# Unsettled Minds, Unsettled Landscapes: Migration and Mental Health

UNSETTLED MINDS, UNSETTLED LANDSCAPES:
MIGRATION AND MENTAL HEALTH



A Thesis Presented
By
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ABSTRACT

UNSETTLED MINDS, UNSETTLED LANDSCAPES:

MIGRATION AND MENTAL HEALTH

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International migration has reached an all-time high in 2015 where many global states were not able to keep up with the numbers of people crossing political borders. With many reasons to flee a landscape, both refugees and undocumented immigrants face the continued stressors that are part of the migratory journey, even years after their journey is over. Many who fled during this time frame were escaping war in Syria, while many others were escaping economic devastation, gender violence, and other forms of insecurity all over the world. Evidence has shown that groups who have experienced violent geographies who have been forcibly displaced have higher rates of psychiatric illness than those who were not exposed to these stressful conditions. The effects of toxic stress do not stop once the individual is taken out of the traumatic landscape; it stays within the individual as they continue their life.

This study will discuss additional stressors associated with the migratory experience during and after resettlement. This thesis discusses three groups of actors associated with migration including NGOs, migrating people, and citizens affected by migration. It will discuss personal accounts of refugees and NGOs who have experience

with displacement. This thesis will focus particularly on issues such as mental health and access to health, education, and employment services for displaced populations. This thesis will also discuss indicators of psychiatric illness in displaced populations and present-day solutions to restructure contemporary immigration systems around the world.

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# CHAPTER 1: INTRODUCTION

Movement across the landscape has always been a way of survival for humans and animals alike. However, humans are complex and require assimilation to the modern world with education, socialization, and stable housing. People migrate for many reasons including economic, violence, and insecurity. In recent decades, the number of migrants on the move hit record-breaking numbers. In 2019, there were 272 million international migrants with numbers projected to increase with time. Around one-third of all international migrants originate from only ten countries, which include India, Mexico, China, the Russian Federation, and the Syrian Arab Republic. Of this group, one out of every seven international migrants are below the age of twenty years. This age cohort is equivalent to fourteen percent of the total global migrant population. In other words, forty million youth who are under twenty-years-old currently on the move (UN 2019).

The significant amount of youth participating in migration have already been affected by the conditions they faced and continue to face on their migratory journey. Kolk found that people who have been exposed to trauma or adversity early in their lives are more likely to experience issues with their mental health as they develop. Understanding the stress of the migratory journey is crucial, because of the numbers of children who are the move. This sets the precedent that something must be done to ensure migrating peoples' health and safety.

The idea that landscapes affect mental health has been widely ignored for decades and has recently reentered the literature. According to Kolk, "Trauma as an etiological agent in the genesis of psychopathology was largely ignored from the end of the second world war till after the Vietnam war, forty years later" (Kolk 2001). Concomitantly, research has been increasing on the topic of stress and migration, primarily focused on the psychological effects that remain present even after the individual has been resettled. It is

hypothesized that each individual who has experienced or is experiencing traumatic events will develop post-traumatic stress disorder (PTSD) after reaching a certain threshold of traumatic exposure (Neuner et al. 2004)

Forcibly displaced people have been reported to have higher rates of mental health disorders when compared to the general public or nationals/citizens/residents. Research from the University of Kansas School of Medicine writes, "Rates of mental health disorders, such as anxiety disorders, PTSD and depression were higher among refugee populations in comparison to the general population. This increased vulnerability has been linked to experiences prior to migration, such as war exposure and trauma" (Hameed et al. 2018).

Neuner, *et al.* shed light on the scale of severity of mental health effects carried by forcibly displaced people across the landscape. The study focused on the prevalence of PTSD among groups during the civil war in Southern Sudan. The groups studied include Ugandan nationals/residents who lived a peaceful life not interrupted by war, Sudanese nationals living in the Southern Sudan war region, and Sudanese refugees who have fled to Uganda. The symptoms reported by the groups who experienced or fled the war met the DSM-IV criteria for PTSD. They found that there was a linear correlation of the prevalence of PTSD between the Sudanese nationals (44.6%) and Sudanese refugees (50.5%) who experienced war when compared with the Ugandan residents (23.2%) who lived a peaceful life unaffected by the war (Neuner et al. 2004)

The literature continues to show significant associations between groups who have experienced violent geographies and exhibit symptoms of mental health disorders. A study conducted on the Karenni refugees from the Burmese-Thai border showed their depression and anxiety rates reached forty-two percent. This is higher than the general US rates which stand between 7-10 percent (Vonnahme et al. 2015).

Oslender defines "geographies of trauma" when he discusses landscapes of fear

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in the book *Violent Geographies, Fear, Terror, and Political Violence.* Oslender marks *La Violencia*, a widespread campaign of violence lasting about ten years in Columbia, as a landscape of fear. During this time, massacres were committed regularly by paramilitary groups, marking many spaces in Columbia with the memory of trauma, producing a generalized landscape of fear which has been visible to the public even after the massacre was deemed over in 1958. The presence of the armed groups left a constant, underlying threat to the local population, leading to chronic stress among the villagers (Gregory and Pred 2006, 120).

## 1.1 RESEARCH QUESTIONS

The research conducted for this thesis aims to find the spatial association between wartime violence, forced displacement, and mental illness. This thesis explores the mechanisms of how violent geographies make an individual more susceptible to develop mental health disorders. This thesis hypothesizes that people who experience violent geographies have a higher risk of exhibiting symptoms of mental health disorders including depression, feelings of hopelessness, fear, anxiety, PTSD, a negative outlook on life, a negative view of self, are at higher risk of substance abuse disorders and suicide.

Everyone experiences some degree of trauma such as a car accident or a loud noise startling them. This kind of trauma may leave no lasting effects on the individual. However, the risk of developing a stress related mental illness increases when an individual experiences harm that is either chronic, repeated, or received by a trusted individual or caretaker early in life (Wolynn 2016, 41). Individuals who experience this kind of stress are more likely to exhibit a range of mental health conditions including depression, anxiety, suicidal thoughts, panic attacks, eating disorders and substance abuse during or after the trauma. Geographer Rachel Pain says survivors who take drugs do so as a survival mechanism, not limited to a coping mechanism (Pain et al. 2019, 8).

This insinuates that there is some kind of permanent anxiety left over from the traumatic event.

Ignacio Martín-Baró was a Spanish born Jesuit Priest, scholar, and social psychologist who directed his attention to the mental health effects of trauma through institutionalized violence, especially the pervasive and destructive, impact of the war on children who are now normalizing violence as a way to settle disputes and whose opportunities in life are shrinking. Martín-Baró discusses the association between violent geographies such as genocides and the effect it has on survivors:

> The spectacle of rapes or tortures, of assassinations or mass extinctions, of bombings and the leveling of entire villages is traumatizing almost by definition. As we said earlier, reacting to such events with uncontrollable anxiety or with some form of autism must be considered a normal reaction to abnormal circumstances, perhaps the only way a person can cling to life and withstand such a suffocating knot of social relations (Baró et al. 1996, 117).

When families flee their homes, they must endure deplorable conditions. Many are separated from their families who may be dead, walking at night, or hiding to avoid being massacred for weeks or months on end without food or water. Mothers fleeing war hush the cries of babies and children. Many become weak and die along the way. It is hard to imagine an individual whose psyche is not affected by such conditions (Baró et al. 1996, 117-118).

Addressing the mental health of those who experienced war has only recently been brought to the literature. Philosophers Kierkegaard, Nietzsche, and Heidegger argued that existentialism was the human condition, dating back to the early nineteenth century. Twentieth century psychologists used existential philosophies to address the symptoms

that arose during and after World War Two, beginning the practice of existential therapy where many soldiers spoke of feelings of hopelessness, meaningless, and the devaluation of human existence.

As of the writing of this thesis, the crisis in Syria has entered its tenth year with no sign of resolution in sight. Syrian children are experiencing traumatic events and war-associated daily stresses that are heavily impacting their psychological well-being and development (Perkins et al. 2018). During times of conflict, children are particularly vulnerable to developing mental health disorders. Increasing rates of global migration mean more children are living in informal settlements and camps which unstable conditions can increase immigrant childrens' risk for developing a mental health disorder. This thesis explores the spatial relationship between landscapes and mental health across the migratory journey. Particularly the spatial relationship between traumatic landscapes and mental health disorders in displaced populations who experienced chronic trauma. This research theorizes that trauma can be studied across spatial landscapes, exploring the transmission of traumatic memories across space and time. This thesis aims to investigate how trauma is transmitted across space and time. How does trauma produce landscapes in which migrants find themselves? What do those landscapes look like? Who are the people and organizations that can help mediate this trauma, and how effective are they at accomplishing their mission?

This chapter explores the role that traumatic landscapes; a place that causes harm, has on the mental health of displaced people. This chapter will discuss traumatic landscapes, the normalization of violence, trauma as a spatial and mobile entity, and the health effects of childhood adversity experienced by immigrant populations.

## 1.2 RESEARCH OBJECTIVES

The research objectives of this thesis are to explore the factors associated with

stress among the migratory journey and the level of care available to displaced populations. This research investigates different factors associated with the journey to asylum, to post resettlement. The research analyzes data across disciplines, personal interviews, participatory research experiences, and fieldwork abroad aimed to provide insight on the factors associated with stress along the resettlement process.

## 1.3 LANDSCAPES OF TRAUMA & THE NORMALIZATION OF VIOLENCE

Violence is categorized into four modes including physical, sexual, psychological attack, and deprivation. This thesis explores how the violence due to traumatic landscapes affect the civilians who experience the event. This type of violence is Collective Violence. The World Health Organization (WHO) defines collective violence as violence committed by larger groups of individuals and can be subdivided into social, political and economic violence" (WHO 2020a).

Violence is the unequal power dynamic between two parties. Violence remains consistent across multiple scales whether it occurs within the household, a domestic partnership, or between states and their citizens. WHO further defines violence as, "The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (WHO 2020a).

Trauma perpetuates the cycle of violence. Martín-Baró discusses a relationship wherein, "Mental health and illness are both a part of, and a result of, social relationships" (Baró et al. 1996, 111). He wrote people and society mutually shape each other, "We are social beings subject to social forces. We are psychosocial beings, we are shaped by society. The individual and society are two mutually dependent realities" (Baró et al., 1996, 68). It goes without saying that individuals do not exist without society, nor society without

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individuals.

Furthermore, Martín-Baró asks the questions, how do the marginalized and the permanently unemployed--people who are tied only by chance or a slender thread to the dominant economic order--survive without falling prey to serious mental disorders? Or are we perhaps dealing with entire populations that suffer full-blown pathologies? (Baró et al. 1996, 90).

Landscapes of trauma condition entire populations to normalize violence, or, in other words, the process by which an individual learns politically relevant attitudinal dispositions and behavior patterns (Baró et al. 1996, 74). However, conditioned behavior is not determined behavior. In psychology, there is variation of how trauma is experienced differently among those who experience a similar traumatic landscape. This subsection will discuss the association between traumatic landscapes and normalized violent behavior among displaced populations. Behavior commonly found in regions of the world are not unanimous to all people and may just represent certain subgroups within the population (Baró et al. 1996, 74). A new normal abnormality is consistently under construction for children who endure these conditions, affecting their adulthood relationships and future endeavors. Martín-Baró believed that violent societies normalize violent behaviors which lead to domestic violence, child abuse, violence against women, and juvenile gangs. He educated many on the association of their corrupt governments and the social issues present every day in their communities such as unemployment, racism, erosion of public education, media censorship, and the rise of religious fundamentalism, absolute dedication to a religion or set of beliefs. He uses the social issue of prolonged, mass unemployment as a marker of an oppressed society, "People who endure prolonged joblessness succumb, more often than not, to progressive passivity and the tendency to self-denigration. And that self denigration, together with the deterioration of their material conditions, inexorably produces a deterioration in their mental health"

(Baró et al. 1996, 134).

Martín-Baró hypothesized that war-like conditions affect the psychology of the exposed individual. He writes in *Writings for a Liberation Psychology*:

> Recently I advanced the hypothesis that situations like war zones, where the climate of polarized tension is experienced with greatest intensity, are a particularly favorable culture medium for psychosomatic disorders. Somatization would indicate that the social polarization had taken root in the body and would be a sign that the person is incapable of handling the stressful situation. This kind of internalized polarization can occasionally lead to autism in children and to problems of a clearly psychotic or schizophrenic character in young people (Baró et al. 1996, 134).

Martín-Baró had his inclinations as to what the cause of some mental illnesses are. However, it is still unclear in the medical community what the cause of autism and schizophrenia are the result of. He discusses when something is not "right" in the individual's landscape, it can have an effect on the body and mind and lead to several different illnesses, both psychological and physiological. These polarized environments can affect even those who hold resilient factors such as strong family connections and emotional support. Chapter 3 will further discuss the effect traumatic landscapes have on society.

## 1.4 TRAUMA AS A MOBILE ENTITY ACROSS THE LANDSCAPE

Coddington and Micieli-Voutsinas believe trauma is spatially present and has the ability to move across the landscape, "Trauma's mobility across spaces, places, and times is central to understanding its relevance to emotional geographies" (Coddington and

Voutsinas 2017, 4). They deploy the term traumatic landscapes, also commonly referred to as landscapes of conflict or violent geographies, as including any environment that increases one's stress response. Coddington and Micieli-Voutsinas posit trauma as something that can be studied on a spatial scale that can move across global scales:

> Framing trauma through its location elsewhere allows for the conception of its movement across places, spaces, and times, and recognizes how it is relationally experienced across scales, bodies, and emotions. Reverberating outwards like aftershocks, trauma has a productively complex relationship to space (Coddington and Voutsinas 2017, 4).

Traumatic landscapes may exacerbate stress, which causes displaced individuals to become vulnerable to experiencing stress related illnesses. Traumatic landscapes can take a toll on physical health and mental health. Surgeon General of California, Nadine Burke Harris describes how this toxic stress affects the human body:

> The amygdala, the brain's fear response activates the fear center and causes the release of stress hormones in our bodies, and they serve an important purpose. They increase our heart rate and how strong our heart beats, it opens out airways and dilates our pupils. It raises our blood pressure and our blood sugar so that we are ready to either fight that bear or run from that bear. But if this process is repeated over and over and over again, without that nurturing, buffering caregiver, then it becomes overactive and can damage children's developing brains, their immune systems, their hormonal systems, and even the way their dna is read and transcribed" (Harris 2019a, 1:46).

## 1.5 TOXIC STRESS, HEALTH DISORDERS, & EARLY DEATH

The Center on the Developing Child at Harvard University defines toxic stress as experiencing strong, frequent, and/or prolonged adversity—such as physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship—without adequate adult support. This kind of prolonged activation of the stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into the adult years. Harris defines toxic stress, "Toxic stress is a health condition like diabetes or asthma. It's the over activity of the stress response. It responds to adversity without adequate buffering, and that leads to those long-term changes" (Harris 2019a, 0:13).

Toxic stress can come from being exposed to traumatic landscapes, which is any environment that is deemed unsafe to live in and can cause physical or psychological health decline. Historical examples of traumatic landscapes include the Great Famine of the mid 1800's in Ireland where one million people died and many others emigrated. The Holocaust occuring in the 1940's is another example where eleven million people were killed by the Nazi's, six million of this number being Jews. Or the Armenian Genocide in the early 1900's where 1.5 million Armenians were exterminated by the Ottoman Empire.

There has been an increasing amount of literature on the relationship between childhood adversity and mental health disorders. According to Pain:

There are generally considered to be three broad forms of trauma: *acute* (or simple) trauma is a response to a one-off experience such as a car accident. *chronic t*rauma is typically caused by prolonged experiences of harm which are repeated and/or multiple. *complex* trauma also arises from prolonged harm, and is usually considered to involve specific elements including betrayal and harm from

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a caregiver early in life (Pain et al. 2019, 4).

Research has consistently shown the effect stress has on childhood development, "Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and brain" (Harvard 2021). In this sense, toxic stress is defined by the prolonged activation of the stress response, affecting both the brain and body:

The constant activation of the body's stress response systems due to chronic or traumatic experiences in the absence of caring, stable relationships with adults, especially during sensitive periods of early development, can be toxic to brain architecture and other developing organ systems (Harvard 2021).

Harris explains the effect adversity has on children, "What happens when kids are experiencing very high levels of stress or adversity is that their bodies release stress hormones and these stress hormones can have an impact on the children's developing brains and bodies" (Harris 2019a, 1:29). The more adverse childhood experiences a child faces, the more negative health effects the child will face as they grow older, "One in four Americans have experienced four or more adverse childhood experiences. That is adversity that is significant enough to double the risk for heart disease, double the risk for stroke, and triple the risk for chronic lung disease, and dramatically increase lifelong health problems" (Harris 2019a, 3:34).

Harris further describes how severe toxic stress affects young children, "Severe, intense or prolonged adversity may lead to overactivity of a child's stress response. In addition, children require the nurturing care of a trusted adult and safe environments to shut off the stress response and restore normal functioning. Without these buffers, the

biological stress response becomes overactive. Children are uniquely vulnerable to the effects of an overactive stress response because their brains and bodies are just developing" (Harris 2019b).

She studies the long-term health effects of childhood adversity using a questionnaire called the Adverse Childhood Experiences (ACE) Questionnaire which is a series of ten questions asking for the participant to answer questions based on if they experienced certain adverse experiences during their first 18 years of life. The questionnaire asks questions regarding physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. The questionnaire is presented in a "circle yes or no" format and displays questions such as "Did a parent or other adult in the household often … Push, grab, slap, or throw something at you? Were you ever hit so hard that you had marks or were injured? Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? Was a household member depressed or mentally ill or did a household member attempt suicide? Did a household member go to prison?" (The Anna Institute 2020). Every time the participant answers yes to any of these questions, they receive one point. If interested in viewing the ACE Questionnaire, see the attachment at the end of this thesis.

Furthermore, the ACE pyramid is a diagram that shows the internal and long term struggles that people who are exposed to trauma face regularly. This thesis has discussed the effects early conflict has in displaced populations, including generational trauma, neurodevelopmental impact, disability, and early death. While adversity affects all displaced people, children are often the most at risk of being affected. Figure 1, the ACE pyramid below shows the effect of adversity on the human population:

Mechanism by which Adverse Childhood Experiences
Influence Health and Well-being Throughout the Lifespan

**Figure 1** The ACE Pyramid. ACEs are strongly related to development of risk factors for disease, and well-being throughout the life course (CDC 2020).

The ACE pyramid shows that generational embodiment and historical trauma are factors contributing to disease, a topic that will be further discussed in Chapter four regarding Jacobs' theory of generational trauma transmitted from family member to family member by situational episodes (Jacobs 2016). These situational episodes carry their own kind of trauma, having the power to spread from parent, to children, to grandchildren. Moving up the ACE pyramid, Chapter four also discussed the disrupted neurodevelopment and cognitive impairment of populations who had experienced a non-emotionally validating environment or were exposed to violent geographies, both events severely impacting psychological functioning. The pyramid further expresses the effects of adversity that may lead to lifelong illnesses, relationship issues, and early death (CDC 2020).

High doses of adversity in childhood are associated with increased risk of

respiratory infections, asthma, atopic diseases, poor growth, obesity, learning and attention disorders, sleep disorders, eating disorders, teen pregnancy, teen paternity, STIs, mental health disorders, substance use and high-risk behaviors, anxiety, cardiovascular disease, diabetes, and depression in adulthood (Harris 2019c).

John Hopkins Bloomberg School of Public Health and the Data Resource Center for Child and Adolescent Health reports that "Having an ACE score of 4 increases a person's risk of emphysema or chronic bronchitis by 400 percent and suicide by 1200 percent" (Johns Hopkins 2019). A child with 4 or more ACEs are twice as likely to develop asthma as children with no ACEs. Displaced populations face additional stressors even after they escape conflict and are resettled in a new landscape. Figure 2 below represents the ratio of deaths associated with four or more ACEs.



**Figure 2** All Odds Ratio Except. (Hughes Et Al, 2017) (Felitti Et Al, 1998) (Harris 2019b)**.**

Toxic stress is experienced by many displaced families as a result of continuous stress prolonged by war, conflict, violence, or oppression. ACEs are associated with an increased risk of premature death. In a study conducted by Brown et al., found ACEs are associated with a premature death, "Individuals with six or more ACEs died nearly [twenty-

years] earlier on average than those without ACEs" (Brown et al. 2009). Premature death was nearly three times greater among people with six or more ACEs by losing an average of 25.2 years to their lives than those without ACEs.

Displaced populations are especially susceptible to experiencing adversities, "Refugees and migrants are especially likely to inhabit environments of syndemic vulnerability-environments in which upstream social, economic, political, and structural determinants put certain people at risk of concurrent and deleteriously interacting forms of health adversity" (Willen 2017).

Many immigrant children are likely to experience multiple adversities among their migratory journey. The American Academy of Pediatrics strongly warned that our government should take precautions in order to reduce the amount of trauma experienced by children, "Eliminate exposure to conditions or settings that may retraumatize children, such as those that currently exist in detention, or detention itself" (Harris 2019c).

The younger the children are when adversity happens to them, the greater the risk to their long-term health and development. Harris explains that adversity can happen to anyone whether a refugee who has fled conflict, or a child who grows up in a home of domestic violence, "What we're seeing with these migrant kids, what they're at risk for, and what they are experiencing right now is an identical biological process to what we've been seeing in kids and families who are growing up right here in the United States" (Harris 2019a, 2:42).

Implementing child safety policies is easier said than done in refugee camps. There is not enough international political will and support to address the conditions refugees face while moving across the landscape. Onto its ninth year, the Syrian conflict continues to traumatize children with war associated threats daily that are heavily impacting their psychological well-being and development (Perkins et al. 2018).

There is still much work to be done to understand the mechanisms of toxic stress

pathways. However, three methods have been suggested which include early detection, early intervention, and safe, stable, and nurturing relationships and environments to help the individual recover and rebuild from the trauma (Harris 2019b). Harris believes with more research, there will be effective treatment for those who have faced high amount of adversity, "The science of toxic stress I believe represents incredible hope for us to be able to interrupt these biological processes and to be able to help to heal the brains and bodies of children who have been exposed to high doses of adversity" (Harris 2019a, 4:51).

## 1.6 MASTER THESIS OUTLINE

Chapter 2 will discuss the methodologies used to conduct the qualitative field work for this research. It will also discuss the key contacts and organizations met with, places of interest, where the interviews took place, discuss why certain methodologies were used, other geographers and spatial researchers who use similar methodologies and techniques, and my own personal work in resettlement in the community.

Chapter 3 discusses the psychological effect that war has on society, specifically how traumatic landscapes affect exposed populations. This chapter will present traumatic events associated with mental health effects on people. Chapter 3 will show examples of displaced people exposed to traumatic landscapes who carry lasting effects of trauma such as a young peasant farmer known as a campesino. The association between psychosis in displaced populations will be discussed further. Other subsections explored include the normalization of violence, diagnostic errors in the field of mental health due to cultural bias and a general mistrust of the *white psychologist*, and the transmission of trauma through family systems.

Chapter 4 explores the transmission of trauma across the landscape and makes a case for trauma being a contagious disease. This chapter describes ways in which trauma

can spread across family systems also known as Transgenerational or Intergenerational trauma. Chapter 4 will also discuss the neurobiological effects that trauma has on the individual.

Chapter 5 presents main challenges associated with the resettlement process. Main challenges were voted on by key contacts that were interviewed for this research, along with testimonies from refugees. Some of the main challenges include children fearing being deported to their origin country when they turn eighteen, temporary housing and constantly moving around, uncertainty and anxiety of the future, no opportunity which leads to more working in the unregulated informal economic sector.

Chapter 6 discusses services of care available to refugees while they are in a camp or are resettled in a new host country. Services that will be compared include healthcare, language classes, social integration, and level of community support.

