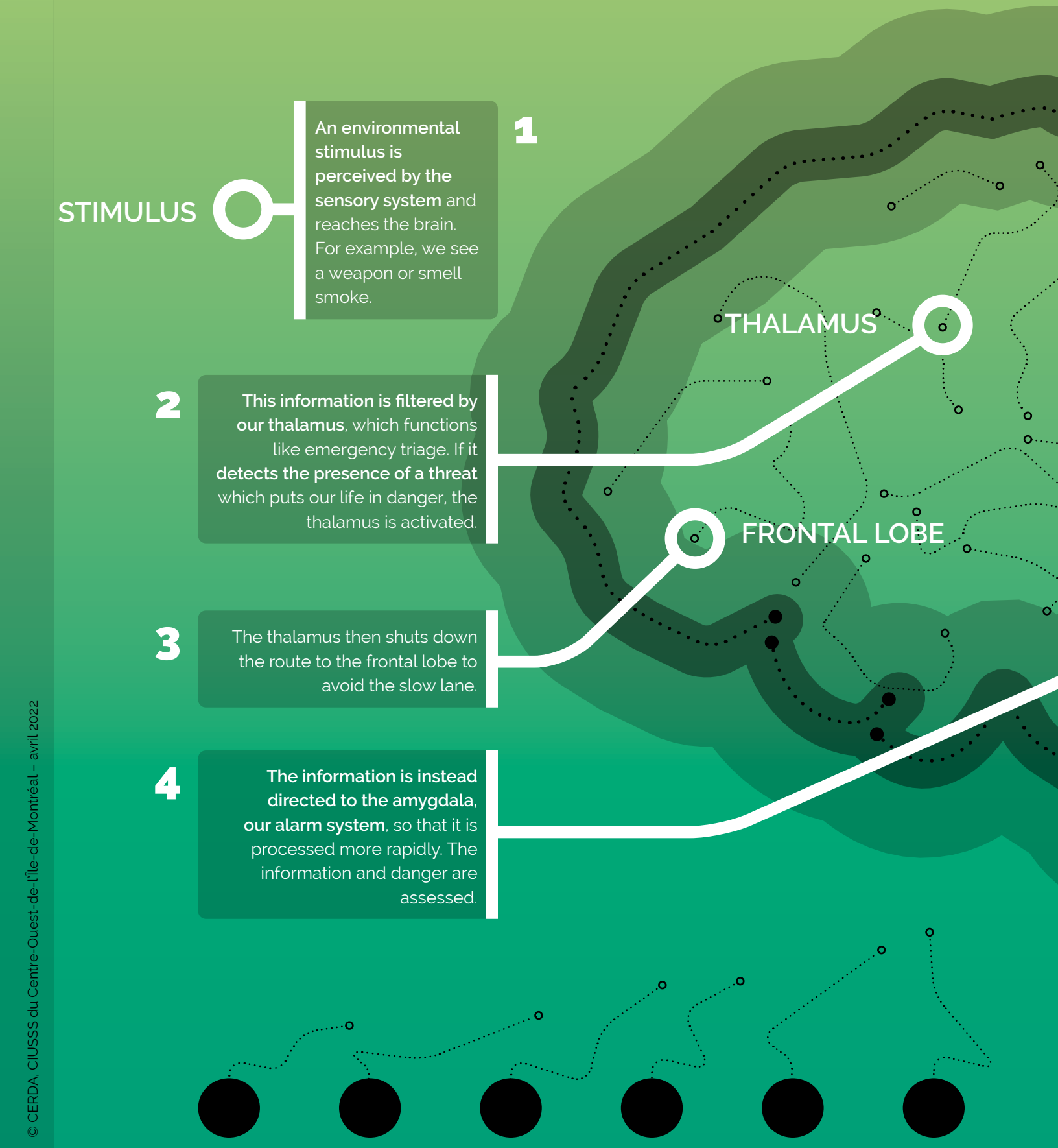
To understand the impact of trauma on the brain, we have to understand three structures of the limbic system which play a crucial role in processing and consolidating information [49], [50]:

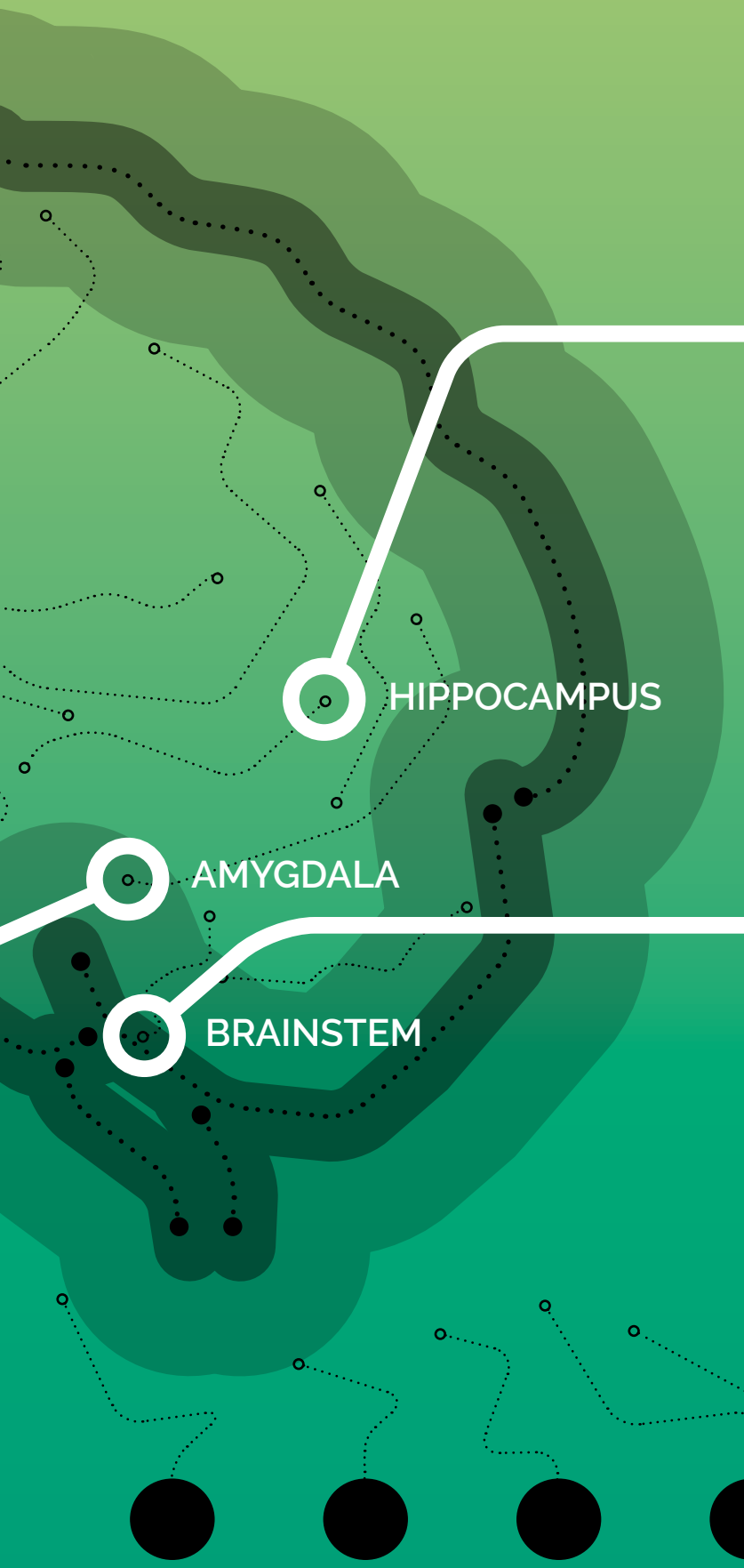
**Thalamus** :
Information triage centre in our brain. It filters information and sorts according to whether an experience is pleasurable or dangerous.

**Hippocamp** :
Internal hard drive which records information. As the memory centre, the hippocamp stores and files our past experiences, emotions, and reactions.

**Amygdala** :
The brain's smoke detector. If danger is perceived, the amygdala sounds the alarm by releasing stress hormones (cortisol and adrenaline), to put the body on alert.

## NEUROBIOLOGY OF STRESS






**5**

The hippocampus is also asked to check whether it is a known danger and how to react.

It permanently records the possible danger, and precise characteristics of the situation. In the fast lane of processing information, the hippocamp does not have time to properly classify the information. This can make it difficult to recall memories later.