Chapter 7 includes the discussion and conclusion section of the thesis. This chapter discusses current immigration policy and suggestions for more humane services available to asylum seekers. Services discussed in this chapter include access to clean water, the right to nutrition, safe housing, education, and healthcare. This chapter will also discuss the significance of community integration in the wellbeing of refugees' mental health, resilience initiatives, and suggestions for successful resettlement.

# CHAPTER 2: RESEARCH METHODOLOGIES

The research goals of this thesis aim to see if there is a consistent relationship between experiencing traumatic landscapes during a prolonged period of one's life, and an increased risk of developing a mental health disorder into adulthood. To understand this assertion in more detail, many interviews with NGOs (Non-Governmental Organizations) and migrating people have been completed in major cities around the world. Some of these cities include Stockholm, Frankfurt, Ljubljana, and Amherst, MA.

The research in this thesis compares the systems of care available to displaced people including the accessibility of mental health services, education, and employment. The research will analyze different major cities' structural immigration policy and humane systems of care available for immigrants. Seeking out to understand the conditions of the migratory journey faced by millions can help communities and policymakers make informed decisions when reforming foreign immigration policy, in turn, saving thousands of people and improving millions of lives. Creating safer borders and improving communication and relationships between countries' peace policies can act as a structural model that can influence other changes in the social framework of human wellbeing.

## 2.1 SEMI-STRUCTURED INTERVIEWS

In this thesis, personal semi-structured interviews, snowball sampling, narrative storytelling, and participatory action were methodologies used when speaking with key contacts and field collaborators. I chose to meet with individuals who work or have experienced displacement and migration. Using a semi-structured approach has provided an atmosphere with direction, while also leaving the discussion open for the interviewee's interpretation and analysis along with any additional comments, clarification, or additional context they may have.

Geographer Kate Coddington uses semi-structured interviews and snowball

sampling when interviewing policymakers, scholars, and NGOs regarding migration policy. The Thai government allowed Coddington to receive a research visa, but it did not allow her to work directly with displaced people. Coddington describes her methodology:

> Over 30 semi-structured interviews with individuals including Thai immigration policymakers, members of Thai and international migration NGOs and scholars studying regional migration issues (in English) focused on the Thai and regional landscapes of refugee protection. I was restricted to interviewing members of NGOs (mostly non-Thai) and policymakers (mostly Thai) by the terms of my agreement with the Thai government as part of receiving a research visa, which forbade me working directly with migrants or refugees themselves. Partnering with the Asian Research Centre for Migration at Chulalongkorn University allowed initial access to several interviewees, and I broadened the network of participants, both through personal connections as well as the snowball method (Coddington 2018).

Aside from using semi-structured interviewing, Coddington commonly uses snowball sampling as part of her research methodology. The subsection below will further discuss snowball sampling.

## 2.2 SNOWBALL SAMPLING

Snowball sampling was used as a supplemental methodology approach (Hay et al. 2016, 150-8) in this thesis. Snowball sampling has been shown to be useful when conducting research in the social sciences. With this technique, the key contact will refer other professionals or organizations with similar research goals to the principal investigator (PI). Snowball sampling is meant to "snowball" into a larger sample size through the course of the research. Snowball sampling is appropriate to use when

searching for a relatively difficult or small population to find, an example being NGOs who work with caring for asylum seekers, undocumented immigrants, LGBTQ, and other marginalized, invisible groups.

Crossman supports snowball sampling as an effective methodology to gain access to niche populations, "It is a very good technique for conducting exploratory research and/or qualitative research with a specific and relatively small population that is hard to identify or locate" (Crossman 2019). Crossman continues:

> If you identify one or two homeless individuals who are willing to participate in your study, they will almost certainly know other homeless individuals in their area and can help you locate them. Those individuals will know other individuals, and so on. The same strategy works for underground subcultures or any population where the individuals prefer to keep their identity hidden, such as undocumented immigrants or ex-convicts (Crossman 2019).

For this method to work, a certain level of trust must be earned, "For participants to agree to identify other members of their group or subculture, the researcher needs first to develop a rapport and a reputation for trustworthiness. This can take some time, so one must be patient when using the snowball sampling technique on reluctant groups of people" (Crossman 2019). Qualitative research methods rely heavily on trust among the principal investigator and key contact. Trust takes time and should never be forced. Trust among key contacts is crucial for credible information, leads on other field sites and collaborators, and for the opportunity for follow up interviews if needed.

Roselinde Den Boer used snowball sampling regularly in her work. She used this technique to identify twenty-seven Congolese refugees whom she met and conducted interviews with:

I largely relied on snowball sampling techniques to identify [twenty-seven] officially registered protracted Congolese refugees, habitually resident outside Congo for at least five years. I contacted my first informants through refugee organizations including Refugee Law Project (RLP), HIAS and Bondeko Refugee Centre. In turn, they introduced me to their families, neighbors, friends, and acquaintances (Den Boer 2015)

## 2.3 NARRATIVE INQUIRY & STORYTELLING

The third methodology in this thesis is Narrative Storytelling which was used when speaking directly with those involved in the migratory journey. The Narrative Storytelling methodology is similar to the Narrative Inquiry approach Dr. Janet Jacobs uses when she describes the transmission of trauma across generations in her book *The Holocaust Across Generations.* Jacobs is a sociologist at the University of Colorado Boulder. She has been teaching and writing for decades on social psychology, women, religion, ethnicity, and genocide.

All of Jacob's human focused research specialties have benefitted from using narrative inquiry as a methodology. Narrative inquiry often works by the oral transmission of stories including but not limited to the immediate family of the survivor, "These narratives were recounted in diverse social settings that included the postwar household, family gatherings, family trips, holiday celebrations, and trips to prewar homes and Holocaust memorials and museums" (Jacobs 2016, 16).

Descendants of trauma survivors can be affected by the oral transmission of trauma by triggering a certain kind of PTSD within themselves associated with the narratives vocalized by their families. In many families, stories are ongoing and repeated throughout descendants' lives, affecting their memory frames that shape perception and

self-identity (Jacobs 2016, 17). Jacobs describes how the narratives affect descendants, "The narratives are experienced by the descendants as intrusions into the present, bringing the survivors, their children, and grandchildren back to a past that is shared through trauma-based narrativity" (Jacobs 2016, 16).

Descendants of trauma survivors share a common place where a traumatic landscape had originated from, creating a shared collective consciousness of the traumatic event that spans across a timeline and across generations:

Through the interweaving of memory with historical events, the narratives of survivors provided a sense of time, place, and lived experience that became part of the knowledge and feelings-states of the descendants. According to the respondents, the survivors' accounts that included descriptions of life in captivity; the living conditions of escape and imprisonment; the witnessing of other's victimization; and accounts of deportation, incarceration, and loss (Jacobs 2016, 16).

Narrative Inquiry/Storytelling as a qualitative research methodology is an underrated research approach in Human Geography. The wealth of data acquired through narrative inquiry is invaluable to the human experience. This method was especially useful when communicating with my key contacts who experienced displacement personally and shared stories from their perspective of the migratory journey. The Narrative Storytelling approach was easily chosen to use as a methodology when speaking with key contacts during the fieldwork process because of the raw nature of the accounts that can only be obtained through the person who has experienced the traumatic landscape.

This thesis has benefitted from narrative inquiry as it shares the storyteller's identity, perspective, and emotions when sharing their story. Narrative can come in the

form of oral testimony, reenactment, triggers, memory, or nightmares. Narrative also shows where this individual stands in society and how their culture influences the tone they use when sharing their story. Whether it be a story of loss, a story of hope, or a story of satire, it is completely up to the narrator to choose which lens they choose when they share their story.

## 2.4 PARTICIPATORY ACTION

The fourth and final methodology used in this thesis was participatory action. This methodology was used when I interned with the organization Catholic Charities. Catholic Charities acts as a refugee resettlement organization run and funded by the Diocese of Springfield, Massachusetts and volunteers in the Pioneer Valley.

While interning for this organization, I helped with various tasks such as caring for children while parents are at their language course, teaching various levels of ESOL to arriving refugees, planned the annual organization celebration, obtained internships for UMass students, and helped teach job skills and interviewing workshops for refugees who were preparing to enter the workforce. I selected the use of participatory action as a methodology based on the active experience I obtained from being part of a community resettlement organization for over two years. Chapter 6 provides further detail of my time with the resettlement agency. Table 1 below shows participants who in some way, shape, or form are associated with resettlement that I met with for this thesis:

**Table 1** Table of Interviewees who participated in field work for this thesis.

| Interviewee | Role | NGO | Method | Location |
|---|---|---|---|---|
| *Yasser* | Syrian Refugee | Personal Reference | Personal Interview, Snowball sampling 2019 | Ljubljana, Slovenia |
| *Sara* | Mental Health Staff | Röda Korsets Center för Torterade Flyktingar, or the Swedish Red Cross Centre for Tortured Refugees | Personal Interview 2018 | Stockholm, Sweden |
| *Ken* | Research and Data | Röda Korsets Center för Torterade Flyktingar, or the Swedish Red Cross Centre for Tortured Refugees | Personal Interview 2018 | Stockholm, Sweden |
| *Erikkson* | Lawyer | Rådgivningsbyrån or Swedish Refugee Advice Center | Skype Interview 2018 | Stockholm, Sweden |
| *Irene* | Director at US Resettlement Agency | Prefers Anonymity | Personal Interview 2018 | Springfield, Ma |
| *Emilia* | Transitional Camp Counselor for young refugee boys | Camp Mondschein Named after the moon's light | Personal Interview 2018 | Frankfurt, Germany |
| *Mendi* | Born in Morocco, moved to Spain. Identifies as Moroccan and as a Spaniard | Clinical Pathologist in a hospital | Personal Interview 2018 | Stockholm, Sweden |
| *Lena* | Swedish Citizen | Student, church volunteer who babysits refugee children | Personal Interview 2018 | Stockholm, Sweden |
| *Sergio* | Mexican Citizen | Airplane Parts Engineer | Personal Interview 2018 | Stockholm, Sweden |
| *Timo* | Swedish Citizen | Language instructor for refugees, teaches over 400 students at once | Personal Interview 2018 | Stockholm, Sweden |
| *Suad* | Staff at Migrationalsverket (Sverige) aka Swedish Migration Agency | Staff at Swedish Migration | Email Interview 2018 | Norrköping, Sweden |

Meetings with interviewees typically occurred in the individual's office where there is privacy and a sound machine. Other common places used for meetings include cafes, outdoor patios, parks, Skype, emails, empty classrooms, and the work office. Fieldwork

began early 2018 and continued into 2019 and the beginning of 2020. Fieldwork sites include Stockholm, Frankfurt, Ljubljana, and cities and towns in western Massachusetts such as Northampton and Amherst. Personal interviews mostly took place in Stockholm, Sweden, while participatory action took place in Massachusetts. A comparative analysis was completed on the cities where fieldwork took place regarding the level of care available for arriving migrants based on the initiatives the city has in place for displaced people.

Materials used while conducting fieldwork included a voice recorder, which required signed written consent from key contacts before recording meetings. A field notebook was taken to field sites to record data, observations, and information to help meet research goals. Consent forms and brief summaries of the research goals were written up and given to key contacts for a deeper understanding of the work.

Organizations and key contacts were chosen by their prominence in the literature and credibility in their departments. With help from these key contacts and organizations, the association between traumatic landscapes and mental health can better be understood and policies can be implemented to help care for people who are living in stateless communities, informal settlements, and refugee camps.

Immigration policy has long been overdue for reform that addresses the mental health of the millions of people involved in international migration. The methodologies used in this thesis help explore the mental health effects that displacement has on moving populations. This research hopes to support the notion that all people have the right to access basic services of care such as healthcare, education, nutrition, and shelter in order to rebuild their life after tragedy. Reforming the immigration system on a global scale can have a significant effect on millions of families, changing the future of foreign immigration policy. Chapter 3 will discuss the psychological effect war has on society.

**CHAPTER 3: THE PSYCHOLOGICAL EFFECT WAR HAS ON SOCIETY**

3.1 THE RELATIONSHIP BETWEEN FORCED DISPLACEMENT & MENTAL HEALTH DISORDERS

Violent geographies come in many different forms and leave lasting effects on more than just those who are exposed to the landscape. People who are exposed to conditions of conflict for an extended period of time are likely to experience symptoms of mental health disorders. This cycle is similar to an individual who is stuck in a relationship where domestic violence occurs regularly, causing the partner(s) to experience repeated, chronic trauma. Geographer Rachel Pain describes how continuous trauma may leave individuals with long-term mental health symptoms, "Ongoing abuse creates fear and leads to a state of constant alertness (hypervigilance), and so feelings reverberate in a similar way to when the survivor lived with the abuser" (Pain et al. 2019, 9). Displaced individuals who experience violent geographies are likely to be experiencing this same chronic cycle of conflict and fear.

The Center on the Developing Child at Harvard University supports the assertion that unstable landscapes can cause long term mental health effects in adulthood:

There is ample evidence that chaotic or unstable circumstances, such as placing children in a succession of foster homes or displacement due to economic instability or a natural disaster, can result in a sustained, extreme activation of the stress response system. Stable, loving relationships can buffer against harmful effects by restoring stress response systems to 'steady state.' When the stressors are severe and long-lasting and adult relationships are unresponsive or inconsistent, it's important for families, friends, and communities to intervene with support, services, and programs that address the source of the stress and the lack

of stabilizing relationships in order to protect the child from their damaging effects (Harvard University 2021).

Repeated studies, including Pain's and Harvard's Center on the Developing Child's, have shown a pattern that these unstable landscapes can severely impact psychological functioning. Early intervention along with supportive relationships and services are essential in preventing the severity of mental health disorders in these populations.

Those who have experienced traumatic landscapes may react to threats differently than those who experienced little to no adversities in their childhood. Some may be mistrustful and hypervigilant, while others perceive threats as normal, everyday occurrences. Psychotherapist Terri J. Haven describes how violence can be normalized and can lead to destructive lifestyles:

> One of two classic ways are found when perceiving a situation. 1. An individual who has been affected by trauma will either remain hypervigilant and detect a threat early in its occurrence, or, 2. see an oncoming threat as a non-threatening event since the individual has 'normalized' potential hazards, seeing these potential threats as a normal part of life even when the hazard may be considered a severe risk to their survival.

In this way, the individual normalizes threatening behavior. In some cases, having an increased emotional tolerance is a survival adaptation and can help one remain calm in a high-stress environment. However, when an individual normalizes threatening behavior, they are at an increased risk of being involved in a threatening relationship, workspace, and home life (Haven 2018).

Geographers Coddington and Micieli-Voutsinas both write about how trauma is normalized in today's society and shapes people, places, emotions, and other aspects of their lives, "What we call 'trauma' is really just a condition of everyday, modern life. In other words, trauma has become—has been—the norm" (Coddington, & Micieli-Voutsinas 2017, 3). Normalizing violence means we fail to see when a behavior is destructive, and we may take part in this behavior ourselves, potentially becoming the abuser.

People who experience violent geographies have a higher risk of exhibiting symptoms of mental health disorders including depression, feelings of hopelessness, fear, anxiety, PTSD, a negative outlook on life, a negative view of self, and are at higher risk of developing substance abuse disorders. Chapter 1 discussed the normalization of violence across the landscape and introduced the idea that violent geographies affect survivors' mental health and increase the risk of developing a mental health disorder. Chapter 2 discussed the methodologies used to perform the research in this thesis. This chapter will analyze some of the work of theoretical influence Ignacio Martín-Baró, and make it relevant to my own research. This chapter will provide evidence that traumatic landscapes can have a significant effect on the mental wellbeing of displaced people.

## 3.2 SYMPTOMATOLOGY OF TRAUMA

Many people who are displaced by war often experience a lost loved one or have witnessed violent attacks. Those who have experienced frequent and severe violence are more likely to suffer from PTSD and other related mental health disorders as discussed above. Children are especially at risk for developing a mental illness because their brains are in the process of developing and they are still learning coping mechanisms. With limited coping mechanisms, one is at risk of exhibiting dissociation, aggression, learning disorders, speech impediments, developmental delays, low self-esteem, substance use disorders, anxiety, depression, and PTSD (Harris 2019b). If the conditions continue, the

child is at risk for having permanent psychological damage into their adult development.

Mental health disorders exhibit a variety of different symptoms and behaviors among individuals. Martín-Baró describes symptoms of mental health issues in children as night terrors, deterioration of the ability to concentrate, regressive behavior, and irritability. He also believes that these symptoms can appear as schizophrenia:

> The prolongation of traumatogenic experiences frequently causes children to seek a psychic flight into fantasy. In some cases, these flights lead to the development of schizoid syndromes of varying severity, which permit the children to escape from a reality they are unable to handle (Baró et al. 1996, 126-7).

When referring to schizoid symptoms, Baró is referring to any behavior that emulates a reality that does not perfectly line up with what is present in the current reality, these behaviors can sometimes be found on the schizophrenia spectrum. These themes also reflect Escape Theory, a belief that refers to the tendency for people to engage in behaviors to avoid an unpleasant psychological reaction, often fleeing into fantasy or alternative mind spaces.

Baró describes the term *Emotional Responsiveness* as a common symptom exhibited by traumatized children in the form of strong emotional responses such as screaming, crying, and terror. These behaviors are coping mechanisms children often exhibit when they do not have access to mental health treatment. Trauma affected children also characteristically develop a relatively stable pattern of emotional insensitivity where the excessive emotional cost of their experiences causes a defensive desensitization which makes them appear cold, insensitive, and even lacking in emotion in their daily lives (Baró et al. 1996, 126). This unstable emotional pattern into adulthood would meet the characteristics for a Borderline Personality Disorder (BPD) diagnosis further discussed in

Chapter 4. Emotional responsiveness can lead a child into a withdrawn state and can have an effect of the quality of their social relationships even into adulthood. A concept that will be further discussed in Chapter 4.

## 3.3 SCHIZOPHRENIA IN DISPLACED POPULATIONS

The majority of people in the world lack a general understanding of basic psychological sciences. Schwartz and Blankenship, researchers in the field of mental health define how mental disorders should be categorized, "By maladaptive patterns of clinically significant disturbances in an individual's cognitions, psychological or emotional states, or behaviors resulting in prominent distress or disability in social, occupational or other important areas of functioning" (Schwartz and Blankenship 2014, 134). This would include symptoms or behaviors that limit an individual from taking care of themselves or their dependents, limit the individual's ability to work and provide, keep up with relationships and daily tasks such as housekeeping, hygiene, appearance, food preparation, bills, and other related daily tasks.

Many people who are forcibly displaced by conflict experience psychic trauma. It is important to have mental health services available to those who have experienced conflict among their migratory journey. Sweden has a model policy for treating refugees who have been affected by conflict. During my fieldwork in May 2018, I met with Sara, a mental health worker from the Swedish Red Cross for Tortured Refugees (IFRC) or the Svenska Röda Korset in Stockholm. The organization provides individualized services for refugees and undocumented people who have experienced torture or migratory related trauma. The clinic regularly treats symptoms associated with trauma that include severe dissociation, suicidal ideation, depression, anxiety disorders, and related illnesses.

When meeting with Sara, the current accepted mainstream treatment for

individuals with who experienced conflict or display symptoms of PTSD was dialectical behavioral therapy (DBT). DBT is a form of cognitive behavioral therapy (CBT) assisted by a provider. Eye movement desensitization and reprocessing (EMDR) is another trauma treatment that is used in the clinic, along with regularly meeting with a psychiatrist. Other forms of treatment that the Swedish Red Cross offers include group therapy, movement yoga, and art and wilderness therapy has also shown to help with PTSD. However, these mainstream approaches are often unsuccessful and unused when the individual is severely affected by trauma. Sara explains the first step at the clinic is stabilization before treatment, "There is no point in trying to push treatment when the individual is unstable. This is sometimes why it takes a long time for clients to be stabilized" (Sara 2018). Sara tries to help her clients by working with their professional networks and case workers.

Schizophrenia is a mental health disorder found at higher rates among displaced populations. A major symptom of schizophrenia is having delusions which are defined as, "A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof to the contrary. The belief is not one ordinarily accepted by other members of the person's culture or subculture" (Chien and Bell 2008, 300). Figure 3 below shows the diagnostic symptoms of an individual who meets the qualifications to be diagnosed as having schizophrenia (Chien and Bell 2008, 298).

## Diagnostic Criteria for Schizophrenia

### Criterion A: Characteristic Symptoms

Two or more of the following, each present for a significant portion of time during a 1 month period (or less if successfully treated):

- Delusions
- Hallucinations
- Disorganized speech
  (e.g., frequent derailment or incoherence)
- Grossly disorganized or catatonic behavior
- Negative symptoms
  (i.e., affective flattening, alogia, or avolition)

**Figure 3** The diagnostic symptoms needed for a diagnosis of schizophrenia ("Racial Differences and" 2008, p 298)

For someone who has been affected by war and all its tragedies, it may be quite common to exhibit two or more of the symptoms presented in the diagnostic figure above. Displaced individuals who have experienced real violence are likely to be observed displaying one or more of the behaviors in the diagnostic table for schizophrenia, however, their symptoms originated from very real fears. The anecdote below describes the story of a peasant farmer who may meet the criteria for a schizophrenia diagnosis, but is actually reacting to very real traumas.

## 3.4 CAMPESINO

Surviving a traumatic landscape is only part of the migratory journey. Even if the war in Syria came to a sudden end, there will still be residual mental health consequences that surface far after one has fled the violent geography (Baró et al. 1996, 118). Martín-Baró discusses a story of a poor farmer (campesino) who fled conflict in El Salvador but continues to carry symptoms of trauma into his new life:

The first time I came into contact with groups of campesinos displaced by the war,
I felt that much of their behavior showed aspects of paranoid delirium. They were
constantly alert and hyper-vigilant, and they mistrusted anyone they didn't know.
They were suspicious of everyone who approached them, scrutinizing gestures
and words, looking for possible danger. And yet, when I learned what had
happened to them and the real dangers still preying on them, as well as their
defenselessness and impotence against any type of attack, I quickly began to
understand that their hyper-mistrust and vigilance were not signs of a persecution
delirium born out of their anxiety, but rather the most realistic response to their life
situation" (Baró et al. 1996, 111).

The hypervigilance that Martín-Baró discusses in this anecdote displays common
symptoms of mental health disorders. This infers that violent geographies such as war
may leave lasting mental health effects on exposed populations and if not treated, may
contribute to a diagnosis in adulthood such as schizophrenia. It is essential to provide
basic services of care to help build resilience in displaced populations.

## 3.5 CONCIENTIZACIÓN

Martín-Baró spoke about conscientization (concientización), a social concept
based on spreading political awareness throughout the population, especially among the
working class. Conscientization seeks to analyze and address the activity of government
structures. It is an in-depth understanding about the political and social truths that appear
in everyday life (Your Dictionary 2021).

Political consciousness can be placed by witnessing landscapes that have higher

relative rates of crime, drug use, rape, corruption, contaminated water sources, homelessness, and other societal failures. A society such as the one described is visibly not a well-functioning landscape. Conscientization seeks to address the abusive cycles of government systems, which is crucial for changing these patterns of structural injustices.

A society is not functioning when over fifty percent of the population are struggling to feed themselves and fear losing their homes. In societies such as these, where war has been active for over a decade, people must rely on other sources to survive. Alternative economic opportunities are placed in the informal economic sector, though may be subject to unsafe conditions and unstable incomes. Martín-Baró believes those who are able to survive in the informal sector will develop invaluable lifetime skills. He explained, "In order to live in an informal economic sector, one must develop tremendous ingenuity to survive and come out ahead socially, tapping into virtues that are completely excluded from the dominant system" (Baró et al. 1996, 100). Chapter 5 will discuss informal economic sectors in further depth.

Martín-Baró spent his life educating people how to think for themselves through a political perspective. He died and never had the chance to finish publishing his work. Instead, devout scholars published Martín-Baró's writings in a book titled *Writings for a Liberation Psychology* published in 1996. The book stresses that it is up to the people to aim for political consciousness to understand what is happening behind the scenes of their government.

Martín-Baró's writing brings up the role of the psychologist and how their work is limited in treatment. Psychologists may alleviate some of the mental strain their clients carry, but they are not able to stop the traumatic event from occurring. Mental health practitioners' limited role prevents them from being able to save their clients from their abusers. In a similar way, they are unable to save a society from their oppressor. Baró believes it is up to the people to change the system and not rely on a savior:

If a psychologist's work is limited to curing, it can become simply a palliative that contributes to prolonging a situation which generates and multiplies the very ills it strives to remedy. Hence, we cannot limit our thinking to the questions of what treatment is most effective for children who have suffered the traumas inherent in war; we cannot limit ourselves to addressing post-traumatic stress. Our analysis has to extend itself to the roots of those traumas, and therefore to the war itself as a social psychopathogenic situation (Baró et al. 1996, 122).

Martín-Baró believes in educating our people about the underlying problem that is responsible for causing the society to suffer, and addressing it in order to have some chance at fixing it for our children (Baró et al. 1996, 135). His work regularly discussed the significance of how trauma is a by-product of society's social structures presented by the power of the elite by using the poor and oppressed as victims.

## 3.6 PSYCHOSIS IN DISPLACED POPULATIONS

When conditions of war progress and threat remains imminent, people flee. Populations displaced by war have been found to have higher rates of mental illness. A psychotic episode or a period of psychosis occurs when an individual has experienced some loss of contact with reality. Kirkbride, an epidemiologist at the University College London shares his findings, "Certain migrants, their children, and their children's children are as much as 10 times more likely to meet diagnostic criteria for psychotic disorder than the majority (usually white Caucasian) population in a given setting" (Kirkbride 2017, 119). This data infers that migrant populations are more likely to experience mental health related issues than those who are not displaced from war.

War has many psychological effects on society, including psychosis, or a loss of reality. The people who earn the least are hit hardest, often being poor, rural farmers whose crops and homes get destroyed during the war. The poorest sectors are the ones who struggle the most by the increased cost of living, rising unemployment rates, and declining health care. Although the poor get hit the hardest, all social classes are affected by the war from repression, assassination, trafficking, the decline of living conditions, police checkpoints, and other suppressed freedom tactics.

Kirkbride has been studying the root of psychosis for decades and has been searching for the link between exposure to severe adversities and psychosis:

The implication is that severe exposure to pre-migratory adversities, including war, famine and persecution, or the hazards involved in the transitory process of migration itself, may be aetiologically relevant to psychosis risk. Exposure to other severely traumatic migration-related experiences, such as witnessing genocide, also increases schizophrenia risk (Kirkbride 2017, 119).

Experiencing violent geographies increases the rates of psychosis in exposed individuals. However, these diagnostic evaluations may be biased. The next subsection will discuss diagnostic errors in modern psychiatry.

## 3.7 DIFFERENCES IN CULTURAL SYMPTOMATOLOGY AND DIAGNOSTIC ERRORS IN THE FIELD OF MENTAL HEALTH

Psychopathology varies across cultures for specific types of behaviors; the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) explains that clinical significance depends on cultural norms. Schwartz and Blankenship point out the

inconsistencies in schizophrenia diagnosis across different racial and cultural backgrounds, "African Americans and Euro-Americans display psychopathology differently and diagnosticians incorrectly assume it is the same with diagnostic errors resulting from clinicians being unaware of or insensitive to cultural differences in how the same disorder can be displayed differently according to race" (Schwartz and Blankenship 2014, 134). Not having the tools to identify proper cultural symptomatology can be an issue for wrongful diagnosis, but with efforts made to address culture first during consultations and treatment, diagnosis can become more accurate.

There are many Caucasion clinicians in the US who may be misdiagnosing African Americans because they do not fully understand their cultural normative behaviors. Research shows that this trend is occurring with African and Caribbean migrants, as they have the highest rate of mental illness among migrant populations. They are up to five times more likely than Euro-Americans to be diagnosed with a mental illness (Schwartz and Blankenship 2014, 134).

Although there is no genetic evidence, this phenomenon has been documented across studies indicating a true increase in prevalence in this population (Schwartz and Blankenship 2014, 143). The study failed to discuss the possibility that displaced people, primarily people of color, come from countries of the Global South where conflict occurs more regularly. These people are more likely to be displaced and mandated to go through mental health screening in order to be processed as an asylum seeker. This process can affect the data that suggests that displaced people have higher rates of mental health disorders than the general public.

The study failed to account for the cultural factors that could explain why these migrants have the highest rates of mental illness. Western trained physicians may over-diagnose people from different cultural backgrounds who display unfamiliar normative behaviors with schizophrenia and other psychotic disorders. This may be a biased

systematic process that consistently labels displaced populations of color with mental health diagnoses at higher rates than the general public. The high rates of mental health diagnoses among these populations leads to increased negative stigmatization against migrant populations.

This lack of clinician understanding of mental illness across cultures regarding symptomatology may result in higher schizophrenia diagnoses among people of different cultural backgrounds. Putting an end to wrongful diagnosis can be prevented by implementing systemic awareness of cultural norms for mental health practitioners (Schwartz and Blankenship 2014, 134). Allowing more opportunities for culturally diverse candidates in clinical mental health settings can also help address the biased diagnostic rates.

The majority of psychologists are white, making it difficult for people of color to relate to and trust their therapist (Chien and Bell 2008, 301). In 2017, 85.8% of psychologists were white and 6.79% were black, while only 3.81% were Asian (Data USA 2017). Making room for mental health practitioners from various cultural backgrounds can help clients to benefit from therapy, as they may be more comfortable relating to each other.

## 3.8 THE PRIVACY MYTH

NPR published an article titled "Therapy Notes Are Being Used Against Migrant Children" which they reposted from the Washington Post. The article shares a case of mistrust among an immigrant child and the US government where his therapy files were being shared among government agencies without his consent. Using information from his files to deem him unsafe, he has been detained and currently remains in US detention. This story illustrates the power the Trump Administration possessed among immigration

affairs. Kevin Euceda is an asylum seeker from Honduras who was found by border patrol on an inflatable raft. It took Euceda three months to get to the US to seek asylum. Once he was in the US, he was told he needed to receive mandatory psychological counseling to relieve some of the trauma he experienced back home in Honduras (NPR 2020).

Kevin opened up about his past and how he was orphaned as a kid. He told the counselor about how a gang took over his house and had him doing tasks for them such as selling drugs and acting as a lookout. He talked about how his grandmother used to beat him, details about his activity in the gang, and how he fled because he would be forced to kill someone once he turned seventeen. He feared that if he was deported back to Honduras, the gang would look for him and kill him. He felt that the therapy was working to relieve some of the trauma and discussed further details of the traumas he faced when he was forced into drug trafficking back home.

His counselor told him the therapy session was confidential unless he spoke of harming himself or others which is standard confidentiality policy. The standard privacy policy that mental health workers use is known as Health Insurance Portability and Accountability Act (HIPAA), a standard policy created to protect client personal information. However, HIPAA holds no power to protect client information from the federal government. The American Psychological Association (APA) says sharing therapy notes is unethical, but it is legal, "The government is acting as the parent in this situation. The Office of Refugee Resettlement has custody of the children so they can ask for the kids records and share them as it sees fit" (NPR 2020, 4:45).

In 2017, The Trump administration had a fear of criminals and gang members coming into the US and participating in criminal activity. Mental health workers were then required by the Trump Administration to ask and find out whether their clients had a criminal history, changing the mission of therapy (NPR 2020, 3:35). Although Kevin's therapist told him the session was confidential, it was not. Two federal agencies and

Immigration and Customs Enforcement (ICE) received his therapy notes easily upon request. Despite receiving asylum and being categorized as a human trafficking victim, Kevin remains in detention because his therapy notes deemed he was a risk to the general public.

The first time he had a court hearing, he thought he would be released that day. However, the ICE attorney handed the therapy notes to the judge and she started cross examining him based on the notes that described his past association with gang violence. As a result of the information in the notes ICE obtained, Kevin has to remain in detention. While in detention, he is still required to continue to go to therapy. He stopped talking about his past with the gang, but continued to open up about his feelings while in detention. Found in his therapy notes, Kevin was reported saying he "Felt like he was going to explode" and another time talked about how he thought about hitting a kid with a ball but decided against it. ICE again accessed his file and read the notes, deciding he was too dangerous to release and has since been in detention for three years (NPR 2020, 5:50). The lack of any real privacy is another reason why people distrust receiving psychological care, fearing that expressed information may take their personal freedoms away. A system that is meant to help them, is being used against them.

Government has more power than the confidentiality between therapist and client. The government can request any individual's medical and mental health records, therapy notes, and insurance claims. Any document that retains any personal information can be authorized and obtained by the government to use as they please. The counselor that originally took Kevin's notes resigned from the position. Events similar to this event perpetuate the stigma of receiving mental health treatment in many groups. Clients will not benefit from treatment if they do not trust the psychologist, especially if the psychologist resembles their oppressor.

Displaced people who experience violent geographies are shown to have higher

rates of mental illness. These populations experience real traumas that stay with them even after their migratory journey has ended. Adversity such as witnessing genocide experienced before, during, or after the migratory journey are risk factors for psychosis and developing a schizophrenia sprectrum disorder. Displaced populations of color are especially at risk of developing a mental health disorder. This can be for reasons such as the majority of displaced people come from the Global South, clinician cultural bias, or systemic racism. The severity of mental health disorders in displaced populations can be prevented if proper services of care are available at time of need. These basic services of care include access to mental health treatment with a culturally conscious practitioner. However, if mental health treatment is to work, clients must trust their provider. Instead, many displaced people have a real founded fear not to open up with their therapist, because what they say will directly affect the direction of their future. In the case of Kevin Euceda, opening up caused him to be in detention for over three years. Chapter 4 will discuss trauma as a spatial disease that has the ability to move across the landscape. It will also discuss the neurobiology of trauma and how it relates to displaced populations.

# CHAPTER 4: TRAUMA; A CONTAGIOUS DISEASE

## PART I

Exposure to traumatic landscapes such as war, famine, disease, and genocide may lead to mental deterioration, especially if the circumstances are chronic and prolonged. There is no way an individual can leave war without being affected and having some kind of trauma or psychic damage, whether they are the aggressors or the victims, or both (Baró et al. 1996, 134). The ten-year Syrian conflict is putting millions of people at risk of developing symptoms of mental health disorders.

Not nearly enough contemporary research has been explored on the psychological effects trauma has on refugee families. In a landscape of war, the perceived surrounding environment is witnessed and felt by the individual, affecting the way they process their cognitive reality. As the individual continues their life, the affects of the trauma remains with them and continues to affect their futures. Similar studies show that people who come from abusive homes have been affected by chronic adversity and abuse, which can show a model of how wartime violence can affect displaced populations if no care is available. The study below demonstrates how abuse can affect the future of survivors, whether referring to displaced people or the general public, "Children clinically referred to residential treatment with a history of abuse scored significantly higher on measures of reactive and verbal aggression than non-abused control children. Finally, a large proportion of homicide offenders come from unfavourable home environments and up to 80 percent of subjects within delinquent samples report witnessing of violence in their childhood or adolescence" (Çelik 2013).

Trauma has the ability to spread across the landscape, affecting more individuals than originally thought. This chapter will discuss how trauma is a spatial disease that can

be transmitted across the landscape, often through the form of family systems. This chapter will also discuss theoretical contributors' Jacob's and Wolynn's work in relation to this research regarding trauma transmission and interruptions in maternal and caretaker bonding.

## 4.1 TRANSMISSION OF TRAUMA WITHIN FAMILY SYSTEMS; STORYTELLING AS A MODE OF TRANSMISSION

Storytelling is one way that trauma remains alive within family systems. The transmission of trauma through storytelling can shape the family's perspective and identity of the trauma that occurred. When survivors of trauma share their stories to young children, they are often unaware that this may interest the child, but the very same may terrify them.

Transmitting trauma through storytelling may overwhelm the child and shape their own relationship to the trauma. In Jacobs book, *the Holocaust Across Generations*, *Trauma and Its Inheritance Among Descendants of Survivors,* a son of a Holocaust survivor talks about how his father embedded the image of his own trauma in his son's head, "There is no way for me to describe what it was like for me to be eight years old in my home and listen to the story of how my aunt, my father's sister, died" (Jacobs 2016, 20). His father continues to tell him stories with vivid detail of faces, names, and smells, "It's a little bit much" says the son about his father's stories (Jacobs 2016, 20).

Jacobs accounts a story of a fieldwork participant whose grandfather and uncle were killed during the Holocaust. The story remains alive by eyewitnesses who recounted the events to the participant's father. They said the Nazis were testing the ovens and took the brother (participant's uncle) and said 'Throw him in.' His father (participant's grandfather) was standing there and said 'No, take me first.' Instead, the Nazis threw the

son in the oven first, then threw the father in next. They both perished in the ovens. A child growing up hearing similar stories may grow to form an identity to these stories, perhaps empathizing with the victims, or growing angry at the actions of the perpetrators. Stories like these can internalize and form a consistent narrative that trauma happened before, and will happen again. These thoughts can turn into an internalized anxiety, or develop into more severe symptoms for the child.

It is difficult to imagine not being affected by witnessing or hearing of this event, even if it was not your own family who had suffered. Storytelling has the means to transmit trauma across spatial social networks and family systems. These modes of trauma transmission can have an effect on the mental health of the family, especially the children. Situational episodes are another mode of the transmission of trauma across the landscape which will be discussed in the next subsection.

## 4.2 TRANSMISSION OF TRAUMA WITHIN FAMILY SYSTEMS: SITUATIONAL EPISODES

A grandchild of a trauma survivor may continue to carry the effects of the trauma even if never experiencing the traumatic landscape for themselves. Situational episodes are experiences in which you find yourself at any point of your life. Situational episodes are experienced by you and the people closest to you, likely being immediate family. Jacobs describes how children of trauma survivors are more likely to experience symptoms of mental health disorders:

Beginning in 1966, psychiatric and psychological studies of first generation descendants described children of survivors as suffering from nightmares, guilt, depression, fear of death, sadness, and the presence of intrusive images,

indicators of post-traumatic stress symptoms among children of survivors (Jacobs 2016, 13).

Children and grandchildren often experience situational episodes where their family member(s) relive past trauma through exhibiting behaviors associated with their lived trauma, often normalizing the behavior in the household. These situational episodes can perpetuate family trauma from generation to generation. A situational episode in Jacobs' book recounts an experience where a daughter is left with a certain trauma after her mother displayed ill-fitted behavior at a family birthday celebration. As a young girl, her mother survived the Holocaust and was determined the wait staff at the restaurant were all Nazis. Her justification for this behavior came from the restaurant serving German food. The mother continued to make additional comments about the proposed Nazi affairs the entire drive home, "After we left there, my mother said very quietly, 'I don't want to go back there. I'm pretty sure they're Nazis'" (Jacobs 2016, 16). She was embarrassed by her mother's behavior and felt uncomfortable spending time with her in public.

Survivors of trauma can unknowingly trigger symptoms of trauma in their family member(s). Jacobs points out the Holocaust was a "dominant psychic reality" not only for survivors, but for the descendants of survivors as well (Jacobs 2016, 13). A new example situational episode accounts a mother who is spending time with her family of fourteen. They are having a meal and chatting about various, light hearted topics. It was a nice time, when all of a sudden, the mother gets triggered by something and she starts talking about her past in Auschwitz. This made many family members feel uncomfortable and unsure of what to do. Her daughter said something along the lines of "Mom, it's not appropriate right now," but then felt guilty for shutting down her mother and continued to feel uncertain of what to say next. The daughter of the survivor says, "This is a version of my own PTSD" (Jacobs 2016, 17).

Although the daughter has not personally experienced the horrors of Auschwitz that her mother had, she has anxiety, shame, and guilt when spending time with her mother. She feels responsible to guide and correct her mother to remain within social normative behaviors, even when she feels uncomfortable doing so. The daughter believed she experienced her own type of trauma from the episode that she received from her mother. In this way, trauma acts as a mobile entity, able to move across the landscape from generation to generation.

Even if we are not the ones who experienced the trauma, growing up around people who are survivors of trauma can leave residual effects on an individual. The daughter in the example above said she suffered a different kind of PTSD while being subjected to growing up with her mother. The daughter may have never experienced torture, loss, or any other kind of direct physical trauma. Instead, she suffers from issues with social construction, continuous exposure to her mother's PTSD, and the guilt from not being able to help effectively treat her mother's PTSD. The daughter felt limited control over helping her mother's triggering perceptions and behaviors which her mother sees as very true and real in the present time. Her mother's behavior has affected her daughter the majority of her life, likely leaving lasting effects on her own cognitive reality of the world.

Whether her mother's intrusive memories would be classified as delusions and diagnosed as schizophrenia is unknown. This is very real for the mother and the daughter who must pick up the pieces of this intergenerational stress. The mother and many other trauma survivors' paranoid behaviors are seen by their descendants as a type of personal trigger:

As a random act of remembrance that was triggered by some reminder in the social environment or a conversation that may stir inner thoughts and memories of which the descendants are unaware, bringing the survivors, their children, and

grandchildren back to a past that is shared through trauma-based narrativity (Jacobs 2016, 17).

For the general public, these triggering behaviors displayed by trauma survivors may be viewed as indicators of a brain disorder or eccentric personality. Seeing situational episodes as a mode of trauma transmission can help build understanding of the trauma that survivors and survivors' families carry, and help break the stigma of mental health disorders. The next subsection will discuss the significance of a consistent, healthy relationship between parent and child.

## 4.3 BROKEN BONDS BETWEEN PARENT AND CHILD

Trauma or separation in childhood may be the root of adult mental illness. Mark Wolynn believes that when there is an interruption between the mother and child, the child may have issues with social construction and issues with forming healthy relationships throughout their life. An interruption between mother and child could be any event that keeps the mother apart from the child for an extended amount of time, causing a break in the emotional bond they share, or never actually establishing a secure bond in the first place.

Wolynn describes examples of interruptions as the mother having emergency, extended hospital stays while the child is young, working long hours, minding other children, having her own personal mental health issues, and other factors. The bond between the mother and child can also be interrupted by increased exposure to traumatic landscapes such as active bombings, genocide, mass rape, civil conflict, loss of partner, death of another child, and other countless, traumatic events (Wolynn 2016, 41). This information makes a case that millions of displaced families may be vulnerable to these

interruptions that may affect social construction and future relationships.

The goal of a caregiver is to build a healthy foundation by which the child will base their future relationships off of, "It's through these early interactions that a child continues to establish a blueprint for managing emotions, thoughts, and behaviors" (Wolynn" 2016, 41). A child is born completely vulnerable and dependent on their mother, they learn to recognize and find comfort and stability in the mother's voice, breath, and smell. The child knows only how to survive with the mother's availability. If something were to happen to the mother that would cause her to be physically or emotionally separated from the child, the child could experience devastating lifelong effects. If the mother is unavailable, other strong, consistent relationships can counter the negative effects of the bonding interruptions.

Wolynn's research stresses the importance of early interactions with the *Mother.* For this paper, the term *Mother* will address all those who have a caretaker position in the child's life including male caretakers, siblings, childcare services, child protection services, border services, refugee camps, foster families, teachers, and anyone who is responsible for a child's wellbeing. Acknowledging that raising a child is a holistic event that requires action from multiple actors in the community paints a clear picture that the mother alone is not responsible for the child's development, it takes a village to raise a child. The next subsection will discuss Wolynn's take on chronic stress on the caretaker and how it affects the child's development.

## 4.4 MOTHER'S TRAUMA WRITES CHILD'S BLUEPRINT

Wolynn believes tumultuous landscapes can have an effect on the mother's emotional availability to her child. It is likely that women who flee conditions of conflict experience shock, numbing, emotional unavailability, despair, and unbearable grief. With

the mother's focus being interrupted by the landscape and conditions of war, she may not be emotionally available to bond with her child. Wolynn states, "An event like this would disrupt the bond the child has experienced up to that point and interrupt the crucial neural development taking place in his two-year-old body and brain. At that age, he wouldn't understand the enormity of the tragedy that caused his mother's attention to shift" (Wolynn 2016, 80-1). Surviving adversity and fleeing war can affect the availability of the mother's affection to her child, therefore affecting the long-term development of the child's brain.

A sudden, prolonged separation from our caregiver is a type of trauma:

As infants, we perceive our mother as our world. A separation from her is felt as a separation from life. Experiences of emptiness and disconnection, feelings of hopelessness and despair, a belief that something is terribly wrong with us or with life itself-all these can be generated by an early separation (Wolynn 2016, 75-6)

Infants need consistent caretaking and bonding in order to grow into a confident, validated, and able individual, "The presence and constancy that a mother establishes during the first years of life is instrumental for the child's psychological and emotional well-being" (Wolynn 2016, 74). Heinz Kohut describes the importance of the gleam in the mother's eye when she gazes at her infant. It is the vehicle by which the child feels validated and affirmed and can begin to develop in a healthy way (Wolynn 2016, 74).

The interrupted bond between the mother and child can be similar to the effects of withdrawing from a drug. Winifred Gallagher describes the severity of the relationship between parent and child, "When they are parted, the infant does not just miss its mother. It experiences a physical and psychological withdrawal . . . not unlike the plight of a heroin addict who goes cold turkey" (Wolynn 2016, 41). Raylene Phillips says that a separation from the mother can be felt as life threatening. Phillips states, "If separation continues for

a prolonged period, the response is despair. The baby gives up" (Wolynn 2016, 41). The baby is already learning to give up, learning conditioned responses to emotional interruptions and attachment with the mother. It is likely that without strong, consistent relationships, this child will continue to give up and may believe that all future relationships will be failures. Trauma such as interruptions in early relationships can predispose children to depression later in life.

Consistent emotional neglect can condition a child to close or withdraw emotionally from a parent. Withdrawing emotions serve as a defense mechanism for children who feel that they are not having their emotional needs met. This often appears as the child behaving as though they have no feelings or affect, appears numb or cold, or seem to have no personality. Being withdrawn is a symptom of many different mental health disorders including depression, PTSD, borderline personality disorder (BPD), or schizophrenia as discussed in Chapter 3. These children were not emotionally validated when they needed it most, and therefore have issues with emotional control, maintaining relationships, impulsivity, and self-esteem (Wolynn 2016, 74).

The case of Suzanne demonstrates how an early interruption in the bond between mother and child could leave lasting effects on the child. Suzanne is thirty, when she was nine months old she was hospitalized with pneumonia for two weeks. She was mostly alone since her mother was home raising the other siblings. The interruption of bonding with her mother caused Suzanne to unconsciously withdraw from her mother. Rejecting her mother's affection was a way to protect herself against being hurt and left again, a common unconscious coping mechanism we do to protect ourselves. Just the thought of hugging her mother made Suzanne cringe, she says "Hugging takes your energy away" (Wolynn 2016, 75).

Suzanne's relationship with her mother may be recycled into her future romantic relationships if not rekindled. Making peace and reconnecting is possible if both parties

are willing to put in the work, "The way the connection is restored can create a blueprint for bonding and separating future relationships" (Wolynn" 2016, 75). David Chamberlain says if the mother and child never thoroughly bond, the child may feel an unexplainable lack of closeness that casts a shadow over daily relationships (Wolynn 2016, 75). Creating an environment that supports caretakers and children is important if we want displaced populations to have the ability to foster healthy relationships and personal wellbeing.

Many families who are separated at international borders are vulnerable to experience these bonding interruptions. Some countries like the US use family separation as a way to deter others from seeking asylum at the border. This policy is a political move that is cultivating trauma in displaced and separated populations. Many of these families are already separated from their loved ones through wartime violence and are unaware of their family's whereabouts which compounds the trauma experienced.

## 4.5 RELATIONSHIP ISSUES

Early interruptions can be visible in many forms, stemming generations back. Oftentimes, caretakers never received proper love and affection from their own parents and may have never developed a healthy bond, resulting in parenting that reflects that learned behavior. This likely perpetuates the same maladaptive behavior for generations until someone changes it (Wolynn 2016, 73). Systems of care need to be available for displaced people if we want to effectively treat mental health disorders caused by war.