**6**

Necessary information about the level of danger as well as survival reactions are then sent **to the brainstem, our command centre**. This triggers a reaction to mobilize the body rapidly to face the danger. It reacts reflexively rather than by reflection.

# STRESS REACTIONS: FIGHT, FLIGHT, OR FREEZE

## WHEN OUR ALARM SYSTEM IS TRIGGERED

As we just saw, when the brain detects a threat in the environment, it triggers an automatic reaction which activates the body to protect itself from danger. To do this, **the brain releases adrenaline and stress hormones, allowing the individual to respond instinctively, rapidly escalating the response to address the situation at hand** [50]. This reaction is not the result of a considered and conscious choice but a biological strategy of survival. Brain and body act together to keep us alive in the face of danger. All their energy and available resources are mobilized to confront the threat. This part of the brain can place everything which is not immediately useful on hold.

When the alarm is triggered, the body activates the danger response. There are three types of reactions: fight, flight, or freeze. It is important to note that we do not consciously choose which reaction we will have to a threat and they are all normal responses to a stressor [49], [51].

## WHEN THE ALARM SYSTEM DOES NOT STOP RINGING

These three reactions to a stressful event are normal adaptations; that is, they help us survive. However, if our danger response is constantly activated and overwhelmed, we store the strategies differently, they become "baked in". **Once we are no longer in the dangerous situation these strategies of protection may become maladaptive**. Our body can be stressed in the present if these old strategies create a onstant state of alert and vigilance. In other words, if our smoke detector is constantly ringing when there is no real danger in the immediate environment, our physical health,well-being and relationships will suffer significant consequences. The stress response (hormones, perspective, physical reactions, beliefs) which allow us to react rapidly to danger were useful at the time, but can harm us in the long run if they become a frequent ongoing response.

The alarm system of someone who has experienced trauma can become temporarily or constantly activated. The person, may (or may not) be aware that the danger is no longer present when **they shift to vigilance mode**. Reactions which were useful adaptations to a past trauma are activated in the present. In situations which remind them of the traumatic event, **the person will automatically manifest fight, flight, or freeze behaviours**. Because this danger response is automatic, the person often has little control over their reactions and they can become exhausting and a source of distress [49], [51], [53].

### TO KEEP IN MIND

The internal systems of a person who has experienced trauma is likely out of balance; it may be subject to permanent state of fear which may be expressed in many ways in daily life. A trauma reaction can have an impact on their mood, a person may have developed negative thoughts about themselves, others, and the world and it may lead the person to avoid everything which reminds them of the traumatic event. . Some experiences or moments of pleasure can reduce the fear, but only temporarily.

**POTENTIAL TRAUMATIC STRESS REACTIONS**

**FIGHT**

- Irritability, anger
- Conflictual interactions
- Imagining or planning scenarios

**FLIGHT**

- Turning inward
- Isolation
- Avoidance of people, spaces, experiences
- Abusive use of television or social media
- Consumption of drugs and alcohol

**FREEZE**

- Inaction
- Powerlessness
- Disconnection from self and environment
- Feeling of being detached from reality
- Inability to react or make decisions

## THÉRÈSE'S STORY

In September 1994, on a rainy day, a bomb hit Thérèse's village. Her family's home, where she had always lived, caught fire. Hardly 12 years old, Thérèse was in the middle of taking in the clothing from the clothes line. She heard a noise and was thrown to the ground by the blast. She has very few memories of what happened, only remembering that she was crouched down with her arms protecting her head. Around her, other houses were on fire and she heard screaming in the distance.

When the bombing happened, Thérèse perceived a threat and reacted instinctively by protecting herself (sensory circuit, thalamus, amygdala). Having previously experienced bombing, she was aware of the intense danger (amygdala – hippocampus – amygdala). In a survival mode, Thérèse acted without really being conscious of what she was doing (prefrontal system blocked). She only recalls being curled up and protecting her head. Her body froze, one of the three instinctive reactions in the face of fear (amygdala – dorsal vagal brake - brain stem circuit).

Thérèse is now a refugee resettled in Québec for eight months and a permanent resident of Canada. The day that Inès, her community worker, was supposed to meet her, it was raining. When Inès realized that Thérèse was not coming to the appointment, she called her by phone. Her daughter Esperance answered and explained that on some rainy days her mother would hide and refuse to go out. Such days remind her of the traumatic event and make her relive strong, associated emotions such as fear. An invasive and reactivated fear takes over and in spite of her prefrontal awareness that bombing seems unlikely, makes her take refuge. Going outside or taking clothes off the line could be additional elements which could prompt the recall the traumatic event (hippocampus, trauma storing, and generalization of stimulus).

# 2.2 REACTIONS AND SYMPTOMS ASSOCIATED WITH TRAUMATIC STRESS

## IN A NUTSHELL

Many areas of life can be affected by a traumatic stress in different ways: emotional, cognitive, physical, behavioural, relational, neurobiological, and spiritual. Understanding all possible manifestations of traumatic stress can improve interventions by helping us understand certain behaviours differently.

While they can be sources of distress, reactions or manifestations are not synonymous with mental health disorders. In doubt, it is important to refer the person to a professional who can make a diagnosis and recommend treatment if needed.

## POST-TRAUMATIC STRESS DISORDER (PTSD)

While this guide does not aim to address the diagnosis or treatment of mental health disorders, we believe it is important to be aware of PTSD. This can help improve our support for refugees; helping us understand certain reactions differently and allowing us to refer them to specialized resources if necessary.

People react in different ways to trauma events. It is thus important to understand possible reactions to a trauma event as a continuum ranging from so-called normal stress reactions to the development of trauma and post-traumatic stress disorder. Some people will also develop other manifestations of traumatic distress (depression, anxiety, somatic disorders, etc.). Experiencing a trauma event does not necessarily lead to developing PTSD. Some reactions and symptoms to difficult eventsmay subside with time and the person may gradually recover their equilibrium. However, some people will develop traumatic reactions which go beyond normal stress reactions. These traumatic reactions are associated with significant traumatizing distress, which can crystalize over time as well as having a strong impact on the person's ability to function in daily life. In such cases, referral to a specialized mental health resource is necessary [24].

### TO KEEP IN MIND

The term "post-traumatic" means that the person is no longer in imminent danger. In mental health care, it is crucial that any trauma-related intervention take place outside the situation of threat. However, in the refugee context, it is common to see some elements of the trauma events persist even after migration and are being repeated in the host country (e.g., conjugal violence, interethnic conflict).

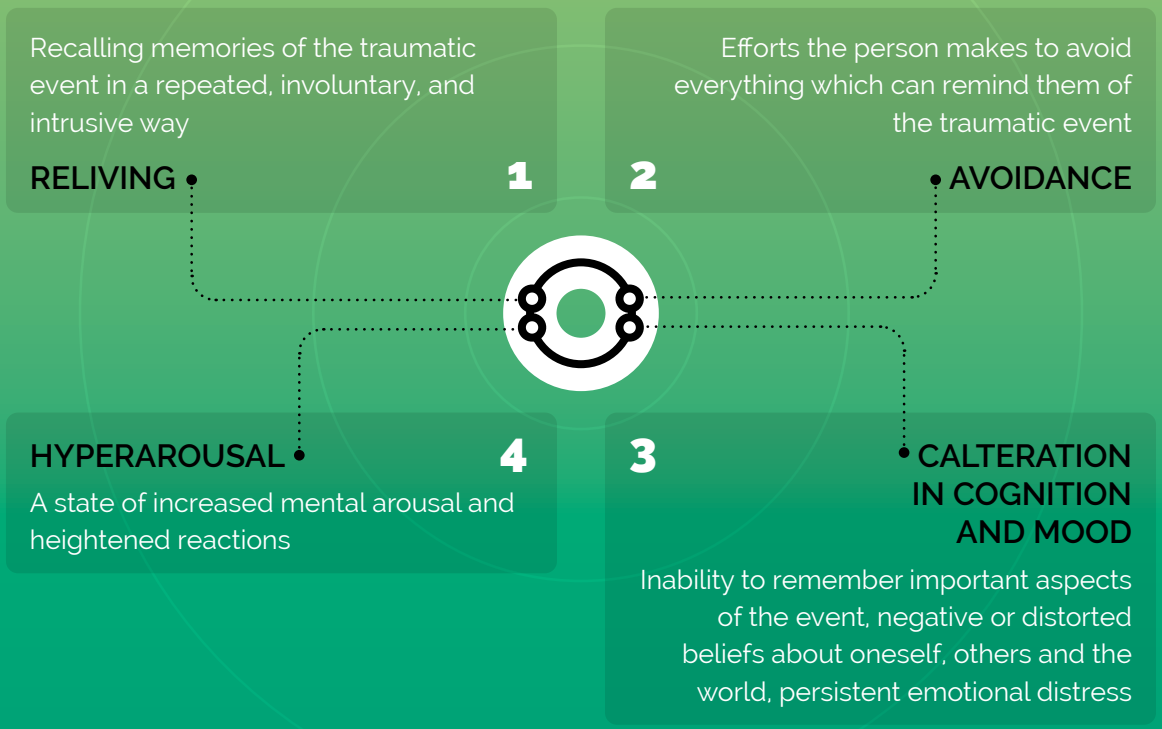
## DIRECT OR INDIRECT EXPOSURE TO A TRAUMATIC EVENT

PTSD may develop after exposure to one or more traumatic events. According to the DSM-5 [10], a traumatic event is any situation in which a person is exposed to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:

- Directly experiencing the traumatic event
- Witnessing, in person, the event experienced by others
- Learning about a traumatic event experienced by a member of the immediate family or close friend
  - In the case of death or danger of death of a family member or friend, the event must have been violent or accidental
- Repeated or extreme exposure to distressing details of the traumatic event (e.g., frontline workers gathering human remains or police repeatedly exposed to explicit facts about the sexual abuse of children)
  - This does not apply to exposure through electronic media, television, film, or photo; unless this exposure takes place in the context of a professional activity

### THE FOUR MAIN TYPES OF PTSD SYMPTOMS

Without going into diagnostic criteria in specific detail, PTSD symptoms can be grouped into four main categories [10].



**THE FOUR MAIN CATEGORIES OF PTSD**

**SOME EXAMPLES ...**

### Reliving

This can take the form of:

- Distressing memories
- Nightmares
- Dissociation (flashbacks – retrospective scenes)

triggered by elements recalling the event (images, sounds, smells, physical sensations, etc.)

### Avoidance

The individual may want to avoid:

- Emotions
- Memories
- Difficult thoughts related to the event
- External things which make them remember the event (people, places, activities, objects, etc.)

### Alteration

In cognition and mood:

- Negative or distorted beliefs (e.g., the entire world is dangerous, you can't trust anyone)
- Difficult emotions (e.g., fear, anger, guilt, shame, etc.)

### Hyperarousal

Can take diverse forms:

- Hypervigilance
- Irritability
- Excess anger (with little or no provocation)
- Concentration problems
- Disturbed sleep
- Exaggerated startle reflex
- Reckless or self-destructive behaviour

## TO KEEP IN MIND

Although the 5th Edition of the DSM set out to be more sensitive to culture and context, the diagnostic criteria of mental health disorders were mainly developed in a western context, and as such they are not universal [46], [47]. With that in mind, we can be more culturally sensitive in our interventions, particularly by paying attention to the ways a person expresses, describes, and understands their experience and distress and by prioritizing open questions.

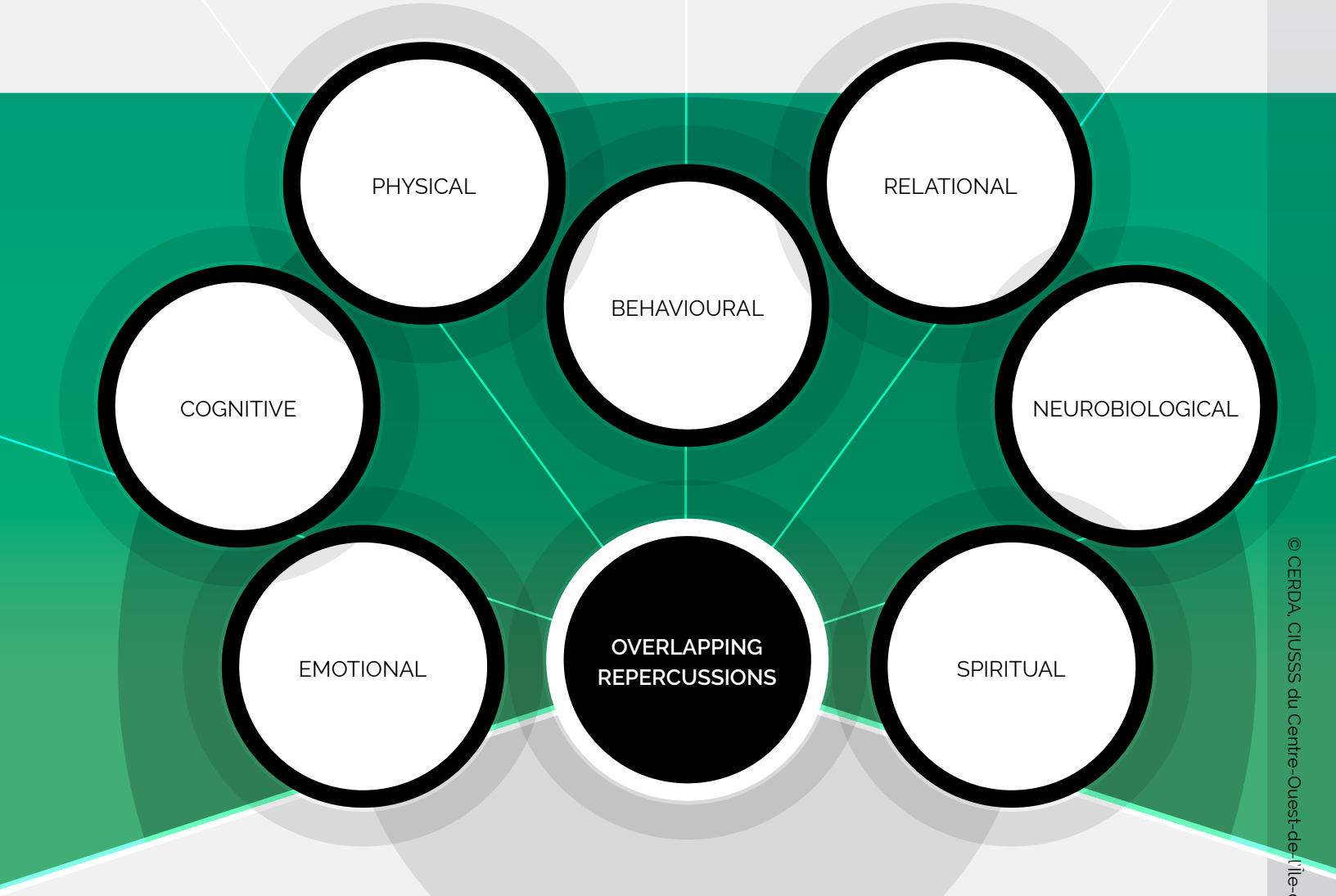
## DID YOU KNOW?

Undesirable reactions after exposure to a traumatic event can become apparent immediately or later [23]. According to the academic literature, an estimated **0 to 15% of people who have experienced potentially traumatic events have what are called delayed reactions**; that is, they manifest traumatic reactions one or more years after exposure to the trauma [11]. Reactions may also be short- or long-lasting [23]. According to the research, **5 to 30% of people who have gone through potentially traumatic events will develop chronic symptoms** [11].

# SPHERES OF LIFE AFFECTED BY TRAUMATIC EXPERIENCE

Beyond the diagnosis of mental health disorders, it is important that practitioners pay attention to the specific impact of the traumatic experience on how the refugees function, because each person experiences the effects of trauma differently.

In this section, we present the possible effects of traumatic stress in seven different spheres: emotional, cognitive, physical, behavioural, relational, neurobiological, and spiritual [23], [51]. Of course, **these spheres are not mutually exclusive**: some reactions or manifestations can appear in multiple spheres. However, we address effects separetely to make it easier to introduce them.




Understanding the harmful effects of traumatic stress on refugees through this sphere-based conceptualisation can help **focus our trauma lens and understand what is going on with the person**, beyond a diagnostic view of their condition [51]. In this way we can construct a more precise understanding of reactions and symptoms and develop personalized intervention plans. The seven spheres will be presented and examples from the Kalunga family's experience will be used to illustrate the different possible manifestations.

## 1. EMOTIONAL

When the emotional sphere is affected, we may observe the person either feeling emotions intensely (overwhelmed by the strength of their emotions) or not enough (emotionally numb or detached from their emotions) since the event.

- This can lead the person to feel emotions such as anger, fear, sadness, guilt, or shame. Experiencing strong emotions may be associated with traumatic stress.
- When trauma happens at a young age, it can affect emotional regulation; the ability to recognize, understand, and express emotions in a healthy and appropriate way.