Common traits among women who experienced an interruption in the bond with their own parent may include love that is withholding, unavailable, self-absorbed, or inconsistent (Wolynn 2016, 68). Early interruptions with a caretaker can cause some degree of anxiety when attempting to bond with a partner in an intimate relationship. This gives rise to a visceral anxiety about relationships that can curb an individual's choice to

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commit to a relationship or may stunt the pursuit of having children (Wolynn 2016, 73). Not having emotional needs met leaves one feeling separated from their mother and finding themselves in relationships with people whose behaviors mimic the inconsistent caretaker's behavior.

Trauma has the ability to recycle itself into future relationships. All Tricia's relationships are short-lived, lasting no longer than a year or two. She plans to leave her current lover and describes him as cold, insensitive, and never there when she needs him. Without realizing it, Tricia described her relationship with her mother in a similar way, "She's distant and emotionally unavailable. I could never go to her for support. She never loved me the way I needed to be loved" (Wolynn 2016, 72). Tricia unconsciously recycles the trauma she experienced into her future relationships.

Tricia discussed a time when her mother was talking about her own mother (Tricia's Grandmother) saying she was selfish and unavailable. Upon further digging, Tricia found out that when her grandmother was just a toddler, her mother (great-grandmother) died and she was sent to live with an aunt, "She often felt like an outsider in the new family and remained resentful for most of her life" (Wolynn 2016, 72). Tricia realized she had been repeating the intergenerational pattern, "A family pattern of daughters who didn't get what they needed from their mother. This pattern reverberated through the family history for at least three generations" (Wolynn 2016, 72). This is the moment that Tricia felt compassion for her mother for the first time. She went on to reconcile the relationship with her mother and her partner. Displaced people who experienced trauma may be unconsciously repeating these intergenerational patterns. Having services of care available for displaced people can help individuals start to recognize these patterns and offer the tools to help change them.

A challenge with studying early interruptions is that they happen in the very beginning of the child's life, before they can properly store and recall memories, "Early

interruptions in general can be difficult to discern, because the brain is not equipped to retrieve our experiences in those first few years of life" (Wolynn 2016, 73). In this way, there are limited early experiences that can be recalled and discussed in treatment.

Continuous exposure to traumatic landscapes perpetuates the cycle of trauma within family systems. Affected individuals are left with either repeating a relationship similar to the tainted one with the emotionally absent caretaker, or allowing themselves the opportunity to recognize and heal the dynamics they hold unconsciously within themselves (Wolynn 2016, 69). Part II of this chapter will discuss the neurobiology of trauma and the effect it has on displaced populations.

# THE NEUROBIOLOGY OF TRAUMA

## PART II

The brain has many responsibilities and sometimes the system gets overwhelmed. A glitch in the system can appear in different ways, sometimes being an aggressive behavior, an auditory hallucination, a delusion of being followed, dissociation, or other symptoms of the brain's response to stress. The more severe and chronic the stress the individual faces is, the more likely they are to exhibit symptoms of mental health disorders over time.

There is a growing literature of findings between the association between PTSD and psychotic disorders. The association between trauma, psychosis, and dissociation is borne through the link that trauma causes the development of delusions and dissociation with the development of auditory hallucinations, prominent in symptoms of schizophrenia (Çelik 2013). Many displaced people are exposed to trauma during their migratory journey, making them vulnerable to experiencing decline in their mental health. This section will discuss cases where trauma has affected the neurobiology of exposed populations and the implication this has on future generations, especially populations who have been forcibly displaced by war such as those who fled the conflict in Syria since 2011.

People who are forcibly displaced often experience many adversities among their migratory journey, making them vulnerable to developing mental health disorders. Kirkbride said, "We already know that compared with the majority population, migrants and their descendants have an increased chance of experiencing psychotic disorders including schizophrenia. On average, this risk is about two and a half times greater" (BMJ 2016). This statistic highlights the necessity of providing systems of care for displaced populations.

Famines are a traumatic landscape that cause many to experience trauma or migrate elsewhere. Events like this affect exposed individuals and their children. Neugebauer et al., found that the cohort conceived at the height of the famine showed a twofold risk of developing schizophrenia. This is a statistically significant risk, (relative risk [RR] = 2.0; 95% confidence interval [CI] = 1.2 to 3.4; $P<.01$) in both men (RR = 1.9; 95% CI = 1.0 to 3.7; $P=.05$) and women (RR = 2.2; 95% CI = 1.0 to 4.7; $P=.04$) (Susser et al, 1996). Researchers are unsure if the risk for schizophrenia is caused by under-nutrition or toxic stress in the early life environmental conditions of the fetal life, or both.

Subsequently, Levine discusses the association between a stressful environment and the likelihood of developing schizophrenia, "Possibly, as suggested by the results, these factors 'programmed' the unborn fetus to maladaptive reaction in a highly stressful postnatal environment" (Levine et al. 2016, 859). Levine suggests the possibility of the sensitivity of childhood and adolescence as a precursor to developing schizophrenia:

> Childhood and adolescence constitute a sensitive period for the risk of schizophrenia under conditions of severe stress. This hypothesis proposes that the association between purposeful inflicted childhood trauma and risk of schizophrenia reflects the 'putative pathogenic influence of the experience of (chronic) humiliation. Collectively, this may indicate that a mechanism of specific childhood neurological developmental disturbances increase the risk of schizophrenia (Levine et al. 2016, 860).

Levine explains the effect violent geographies have on the young psyche, "The current study results demonstrate that compared with suitable counterparts, the combined prenatal and postnatal (i.e. childhood and adolescence) exposures to the maximal adversities of genocide constitute a critical period that elevates the risk of schizophrenia,

due to likely malnutrition, neurodevelopmental insults, and psychosocial adversities" (Levine et al. 2016, 861).

Data shows that those who have experienced trauma are more likely to be diagnosed with a mental health disorder such as schizophrenia. Delusions and hallucinations are common symptoms in schizophrenia. However, 8-30% of the general public report delusional experiences or hallucinations in their lives and are not diagnosed with schizophrenia (Kesby et al, 2018). This information suggests that many people collectively experience symptoms of mental health disorders but do not receive treatment. Even if they do not meet the criteria for a schizophrenia diagnosis, they are still visibly exhibiting symptoms of residual trauma.

Trauma can play a main role in developing other mental health disorders such as depression and BPD. BPD or borderline personality disorder is a mood disorder affecting 1.6% of the population with 75% of the people diagnosed being women (Salters-Pedneault 2020). Another source claims up to 5.6% of the US population may have BPD (File, Hurley, and Taber 2017). BPD is more commonly diagnosed than schizophrenia which appears in about 1% of the population, or 1.2% in the United States (American Addiction Centers 2020).

Borderline personality disorder is a mental health disorder categorized by feelings of extreme highs and extreme lows. Those with BPD struggle with regulating their emotions which causes disruptions in their daily lives and relationships. Individuals with BPD who were not receiving medication have shown increased activity in the area of the amygdala and hippocampus (left side only) (File, Hurley, and Taber 2017). The amygdala is the fear center of the brain, inferring that individuals with BPD experience emotions more intensely than their counterparts. Individuals with BPD are also more likely to suffer from PTSD, depression, anxiety, paranoia, dissociation, and avoidant behavior.

The brains of people with BPD are similar to those of trauma survivors, "But in

essence, if you have BPD, your brain is on high alert. Things feel more scary and stressful to you than they do to other people. Your fight-or-flight switch is easily tripped, and once it's on, it hijacks your rational brain, triggering primitive survival instincts that aren't always appropriate to the situation at hand" (HelpGuide 2019). Traumatic landscapes are associated with developing this disorder, "Most mental health professionals believe that borderline personality disorder (BPD) is caused by a combination of inherited or internal biological factors and external environmental factors, such as traumatic experiences in childhood" (HelpGuide 2019).

In order to be diagnosed with BPD, one must exhibit at least five out of the nine symptoms of BPD which includes fear of abandonment, unstable relationships, shifting self-image, impulsivity, self-harm, extreme emotional mood swings/explosive, inappropriate anger, chronic feelings of emptiness, suspicion of others' motives, or being out of touch with reality (HelpGuide 2019). Some of these symptoms are also indicators of schizophrenia including impulsivity and being out of touch with reality.

The condition of an individual's environment is extremely crucial while they are developing. Individuals who have experienced displacement face many adversities and stressors during their migratory journey and everyday lives. Being exposed to years of toxic patterns can cause permanent mental health issues in populations that grew up in conflicted landscapes including PTSD, schizophrenia, and borderline personality disorder. The trauma one has experienced along this journey is perpetuated by continuous inhumane policies that separate families and criminalize movement.


## 4.6 MENTAL HEALTH DISORDERS AMONG YOUTH

Wolynn believes mental health starts in the womb, "The first nine months outside the womb function as a continuation of the neural development that occurs within the

womb. Which neural circuits remain, which are discarded, and how the remaining circuits will be organized depend on how an infant experiences and interacts with the mother or caregiver" (Wolynn 2016, 40-1).

Trauma has the most severe effect on children, many too young to even remember the trauma. Wolynn explains how trauma is fragmented in young children:

> The hippocampus, the part of the brain associated with forming, organizing, and storing memories, has not fully developed its connections to the prefrontal cortex (the part of the brain that helps us interpret our experiences) until sometime after the age of two. As a result, the trauma of an early separation would be stored as fragments of physical sensations, images, and emotions, rather than as clear memories that can be pieced into a story. Without the story, the emotions and sensations can be difficult to understand (Wolynn 2016, 73).

Coddington et al., discusses a flashback as a vivid sensation that is also a well known symptom of PTSD, "Flashbacks often occur in different times and places than the initial traumatic event itself; the traumatized psyche repeats its pain, (re)focusing upon a place—and time—that cannot be located" (Coddington and Micieli-Voutsinas 2017, 4).

Many displaced populations who experience traumatic landscapes experience major symptoms of PTSD including flashbacks, hypervigilance, panic attacks, and anxiety. All of these symptoms are indicators that trauma has occurred in an individual's life (Haven 2018). Other feelings such as grief, anger and depression arise from the significant losses (e.g. home, social networks, children) that survivors may have suffered as a result of traumatic events. Rebuilding from trauma may be accompanied by feelings of guilt, shame and loneliness because of the stigma compounded by other people's responses to the survivor (Haven 2018, Section 3.2, 5).

PTSD can affect anyone, at any age. Children and teens experience the effects of trauma differently than adults. In children younger than six, symptoms of trauma include, "Wetting the bed after having learned to use the toilet, forgetting how to or being unable to talk, acting out the scary event during playtime, and being unusually clingy with a parent or other adult" (Perkins et al. 2018). Older children and teens who experienced trauma may develop disruptive, disrespectful, or destructive behaviors.

Children who experience traumatic landscapes such as the war in Syria have displayed clear symptoms of PTSD. Seventy-one percent of Syrian migrant children have displayed symptoms indicative of trauma which include bedwetting\involuntary urination, speech impediments, isolation, going mute, aggression, substance use, self-harm, and suicide attempts reported among children as young as age twelve (OCHA 2017). With over 4,000 attacks on schools in Syria, many children have been exposed to air strikes, bombs, losing loved ones, and the many other tragedies of war (The Guardian 2017). Eighty-four percent of adults and almost all children said that ongoing bombing and shelling is the number one cause of psychological stress in children's daily lives (OCHA 2017, 2). These symptoms indicate an unbalanced state, both in the political landscape and in the homeostasis of one's mind.

Children who experience toxic stress in their early childhood are likely to experience a disruption in their developing brain along with increasing the risk of heart disease, substance abuse, depression, and other mental health disorders that follow them into their adult lives. The study found that drug use was a common coping mechanism adolescents often used, "Fifty-one percent said adolescents are turning to drugs to cope with the stress" (OCHA 2017, 2).

In a landscape of war, opportunity is sparse, leaving many adolescents vulnerable to joining armed groups, "Fifty-nine percent of adults know of children and adolescents who have been recruited into armed groups" (OCHA 2017, 2). As the war continues into

its tenth year with no resolution in sight, 89% of children have exhibited more fearful and nervous behaviors and are continuously uncertain about their futures (OCHA 2017, 1). When children are under threat for a prolonged period of time, they sit with the trauma and feel the experiences within themselves. It is likely that exposure to prolonged traumatic landscapes can leave children with disrupted visceral beliefs. Wolynn defines visceral as, "We experience feelings, beliefs, and body sensations that live inside us without the story that connects them to the past," (Wolynn 2016, 76). The story below casts light on how harmful witnessing trauma can be on the psyche.

*RESURFACING TRAUMA*

The Lancet published a story of a six-year old child refugee from Iran who was brought to the emergency department (ED) at a hospital in Sydney, Australia. The family was placed in a detention facility in Sydney Australia for over a year. They were waiting for their asylum application to be processed. The mother of the six-year old child said he refused to eat, drink, and speak after witnessing a man cut his wrists in a suicide attempt at the detention facility. Additionally, six months ago the child was exposed to riots where other detainees set themselves on fire. Since then, the six-year old had started to withdraw from playing with other children, along with nightmares and bed-wetting. The child has experienced PTSD and has since been experiencing symptoms of mental health decompensation (Willen et al. 2017, 970).

The boy was then moved to a hospital where he received inpatient care. Every time the boys' father visited the child at the hospital, the boy experienced severe separation anxiety, causing his symptoms to return. Australia's Minister of Immigration denied a petition to release the boy to his family and instead placed him in community foster care to deter other displaced populations from seeking asylum at the border, "The

minister's denial did not dispute the causes or the magnitude of the boy's suffering; rather, it was framed to avoid setting a precedent that would mandate the release of other children in similar situations in the future (Willen et al. 2017, 970).

The separation of families in times of severe stress exacerbates symptoms of trauma experienced by both the parents and children involved. Current immigration policy continues to use detention regularly, dismissing the psychological effects it has on the children and their families. Using these methods, Australia continues to deter people from seeking asylum by mandating "the detention of undocumented migrant children, unaccompanied minors, and families more than a decade later" (Willen et al. 2017, 970). The next subsection will discuss the neurobiological effects of trauma in the brain.

## 4.7 THE FEAR CENTER OF THE BRAIN

Traumatic landscapes can affect the neurobiology of exposed populations. An efficient machine, the threatened brain seems to keep certain memories for survival purposes, "It's as though we have rewritten history, keeping only those memories that support our primitive defensive structure, defenses that have been with us so long, they become us" (Wolynn 2016, 76). Our survival depends on our ability to stay alive and screen out potential threats. This leaves us wearing a lens of hypervigilance, always seeking out potential threats, and always on edge. Neuropsychologist Rick Hanson provides an illustration of trauma being stored in the brain, "The mind is like Velcro for negative experiences, and Teflon for positive ones (Wolynn 2016, 77). Hanson means the amygdala stores trauma for survival purposes, and states that positive experiences do not offer the same degree of survival protection that traumatic experiences do. He compares positive experiences to Teflon, not storing (sticking) in the brain like trauma does. In this way, as Hanson believes, our brain's memory system becomes biased. Survivors of

trauma may have plenty of positive memories, but they are not stored to the degree that traumatic experiences are. Displaced populations are likely to have experienced this heightened activity in the amygdala, causing hypervigilant behavior.

Hypervigilance is a common symptom experienced by people who have PTSD. Being hypervigilant is being highly-receptive to external events which can lead to stress or further anxiety related disorders. Hypervigilance can be useful to keep an individual alert in order to survive a predator. However, many individuals who were exposed to trauma remain hypervigilant even when in calm, non-threatening environments, seemingly appearing that the individual is not adjusted to their environment and displaying ill-fitted behavior. The trauma experienced by the individual continues to be carried with them as they continue their life even when their migratory journey is over.

Living in a constant state of fear can leave a severe effect on the brain and body. Individuals who are under continuous threat are likely to have long-term traumatic memories stored within their amygdala, the fear center of the brain. Our amygdala uses about two thirds of its neurons scanning for threats. As a result, painful and frightening events are more easily stored in our long-term memory than pleasant events. This is known as a negativity bias and interferes with impairments in emotional regulation (Wolynn 2016, 67-7).

Feeling painful states are also felt deeper by individuals who have mood dysregulation disorders such as those with bipolar disorder, autism, ADHD, depressive disorder, anxiety disorders, PTSD, and borderline personality disorder. Providing evidence that the amygdala is responsible for deep feeling states, Chai declares, "Bipolar disorder patients exhibited elevated functional connectivity between MPFC [medial prefrontal cortex] and amygdala while viewing sad stimuli compared with healthy controls" (Chai et al. 2011). The prefrontal cortex is responsible for executive functioning and is inhibited when the amygdala is threatened. Behaviors like judgement and impulse control

are inhibited when the amygdala suspects fear (Harris 2019b). Those under severe stress are likely to fall victim to impaired behaviors of judgement and impulse control, similar to individuals who suffer from addiction, bipolar disorder, BPD, and schizophrenia. This state of severe stress is often seen in displaced populations who are at risk of developing these disorders.

Individuals with mental health disorders such as bipolar disorder and schizophrenia have impaired executive functioning based on fMRI studies. "The decoupling of DLPFC [dorsal lateral prefrontal cortex] with MPFC [medial prefrontal cortex] in bipolar disorder and schizophrenia," as Chai says, "is consistent with the impaired executive functioning seen in these disorders'' (Chai et al. 2011). The medial prefrontal cortex is critical for internal, self-referential processing, the ability to process information relevant to oneself. This information suggests at least a partial explanation for why individuals with schizophrenia have impairments in reality monitoring (Chai et al. 2011). In this way, the chronic fear that displaced people experience during their migratory journey may affect their neurobiological development, risking the minds of millions of displaced people.


4.8 THE INHERITANCE OF FEAR

Brian Dias and Kerry Ressler at Emory University School of Medicine found evidence that sensitivity toward the M71 odorant receptor can be inherited, inferring that fear sensitivities can be passed down to subsequent generations. Dias and Ressler found when fear conditioning mice to this scent, the pups and grandpups inherited sensitivity to the odor even if they have never encountered the smell before. The odor was acetophenone which smells similar to the scent of cherry blossoms.

The researchers paired the exposure of the odor with a mild electric shock and

measured the startle response in each exposed mouse (Emory 2013). They found that both the fear conditioned mother and father mice can pass on a learned sensitivity of the odor acetophenone (cherry blossom) to their pups. However, mothers were unable to pass the sensitivity to fostered pups, suggesting that the odor sensitivity is not transmitted by social interaction, but rather genetics. The affected mothers and their pups were also found to have more space in the olfactory bulb, the area in the brain where odors are processed (Emory 2013). Dias and Ressler found that the offspring of these fear conditioned mice had increased amounts of cherry blossom scent receptors and also displayed symptoms of anxiety when the scent was released when compared to control mice. In this way, fear has the ability to predispose populations to stress related disorders in their daily lives, including populations who experienced violent geographies.

The researchers found an epigenetic change in the DNA from the odor sensitive father's sperm, "In mice taught to fear acetophenone, the odorant receptor gene that responds to acetophenone has a changed pattern of methylation: a chemical modification of DNA that tunes the activity of genes" (Emory 2013). Ressler continues, "While the sequence of the gene encoding the receptor that responds to the odor is unchanged, the way that gene is regulated may be affected" (Emory 2013). These findings suggest that fear sensitivities can be genetically passed onto children through traumatic experiences. Geographically, displaced populations are disproportionately affected by stress inducing landscapes, being more susceptible to developing a stress related disorder than the general public.


4.9 THE LONG-TERM EFFECTS STRESS HAS ON THE BODY

Many displaced individuals are exposed to trauma during their migratory journey. Trauma causes the body to be in a constant state of stress which has many detrimental

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effects on healthy development; "Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body and brain" (Harvard 2021). The body has many responses when experiencing fear. Stress activates the sympathetic nervous system which is responsible for our survival. It activates an adrenaline rush within the stressed individual which increases the heart rate and pumps blood to essential muscles used when fleeing to safety. These muscle groups are often associated with survival behaviors such as running, climbing, leaping, and similar forms of fleeing movement. When blood is being used to activate these muscle groups, less blood is sent to our non-essential organs such as the liver, kidney, and brain. The blood also clots easier to prevent the individual from bleeding to death (Finkelstein 2020).

The body has many survival mechanisms to save one's life such as an adrenaline rush, increased blood flow to essential organs, and blood that clots easier. However, when the stress response is constantly in the "on" position, it can lead to sympathetic overdrive, "Constantly diverting blood flow from our intestinal tract to our major muscle groups, we improperly digest our food, thereby failing to convert it into nutrients. Meanwhile, our arteries get worn down, from the heart constantly beating harder and faster than it needs to in a normal, relaxed state" (Finkelstein 2020). Those who have experienced violent geographies are more likely to have issues into their adult lives with their arteries, digestion, and heart.

Many displaced people experience acute mental stress provoked by the many traumas they face while moving across the landscape. However, for many, the stress does not remain acute. Displacement lasts for several years, sometimes decades. The migratory stress turns into trauma that is carried and passed on to family systems in the form of health issues. High-stress environments can perpetuate the sympathetic nervous system and leave lasting effects on survivors and descendants of survivors, "Family

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history of early onset heart disease and chronic stress can increase your risk of heart disease" (Finkelstein 2020).

Painter et al found that those who were conceived during the Dutch Hunger had a higher cumulative incidence of coronary artery disease (CAD) (13% hazard ratio) than those who were not exposed to the famine (Painter et al. 2006). Those exposed were more likely to have CAD earlier in their lives than those who were not conceived during the famine. This suggests that traumatic landscapes are associated with the mental and physical development of exposed individuals into adulthood, written into their biology, and waiting to transmit to subsequent generations.

## 4.10 ADULT PTSD

Symptoms of PTSD for adults include flashbacks, bad dreams, intrusive and frightening thoughts, memory issues, distorted feelings, loss of interest in previously enjoyed activities or depression, being easily startled, hypervigilant or on-edge behavior, sleeping issues, and unstable or angry outbursts (Perkins et al. 2018). PTSD can be a co-morbid condition and exhibit itself along with other psychological disorders including depression, dissociation, depersonalization, aggressive behavior, and impairment in the capacity to experience pleasure, satisfaction, and fun (Kolk 2001). It is important to address symptoms associated with trauma immediately rather than waiting until symptoms progress into self-harm, or worse, suicide; "The lifetime suicide risk among patients with untreated depressive disorder is nearly 20%" (Vonnahme et al. 2015). This is a significant statistic that shows mental health disorders should be taken seriously. Treatment should be available and made a priority to vulnerable populations, including displaced people who have fled conflict.

## 4.11 THE DOPAMINE HYPOTHESIS | TRAUMATIC LANDSCAPES AND CHANGES IN NEUROTRANSMITTER REUPTAKE

Being in a chronic state of fear can affect an individual's neurotransmitter reuptake system. This subsection will primarily discuss Dopamine Receptors, also known as D2 receptors. Haven explains the relationship between trauma and excessive receptor production:

> Trauma is the inability to complete the threat response. The event is too much or too fast for our nervous system to manage. The nervous system creates adaptive responses to trauma. These include an increased pain threshold and the internal system either shutting down or speeding up. A disease characterized by a variable degree of chronic trauma associated with hyper-reactivity, a defense mechanism could be excessive neurotransmitter production that would result in excessive receptor production--in time, epigenetically changing the baseline neurotransmitter reuptake" (Haven 2018).

Haven suggests that trauma can affect the level of neurotransmitter reuptake, whether too low or excessive. Schizophrenia has deficits of serotonin and norepinephrine, but has excessive activation of the neurotransmitter dopamine:

> The dopamine hypothesis of schizophrenia proposes that excess activation of D2 receptors is the cause of the positive symptoms *(delusions, hallucinations, and thought disorder)* in schizophrenia. However, antipsychotic drugs that block dopamine D2 receptors are highly effective in treating the psychosis, but have limited effects on the negative symptoms *(deficits in social abilities and speech,*

*affective flattening)* (Bókkon et al. 2011).