**Jean-Marie** speaks of the moment in which he saw his son Jonathan dead without emotion. He says, "There is no point being emotional."

**Léo** gets angry easily – when he can't tie his shoe laces or when his mother refuses him something.

## 2. COGNITIVE

When a person experiences traumatic stress, their perception of self, others, and the world around them can change. Their beliefs, thoughts and overall cognitive functioning can be affected in every day experience.

- Reliving the traumatic event as though it happened again (flashbacks) and intrusive thoughts.
- Difficulties concentrating.
- Wrongly interpreting situations as dangerous because of similarities with the traumatic event.
- Holding certain beliefs about oneself related to feelings of shame or guilt for having survived: "what happened was my fault."
- Idealising the actions of the person responsible for the trauma, if the trauma was interpersonal.

**Thérèse** has difficulty concentrating and reports memory loss.

**Espérance** stares at nothing at times: she becomes silent, does not listen when someone speaks to her, and seems to be disconnected from what is happening around her.

## 4. BEHAVIOURAL

This sphere refers to (not always appropriate) behavioural strategies which people use to try to regain control over their lives or manage the intensity of their emotions and reduce their suffering.

- Avoidance behaviours
- Use of substances
- Compulsive behaviours (e.g., overeating)
- Impulsive behaviours (e.g., high risk behaviours)
- Self-destructive and self-mutilation behaviours.

**Jean-Marie** has difficulty falling asleep and staying asleep.

**Léo** as nightmares and wets his bed.

## 5. RELATIONAL

People who have experienced traumatic stress have often experienced abuse and breaches of trust. They may thus have difficulty trusting others and maintaining relationships. This can be manifested in different ways.

- Tendency to isolate or withdrawn into oneself
- Feeling of solitude and of being different from others
- Conflictual relationships marked by fear inirritability

**Thérèse** reacts explosively to the advice of Inès, the community worker, and accuses her of providing false information and of discrimination.

**Espérance** has difficulty trusting others: she does not make any friends at school.

## 3. PHYSICAL

Most people who have experienced traumatic stress present so-called somatic symptoms in their bodies. However, some people are unable to make the connection between their physical symptoms and traumatic stress.

- Sleep, gastro-intestinal, cardiovascular, neurological, musculoskeletal, respiratory, dermatological, and urological disorders may be reported.
- When a person's alarm system is constantly activated to prepare them to face danger, it can exhaust the body.
- An evaluation may determine that the physical problems cannot be explained by any medical condition.

**Léo** binges on food.

**Jean-Marie** drinks alcohol every day, to the point of falling asleep on the couch.

## 6. NEUROBIOLOGICAL

As we saw earlier in this chapter, experiencing trauma can alter brain structure. These modifications have repercussions on a person's reactions and ability to function.

**Jean-Marie** is always in a state of alert, particularly when he is walking in the street with Léo.

**Espérance** jumps at the slightest noise. She says she can never entirely relax.

## 7. SPIRITUAL

Trauma can make a person lose their bearings, distort their personal beliefs, and disrupt their spiritual life.

- Impression that life is frozen since the traumatic event
- Questioning identity and existence
- Difficulty in finding meaning in the traumatic experiences and sometimes in life as a whole
- A feeling of injustice or, conversely, a feeling of having deserved what happened as a punishment

**Jean-Marie** feels he is being punished and that he deserves what happened to him.

**Espérance** expresses a feeling of shame and lack of self-esteem.

## TRAUMA-INFORMED PRACTICE

Some post-traumatic reactions can translate into difficulties concentrating and remaining attentive. The practitioner must be conscious of this to ensure that the person is really grasping and retaining information (e.g., ask the person to repeat the plan or write the relevant information on a sheet of paper as a reminder, etc.). The practitioner must also keep in mind that not remembering is not necessarily a sign that the person is not interested [25].

# 2.3 POSITIVE ADAPTATIONS TO TRAUMATIC STRESS

## IN A NUTSHELL

Resilience allows people to regain equilibrium after adverse experiences and post-traumatic growth allows them to emerge transformed from the experience.

Resilience is influenced by personal characteristics and environment. It is important to support resilience to promote recovery.

To conclude this chapter, we will go beyond adverse manifestations resulting from a traumatic experience and look at positive adaptation to traumatic stress using the concepts of resilience and post-traumatic growth.

These are understood as dynamic processes in a person's history which can occur at any stage of coping with traumatic stress.

## RESILIENCE

Resilience is a person's ability to regain equilibrium after adversity [11]. We sometimes hear that resilient people manage to rebound after a challenging event; they create strategies to move towards well-being. Despite their experiences of adversity and associated suffering, many refugees have **internal, family, social and community resources which allow them to maintain or regain balanced physical and psychological functioning** after facing difficult experiences [18].

As we saw above, the great majority of people regain their equilibrium without needing a specific intervention. However, when a person's environment does not provide some measure of safety and stability (e.g., stress of adapting to a new society, poverty, social exclusion, discrimination), it becomes more challenging for the person to mobilize their internal resources.

### TO KEEP IN MIND

Resilience does not depend solely on internal resources or an innate ability to rebound, but is greatly influenced by the person's environment. To promote post-traumatic recovery, particularly in contexts in which multiple stress factors are present, it is essential to intervene at the level of the environment (e.g., social, spiritual, community and political support, financial and material resources) as well as the individual level (e.g., beliefs, personal coping strategies) [11].

# POST-TRAUMATIC GROWTH

Like resilience, the concept of post-traumatic growth is important to consider when working with refugees who have had traumatic experiences. A traumatic experience can overthrow and shake the person's universe and belief systems. They can begin to see themselves, others, and life more generally differently.

This difficult experience can also represent an opportunity for the person to redefine and reorganize themselves and review aspects of their life, such as priorities and goals, and relationships with others. However, not everyone feels the need to change their life or seek meaning after a traumatic event [53]. Post-traumatic growth should not be viewed as a systematic objective of recovery. Moreover, post-traumatic growth does not mean absence of distress or of post-traumatic symptoms [54].

Post-traumatic growth is a process by which **a person who survives a traumatic event emerges transformed by their experience**. It can also be understood as a cognitive coping strategy for someone going through very difficult times. Post-traumatic growth thus refers to positive changes which can occur in the lives of people after adversity [55]:

- Greater appreciation for life
- Trust in one's abilities to face adversity
- Greater appreciation for human relationships
- Spiritual development
- Social and community involvement

## TO KEEP IN MIND

While many people show resilience in the face of adversity, others will need specialized help. The presence of dissociative reactions, risk of suicide and depression which limits the person's day-to-day functioning can indicate the need to refer the person to mental health professionals (psychotherapist, psychologist, doctor, psychiatrist, etc.). Do not remain alone in your interventions [24].

## INDIVIDUAL MEETING BETWEEN THÉRÈSE AND INÈS

After several meetings with the entire family, Inès offered Thérèse individual meetings to better meet her needs. During the first meetings with the entire family,

Thérèse spoke a lot, especially about her family members. When Inès tried to question her about her own situation, she avoided the question by talking about her husband's state or the difficulties her son was having at school. When the community worker asked her what she needed, Thérèse mainly spoke about access to resources and services. She nevertheless wished to take steps herself to improve her family's living conditions and the situation of her children at school.

To discuss the problems the children were encountering, Inès suggested individual weekly meetings. Thérèse accepted. However, she systematically arrived late to these meetings. Although Inès suggested changing the scheduled times, Thérèse declined the offer, saying that she would be more careful in the future. But the situation did not change. Moreover, Thérèse seemed irritable during these meetings. She raised her voice, interrupted, and abruptly contradicted Inès when she suggested support for the children (e.g., tutoring, extracurricular activities).

### SUPPORT CHALLENGES

- Understanding why Thérèse was always late to meetings with the community worker.
- Getting Thérèse to open up about her role as a mother and the changes she has experienced since coming to Quebec.
- Helping Thérèse to open up about her own difficulties.
- Identifying her different sources of stress
- Promoting a support alliance, allowing co-construction, by defining each of their roles.

### SUPPORTING RESILIENCE

- Acknowledge how hard Thérèse works for her family's well-being: "I see how important it is for you that the children integrate well. I feel you do a lot for your family."
- Help Thérèse find activities which can be a source of relaxation, pleasure, or at least expression to promote feelings of well-being.
- Find a support network, such as a group of women, or encourage Thérèse to get involved in neighbourhood activities.
- Approach the possibility of psychotherapy to address more personal difficulties in an appropriate framework.