This study shows that D2 receptors are at least in part associated with symptoms of schizophrenia. Additional studies support the dopamine hypothesis, "The elevation in apparent D2 High receptors *in vivo* in schizophrenia matches the elevation in D2 High receptors *in vitro* in animal models of psychosis" (Seeman 2013).

Schizophrenia can be disabling and can greatly interfere with day-to-day activities (HealthDay 2015). There are many unanswered questions regarding the cause of schizophrenia. Some researchers suggest there is a disturbance of PV neurons causing excessive synaptic pruning in early adulthood (Woo 2014). Other models suggest trauma can disrupt the production and reuptake of dopamine, contributing to impulsive behavior. Individuals with schizophrenia have excessive production of the neurotransmitter dopamine, suggesting that trauma may be a contributing factor to developing the illness.

Individuals with high dopamine production in the brain may be more likely to take part in risk-taking behaviors and are more likely to develop addictions, "People with high levels of dopamine in the brain may have a lower sensitivity to its effects, meaning that they need to have more intense experiences in order to feel pleasure that this brain chemical causes. This, in turn, can be bound into the person's experience using drugs and alcohol, which directly affect the dopamine system" (Crane 2019). If traumatic landscapes are associated with changes in neurotransmitter regulation, then those who have experienced warlike conditions are more likely to experience these proposed changes in dopamine regulation.

People with schizophrenia are behaviorally extra sensitive to dopamine-like drugs such as amphetamine. This super-sensitivity may be an increased presynaptic release of dopamine or a postsynaptic elevation of D2 receptors or of D2 High receptors in active stages of schizophrenia (Seeman 2013). Similar to how the odor of acetophenone or

cherry blossom sensitivity affects the fear conditioned pups discussed earlier in this chapter, comparably, dopamine sensitivity affects the behaviors of individuals with schizophrenia.

Experiencing chronic, traumatic environments has been linked to mental illness. Not only do these landscapes affect the development of the individual, they also affect the production of neurotransmitters in exposed populations and subsequent generations, making them more vulnerable to developing risky behaviors, addictions, and schizophrenia. This may suggest that traumatic ancestral landscapes may play a role in the brain development of subsequent generations. This suggests that children who are currently experiencing displacement may be vulnerable to exhibiting behaviors associated with schizophrenia and may pass this vulnerability onto their children and their children's children. This information can be used to illustrate the magnitude of misfortune that displaced people face during their migratory journey and the effects the trauma has on future generations.

People with schizophrenia have more dopamine receptors (D2) and different neurotransmitter activity than those without the diagnosis. Receptors are created, or expressed, by the DNA of the cell, and they can be increased, or upregulated, when the signal is weak, or decreased, or downregulated, when it is strong. The more receptors a cell has, the more the cell will respond to it. Children are especially vulnerable to developing changes in their neurotransmitter regulatory system because they are born with surplus receptors and absorb their environment like a sponge. This can be problematic for a child who grows up during wartime violence where they may normalize the landscape.

A child is born with many receptors, ready to learn and absorb the world around them. If that world is an active war zone, children may be continuously experiencing the stress cycle and struggle to reach their developmental milestones. Introducing chronic,

toxic stress into a child's life is the recipe that can grow into diagnosed schizophrenia later in life. Trauma has the ability to affect hormones, receptors, neurotransmitters, neurons, and DNA. This implies that traumatic landscapes such as the conflict in Syria has the ability to permanently change the biology of displaced populations. If conflict continues, entire populations of people will be vulnerable to developing mental and physical health disorders including schizophrenia, PTSD, depression, heart disease, and other disorders. Chapter 5 will discuss the main challenges that were continuously brought up during fieldwork meetings for this research.

# CHAPTER 5: MAIN CHALLENGES ASSOCIATED WITH CONTEMPORARY MIGRATION

Growing up in a refugee camp or informal settlement may perpetuate the cycle of poverty and destitution. The main goal of a refugee camp is to offer a safe place for people who fled conflict. These camps provide substandard education for displaced youth, often being short-staffed teachers and service providers. Refugee camps also frequently run into supply shortages and heavily rely on humanitarian efforts and volunteer work to function.

Displaced populations face many adversities during their migratory journey, leaving many susceptible to exhibiting symptoms of mental health disorders. Without access to services and support, displaced populations are less likely to have a chance of success at a normal life. Resilience is important at a time like this, when so many are uncertain of their futures or their family's whereabouts. *Body Respect* Author Linda Bacon describes resilience as "Our capacity to handle challenges, whether everyday disappointments or serious catastrophes" (Bacon 2014). Bacon discusses how defining resilience as the ability to bounce back from difficulty is insufficient. Resilience also requires having resources to support the individual in bouncing back. If resilience is defined as an individual trait, individuals get blamed for their inability to recover from adversity.

It is easy to be affected by the conditions of war and displacement, paving the way for a future of instability. Many factors can perpetuate the stress experienced by migrating populations including a lack of basic services of care that include education, stable housing, and family reunification. Other major challenges associated with contemporary migration include deporting immigrant children, temporary status, and not having the right

to work in the formal economy, causing many to face destitution or work in the informal economic sector. This chapter will discuss the main challenges associated with migration that cause additional stress to the displaced individual. The information discussed in this chapter is based on archival data and data collected from the testimonies of field collaborators and immigrant contacts. The information is placed in the Za'atari Refugee Camp in Jordan, the Kutupalong Refugee Camp in Bangladesh, spaces in Germany, Stockholm, and the informal Sorgenfri Camp in Malmö, Sweden.

## 5.1 SUBSTANDARD EDUCATION AND SERVICES AVAILABLE IN THE ZA'ATARI REFUGEE CAMP

Basic needs are not being met in refugee camps because of the lack of political will and funding. In refugee camps, educational services are not meeting international standards. Addressing the right for an individual to have access to education is a human right as is written in the 1989 Convention on the Rights of the Child and the 1951 Refugee Convention:

Education protects refugee children and youth from forced recruitment into armed groups, child labour, sexual exploitation and child marriage. Education also strengthens community resilience. Education empowers by giving refugees the knowledge and skills to live productive, fulfilling and independent lives. Education enlightens refugees, enabling them to learn about themselves and the world around them, while striving to rebuild their lives and communities (UNHCR 2019).

There is a large disparity in the educational services available to migrant children compared to children who attend traditional schooling, "Children make up 31 percent of

the total world population, but make up 51% of the refugee population" (UNHCR 2016). Furthermore, 91 percent of the world's children attend primary school, while 61 percent of refugee children attend primary school. Eighty-four percent of the world's adolescents attend secondary school, while 23 percent of refugee adolescents attend secondary school. Additionally, 37 percent of people globally attend higher education at a university, while only 1 percent of refugees attend university (UNHCR USA 2018). The data shows there is a clear disparity of educational services available to refugee populations, stunting their economic opportunity outside the camp, perpetuating the cycle of poverty and destitution.

Children are not getting their basic education and emotional needs met. In the Za'atari Camp in Jordan, there are fifteen schools in the camp of 80,000 people who are mostly displaced people from Syria. There are not enough qualified teachers in the camp. As an effort to supply education to the children in the Za'atari camp, Jordanian officials have been allowing students from the Za'atari camp to attend schools in Jordan. One hundred ninety-eight schools were designated to run double shifts where children take turns coming for education lessons either during the morning or in the afternoon for about three-four hours per day.

However, many of the Syrian students were bullied for not being able to keep up with lessons and stopped attending the Jordanian schools. A displaced Syrian student studying in a Jordanian school said he was behind in school and asked the student next to him for help. Instead of receiving help, the teacher approached and hit both of the children. This event caused the student from Syria to stop attending the school in Jordan (Summers 2017). Figure 4 shows a map of the Za'atari refugee camp in Jordan.

**Figure 4** The Zaatari refugee camp in Jordan, near the Syrian border (Gordon 2013)

According to Save the Children, about 50% of Syrian households in Jordan rely on income from the child. The pressure on the child to generate income leaves the child to pursue work instead of attending school. Ali, a fourteen-year old has dropped out of school to pick fruit in order to support his four siblings and single mother. Stories like his are similar across the camps, leaving many children behind in their education. Girls in particular have been targeted for abuse and harassment on their way to and from school. As a result, many young girls are removed from school and are then at a higher risk of being married off in order to ease the financial pressures on her family (Summers 2017).

When Special Envoy Angelina Jolie visited Kutupalong, the world's largest and most densely populated refugee settlement in Bangladesh, she was concerned that the

future of Rohingya children could be at risk for continued poverty, destitution, and lack of opportunity. Jolie wants to ensure children can gain access to formal education that leads to recognized qualifications. Jolie said, "Until the Rohingya refugees can voluntarily return home to Myanmar, we have a collective responsibility to ensure that they can continue to live dignified lives in Bangladesh" (UNHCR 2019). Political will, international support, and investment for the education and future of children is necessary for them to live valuable and fulfilled lives. Without an urgent expansion and strengthening of educational opportunities, these children will disproportionately lack the tools and access to opportunities that could move them out of poverty.

Teaching gender roles and other cultural behaviors is part of Sweden's education resettlement system. Timo, a Swedish language instructor who regularly has over four hundred refugee students discusses his approach to successful teaching, "Remember their names, all four hundred of them. I try to teach gender roles, as in men cook and clean just as often as women do" (Timo 2018). Timo then shared a story about how one of his students was surprised by Swedish gender roles and was upset that he did not know how to make pancakes. Timo offered the student encouraging words and explained how change takes time.

Timo explains how adapting to a new social environment can take years for his refugee students, "It takes time to adapt from different cultures when they come here. And they will adapt, all political people have underestimated it. It takes years. You can't just think they are going to adapt in two weeks, it takes years" (Timo 2018). Knowing it takes years to adapt to a new environment could push policy makers to invest in more educational services for displaced people. The map below shows the location where the majority of field work took place.

**Figure 5** The map shows the fieldwork site in Stockholm, Sweden

## 5.2 UNSTABLE HOUSING AND FAMILY REUNIFICATION

Many displaced people do not have stable living conditions and often live in informal settlements, abandoned buildings, camps, or anywhere they can find shelter. These landscapes often lack potable water systems, sanitary living conditions, health services, or community support. An environment that lacks basic services of care can lead to the decline of physical and mental wellness. An article published by the Kansas Journal of Medicine describes how refugees are more likely to experience ongoing PTSD, even

after resettlement:

> Moreover, the mental health of refugees is thought to be distinct from the experiences of other traumatized populations, such as veterans and sexual assault victims, due to their unique traumatic experiences as well as acculturative stress that follows the resettlement process, which features entirely new settings, practices, and a lack of familiar support systems (Hameed et al. 2018).

Globally, mental health disorders are at an all-time high with one in four people in the world being affected by mental and neurological disorders at some point in their lives (WHO 2001). However, mental health treatment is almost non-existent in refugee camps. Sara is a counselor from the Swedish Red Cross for Tortured Refugees in Stockholm who works with refugees who have been resettled in Stockholm. Many of Sara's clients suffer from mental health disorders such as PTSD and severe depression. She says a common issue she sees among her clients is being separated from their families and not having stable living conditions which hinders their treatment goals. Sara discusses why family reunification is so important:

> When we got the harder asylum laws in 2015, we saw our patients' family reunification cases get harder. For example, for parents trying to get their underage children to Sweden of course will have trouble focusing on their treatment goals. They can't focus on anything except their children being in Afghanistan or wherever. So I would like to see more research about how that sort of stress doesn't help with integration and treatment or any kind of success. Because it's so obvious for us [counselors] that the only thing they [refugees] want help with is being with their kids and their kids' safety. And then when they get help with family

reunification, the only thing they want is to get somewhere to live, and somewhere to work of course. And if all that's settled then there would be much less patients in the specialist's psychiatry (Sara 2018).

Sara believes that when families are unified and have a stable living situation, they are more likely to successfully settle into their new landscape. Sara describes how stable housing is essential for the mental wellbeing of her clients:

I think they [refugees] need stable living situations. If they have that, many people would say that it's so much easier for them to focus on going to school, or work, or going to their treatment, taking care of their children. And it's so much stress if they have to live with other people or so on, or if they can't sleep, it affects their sleep. The living situation I think is really really important (Sara 2018).

Sara believes temporary status also provokes anxiety in displaced populations, which will be discussed later in this chapter. The next subsection will discuss the stress associated with deporting immigrant children once they turn eighteen.

## 5.3 DEPORTING CHILDREN BACK TO THEIR ORIGIN COUNTRY ONCE THEY TURN EIGHTEEN

Deporting immigrant children has been a voiced concern among both immigrants and nationals alike. When immigrant children turn eighteen in the country they sought asylum in, they are due to be deported back to their origin country which may still be unsafe. This includes those who have been in a host country for years, who speak the language, and who have culturally identified with the landscape.

Eriksson, a lawyer from Rådgivningsbyrån (The Swedish Refugee Advice Center) works primarily with families from Afghanistan who fear for their futures because there are no international protections in place protecting them from deportation when they turn eighteen, the international age of adulthood. Many of these families traveled over 3,500 miles to seek asylum. Eriksson explains how his most common legal case are asylum seekers from Afghanistan who are over eighteen and lose European Union (EU) asylee protection, "Right now the typical case would be an Afghanistan guy who claims to be under eighteen, but is over eighteen and is trying to stay anyway" (Eriksson 2018). However, with no proof or paperwork, there is nothing Eriksson can do to spare the young men from being deported once they turn eighteen. Figure 6 The map shows the distance from Afghanistan to Stockholm, Sweden (About 3,530 miles). This is the distance many of Eriksson's immigrant clients traveled from.
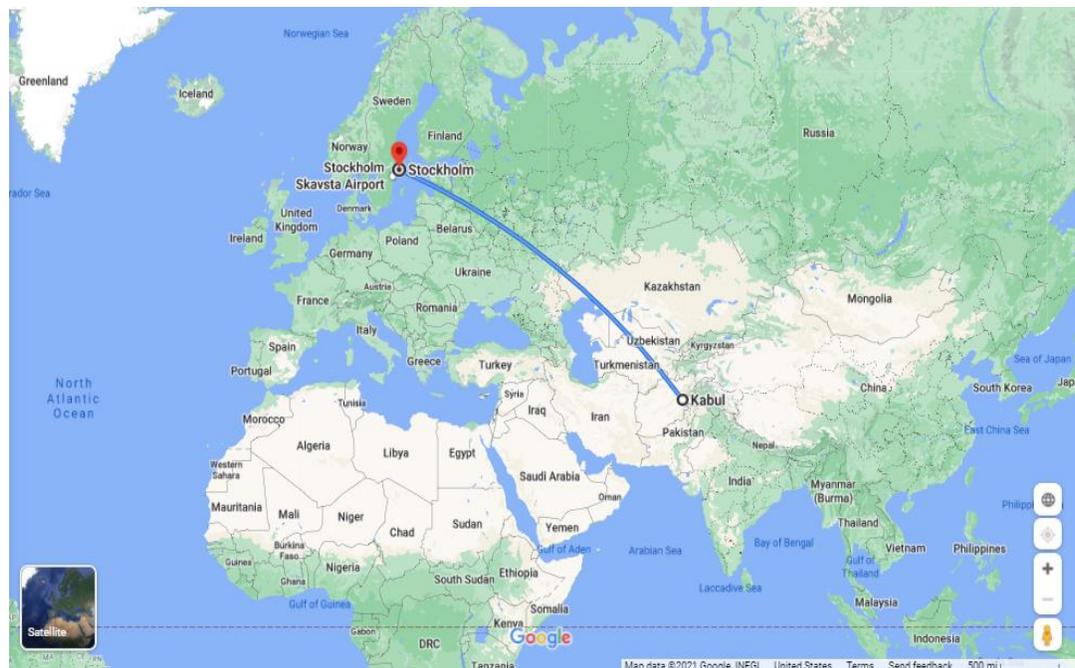


**Figure 6** The map shows the distance from Afghanistan to Stockholm, Sweden (About 3,530 miles)

Eriksson explains the process of what happens to the typical young adult when seeking asylum in Sweden:

When he's under eighteen and if he doesn't have a network or any other connections back in Afghanistan, he's considered to have the rights to asylum. He's not considered to be a refugee, but there's a subsidiary protection within the EU that is to be considered according to the Swedish authorities. But the second he turns eighteen, he is not a child anymore, he is able to go back. So there is quite a harsh line between being eighteen and not being eighteen (Eriksson 2018).

Once the asylees turn eighteen, their rights are taken from them. Rather than helping them assimilate into the community, the state sends the individuals back home to their origin country, where political and economic conflict may continue. Even when the asylee has their papers, they do not want them to be processed for fear of being involuntarily deported back to their origin country. Geographer Reece Jones often writes about the criminalization of immigrants. Instead of the state having a system set up for permanent resettlement, the state is trained to treat asylees like criminals and arrest and deport them. Even if they are offered asylum, the status may be temporary and subject to being moved from facility to facility, contributing to the stress experienced by the individual.

5.4 TEMPORARY STATUS

Temporary status leads to uncertainty of the future and hopelessness for many. Eriksson spoke at lengths of how temporary resettlement is one of the major stressors among displaced people. When the young men from Afghanistan were in the care of the

state, they were taught the language, received aid, education, and became acculturated with the landscape and the people. However, once the boys turned eighteen, they were sent back to Afghanistan. This policy disturbed the lawyer because it was counterproductive as it successfully assimilated the boys to their host country, then pulled the rug out from under their feet by sending them back to their origin country of conflict.

Turning eighteen is usually something to be celebrated, but not for those who have temporary status in a country. Aging out of current EU asylee protection is similar to the stress of aging out of the US foster care system; both systems give up legal responsibility to provide services past the age of eighteen. This creates pressure for displaced youth who have temporary status to become autonomous in a world that will be taken from them once they turn eighteen. Eriksson speaks about how displaced people are often tense and stressed because they never really settle down and are unable to be fully autonomous. They are usually moved around from facility to facility, making it difficult to meet new friends, settle down, and start a new life.

Displaced people come from all over the developing world risking their lives, entrusting smugglers, crossing dangerous seas and landscapes, and constantly being on the move with uncertainties about the future. These conditions are stress inducing and can cause an individual to exhibit symptoms of mental health disorders. I met with Yasser, a Syrian refugee who has been on his migratory journey for over five years and is temporarily residing in Slovenia. For many, the migratory journey lasts longer, often decades. The map below (Figure 7) shows the location where I met with Yasser in Ljubljana, Slovenia.

**Figure 7** Slovenia is a country settling Syrian refugees. It is pinned on the map

Yasser describes how each stage of the migratory journey has its own stress. The most threatening part of his journey was the boat trip across the Mediterranean Sea between Turkey and Greece. Yasser further describes how his migratory experience has left him with permanent anxiety:

The most common symptoms were anxiety, fear of the unknown, nervousness, panic attacks, and that resulted in a kind of permanent feeling of anxiety. The trauma is often present in my life, especially the feeling of being deprived, beside the permanent anxiety in my daily life (Yasser 2019).

Although Yasser still carries symptoms of trauma from the conflict in Syria and his journey across the Mediterranean to Slovenia, he has benefitted from the country that is

hosting him. Yasser says, "On the other side, I have had positive effects such as intercultural skills, self-learning skills, learning and meeting new cultures of people, becoming more active in helping others, [and] building my independence" (Yasser 2019).

Yasser was diagnosed with PTSD and was put on Sertraline also known as Zoloft, a widely used selective serotonin reuptake inhibitor (SSRI) used to treat individuals living with depression, anxiety, PTSD, and panic disorders. Zoloft can be dangerous when paired with alcohol. It can cause erroneous behavior, memory loss, and black outs. SSRI's also are known to cause serotonin syndrome (SS) that is further discussed in Chapter 7.

When asked how Yasser was able to cope with the stress of displacement, Yasser answered, "I always tried to approach it with thinking of it as an opportunity of self-learning" (Yasser 2019). Yasser is currently continuing his education in Slovenia while awaiting five years to receive Slovenian citizenship.

## 5.5 THE *RIGHT* TO WORK ~WORKING RESTRICTIONS

Germany was accepting high rates of refugees in the years proceeding to 2016. Marcel Fratzscher, head of the DIW Economic Institute said, "Immigrants had filled more than two-thirds of the almost 1.5 million new jobs created in Europe's largest economy over the past five years" (Business Insider 2015). Germany's population is decreasing, leaving many low skilled jobs behind that need to be filled in order to continue with a growing economy. With Germany accepting refugees, they now have a wave of people that can be trained and able to fill these jobs which can lead to future economic stability and productivity in the country (Business Insider 2015). However, not all migrating people qualify as refugees; many are undocumented immigrants who are not eligible to work in the formal economy.

A main challenge associated with migration is that many countries do not give out

working permits to undocumented people, or non-asylum-seeking individuals. This affects millions of people as the majority of international migrants are able-bodied and of working age:

Three out of every four international migrants are of working age (20-64 years). In 2019, 202 million international migrants, equivalent to 74 per cent of the global migrant population, were between the ages of 20 and 64. More than three quarters of international migrants were of working age in Eastern and South-Eastern Asia, Europe and Northern America (UN 2019).

Irene, director at a US Resettlement Agency describes why some countries do not readily give out workers permits to undocumented immigrants; "To protect their economy. Employing migrants with low wages can keep infrastructure costs to a minimum for developers" (Irene 2018).

When a state does not allow a group of people the right to work, they are violating their basic human rights of equality, the right for an adequate living standard, the right to desirable work, and to join trade unions. Emilia, a German NGO employee who works at a transitional camp for refugee boys agrees that not being granted the right to work is a challenge for migrating populations. Emilia states:

A major issue is that Germany doesn't give out a working license which is a problem because these migrants want to work and there is low skilled work to be done because a lot of Germans don't want to do this work; like masonry, painting, construction, and other jobs. Lots of immigrants are not working because they are forbidden to work. Even if they are doctors, they are forbidden to work (Emilia 2018).

Emilia had some political advice when asked what she would do to reform resettlement policy:

> Keep the ones who want to do the work. If they are willing to do the work, let them legally work there. If you work legally, you can get citizenship. When you are finally allowed to work in Germany, you can work forever (Emilia 2018).

Emilia continued to discuss that once an individual receives citizenship, they are a permanent German citizen and can legally work. Emilia believes in granting more displaced populations the right to work and the right to gain citizenship from their experience.

## 5.6 INFORMAL ECONOMIC SECTORS

Not having the right to work in the formal economy causes many displaced populations to turn to the informal economic sector for economic opportunities: "Their exclusion from the dominant socio-economic system forces them to seek alternative ways to survive" (Baró et al. 1996, 90). These informal jobs include but are not limited to manual labor jobs such as painting, farm hand, construction, housekeeper, maintenance, and survival behaviors such as begging, stealing, bartering, sex, and other services. Not having the right to work can lead to unstable and dangerous methods of making money. Restricting working rights can be seen as discriminating against entire populations of moving people and putting them at an increased risk of danger.

Displaced populations have a disproportionate disadvantage of obtaining legitimate careers and access to services that many of the country's citizens have

birthright access to. Rachel Pain makes the association that the lack of available services to displaced populations can amount to a type of traumatic experience: "There can also be a lack of understanding or even denial from services and institutions including health professionals, the police, the courts, social services, employment and immigration services. This can compound trauma, whereas well-informed and compassionate service providers can make a big difference" (Pain et al. 2019, 3). Working for financial compensation is a human right. However, the state does not recognize displaced people as citizens who can contribute to the country's gross domestic product (GDP), leaving many with limited legal financial opportunities. Instead, many undocumented displaced people find alternative methods of making money such as what happened in Malmö, Sweden in 2015 as will be discussed below.

## 5.7 THE SORGENFRI CAMP; MALMÖ, SWEDEN

The Sorgenfri Camp in Malmö, Sweden was the nation's largest informal settlement for two years leading up to 2015. It was a setup of illegal temporary homes at an industrial yard. Most of the immigrants staying at the camp came from Romania and Bulgaria and were not part of the state's formal resettlement system. Many undocumented immigrants avoid seeking asylum for a well-founded fear of deportation. To remain under the radar, they find themselves living in informal settlements usually located on the outskirts of economic hubs. The map (Figure 8) shows the location of the Sorgenfri Camp in Malmö, Sweden in relation to Stockholm.