## FIRST MEETING BETWEEN ESPÉRANCE AND SONIA, SCHOOL SOCIAL WORKER

On Inès' referral, Sonia, a school social worker, met Espérance concerning manifestations of post-traumatic stress. Inès realized that Espérance had possibly suffered sexual violence before coming to Canada. Aware of the sensitivity of the subject, which Sonia approached with delicacy, she first focused on establishing a relationship of trust with the teenager.

In the meeting, Espérance was very polite, answering Sonia's questions and prompting very well, even too well. Sonia sensed a kind of detachment and avoidance in the young woman, a feeling which grew stronger when they discussed school. Espérance adopted a neutral and apparently unemotional tone. She explained that she felt good there and learned interesting things. Sonia saw that Espérance was very interested in dramatic arts, a class in which, according to her teacher, she seemed to excel.

However, Sonia became aware of social withdrawal and detachment behaviours. Sonia tried to pursue the questioning to better understand what Espérance had undergone and which might have repercussions now, notably in her behaviour and relationships. When Espérance focused on the obstacles she might encounter, her responses were brief and she avoided looking at Sonia. She gave the impression of not really being engaged by her interventions. Several times, Sonia found that she was even absent or disconnected. Espérance played in a repetitive way with the sleeves of her jacket and stared at nothing.

As the weekly meetings continued, Espérance relaxed and seemed to open up more. She mentioned that she sometimes had difficulty concentrating in school. In her words, she sometimes felt outside herself and that generally happened when she had to listen to her teacher or answer a question.

### SUPPORT CHALLENGES

- Acknowledging and intervening in a context in which Espérance seems absent.
- Supporting and promoting dialogue with Espérance by normalizing the existence of her moments of absence.
- Identifying Espérance's strengths, talents, and sources of pleasure.

### PROMOTING RESILIENCE

- Give Espérance opportunities to develop her passion for dramatic arts.
- Validate what Espérance is experiencing and help her find words to express what she is feeling during her moments of absence, "How do you feel at that moment?" "Is there an image or a word which comes to mind to describe yourself in those moments?"
- Discuss Espérance's social withdrawal behaviour without judgement and with compassion, "It's a survival strategy which can help to protect us but can unfortunately last, which can cut us off from others when there is no real danger."
- Make sure there is mental health support and refer Espérance to specialized mental health care if necessary.

## FOR MORE INFORMATION

The impact of traumatic stress on the brain is complex. Here are some resources if you want to learn more about it:

**Online Resources**

- Video 1 : *https://bit.ly/IFS-video1*
  Video 2 : *https://bit.ly/IFS-video2*
  Video 3 : *https://bit.ly/IFS-video3*
  Series of three animated videos (in French), developed by the IFS Centre in France, illustrating the impact of stress on the brain. They are based on the approach of Bessel van der Kolk.
- *https://bit.ly/info-trauma*
  Website developed through a collaboration between the Douglas Mental Health University Institute and McGill University, offering case studies of interventions with people who have experienced different traumatic events, as well as training tools for professionals.

**Books**

- *Comment aider les victimes souffrant de stress post-traumatique* by Pascale Brillon (2017)
- *The Body Keeps the Score: Brain, Mind and Body in the Healing of Trauma* by Bessel van der Kolk (2015)

**To learn more about trauma and resilience in children**

- CAMH Guide, *Raising Resilient Children and Youth*: *https://bit.ly/favoriser-resilience*
- National Childhood Traumatic Stress Network website: *https://www.nctsn.org/*

## WRAP-UP

In this second chapter, we saw that experiencing a traumatic event can have significant repercussions on how the brain functions, such as activating survival mode. When our internal alarm system is always activated, even in the absence of real and immediate danger, we are in a state of alert which can very rapidly become extremely exhausting for the body. We also identified certain signs of distress to help you be more attuned to detecting certain post-traumatic reactions. These reactions are individual for each person: they can affect different spheres of life, appear a long time after the traumatic event, and last over time or not. Finally, we discussed positive adaptations after a traumatic experience - resilience and post-traumatic growth - which allow people to rebound and emerge transformed from their traumatic experience. The third chapter will delve into support work; examining the fundamentals of the trauma-informed approach so you can integrate it into your practice.

# CHAPTER 3
# WORKING WITH REFUGEES: THE TRAUMA-INFORMED APPROACH

> « You have to really listen. And to listen, you have to start by shutting up. [...] It takes time with the most traumatized people. Sometimes it's a bit difficult. Once they trust, it comes out. They have lots to say. »
>
> Psychologist

The third chapter of this guide presents trauma-informed practice. This approach recognizes the impact of migration histories and potentially traumatic experiences on the well-being and mental health of refugees, without losing sight of their resilience. In this way, it helps people who have suffered traumatic experiences to take power back, without focusing the intervention on past trauma.

The trauma-informed approach arose from the observation that many people who seek help from service organizations (e.g., for toxicomania, conjugal violence, mental health, etc.) have lived through traumatic experiences [23], [25], even when these experiences are not why they are seeking help.

This approach was developed because of the connection established between traumatic events and incidence of dependency, depression, suicide, and physical illness [56]. At the heart of the trauma-informed approach lies the recognition that trauma is one factor contributing to a person's condition, even if this is not the main reason for the consultation or intervention [23]. Understanding how potentially traumatic experiences can affect people is key to supporting them with empathy (as presented in Chapter 2).

While not yet scientifically supported, due to lack of substantial data, this approach has demonstrated its potential in reducing PTSD symptoms, particularly in young refugees [57], [58]. The International Society for Social Pediatrics and Child Health (ISSOP) likewise views this approach as the best practice to support child refugees [59].

The trauma-informed approach was developed to meet the needs of people who have lived through traumatic experiences, in settings where disclosure prior to intervention is unnecessary. **This approach is a posture or philosophy of intervention which allows a safe context to be established to promote the well-being of the people receiving support.** The trauma-informed approach needs to be distinguished from trauma-focused therapies [23].

## DID YOU KNOW?

**Trauma-focused therapies** are treatments for PTSD. They aim to lighten the emotional burden of intrusive memories and reminders of the traumatic event to reduce psychological distress and improve the person's functioning [60]. This kind of therapy is provided by specialized psychotherapists. We are thinking in particular of cognitive-behavioural therapies, of trauma-focused narrative or integrative therapies. While trauma-focused therapies seem promising, their use with a refugee clientele has not yet been widely studied and there is insufficient research on how the benefits persist over time [61].

**The trauma-informed approach** is not a specific intervention technique or type of psychotherapy. The objective is not to provide treatment for traumatic stress. Practitioners can adopt this approach in diverse settings. Its point of departure is knowledge and awareness of the multiple impacts that a traumatic event can have on a person's life and the potential reactions which may ensue. Because the approach is transversal, it can be adopted by practitioners working at any level of the pyramid of mental health interventions (see Introduction).

## TRAUMA-INFORMED PRACTICE

Trauma-informed practice means paying attention to the reactions manifested in the "here and now" and not the traumatic events themselves.

Refugees often have histories marked by adversity and traumatic experiences of which practitioners are not always aware. The demands of getting set up in the host country as well as the power differential between the refugees receiving support and service providers can recreate dynamics of past traumatic events, events during which the person may have experienced loss of power and control.

Practitioners working with refugees may observe different reactions (hypervigilance, irritability, lack of trust) connected to events in the country of origin which may reoccur in different ways in the host country. Recognizing that these behaviours are potentially reactions to a threat whose effects continue and can be reactivated (e.g., fight, flight or freeze reactions), we understand the need to provide a safe welcome and establish a trauma-informed environment so that refugees receiving support can regain power and control.

The next section explores the importance of these ideas in more depth as well as ways they can be put into practice with refugees.