**Figure 8** Sweden's largest informal settlement, the Sorgenfri Camp located in Malmö, Sweden. About 381 miles from Stockholm starred on the map

Undocumented immigrants staying in the Sorgenfri Camp often work informal jobs and send most of the money they earn back home to their families. Common conditions reported in the Malmö camp included women engaging in sex work, people begging on street corners, people living in their cars, children sleeping in industrial buildings, vermin running about, and gang members renting industrial space for a club hangout space.

The camp was a place for drifters who passed by and needed a place to sleep temporarily. A perfect place for the displaced to settle, at least temporarily. This makeshift

camp was a lawless place where people could settle their battles, deal drugs, drag race, and engage in other behaviors. Three police officers processed reports on weapon-related crimes at the camp, each found 0.22 caliber ammunition on the property which infers weapon related crimes occurred in the campgrounds (Karlsson 2015). After polarized tension coming from some citizens regarding the camp's impact on the community, the state eventually shut down the Sorgenfri camp, forcing the immigrants to leave. Some immigrants stayed and sought asylum in Sweden, while others did not because they did not want to give up their home citizenship in Romania or Bulgaria permanently, a requirement in order to receive asylum services.

The former prime minister Göran Persson of Sweden has influenced the current government on these policies, trying to ban beggars with a speech and is quoted saying: "If we allow one group to get down on their knees, it's just a question of which group is next. You should stand up and fight for your rights, not sit down and beg" (Karlsson 2015). Persson encourages Romanian beggars to go home to fight against Romanian discrimination in their home countries in the EU. Disregarding problems prolongs the toxic conditions present among many communities.

The migratory journey comes with many stressors that can be exacerbated by challenges in the states' resettlement system. Main challenges include but are not limited to inadequate education, lack of efforts made to address family reunification, insufficient housing, deporting immigrant youth, temporary status, and working restrictions. Chapter 6 will discuss post resettlement services of care available to refugees from host countries.

## CHAPTER 6: POST RESETTLEMENT CARE AVAILABLE FOR REFUGEES

Syria accounts for the world's largest number of forcibly displaced people with more than half of the population being forced to flee their homes since 2011. The conflict in Syria has affected about 13.5 million people who fled and sought shelter as an internally displaced person (IDP) or international refugee. The majority of these migrants crossed borders into Lebanon, Jordan, and other surrounding countries (USA for UNHCR 2020). Most refugees are not given the opportunity to resettle in a host country and instead, live in uncertain spaces for decades. Figure 9 below illustrates the countries who are hosting displaced people from Syria.



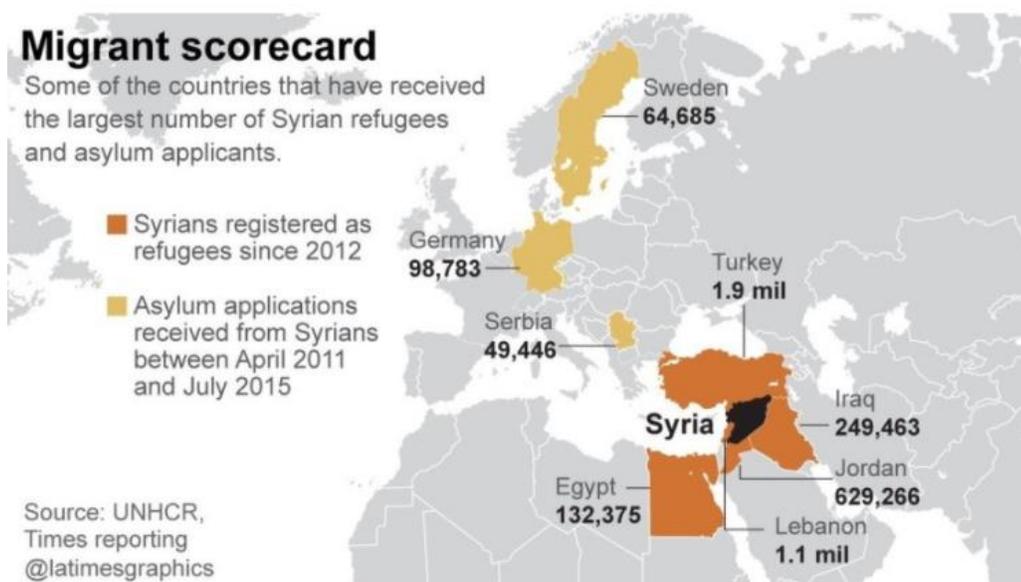**Figure 9** The map shows the countries that are processing Syrian asylum claims (LA Times 2015)

The Global Compact for Migration is a model that seeks to help millions of displaced people around the world. The Intergovernmental Conference on the Global Compact for Migration was held in Marrakech, Morocco on December 10-11, 2018. On this day, 164 nations agreed to support initiatives to make immigration safer and more

humane in the following years to come, affecting millions of migrating people. The conference adopted the Global Compact for Safe, Orderly and Regular Migration that seek to attain a sustainable migration plan, "laying out the first-ever global cooperation framework for sharing responsibility to protect the world's 258 million people on the move — 3.4 percent of its population — and supporting the host communities working to accommodate them" (UN 2018). A safer journey promotes healthier people, fewer fatalities, and hope for the future of displaced people.

Experiencing a chronic, traumatic landscape may take one's identity from them, especially when experiencing trauma from an early age. Without opportunities and support, these traumatic patterns are normalized and perpetuate displacement and destitution for the child. Imad Fakhoury, Jordanian Minister of Planning and International Cooperation believes the world should not forget about the Syrian people. Fakhoury states, "We in Jordan for example, very early on believed that we cannot afford to have a lost Syrian generation. Syrian boys and girls [who] don't go for [schooling] for five, six, seven, ten years, they'll be left vulnerable to radicalization" (PBS 2016).

According to Fakhoury, safekeeping refugees in Jordan is the most cost-effective option for offering shelter to the millions of displaced people who fled the Syrian conflict since 2011. Fakhoury states that the EU is providing Jordan with funding to take in refugees and has already given Jordan 1.5 billion dollars and pledged an additional four billion in international aid. The alternative option would cost ten times as much when refugees reach Europe and have to be further processed. Like many countries, Jordan's economy is struggling. Minister Fakhoury states that Jordan is "fatigued as a nation" and struggles with acculturating Syrian refugees in a country that is simultaneously struggling with their own economy (PBS 2016).

Every country that resettles refugees does so in their own jurisdictive power; different countries have different means of support and policies. The purpose of this

chapter is to highlight the written and unwritten resettlement methods available to displaced populations in different landscapes. This chapter will discuss services available to those who were fortunate enough to be resettled in a host nation. Some of the material discussed will be directly from my own participatory action approach used when working with refugees. It will discuss the role of resettlement agencies, mental health services available to refugees, and transferable work licenses and certifications.

## 6.1 THE ROLE OF RESETTLEMENT AGENCIES

Nations around the world offer different levels of care when receiving and resettling refugees. In the US, the Department of Homeland Security subcontracts to nine faith-based agencies. The United States Conference of Catholic Bishops (USCCB) is a national agency that subcontracts to local agencies such as Catholic Charities, an organization located in Springfield, Massachusetts, who resettle and assimilate refugees. The agency has branched into Northampton, Easthampton, and Amherst where I have been using a participatory action approach in assisting with resettlement services.

The Department of State communicates information to the UNHCR who send refugees to agencies such as these. The UNHCR knows which refugees are allocated to which country. Irene, Director of an undisclosed US resettlement agency describes the three-tiered solution for migration:

Option one is the preferred solution which is for the agency to return the refugee home when things get quieter. Option two is to establish status in the first country of asylum. This is not a bad option because many times based on the proximity of geography, the refugee shares a similar culture and language to the nation nearby. If option two fails, then the refugee may be accepted and shipped off to another

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country (Irene 2018).

Irene further states that in order to be resettled, refugees must enter the lottery system, "Unfortunately, less than one percent of refugees get their number picked to get resettled" (Irene 2018). She states, "If a refugee is picked for resettlement, the process begins. This should take between eighteen months to two years to process a single case to ensure that the individual is qualified and meets all the proper criteria for resettlement. However, cases often get extended causing processing times to be prolonged. Eventually, when the case is processed, approved, and the refugee gets resettled in the US, they are given their Employment Authorization Document (EAD) and are immediately eligible to work in the states as a tax paying individual" (Irene 2018). Figure 10 below shows the communities where refugees are resettled in Western Massachusetts.



**Figure 10** The towns of Amherst, Northampton, and Easthampton, Massachusetts. Efforts are being made to resettle refugees in these towns (WesternMassEMS 2020, Catholic Charities 2020)

In Northampton and Amherst, MA, as soon as refugees arrive, they are signed up for MassHealth health insurance. An employee from Catholic Charities is assigned to coordinate all health care coverage and appointments for the first ninety days after the refugee family's arrival. All families will receive their first health care visits at Caring Health Center, a contracted health care provider with the Office of Refugee Resettlement in Western Massachusetts, that provides post-arrival mandated medical examinations and treatment to newly resettled families.

New refugee arrivals in the U.S. have mandatory healthcare guidelines to follow. If a serious health condition exists, staff will help schedule an appointment within seven days of arrival. If a mental health disorder has been identified in health records, staff will assist with scheduling an evaluation with a clinician within thirty days of arrival. This includes assisting in follow up appointments with appropriate providers through either continued therapy or preventative treatment options. All other general health screenings such as physical exams and immunizations must be done thirty days after arrival for adjustment of status to become a permanent resident status (Catholic Charities 2014).

The families also receive a caseworker who helps transport them to mandatory meetings and teaches computer and financial literacy skills. The case workers help the families learn more about contemporary banking in the US such as paying bills, credit scores, loans, job interview skills, drafting emails, sending letters, learning medical terminology, translation and related services. Every case worker has different priorities dependent on the needs of the family.

Before Catholic Charities decides to resettle a family into a new community, they make sure to scope out the community before they make a decision. The Catholic Charities director makes sure to meet the locals in the community, the mayor, the city officials, tour the schools, and analyze the local infrastructure to see if the community

would be a fit environment for the new refugee family. The organization also takes into account the proximity of utilities, available transportation to the downtown area, population, and accessibility before resettling a refugee family in the community.

Catholic Charities relies heavily on the efforts of part time employees and volunteers in the community. These additional services include picking refugees up at the airport, language translation services, ensuring housing meets state guidelines for safety, sanitary, affordability, and furnishing standards. Refugee families are also provided food and food security programs. Within ten working days, staff must assist the individual to enroll in employment services or English as a Second Language (ESL) course often taught by part time employees and volunteers. Weekly cultural orientation classes are also scheduled into the newly arrived refugees' agenda.

Staff also assist in helping newly resettled refugee families apply for services such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), food stamps, energy assistance, food banks, Social Security Income (SSI), Medicaid, and assistance with transportation such as bus passes. Staff and volunteers teach job skills, assist with resume building, conduct mock interviews, teach email and telephone etiquette, and network within the community to obtain job opportunities. Staff also assist in providing information to the US Department of Homeland Security (AR-11), providing information regarding travel loans, and applying for a new US Social Security card within seven days of arrival.

Childcare is often available for the refugees with busy schedules by volunteers in the community who fill out an application and undergo a criminal record background check. Childcare is offered daily by volunteers while the children's parents are in their language class, working, or at appointments. Children who are of school age are enrolled in school within thirty days after arrival. When a refugee family is settled, the agency organizes a Circle of Care (COC) group in the community who pledge to support the

refugee family for a five-year quota after resettlement (Catholic Charities 2014). Those who pledge their support do so in ways of checking in on the family, offering their services of childcare, tutoring, rides to religious places of worship, and by offering their friendship.

The agency follows a Reception and Placement Core Services Checklist when accepting and resettling refugees in the Pioneer Valley. The checklist is to assist resettlement staff and volunteers with ensuring that all core services and procedures are followed. Oftentimes, refugees are unfamiliar with the language of the country they are resettling in and are mandated to receive approximately twenty hours of language practice a week. Sometimes, these quotas are not met because of the refugee family's busy schedule, mental fatigue, and a shortage of teachers and volunteers in the community. COC groups also teach refugees how to convert scales and measurement systems such as metric units including meters to feet, kilometers to miles, or kilograms to pounds. Before they are resettled in the US, refugees must undergo a background check.

## 6.2 BACKGROUND CHECKS

Refugees being resettled by receiving nations must undergo a highly sensitive security clearance before being granted residency. This includes validated biodata such as date of birth, religion, position, salary, parents' names, background check, health records, family networks and any associations with terror groups such as the Islamic State. Health and criminal records are also processed before any person is granted entry. The US may not allow someone into the country if they are not updated with standard vaccinations, have a record of certain mental illnesses or addictions, or have any criminal offenses/convictions, such as a Driving Under the Influence (DUI), as they are seen as indicators of a threat to the general-public (e-CFR, Part 34 2020). Any individual who may be associated with terror groups will not be resettled in a receiving nation.

Some receiving countries have strict policies regarding national security and may choose not to resettle individuals from certain countries in conflict. This is the reason why the US does not regularly receive refugees from Syria; "The number of Syrian refugees allowed into the United States in fiscal 2016 was 12,587. In fiscal 2018, the United States admitted 62" (Zezima 2019). These strict policies can prevent vulnerable populations from receiving care. Other developed nations such as Sweden and Germany have similar resettlement policies in place for receiving refugees. With the decline of resettling refugees, more people are left untreated and vulnerable to developing mental health disorders. However, those who are resettled in a receiving-nation have more access to mental health care services; though, these services have been biased and insufficient. The following subsection will discuss the mental health care services available to newly resettled refugees in Stockholm, Sweden.

## 6.3 MENTAL HEALTH SERVICES AVAILABLE TO REFUGEES

Treatment for psychological disorders is still in its infancy; "The United States government first collected information on mental disorders in 1840, when the national census listed two generally accepted conditions: idiocy and insanity. A century later, psychiatrists knew more" (Esquire 2014). Psychology has come a long way since the mid-1800s, but like any other discipline, it is still evolving.

Mental illness is omnipresent across the landscape. However, there is a disparity between who receives mental health services across the globe; "Currently, more than 40% of countries have no mental health policy and over 30% have no mental health programme. Around 25% of countries have no mental health legislation" (WHO 2001). Many refugee camps are located in or near developing world countries that do not have access to standard mental health care services. This disproportionately affects refugee

populations' ability to access these services of care. If we want to offer care, then psychology needs to continue developing mental health care practices and expanding these services to meet the demand.

Dr. Gro Harlem Brundtland of WHO believes the contemporary mental health care model is a failure, "Mental illness is not a personal failure. In fact, if there is failure, it is to be found in the way we have responded to people with mental and brain disorders," (WHO 2001). Although mental health practitioners are in high demand, there is a global shortage of mental health care providers. There is only one available psychiatrist per 100,000 people in over half the countries in the world. Over 40% of countries have less than one hospital bed reserved for people struggling with mental health disorders per 10,000 people (WHO 2001).

Generally speaking, mental health is severely underfunded, "Currently, more than 33% of countries allocate less than 1% of their total health budgets to mental health, with another 33% spending just 1% of their budgets on mental health" (WHO 2001). About 25% of countries do not have the three most commonly prescribed drugs used to treat schizophrenia, depression and epilepsy at the primary health care level (WHO 2001). The Swedish Red Cross (IFRC) in Stockholm offers medication and certain therapies to treat PTSD such as DBT, CBT, and other therapies like yoga and meditation. However, Sara, a provider at the IFRC says these therapies are useless unless the clients are stable first.

Sara also discusses that recovery does not happen overnight. Many factors are associated with the stress of the migratory journey, especially if the family has been separated. Sara says that clients who are separated from their families have a difficult time accepting treatment because they are in a state of stress so severe that they are unable to focus on treatment. Sara says:

It's so obvious for us health providers that the only thing our clients want help with

is being with their families. And then when they get help with family reunification, the only thing they want is to get somewhere to live, and then somewhere to work of course. And if all that's settled then there would be much less patients in the specialist's psychiatry (Sara 2018).

Family reunification is an essential service that should be provided for displaced populations, as they have a difficult time recovering from trauma when they do not know their family's whereabouts or even if they are alive.

## 6.4 MEASURING SUCCESS

When refugees seek care at the Swedish Red Cross, they work with a mental health provider to become aware of their symptoms and work on alleviating core issues. Sara discusses success in the refugee clients at the clinic:

Success is a measurable reduction of symptoms of their diagnosis. A goal of treatment is for people to feel helped and feel empowered. Success is when they know where they are, what they are doing, what they can choose between, and how they can communicate with authorities. Of course, many of our patients are newcomers in Sweden, some of them have lived twenty years in Sweden as well but may not know about the Swedish welfare system and so on. So I think that helps them with their stress and if they have less stress in their life, they are better at handling their symptoms of trauma (Sara 2018).

Sara continues to discuss what success looks like for the client, "When people are able to live their normal life, when they feel they are able to continue their life, they got a

job, they're living. That's how I measure success" (Sara 2018).

Ken, another employee at the Swedish Red Cross describes his role trying to measure success at the organization:

> Some of what I am doing here is trying to look at how to measure impact which can be called success here. It's looking at some of these assessments that the therapists do when people first come here. For example, to measure PTSD, psychologists measure trauma when the refugees first arrive and again when they discharge to see whether there has been a change (Ken 2018).

Anyone can experience trauma and exhibit symptoms of mental health disorders. Many people do experience these symptoms, but carry on with their responsibilities, work, and child rearing. Others respond to trauma more severely where their ability to be autonomous will be affected. Ken describes what success looks like in his clients:

> Success is people able to live their normal life and want to continue with their life. Success is also when they get a job and they are living and don't need therapy anymore. Success can be that they leave therapy happy. And the reason they leave therapy is that their life has started, they got a job, they're living. So that's a measure of success for them (Ken 2018).

Success for refugee populations is attainable when proper services of care are available. Displaced people are more likely to thrive in an environment where they have access to services such as transferable work licenses. These transferable programs are an essential service that allow displaced people the opportunity to be part of an active workforce.

## 6.5 TRANSFERABLE WORK LICENSES AND CERTIFICATIONS

The city of Holyoke, Massachusetts received displaced people from the Dominican Republic, the U.S. Virgin Islands, and Puerto Rico when Hurricane Maria hit in 2017 (Segarra and Bubello 2017). The city found that many people from Puerto Rico were teachers, nurses, electricians, and hairdressers, but were unable to qualify as teachers or hairdressers in the U.S. because of different standards and certifications. Figure 11 & Figure 12 below show the path of Hurricane Maria that led to the displacement of many.
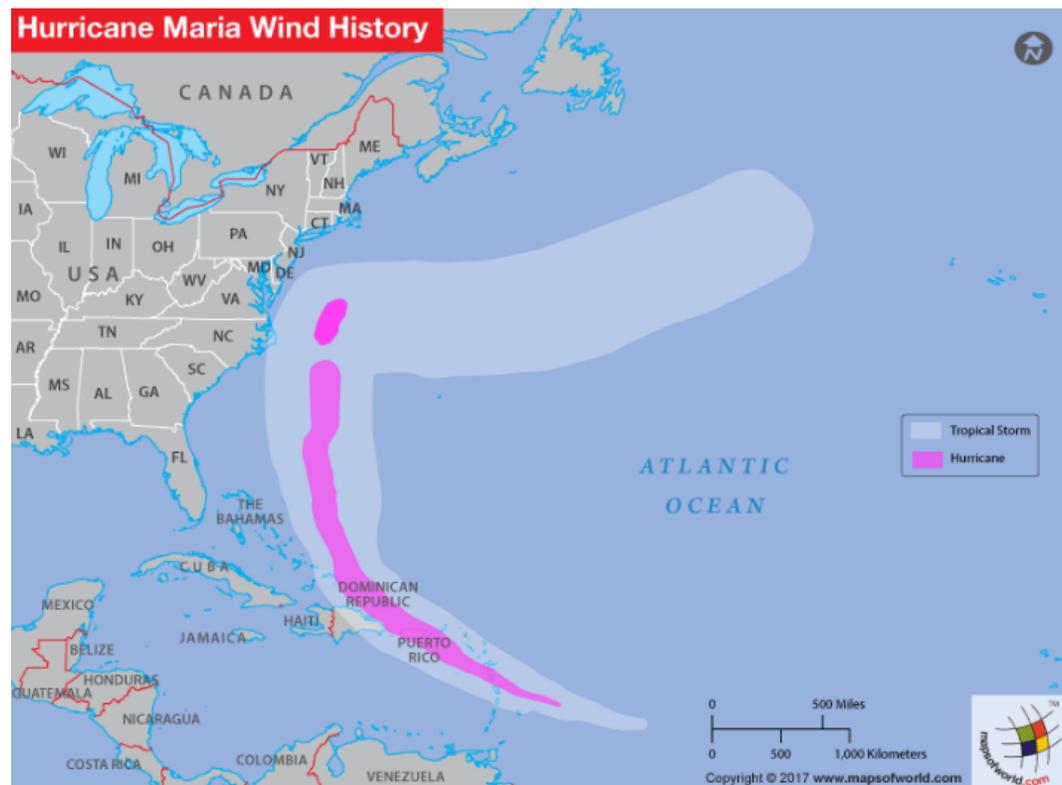


**Figure 11** The path of Hurricane Maria. The map shows the hurricane approaching the Caribbean islands in the Northern Atlantic Ocean (Maps of World 2017)

**Figure 12** The map shows the projection of Hurricane Maria. This event occurred in September 2017, affecting many countries in the Northern Atlantic Ocean (Daily Mail 2017)

In the current US system, nurses are not able to work in the U.S. unless they pass the National Council Licensure Examination (NCLEX-RN). There is only one testing center in Puerto Rico that offers the NCLEX-RN exam. Mar, a displaced nurse from Puerto Rico, was licensed through the Professional Association of Nursing of Puerto Rico, a process involving sixty hours of coursework every two years, a lawyer, a lot of paperwork, and a $300 payment. However, he will not be able to work as a nurse in the U.S. unless he passes the NCLEX-RN, a mandatory requirement.

Applicants from non-English speaking countries must complete a Commission on Graduates of Foreign Nursing Schools (CGFNS) evaluation and the Test of English as a Foreign Language (TOEFL). The process can take months and can be expensive.

Holyoke, Massachusetts offered their support by working with the state to help pass a waiver that permitted individuals to work in positions that they held back home, "Massachusetts' government is trying to find ways to expedite licensure, bypass it temporarily, or adjust reciprocity laws" (Betancourt 2018). This adjusted licensure model can be used when resettling displaced people as an effort for successful integration. A map of Holyoke, Massachusetts (Figure 13) is highlighted in red below.



**Figure 13** The city of Holyoke is helping immigrants acclimate in their environment. Holyoke is highlighted on the map and is a city in Hampden Country, Massachusetts

In order to be a teacher in the U.S., educators must pass the Massachusetts Tests for Educator Licensure (MTEL). In a policy adjustment, the Massachusetts Department of Elementary and Secondary Education (ESE) has determined that educators temporarily relocating from Puerto Rico can be considered as exchange teachers, and will be exempt from the requirement of Massachusetts licensure.

Paradigm Shift is an initiative of the Diverse Teacher Workforce Coalition of Western Massachusetts. The organization works with a network of school districts, colleges, universities, unions, workforce agencies, and community organizations in an attempt to help diversify the teacher workforce in the region (Paradigm Shift 2019). The

organization also offers displaced people the option of receiving help studying and preparing for the MTEL. For the remaining licensed professionals, the Massachusetts Division of Professional Licensure oversees management of its twenty-eight different boards of registration, including those of cosmetologists, social workers, plumbers, and veterinarians (Betancourt 2018).