## TRAUMA-INFORMED INTERVENTIONS

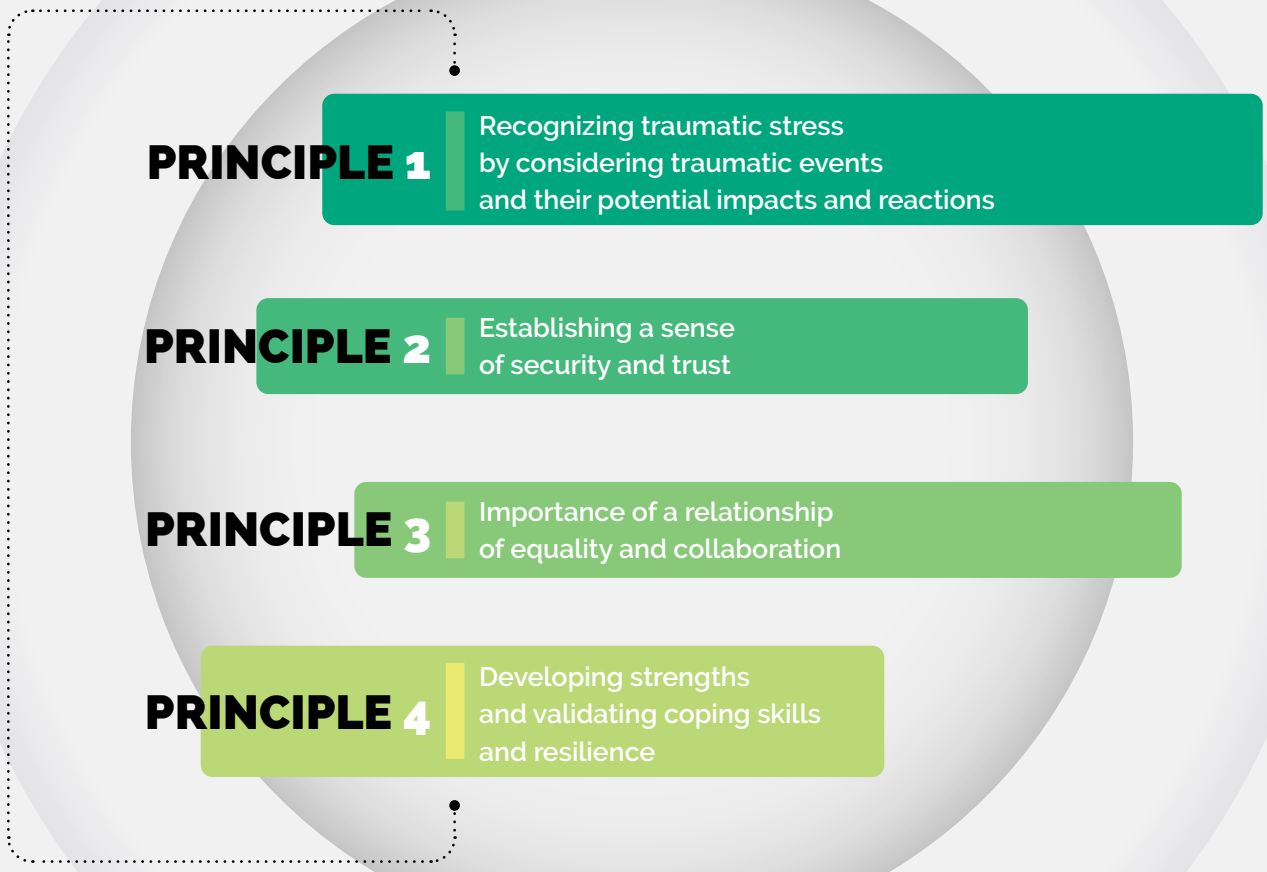
While arrival in the host country was a relief, particularly for the parents, the first year of settling in held its own challenges and reactions for each person. For Thérèse, meeting a new community worker would be accompanied by insecurity and distrust; Jean-Marie's difficulties in finding work would lead to lassitude and sleeping problems; for Espérance, some school contexts would bring on difficulties concentrating and moments of absence. For Léo, a feeling of hunger accompanied his surges of anger. Stressful events in the host country may recall certain aspects of the pre-migration and peri-migration history and reactivate them. These may be moments of the past marked by fear for one's life due to violence, persecution, grief, the impossibility of acting or of meeting basic needs due to a total lack of means.

Having been informed of events the family experienced throughout their migration, practitioners began to realize that these behaviours could be connected to the family's past. Hence the importance of a trauma-informed practice.

# 3.1 FOUR PRINCIPLES OF A TRAUMA-INFORMED APPROACH

## IN A NUTSHELL

A trauma-informed approach recognizes the impact of migration histories and potentially traumatic experiences on the mental health of refugees without focusing the intervention on past traumas. Enabling people who have lived through traumatic experiences to regain control and reappropriate the power to act lies at the heart of this approach.



# PRINCIPLE 1 : RECOGNIZING TRAUMATIC STRESS BY CONSIDERING TRAUMATIC EVENTS AND THEIR POTENTIAL IMPACTS AND REACTIONS

Potentially traumatic events are common in human existence and in the histories of refugees. They affect all spheres of life. The first principle of this approach asserts the importance of practitioners being aware and developing the necessary knowledge to understand the place and effect of trauma in a person's life and possible links between the traumatic experience and physical and mental health issues [23], [25].

## HOW TO PUT THIS PRINCIPLE INTO PRACTICE WHEN WORKING WITH REFUGEES?

1 **Consider the contexts and potentially traumatic events experienced** by the people you are supporting.

- Without necessarily questioning people about it, find out about the adverse events refugees could have undergone in their country of origin or during migration: geopolitical situations, national or international conflicts, wars, violence, political or financial instability, ethnic or religious dimensions of the conflicts, human rights (political freedom, situations of women, children, religious or ethnic minorities, LGBTQI+ people, etc.).
- By following the news or reading about the country of origin or country of transit, you can get information which will help you understand some aspects of the person's migration. Keep in mind that each person's story is different and each experience is unique. It is important not to make assumptions about what the people you are supporting have gone through.
- Think about how the person and their family are experiencing integration into Quebec (experiences with different systems of education, work, health, etc.) and the barriers they are encountering (lack of qualifications and Canadian work experience, family separation, grief, difficulty finding housing, discrimination, racism, etc.).

2 **Learn about reactions and manifestations associated with traumatic stress** so that you can recognize them in interactions with the people you are supporting.

- This knowledge can help you "understand differently." Instead of interpreting or judging certain behaviour as problematic, you can understand it as a strategy developed by the person to cope or survive a traumatic experience.

3 **Learn to recognize certain possible reactions** in the people you are supporting.

- People who have lived through traumatic events may have strong reactions when things remind them of the event or when they are led to talk about it. These reactions fall within a broad range of potential emotions (e.g., anger, fear, sadness), stress and anxiety reactions (e.g., sweating, accelerated speech), or conversely neutrality in affect and behaviour.

Whether during a meeting with a practitioner or in daily life, numerous things can recall the traumatic event. These may be external (e.g., smell, sound, colour, discussion) or internal (e.g., physical sensation). Appearing trivial to another, they can be overwhelming to the person.

It is also important to understand that reactions can be triggered during your interactions with the person by stressors unassociated with the trauma; such as disclosure to a stranger, fear of judgement, or having to speak in a foreign language. It is thus important that the person be able to name what they are experiencing at the time and to ask about their comfort and well-being during the meeting.

## TRAUMA-INFORMED PRACTICE

Distress can be made more acute if the person receiving support is not ready to address certain subjects, if they do not have the necessary tools and resources to withstand being reminded of certain elements associated with a traumatic event, or if a relationship of trust with the practitioner is not yet fully established [49].

The table on the following page provides common examples of potentially stigmatizing language and phrases which are sometimes used with people who have had traumatic experiences. It suggests potential ways of reframing using a trauma-informed perspective [25]. Putting this approach into practice thus requires questioning ourselves, trying to understand what is going on, and considering the possibility that certain manifestations (behaviours, emotions, cognition) presented by people who have experienced trauma may fulfill adaptive functions.

## UNDERSTANDING DIFFERENTLY: SOME EXAMPLES

| INSTEAD OF SEEING A PERSON WHO SEEMS... | TRY TO UNDERSTAND THAT MAYBE THIS PERSON IS... |
|---|---|
| ATTENTION-SEEKING | trying to create a relationship using the resources available to them. |
| TO HAVE A CONTROLLING, EVEN MANIPULATIVE, ATTITUDE IN MEETINGS | trying to regain power after being in a very vulnerable situation or trying to adapt to an environment perceived in the past as very threatening, from which they must protect themselves. This person may also have difficulty formulating requests or expressing needs. |
| NOT TO BE PAYING ATTENTION | having difficulties concentrating or lacking in cognitive availability. |
| TO BE OVERREACTING | manifesting hypervigilance. |
| TO BE BEHAVING INAPPROPRIATELY | using coping strategies that have become dysfunctional. |
| NOT TO BE MAKING AN EFFORT | presenting survival mechanisms which are a source of fatigue and exhaustion. |
| TO HAVE A DIFFICULT AND ANGRY PERSONALITY | experiencing injustice and anger in relation with what they have experienced (the meeting itself or anyone they meet can be the target of this anger). |
| TO EXPRESS NEGATIVITY OR A SELF-CRITICAL DISCOURSE | feeling guilty or that they deserve what happened; this can affect self-esteem and ability to think about the future. |

## PRINCIPLE 2 : ESTABLISHING A SENSE OF SECURITY AND TRUST

People who have had traumatic experiences can be very distrustful of both institutions and individuals. Some may have experienced abuse of power in their interpersonal relations and significant breaches of trust. These experiences can make a person fearful of practitioners, even when the practitioners have compassion and good will [25].

### HOW TO PUT THIS PRINCIPLE INTO PRACTICE?

- When the person comes to your office, make sure that their experience is pleasant and comfortable. For example, welcome them warmly, make toys available in the waiting room for children (if possible and relevant, include material representing children from diverse backgrounds), provide documents in different languages, make people from LGBTQI+ communities feel welcome by displaying the rainbow flag, etc.
- Find out how trustworthy behaviour is demonstrated in the culture of the refugee. Show that the organization or practitioner is trustworthy; that is, respect commitments, avoid cancelling meetings, advocate to ensure the person has access to services they need.
- Ensure free and informed consent: provide complete information about the scope and the limit of services provided. Seek the person's approval for any intervention plan or steps undertaken and take the time to respond to their questions and concerns.

## PRINCIPLE 3 : IMPORTANCE OF A RELATIONSHIP OF EQUALITY AND COLLABORATION

Because of the unpredictable and intense nature of traumatic events, people who go through them feel a strong sense of loss of control. During the intervention, it is important to be careful not to recreate situations in which the person feels obliged or forced as this could recall the traumatic event. Establishing collaborative and egalitarian relationships is essential to providing trauma-informed services so that the refugee can assert themselves in each decision, at every stage of the intervention [25].

### HOW TO PUT THIS PRINCIPLE INTO PRACTICE?

- If possible, decisions about interventions and services provided should be made collaboratively with the person you are supporting.
- Allow the person you are supporting to decide on the rhythm of interventions; let them know they can slow down, take breaks, or stop if necessary.
- Let the person you are supporting know that you believe in them and that you are supporting their efforts to feel better or recover.

# PRINCIPLE 4 : DEVELOPING STRENGTHS AND VALIDATING COPING SKILLS

People who have gone through traumatic stress may have developed strategies allowing them to cope and survive the event. However, some of these strategies may become inappropriate and harmful to the person's well-being once the threat is no longer present. This fourth principle is about identifying and developing the person's strengths to promote resilience and coping skills corresponding to their new reality in the host country. Coping strategies refer to techniques adapted to the needs of the person which help them to gather recuperate in times of stress or refocus when they perceive or become aware of triggers [25].

## HOW TO PUT THIS PRINCIPLE INTO PRACTICE?

### Developing Strengths

- Encourage the person you are supporting to identify their strengths (see sample questions below);
- Acknowledge the person's ability to overcome adversity in daily life and the inner strength they must have exercised to get to where they are today;
- Adopt an intervention style based on the supported person's strengths - this means prioritizing open questions to explore their motivations, strengths, and sources of support, such as:
  - Who supported you?
  - According to your friends, what are your greatest strengths?
  - What motivates you to continue?
  - What are your hopes for the future?
  - What are your interests or passions?
  - What helped you to continue, even when you were not sure you could do it?
  - What do you do to take care of yourself (family, children, etc.)?

### Consolidating Coping Skills

- Once a person's strengths have been identified, explore how they can take up activities centered around those strengths, which help them feel good about life and allow them to recharge in times of stress; e.g., sports, cooking, having coffee with a friend, volunteering in the community, etc.
- For people who have difficulty calming down when they are stressed, you can propose relaxation techniques. These can be tried out as new strategies to cope with stress which promote relaxation, through breathing and centering oneself in the present (see "For More Information" section at the end of this chapter).
- Professional support may be necessary while learning these strategies to help the person you are supporting relax and can have many positive effects, such as alleviating hyperarousal symptoms, better sleep, and regaining control over anxiety. [25].

## TO KEEP IN MIND

### UNDERSTANDING DIFFERENTLY

Trauma-informed practice may require changes to your thinking and language. Behaviour and reactions of people who have had traumatic stress can be misunderstood, misinterpreted, or even stigmatized (identifying what is lacking or wrong with the person rather than adopting a caring attitude). As a practitioner, you are playing a very important role and you can understand trauma responses differently, shifting from "what's wrong with this person" to "what happened to this person" or "what is this person doing to survive a traumatic event." This may be particularly useful when you are having difficulty understanding what is going on with the person you are supporting or when you hit an impasse. You may not know the full story of the person you are supporting; however, working in this way can help shed light on some of the complexity of the situation and allow you to shape your interventions accordingly [12], [25].

## DID YOU KNOW?

What can we do when we realize that someone is in a state of agitation and distress in reaction to something reminding them of a traumatic event they experienced?

- Help them name or reflect the state or emotion observed and validate with an open question, "I sense you are somewhat agitated right now, what's happening to you today?"
- Normalize the person's reactions, "It's normal that you feel emotional, stressed ..."
- Suggest a break, validate the person's rhythm, "We can take a break; go at your own rhythm."

In the following vignettes, we see Natalia, a practitioner working with Léo, and Paolo, a practitioner supporting Jean-Marie, trying to put their new understanding of traumatic stress and a trauma-informed approach into practice.

## MEETING BETWEEN LÉO AND NATALIA, SCHOOL SOCIAL WORKER

On the request of the teacher, Natalia, a school social worker, met Léo. The teacher had observed the following disturbing behaviour in the classroom.

**Observable behaviours**

- Léo binges on snacks offered by a classmate
- Léo gets angry when asked to leave some for the other children
- Léo pushes the other children

**What the teacher knows about Léo's situation**

- Léo grew up in a refugee camp
- Léo just arrived in Canada
- Léo was not in school before coming to Canada

Natalia is also worried about this behaviour. She might have suspected attention deficit hyperactivity disorder (ADHD) but she decided to try to understand Léo differently, through discussions with his parents. She thinks about it and understands...

1 **Scarcity of food in the past**

In the refugee camp, pushing others to get food was a normal, necessary, and highly adaptive means of survival.

2 **... Or in the present**

Léo is motivated by hunger: there is not enough food at home.

3 **Social learning in different contexts**

In the camp, Léo learned that hoarding food was a normal means of survival. Léo's mother gave him a big hug if he came home with extra food.

4 **Difficulties regulating emotions**

Léo was born in a refugee camp and never formally educated. He may have difficulties understanding the norms and expectations of people in the classroom setting, leading to frustration and irritation.

Trying to understand Léo's behaviour from different angles in relation to his migration and his life in the refugee camp, Natalia envisages the following interventions:

**Recognize and understand**

- Verify whether Léo's basic needs are being met (e.g., food security) and intervene accordingly.
- Recognize Léo's triggers (alarms) in order to intervene.
- Help enable Léo to recognize his alarms .

**Establish a feeling of security and bond of trust**

- Make sure Léo understands why he is meeting and talking with Natalia.
- Reassure Léo that he can go at his own rhythm ( e.g., take breaks).
- Establish a relationship of trust with Léo by showing trustworthiness as an adult.
- Discuss with Léo what he experiences (what is going on for him) when it is snack-time in the classroom.

**Consolidate strengths and coping strategies**

- Normalize what Léo is experiencing: his behaviour was important for his survival in the past.
- Teach, practice and model techniques of relaxation and mindfulness Léo can use when he recognizes his alarms.
- Encourage creative activities, allowing Léo to express himself.

Natalia is careful not to neglect Léo's immediate, basic needs in the "here and now." She realizes that there is a risk of not paying attention to current problems if she focuses solely on past trauma.

# MEETING BETWEEN JEAN-MARIE AND PABLO, EMPLOYABILITY OFFICER

Pablo, a service provider who helps with employment, met Jean-Marie, who is currently looking for work. When Jean-Marie was asked about his last work experience, he gave few details. He explained that his boss had decided to terminate his job because of a slow-down. During the meeting, Jean-Marie disclosed a few things which made Pablo believe he was not doing well.

**Observable behaviour**

- Jean-Marie says he is facing discrimination in his job search.
- During the day, Jean-Marie is in the habit of drinking beer and watching a lot of TV.
- Jean-Marie says, "I am ashamed, I can do nothing to support my family. I am no longer a man. I should have stayed in my country with my dead son."