Similarly, Careerpoint, a bi-lingual job placement organization in Holyoke, MA has continued to place the displaced with jobs in their new community, "They'd helped 354 people as of Jan. 2 [2018]" (Betancourt 2018). The majority of refugees are never resettled in a new country, leaving millions living in refugee camps and informal settlements. Global nations have the power to support safe and humane immigration, alleviating some of the toxic stress that many displaced populations face among their migratory journey.

## 6.6 THE SIGNIFICANCE OF COMMUNITY ENGAGEMENT IN REFUGEES' WELL-BEING

Some NGOs like Sesame Workshop are practicing successful community assimilation practices by implementing creative play in refugee camps. Creative play can help children learn to connect with their peers and promote healthy growth and resilience. Other organizations like Camp Mondschein are assimilating refugees to their new landscape through sports and team activities. However, with such a pressing, international geopolitical topic like migration, NGOs are not powerful enough to alleviate all suffering faced by displaced populations. This has left much of the responsibility of assimilating refugees in their new landscape up to volunteers in the community.

Creative play has been shown to help foster brain growth in children, promote social connection in relationships, and increase resiliency against developing an adulthood mental illness. According to a *60-Minutes* video on implementing creative play

in refugee camps, the average length of time for a refugee to stay in a camp is approximately twenty years, or two decades (CBS 2019). The severity of migration sparked a partnership between two of Syria's leading non-profit institutions; Sesame Workshop, creator of Sesame Street, and the International Rescue Committee (IRC). The IRC is a refugee assistance organization originally founded by Albert Einstein.

Sesame Workshop and the IRC teamed up with a common goal; to help the youngest refugees living in refugee camps. They used the Za'atari and the Azraq refugee camps in Jordan as model studies. Combined, both camps have about 115,000 people living inside them. This is a small percentage of the six million Syrian refugees who fled conflict in Syria. The MacArthur Foundation launched a competition with a $100,000,000 prize for any organization to solve a major global problem. The problem that Sesame Workshop and the IRC wanted to solve was trauma, especially toxic stress among refugee children in war torn countries such as Syria. Their pitch included Sesame Workshop creating a new show based on living in a refugee camp working directly with refugee youth.

This means that the two organizations will offer in-person services to over one million children over the course of five years. Additionally, the education content from the new show would reach nearly eight million children and expose them to the real-life content of living in a refugee camp (CBS 2019). Sesame Workshop and the IRC hope that the implementation of these creative services will help the refugee children connect with each other and continue to foster growth both intellectually and creatively. The organizations also hope that they have created a model that will be picked up and implemented in other refugee camps around the world.

They are hoping that their initiative helps express children's creativity, stimulate their minds, and promote growth and connection within their social relationships. The concept of creative play, or dramatic play is a successful tool in helping children's mental health development. Public Broadcast Service (PBS) supports implementing creative play

for children, "Creativity also fosters mental growth in children by providing opportunities for trying out new ideas, and new ways of thinking and problem-solving" (PBS 2020). PBS continues "One of the strongest benefits of play is the way it enhances social development" (PBS 2020).

Emilia, a German NGO employee who works with young refugee boys, helps them assimilate into the German culture through sports activities. The organization runs a camp called camp Mondschein, which translates to "Moonshine." The camp was created to help refugee boys meet local boys their age. The program hosts viewings of fútbol/soccer, concerts, has a cafe, restaurant, and other activities to help the boys meet each other and assimilate into the community. Emilia mostly assists refugees from Africa, although she has had some from Syria as well.

When asked why she works only with boys, she answers, "They show up alone, without parents" (Emilia 2018). When asked if there are there any programs for girl refugees, Emilia answered, "There is a program for girl refugees called *Girls Cafe* where girls meet at cafes, drink coffee, and talk about girl topics. Only girls allowed. Other German hobbies for girls include maybe playing an instrument or riding horses" (Emilia 2018).

I asked Emilia what success looks like for refugees in Germany. She answered, "Success looks like the refugees getting accepted to work. Working and paying taxes, getting assimilated into community" (Emilia 2018). I asked her if she had any suggestions to make the German Resettlement policy better, she answered, "Germany is underdeveloped in the aspect of social media coverage and outreach in the nonprofit world. If we had better media, we would probably get more money for the refugees" (Emilia 2018).

I asked Emilia if she has any advice on better assimilation for refugees in Germany. She responded, "Explain daily life duties, like go to the supermarket with them and explain

how daily life works. Help them with understanding social norms of everyday lives, stuff like that" Emilia continued, "Let them know it is okay for women to go outside after dark because in their culture, if a woman goes out after dark, she is a prostitute. It is not like that here" Emilia also stressed the importance of active team-oriented activities like sports teams, "Help include them in our hobbies like fútbol [soccer] club to help them be part of our society" (Emilia 2018).

Sports are a universal doctrine that any country and any gender can take part of, building social networks since millennia. Similar to German assimilation, Spanish assimilation identifies soccer or Fútbol, as a successful integration strategy for refugee youth. Mendi, a Moroccan born key contact who lives and works in Spain discussed how soccer can be a successful integration strategy, but addresses the challenges in providing that service when the country is struggling itself. Mendi states, "In Spain we love Fútbol, but that's a simple approach for integration. I think the problem goes beyond that." He continued, "In order to help people, they [Spain] need to feel helped themselves first. In order to help people, they need to have their needs met first" *Mendi 2018). Mendi then spoke about how Spain has bigger problems to deal with like unemployment, corruption, and Catalonia's independence. Mendi discussed the matters of Urdangarin, the husband of the Princess of Spain who was caught embezzling money into offshore accounts and didn't pay taxes on it. He accepted payments but didn't report it, he kept it for himself.

Mendi also spoke about the problems with corruption with the Partido Popular, the political party in charge of Spain. He discussed how Catalonia wants independence, but is drawing people's attention away from Spain's major problems like unemployment. All of these issues in Spain make the increase in refugee matters not a major concern, "They [Spain] have their own problems." Mendi thinks assimilation is important, but is not limited to sports, he states, "First priority is education, second is job. I think we should focus on the youngest" (Mendi 2018). Emilia and Mendi both believe social networks and education

can help youth build resilience in their new landscape.

Emilia believes the state would get more funding if they utilized media more and showed the refugee experience on screen. Mendi believes the state should place mental health as a priority when processing asylum claims. Mendy states, "Sweden is more welcoming than Spain because they don't have the problems that Spain does that I mentioned earlier. They have more commodities and human development index than Spain. My personal opinion, Europe needs to understand that refugees are not there on impulse. But sometimes there are security issues, PTSD, anxiety disorders that should be dealt with by professionals. Countries that don't have this, need strategies to implement this" (Mendi 2018). Mendi continues to discuss how there is a *Refugees Welcome* sign in Madrid, Spain, but the sign means nothing if people do not actually make refugees feel welcome. Figure 14 shows the Refugees Welcome sign as refugees enter Madrid, the capital of Spain.



**Figure 14** A sign reading *Refugees Welcome* in Madrid, Spain (Gallivance 2017)

Simply fleeing war is not enough to make an individual resilient against developing a mental health disorder; they need a support system, positive relationships, and an accepting community. Many individuals who remained resilient in the face of adversity benefitted from being with family, engaging in trusting, social relationships, and supportive community initiatives. Research has shown that resilience can be learned, this is why cultivating healthy social emotional development in children and families is a growing research trend across disciplines (Harvard 2021).

Community initiatives are a successful practice that lead to resilience for those rebuilding their lives in a new landscape. As assessed in this thesis, the assertion is made that traumatic landscapes affect the mental health of exposed populations. When comparing mental health and displaced people on a global scale, those who were openly welcomed and treated with humane processing protocols were more likely to experience resiliency from developing a mental health disorder. Pain writes how place can affect mental health. She discusses how improving the external environment will directly improve one's wellbeing, "The research shows the key role that the world outside the survivor has in prolonging and intensifying trauma, but also in helping to heal" (Pain et al. 2019, 3). Treating displaced people with compassion can help heal the trauma they experienced and further promote mental health well-being.

Access to services such as health and nutrition, education, and creative play are important services that should not be overlooked in any population, including displaced populations. When comparing different cities across the global scale, higher quality of care offered to migrants by the community was associated with resiliency against adulthood mental illness. Migrants were found to be more resilient against developing a mental illness when given the opportunity for family reunification, education, legal services, cultural assimilation, job placement, healthcare, and mental health services.

Liana Chase stresses how important community initiatives are for resiliency especially when there are limited to no access to mental health care services. In the journal *Forced Migration Review,* Chase describes the rising rate of suicide among both Bhutanese refugees who have been resettled in the US and those still living in the camps. Since most of the resettlement work is completed by volunteers in the community, refugees' well-being is highly dependent on the services and connection from the volunteers and community members. Communities often find themselves supplementing professional services in order to promote psychosocial well-being. Chase uses a case study in Burlington, Vermont where many Butanese refugees have been resettled to provide scope on how important successful community initiatives are for newly resettled refugees' wellbeing:

> Among Bhutanese refugees, it is widely believed that remaining engaged, both physically and mentally, is critical to preventing states of mental distress, as is sharing feelings of distress through conversation. Most interviewees only felt comfortable sharing their 'burden' with one or two trusted friends or relatives; in light of the separation caused by resettlement, forums for meeting new friends are more vital than ever to promoting emotional expression and social support (Chase 2012).

Chase addresses how this case study in Vermont can shed light on the challenges migrants face in their day to day lives and how the community can help build resilience among displaced people. Community initiatives can be anything in the form of caring and connecting with the new community members including simply talking with them, having coffee together, craft circles, walking groups, sports groups, help with job placement or skill building, or creative play for the youth. Many of the displaced children enjoy sports,

creative play, or time in nature. These activities help build social relationships and help promote confidence and good health. Implementing creative-play education programs for displaced children and youth has shown multiple benefits for overall well-being and resilience.

A common theme addressed in this chapter showed that many receiving countries such as Jordan and Spain suffer from their own internal political and economic issues, making responsibility sharing challenging and leaving much of the pressure of resettling refugees to countries higher on the human development index like Sweden. Such countries are likely to offer contemporary mental health treatment models to asylees. However, there is a cap at how many people can be resettled and receive care in these countries. These models often continuously displace people as their status may not qualify them as an international refugee.

This chapter addressed services of care such as family reunification, promoting social relationships, and education as important factors when assisting separated families. The ability of being autonomous and having job accessibility is a measure of successful integration. This can be done by reaching out to community members about job opportunities, transferable work licenses, or by helping displaced people certify their skills locally in order to be considered for the local job market. This chapter also assessed the importance of supportive relationships and community engagement initiatives both in refugee camps and in the receiving community. Chapter 7, the final chapter will further discuss integral solutions that are being implemented in informal settlements and refugee camps. Chapter 7 will also discuss the theoretical framework and future directions of this research.

# CHAPTER 7: DISCUSSION

## PART I

Displaced people are more prone to developing mental health disorders and physical health problems, along with an early death when compared to their counterparts. Children who experience warlike landscapes are hit the hardest since they are still developing. Conditions that perpetuate the stress experienced by migrating populations include being separated from family, whether by detention or along the migratory journey. Many people still do not know the whereabouts of their families, like those who have survived the Yazidi genocide, leaving thousands of children still unaccounted for. Other conditions that perpetuate the migratory experience include fear of being put in detention for an unspecified amount of time, deportation, temporary status, work ineligibility, and not being welcomed into the new landscape. These factors contribute to the stigma associated with migrating populations and impose a greater risk of developing a mental health disorder among displaced people. If states can work together to mitigate some of this stress, displaced people can become more resilient as they continue their lives.

Some practices have shown success in not only assimilating refugees to their new landscape, but also helping individuals develop strong connections with peers, which can help them remain resilient against symptoms of mental health disorders. These activities were discussed in Chapter 6 and included Camp Mondschein whose goal is assimilating youth refugees with local peers as an effort to help these kids get comfortable with their new landscape and make friends. Having strong social support networks are vital for resilience in displaced populations. These activities are organized with peers and include soccer games, time at the cafe, concerts, and other activities. Chapter 6 also discussed how efforts made by organizations such as Sesame Workshop promoting the arts and

drama can also help promote healthy growth, strong relationships, and resilience.

This chapter will discuss the most essential services that displaced populations need to remain resilient during their migratory journey. It will define possible solutions to everyday problems that migrant communities face, including access to family reunification services, potable water, nutrition, housing, education, and healthcare. This chapter will also discuss why mental health care should be implemented as a standard service available to displaced populations, comparable to the basic services prioritized such as water and nutrition.

## 7.1 FAMILY REUNIFICATION

Key contacts have vocalized in Chapter 6 that family separation is a major factor contributing to symptoms of mental health disorders in displaced populations. Nadine Burke Harris believes it is our responsibility as a society to provide care to the children separated from their parents and waiting in detention facilities, "... It's our obligation to provide these children care given the trauma that we have inflicted on them and what we know about the long-term damage that that can cause. If we believe and if we say that we are a moral country, then we have to act that way" (Harris 2019a, 3:12).

Martin Baró believes with proper support available for displaced populations, trauma can be significantly decreased, "Although war marks a child, there is no reason for it to stigmatize or traumatize, as long as the necessary support or relatives is available" (Baró et al. 1996, 127). Education and awareness on the politics and conditions of the migratory journey require international support and funding for vulnerable populations wellbeing. Understanding the mental health of refugees is imperative to creating a more humane resettlement system that offers a care-first approach as opposed to the unworkable current situation. Governments around the world need to have the political will

to address international conflict in order to aim toward a less traumatized society. The political will needs to be present among all nations participating in peace practices for change to occur.

## 7.2 ACCESS TO POTABLE WATER

A report from WHO and UNICEF showed that about 2.1 billion people globally -- more than a quarter of the world's population lack access to clean water (McPhillips 2019). Contaminated water sources are a global issue affecting landscapes found all over the world. The WHO and UNICEF joined together to create the report *Progress on Drinking Water, Sanitation and Hygiene* to highlight the work and goals that the organizations aim to accomplish, "By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance" (WHO and UNICEF 2017, 16).

People around the world have unequal access to clean water. Those living in poorer, rural landscapes, developing world countries, informal settlements, and refugee camps are more likely to be exposed to compromised water quality. Even communities in developed world countries like the US struggle to access clean water systems, "The American Society of Civil Engineers gave the U.S. a 'D' grade for the quality of its drinking water systems based on an evaluation of their safety, condition, capacity and other criteria. Of the 25 states with individual grades, none scored higher than a 'C+.' Pennsylvania, Louisiana, Arkansas and Alaska all received 'D' grades" (USA Today 2017). Domestically, nearly 63 million people, or a fifth of the United States lack access to clean drinking water. Many of these places that lack clean water systems are small towns that fall under the

national median income and do not have the resources to implement potable water systems. Many local water treatment plants, especially those in small, poor and minority communities, cannot afford the equipment necessary to filter out contaminants. Those can include arsenic found naturally in rock, chemicals from factories, and nitrates and fecal matter from farming.

In several Southwestern states, two-million people received groundwater tainted with arsenic, radium or fluoride from their local water systems, with many exposed to these chemicals for years until hundreds of small, low-income communities could afford to filter them out. Some towns still have not cleaned up their water and still rely on their tainted water system for domestic uses such as bathing, cooking, and drinking (USA Today 2017).

The US government recognizes the challenges of implementing clean water systems in low-income communities, "In the final months of the Obama administration, the EPA's Office of Water published a report highlighting aging infrastructure, unregulated contaminants and financial support for small and poor communities as top concerns for drinking water quality going forward" (USA Today 2017). Thousands of rural towns use substandard water systems because communities often lack the expertise and resources to provide safe drinking water.

For example, the town of Walsh, Colorado located at the southeast corner of the state has a population of just over five hundred people who are exposed to unsafe drinking water. The town has released information about water samples they collected in July of 2018 that showed high nitrate levels, "The nitrate levels measured 11.2 milligrams per liter (mg/L). This is above the nitrate maximum contaminant level (MCL) of 10 mg/L. Nitrate in drinking water is a serious health concern for infants less than six months old" (Colorado 2018). High levels of nitrate from farm runoff and groundwater rock are linked to cancer and low oxygen levels in babies (USA Today 2017).

Boiling water does not kill nitrates, instead, it can lead to more harmful effects,

"Nitrate is a concern for infants because they can't process nitrates in the same way adults can. Excessive boiling can make the nitrates more concentrated, because nitrates remain behind when the water evaporates" (Colorado 2018). In infants under six months old, drinking water in excess of the MCL can make a child ill, and may result in death. Experts also warn that contamination in water can lead to cancer, gastrointestinal disease and developmental delays in children (USA Today 2017). If this is happening in the US, it is happening in developing world countries, unincorporated low-income rural areas or informal settlements, and refugee camps, affecting millions of people globally. Establishing clean water systems in impoverished landscapes is an integral part of building healthy, resilient, and thriving communities.


## 7.3 NUTRITION

Health and resilience are deeply associated with having a sustainable source of food, income, clean water, stable housing, and having other basic needs met. Globally, around one billion people currently live in slums or informal settlements that lack access to clean water, nutrition, and health services. Migrants make up a large portion of this population, often residing in subpar environments (Unite for Sight 2018). Displaced people are often malnourished and have micronutrient deficiencies due to their uncertain migratory journey and informal, temporary settlements. Malnourished individuals have a higher risk of suffering long-term effects such as impeded growth or development (UNHCR 2019b). Children are the most vulnerable to malnutrition because they are still developing, "There were 74,000 admissions of children to inpatient malnutrition programs in over 70 countries around the world" (Beery 2019).

Non-communicable diseases (NCDs) or chronic diseases are not transmitted from person to person, but can surface in adverse living conditions that many face in developing

countries and migrant camps. Untreated NCDs are often brought on by malnutrition and are responsible for more than 36 million deaths each year, and about 80% of all NCD deaths occur in low and middle-income countries (WHO 2013). Displaced populations are increasing which causes the migratory journey to be especially dangerous because of limited awareness of diseases, limited access to diagnostic testing, and inadequate treatment available to migrant populations.

Many informal settlements and refugee camps lack access to proper nutrient-rich food, leaving people to seek alternative methods of food collection or production. However, agricultural practices are often faced with inconsistent rainfall, lack of clean water sources, unfavorable climate, or are not allowed within some refugee camps. Some people in the camp have developed innovative social mechanisms for obtaining more food. One method is through a process called recycling in which they leave the camp and reenter under a new identity, thereby gaining an extra ration card. Recycling in itself is a dangerous process and also contributes to the presence of a black market in many refugee camps (Unite for Sight 2018).

It is common to find high rates of malnutrition where there is lack of food security. Among the many forms of micronutrient deficiencies in refugee camps, iron deficiency which leads to anemia, and vitamin A deficiency are amongst the most visible forms. Anemia, or low haemoglobin levels affects many pregnant women and leads to fatigue, dizziness, headache, loss of appetite, and numbing of fingers and toes (UNHCR 2008). Vitamin A deficiency affects the eyes, leading to night blindness and xerophthalmia. Foods rich in vitamin A to prevent this include vegetables, pawpaw, and tomatoes. Other common nutrient deficiencies in refugee populations include Vitamin C, protein body-building foods or Protein Energy Malnutrition (P.E.M.), and Iodine deficiency which is known to cause Goiter, and mental impairment known to be critical to school going children (UNHCR 2008). Seeing food security as an issue in many refugee camps, the High

Commissioner for Refugees has put a high priority on improving the nutritional status of refugee populations. The UNHCR and the World Food Programme (WFP) have partnered with organizations in Kenya and Ethiopia to implement Multi-Story Gardens (MSG) in refugee camps. These gardens are part of a food security strategy to support dietary diversity and enhance refugee contributions to their own food consumption. The MSG are particularly indicated for the dry and non-fertile areas where the refugee camps are located and where both the soil quality is not ideal for farming and water quantity inadequate. Issues of water harvesting, pest control, nutrition, meal planning, women's empowerment and the actual construction and maintenance of the multi-storey garden are addressed in the training module (UNHCR 2019c). See Figure 15 to view a MSG.



**Figure 15** Multi-story Gardening (MSG) is a method used to promote good health in refugee camps. In many refugee camps, the climate is unable to produce agriculture, so many turn to MSG to grow their nutrient based foods. California, Kenya, and Ethiopia already use this practice (UNHCR 2008)

With help from the Ministry of Health (MOH), UNICEF, UNHCR, and the World Food Programme, nutrition programs in refugee camps are able to be put in place. These programs include principles and standards for nutrition that provide services for infants,

young children, breastfeeding mothers, and all residents in the camp. Every refugee who is registered with the camp has access to these nutritional programs (UNHCR 2019b). Basic services of care such as nutrition are implemented in refugee camps, making it possible to implement mental health care services as well. Mental health services should be regarded as a standard procedure when caring for displaced people, as they have almost certainly experienced many adversities pre, during, and after their migratory journey.

## 7.4 HOUSING

Living in informal settlements is a health hazard. The majority of displaced people from the Syrian conflict live in squalor conditions, "Ninety percent of Syrian refugees live in urban areas in neighboring countries, often in overcrowded informal settlements and dangerous locations" (USA for UNHCR 2020). Living in informal settlements also increases the risk of contracting Malaria, a Mosquito-borne infectious disease. Some camps give out mosquito nets, but this is not guaranteed. Inadequate housing conditions also attract rodents which increases the risk of Lassa fever (Unite for Sight 2018). Inadequate housing is an important public health issue because it perpetuates the stress and long-term health outcomes faced by displaced populations.

Establishing adequate housing for refugee populations provides them with one of the most fundamental levels of care needed for human growth. American psychologist Abraham Maslow started a new wave in psychology known as Humanistic Psychology, studying individual happiness and growth. This model is a common theory taught in psychology programs around the world and was popularized by Freud and Skinner. Humanistic psychology arose out of the collective PTSD that affected the millions of people following World War Two. His new human-centered approach to psychology

addressed that human beings are driven by different factors at different times in their lives, "These driving forces are hierarchical, in the sense that we generally start at the bottom layer and work our way up" (Personality & Spirituality 2019).

This design is similar to a pyramid concept that displays different levels of human motivation as you move up in stages. The pyramid shows different factors associated with human growth that include biological drives, psychological needs, safety, belonging, and purpose. The bottom, most basic needs are air, water, shelter. If an individual has those needs consistently met, it is hypothesized that they may move up the pyramid and are able to obtain stable employment, healthy relationships, self-esteem, and purpose. However, if the most basic needs like clean water, food, and shelter are not obtained, Maslow hypothesizes that the individual is unable to move up the pyramid. Figure 16 shows Maslow's Hierarchy of Needs.



**Figure 16** The levels of Maslow's Hierarchy of Needs (McLeod 2020)

People who live in informal settlements or refugee camps often lack basic, physiological care. This assertion implies that people who live in conditions that do not meet basic physiological care such as food, water, warmth, and adequate housing will not progress toward self-actualization, therefore never obtaining a sense of love or belonging, healthy sense of self, and life fulfilment (Personality & Spirituality 2019). With limited political support and international funding, entire populations of displaced people without access to mental health care will remain living in a system that perpetuates destitution.

## 7.5 ACCESS TO EDUCATION

Refugee camps were originally meant to be temporary, but for many, the camps become permanent holding areas. The average length of time a person stays in a refugee camp is 18-20 years, or longer depending on their geography. Oftentimes, children are born and raised in refugee camps and globally have disproportionate access to education when compared to non-refugee children; "Only 61 per cent of refugee children attend primary school, compared to 92 per cent of children globally" (UNHCR 2018b).

Because of multiple factors including bullying, poor adaptation planning, and low community support from host communities, many refugee children leave school at a young age. As conflict continues, more refugee children are at risk of discontinuing their education, "The number of out-of-school refugee children has increased by 500,000 in the last year alone. If current trends continue, hundreds of thousands more refugee children will be added to these disturbing statistics unless urgent investment is made" (UNHCR 2018b). According to the UN, "617 million children and adolescents lack minimum proficiency in reading and mathematics" (UN 2019a). Many of these children live in developing world countries, or are displaced due to poor economic or political issues in

their origin country. There are visible differences in children who have access to education when compared to those who do not. Children who have access to education are more likely to train and obtain a skill or occupation that allows them access to stable employment when compared to children who lack access.