**What Pablo knows about Jean-Marie's situation**

- Jean-Marie lost his job at the beginning of the COVID-19 pandemic.
- Jean-Marie gets Léo at school at 4pm every day and helps him with his home-work when they get home.
- Jean-Marie lost his older son, Jonathan, in the refugee camp.

Pablo is concerned about Jean-Marie, who expresses shame and tends to drink during the day. He recognizes that Jean-Marie is a good father to Léo and Espérance. He observes that Jean-Marie is more talkative when he discusses his children. Before continuing his intervention, Pablo takes the time, through gentle questioning, to understand the behaviour of the father of the family.

**1 Role of provider for the family**

- In the DRC and in the refugee camp, Jean-Marie always worked to meet the needs of his family.
- For Jean-Marie, it is very shameful that his wife is working to support the family financially when he does not have a job.

**2 Guilt relating to the death of his elder son**

- Jean-Marie was at work when his son Jonathan died. He believes that if he had been present, he could have saved his son's life (his son was sick with cholera).
- This thought is keeping Jean-Marie from seeking work more actively. He likes spending time with Léo and Espérance after school; it brings him some comfort. .

**3 Difficulties regulating emotions**

- Jean-Marie has extremely painful intrusive thoughts and memories.
- Jean-Marie uses flight behaviour, drinking alcohol and watching a lot of television (coping strategies).

In light of his new understanding of Jean-Marie's emotional experiences and daily life, Pablo envisages the following trauma-informed interventions:

**Establish a feeling of security and bond of trust**

- Recognize and normalize Jean-Marie's suffering.
- Take the time to establish a relationship of trust with him (acknowledge his determination, motivation, courage in reaching out for support).
- Explore with Jean-Marie the fact that he feels responsible for the death of his son Jonathan, and this influences his shame and guilt, feelings strongly associated with post-traumatic symptoms.
- Explore and work on Jean-Marie's emotions (blame, shame, guilt: identify, express, manage).

**Consolidate strengths and coping strategies**

- Recognize and verbalize Jean-Marie's strengths: this is a father who helps his son do his homework every day, is there when his daughter comes back from school, starts making dinner before his wife gets back from work, etc. (significant family support).
- Explore how Jean-Marie's current coping strategies are working; discuss and teach him new ones (mindfulness, sports, social involvement, etc.).

**Promote regaining control**

- Ask Jean-Marie what jobs he held before coming to Canada and what he would like to do now.
- Work with Jean-Marie to explore his talents, strengths, training and skills.
- Help Jean-Marie find additional or new training depending on his needs.
- Guide him and allow him to carry out his plans with Pablo's support.

# FOR MORE INFORMATION: RELAXATION TECHNIQUES

Many stress management strategies with proven effectiveness can be found in the literature. For example, relaxation techniques are one component of cognitive-behavioural (CBT) interventions which have a certain demonstrated effectiveness with refugees [62]. Relaxation techniques can vary according to the person's needs: taking a walk, listening to music, speaking with a friend, and others forms of relaxation which work with the person's culture [63], [64].

Here are two easy-to-learn techniques which can help people who have experienced traumatic stress calm down in stressful situations. It is important to practice these techniques with the people you are supporting. For example, when you are with a person who is nervous or whose stress level is rising, you can propose trying one of these techniques together.

**Box breathing [65]: this exercise helps counter rapid breathing and calms the nervous system**

- Sitting upright, breath in through the nose for four seconds. Count four seconds slowly in your head. Pay attention to your body while your lungs fill with air.
- Hold your breath for four seconds.
- Breath out through your mouth for four seconds. Pay attention to your body exhaling air from your lungs.
- Hold your breath for four seconds.
- Repeat as necessary.

**5-4-3-2-1. This exercise brings us back to the present moment and allows us to recover a feeling of security [66].**

Count slowly, in your head or out loud:

- Five things you can see (the sun through the window, glass of water on the table)
- Four things you can hear (the air conditioner, passing cars)
- Three things you can feel against your skin (chair you are sitting on, your clothing)
- Two things you can smell (coffee, your shampoo)
- One thing you can taste (toothpaste, what you ate for lunch)

Mindfulness meditation apps may also be useful to people who are comfortable with technology

Calm: *https://www.calm.com/*

# WRAP-UP

In this last chapter, we presented the four principles of a trauma-informed approach. These suggest ways of understanding differently the reactions and symptoms you may perceive in refugees you are supporting.

Before concluding this chapter, we want to highlight that this approach encourages practitioners to return to the basics: raising awareness, training, and encouraging the involvement of the people we are supporting.

These steps are necessary to any type of support work. Whether our mandate is to help the person find housing, support them in their professional integration, or offer support as a psychotherapist, working with refugees puts us in contact with traumatic experiences. We need to be informed, prepared, and aware of our strengths and limits so we can interact in a way which inspires engagement and trust.

To conclude, here are three rules of thumb to practising this approach with refugees:

**UNDERSTAND THE GENERALIZED EFFECTS**
of traumatic stress and ways of building resilience

**RECOGNIZE POTENTIAL REACTIONS AND SYMPTOMS**
caused by traumatic experiences to avoid re-traumatization

**MEET NEEDS**
by putting knowledge of trauma experience into practice

While traumatic experiences are often part of refugee migration and refugees have a clinically higher prevalence of stress-related psychological disorders than the general population, it does not follow that all refugees necessarily suffer from traumatic stress. Even in the case of people who have experienced significant traumatic events, we should not automatically assume these traumatic experiences are associated with mental health disorders. It is important to recognize that refugees, just like anyone else who is exposed to trauma events, often show great resilience despite past adversities.

It is not rare to observe high-level functioning in refugees who show symptoms connected to significant mental health problems. It is essential to keep in mind this broader conception of refugees as unique human beings who have lived through different experiences, have diverse reactions, and often possess impressive assets.

# CONCLUSION

This guide aims to help practitioners working with refugees gain awareness of psychological trauma. It is not an attempt to offer training in specialized mental health knowledge and interventions, but provides basic awareness of traumatic stress and of an informed, accessible and caring posture to all practitioners, whatever their mandate.

We have seen that refugees' migration histories are often marked by potentially traumatic events at all stages of their journey, from departure from the country of origin to arrival in the host country. Because such events may make people vulnerable, being trauma-informed means being aware that they might have experienced trauma, without asking for or insisting on disclosure.

While experiencing trauma eventes can have multiple impacts on mental health, we saw it does not necessarily lead to traumatic stress and can also result in growth and resilience. A trauma-informed posture also allows us to recognize the existence of plural reactions; the person's strengths and their coping skills can serve as levers for interventions.

We saw that numerous spheres can be affected by traumatic stress: physical, cognitive, and even relations to the world, others, and self-image. A trauma-informed outlook is about observing traumatic manifestations when they arise, detecting their triggers, and understanding how they may explain certain behaviour and reactions in refugees. For example, a particular date may lead to a missed appointment or a practitioner's failure to listen may recall a context of domination and provoke withdrawal and a feeling of insecurity. Trauma-informed practice means recognizing these manifestations and being flexible in the ways we understand the barriers people encounter, and adjusting our interventions accordingly.

## SPACES FOR DIALOGUE

Clinical expertise and research results together lend us ways to think about sensitive and appropriate interventions with specific clienteles. Several initiatives offer spaces for reflection to professionals in diverse settings:

- In Quebec, CERDA has developed diverse tools for professionals working with refugees to promote knowledge-transfer, best practices, and co-development of innovative practice (webinars, info-sheets, infographics, comic strips, etc.): *www.cerda.info*.
- In Ontario, CAMH has a project on immigrant and refugee mental health. Their website is full of resources such as courses, webinars, tools, and links a pan-Canadian community of practitioners: *https://bit.ly/sitecamh*.

## IN-DEPTH TOPICS

Pour aller plus loin dans la compréhension de l'approche sensible aux traumatismes, quelques références sont suggérées :

- For more information about the trauma-informed approach, we suggest the following references: Klinic Community Health Centre (2013): Trauma-Informed. The Trauma Toolkit, Second Edition. Available at: *https://trauma-informed.ca/wp-content/uploads/2013/10/Trauma-informed_Toolkit.pdf*
- Arthur, E., Seymour, A., Dartnall, M., Beltgens, P., Poole, N., Smylie, D., North, N., and Schmidt, R. (2013). Trauma-Informed Practice Guide. British Columbia Centre of Excellence for Women's Health; BC Ministry of Health, Mental Health and Substance Use Branch; and Vancouver Island Health Authority, Youth and Family Substance Use Services. Available at: *https://bit.ly/guidetrauma*

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