According to Save the Children, 171 million people worldwide could be lifted out of poverty through learning basic reading skills. Those with a single year of secondary education receive a .25% increase in wages later in life. Of these 171 million people, 50 million are children and living in conflict affected landscapes and are unable to attend school. In Syria alone, about 4,000 schools have either been destroyed, damaged, or have been occupied by military groups (Save the Children 2021). This places a significant barrier on having regular access to education and perpetuates the cycle of poverty in displaced populations.

According to the UN, the Universal Declaration of Human Rights (UDHR) states in Article 26 that education is a human right:

Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial or religious groups, and shall further the activities of the United Nations for the maintenance of peace. Parents have a prior right to choose the kind of education that shall be given to their children (UN 2019b)

The UN has continuously put in efforts to expand education in many developing countries.

Additionally, the United Nations has seventeen Sustainable Development Goals they plan on implementing to help the world's children develop into healthy and capable adults. Of these seventeen goals, number four is to ensure quality education by practicing inclusive and equitable education and promoting lifelong learning opportunities for all (UN 2019a). Education is a critical goal because it can improve the quality of life for displaced individuals and families. Education can also lead to developing innovative solutions to the world's greatest problems. Filippo Grandi of the UNHCR describes the importance of education, "Education is a way to help children heal, but it is also key to rebuilding their countries. Without education, the future of these children and their communities will be irrevocably damaged" (UNHCR 2018b). This suggests that education can promote resilience in displaced populations.

The Center for Global Development's (CGD) global education program seeks to use education as a social equalizer, educating students about the deep-rooted inequalities among political and social spheres including gender. The CGD's research examines the mechanisms through which education can give children equal life opportunities and build the human capital that nations need to prosper. Africa, a continent that holds many displaced people, is committing to provide free secondary education to more of its countries. However, children from poor, rural communities get educated in substandard schools where they do not acquire basic numeracy and literacy skills, or receive no education at all (UNHCR 2020a). Many youth from Syria fled to Africa for safety after the conflict and will be directly affected by the education system there.

In order to support global education for the youth, there needs to be enough adequately trained teachers who are willing to teach in these landscapes. The UN states, "For quality education to be provided to the children of impoverished families, investment is needed in educational scholarships, teacher training workshops, school building and

improvement of water and electricity access to schools" (UN 2019a). Universities, NGOS, and international organizations can apply for funding to train teachers in workshops and send them to appropriate need-based camps in developing world countries to help educate those who need it the most. Host countries can also work to eliminate barriers that block access to education such as requirements for birth certificates which many leave behind in the wreckage (UNHCR 2018b).

## 7.6 ACCESS TO QUALITY HEALTHCARE

People living in informal settlements, developing world countries, or refugee camps often lack basic services of care such as healthcare, education, and psychological services including mental health care. It is crucial to ensure that standard health care practices are accessible for moving populations, especially since these populations have higher rates of vulnerability than the general public, "Mass population movements can result in high rates of malnutrition, sickness and death" (UNHCR 2019c). Health care services in camps should place access to mental health care as equivalent as standard immunization. Access to immunizations include the availability of the Measles vaccine or MMR vaccine which protects against preventable diseases like measles, mumps, and rubella. Measles is an infectious disease which can be transmitted to others by contaminated airborne airspace by coughing, sneezing, or sharing the same airspace (CDC 2019). Doctors Without Borders or Médecins Sans Frontières (MSF) performed 1.4 million Measles vaccinations in 2018, collaborating with national health systems to ensure efficient, successful health initiatives (Beery 2019).

Displaced populations are at higher risk of being exposed to disease, this is not limited to infectious disease, but also includes disease of the mind. Not unlike water or education, mental health is an issue that should be equally provided for in refugee camps.

A recent report from the UN found an association between mental health disorders and living in conflict zones, "One in five people living in conflict zones suffers from mental health disorders. Treatment for these conditions is a crucial element of comprehensive medical care, and yet it is often forgotten in news coverage, or assumed to be limited to addressing post-traumatic stress disorder" (Beery 2019). The effect of conflicted landscapes leaves lasting effects on these populations without having accessibility to mental health treatment. Mental health care services should be accessible by all people, including moving populations regardless of status or origin. In 2018, members from Doctors Without Borders, performed more than 400,000 mental health consultations in dozens of countries, helping many rebuild and gain agency in their lives (Beery 2019).

Many of these countries do not have the educational systems in place to provide accredited mental health practitioner programs to train people to help others. Post war geographies lack available treatment options for mental health disorders, leaving the population to take it upon themselves to deal with their affected minds. People in some countries such as Syria have a disproportionate disadvantage of receiving care for their illness.

When discussing mental health in Syria, Satoo, a psychiatrist and managing Director of the WHO, states "There are only 2 psychiatrists for almost 4 million people, and only 2 facilities have the capacity to treat people suffering from severe mental health conditions through inpatient care" (WHO 2019a). Expanding training programs is one way to address this specialist gap:

WHO, supported by European Civil Protection and Humanitarian Aid Operations (ECHO), is implementing the Mental Health Gap Action Programme (mhGAP), which is designed to address common mental, neurological and substance abuse

conditions. By training general practitioners to treat mild to moderate mental health conditions, the burden on specialized staff is decreased. Despite his already heavy workload, Dr Satoo is the proud supervisor of 43 mhGAP trainees" (WHO 2019a).

Giving practitioners the tools and spaces to help vulnerable populations address and treat symptoms of mental health disorders can improve the health of displaced populations.

One of these facilities, the Sarmada Mental Health Facility in north-western Syria provides hospitalization for a month that offers therapy, medication, and follow up services for people with various mental health conditions including schizophrenia, bipolar, and psychosis. WHO supports the Sarmada Facility with twenty inpatient beds along with an outpatient clinic that provides approximately 321 mental health consultations per month. The Sarmada Facility can be used as a model of mental health care for displaced populations.

Additionally, one of the biggest limitations in receiving care is the stigma associated with having a mental illness. Receiving family support is vital for a patient's recovery, but also one of the biggest challenges, "There is an element of stigma because no one would dare to admit that their family member suffers from mental health conditions," Satoo says. "Families can get very angry at the patient and the community can expel them. As a result, people postpone or don't seek care. Despite our efforts to break this stigma, a lot of patients go to religious healers rather than a psychiatrist. They tell them they are possessed or under the influence of bad spirits" (WHO 2019a). Raising awareness about mental health is an important step in reducing symptoms of mental health disorders because many people are unaware that they or their families may be living with debilitating symptoms that these kinds of services can help address. Stigma

toward mental health disorders is not just present in post war populations, it is present in developed countries despite having mental health infrastructure. The stigma remains in the community, education systems, and the workforce. Education to address this stigma needs to be put in place if we want to collectively see change, especially in these vulnerable populations.

Improving the quality of education practitioners receive is essential to treating people effectively. It is common to be misdiagnosed by a practitioner. This can happen based on the background of the practitioner who is doing the mental health evaluation, cultural limitations, and the questions they do and do not ask. The questions asked during a mental health evaluation directly affects the diagnosis given to you, many times overlooking the right diagnosis because the right questions were never asked. If the patient is never asked about hallucinations or delusions persisting longer than six months, they will never receive the correct diagnosis of schizophrenia, and will not receive proper care. This is similar to a client who is presenting as depressed but is actually bipolar. If the practitioner never asks about previous manic behavior, the client could receive a wrong diagnosis of depression and be prescribed antidepressants or selective serotonin reuptake inhibitors (SSRIs) without also taking a mood stabilizer which can induce mania in bipolar patients. Often, this mania can result in a psychosis, or loss of reality.

Psychosis can be induced in all people, whether it comes from sleep deprivation, overwhelming stress, drug use, or as a result of medical error on the psychiatrist's side. For many, psychosis starts with mania, but this is not always the case. Mania can appear in many forms and can vary in severity. Some people with bipolar disorder may stay up for days and become out of touch with reality, others may behave in erratic ways; symptoms present themselves differently in each individual. Many people experience these exact mental health symptoms, and may never receive a diagnosis, therefore; never receiving proper treatment. In this way, providing the space for providers to receive better

education regarding diagnostic standards is as essential as providing clean water and nutrition in refugee camps.

Being prescribed the wrong medication that causes unwanted side effects is quite common. Diagnostic and medical errors are the third leading cause of death and are highly under recognized, "Analyzing medical death rate data over an eight-year period, Johns Hopkins patient safety experts have calculated that more than 250,000 deaths per year are due to medical error in the U.S" (Johns Hopkins Medicine 2016). This is higher than respiratory disease, which kills about 150,000 people per year. This is a systemic problem that is perpetuated by poorly coordinated care, fragmented insurance networks, lack of physician accountability, and other factors.

Even if a medication seems to be working, the body can stop responding to medication at any time and may need to be adjusted or tapered off over time. Side effects from medications on the market today are quite common, some complications can even be life threatening. Many receiving SSRIs may experience impulsivity, suicidal ideation (SI), and serotonin syndrome (SS). Symptoms of SS include nausea, vomiting, tremor, excessive sweating, and can lead to a high fever, uneven heartbeat, and even passing out (WebMD 2020). Experiencing these side effects can be prevented if practitioner programs start to take mental health education seriously. Placing quality mental health services as a priority alongside clean water, nutrition, and education in refugee camps is essential and possible, depending on the availability and distribution of resources.

Furthermore, there is an association between antidepressants and REM sleep behavior disorder (RBD), sleep paralysis, and other parasomnias (Kierlin and Littner 2011). Additionally, Venlafaxine (Effexor) is known as a serotonin-norepinephrine reuptake inhibitor (SNRI) drug that is marketed to treat depression. However, if you suddenly stop taking the medication, it is common to experience chronic mood swings,

migraines or *brain zaps*, nightmares, vomiting, and suicidal ideation (NAMI 2020).

In Finland, mental health practitioners prefer the Open Dialogue method of therapy instead of using psychiatry as a starting point. They try to avoid the use of antipsychotic medication and instead try to treat the first episode of psychosis through open dialogue. Practitioners only prescribe sleeping pills temporarily until a proper sleep pattern is in place, since sleep deprivation can trigger psychosis. It is an approach to psychosis that stresses flexibility, rapid response to crisis, family-centered therapy meetings, and individual therapy, "Open dialogue reflects a way of working with networks by encouraging dialogue between the treatment team, the individual and the wider social network" (Lakeman 2014). It has evolved to become part of the integrated service culture.

Open dialogue is used and encouraged with all the family members and two therapists. After listening to everyone, the therapists discuss between themselves why they think the person is having a particular delusion, "Dialogue is a communicative process through which reality is socially constructed and problems are seen as reformulated in every conversation" (Lakeman 2014). Therapists use open dialogue with the family and the individual experiencing psychosis to further discuss causes, triggers, harm reduction, and solution-based thinking. This open dialogue model may show more promise than the typical pharmaceutical approach, "It has, he argued, improved outcomes to the point where at the end of two years, 84 percent of people with first episode psychosis had returned to work or school and only 20 percent were taking anti-psychotic medications. Contentiously, Whitaker also argues that schizophrenia (i.e., symptoms of psychosis lasting longer than six months) is disappearing from the region" (Lakeman 2014). This implies that perhaps immediate intervention of psychosis can be reversed and people can live healthy, productive, and purposeful lives with minimal use of psychotropic medication.

Open dialogue or family therapy works in theory, but many of the people who are affected by mental health disorders struggle with adversity which oftentimes comes

directly from within the family system as was discussed in Chapter 4 by the work of Wolynn and Jacobs. If the family has open communication and they collectively identify a problematic behavior within a family member who may be triggering the psychosis of another, then an intervention can be made to change this behavior. The trigger may appear as verbal, physical, sexual, financial, or gender-based violence. However, if the family is not in a collective agreement and shifts blame of triggers, then healing will not occur, and the pattern will often repeat itself.

For a system of care to work, practitioners must be more culturally aware and diverse, ask the right questions, prescribe the right medication if needed, and help the client receive follow up care and regular treatment if needed. In theory, mental health care is great, but the reality is sloppy, unaccounted for, and disproportionate in who can and cannot receive services of care. However, some studies show that those with mental health disorders such as schizophrenia can heal and live a more *normal* life with support and self-healing, "The findings suggest that in terms of grey matter volume, the brains of schizophrenic patients become more 'normal' the longer that they have the condition" (Nield 2016). However, many people living in developing world countries and camps continue suffering from untreated mental health disorders. Part 2 of this chapter will discuss theoretical contributions and framework behind the work presented in this thesis and the need of addressing mental health care as a priority in displaced populations.

# CONCLUSION

## PART II

## 7.7 THEORETICAL CONTRIBUTIONS: EDUCATIONAL REFORM AND RETHINKING MENTAL HEALTH DISORDERS

The work in this thesis parallels themes similar to the work of Rachel Pain, Kate Coddington, Bessel van der Kolk, and many other contributors who have devoted their careers to researching traumatic landscapes and human health. Chapter 4 discussed Jacobs' theory of generational trauma being transmitted in the family system, which also helped to sculpt this research (Jacobs 2016 13). Nadine Burke Harris and her discussions on adversity have also played a contributing role in this analysis of the effect of displacement on mental health. Many disciplines have supported the theoretical model suggesting a relationship between childhood adversity and mental health decline, suggesting that the more adversity a child faces, the more their life will be disrupted and growth will be hindered.

New research in Evolutionary Anthropology supports the belief that what we know as mental health disorders, are actually responses to adversity. This theory supports the assertion that adversity experienced among the migratory journey can lead to depression, anxiety, and PTSD. However, the contemporary method of simply treating mental health disorders with pharmaceuticals has its limitations:

[Syme] Compares treating anxiety, depression or PTSD with antidepressants to medicating someone for a broken bone without setting the bone itself. She believes that these problems look more like sociocultural phenomena, so the solution is not

necessarily fixing a dysfunction in the person's brain but fixing dysfunctions in the social world (Escalante 2020).

Medication alone does not solve the real horrors that displaced populations face such as losing family, crossing oceans, and risking their lives. Real reform must occur and asylum policies need to change and be more humane if we want to promote resilience in displaced populations.

Asylum policies need to incorporate all displaced people and allow them opportunities, or they will continuously live in destitution. In addition to changing asylum policies, our view of these disorders needs to change as well. When we view attention deficit hyperactivity disorder (ADHD) and other diagnoses as a disorder, we fail to see individuals as highly motivated and skilled people, who just lack the opportunity to advance. The study discusses how ADHD can be seen not as a disorder, but as a mismatch in the human environment. Contemporary education models designed to enhance learning for students with ADHD and other diagnoses can be used as a template for improving education for displaced people through reformed asylum policies.

Hagan discusses how education is a fairly new trend in our evolutionary history and is a limiting space for people with ADHD, "There is little in our evolutionary history that accounts for children sitting at desks quietly while watching a teacher do math equations at a board." The study continues, "If ADHD is not a disorder, but a mismatch with a human environment, then suddenly it's not a medical issue. It's an issue for educational reform" (Escalante 2020). The study suggests placing reforms in schools to better shape students with diagnoses' educational success.

Children with ADHD repeatedly get reminded that they are not good at school assignments, and as a result, may not feel good about themselves, directly affecting their self-esteem and feelings of self-worth. It is not the diagnosis that makes them not feel

good enough, it is how they are treated while having the diagnosis and the stigma associated with it. Finland has a role model policy for their educational system where substantial physical activity is part of the school day, and rates of ADHD are very low. Meanwhile, in the U.S. children are asked to sit still for the majority of the day. Elementary school students often get only 15-20 minutes of recess a day, a far cry from the 60-90 minutes their parents had, "Given the evidence that kids' focus and cognition are improved by physical activity" (Escalante 2020), it is not surprising that ADHD rates in the U.S. have gone up over the last 15 years. The article stresses that treatments should not suddenly stop, but instead explore new ways of studying these conditions, "Research on depression, anxiety, and PTSD, should put greater emphasis on mitigating conflict and adversity and less on manipulating brain chemistry" (Escalante 2020). A dangerous and non-emotionally validating asylum system can perpetuate symptoms of mental health disorders and may lead to a loss of reality, or psychosis. When psychosis presents longer than six months, a schizophrenia diagnosis is given.

## 7.8 REFLECTIONS ON THE PROJECT

At the start of my research, I believed mental health disorders were more prominent in certain geographical regions than others. What I found was a severe limitation of mental health care systems in place globally, directly skewing the available data of those suffering from mental health disorders. Seeing a country having low rates of mental illness does not mean the population does not suffer, it may mean that many of these people are suffering invisibly and are unaccounted for in the global statistics.

Many of the nations where people migrate from do not have a system in place to treat mental illness, leaving the data on mental health disorders with severe limitations, neglecting millions of people's mental health. Mental health disorders can happen to

anyone, any gender, any socioeconomic status, and from any country. Adversity and a lack of support system are two of the major risk factors when assessing mental health disorders. Adversity can happen in the household where domestic violence occurs regularly. This violence includes verbal, psychological, physical, sexual, gender-based, or financial abuse. It can also occur on a larger scale such as fleeing an active war zone, extreme poverty and destitution, famine, or genocide which can all increase an individual's chance of developing a mental health disorder.

## 7.9 FUTURE RESEARCH DIRECTIONS

The future of immigration policy is bleak if no reform is made. Families separated at the border and put in detention facilities exacerbates the families' stress and leaves them susceptible to developing mental health disorders and other health complications. A preventative measure in immigration policy is meeting all migrant populations' most basic, human needs such as clean water, nutrition, stable housing, and access to healthcare and education. Family status is a major factor associated with immigrants' mental health. Immigrants' mental health is compromised when the individual is separated from their family whether it is in detention, a kidnapping, or other forms of separation during displacement. Many Yazidis from northern Afghanistan remain missing and are at risk for developing mental health disorders rooted from their time in captivity by ISIS, "There are about 3,000 Yazidis who are unaccounted for, their family not knowing if they are alive" (The Washington Post 2019a).

Temporary status is a major stressor among displaced populations, as spatial stabilization leads to mental stabilization. Those who receive temporary status are often uncertain of their futures and are unsure if they should ever really settle down and make connections to their new landscape. Many young refugees struggle with this phenomenon

when they seek asylum in new countries. The country may host them until they become

adults at the age of eighteen, but then have the right to deport the displaced youth. These

factors exacerbate stress for displaced people during their migratory journey.

## 7.10 BORDER REFORM & CONCLUDING THOUGHTS

The start of reform would be to use an alternative approach to family separation

and detention at the border. Separation and detention are especially difficult for children

who are left traumatized by the events they witness while in detention, like self-harming

behaviors among other detained people. Separating families is inhumane, unethical, and

a method the US uses to deter people from seeking asylum at the border. There is a

growing area of study on using alternatives to detention at the border as a hope to make

borders more humane and to prevent further adversity toward displaced people.

Urban scholar Larry Herzog envisions that the future of the US and Mexican border

can potentially become a space that resembles an airport. He uses this metaphor to

describe that it is possible to have a visually appealing place that also has high level

security. He uses the metaphor of the airport to show that it is a functional, yet safe place

that people are generally comfortable in. Even the layout of the airport with many shops

and food options can make it more friendly and comfortable. He mentions how border

security is quite the opposite: a hindering place made of concrete, a criminalizing space.

What Herzog meant by his airport metaphor is that if border security were designed to be

more inviting, it would foster a better relationship between the two countries and can be

used as a model for other major borders around the world (Herzog 2015).

Circling back to the main theme of this research, the mental health of displaced

people was impacted by experiencing traumatic landscapes, exacerbated by the

continuous stress accrued during and after the migratory journey. This thesis indicated

that refugees are more likely to experience adversities that can lead to issues with mental health and development. Refugees are also likely to continue to experience the effects of adversity even after they resettle in a new landscape, as they must start new lives, obtain work, and acculturate themselves within the new landscape. This is challenging to do if your family has been separated from you, has temporary status and fear of being deported, is unable to work due to political restrictions, and lacks community support. These are the main challenges associated with displacement that have appeared throughout writing this thesis.

People who are exposed to violent geographies are more likely to experience mental health disorders when compared to unaffected populations. The mental health of displaced people is deteriorating as their basic needs continuously fail to be met. These needs include family reunification, steady housing, education, employment, healthcare, and support from their community. Providing basic systems of care can help promote growth and resiliency in migrants' mental health. When basic systems of care are not provided, the individual will be more likely to perpetuate the cycle of poverty, destitution, and hopelessness.

This thesis showed the association between conflicted landscapes and mental health disorders prevalent among displaced populations. Studies across interdisciplinary fields share a mutual belief that treating displaced people with basic systems of care has been shown to increase resilience in migrating populations. The Center on the Developing Child at Harvard University supports this claim:

The most effective prevention of adulthood mental illness is to reduce exposure of extremely stressful conditions, such as lack of access to adequate nutrition and clean water, recurrent abuse, chronic neglect, caregiver mental illness or substance abuse, and/or violence or repeated conflict. Research shows that, even

under stressful conditions, supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response (Harvard 2021).

These conditions are prevalent among displaced populations. Expanding the systems of care in post-war landscapes can help mitigate some of the symptoms associated with toxic stress and help populations remain resilient among developing symptoms of mental health disorders.

All people need basic systems of care to remain resilient through the challenges of their migratory journey. Whether speaking of undocumented immigrants, refugees, economic migrants, all people deserve basic care in the form of clean water, nutritious food, mental health services, housing, and a safe landscape. When all of these physiological and psychosocial needs are met, then displaced populations will be more resilient in their new landscape and have a lower risk of developing a mental health disorder. However, if the community and state fail to meet basic care standards toward migrant populations, immigrants will be less likely to thrive in their new landscape and may suffer mental health decline.

The majority of migrants will remain in refugee camps, informal settlements, or resettle in a neighboring country that may lack these basic forms of care. The state has not implemented enough preventative measures in place to help migrating populations become resilient. Many of these impoverished places lack international support and political will. However, there are some NGOs that offer humanitarian aid services. These organizations include the Red Cross, Save the Children, Doctors Without Borders, and the UNHCR who have been directly working with refugees in these camps.

Planning for a humane, sustainable refugee policy will need support from other nations, discussion regarding responsibility sharing, and educating receiving nations on

the impact and association between geopolitical conflict and the effect it has on millions of displaced people. When populations flee conflict, their main goal is survival. Having stable access to basic systems of care such as potable water and nutrition helps promote mental health clarity and resiliency. Without having their basic needs met, psychological and physical development can exacerbate mental and physical health issues and be transmitted to their closest networks and descendants. Seventeenth century philosopher Benedict Spinoza, who had an influence on Martin-Baró draws upon Stoic doctrines. Spinoza supports the assertion that populations thrive when basic needs are met and suggests that is the future to strive for:

> This is the end I aim at: to acquire knowledge of the union of mind with the whole of nature. . To do this it is necessary first to understand as much as nature as suffices for acquiring such knowledge, and second to form a society of the kind which permits as many as possible to acquire such knowledge. Third, attention must be paid to moral philosophy. . . Fourthly, because health is no small means to achieving this end, the whole of medicine must be worked out. And fifthly . . . because it is possible to gain more free time and convenience in life, mechanics is in no way to be despised" (Ayer et al.1994, 429).

Despite this passage being several hundred years old, the philosophy supporting it can be used when addressing asylum laws. This thesis discussed the effect migration can have on the individual and how humane asylum laws have the power to change millions of displaced peoples' futures.

# APPENDIX

ACE QUESTIONNAIRE. The questionnaire uses a simple 10 question survey inquiring the occurrence of adverse childhood events in one's history. The more adverse events that occurred in childhood, the more likely the individual is to have issues with their physical and mental health in adulthood. Click to view a sample of the ACE Questionnaire:

Finding Your ACE Score.pdf

(The Anna Institute 2020).

https://www.theannainstitute.org/Finding%20Your%20ACE%20Score.pdf

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